ALLINA HEALTH

2024 Benefit Description

Premier Health Savings Plan

Language Access Services

This information is available in other languages. Free language assistance services are available by calling the toll free number below. For TTY, call 711.

Si habla español, tiene a su disposición servicios gratuitos de asistencia con el idioma. Llame al 1-855-903-2583. Para TTY, llame al 711.

Yog tias koj hais lus Hmoob, muaj kev pab txhais lus pub dawb rau koj. Hu rau 1-800-793-6931. Rau TTY, hu rau 711.

Haddii aad ku hadasho Soomaali, adigu waxaad heli kartaa caawimo luqad lacag la'aan ah. Wac 1-866-251-6736. Markay tahay dad maqalku ku adag yahay (TTY), wac 711.

နမ့်ကတိၤကညီကျိာ်ဒီး, တၢ်ကဟ့ၣ်နၤကျိာ်တၢ်မၤစၢၤကလီတဖၣ်နူၣ်လီၤ. ကိး 1-866-251-6744 လၢ TTYအဂီၢ်, ကိး 711 တက့ၢ်.

إذا كنت تتحدث العربية، تتوفر لك خدمات المساعدة اللغوية المجانية. اتصل بالرقم 1-866-569-9123. للهاتف النصي اتصل بالرقم 711.

Nếu quý vị nói Tiếng Việt, có sẵn các dịch vụ hỗ trợ ngôn ngữ miễn phí cho quý vị. Gọi số 1-855-315-4015. Người dùng TTY xin gọi 711.

Afaan Oromoo dubbattu yoo ta'e, tajaajila gargaarsa afaan hiikuu kaffaltii malee. Argachuuf 1-855-315-4016 bilbilaa. TTY dhaaf, 711 bilbilaa.

如果您說中文，我們可以為您提供免費的語言協助服務。請撥打 1-855-315-4017。聽語障專 (TTY)，請撥打 711。

Если Вы говорите по-русски, Вы можете воспользоваться бесплатными услугами переводчика. Звоните 1-855-315-4028. Для использования телефонного аппарата с текстовым выходом звоните 711.

Si vous parlez français, des services d'assistance linguistique sont disponibles gratuitement. Appelez le +1-855-315-4029. Pour les personnes malentendantes, appelez le 711.

አማርኛ የሚናገሩ ከሆነ፣ ነጻ የቋንቋ አገልግሎት እርዳ አለሎት። በ 1-855-315-4030 ይደውሉ ለ TTY በ 711።

한국어를 사용하시는 경우, 무료 언어 지원 서비스가 제공됩니다. 1-855-904-2583 으로 전화하십시오. TTY 사용자는 711 로 전화하십시오.

ຖ້າເຈົ້າເວົ້າພາສາລາວໄດ້, ມີການບໍລິການຊ່ອຍເຫຼືອພາສາໃຫ້ເຈົ້າຟຣີ. ໃຫ້ໂທຫາ 1-866-356-2423 ສຳລັບ. TTY, ໃຫ້ໂທຫາ 711.

Kung nagsasalita kayo ng Tagalog, mayroon kayong magagamit na libreng tulong na mga serbisyo sa wika. Tumawag sa 1-866-537-7720. Para sa TTY, tumawag sa 711.

Wenn Sie Deutsch sprechen, steht Ihnen fremdsprachliche Unterstützung zur Verfügung. Wählen Sie 1-866-289-7402. Für TTY wählen Sie 711.

ប្រសិនបើអ្នកនិយាយភាសាខ្មែរមន អ្នកអាចរកបានសេវាជំនួយភាសាឥតគិតថ្លៃ។ ទូរស័ព្ទមកលេខ 1-855-906-2583។ សម្រាប់ TTY សូមទូរស័ព្ទមកលេខ 711។

Diné k'ehjí yáníłt'i'go saad bee yát'i' éí t'áájíík'e bee níká'a'doowołgo éí ná'ahoot'i'. Kojį éí béésh bee hodíílnih áǫįęęǫíóąǫąęįą. TTY biniiyégo éí íáájį' béésh bee hodíílnih.

Notice of Nondiscrimination Practices

The claims administrator complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or gender. The claims administrator does not exclude people or treat them differently because of race, color, national origin, age, disability, or gender.

The claims administrator provides resources to access information in alternative formats and languages:

- Auxiliary aids and services, such as qualified interpreters and written information available in other formats, are available free of charge to people with disabilities to assist in communicating with the claims administrator.
- Language services, such as qualified interpreters and information written in other languages, are available free of charge to people whose primary language is not English.

If you need these services, contact the claims administrator at 1-800-382-2000 or by using the telephone number on the back of your member identification card. TTY users call 711.

If you believe that the claims administrator has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or gender, you can file a grievance with the Nondiscrimination Civil Rights Coordinator

- by email at: Civil.Rights.Coord@bluecrossmn.com
- by mail at: Nondiscrimination Civil Rights Coordinator
  Blue Cross and Blue Shield of Minnesota and Blue Plus
  M495
  PO Box 64560
  Eagan, MN 55164-0560
- or by telephone at: 1-800-509-5312

Grievance forms are available by contacting the claims administrator at the contacts listed above, by calling 1-800-382-2000 or by using the telephone number on the back of your member identification card. TTY users call 711. If you need help filing a grievance, assistance is available by contacting the claims administrator at the numbers listed above.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights

- electronically through the Office for Civil Rights Complaint Portal, available at:
  ocrportal.hhs.gov/ocr/portal/lobby.jsf
- by telephone at:
  1-800-368-1019 or 1-800-537-7697 (TDD)
- or by mail at:
  U.S. Department of Health and Human Services
  200 Independence Avenue SW
  Room 509F
  HHH Building
  Washington, DC 20201

Complaint forms are available at hhs.gov/ocr/office/file/index.html.

Customer Service

Blue Cross Blue Shield of Minnesota Questions?	The claims administrator's customer service staff is available to answer your questions about your coverage and direct your calls for prior authorization, preadmission notification, preadmission certification, and emergency admission notification. Customer service staff will provide interpreter services to assist you if needed. This includes spoken language and hearing interpreters. Monday through Friday: 7am - 8pm United States Central Time Hours are subject to change without prior notice.
Blue Cross Blue Shield of Minnesota Customer Service Telephone Number	Claims administrator: (651) 662-5859 or toll-free 1-800-509-5310, select prompt 1
Blue Cross Blue Shield of Minnesota Website	www.bluecrossmn.com/allinahealth
Medical Claims Administrator's Mailing Address	Claims review requests, and written inquiries may be mailed to the address below: Blue Cross and Blue Shield of Minnesota P.O. Box 64338 St. Paul, MN 55164 Prior authorization requests should be mailed to the following address: Blue Cross and Blue Shield of Minnesota Utilization Management Department P.O. Box 64265 St. Paul, MN 55164
Stop-Smoking Support	Stop-Smoking Support is a telephone-based service designed to help you quit using tobacco your way and at your pace. To participate, call the support line at 1-888-662-BLUE (2583) or enroll at bluecrossmn.com, the member center at the claims administrator's website. A Quit Coach will work with you one-on-one to develop a personalized quitting plan that addresses your specific concerns. You will receive written materials and personalized help for up to 12 months.
Express Scripts Questions?	Express Scripts customer service representatives are available 24 hours a day, 7 days a week, to answer questions about your prescription drug coverage, claims as well as help you find a pharmacy.
Express Scripts Customer Service Telephone Number	Toll-free 1-800-509-5310, select prompt 2
Express Scripts Website	www.express-scripts.com/allinahealth

Pharmacy Claims Administrator's Mailing Address	Written claims for reimbursement should be submitted to: Express Scripts, Inc. Attn: Commercial Claims P.O. Box 14711 Lexington, KY 40512-4711 Written clinical appeals should be mailed to the address below: Express Scripts, Inc. Attn: Clinical Appeals Department P.O. Box 66588 St. Louis, MO 63166-6588 Written administrative appeals should be mailed to the address below: Express Scripts, Inc. Attn: Clinical Appeals Department P.O. Box 66588 St. Louis, MO 63166-6588
HelpCare Advisor Program Questions?	With the HelpCare Advisor program, you will have access to registered nurses, 24 hours a day, 7 days a week, who can help assist you with clinical triage, condition education, symptom support and disease case management. These advisors will also support you in navigating care.
HelpCare Advisor Program Customer Service Telephone Number	Toll-free 1-800-509-5310, select prompt 3

Table of Contents

Language Access Services i

Notice of Nondiscrimination Practices ii

Benefit Overview 2
- Your Benefits 2
- Benefit Period 2
- Networks 2
- General Provisions 2

Benefit Chart 4
- Benefit Descriptions 4
- Ambulance 5
- Bariatric Surgery 7
- Behavioral Health Mental Health Care 8
- Behavioral Health Substance Use Care 11
- Chiropractic Care 13
- Dental Care 14
- Emergency Care 16
- Gender Affirming Care 17
- Home Health Care 18
- Hospice Care 20
- Hospital Inpatient Care 21
- Hospital Outpatient Care 23
- Infusion Therapy 25
- Maternity Care 26
- Medical Equipment and Supplies 28
- Office Visit and Professional Services 30
- Physical, Occupational, and Speech Therapy 35
- Preventive Care 37
- Reconstructive Surgery 39
- Skilled Nursing Facility Care 40

General Exclusions 42

Health Care Management 46
- Medical and Behavioral Health Care Management 46
  - Prior Authorization 46
  - Admission Notifications 47
  - Medical and Behavioral Health Care Management Overview 47

How Your Program Works 49
- Out-of-area Care 49
- General Provider Payment Methods 49
  - Participating Providers 49
  - Nonparticipating Providers 51
- Women's Health and Cancer Rights Act 52
- Coverage of Health Care Services on the Basis of Gender 52
- Inter-Plan Arrangements 53
  - Out-of-area Services 53
  - Plan Arrangements 53
- Inter-Plan Arrangements Eligibility – Claim Types 53
- BlueCard® Program 53
- Special Cases: Value-Based Programs 53
- Inter-Plan Programs: Federal/State Taxes/Surcharges/Fees 54
- Nonparticipating Providers Outside the Claims Administrator's Service Area 54

BlueCross Blue Shield Global® Core 54
Out-of-country Benefits 54
Your Provider Network 55
How to Get Your Physicians' Professional Qualifications 55
Continuity of Care 55
Time Periods 59
Funding 59
Controlling Law 59
Fraudulent Practices 59
Charges that Are Your Responsibility 59
COORDINATION OF BENEFITS 62
Definitions 62
Order of Benefits Rules 62
Effect on Benefits of This Health plan 63
Right to Receive and Release Needed Information 63
Facility 63
Reimbursement and Subrogation 64

How to File a Claim 68
Type of Claims 68
Pre-Service Claim 68
Urgent Care Claim 68
Concurrent Care Claim 69
Post-Service Claim 69
Change in Claim Type 69
Filing Claims 69
Urgent Care Claims 69
Pre-Service Claims 69
Post-Service Claims 69
Incorrectly Filed Claims 69
Timeframes for Deciding Claims 70
Urgent Care Claims 70
Pre-Service Claims 70
Concurrent Care Extension Request 70
Concurrent Care Reduction or Early Termination 70
Post-Service Claims 70
Extensions of Time 70
Incomplete Claims 70
Notification of Initial Benefit Decision 71
Right of Examination 71
Appeals of Adverse Benefit Determinations 71
Appeal Procedures 71
Filing Appeals 72
Urgent Care Appeals 72
Timeframes for Deciding Appeals 72
Urgent Care Claims 72
Pre-Service Claims 72
Post-Service Claims 72
Concurrent Care Claims 72

Appeal Process 73
Notification of Appeal Decision 73
Voluntary Appeals 73
External Review 73
Standard External Review 73
Expedited External Review 74
General Rules 74
Additional Provisions 75

Authorized Representative 75
Claims Payment 75
No Third Party Beneficiaries 76
Release of Records 76
Right of Examination 76

Employee Retirement Income Security Act (ERISA) Statement of Rights 77

Terms You Should Know 78

Prescription Drug Appendix 89

Fertility Benefit Appendix 104

INTRODUCTION

This Document contains a summary of the Allina Premier Health Savings Account (HSA) Medical and Prescription Drug plan (called the “plan” in this document) effective January 1, 2024. The plan is a component of the Allina Health Comprehensive Welfare Benefit Plan.

Coverage under this plan for eligible employees and dependents will begin as defined in the Allina Health Eligibility & Enrollment Booklet, which, along with this document, is the Summary Plan Description (“SPD”) for your coverage.

All coverage for dependents and all references to dependents in this SPD are inapplicable for employee-only coverage.

This plan, financed and administered by Allina Health, is a self-insured medical plan. Blue Cross and Blue Shield of Minnesota (Blue Cross) is the medical claims administrator and provides medical administrative services only. Express Scripts, Inc. is the pharmacy claims administrator and provides prescription drug administrative services only. The claims administrators do not assume any financial risk or obligation with respect to claims. Payment of benefits is subject to all terms and conditions of this SPD, including medical necessity. The eligibility and enrollment rules and other important rights you have as a participant in this Medical and Prescription Drug plan Option are contained in a separate booklet entitled “Allina Health Eligibility & Enrollment Booklet.” To fully understand our benefits, you must carefully review this Benefit Description together with the Allina Health Eligibility & Enrollment Booklet.

Your Benefits

This SPD outlines the coverage under this plan. Please be certain to check the Benefit Overview section to identify covered benefits. You must also refer to the General Exclusions section to determine if services are not covered. The Terms You Should Know section defines terms used in this SPD. All services must be medically necessary to be covered, and even though certain non-covered services may be medically necessary, there is no coverage for them. If you have questions, call Customer Service using the telephone number on the back of your ID card. Providers are not beneficiaries under this plan.

IMPORTANT! When receiving care, present your identification (ID) card to the provider who is rendering the services. If you have questions about your coverage, please contact the claims administrator at the address or telephone numbers listed on your ID card.

Benefit Overview

Your Benefits

This benefit booklet outlines the general coverage under this plan. Please be certain to check the "Benefit Chart" section to identify specifically covered benefits. All services must be medically necessary and appropriate to be covered.

Please also review the "Not Covered" sections of the Benefit Chart and "General Exclusions" to determine services that are not covered. Some services and supplies are not covered, even if a provider considers them to be medically necessary and appropriate.

The "Terms You Should Know" section defines terms used in this benefit booklet. If you have questions, contact customer service using the telephone number listed on the back of your member ID card.

Note: Certain benefits may be subject to day, visit, and/or hour limits. In connection with such benefits, all services you receive during your covered calendar year will reduce the remaining number of days, visits, and/or hours available under that benefit, regardless of whether you have satisfied your deductible.

Benefit Period

Your health plan's benefit period is based on a calendar year. The calendar year is January 1 to December 31.

During this time, charges for covered services must be incurred in order to be eligible for payment by the plan. A charge shall be considered incurred on the date you receive the service or supply for which the charge is made.

Networks	
Your online provider directory lists in-network providers in our service area and may change from time to time, including as providers or the claims administrator initiate or terminate network contracts. Prior to receiving services, it is recommended that you verify your provider's network status with the claims administrator, including whether the provider is in-network for your particular plan. Not every provider is in-network for every plan. For a list of providers in the directory, visit www.bluecrossmn.com/allinahealth ("Member Sign in" then "Find a Doctor") or contact customer service at the telephone number listed on your member ID card.	
• Participating in-network providers - medical • Allina Elevate Network Providers (All Allina Health and a few network partners)	Please note that there is no coverage for services received from out-of-network providers except for medical emergency care (where it is covered at the in-network level), for urgent care (where it is covered at the out-of-network level), or as approved through the plan's referral process (where it is covered at the in-network level of benefits). Referral network services – only when the covered services to which you need access cannot be provided by an in-network provider, and it is recommended by the Allina Health Network Deficiency Team or decided by the claims administrator through the claim and appeal procedures that it is medically necessary for you to obtain covered services from an out-of-network provider, then covered services can be obtained at in-network rates from a referral network provider, which is a provider with a contract with Blue Cross. Refer to the description of referral network providers in the "Referral Claim Procedures" section.

General Provisions

Benefits	Allina Elevate Network Providers	Out-of-network Urgent Care Providers
Deductible including pharmacy • Individual • Family	 You pay $2,000 You pay $4,000	 You pay $2,500 You pay $5,000
Deductible - Non-embedded If you have other family members on the plan, the overall family deductible must be met before the plan begins to pay. The individual deductible applies to individual coverage only.		
Amounts accumulated toward the in-network deductible do not accumulate toward the out-of-network deductible. When the in-network deductible is satisfied, covered services from in-network providers will be paid at the covered percentage. Amounts accumulated toward the out-of-network deductible do not accumulate toward the in-network deductible. When the out-of-network deductible is satisfied, covered services from all out-of-network urgent care providers will be paid at the covered percentage.		
Coinsurance	Generally, you pay nothing after deductible for the remainder of the calendar year	Generally, you pay nothing after deductible for the remainder of the calendar year
Out-of-pocket Limits - eligible medical services including pharmacy • Individual • Family	 You pay $2,000 You pay $4,000	 You pay $2,500 You pay $5,000
Out-of-pocket Limit - Non-embedded If you have other family members on the plan, the overall family out-of-pocket limit must be met. The individual out-of-pocket limit applies to individual coverage only.		
Lifetime Maximum (per person) • Palliative Care • Total benefits paid to all providers combined	 $4,000 Not applicable	

Benefit Chart

The health plan provides coverage of benefits for the following services you receive from a provider when such services are determined to be medically necessary and appropriate. All benefit limits, deductibles and copays amounts are described in "Benefit Overview." In-network care is generally covered at a higher level of benefits than out-of-network care.

Except as specifically provided in the health plan or as mandated or required to be provided based on federal law, no benefits will be provided for services, supplies, prescription drugs, or charges that are noted under “Not Covered” in the benefit charts or in the “General Exclusions.”

Prior authorization, admission notification, emergency admission notification, and continued stay approvals are required for specific services. Please refer to "Health Care Management." You are required to obtain prior authorization and continued stay approvals for specific services when you use nonparticipating providers in Minnesota and any provider outside of Minnesota. For more information, please call customer service at the telephone number listed on the back of your member ID card.

Benefit Descriptions

Please refer to the following pages for a more detailed description of benefits.

Ambulance

The Plan Covers:	In-network Providers	Out-of-network Providers
• Medically necessary and appropriate air or ground ambulance transportation licensed to provide basic or advanced life support from the place of departure to the nearest medical facility equipped to treat the medical emergency	You pay nothing after deductible	Same as in-network services
• Medically necessary and appropriate air or ground ambulance transportation licensed to provide basic or advanced life support from the place of departure to the nearest medical facility equipped to treat a non-medical emergency	You pay nothing after deductible	Same as in-network services

Ambulance – Notes

1. Ambulance service providing transportation by means of a specially designed and equipped vehicle used only for transporting the sick and injured:
   a. from your home, the scene of an accident or medical emergency to a hospital or skilled nursing facility provider;
   b. between hospitals; or

   between a hospital and a skilled nursing facility provider; when such facility provider is the closest institution that can provide covered services appropriate for your condition. If there is no facility provider in the local area that can provide covered services appropriate for your condition, then ambulance service means transportation to the closest facility provider outside the local area that can provide the necessary service.
2. Transportation and related emergency service provided by an ambulance service will be considered emergency ambulance service if the injury or condition is considered medical emergency care. Use of an ambulance as transportation to an emergency room for an injury or condition that is not considered medical emergency care will not be covered as medical emergency ambulance service. Please refer to "Terms You Should Know" for a definition of medical emergency.
3. Benefits include non-emergency medically necessary and appropriate prearranged or scheduled ambulance service requested by an attending physician or nurse from the place of departure to the closest facility provider that can provide the necessary service.
4. Medical emergency services and other ambulance services are subject to the No Surprises Act.

Ambulance – Not Covered

1. Non-emergency ambulance services.
2. Ambulance transportation costs that exceed the allowable cost applicable to transport from the place of departure to the nearest medical facility capable of treating your condition (example: facility A is the closest medical facility capable of treating your condition but you are transported to facility B. The plan will cover eligible medically necessary and appropriate ambulance transportation costs that would otherwise apply to transportation to facility A. If you are transported by ambulance to facility B, the cost of transportation service in excess of the eligible ambulance transportation costs that would otherwise apply to transportation to facility A are not covered under the plan, and you will be responsible for those costs).
3. Travel, transportation, or living expenses, whether or not recommended by a physician, except as provided herein.
4. Ambulance transportation services that are not medically necessary and appropriate for basic or advanced life support.
5. Transportation services, including ambulance services that are mainly for your convenience.

Ambulance – Not Covered
6. Transportation to a residence. 7. Conventional air services, such as commercial airlines.

Bariatric Surgery

The Plan Covers:	In-network Providers	Out-of-network Providers
• Medically necessary and appropriate inpatient hospital/facility services for bariatric surgery from admission to discharge: ▪ room and board and general nursing care ▪ intensive care and other special care units ▪ operating, recovery, and treatment rooms ▪ anesthesia ▪ prescription drugs and supplies used during a covered hospital stay ▪ laboratory and diagnostic imaging • Medically necessary and appropriate outpatient hospital/facility services for bariatric surgery: ▪ scheduled bariatric surgery/anesthesia ▪ laboratory and diagnostic imaging ▪ all other eligible outpatient hospital care related to the scheduled bariatric surgery provided on the day of surgery	**Eligible members, regardless of age:** You pay nothing after deductible when you use **Allina Designated Bariatric Network Provider**	NO COVERAGE

Bariatric Surgery – Notes
1. For professional services related to eligible bariatric surgery services, refer to Office Visit and Professional Services.
2. Outpatient hospital/facilities include designated freestanding ambulatory surgical centers.

Bariatric Surgery – Not Covered
1. Services you receive from an out-of-network provider.

Behavioral Health Mental Health Care

Your mental health is just as important as your physical health. That is why your health plan provides professional, confidential mental health care that addresses your individual needs. You have access to a wide range of mental health and substance use disorder professional providers, so you can get the appropriate level of responsive, confidential care.

The Plan Covers:	In-network Providers	Out-of-network Providers
• Outpatient health care professional services including: ▪ office visit ▪ telehealth services ▪ individual/group/family therapy (office/in-home mental health services)	You pay nothing after deductible	NO COVERAGE
▪ all other professional services in an office or clinic ▪ assessment and diagnostic services such as psychological/neuropsychological testing and evaluation	You pay nothing after deductible	NO COVERAGE
▪ all other professional services in an outpatient hospital/facility ▪ assessment and diagnostic services such as psychological/neuropsychological testing and evaluation	You pay nothing after deductible	NO COVERAGE
• Outpatient hospital/outpatient behavioral health treatment facility services including: ▪ assessment and diagnostic services ▪ individual/group therapy ▪ crisis evaluations ▪ observation beds ▪ family therapy	You pay nothing after deductible	NO COVERAGE
• Professional health care services including: ▪ clinic-based partial programs ▪ clinic-based day treatment ▪ clinic-based Intensive Outpatient Programs (IOP)	You pay nothing after deductible	NO COVERAGE
• Facility health services including: ▪ hospital-based partial programs ▪ hospital-based day treatment ▪ hospital-based Intensive Outpatient Programs (IOP)	You pay nothing after deductible	NO COVERAGE
• Inpatient health care professional services including: ▪ individual psychotherapy ▪ group psychotherapy ▪ psychological testing ▪ counseling with family members to assist in your diagnosis and treatment	You pay nothing after deductible	NO COVERAGE

The Plan Covers:	In-network Providers	Out-of-network Providers
• Inpatient hospital/residential behavioral health treatment facility services including: ▪ all eligible inpatient services ▪ emergency holds	You pay nothing after deductible	NO COVERAGE

Behavioral Health Mental Health Care – Notes

1. Office visits may include medical history; medical examination; medical decision making; testing; counseling; coordination of care; nature of presenting problem; physician time; or psychotherapy.
2. Court-ordered treatment for mental health care that is based on an evaluation and recommendation for such treatment or services by a licensed psychiatrist or a doctoral level licensed psychologist, is deemed medically necessary and appropriate.
3. Court-ordered treatment for mental health care that is not based on an evaluation and recommendation as described above will be evaluated to determine medical necessity and appropriateness. Court-ordered treatment that does not meet the criteria above will be covered if it is determined to be medically necessary and appropriate and otherwise covered under this health plan.
4. Outpatient family therapy is covered if rendered by a health care professional and the identified patient must be a covered member. The family therapy services must be for the treatment of a behavioral health diagnosis.
5. For home health related services, please refer to "Home Health Care."
6. For laboratory and diagnostic imaging services billed by a health care professional, please refer to "Office Visit and Professional Services." For laboratory and diagnostic imaging services billed by a facility, please refer to "Hospital Inpatient Care" or "Hospital Outpatient Care."
7. Coverage is provided for crisis evaluations delivered by mobile crisis units.
8. Inpatient facility service and inpatient medical benefits (except room and board) provided by a facility provider or professional provider as previously described, are also available when you are an outpatient.
9. Admissions that qualify as "emergency holds," as the term is defined in Minnesota statutes, are considered medically necessary and appropriate for the entire hold.
10. Benefits are only available for mental health care services provided on a partial hospitalization basis when received through a partial hospitalization program. A mental health care service provided on a partial hospitalization basis will be deemed an outpatient care visit and is subject to any outpatient care cost-sharing amounts.
11. Coverage is provided for inpatient care and outpatient care for the treatment of mental illness. A mental illness service provided on a partial hospitalization basis will be deemed to be an outpatient care visit subject to any outpatient care cost-sharing amounts.
12. Based on the federal Mental Health Parity and Addiction Equity Act, members have the right to parity in mental health and substance use disorder treatment. Generally, this law provides that:
    a. mental health and substance use disorder services are to be covered on the same basis as similar medical services;
    b. cost-sharing for mental health and substance use disorder services can be no more restrictive than cost-sharing for similar medical services; and
    c. treatment restrictions and limitations such as prior authorization and medical necessity can be no more restrictive than for similar medical services.
13. Coverage is provided on the same basis as other benefits for treatment of emotionally disabled dependent children in a licensed residential behavioral health treatment facility. "Emotionally disabled child" shall have the meaning set forth by the Minnesota Commissioner of Human services in the rules relating to residential treatment facilities.
14. The plan covers telehealth services.

Behavioral Health Mental Health Care – Notes
15. Coverage is provided for treatment for pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections (PANDAS) and for treatment for pediatric acute-onset neuropsychiatric syndrome (PANS). Treatments must be recommended by your physician and include, but are not limited to: antibiotics, medication and behavioral therapies to manage neuropsychiatric symptoms, plasma exchange, and immunoglobulin.
16. Benefits are provided for intensive behavioral therapy programs including, but not limited to: Early Intensive Behavioral Intervention (EIBI), Applied Behavioral Analysis (ABA), Intensive Behavioral Intervention (IBI), and Lovaas Therapy for the treatment of autism spectrum disorders, which are any of the pervasive developmental disorders defined by the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, or its successor.
17. Coverage is provided for outpatient Certified Peer Specialist and Certified Family Specialist services (otherwise known as peer support services).

Behavioral Health Mental Health Care – Not Covered
1. Services related to mental illness not listed in the most recent editions of the *International Classification of Diseases (ICD)* and *Diagnostic and Statistical Manual for Mental Disorders (DSM).*
2. Custodial care.
3. Evaluations that are not performed for the purpose of diagnosing or treating mental health or substance use disorder conditions such as: custody evaluations; parenting assessments; educational classes for Driving Under the Influence (DUI) or Driving While Intoxicated (DWI) offences; competency evaluations; adoption home status; parental competency; and domestic violence programs.
4. Services or room and board for foster care, group homes, shelter care and lodging programs, and halfway house services.
5. Services for skills training.
6. Services for or related to marriage/couples counseling.
7. Services primarily educational in nature, except nutritional education for individuals diagnosed with anorexia nervosa, bulimia or eating disorders not otherwise specified (NOS) and except as provided herein.
8. Services for or related to therapeutic support of foster care (services designed to enable the foster family to provide a therapeutic family environment for support for the foster child’s improved functioning).
9. Educational services for the treatment of learning disabilities.
10. Services for therapeutic day care and therapeutic camp services.

Behavioral Health Substance Use Care

The Plan Covers:	In-network Providers	Out-of-network Providers
• Outpatient health care professional services including: ▪ office visit ▪ telehealth services ▪ individual/group/family therapy	You pay nothing after deductible	NO COVERAGE
▪ all other professional services in an office or clinic ▪ assessment and diagnostic services ▪ opioid treatment, including Medication Assisted Treatment (MAT)	You pay nothing after deductible	NO COVERAGE
▪ all other professional services in an outpatient hospital/facility ▪ assessment and diagnostic services ▪ opioid treatment, including Medication Assisted Treatment (MAT)	You pay nothing after deductible	NO COVERAGE
• Outpatient hospital/outpatient behavioral health treatment facility services including: ▪ Intensive Outpatient Programs (IOP) and related aftercare services ▪ partial hospitalization	You pay nothing after deductible	NO COVERAGE
• Inpatient health care professional services	You pay nothing after deductible	NO COVERAGE
• Inpatient hospital/facility services • Residential behavioral health treatment facility services	You pay nothing after deductible	NO COVERAGE

Behavioral Health Substance Use Care – Notes

1. Office visits may include medical history; medical examination; medical decision making; testing; counseling; coordination of care; nature of presenting problem; physician time; or psychotherapy.
2. Outpatient family therapy is covered if rendered by a health care professional, and the identified patient must be a covered member. The family therapy services must be for the treatment of a behavioral health diagnosis.
3. Benefits provided for individual and group counseling and psychotherapy, psychological testing, and family counseling for the treatment of substance use disorder include the following:
   a. inpatient hospital or substance use disorder treatment facility provider services for detoxification;
   b. substance use disorder treatment facility provider services for non-hospital inpatient residential treatment and rehabilitation services;
   c. outpatient hospital/facility or substance use disorder treatment facility provider or outpatient substance use disorder treatment facility provider services for rehabilitation therapy;
   d. court-ordered treatment provided by the Department of Corrections is covered when included in a sentencing order and is based on a chemical assessment conducted by the Department of Corrections;
   e. admissions that qualify as "emergency holds," as the term is defined in Minnesota statutes, are considered medically necessary and appropriate for the entire hold; and
   f. coverage includes Medication Assisted Treatment (MAT) for opioid use disorder.
4. For purposes of this benefit, a substance use disorder service provided on a partial hospitalization basis shall be deemed an outpatient care visit and is subject to any outpatient care cost-sharing amounts.

Behavioral Health Substance Use Care – Notes

5. For laboratory and diagnostic imaging services billed by a health care professional, please refer to "Office Visit and Professional Services." For laboratory and diagnostic imaging services billed by a facility, please refer to "Hospital Inpatient Care" or "Hospital Outpatient Care."
6. For home health related services, please refer to "Home Health Care."
7. For medical stabilization during detoxification services billed by a facility, please refer to "Hospital Inpatient Care" or "Hospital Outpatient Care."
8. Based on the federal Mental Health Parity and Addiction Equity Act, members have the right to parity in mental health and substance use disorder treatment. Generally, this law provides that:
   a. mental health and substance use disorder services are to be covered on the same basis as similar medical services;
   b. cost-sharing for mental health and substance use disorder services can be no more restrictive than cost-sharing for similar medical services; and
   c. treatment restrictions and limitations such as prior authorization and medical necessity can be no more restrictive than for similar medical services.
9. The plan covers telehealth services.
10. Coverage is provided for outpatient Certified Peer Recovery and Certified Family Specialist services (otherwise known as peer support services).

Behavioral Health Substance Use Care – Not Covered

1. Services for substance use disorder or addiction not listed in the most recent editions of the *International Classification of Diseases (ICD)* and *Diagnostic and Statistical Manual for Mental Disorders (DSM).*
2. Custodial care.
3. Services or confinements ordered by a court or law enforcement officer that are not medically necessary and appropriate.
4. Evaluations that are not performed for the purpose of diagnosing or treating substance use disorder or addictions including, but not limited to: custody evaluations; parenting assessments; educational classes for Driving Under the Influence (DUI)/Driving While Intoxicated (DWI) offenses; competency evaluations; adoption home status; and parental competency and domestic violence programs.
5. Services or room and board for foster care, group homes, shelter care, and lodging programs, and halfway house services.
6. Services for skills training.
7. Substance use disorder interventions, defined as a meeting or meetings, with or without the affected person, of a group of people who are concerned with the current behavioral health of the affected person, with the intent of convincing the affected person to enter treatment for the condition.
8. Services provided during a telehealth visit for the sole purpose of: scheduling appointments; filling or renewing existing prescription medications; reporting normal medical test results; providing educational materials; updating patient information; requesting a referral; additional communication on the same day as an onsite medical office visit; and services that would similarly not be charged for in an onsite medical office visit.
9. Services for therapeutic day care and therapeutic camp services.
10. Services for hippotherapy (equine movement therapy).

Chiropractic Care

The Plan Covers:	In-network Providers	Out-of-network Providers
• Spinal manipulations - includes office visit	You pay nothing after deductible	NO COVERAGE
• Other chiropractic services including therapies	You pay nothing after deductible	NO COVERAGE
• Acupuncture services for the treatment of chronic pain, nausea associated with surgery, chemotherapy or pregnancy	You pay nothing after deductible	NO COVERAGE

Chiropractic Care – Notes
1. Benefits include coverage for spinal manipulations for the detection and correction by manual or mechanical means of structural imbalance or subluxation resulting from or related to distortion, misalignment, or subluxation of or in the vertebral column 2. For laboratory and diagnostic imaging services billed by a health care professional, please refer to "Office Visit and Professional Services." For laboratory and diagnostic imaging services billed by a facility, please refer to "Hospital Inpatient Care" or "Hospital Outpatient Care." 3. Office visits may include medical history; medical examination; medical decision making; testing; counseling; coordination of care; nature of presenting problem and chiropractor time.

Chiropractic Care – Not Covered
1. Services for or related to vocational rehabilitation (defined as services provided to an injured employee to assist the employee to return to either their former employment or a new position, or services to prepare a person with disabilities for employment), except when medically necessary and appropriate and provided by an eligible health care provider. 2. Services for outpatient therapy and rehabilitation services for which there is no expectation of restoring or improving a level of function or when no additional functional progress is expected to occur, unless medically necessary and appropriate. 3. Services for or related to therapeutic massage. 4. Maintenance services. 5. Services for or related to rehabilitation services that are not expected to make measurable or sustainable improvement within a reasonable period of time, unless they are medically necessary and appropriate and part of specialized maintenance therapy to treat the member's condition. 6. Custodial care.

Dental Care

The Plan Covers:	In-network Providers	Out-of-network Providers
This is not a dental plan. The following limited dental-related coverage is provided: • Accident-related dental services from a physician or dentist for the treatment of an injury to sound natural teeth • Treatment of cleft lip and palate including: ▪ dental implants ▪ removal of impacted teeth or tooth extractions ▪ related orthodontia ▪ related oral surgery ▪ bone grafts • Oral surgery and anesthesia for: ▪ removal of impacted teeth ▪ removal of tooth root without removal of the whole tooth • Diagnostic evaluation, surgical and nonsurgical treatment of Temporomandibular Disorder (TMD) and Craniomandibular Disorder (CMD) including: ▪ orthognathic surgery ▪ related orthodontia • Tooth extraction when due to a medical diagnosis (see NOTES)	You pay nothing after deductible	NO COVERAGE
• Services for the treatment of ectodermal dysplasia including: ▪ orthodontia ▪ bone grafts ▪ dental implants ▪ dentures ▪ bridgework	You pay nothing after deductible	NO COVERAGE

Dental Care – Notes
1. For medical services, please refer to "Hospital Inpatient Care," "Hospital Outpatient Care," "Office Visit and Professional Services," etc. 2. For hospital/facility services, please refer to "Hospital Inpatient Care" and "Hospital Outpatient Care." 3. Tooth extraction coverage is limited to dental services required for treatment of an underlying medical condition, e.g., removal of teeth to complete radiation treatment for cancer of jaw, cysts and lesions. 4. Services for surgical and nonsurgical treatment of temporomandibular joint (TMJ) disorder and craniomandibular disorder must be covered on the same basis as any other body joint and administered or prescribed by a physician or dentist. 5. Mandibular staple implant is covered, provided the procedure is not done to prepare the mouth for dentures. 6. Bone grafts (the building up of bone in the upper or lower jaw) for the purpose of reconstruction of the jaw is a covered service, but not for the sole purpose of supporting a dental implant, dentures or a dental prosthesis.

Dental Care – Notes

7. Sound natural teeth means teeth and tissue that are viable, functional and free of disease. A sound natural tooth:
    a. has no decay,
    b. has no filling on more than two (2) surfaces,
    c. does not have bone loss of more than 50%,
    d. has not had a root canal procedure (removing the tissue inside the tooth root), and
    e. has not been replaced by any artificial means (for example, implants, fixed or removable bridges, dentures, dental appliance, or crowns).
8. Accident-related dental services, treatment and/or restoration of a sound natural tooth must be initiated within six (6) months of the date of injury or within 12 months of your effective date of coverage under this plan. Coverage is limited to the initial treatment (or course of treatment) and/or initial restoration. Only services performed within 24 months from the date of treatment or restoration is initiated are covered. Coverage for treatment and/or restoration is limited to re-implantation of original sound natural teeth, crowns, fillings and bridges.
9. The health plan covers anesthesia and inpatient and outpatient hospital charges when necessary to provide dental care to a member who is a child under age five (5); is severely disabled; or has a medical condition that requires hospitalization or general anesthesia for dental treatment. For hospital/facility charges please refer to "Hospital Inpatient Care" or "Hospital Outpatient Care." Dental services are not covered unless otherwise noted.
10. Services for diagnostic evaluation, surgical, and nonsurgical treatment of temporomandibular disorder and craniomandibular disorder, including orthognathic surgery and related orthodontia, must be covered on the same basis as any other body joint and administered or prescribed by a physician or dentist.

Dental Care – Not Covered

1. Services for or related to orthodontia, except as provided herein.
2. Oral surgery procedures, except as provided herein.
3. Services for or related to treatment of cracked or broken teeth due to biting or chewing.
4. Dentures, regardless of the cause or the condition, and any associated services including bone grafts.
5. Dental implants and associated services, except when related to services for cleft lip and palate.
6. Services for or related to replacement of a damaged dental bridge from an accident-related injury.
7. Osteotomies (cutting of the bone), osteoplasty (building up the bone), and other procedures associated with the fitting of dentures or dental implants, except as provided herein.
8. Services for or related to dental or oral care, treatment, orthodontics, surgery, supplies, anesthesia, or facility charges, except as provided herein.
9. Services to treat bruxism (excessive grinding of teeth or clenching of the jaw), including dental splints.
10. Charges for routine dental care, except as provided herein.
11. Services for or related to gingival and periodontal (the gums and bone that surround and support the teeth) procedures.

Emergency Care

The Plan Covers:	In-network Providers	Out-of-network Providers
• Outpatient health care professional services to treat an emergency medical condition as defined by applicable law	You pay nothing after deductible	Same as in-network services
• Outpatient hospital/facility services to treat an emergency medical condition as defined by applicable law	You pay nothing after deductible	Same as in-network services

Emergency Care – Notes
1. In emergency situations, where you must be treated immediately, go directly to your nearest hospital emergency provider; or call "911" or your area’s emergency number. When determining if a situation is a medical emergency the claims administrator will take into consideration presenting symptoms including, but not limited to, severe pain and a reasonable layperson's belief that the circumstances required immediate medical care that could not wait until the next business day. 2. For follow up care, please refer to “Hospital Outpatient Care,” “Hospital Inpatient Care” and “Office Visit and Professional Services.” 3. In some circumstances where you were not able to choose the provider who rendered care for emergency services, you are not responsible for any amounts above what you would have been required to pay (such as deductibles and coinsurance) had you used a participating provider, unless you gave advance written consent to the nonparticipating provider. Please refer to “Special Circumstances.” 4. If the care you receive is due to a medical emergency, prior authorization is not required. 5. Please refer to "Terms You Should Know" for a definition of medical emergency. 6. For inpatient services, please refer to "Hospital Inpatient Care" and "Office Visit and Professional Services." 7. For urgent care visits, please refer to "Hospital Outpatient Care" and "Office Visit and Professional Services." 8. The plan covers emergency department, pre-stabilization, post-stabilization and urgent care to evaluate and treat a medical emergency. 9. The plan’s coverage of medical emergencies will comply with the No Surprises Act.

Gender Affirming Care

The Plan Covers:	In-network Providers	Out-of-network Providers
• Outpatient health care professional services including: ▪ office visit	You pay nothing after deductible	NO COVERAGE
• Professional services for gender affirming procedures for the treatment of gender dysphoria	You pay nothing after deductible	NO COVERAGE

Gender Affirming Care – Notes
1. The Plan covers medically necessary and appropriate gender affirming health care as outlined in the Standards of Care for the Health of Transgender and Gender Diverse People, from the World Professional Association for Transgender Health (WPATH). 2. Office visits may include medical history; medical examination; medical decision making; testing; counseling; coordination of care; nature of presenting problem; physician time; or psychotherapy. 3. Gender affirming care includes, but is not limited to, breast/chest procedures, genital procedures, facial procedures, thyroid cartilage reduction, voice therapy, hair removal, and hormone therapy. These services are covered when they are medically necessary and appropriate for the treatment of gender dysphoria. 4. Services include related preparation and follow-up care. 5. Gender-specific preventive services are covered for transgender persons appropriate to their anatomy. For preventive care services, please refer to "Preventive Care." 6. For outpatient counseling services, please refer to “Behavioral Health Mental Health Care.” 7. For hospital/facility services, please refer to "Hospital Inpatient Care" and "Hospital Outpatient Care." 8. For laboratory and diagnostic imaging services billed by a health care professional, please refer to "Office Visit and Professional Services." For laboratory and diagnostic imaging services billed by a facility, please refer to "Hospital Inpatient Care" or "Hospital Outpatient Care." 9. For therapeutic injections, please refer to "Hospital Outpatient Care" or "Office Visit and Professional Services." 10. For more information contact customer service at the telephone number on the back of your member ID card or visit www.bluecrossmn.com/allinahealth.

Home Health Care

The Plan Covers:	In-network Providers	Out-of-network Providers
• Skilled care and other home care services ordered by a physician and provided by employees of an approved home health agency including, but not limited to: ▪ intermittent skilled nursing care in your home by a: • licensed registered nurse • licensed practical nurse ▪ physical therapy and occupational therapy by a licensed therapist and speech therapy by a certified speech and language pathologist ▪ services provided by a medical technologist ▪ services provided by a licensed registered dietitian ▪ services provided by a respiratory therapist ▪ services of a home health aide or master's level social worker employed by the home health agency when provided in conjunction with covered services ▪ use of appliances that are owned or rented by the home health agency ▪ home health care following early maternity discharge ▪ palliative care ▪ prescription drugs dispersed by the home health agency	You pay nothing after deductible	NO COVERAGE

Home Health Care – Notes
1. Intermittent skilled nursing care consists of up to two (2) consecutive hours of care per date of service in the member's home. 2. Extended hours skilled nursing care (also known as private-duty nursing) consists of greater than two (2) consecutive hours of care per date of service in the member's home. Extended hours skilled nursing care services provide complex, direct skilled nursing care to develop caregiver competencies through training and education to optimize the member's health status and outcomes. The frequency of the nursing tasks is continuous and temporary in nature and is not intended to be provided on a permanent, ongoing basis. 3. Services include related preparation and follow-up treatment care. 4. Office visits may include medical history; medical examination; medical decision making; testing; counseling; coordination of care; nature of presenting problem; physician time; or psychotherapy. 5. Health aide services when you are also receiving covered nursing services or therapy and rehabilitation services. 6. Benefits for home/suite infusion therapy and related home health care are listed under "Infusion Therapy." 7. For supplies and durable medical equipment billed by a home health agency, please refer to "Medical Equipment and Supplies."

Home Health Care – Notes

8. The plan covers outpatient palliative care for members with a new or established diagnosis of progressive debilitating illness, including illness which may limit the member's life expectancy to two (2) years or less. The services must be within the scope of the provider's license to be covered. Palliative care does not include hospice or respite care.
9. **Home health care and home/suite infusion therapy combined limit: 120 visits per person per calendar year. The one (1) home health care visit following early maternity discharge does not apply to the 120 visit limit.**
10. Home health care visit following early maternity discharge provided by a registered nurse including, but not limited to, parent education, assistance and training in breast and bottle feeding, and conducting any necessary and appropriate clinical tests. The home visit must be conducted within four (4) days following the discharge of the mother and newborn child.

Home Health Care – Not Covered

1. Homemaker services.
2. Maintenance services.
3. Services for dialysis treatment you receive from a home health agency.
4. Custodial care.
5. Services for food or home-delivered meals you receive from a home health agency.
6. Services for or related to extended hours skilled nursing care, also referred to as private-duty nursing care.

Hospice Care

The Plan Covers:	In-network Providers	Out-of-network Providers
• Hospice care for terminal condition	You pay nothing after deductible	NO COVERAGE

Hospice Care – Notes
1. Benefits are limited to members with a terminal condition, which requires the member’s primary physician to certify, in writing, a life expectancy for the member of six (6) months or fewer. Hospice benefits begin on the date of admission to a hospice program. 2. Hospice program inpatient respite care is for the relief of the member’s primary caregiver and is limited to a maximum of five (5) consecutive days at a time. 3. Hospice care coverage is limited to a maximum benefit of 30 days per person per calendar year. 4. Home respite care is for the relief of the member's primary caregiver and is limited to a maximum of five (5) consecutive days per admission to the hospice program. 5. Hospice program general inpatient care is for control of pain or other symptom management that cannot be managed in a less intense setting. 6. Benefits include family counseling related to the member's terminal condition. 7. Medical care services unrelated to the terminal condition under the hospice program are covered but are separate from the hospice benefit.

Hospice Care – Not Covered
1. Services for respite care, except as provided herein. 2. Room and board expenses in a residential hospice facility. 3. Services for dialysis treatment you receive from hospice or a hospital program for hospice care. 4. Custodial care. 5. Services for food or home-delivered meals you receive from hospice or a hospital program for hospice care.

Hospital Inpatient Care

The Plan Covers:	In-network Providers	Out-of-network Providers
• Hospital room and board, and general nursing services • Special care unit which is a designated unit which has concentrated all facilities, equipment, and supportive services for the provision of an intensive level of care for critically ill patients • Use of operating, delivery, and treatment rooms and equipment • Anesthesia, anesthesia supplies and services rendered in a facility provider by an employee of the facility provider. Administration of anesthesia ordered by the attending health care provider and rendered by a health care provider other than the surgeon or assistant at surgery • Medical and surgical dressings, supplies, casts, and splints • Prescription drugs provided to you while you are inpatient in a facility • Whole blood, administration of blood, blood processing, and blood derivatives • Diagnostic services • Telehealth services • Communication services of a private-duty nurse or a personal care assistant up to 120 hours per hospital admission for ventilator dependent persons • Therapy and rehabilitation services	You pay nothing after deductible	NO COVERAGE
• Magnetic esophageal ring surgery services (see NOTES)	You pay nothing after deductible	NO COVERAGE

Hospital Inpatient Care – Notes
1. **Coverage for magnetic esophageal ring surgery services is limited to services provided by Surgical Specialists of MN and Abbott Northwestern Hospital.** 2. The health plan covers inpatient services from a facility provider. Benefits will be covered only when, and so long as, they are determined to be medically necessary and appropriate for the treatment of the member's condition. 3. The plan covers the following organ donor services when billed under the donor recipient's name and the donor recipient is covered for the organ transplant under the plan: a. potential donor testing; b. donor evaluation and work-up; and c. hospital and professional services related to organ procurement. 4. Diagnostic services include the following when ordered by a health care provider: a. diagnostic imaging consisting of radiology, magnetic resonance imaging (MRI), ultrasound and nuclear medicine; b. diagnostic pathology consisting of laboratory and pathology tests;

Hospital Inpatient Care – Notes
c. diagnostic medical procedures consisting of ElectroCardioGram (ECG), ElectroEncephaloGram (EEG), and other electronic diagnostic medical procedures and physiological medical testing approved by the claims administrator; and d. allergy testing consisting of percutaneous, intracutaneous, and patch tests. 5. The health plan covers anesthesia and inpatient hospital services when necessary to provide dental care to a member who is a child under age five (5); is severely disabled; or has a medical condition that requires hospitalization or general anesthesia for dental treatment. Dental services are not covered unless otherwise noted. 6. For facility services related to bariatric surgery, please refer to “Bariatric Surgery.” 7. The plan covers telehealth services.

Hospital Inpatient Care – Not Covered
1. Charges for inpatient admissions which are primarily for diagnostic studies. 2. Personal comfort items such as telephone, television. 3. Communication services provided on an outpatient basis or in the home. 4. Services for or related to extended hours skilled nursing care, also referred to as private-duty nursing care.

Hospital Outpatient Care

The Plan Covers:	In-network Providers	Out-of-network Providers
• Outpatient hospital/facility services • Surgeon or assistant at surgery • Use of operating, delivery, and treatment rooms and equipment • Medical and surgical dressings, supplies, casts and splints • Radiation and chemotherapy • Dialysis treatment • Respiratory therapy • Cardiac rehabilitation • Physical, occupational, and speech therapy • Diabetes outpatient self-management training and education, including medical nutrition therapy • Palliative care • Prescription drugs provided to you while you are outpatient in a facility • Whole blood, administration of blood, blood processing, and blood derivatives	You pay nothing after deductible	NO COVERAGE
• Laboratory services, except as listed below	You pay nothing after deductible	NO COVERAGE
• Diagnostic imaging services	You pay nothing after deductible	NO COVERAGE
• Laboratory screening for cotinine alkaloid	You pay nothing after deductible	NO COVERAGE
• Resiliency training (see NOTES) • Magnetic esophageal ring surgery services (see NOTES) • Palliative care	You pay nothing after deductible	NO COVERAGE
• Facility billed freestanding ambulatory surgical center services	You pay nothing after deductible	NO COVERAGE
• Urgent care center visits including: ▪ facility billed services	You pay nothing after deductible	You pay nothing after deductible
▪ facility laboratory services	You pay nothing after deductible	You pay nothing after deductible
▪ facility diagnostic imaging services	You pay nothing after deductible	You pay nothing after deductible

Hospital Outpatient Care – Notes
1. Coverage for magnetic esophageal ring surgery services is limited to services provided by Surgical Specialists of MN and Abbott Northwestern Hospital.
2. Palliative care is limited to a maximum benefit of $4,000 per person per lifetime.
3. **Resiliency training is limited to one assessment and one training program per person per lifetime, with payment conditioned upon completion of the program.**
4. Pre-admission testing is covered for tests and studies required in connection with your admission rendered or accepted by a hospital on an outpatient basis prior to a scheduled admission to the hospital as an inpatient.
5. Coverage is provided for hospital services and supplies for outpatient surgery including removal of sutures, anesthesia, anesthesia supplies and services rendered by an employee of the facility provider, other than the surgeon or assistant at surgery.
6. Coverage is provided for anesthesia, anesthesia supplies and devices rendered in a facility provider by an employee of the facility provider. Administration of anesthesia ordered by the attending health care provider and rendered by a health care provider other than the surgeon or assistant at surgery.
7. The plan covers outpatient palliative care for members with a new or established diagnosis of progressive debilitating illness, including illness which may limit the member's life expectancy to two (2) years or less. The services must be within the scope of the provider's license to be covered. Palliative care does not include hospice or respite care.
8. The health plan covers anesthesia and outpatient hospital services when necessary to provide dental care to a member who is a child under age five (5); is severely disabled; or has a medical condition that requires hospitalization or general anesthesia for dental treatment. Dental services are not covered unless otherwise noted.
9. The plan covers telehealth services.
10. The Plan covers Percutaneous Tenotomy (Tenex) if an Allina Health physician both determines the member is a candidate for the procedure and performs the procedure, subject to member cost-sharing that applies for outpatient procedures/surgery under the Plan.

Hospital Outpatient Care – Not Covered
1. Services and prescription drugs for or related to assisted reproductive technology, except as described in the Fertility Benefit Appendix.

Infusion Therapy

The Plan Covers:	In-network Providers	Out-of-network Providers
• Home infusion and suite infusion therapy services • Intravenous solutions and pharmaceutical additives, pharmacy compounding and dispensing services • Medical/surgical supplies • Nursing services associated with infusion therapy	You pay nothing after deductible	NO COVERAGE

Infusion Therapy – Notes
1. Benefits will be provided when performed by a home infusion and/or suite infusion therapy provider at an infusion suite or home setting. 2. Specific adjunct non-intravenous therapies are included when administered only in conjunction with infusion therapy. 3. Home health care and home/suite infusion therapy combined limit: 120 visits per person per calendar year.

Infusion Therapy – Not Covered
1. Home/suite infusion services or supplies not specifically listed as covered services. 2. Nursing services to administer home/suite infusion therapy when the patient or caregiver can be successfully trained to administer therapy.

Maternity Care

The Plan Covers:	In-network Providers	Out-of-network Providers
• Prenatal hospital/facility provider services	You pay nothing	NO COVERAGE
• Prenatal professional services • Family planning services	You pay nothing	NO COVERAGE
• Maternity education for pregnancy, birth and parenting classes as defined by Allina Health System (see NOTES)	You pay nothing	NO COVERAGE
• Health care professional services for: ▪ delivery in a hospital/facility ▪ examination of the newborn infant while the mother is an inpatient	You pay nothing after deductible	NO COVERAGE
▪ postpartum care • office visit	You pay nothing after deductible	NO COVERAGE
• all other eligible services - office/clinic	You pay nothing after deductible	NO COVERAGE
• all other eligible services – outpatient hospital/facility	You pay nothing after deductible	NO COVERAGE
• Inpatient hospital/facility services for: ▪ delivery in a hospital/facility ▪ postpartum care	You pay nothing after deductible	NO COVERAGE
• Acupuncture services for the treatment of chronic pain, nausea associated with surgery, chemotherapy or pregnancy	You pay nothing after deductible	NO COVERAGE

Maternity Care – Notes
1. For more information or to register for pregnancy, birth or parenting classes contact Allina Health Class Registration toll free at 1-866-904-9962. For questions about reimbursement call Blue Cross Customer Service toll free at 1-800-509-5310 and select prompt 1. 1. Home health care visit following early maternity discharge provided by a registered nurse including, but not limited to, parent education, assistance and training in breast and bottle feeding, and conducting any necessary and appropriate clinical tests. The home visit must be conducted within four (4) days following the discharge of the mother and newborn child. 2. If you think you are pregnant, you may contact your physician or go to an in-network obstetrician or nurse midwife. When your pregnancy is confirmed, you may continue to receive follow-up care which includes prenatal visits, medically necessary and appropriate sonograms, delivery, postpartum and newborn care in the hospital. 3. Normal pregnancy – normal pregnancy includes any condition usually associated with the management of a difficult pregnancy but is not considered a complication of pregnancy. 4. Hospital, medical and surgical services rendered by a facility provider or professional provider for: a. Complications of pregnancy - physical effects directly caused by pregnancy but which are not considered from a medical viewpoint to be the effect of normal pregnancy. Services related to miscarriage, ectopic pregnancy or those that require cesarean section are covered as delivery. b. Prenatal care - the comprehensive package of medical and psychosocial support provided throughout the pregnancy, includes risk assessment, gestational diabetes screening, serial surveillance, prenatal education, and use of specialized skills and technology, when needed, as defined by Standards for Obstetric-Gynecologic Services issued by the American College of Obstetricians and Gynecologists.

Maternity Care – Notes
5. Under federal law, group health plans such as this plan are required to provide benefits for any hospital length of stay in connection with childbirth as follows: a. inpatient hospital coverage for the mother (to the extent the mother is covered under this health plan) is provided for a minimum of 48 hours following a vaginal delivery and 96 hours following a cesarean section. If the length of stay is less than these minimums, one (1) home health care visit within four (4) days after discharge from the hospital is covered under this health plan. Please refer to "Home Health Care." b. inpatient hospital coverage for the newborn (to the extent the newborn is covered under this health plan) is provided for a minimum of 48 hours following a vaginal delivery and 96 hours following a cesarean section. If the length of stay is less than these minimums, one (1) home health care visit within four (4) days after discharge from the hospital is covered under this plan. Please refer to "Home Health Care." 6. Under federal law, the health plan may require that a provider obtain authorization from the health plan for prescribing a length of stay greater than the 48 hours (or 96 hours) mentioned above. 7. For laboratory and diagnostic imaging services billed by a health care professional, please refer to "Office Visit and Professional Services." For laboratory and diagnostic imaging services billed by a facility, please refer to "Hospital Inpatient Care" or "Hospital Outpatient Care."

Maternity Care – Not Covered
1. Health care professional services for childbirth deliveries in the home. 2. Services for or related adoption fees. 3. Services for or related to surrogate pregnancy including: diagnostic screening, physician services, assisted reproductive technology, and prenatal/delivery/postnatal services when the surrogate is not a covered member under this plan, except as set forth in the Fertility Benefit Appendix. 4. Services for childbirth classes. 5. Services for or related to preservation, storage, and thawing of human tissue including, but not limited to: sperm; ova; embryos; stem cells; cord blood; and any other human tissue. 6. Services for donor ova or sperm. 7. Services for or related to an elective cesarean (C)-section for the purpose of convenience. 8. Services and prescription drugs for or related to the selection of gender in embryos. 9. Services for or related to elective termination of a pregnancy when using out-of-network providers.

Medical Equipment and Supplies

The Plan Covers:	In-network Providers	Out-of-network Providers
• Durable medical equipment (DME) • Amino acid-based elemental formula • Corrective lenses, frames and contact lenses after cataract surgery (purchased within 24 months of cataract surgery) • Wigs (scalp hair prostheses) for hair loss due to alopecia areata or cancer • Cooling caps for cancer treatment • Hearing aids for hearing loss that cannot be corrected by other covered procedures. Maximum of one (1) hearing aid for each ear every three (3) years	You pay nothing after deductible	NO COVERAGE
• Insulin infusion devices	You pay nothing after deductible	NO COVERAGE
• Blood Glucose monitors • Ostomy supplies • Diabetic supplies, including: cotton balls; alcohol swabs; and other diabetic supplies	You pay nothing after deductible	NO COVERAGE
• Corrective lenses, frames and contact lenses for refractive errors	You pay nothing Corrective lenses, frames and contract lenses is limited to $250 per member per calendar year when purchased through Allina Health clinics	NO COVERAGE
• Purchase of a personal electric breast pump • Purchase of a manual breast pump • Rental of a hospital grade breast pump	You pay nothing	NO COVERAGE
• Orthotics	You pay nothing after deductible	NO COVERAGE
• Prosthetics, such as breast prostheses, artificial limbs, and artificial eyes	You pay nothing after deductible	NO COVERAGE
• Cochlear implants	You pay nothing after deductible	NO COVERAGE
• Non-investigative bone conductive hearing devices	You pay nothing after deductible	NO COVERAGE

Medical Equipment and Supplies – Notes
1. The health plan covers the approved rental, purchase, fitting, necessary adjustments, repairs, and replacements of prosthetic devices and supplies which replace all or part of an absent body organ and its adjoining tissues, or replace all or part of the function of a permanently inoperative or malfunctioning body organ (excluding dental appliances and the replacement of cataract lenses). Initial and subsequent prosthetic devices to replace the removed breast(s) or a portion thereof are also covered. 2. Coverage is provided for the following when required in connection with the treatment of diabetes and when prescribed by a health care provider legally authorized to prescribe such items under the law: a. equipment and supplies: all physician prescribed medically necessary and appropriate equipment and supplies, including but not limited to, blood glucose monitors, monitor supplies, and insulin infusion devices. 3. The health plan covers the approved rental, purchase, adjustment, repairs and replacement of durable medical equipment for therapeutic use including supplies and accessories necessary for the effective functioning of covered durable medical equipment. 4. Amino acid-based elemental formula, a type of exempt formula which is regulated by the U.S. Food and Drug Administration (FDA) and is prescribed for infants or children with specific medical or dietary problems. An amino acid-based formula contains proteins which are broken down into their simplest and purest form making it easier for the body to process and digest. An infant or child may be placed on an amino acid-based formula when unable to digest or tolerate whole proteins found in other formulas due to certain allergies or gastrointestinal conditions. Examples of amino acid-based elemental formulas are Neocate®, EleCare®, PurAmino™ (formerly Nutramigen® AA™ LIPIL), Vivonex®, Tolerex®, Alfamino, and E028 Neocate Splash. 5. The health plan covers the approved rental, purchase, fitting, necessary adjustment, repairs and replacement of a rigid or semi-rigid supportive orthotic device which restricts or eliminates motion of a weak or diseased body part. 6. Wigs (scalp hair prostheses) for hair loss due to alopecia areata or cancer. 7. Hearing aids, maximum of $3,000, per person, (one) 1 per ear, every (three) 3 years. 8. Corrective lenses, frames and contact lenses must be purchased within 24 months of cataract surgery.

Medical Equipment and Supplies – Not Covered
1. Services for or related to hearing aids or devices, except as provided herein. 2. Durable medical equipment, supplies, and prosthetics for convenience, personal, or recreational use. 3. Services or supplies that are primarily and customarily used for a nonmedical purpose or used for environmental control or enhancement (whether or not prescribed by a physician), including, but not limited to: exercise equipment; air purifiers; air conditioners; dehumidifiers; heat/cold appliances; water purifiers; hot tubs; whirlpools; hypoallergenic mattresses; waterbeds; computers and related equipment; car seats; feeding chairs; pillows; food or weight scales; and incontinence pads or pants. 4. Modifications to home, vehicle, and/or workplace, including vehicle lifts and ramps. 5. Blood pressure monitoring devices. 6. Replacement of properly functioning durable medical equipment. 7. Repair, maintenance or replacement of rental equipment (this is included in the price of the rental equipment). 8. Duplicate equipment, prosthetics, or supplies. 9. Communication devices, except when exclusively used for the communication of daily medical needs and without such communication the patient's medical condition would deteriorate. 10. Devices for maintenance services. 11. Biofeedback devices in the home. 12. Wigs (scalp hair prostheses), except as provided herein. 13. Charges for breast pumps, except as provided herein. 14. Services for eyeglasses or contact lenses, or prescribing or fitting eyeglasses or contact lenses, except as provided herein.

Office Visit and Professional Services

The Plan Covers:	In-network Providers	Out-of-network Providers
• General physician office visits	You pay nothing after deductible	NO COVERAGE
• Specialist physician office visits	You pay nothing after deductible	NO COVERAGE
• E-visits • Telephone consultations	You pay nothing after deductible	NO COVERAGE
• Urgent care center visits including: ▪ office visit for urgent care	You pay nothing after deductible	You pay nothing after deductible
▪ professional laboratory services for urgent care	You pay nothing after deductible	You pay nothing after deductible
▪ professional diagnostic imaging services for urgent care	You pay nothing after deductible	You pay nothing after deductible
▪ all other professional services for urgent care	You pay nothing after deductible	You pay nothing after deductible
• Retail health clinic ▪ retail health clinic office visit	You pay nothing after deductible	NO COVERAGE
▪ laboratory services	You pay nothing after deductible	NO COVERAGE
▪ all other professional services	You pay nothing after deductible	NO COVERAGE
• Professional office and outpatient laboratory services	You pay nothing after deductible	NO COVERAGE
• Professional office and outpatient diagnostic imaging services	You pay nothing after deductible	NO COVERAGE
• Professional billed services received at a freestanding ambulatory surgical center	You pay nothing after deductible	NO COVERAGE

The Plan Covers:	In-network Providers	Out-of-network Providers
• Hinge Health musculoskeletal (MSK) condition management program • Advanced care planning in a physician's office • Comprehensive medication review program (see NOTES) • Health education for the management of chronic health problems including: ▪ early pregnancy ▪ family planning services ▪ nutrition ▪ breast self-exam ▪ cholesterol ▪ instructions regarding medication • Laboratory screening for cotinine alkaloid	You pay nothing	NO COVERAGE
• Outpatient sleep studies • Bariatric surgery to correct morbid obesity including: ▪ anesthesia ▪ assistant surgeon • Palliative care • Magnetic esophageal ring surgery services (see NOTES) • Resiliency training (see NOTES)	You pay nothing after deductible	NO COVERAGE
• Acupuncture services for the treatment of chronic pain, nausea associated with surgery, chemotherapy or pregnancy	You pay nothing after deductible	NO COVERAGE
• All other professional services – office/clinic	You pay nothing after deductible	NO COVERAGE
• All other professional services – outpatient hospital/facility	You pay nothing after deductible	NO COVERAGE

Office Visit and Professional Services – Notes
1. The Plan will cover, under normal Plan cost-sharing rules for office visits, diagnostic testing for detection of SARS-CoV-2 or the virus that causes COVID-19 (as long as such test is performed at an in-network provider, medically necessary, FDA-approved and not required for employment purposes), including serological testing that is used to detect antibodies against COVID-19 (as long as such test is performed at an in-network provider, medically necessary, FDA-approved and not required for employment purposes). No COVID-19 testing will be covered if performed at an out-of-network provider. The Plan will cover up to four (4) over-the-counter (OTC) COVID-19 tests at $0 copay for each covered person per month, as long as such tests will be used for personal use and not employment use (i.e., the test is not used by a covered person who needs a negative COVID-19 test to access the employer's worksite). This means, for example, that a family of four (4) covered persons under the Plan, can receive up to sixteen (16) OTC COVID-19 tests per month for $0 copay, as long as they will be used for personal and not employment reasons. You have the following options for purchase of an OTC COVID-19 test kit: ▪ A. Participating Pharmacy: If you present your prescription drug card at the pharmacy counter (not general check-out register) of a participating pharmacy when purchasing COVID-19 tests for personal use, they will adjudicate at the point of sale for $0, meaning you will not have to pay for the tests out-of-pocket and you will not need to submit a manual claim for reimbursement to the Plan. To submit a manual claim for reimbursement, you will need to complete a Prescription Drug Reimbursement Claim Form. You can download the form at- Prescription Reimbursement Claim Form | Express Scripts (express-scripts.com) and submit it online, or by mail or fax, with your pharmacy receipt by the claim filing deadline described in the Plan's summary plan description. ▪ B. Direct-to-Home Shipping Program: Allina Health Pharmacy will mail COVID-19 over-the-counter tests directly to your home at no cost, subject to the rules and limitations set forth above. To request tests, please call your local Allina Health Pharmacy or go to www.express-scripts.com/allinahealth and click "Find a Pharmacy." For assistance in receiving this benefit at an in-network pharmacy or submitting a receipt for reimbursement, contact Express Scripts at 1-800-509-5310.When you present your pharmacy card at the point-of-sale or you submit a manual claim for reimbursement to ESI, you are representing that the test is for personal, not employment reasons, you will not resell the test and you will not submit the test for reimbursement to another source (e.g., HSA, HRA or Health FSA). ▪
2. The Plan will cover 100% of the cost for (i) an immunization that has an "A" or "B" rating from the United States Preventive Services Task Force and is intended to prevent COVID-19, and (ii) an immunization that has in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved and is intended to prevent COVID-19, as long as the immunization is provided in-network. 3. Palliative care is limited to a maximum benefit of $4,000 per person per lifetime. 4. Resiliency training is limited to one assessment and one training program per person per lifetime, with payment conditioned upon completion of the program. 5. If you meet the criteria for coverage, you may qualify for the Comprehensive Medication Review program/Medication Therapy Disease Management Program. The Program covers private consultations with a designated clinical pharmacist. If you take several medications, have diabetes, or coronary artery disease, you may be eligible for the program. To find out if you qualify or for more information about the Program and available providers, contact Allina Health at PharmacyCMR@allina.com. 6. Coverage for magnetic esophageal ring surgery services is limited to services provided by Surgical Specialists of MN and Abbott Northwestern Hospital. 7. Benefits are provided for medical care rendered concurrently with surgery during one inpatient stay by a professional provider other than the operating surgeon for treatment of a medical condition separate from the condition for which surgery was performed. Benefits are provided for medical care by two or more professional providers rendered concurrently during one inpatient stay when the nature or severity of your condition requires the skills of separate physicians. 8. Diabetes Self-Management Education and Support (DSMES) Services: When your health care provider certifies that you require diabetes education and support, coverage is provided for the following situations when rendered through DSMES services: a. when diabetes is diagnosed;

Office Visit and Professional Services – Notes
b. when a new medication is prescribed; c. when diagnosed with diabetes and you are at risk for complications including, but not limited to, having problems controlling your blood sugar, been treated in the emergency room or experienced a hospital stay, diagnosed with eye disease related to diabetes, experiencing a lack of feeling in your feet or other foot problems, or been diagnosed with kidney disease related to diabetes. DSMES may be provided individually or in a group setting. 9. If more than one (1) surgical procedure is performed during the same operative session, the plan covers the surgical procedures based on the allowed amount for each procedure. The plan does not cover a charge separate from the surgery for pre-operative and post-operative care. 10. Physician services include services of an optometrist and an advanced practice nurse when performed within the scope of their licensure. 11. The plan covers treatment of diagnosed Lyme disease on the same basis as any other illness. 12. Office visits may include medical history; medical examination; medical decision making; testing; counseling; coordination of care; nature of presenting problem; physician time; and psychotherapy. 13. A retail health clinic, located in a retail establishment or worksite, provides medical services for a limited list of eligible symptoms (e.g., sore throat, cold). If the presenting symptoms are not on the list, the member will be directed to seek services from a physician or hospital/facility provider. Retail health clinics are staffed by eligible nurse practitioners or other eligible health care providers that have a practice arrangement with a physician. The list of available medical services and/or treatable symptoms is available at the retail health clinic. Access to retail health clinic services is available on a walk-in basis. 14. The plan covers the following organ donor services when billed under the donor recipient's name and the donor recipient is covered for the organ transplant under the plan: a. potential donor testing; b. donor evaluation and workup; and c. hospital and professional services related to organ procurement. 15. The plan covers certain routine patient costs for approved clinical trials. Routine patient costs include items and services that would be covered for members who are not enrolled in an approved clinical trial. 16. Diagnostic services include the following when ordered by a health care provider: a. diagnostic imaging consisting of radiology, magnetic resonance imaging (MRI), ultrasound and nuclear medicine b. diagnostic pathology consisting of laboratory and pathology tests c. diagnostic medical procedures consisting of ElectroCardioGram (ECG), ElectroEncephaloGram (EEG), and other electronic diagnostic medical procedures and physiological medical testing approved by the claims administrator; and d. allergy testing consisting of percutaneous, intracutaneous, and patch tests. 17. Eligible therapeutic drugs, including specialty drugs, administered by a health care provider required in the diagnosis, prevention and treatment of an injury or illness, provided that the drugs are not "usually self-administered" by a member and when the administration of the drug and the medication are billed by the health care provider and eligible under the “Office Visit and Professional Services” benefit. 18. The plan covers outpatient palliative care for members with a new or established diagnosis of progressive debilitating illness, including illness which may limit the member's life expectancy to two (2) years or fewer. The services must be within the scope of the provider's license to be covered. Palliative care does not include hospice or respite care. 19. The plan covers services for or related to growth hormone replacement therapy if it is determined to be medically necessary and appropriate and otherwise covered under this health plan. 20. Please refer to “Preventive Care” for female sterilization. 21. You are entitled to receive care at the in-network level from out-of-network providers if these services are covered under your plan: a. the voluntary planning of the conception and bearing of children; b. the diagnosis of infertility (the medically documented inability to conceive for 12 months); c. the testing and treatment of a sexually transmitted disease; or d. the testing of AIDS or other HIV-related conditions.

Office Visit and Professional Services – Notes
22. E-visit is a patient-initiated, limited online evaluation and management health care service provided by a physician or other qualified health care provider using the internet or similar secure communications network to communicate with an established patient. For more information about virtual care options, log onto the member website at bluecrossmn.com or call customer service at the telephone number listed on the back of your member ID card. 23. The plan covers telehealth services. 24. The plan covers at-home exercise therapy for members experiencing musculoskeletal (MSK) related joint, bone or muscle pain. This MSK Condition Management Program provides a holistic approach from prevention, to acute, to chronic, to pre- and post-surgical care. The MSK Condition Management Program utilizes a unique, non-invasive pain management device as well as sensor and computer-vision based technology to partner a member with a Hinge Health physical therapist and health coach to provide up to 365 days of therapy and education. To register, please visit the member website www.bluecrossmn.com/allinahealth. 25. The plan covers hearing aid examinations/fitting/adjustments

Office Visit and Professional Services – Not Covered
1. Out-of-network provider-initiated communications. 2. Services for autopsies. 3. Separate services for pre-operative and post-operative care for surgery billed by an out-of-network provider. 4. Services and supplies for or related to weight reduction programs, including all diagnostic testing related to weight reduction programs, except as provided herein. 5. Services for or related to vision correction surgery such as the correction of myopia, hyperopia or presbyopia, including but not limited to corneal microsurgery, such as keratomileusis, keratophakia, radial keratotomy, corneal ring implants, Laser-Assisted in Situ Keratomileusis (LASIK) and all related services. 6. Services for or related to vocational rehabilitation (defined as service provided to an injured employee to assist the employee to return to either their former employment or a new position, or services to prepare a person with disabilities for employment), except when medically necessary and appropriate and provided by an eligible health care provider. 7. Services provided during an e-visit for the sole purpose of: scheduling medical appointments; reporting normal medical test results; providing educational materials; updating patient information; requesting a referral; additional communication on the same day as an onsite medical office visit; and services that would similarly not be charged for in an onsite medical office visit. 8. Services provided during a telehealth visit for the sole purpose of: scheduling appointments; filling or renewing existing prescription medications; reporting normal medical test results; providing educational materials; updating patient information; requesting a referral; additional communication on the same day as an onsite medical office visit; and services that would similarly not be charged for in an onsite medical office visit. 9. Services and prescription drugs for or related to assisted reproductive technology fertilization, except as described in the Fertility Benefit Appendix. 10. Services for or related to reversal of sterilization.

Physical, Occupational, and Speech Therapy

The Plan Covers:	In-network Providers	Out-of-network Providers
• Habilitative and rehabilitative office visits from a physical therapist	You pay nothing after deductible	NO COVERAGE
• Habilitative and rehabilitative therapies from a physical therapist	You pay nothing after deductible	NO COVERAGE
• Habilitative and rehabilitative office visits from an occupational therapist	You pay nothing after deductible	NO COVERAGE
• Habilitative and rehabilitative therapies from an occupational therapist	You pay nothing after deductible	NO COVERAGE
• Habilitative and rehabilitative office visits from a speech or language pathologist	You pay nothing after deductible	NO COVERAGE
• Habilitative and rehabilitative therapies from a speech or language pathologist	You pay nothing after deductible	NO COVERAGE
• Allina Spine Center of Excellence (see NOTES)	You pay nothing after deductible	NO COVERAGE

Physical, Occupational, and Speech Therapy – Notes

1. **For more information regarding eligible services provided by Allina Spine Center of Excellence and to determine if you meet criteria call toll free at 1-800-827-8313.**
2. Coverage includes benefits for spinal manipulations for the detection and correction by manual or mechanical means of structural imbalance or subluxation resulting from or related to distortion, misalignment, or subluxation of or in the vertebral column.
3. For physical, occupational and speech therapy services billed by a hospital/facility, please refer to "Hospital Inpatient Care" and "Hospital Outpatient Care."
4. Office visits may include an evaluation or re-evaluation of the following therapies:
   a. physical;
   b. occupational;
   c. speech; or
   d. swallowing.
5. For laboratory and diagnostic imaging services billed by a health care professional, please refer to "Office Visit and Professional Services." For laboratory and diagnostic imaging services billed by a hospital/facility, please refer to "Hospital Inpatient Care" or "Hospital Outpatient Care." The plan covers at-home exercise therapy for members experiencing musculoskeletal (MSK) related joint, bone or muscle pain. This MSK Condition Management Program provides a holistic approach from prevention, to acute, to chronic, to pre- and post-surgical care. The MSK Condition Management Program utilizes a unique, non-invasive pain management device as well as sensor and computer-vision based technology to partner a member with a Hinge Health physical therapist and health coach to provide up to 365 days of therapy and education. To register, please visit the member website www.bluecrossmn.com/allinahealth.

Physical, Occupational, and Speech Therapy – Not Covered

1. Services for or related to vocational rehabilitation (defined as service provided to an injured employee to assist the employee to return to either their former employment or a new position, or services to prepare a person with disabilities for employment), except when medically necessary and appropriate and provided by an eligible health care provider

Physical, Occupational, and Speech Therapy – Not Covered
2. Services for outpatient therapy and rehabilitation services for which there is no expectation of restoring or improving a level of function or when no additional functional progress is expected to occur, unless medically necessary and appropriate

Preventive Care

The Plan Covers:	In-network Providers	Out-of-network Providers
Preventive care services to prevent illness, disease or other health problems before symptoms occur are covered according to a predefined schedule based on certain risk factors. These include, but are not limited to, recommendations of the United States Preventive Services Task Force (USPSTF), Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control, Health Resources and Services Administration (HRSA), American Academy of Pediatrics (AAP), and the Internal Revenue Service (IRS). For more information regarding preventive care services, log onto the member website at bluecrossmn.com or call customer service at the telephone number listed on the back of your member ID card.		
Adults and children age 6 and older		
• Preventive physical examinations	You pay nothing	NO COVERAGE
• Routine vision screening	You pay nothing	NO COVERAGE
• Hearing screening	You pay nothing	NO COVERAGE
• Adult immunizations that require administration by a health care provider, including the immunizing agent, when required for the prevention of disease	You pay nothing	NO COVERAGE
• Diagnostic services and procedures ▪ surveillance tests for ovarian cancer - (CA125 tumor marker, trans-vaginal ultrasound, pelvic examination)	You pay nothing	NO COVERAGE
• Routine gynecological examinations, including a Papanicolaou (PAP) test	You pay nothing	NO COVERAGE
• Mammograms, 2 dimensional (2D) or 3 dimensional (3D), annual routine and medically necessary and appropriate	You pay nothing	NO COVERAGE
• Colorectal cancer screening • Prostate specific antigen (PSA) tests and digital rectal examinations for men of all ages	You pay nothing	NO COVERAGE
Pediatric		
• Infants and children ▪ preventive physical examinations from birth to age six (6) ▪ developmental assessments from birth to age six (6)	You pay nothing	NO COVERAGE
▪ pediatric immunizations from birth to age 18	You pay nothing	NO COVERAGE
▪ Diagnostic services and procedures from birth to age 6	You pay nothing	NO COVERAGE

Preventive Care – Notes

1. Preventive care services are consistent with applicable federal statutes, regulations, and related guidance. The Plan will cover new preventative care recommendations and guidelines at 100% as soon as administratively feasible following the date the recommendations or guidelines are issued, but in no event later than January 1 of the year following the year in which the recommendation or guideline was issued.
2. Preventive examinations include a complete medical history, complete physical examination, as well as screening and counseling for obesity, depression, and tobacco cessation.
3. Pediatric preventive care services are limited to those on the health plan's preventive schedule. Gender, age and frequency limits may apply.
4. The claims administrator periodically reviews the schedule of covered services based on the requirements of the Patient Protection and Affordable Care Act of 2010, and recommendations from USPSTF, ACIP of the Centers for Disease Control, HRSA, and the IRS. Therefore, the frequency and eligibility of services is subject to change. Benefits include periodic physical examinations, well child visits, immunizations and selected diagnostic tests. For a current schedule of covered services, log onto the member website at bluecrossmn.com (choose the "Live Healthy" tab at the top, then "Preventive Care"), or contact customer service at the telephone number listed on the back of your member ID card.
5. The plan covers: an initial physical examination to confirm pregnancy, folic acid supplement for members planning to become pregnant, counseling for contraceptive methods, counseling and support for breastfeeding, and the purchase of an electric or manual breast pump, or rental charges for a hospital-grade breast pump, and breast pump supplies.
6. The plan covers screening for sexually transmitted disease or HIV at the in-network level.
7. Benefits are provided for surgical implants and tubal ligation for elective sterilization for females which meet the recommendations and criteria established by the United States Preventive Services Task Force (USPSTF), Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control, and the Health Resources and Services Administration (HRSA). For more information regarding elective sterilization coverage log onto the member website at bluecrossmn.com or call customer service at the telephone number listed on the back of your member ID card.
8. Benefits are provided for a full range of FDA-approved preventive contraceptive methods and for patient education/counseling, for women with reproductive capacity as prescribed which meet the recommendations and criteria established by the United States Preventive Services Task Force (USPSTF), Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control, and the Health Resources and Services Administration (HRSA), as applicable. Medical management may apply.
9. Services for complications related to female contraceptive drugs, devices, and services for women with reproductive capacity may be covered under other plan benefits. Please refer to "Hospital Inpatient Care, "Hospital Outpatient Care, "Office Visit and Professional Services," etc. for appropriate benefit levels.
10. Please refer to "Hospital Inpatient Care," "Hospital Outpatient Care," "Office Visit and Professional Services," etc. when services are for: complications or an illness/injury diagnosed as a result of preventive care services, or preventive care services in excess of applicable federal preventive recommendations and criteria.
11. Benefits are provided for the following tests or procedures when ordered by a physician for the purpose of early detection of colorectal cancer:
    a. diagnostic laboratory and pathology screening services such as a fecal-occult blood or fecal immunochemical test
    b. diagnostic imaging screening services such as barium enema
    c. surgical screening services such as flexible sigmoidoscopy and colonoscopy and hospital services related to such surgical screening services
    d. such other diagnostic pathology and laboratory, diagnostic imaging, surgical screening tests and diagnostic screening services consistent with approved medical standards and practices for the detection of colon cancer.

Reconstructive Surgery

The Plan Covers:	In-network Providers	Out-of-network Providers
• Reconstructive surgery which is incidental to or follows surgery resulting from injury, sickness, or other diseases of the involved body part • Reconstructive surgery performed on a dependent child because of congenital disease or anomaly which has resulted in a functional defect as determined by the attending health care provider. • Elimination or maximum feasible treatment of port wine stains • Treatment of cleft lip and palate including: ▪ dental implants ▪ removal of impacted teeth or tooth extractions ▪ related orthodontia ▪ related oral surgery ▪ bone grafts	You pay nothing after deductible	NO COVERAGE

Reconstructive Surgery – Notes
1. If more than one (1) surgical procedure is performed by the same provider during the same operation, the plan covers the surgical procedures based on the allowed amount for each procedure. The plan does not cover a charge separate from the surgery for pre-operative and post-operative care. 2. Congenital means present at birth. 3. For hospital/facility services, please refer to "Hospital Inpatient Care" and "Hospital Outpatient Care."

Reconstructive Surgery – Not Covered
1. Repairs of scars and blemishes on skin surfaces. 2. Oral surgery procedures, except as provided herein. 3. Dentures, regardless of the cause or condition, and any associated services including bone grafts. 4. Dental implants and associated services, except when related to services for cleft lip and palate.

Skilled Nursing Facility Care

The Plan Covers:	In-network Providers	Out-of-network Providers
• Skilled care ordered by a physician • Room and board • General nursing care • Prescription drugs used during a covered admission • Physical, occupational, and speech therapy	You pay nothing after deductible	NO COVERAGE

Skilled Nursing Facility Care – Notes
1. Skilled care ordered by a physician includes skilled care ordered by an advanced practice nurse or physician assistant when ordered within the scope of their licensure.

Skilled Nursing Facility Care – Not Covered
1. Custodial care. 2. Services after you have reached the maximum level of recovery possible for your particular condition and no longer require definitive treatment other than routine supportive care. 3. Services when confinement is intended solely to assist you with the activities of daily living or to provide an institutional environment for your convenience. 4. Services for or related to extended hours skilled nursing care, also referred to as private-duty nursing care.

Transplant

The Plan Covers:	In-network Providers	Out-of-network Providers
• Bone marrow/stem cell • Heart • Heart-lung • Liver • Liver-kidney • Lung	You pay nothing of the transplant payment allowance after deductible for the transplant admission when you use a Blue Distinction Centers for Transplant (BDCT) provider	NO COVERAGE

Transplant – Notes
1. Prior authorization must be obtained before a transplant procedure. 2. The donor's medical expenses directly related to the organ donation are covered under the recipient's plan. Treatment of any medical complications that occur to the donor are not covered under the recipient's plan. 3. Eligible transplants not performed in conjunction with a major organ transplant noted above are covered on the same basis as any other illness. Please refer to "Hospital Inpatient Care," "Hospital Outpatient Care," and "Office Visit and Professional Services." For services not included in the transplant payment allowance, refer to the individual benefit sections that apply to the services being performed to determine the correct level of coverage. 4. BDCT facilities have a contract with the Blue Cross and Blue Shield Association (an association of independent Blue Cross and Blue Shield plans) to provide transplant procedures. These facilities have been selected to participate in this nationwide network based on their ability to meet defined clinical criteria that are unique for each type of transplant. Facilities are reevaluated regularly to ensure that they continue to meet the established criteria to participate in this network. 5. Eligible transplant services provided by participating transplant providers will be paid at the Blue Distinction Centers for Transplant (BDCT) provider level of benefits when the transplant services are not available at a BDCT provider. 6. If you live more than 50 miles from a BDCT provider, there may be a benefit available for travel expenses directly related to a preauthorized transplant.

Transplant – Not Covered
1. Services for or related to surgical implantation of nonhuman or mechanical devices that serve as a human organ. An exception is the surgical implantation of FDA-approved Ventricular Assist Devices (VAD) to serve as a temporary bridge to a heart transplant. 2. Benefits for travel expenses when you are using a Non-BDCT provider.

General Exclusions

Except as specifically provided in this health plan or as the plan is mandated or required to provide based on federal law, no benefits will be provided for services, supplies, prescription drugs or charges noted under "Not Covered" in the Benefit Chart and as noted below.

No benefits will be provided for the following:

1. Services for or related to bariatric surgery when you use a nonparticipating provider.
2. Services which are not medically necessary and appropriate based on the definition of “medically necessary and appropriate” in “Terms You Should Know.”
3. Services which are experimental/investigative in nature, except for certain routine care for approved clinical trials.
4. Services that are prohibited by law or regulation.
5. Services rendered prior to your effective date of coverage.
6. Services incurred after the date of termination of your coverage.
7. Services for dependents if you have employee-only coverage.
8. Services that are provided without charge, including services of the clergy.
9. Services rendered by a provider who is a member of your immediate family.
10. Services that are not within the scope of licensure or certification of a provider.
11. Services from providers who are not health care providers.
12. To the extent benefits are provided to members of the armed forces while on active duty or to members in Veteran's Administration facilities for service-connected illness or injury, unless you have a legal obligation to pay.
13. Custodial care, nonskilled care, adult daycare or personal care attendants.
14. Services for or related to care that can be provided by a non-skilled caregiver who has been trained or is capable of being trained.
15. Room and board for outpatient services.
16. Services for or related to cosmetic health services or surgery and related services, and treatment for conditions or problems related to cosmetic surgery or services, except as provided herein.
17. Any portion of a charge for a covered service or supply that exceeds the allowed amount, except as provided herein.
18. Physical examinations for the sole purpose of obtaining/maintaining employment, insurance, licensing, certification, or physicals for school, camp, or sports.
19. Services for or related to lenses, frames, contact lenses, and other fabricated optical devices or professional services for the fitting and/or supply thereof, including the treatment of refractive errors such as radial keratotomy, except as provided herein.
20. Services for palliative or cosmetic foot care including flat foot conditions, the treatment of subluxations of the foot, care of corns, bunions, (except capsular or bone surgery), calluses, toenails (except surgery for ingrown toenails), fallen arches, weak feet, chronic foot strain, and symptomatic complaints of the feet.
21. Services, testing, equipment, devices, technologies and supplies purchased or available over-the-counter, whether or not prescribed by a health care provider, unless covered under preventive care.
22. Services for or related to hearing aid devices and tinnitus maskers, except as provided herein.
23. Physical, occupational, and speech therapy services for or related to the treatment of learning disabilities and disorders, except when medically necessary and appropriate and provided by an eligible health care provider.
24. New to market FDA-approved drugs, devices, diagnostics, therapies, and medical treatments until they have been reviewed and approved by the claims administrator and deemed eligible for coverage.

25. To the extent payment has been made under Medicare when Medicare is primary; however, this exclusion shall not apply when the group is obligated by law to offer you all the benefits of this health plan and you elect this coverage as primary.
26. Charges for the covered patient's failure to keep a scheduled visit.
27. Charges billed by your provider for the completion of a claim form.
28. Any other medical or dental service or treatment or prescription drug, except as provided herein.
29. For treatment or services for injuries resulting from the maintenance or use of a motor vehicle, including a motor vehicle accident, if such treatment or service is eligible, paid or payable under a plan or policy of motor vehicle insurance, including a certified or qualified plan of self-insurance, or any fund or program for the payment of extraordinary medical benefits established by law, including medical benefits payable. Charges that are eligible, paid, or payable under any medical payment, automobile personal injury protection that is payable without regard to fault, including charges for services that are applied toward any deductible, copay or coinsurance requirement of such a policy.
30. Fees, dues, nutritional supplements, food, vitamins, and exercise therapy for or related to weight loss programs.
31. Services for or related to care that is custodial or not normally provided as preventive care or for treatment of an illness/injury.
32. Services which are not prescribed by or performed by or upon the direction of a professional provider.
33. Services which are submitted by another professional provider of the same specialty for the same services performed on the same date for the same member.
34. Services that are primarily for the convenience of the member, physician, or health care provider or are more costly than alternative services or sequence of services that are clinically appropriate and are likely to produce equivalent therapeutic or diagnostic results to treat the member's illness, injury, or disease.
35. Services performed by a professional provider enrolled in an education or training program when such services are related to the education or training program.
36. Services after you have reached the maximum level of recovery possible for your particular condition and no longer require definitive treatment other than routine supportive care.
37. Services for or related to tobacco cessation program fees and/or supplies, except as provided herein.
38. Services for or related to weight reduction programs, including all diagnostic testing related to weight reduction programs, unless medically necessary and appropriate.
39. Services for or related to any illness or bodily injury which occurs in the course of employment if benefits or compensation are available, in whole or in part, under the provisions of any federal, state, or local government's workers' compensation, occupational disease or similar type legislation. This exclusion applies whether or not you claim the benefits or compensation.
40. Expenses incurred for services, supplies, medical care or treatment received at a health care provider that represents to a patient that they will not owe the required cost-sharing amount (including, for example, deductibles, copays, and coinsurance) described in this plan.
41. Services for or related to acupuncture, except for medically necessary and appropriate acupuncture services for the treatment of chronic pain (defined as a duration of six (6) months); and for the prevention and treatment of nausea associated with surgery, chemotherapy, or pregnancy.
42. Services for or related to recreational therapy (defined as the prescribed use of recreational or other activities as treatment interventions to improve the functional living competence of persons with physical, mental, emotional and/or social disadvantages); educational therapy (defined as special education classes, tutoring, and other nonmedical services normally provided in an educational setting); or forms of nonmedical self-care or self-help training, including, but not limited to: health club memberships; aerobic conditioning; therapeutic exercises; work hardening programs; spas; etc., and all related material and products for these programs.
43. Services for furnishing medical records or reports and associated delivery services.
44. Services for transportation, other than local ambulance service, to the nearest medical facility provider that can provide the necessary services/is equipped to treat the condition, except as provided herein.
45. Ambulance transportation costs that exceed the allowable cost from the place of departure to the nearest medical facility that can provide the necessary service/is equipped to treat the condition.

46. Services for or related to therapeutic massage.
47. Services for or related to experimental infertility treatment procedures, surrogacy services, or cryopreservation of eggs or sperm, except as described in the Fertility Benefit Appendix.
48. Charges for donor ova or sperm, except as described in the Fertility Benefit Appendix.
49. Services for or related to preservation, storage, and thawing of human tissue, including, but not limited to: sperm; ova; embryos; stem cells; cord blood; and any other human tissue, except as described in the Fertility Benefit Appendix.
50. Services and prescription drugs for or related to Assisted Reproductive Technology (ART) including Artificial Insemination (AI), and IntraUterine Insemination (IUI) procedures, except as described in the Fertility Benefit Appendix.
51. Services provided during an e-visit for the sole purpose of: scheduling medical appointments; reporting normal medical test results; providing educational materials; updating patient information; requesting a referral; additional communication on the same day as an onsite medical office visit; and services that would similarly not be charged for in an onsite medical office visit.
52. Services provided during a telehealth visit for the sole purpose of: scheduling appointments; filling or renewing existing prescription medications; reporting normal medical test results; providing educational materials; updating patient information; requesting a referral; additional communication on the same day as an onsite medical office visit; and services that would similarly not be charged for in an onsite medical office visit.
53. Services and fees for or related to health clubs and spas.
54. Services for or related to the repair of scars and blemishes on skin surfaces.
55. Services for hippotherapy (equine movement therapy).
56. Maintenance services unless part of a specialized therapy for the member’s condition.
57. Services that do not involve direct patient contact such as delivery services and recordkeeping billed by an out-of-network provider.
58. Services primarily educational in nature, except as provided herein.
59. Services for or related to functional capacity evaluations for vocational purposes or the determination of disability or pension benefits.
60. Services for or related to gene therapy or cellular therapy until they have been evaluated by the claims administrator and deemed eligible for coverage.
61. Services for or related to any treatment, equipment, drug, and/or device that does not meet generally accepted standards of practice in the medical community, including but not limited to, homeopathy, naturopathy, and reiki.
62. Charges for chelation therapy, except when medically necessary and appropriate.
63. Charges for growth hormone replacement therapy, except for services that meet medical necessity and appropriateness criteria.
64. Investigative or non-FDA approved drugs, except as provided by law.
65. Charges for selected drugs or classes of drugs which have shown no benefit regarding efficacy, safety, or health outcomes.
66. Prescription drugs including, but not limited to, biological products, biosimilars, and gene or cellular therapies, that have an alternative drug available that is similar in safety and effectiveness and is more cost-effective.
67. Solid or liquid food, standard or specialized infant formula, banked breast milk, nutritional supplements, and electrolyte solution, except if administered by tube feeding and as provided in the "Benefit Chart."
68. Charges for therapeutic drugs that can be self-administered.
69. Self-administered drugs that are available for coverage under any applicable pharmacy/prescription drug benefit.
70. Blenderized food, baby food, or regular shelf food when used with an enteral system, or banked breast milk.
71. Infant formula with intact proteins.
72. Any formula (standard and specialized), when used for the convenience of you or your family members.

73. Any non-prescription substance utilized for the sole purpose of weight loss or gain, or for caloric supplementation, limitation or maintenance.
74. Vitamin or dietary supplements, except as provided herein.
75. Charges for food supplements.
76. Nonprescription supplies such as alcohol, cotton balls, and alcohol swabs.
77. Intact protein/protein isolates, including but not limited to, semisynthetic, natural, plant-based, or hydrolyzed, when taken orally (for example, protein powders).
78. Bulk powders, chemicals, ingredients, and products used in prescription drug compounding.
79. Normal food products used in the dietary management of rare hereditary genetic metabolic disorders.
80. Services for or related to fetal tissue transplantation.
81. Travel expenses for an organ donor.
82. Organ donor expenses for complications incurred after the organ is removed if the donor is not covered under this health plan.
83. Organ donor expenses when the recipient is not covered for the organ transplant under this health plan.
84. Outpatient prescription drugs whether purchased through a mail service pharmacy/90dayRx or a retail pharmacy, are not covered under this plan. Refer to your employer for prescription drug plan materials that explain your coverage.
85. Charges for therapeutic devices or appliances (e.g., support garments and other non-medicinal substances).

Health Care Management

Medical and Behavioral Health Care Management

The claims administrator reviews services to verify that they are medically necessary and appropriate, and that the treatment provided is the proper level of care. The claims administrator's review includes applying medical criteria that may require a provider to submit a treatment plan. All applicable terms and conditions of your plan including exclusions, deductibles, copays, and coinsurance provisions continue to apply with an approved prior authorization or admission notification, or emergency admission notification.

Prior authorization and admission notification are required for specific services.

If the care you receive is due to a medical emergency, prior authorization is not required.

If you are admitted to the hospital due to an emergency, admission notification is required as soon as reasonably possible, no later than two (2) business days, following the admission.

Prior Authorization

Prior authorization is a process that involves a benefits review and determination of medical necessity and appropriateness before a service is rendered. Prior authorization should be obtained before a service is rendered and, if applicable, before additional services are rendered beyond what has previously been approved. The claims administrator's prior authorization list describes the services for which prior authorization is required. The prior authorization list is subject to change due to changes in the claims administrator's medical and behavioral health policies. The claims administrator reserves the right to revise, update and/or add to this list at any time without notice. The most current list is available on the claims administrator's website at bluecrossmn.com or contact customer service at the telephone number listed on the back of your member ID card. They will direct your call.

A continued stay review (inpatient) or extension request (outpatient) is a process that involves review of an ongoing service for a member with an existing authorization or an admission notification for acute hospitalization. It includes determining whether the current health care facility is still the most appropriate to provide the level of care required for the patient, or whether continued care is medically necessary. These types of review may also be referred to as "concurrent review."

Participating Providers in Minnesota and Bordering Counties

For services that require prior authorization participating providers in Minnesota and bordering counties are required to obtain prior authorization for you. Participating providers in Minnesota and bordering counties who do not obtain required prior authorization are responsible for the charges (except where other benefit exclusions apply).

Nonparticipating Providers and Participating Providers Located Outside of Minnesota and Bordering Counties

You are required to obtain prior authorization when you use nonparticipating providers and any provider outside of Minnesota/bordering counties. Some of these providers may obtain prior authorization for you. Verify with your providers if this is a service they will perform for you or not. If prior authorization is not completed and at the point the claim is processed it is found that services received from a nonparticipating provider or any provider outside of Minnesota/bordering counties were not medically necessary and appropriate, you are liable for all of the charges.

The claims administrator prefers that all requests for prior authorization be submitted in writing to ensure accuracy. **Please contact customer service at the telephone number listed on the back of your member ID card for the appropriate fax number or mailing address for prior authorization requests.**

Standard review process

The claims administrator requires that you or the provider contact them at least 10 business days prior to the provider scheduling the care/services to determine if the services are eligible. The claims administrator will notify you of their decision within 10 business days, provided that the prior authorization request contains all the information needed to review the service.

Expedited review process

The claims administrator will use an expedited review process when the application of a standard review could seriously jeopardize your life or health or if the attending health care professional believes an expedited review is warranted. When an expedited review is requested, the claims administrator will notify you as expeditiously as the medical condition requires, but no later than 72 hours from the initial request, unless more information is needed to

determine whether the requested benefits are covered. If the expedited determination is to not authorize services, you may submit an expedited appeal. Please refer to "Appeals of Adverse Benefit Determinations" for more information about submitting an expedited appeal.

The claims administrator prefers that all requests for prior authorization be submitted to them in writing to ensure accuracy. Please contact customer service at the telephone number listed on the back of your member ID card for the appropriate fax number or mailing address for prior authorization requests.

Admission Notifications

- **Admission notification** is a process whereby the provider, or you, inform the claims administrator that you will be admitted for inpatient hospitalization or post-acute care services separate from prior authorization. The claims administrator requires that you, or your provider, as determined below, call us at least two (2) days prior to being admitted, or as soon as reasonably possible, no later than two (2) business days, following the admission.
- **Emergency admission notification** is a process whereby the provider, or you, inform the claims administrator of an unplanned or emergency admission, no later than two (2) business days, following the admission.

Upon receipt of an admission notification, when required, the claims administrator will provide a review of medical necessity and appropriateness related to a specific request for care or services. As needed during an admission, the claims administrator will review the continued stay to determine medical necessity and appropriateness and to help you when you are discharged.

You, or your provider, may also be required to obtain prior authorization for the services or procedures done during a hospital stay; for example, an elective surgery that requires you to be admitted to the hospital. Please refer to "Prior Authorization" in this section to determine if you, or your provider, is responsible for obtaining any required prior authorization(s).

Participating Providers

Participating providers in Minnesota and participating providers outside of Minnesota are required to provide admission notification and emergency admission notification for you. You will not be held responsible if notification is not completed when using participating providers.

Nonparticipating Providers

You are required to provide admission notification to the claims administrator if you are going to receive care from any nonparticipating providers. Some of these providers may provide admission notification for you. Verify with your provider if this is a service they will perform for you or not.

To provide admission notification, contact customer service at the telephone number listed on the back of your member ID card.

Note: If, at the point the claim is processed, it is found that any services received from a nonparticipating provider were not medically necessary and appropriate, you are liable for all the charges.

Medical and Behavioral Health Care Management Overview

The following chart is an overview of the information outlined in the previous section. For more detail, refer to the previous section.

Services received from:	Prior Authorization	Admission Notification	Emergency Admission Notification
Participating Provider Minnesota/Bordering Counties	Provider is responsible to request this for you and the provider must send the request in writing at least 10 business days prior to services.	Provider is responsible for completing the notification at least 72 hours prior to the admission, or as soon as reasonably possible, no later than two (2) business days, following the admission.	Provider is responsible for completing the notification as soon as reasonably possible, no later than two (2) business days, following the admission.

Services received from:	Prior Authorization	Admission Notification	Emergency Admission Notification
Participating Provider Outside of Minnesota/ Bordering Counties	You are responsible for obtaining the prior authorization and you must send the request in writing at least 10 business days prior to services.	Provider is responsible for completing the notification at least 72 hours prior to the admission or as soon as reasonably possible, no later than two (2) business days, following the admission.	Provider is responsible for completing the notification as soon as reasonably possible, no later than two (2) business days, following the admission.
Nonparticipating Provider Nationwide	You are responsible for obtaining the prior authorization and you must send the request in writing at least 10 business days prior to services.	You are responsible for completing the notification and you must call at least 72 hours prior to the admission or as soon as reasonably possible, no later than two (2) business days, following the admission.	You are responsible for completing the notification and you must call as soon as reasonably possible, no later than two (2) business days, following the admission.

How Your Program Works

Your health plan lets you get the care you want from the provider you select. When you or a covered family member needs medical care, you can choose between two (2) levels of health care services: **Allina Elevate Network** or **out-of-network urgent care.**

Network Care

Network care is care you receive from providers in the health plan's Allina Elevate network .

When you receive health care within the Allina Elevate network, you receive maximum coverage and maximum convenience. You present your member ID card to the provider who submits your claim.

Out-of-Network Care

Out-of-network care is care you receive from providers who are not in the Allina Elevate network.

When you go outside the network, you will still be covered for eligible urgent care services. However, your out-of-network urgent care benefits generally will be paid at the lower, out-of-network level. Additionally, prior authorization may be required from the claims administrator before services are received. For specific details, please refer to "Health Care Management."

Please note that you may incur significantly higher financial liability when you use out-of-network urgent care providers compared to the cost of receiving care from Allina Elevate network providers. If you receive urgent care services from out-of-network providers, you may be responsible for any deductibles or coinsurance plus the DIFFERENCE between what the claims administrator would reimburse for the out-of-network provider and the actual charges the out-of-network provider bills. This difference does not apply to your out-of-pocket limit. This is in addition to any applicable deductible, copay or coinsurance. Benefit payments are calculated on the claims administrator's allowed amount, which is typically lower than the amount billed by the provider. In addition, participating facilities may have nonparticipating professionals practicing at the facility and you may be responsible for significantly higher out-of-pocket expenses for the nonparticipating professional services, to the extent permitted under the No Surprises Act.

Out-of-Area Care

Your health plan also provides coverage for urgent care only for you and your eligible dependents who are temporarily away from home, or those dependents who permanently reside away from home.

If you are traveling and an urgent injury or illness occurs, you should seek treatment from the nearest hospital, emergency room or clinic:

If the illness or injury is a true emergency, it will be covered at the Allina Elevate network level, regardless of whether the provider is in the local Blue Cross and Blue Shield PPO network. If the treatment results in an admission, the local Blue Cross and Blue Shield PPO network provider must obtain prior authorization from the claims administrator. However, it is important that you confirm the claims administrator's determination of medical necessity and appropriateness. If the admission is not considered to be medically necessary and appropriate, you will be responsible for all costs associated with the stay. For specific details, please refer to "Health Care Management."

If the illness or injury is not a medical emergency or does not necessitate urgent care, you are required to use providers in the Allina Elevate network. If you receive urgent care from an out-of-network provider, benefits for eligible services will be provided at the lower, out-of-network level of benefits. Medical emergency care is covered at in-network rates.

General Provider Payment Methods

This is a general summary of provider payment methodologies only. Provider payment methodologies may change from time to time and every current provider payment methodology may not be reflected in this summary. Please note that some of these payment methodologies may not apply to your particular plan.

Participating Providers

Under the payment arrangements of the participating provider agreements, providers have agreed to provide care and receive the contractual allowed amount as payment in full, less member cost-sharing (e.g., deductible, coinsurance, copays) or amounts paid by other insurance for health services. The allowed amount may vary from one (1) provider to another for the same service. These payment amounts generally result in the provider being paid less overall than its billed charges.

The allowed amount may not include other payment adjustments which may occur periodically including settlements to capture complex claims accurately, settlements for withhold, capitation, outlier cases, fee schedule adjustments, rebates, prospective payments, or other methods. Such adjustments are completed without reprocessing individual claims. These settlements will not cause any change in the amount members paid at the time of claims processing. If the payment to the provider is decreased, the amount of the decrease is credited to the claims administrator, and if the payment to the provider is increased, the claims administrator will pay that cost.

Several industry-standard methods are used to pay health care providers. If the provider is "participating" they are under contract and the method of payment is part of the contract. Most contracts and payment rates are negotiated or revised on an annual basis.

Depending upon your health plan, a participating provider may be an in-network provider or may be an out-of-network provider. Payment will be based upon which network the participating provider is in for your health plan. Please refer to "How Your Plan Works" for additional detail on covered services received in the in-network and out-of-network.

- Professional (i.e., doctor visits, office visits)
  - **Fee-for-Service or Discounted Fee-for-Service -** Providers are paid for each service or bundle of services. Payment is based on a fee schedule allowance for each service or a percentage of the provider's billed charges.
  - **Withhold and Bonus Payments -** Providers are paid based upon a fee schedule or percentage of billed charges, and a portion is withheld. As an incentive to promote high quality and cost-effective care, the provider may receive all or a portion of the withhold amount based upon the cost-effectiveness of the care while demonstrating the optimal treatment for patients.
  - **Capitation Payments –** Providers may be paid in part based upon a per person per month capitation amount. This amount is calculated based upon historical costs and volumes to determine the average costs for providing medically necessary care to a patient.
- Institutional (i.e., hospital and other facility provider)
  - Inpatient care
    - **Payments for each Case (case rate) or for each day (per diem) -** Providers are paid a fixed amount based upon the member's diagnosis at the time of admission in a hospital facility.
    - **Percentage of Billed Charges -** Providers are paid a percentage of the hospital's or facility provider's billed charges for inpatient services.
    - **DRG Payments –** All Patient Refined Diagnosis Related Groups (APR DRG) or other DRG payments apply to most inpatient claims. DRG payments are based upon the full range of services the patient typically receives to treat the condition.
  - Outpatient care
    - **Enhanced Ambulatory Patient Groupings (EAPG) –** Used for payment on most outpatient claims. EAPG payments are based upon the full range of services the patient typically receives to treat the condition.
    - **Payments for each Category of Services -** Providers are paid a fixed or bundled amount for each category of outpatient services a member receives during one (1) or more related visits.
    - **Payments for each visit -** Providers are paid a fixed or bundled amount for all related services a member receives during one (1) visit.
    - **Percentage of Billed Charges –** Providers are paid a percentage of their regular billed charges for services.
- Special Incentive Payments

  As an incentive to promote high quality, cost-effective care and to recognize those providers that participate in certain quality improvement projects, providers may be paid extra amounts based on the quality of the care and on savings that the provider may generate through cost effective care. Certain providers also may be paid in advance in recognition of their efficiency in managing the total cost of providing high quality care and implementing programs such as care coordination. Quality is measured against adherence to recognized quality criteria and improvement such as optimal diabetes care, supporting tobacco cessation, cancer screenings, and other services.

Cost of care is based on quantifiable criteria to demonstrate managing claims costs. These quality and cost incentives are not reflected in claims payment.

- Pharmacy Payment

  Generally, four (4) types of pricing are compared and the lowest amount is paid the:

  - average wholesale price of the prescription drug, less a discount, plus a dispensing fee;
  - pharmacy's retail price;
  - maximum allowable cost the claims administrator determines by comparing market prices (for generic drugs only); or
  - pharmacy's billed charge.

Nonparticipating Providers

A nonparticipating provider does not have any agreement with the claims administrator or another Blue Cross and/or Blue Shield plan. Nonparticipating providers are not credentialed or subject to the requirements of a participating agreement.

The allowed amount for a nonparticipating provider is not the amount billed and is usually less than the allowed amount for a participating provider for the same service and can be significantly less than the billed charge. Members are responsible to pay the difference between the claims administrator's allowed amount and the nonparticipating provider's billed charge, unless the provider is forbidden from balance billing under the No Surprises Act. This amount can be significant and does not count toward any out-of-pocket limit contained in the plan.

Payment for covered services provided by a nonparticipating provider will be made at the out-of-network level, unless the plan is required to pay at the in-network level under the No Surprises Act. Please refer to "Out-of-network Care" and "In-network Care" for additional detail on covered services received in-network and out-of-network.

Example

The following illustrates the different out-of-pocket costs you may incur using nonparticipating versus participating providers. The example presumes that your deductible has been satisfied and that the health plan covers 80% for participating providers and 60% for nonparticipating providers.

	Participating Provider	Nonparticipating Provider
Provider charge:	$150	$150
Allowed amount:	$100	$80
Plan pays:	80% ($80)	60% ($48)
Coinsurance you owe:	20% ($20)	40% ($32)
Difference up to billed charge you owe:	None	$70 ($150 minus $80)
You pay:	$20	$102

Special Circumstances

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copay, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that is not in your health plan's network.

What is "balance billing" (sometimes called "surprise billing")?

Nonparticipating providers and facilities that have not signed a contract with your health plan may be permitted to bill you for the difference between what your plan agreed to pay and the full amount charged for a service. This is called "balance billing." This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you cannot control who is involved in your care-like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by a nonparticipating provider.

Your Rights and Protections Against Surprise Medical Bills

There may be circumstances where you require medical or surgical care and you do not have the opportunity to select the provider of care. These circumstances could include nonparticipating providers in an in-network hospital, your in-network physician using a nonparticipating laboratory, post-stabilization following emergency services, or medically necessary air ambulance services.

When you get emergency care or get treated by a nonparticipating provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing. In-network cost-sharing for these services must be applied to your in-network deductible/out-of-pocket maximum.

When a claim is identified as a special circumstance, payment will be made to the nonparticipating provider when required by law. These nonparticipating providers can negotiate with the claims administrator for a higher allowed amount after the initial payment has been made. This may result in an increase to the amount applied to your in-network cost-sharing. For additional information, you can contact customer service at the telephone number listed on the back of your member ID card or log onto your claims administrator's website atwww.bluecrossmn.com/allinahealth.

You are protected from balance billing for:

- Certain services at an in-network hospital or ambulatory surgical center - When you get services from an in-network hospital or ambulatory surgical center, certain providers may be nonparticipating providers. In these cases, the most those providers may bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers cannot balance bill you and may not ask you to give up your protections not to be balance billed.
- Emergency services - If you have an emergency medical condition and get emergency services from a nonparticipating provider or facility, the most the provider or facility may bill you is your plan's in-network cost-sharing amount (such as copayments and coinsurance). You can't be balance billed for these emergency services. This includes services you may get after you are in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.
- Surprise Air Ambulance Bills – Emergency air ambulance transportation that is provided to you by nonparticipating providers will be reimbursed at in-network cost-sharing rates. Nonparticipating air ambulance providers cannot balance bill you. They can only bill you for the usual cost-sharing amount set by your plan. In addition, in-network cost-sharing for these services must be applied to your in-network deductible/out-of-pocket maximum. Please refer to "Ambulance" for coverage of benefits.

Steps You Can Take

If you receive a bill from a nonparticipating provider while using a participating hospital or facility, and you did not provide written consent to receive the services, this could be a "surprise" or "balance" bill. If you have questions regarding what a "surprise" or "balance" bill is, call customer service at the number on the back of your ID card or visit the claims administrator's website at www.bluecrossmn.com/allinahealth. The extent of reimbursement in certain medical emergency circumstances may also be subject to state and federal law, please refer to "Emergency Care" for coverage of benefits. You may appeal a decision that your claim does not qualify as a special circumstance. Please refer to "Appeal Process."

Women's Health and Cancer Rights Act

Under the federal Women's Health and Cancer Rights Act of 1998, you are entitled to the following services:

1. all stages of reconstruction of the breast on which the mastectomy has been performed;
2. surgery and reconstruction of the other breast to produce a symmetrical appearance; and
3. prostheses and physical complications at all stages of mastectomy, including lymphedema, in a manner determined in consultation with the attending physician and patient.

Coverage may be subject to annual deductible, copay, and coinsurance provisions as may be deemed appropriate and as are consistent with those established for other benefits under the plan or coverage.

Coverage of Health Care Services on the Basis of Gender

Federal law prohibits denying or limiting health services, that are ordinarily or exclusively available to individuals of one gender, to a transgender individual because of the individual's gender assigned at birth, gender identity, or gender otherwise recorded is different from the one to which such health services are ordinarily or exclusively available. Eligible, covered services must be medically necessary and appropriate, and remain subject to any requirements outlined in the claims administrator's applicable medical and behavioral health policies and/or federal law.

Inter-Plan Arrangements

Out-of-area Services

The claims administrator has a variety of relationships with other Blue Cross and/or Blue Shield Licensees. Generally, these relationships are called "Inter-Plan Arrangements." These inter-plan arrangements work based on rules and procedures issued by the Blue Cross Blue Shield Association ("Association"). Whenever you access health care services outside the geographic area the claims administrator serves, the claim for those services may be processed through one (1) of these inter-plan arrangements. The inter-plan arrangements are described below.

Plan Arrangements

When you receive care outside of the claims administrator's service area, you will receive it from one (1) of two (2) kinds of providers. Most providers ("participating providers") contract with the local Blue Cross and/or Blue Shield plan in that geographic area ("Host Blue"). Some providers ("nonparticipating providers") don't contract with the Host Blue. The claims administrator explains below how the claims administrator pays both kinds of providers.

Inter-Plan Arrangements Eligibility - Claim Types

All claim types are eligible to be processed through inter-plan arrangements, as described above, except for all dental care benefits except when paid as medical claims/benefits, and those prescription drug or vision care benefits that may be administered by a third party contracted by the plan administrator to provide the specific service or services.

BlueCard® Program

Under the BlueCard® Program, when you receive covered health care services within the geographic area served by a Host Blue, the claims administrator will remain responsible for doing what the claims administrator agreed to in the contract. However, the Host Blue is responsible for contracting with and generally handling all interactions with its participating providers.

Whenever you receive covered health care services outside the claims administrator's service area and the claim is processed through the BlueCard program, the amount you pay for covered health care services is calculated based on the lower of:

- the billed charges for covered services; or
- the negotiated price that the Host Blue makes available to the claims administrator.

Often, this "negotiated price" will be a simple discount that reflects an actual price that the Host Blue pays to your health care provider. Sometimes, it is an estimated price that takes into account special arrangements with your health care provider or provider group that may include types of settlements, incentive payments, and/or other credits or charges. Occasionally, it may be an average price, based on a discount that results in expected average savings for similar types of health care providers after taking into account the same types of transactions as with an estimated price.

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

Special Cases: Value-Based Programs

BlueCard® Program

If you receive covered health care services under a value-based program inside a Host Blue's service area, you will not be responsible for paying any of the provider incentives, risk-sharing, and/or care coordinator fees that are a part of such an arrangement, except when a Host Blue passes these fees to the claims administrator through average pricing or fee schedule adjustments. Additional information is available upon request.

Value-Based Programs: Negotiated (non-BlueCard Program) Arrangements

If the claims administrator has entered into a Negotiated Arrangement with a Host Blue to provide value-based programs to employer on your behalf, the claims administrator will follow the same procedures for value-based programs administration and care coordinator fees as noted above for the BlueCard program.

Inter-Plan Programs: Federal/State Taxes/Surcharges/Fees

Federal or state laws or regulations (that are not preempted by ERISA) may require a surcharge, tax or other fee that applies to self-funded accounts. If applicable, the claims administrator will include any such surcharge, tax or other fee as part of the claim charge passed on to you.

Nonparticipating Providers Outside the Claims Administrator's Service Area

Member Liability Calculation

When covered health care services are provided outside of the claims administrator's service area by nonparticipating providers, the amount you pay for such services will normally be based on either the Host Blue's nonparticipating provider local payment or the pricing arrangements required by applicable law. In these situations, you may be responsible for the difference between the amount that the nonparticipating provider bills and the payment the plan will make for the covered health care services as set forth in this paragraph. Federal law, as applicable, will govern payments for out-of-network emergency services.

Blue Cross Blue Shield Global® Core

If you are outside the United States, the Commonwealth of Puerto Rico, and the U.S. Virgin Islands (hereinafter "BlueCard service area"), you may be able to take advantage of Blue Cross Blue Shield Global Core when accessing covered health care services. Blue Cross Blue Shield Global Core is unlike the BlueCard program available in the BlueCard service area in certain ways. For instance, although Blue Cross Blue Shield Global Core assists you with accessing a network of inpatient, outpatient and professional providers, the network is not served by a Host Blue. As such, when you receive care from providers outside the BlueCard service area, you will typically have to pay the providers and submit the claims yourself to obtain reimbursement for these services.

If you need medical assistance services (including locating a doctor or hospital) outside the BlueCard service area, you should call the service center at 1.800.810.BLUE (2583) or call collect at 1.804.673.1177, 24 hours a day, seven (7) days a week. An assistance coordinator, working with a medical professional, can arrange a physician appointment or hospitalization, if necessary.

Inpatient Services

In most cases, if you contact the service center for assistance, hospitals will not require you to pay for covered inpatient services, except for your deductibles, coinsurance, etc. In such cases, the hospital will submit your claims to the service center to begin claims processing. However, if you paid in full at the time of service, you must submit a claim to receive reimbursement for covered health care services. **You must contact the claims administrator to obtain approval for non-emergency inpatient services.**

Outpatient Services

Physicians, urgent care centers and other outpatient providers located outside the BlueCard service area will typically require you to pay in full at the time of service. You must submit a claim to obtain reimbursement for covered health care services.

Submitting a Blue Cross Blue Shield Global Core Claim

When you pay for covered health care services outside the BlueCard service area, you must submit a claim to obtain reimbursement. For institutional and professional claims, you should complete a Blue Cross Blue Shield Global Core claim form and send the claim form with the provider's itemized bill(s) to the service center (the address is on the form) to initiate claims processing. Following the instructions on the claim form will help ensure timely processing of your claim. The claim form is available from the claims administrator, the service center or online at bcbsglobalcore.com. If you need assistance with your claim submission, you should call the service center at 1.800.810.BLUE (2583) or call collect at 1.804.673.1177, 24 hours a day, seven (7) days a week.

Out-of-Country Benefits

Eligible medical emergency services coordinated through the Blue Cross Blue Shield Global Core program (please refer to "Inter-Plan Arrangements," "Blue Cross Blue Shield Global Core") will process at the in-network level of coverage and eligible urgent care services coordinated through the Blue Cross Blue Shield Global Core program will process at the out-of-network level.

Call the Blue Cross Blue Shield Global Core service center within 24 hours of a medical emergency at 1-804-673-1177. You will be advised by the service center if services are not eligible under this program.

If you do not call the Blue Cross Blue Shield Global Core service center or services are not eligible under this program, eligible services will process at the out-of-network level of benefits.

Services not covered under the plan will not be considered for benefits.

Your Provider Network

Your provider network is your key to receiving the higher level of benefits. Your Allina Elevate Network providers are all Allina Health and affiliated providers and facilities only.

To determine if your physician is in-network, call the customer service toll-free telephone number listed on the back of your member ID card.

Getting your care "through the network" also assures you get quality care. All physicians are carefully evaluated before they are accepted into the network. The claims administrator considers educational background, office procedures and performance history to determine eligibility. Then the claims administrator monitors care on an ongoing basis through office record reviews and member satisfaction surveys.

Please note that while you or a family member can use the services of any in-network physician or specialist without a referral and receive the maximum coverage under your health plan, you are encouraged to select a personal physician. This helps establish an ongoing relationship based on knowledge and trust and helps make your care consistent. Your personal physician can help you select an appropriate specialist and work closely with that specialist when the need arises. In addition, primary care providers or their covering physicians are on call 24/7.

Remember:
If you want the higher level of benefits, it is *your* responsibility to ensure that you receive in-network care. You may want to double-check any provider recommendations to make sure the doctor or facility provider is in-network. Your provider directory lists network providers in our service area and may change from time to time, including as providers or the claims administrator initiate or terminate network contracts. Prior to receiving services, it is recommended that you verify your provider's network status with the claims administrator, including whether the provider is a network provider for your particular plan. Not every provider is a network provider for every plan. For a list of providers in the directory, visit www.bluecrossmn.com/allinahealth ("Member Sign in" then "Find a Doctor") or call the customer service toll-free telephone number listed on the back of your member ID card. For benefit information, please refer to "Benefit Overview."

How to Get Your Physicians' Professional Qualifications

To view Board Certification information, hospital affiliation or other professional qualifications of your provider, visit your member website at www.bluecrossmn.com/allinahealth, or contact customer service at the telephone number listed on the back of your member ID card.

Continuity of Care

Continuity of Care

If you are a current member or dependent, this section applies to you. If the relationship between your in-network clinic or physician and the claims administrator ends, rendering your clinic or provider out-of-network, and the termination was by the claims administrator and was not for cause, you may request to continue to receive care for a special medical need or condition for a reasonable period of time before transferring to an participating provider as required under the terms of your coverage under the health plan. The claims administrator will authorize this continuation of care for a terminal illness in the final stages or for the rest of your life if a physician, advanced practice nurse, or physician assistant certifies that your life expectancy is 180 days or less. The claims administrator will also authorize this continuation of care at the in-network level if you are engaged in a current course of treatment for any of the following conditions or situations:

Continuation for up to 120 days if you:
1. have an acute condition;
2. have a life-threatening mental or physical illness;
3. have a physical or mental disability rendering you unable to engage in one (1) or more major life activities provided that the disability has lasted or can be expected to last for at least one (1) year, or that has a terminal outcome;
4. have a disabling or chronic condition in an acute phase or that is expected to last permanently;
5. are receiving culturally appropriate services from a provider with special expertise in delivering those services;
6. are receiving services from a provider that speaks a language other than English; or

Continuation through the postpartum period (six (6) weeks post-delivery) for a pregnancy beyond the first trimester.

Continuation is for up to 90 days for members (1) undergoing a course of institutional or inpatient care from the provider or facility; (2) scheduled to undergo non-elective surgery from the provider; or (3) undergoing treatment within the first trimester of pregnancy.

Transition to In-network Providers

The claims administrator will assist you in making the transition from an out-of-network to an in-network provider if you request them to do so. Please contact customer service for a written description of the transition process, procedures, criteria, and guidelines.

Limitation

Continuity of Care applies only if your provider agrees to: 1) adhere to all of the claims administrator's prior authorization requirements; and 2) provide the claims administrator with necessary medical information related to your care.

Continuity of Care does not apply to services that are not covered under the health plan, does not extend benefits beyond any existing limits, dollar maximums, or coverage termination dates, and does not extend benefits from one (1) plan to another.

Provider Termination for Cause

If it is known that the claims administrator has terminated its relationship with your provider for cause, the claims administrator will not authorize continuation of care with, or transition of care to, that provider. Your transition to an in-network provider must occur on or prior to the date of such termination for you to continue to receive in-network benefits.

NO SURPRISES ACT NOTICE

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing.

What is “balance billing” (sometimes called “surprise billing”)?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that isn’t in your health plan’s network.

“Out-of-network” describes providers and facilities that haven’t signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay and the full amount charged for a service. This is called “balance billing.” This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit.

“Surprise billing” is an unexpected balance bill. This can happen when you can’t control who is involved in your care—like when you have an emergency or when you schedule a visit at an in- network facility but are unexpectedly treated by an out-of-network provider. Surprise medical bills could cost thousands of dollars depending on the procedure or service.

You are protected from balance billing for:

Emergency services

If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most the provider or facility may bill you is your plan’s in-network cost- sharing amount (such as copayments and coinsurance). You can’t be balance billed for these emergency services. This includes services you may get after you’re in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post- stabilization services.

Certain services at an in-network hospital or ambulatory surgical center

When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers may bill you is your plan’s in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers can’t balance bill you and may not ask you to give up your protections not to be balance billed.

If you get other services at these in-network facilities, out-of-network providers can’t balance bill you, unless you give written consent and give up your protections.

You’re never required to give up your protections from balance billing. You also aren’t required to get care out-of-network. You can choose a provider or facility in your plan’s network.

When balance billing isn’t allowed, you also have the following protections:

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.

- Your health plan generally must:

    - Cover emergency services without requiring you to get approval for services in advance (prior authorization).
    - Cover emergency services by out-of-network providers.
    - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.

- Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.

If you believe you've been wrongly billed, you may contact No Surprises Help Desk (NSHD) at 1- 800-985-3059.

Visit https://www.cms.gov/nosurprises for more information about your rights under federal law.

GENERAL INFORMATION

No agent can legally change the health plan or waive any of its terms. Allina Health System, as plan sponsor, reserves the power at any time and from time to time (and retroactively, if necessary or appropriate to comply with applicable law), to terminate, modify or amend, in whole or in part, any or all provisions of the plan.

Plan Administration

Plan Administrator

For information regarding Plan Administration, please refer to the "Plan Administration" section of the Eligibility & Enrollment Booklet.

Time Periods

When the time of day is important for benefits or determining when coverage starts and ends, a day begins at 12:00 a.m. United States Central Time and ends at 12:00 a.m. United States Central Time the following day.

Funding

This plan is a self-insured medical plan funded by contributions from the employer and/or employees. Funds for benefit payments are provided by the employer according to the terms of its agreement with the claims administrator. Your contributions toward the cost of coverage under the health plan will be determined by the employer each year. The claims administrator provides administrative services only and does not assume any financial risk or obligation with respect to providing benefits.

Controlling Law

Except as they may be subject to federal law, including ERISA, any questions, claims, disputes, or litigation concerning or arising from the health plan will be governed by the laws of the State of Minnesota.

Fraudulent Practices

Coverage for you or your dependents will be terminated (including retroactively) if you or your dependent engage in fraud of any type or intentional misrepresentation of material fact including, but not limited to: submitting fraudulent misstatements or omissions about your medical history or eligibility status in connection with enrollment; submitting fraudulent, altered, or duplicate billings for personal gain; and/or allowing another person not eligible for coverage under the plan to use your or your dependent's coverage or to remain covered under the plan. Allina Health System reserves the right to recover any and all benefit payments made for services received by ineligible dependents and to terminate your employment.

Payments Made in Error

Payments made in error or overpayments may be recovered by the claims administrator, ESI or the Plan Administrator as provided by law or equity. This includes the right to recoup from any future benefits to be paid to or on behalf of you or your eligible dependents. Payment made for a specific service or erroneous payment shall not make the claims administrator, ESI or the plan administrator liable for further payment for the same service.

Your claims may be reprocessed due to errors in the allowed amount paid to network providers, out-of-network participating providers, or nonparticipating providers. Claim reprocessing may result in changes to the amount you paid at the time your claim was originally processed.

Liability for Health Care Expenses

Charges That Are Your Responsibility

In-Network Providers (Allina Elevate Network)

When you use in-network providers for covered services, payment is based on the allowed amount. You are not required to pay for charges that exceed the allowed amount. You are required to pay the following amounts:

1. deductibles and coinsurance;
2. copays;
3. charges that exceed the benefit maximum; and
4. charges for services that are not covered.

Out-of-Network Providers

Out-of-Network Participating Providers

When you use out-of-network participating providers for covered services, payment is based on the allowed amount. You may not be required to pay for charges that exceed the allowed amount. All out-of-network participating providers in Minnesota accept the claims administrator's payment based on the allowed amount. Most out-of-network participating providers outside Minnesota accept the claims administrator's payment based on the allowed amount. However, contact your out-of-network participating provider outside Minnesota to verify if they accept the claims administrator's payment based on the allowed amount (to determine if you will have additional financial liability). You are required to pay the following amounts:

1. charges that exceed the allowed amount if the out-of-network participating provider outside Minnesota does not accept the claims administrator's payment based on the allowed amount;
2. deductibles and coinsurance;
3. copays;
4. charges that exceed the benefit maximum; and
5. charges for services that are not covered.

Nonparticipating Providers

When you use nonparticipating providers for covered services, payment is still based on the allowed amount. However, because a nonparticipating provider has not entered into a network contract with the claims administrator or the local Blue Cross and/or Blue Shield plan, the nonparticipating provider is not obligated to accept the allowed amount as payment in full. This means that you may have substantial out-of-pocket expense when you use a nonparticipating provider, except when the No Surprises Act applies. You are required to pay the following amounts, when the No Surprises Act does not apply:

1. charges that exceed the allowed amount;
2. deductibles and coinsurance;
3. copays;
4. charges that exceed the benefit maximum;
5. charges for services that are not covered including services that the claims administrator determined are not covered based on claims coding guidelines; and
6. charges for services that are investigative or not medically necessary and appropriate.

Changing **Medical** Program Options

If you switch Medical Program benefits options mid-year, any amount accumulated toward the deductible or out-of-pocket maximum will be credited toward your new option's deductible **and** out-of-pocket maximum.

Medical Policy Committee and Medical Policies

The claims administrator applies medical policies in order to determine benefits consistently for members. Internally developed policies are subject to approval by the claims administrator's Medical Policy Committee, which consists of independent community physicians who represent a variety of medical specialties as well as a clinical psychologist and pharmacist. The remaining policies are approved by other external specialists. For all policies, the claims administrator's goal is to find the right balance between making improved treatments available and guarding against unsafe or unproven approaches. From time-to-time, new medical policies may be created or existing medical policies may change. Covered benefits will be determined in accordance with the claims administrator's policies in effect at the time treatment is rendered or, if applicable, prior authorization may also be required. Internally developed medical policies can be found at the member website. All medical policies are available upon request.

In addition, Allina Health may, from time to time, determine that the plan will cover procedures or services for "emerging technologies" (as defined by Allina Health). The criteria for any such procedure as developed by Allina Health, is available online at www.bluecrossmn.com/allinahealth or by calling Customer Service at (651) 662-5859 or toll free 1-800-509-5310, select prompt 1.

Eligibility, Enrollment, Change in Status, Special Enrollment, When Coverage Begins and When Coverage Ends

Please refer to the Eligibility & Enrollment Booklet for information regarding the following:

- Eligibility;
- Enrollment;
- Change in status;
- Special enrollment;
- Claims procedures for eligibility, enrollment, contributions and plan administrative determinations;
- Cost of coverage;
- When coverage begins;
- When coverage ends; and
- General provisions.

COORDINATION OF BENEFITS

Most health plans, including this plan, contain a coordination of benefits (COB) provision. The COB provision is used when you, your spouse, or your covered dependents received a health care service and had active benefits under more than one (1) plan at the time of that service.

When you have health care coverage under more than one (1) plan, benefits will be coordinated. The “Order of Benefits Rules” determine which plan provides benefits first. Your benefits under this plan are not reduced if the rules require this plan to pay first. Your benefits under this plan may be reduced if another plan pays first.

The section does not apply to your Prescription Drug Plan because there is no coordination of benefits for prescription drug coverage.

Coordination of benefits is to ensure that your covered expenses will be processed, while ensuring that the claim charges are not overpaid. If you receive funds to pay a provider directly, and you receive more funds than you should have, you will be expected to repay any overpayment and such overpayment can be recouped by any method allowed by law.

Definitions

These definitions apply only to this section.

1. "Plan" is any of the following that provides benefits or services for, or because of, medical or dental care or treatment:
   a. group insurance or group-type coverage, whether insured or uninsured. This includes prepayment, group practice, individual practice coverage, and group coverage other than school accident-type coverage;
   b. coverage under a government plan or one required or provided by law; or
   c. individual coverage.

   "Plan" does not include a state plan under Medicaid (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act as amended from time to time). "Plan" does not include any benefits that, by law, are excess to any private or other nongovernmental program.

   "Plan" does not include hospital indemnity, specified accident, specified disease, or limited benefit insurance policies.

   Each contract or other arrangement for coverage is a separate plan. Also, if an arrangement has two (2) parts and this section applies only to one (1) part, each of the parts is a separate plan.
2. "This plan" means the part of the plan document that provides health care benefits.
3. "Primary plan/secondary plan" means the Order of Benefits Rules establishing whether this plan is the primary plan or secondary plan when compared to the other plan covering the person.

   When this plan is a primary plan, its benefits are determined before any other plan and without considering the other plan's benefits. When this plan is a secondary plan, its benefits are determined after those of the other plan and may be reduced because of the other plan's benefits.

   When you are covered under more than two (2) plans, this plan may be a primary plan as to some plans, and may be a secondary plan as to other plans.
4. "Allowable expense" means the necessary, reasonable, and customary item of expense for health care, covered at least in part by one (1) or more plans covering the person making the claim. "Allowable expense" does not include an item of expense that exceeds benefits that are limited by statute or this plan. "Allowable expense" does not include outpatient prescription drugs, except those eligible under Medicare.

   When a plan provides benefits in the form of services, the reasonable cash value of each service rendered will be considered both an allowable expense and a benefit paid.
5. "Claim determination period" means a calendar year. However, it does not include any part of a year the person is not covered under this plan, or any part of a year before the date this section takes effect.

Order of Benefits Rules

This plan uses the following rules to establish which plan is the primary plan:

You and Your Dependents

1. When your other plan does not include order of benefit rules, then that plan is the primary plan.
2. The plan that covers the person as an employee, member, or subscriber (that is, other than as a dependent) is the primary plan over the plan that covers the member as a dependent.

Dependent Children

1. Birthday Rule
   a. The plan of the parent whose birthday falls earlier in the calendar year is the primary plan.
   b. If both parents have the same birthday, the plan that covered the parent longer is the primary plan.
2. Separated or Divorced Parents
   a. The plan of the parent with custody of the child is the primary plan.
   b. The plan of the spouse of the parent with custody is the secondary plan.
   c. When a court decree specifies the parent who is financially responsible for the child's health care expenses, and the plan of that parent has actual knowledge of those terms, the plan of that parent is the primary plan. This rule applies to claim determination periods or plan years commencing after the plan is given notice of the court decree.

Other

The plan of an individual who is covered as an employee is the primary plan over the plan of an individual who is either laid-off or retired.

When the member who received care is covered under the No-Fault Automobile Insurance Act or similar law or traditional automobile "fault" type coverage, that coverage applies benefits first.

When none of these circumstances applies, the plan that has continuously covered the individual for the longest time is the primary plan.

Medicare and TRICARE

This plan will comply with the Medicare Secondary Payor (MSP) and TRICARE provisions of federal law to determine which plan is a primary plan and which is a secondary plan.

Medicare or TRICARE will be primary and this plan will be secondary only to the extent permitted by MSP or TRICARE rules.

When Medicare or TRICARE is the primary plan, this plan will coordinate benefits up to Medicare's or TRICARE's allowed amount.

Effect on Benefits of This Health Plan

When this section applies:

1. When the Order of Benefits Rules require this health plan to be a secondary plan, this part applies. Benefits of this health plan may be reduced.
2. Reduction in this plan's benefits may occur under circumstances such as the following:

   The benefits that would be payable under this health plan without applying coordination of benefits are reduced by the benefits payable under the other plans for the expenses covered in whole or in part under this health plan. This applies whether or not claim is made under a plan.

   When a plan provides benefits in the form of services, the reasonable cash value of each service rendered is considered both an expense incurred and a benefit payable. When benefits of this health plan are reduced each benefit is reduced in proportion to any applicable benefit limit, such as the deductible, of this health plan.

Right to Receive and Release Needed Information

Certain facts are needed to apply these coordination of benefits rules. The claims administrator has the right to decide which facts are needed. The claims administrator may get needed facts from, or give them to, any other organization or person. They do not need to tell, or get the consent of, any person to do this. Each person claiming benefits under this plan must provide any facts needed to pay the claim.

Facility of Payment and Right of Recovery

When another plan pays an amount that should have been paid under this plan, this plan may pay that amount to the organization that made that payment. That amount will then be considered a benefit under this plan. This plan will not have to pay that amount again. If this plan pays more than it should have paid under these coordination of benefit rules, this plan may recover the excess from any of the following:

1. the persons this plan paid for whom this plan has paid;
2. insurance companies; or
3. other organizations.

Any payment made or amount paid includes the reasonable cash value of any benefits provided in the form of services.

Reimbursement and Subrogation

For information regarding reimbursement and subrogation, please refer to the subrogation and reimbursement provisions in the “Plan Administration” section of the Eligibility & Enrollment Booklet**.**

NONDISCRIMINATION – ACA SECTION 1557

Allina Health complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, gender identity or sex. Allina Health does not exclude people or treat them differently because of race, color, national origin, age, disability, gender identity or sex.
Allina Health:

- provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - qualified sign language interpreters, and
  - written information in other formats (large print, audio, accessible electronic formats, other formats)
- provides free language services to people whose primary language is not English, such as:
  - qualified interpreters, and
  - information written in other languages.

If you need these services, contact the HR Service Center.
If you believe that Allina Health has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, gender identity or sex, you can file a grievance with:

Allina Health Grievance Coordinator
P.O. Box 43
Minneapolis, MN 55440-0043
Phone: 612-262-0900
Fax: 612-262-4370
GrievanceCoordinator@allina.com

You can file a grievance in person or by mail, fax or email. If you need help filing a grievance, the Allina Grievance Coordinator can help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

TERMINATION OF COVERAGE

For information on when coverage ends, refer to the “When Coverage Ends” section of the Eligibility & Enrollment Booklet.

Continuation of Group Coverage

For information regarding continuation of group coverage, please refer to COBRA Continuation Coverage provisions in the “When Coverage Ends” section of the Eligibility & Enrollment Booklet.

IDENTIFICATION (ID) CARD

If your card is lost or stolen, please contact customer service immediately. You can also request additional or replacement cards online by logging onto www.bluecrossmn.com/allinahealth.

How to File a Claim

Under Department of Labor regulations, claimants are entitled to a full and fair review of any claims made under this plan. The claims procedures described in this benefit booklet are intended to comply with those regulations by providing reasonable procedures governing the filing of claims, notification of benefit decisions, and appeals of adverse benefit determinations. A claimant must follow these procedures in order to obtain payment of benefits under this plan. If the claims administrator, in its sole discretion, determines that a claimant has not incurred a covered expense or that the benefit is not covered under this plan, no benefits will be payable under this plan. All claims and questions regarding claims should be directed to the claims administrator. For claims procedures applicable to prescription drugs, see the Prescription Drug Claims Procedures section later in this SPD.

Referral Claim Procedures

If you believe you cannot obtain eligible health services from a network provider and you wish to obtain such services, you may submit a request for recommendation of referral to a referral network provider (an out-of-network provider who nevertheless has a contract in place with the claims administrator) to the Allina Health Network Deficiency Team at 1-800-509-5310 (option1). If the Allina Health Network Deficiency Team does not recommend your referral and you have not received the service, you may submit a pre-service claim to the claims administrator in the time and manner discussed below using the form available here: https://www.bluecrossmn.com/sites/default/files/DAM/2022-04/BlueCross-selfinsured-complaint-form-X19238R02.pdf. If the claims administrator, in its sole discretion, determines the covered services you are requesting can be obtained from an in-network provider, so that it is not medically necessary for you to obtain care from a referral network provider, it will issue an adverse benefit determination that notifies you of your right to appeal that decision to the claims administrator, under the plan's appeal process described below.

If you obtain covered services from a referral network provider despite the Allina Health Network Deficiency Team not recommending referral, you may file a post-service claim for benefits with the claims administrator using the form available here: https://www.bluecrossmn.com/sites/default/files/DAM/2022-04/BlueCross-selfinsured-complaint-form-X19238R02.pdf. If the claims administrator, in its sole discretion, determines the covered services you are requesting could have been be obtained from an in-network provider, so that it was not medically necessary for you to obtain care from a referral network provider, it will issue an adverse benefit determination that notifies you of your right to appeal that decision to the claims administrator, under the plan's appeal process described below.

No benefits will be payable under this plan (except in the case of emergency or urgent care needs) for services provided by a referral network provider if the referral was not recommended by the Allina Health Network Deficiency Team or approved by the claims administrator. Except in the event of emergency or urgent care needs, the plan will not pay for care provided by an out-of-network provider.

Types of Claims

A "claim" is any request for a plan benefit made in accordance with these claims procedures. You become a "claimant" when you make a request for a plan benefit in accordance with these claims procedures. There are four (4) types of claims, each with different claim and appeal rules. The primary difference is the timeframe within which claims and appeals must be determined. A communication regarding benefits that is not made in accordance with these procedures will not be treated as a claim.

Pre-Service Claim

A "pre-service claim" is any request for a plan benefit where the plan specifically conditions receipt of the benefit, in whole or in part, on receiving approval in advance of obtaining the medical care, unless the claim involves urgent care, as defined below. If the plan does not require a claimant to obtain approval of a medical service prior to getting treatment, then there is no "pre-service claim." The claimant simply follows these claims procedures with respect to any notice that may be required after receipt of treatment, and files the claim as a post-service claim.

Urgent Care Claim

An "urgent care claim" is a special type of pre-service claim. An "urgent care claim" is any pre-service claim for medical care or treatment with respect to which the application of the time periods that otherwise apply to pre-service claims could seriously jeopardize the life or health of the claimant or the claimant's ability to regain maximum function, or, in the opinion of a physician with knowledge of the claimant's medical condition, would subject the claimant to severe

pain that cannot be adequately managed without the care or treatment that is the subject of the claim. The claims administrator will determine whether a pre-service claim involves urgent care, provided that, if a physician with knowledge of the claimant's medical condition determines that a claim involves urgent care, the claim will be treated as an urgent care claim.

IMPORTANT: If a claimant needs medical care for a condition that could seriously jeopardize their life, there is no need to contact the claims administrator for prior approval. The claimant should obtain such care without delay.

Concurrent Care Claim

A "concurrent care claim" arises when the claims administrator has approved an ongoing course of treatment to be provided over a period of time or number of treatments, and either (a) the claims administrator determines that the course of treatment should be reduced or terminated, or (b) the claimant requests extension of the course of treatment beyond that which the claims administrator has approved. If the plan does not require a claimant to obtain approval of a medical service prior to getting treatment, then there is no need to contact the claims administrator to request an extension of a course of treatment. The claimant follows these claims procedures with respect to any notice that may be required after receipt of treatment, and files the claim as a post-service claim.

Post-Service Claim

A "post-service claim" is any request for a plan benefit that is not a pre-service claim or an urgent care claim.

Change in Claim Type

The claim type is determined when the claim is initially filed. However, if the nature of the claim changes as it proceeds through these claims procedures, the claim may be re-characterized. For example, a claim may initially be an urgent care claim. If the urgency subsides, it may be re-characterized as a pre-service claim. It is very important to follow the requirements that apply to your particular type of claim. If you have any questions regarding the type of claim and/or what claims procedure to follow, contact the claims administrator.

Filing Claims

Except for urgent care claims, discussed below, a claim is made when a claimant (or authorized representative) submits a request for plan benefits to the claims administrator. A claimant is not responsible for submitting claims for services received from in-network or out-of-network participating providers. These providers will submit claims directly to the local Blue Cross and Blue Shield plan on the claimant's behalf and payment will be made directly to these providers. If a claimant receives services from nonparticipating providers, they may have to submit the claims themselves. If the provider does not submit the claims on behalf of the claimant, the claimant should send the claims to the claims administrator. The necessary forms may be obtained by contacting the claims administrator. A claimant may be required to provide copies of bills, proof of payment, or other satisfactory evidence showing that they have incurred a covered expense that is eligible for reimbursement.

Payment of a claim does not preclude the right of the claims administrator to deny future claims or take any action it determines appropriate, including rescission of the contract and seeking repayment of claims already paid.

Urgent Care Claims

An urgent care claim may be submitted to the claims administrator by calling the telephone number located on the back of your ID card.

Pre-Service Claims

A pre-service claim (including a Concurrent Care claim that is also a pre-service claim) is considered filed when the request for approval of treatment or services is made and received by the claims administrator.

Post-Service Claims

A post-service claim must be filed within 30 days following receipt of the medical service, treatment or product to which the claim relates unless (a) it was not reasonably possible to file the claim within such time; and (b) the claim is filed as soon as possible and in no event (except in the case of legal incapacity of the claimant) later than 12 months after the date of receipt of the service, treatment or product to which the claim relates.

Incorrectly Filed Claims

These claims procedures do not apply to any request for benefits that is not made in accordance with these claims procedures, except that (a) in the case of an incorrectly-filed pre-service claim, the claims administrator will notify the claimant as soon as possible but no later than five (5) days following receipt of the incorrectly-filed claim; and (b) in the

case of an incorrectly-filed urgent care claim, the claims administrator will notify the claimant as soon as possible, but no later than 24 hours following receipt of the incorrectly-filed claim. The notice will explain that the request is not a claim and describe the proper procedures for filing a claim. The notice may be oral unless the claimant specifically requests written notice.

Timeframes for Deciding Claims

Urgent Care Claims

The claims administrator will decide an urgent care claim and notify you of the decision as soon as possible, taking into account the medical exigencies, but no later than 72 hours after receipt of the claim.

Pre-Service Claims

The claims administrator will decide a pre-service claim and notify you of the decision within a reasonable time appropriate to the medical circumstances, but no later than 15 days after receipt of the claim.

Concurrent Care Extension Request

If a claim is a request to extend a concurrent care decision involving urgent care and if the claim is made at least 24 hours prior to the end of the approved period of time or number of treatments, the claims administrator will decide the claim and notify you of the decision within 24 hours after receipt of the claim. Any other request to extend a concurrent care decision will be decided in the otherwise applicable timeframes for pre-service, urgent care, or post-service claims.

Concurrent Care Reduction or Early Termination

The claims administrator's decision to reduce or terminate an approved course of treatment is an adverse benefit determination that a claimant may appeal under these claims procedures, as explained below. The claims administrator will notify the claimant of the decision to reduce or terminate an approved course of treatment sufficiently in advance of the reduction or termination to allow the claimant to appeal the adverse benefit determination and receive a decision on appeal before the reduction or termination.

Post-Service Claims

The claims administrator will decide a post-service claim and notify the claimant of any adverse decision within a reasonable time, but no later than 30 days after receipt of the claim.

Extensions of Time

A claimant may voluntarily agree to extend the timeframes described above. In addition, if the claims administrator is not able to decide a pre-service or post-service claim and notify the claimant of the decision within the timeframes described above due to matters beyond its control, these timeframes may be extended for up to 15 days, provided the claimant is notified in writing prior to the expiration of the initial timeframe applicable to the claim. The notice will describe the matters beyond the claims administrator's control that justify the extension and the date by which the claims administrator expects to render a decision. No extension of time is permitted for urgent care claims.

Incomplete Claims

If any information needed to process a claim is missing, the claim will be treated as an incomplete claim. If an urgent care claim is incomplete, the claims administrator will notify the claimant as soon as possible, but no later than 24 hours following receipt of the incomplete claim. The notice will explain that the claim is incomplete, describe the information necessary to complete the claim and specify a reasonable time, no less than 48 hours, within which the claim must be completed. The notice may be oral unless the claimant specifically requests written notice. The claims administrator will decide the claim and notify the claimant of the decision as soon as possible but no 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 submit the specified information.

If a pre-service or post-service claim is incomplete, the claims administrator will notify the claimant as soon as possible. The notice will explain that the claim is incomplete and describe the information needed to complete the claim. The timeframe for deciding the claim will be suspended from the date the claimant receives the notice until the date the necessary information is provided to the claims administrator. The claims administrator will decide the claim following receipt of the requested information and provide the claimant with written notice of the decision within the time period required by Department of Labor claims procedure regulations.

Notification of Initial Benefit Decision

The claims administrator will provide the claimant with written notice of an adverse benefit determination on a claim. A decision on a claim is an "adverse benefit determination" if it is (a) a denial, reduction, or termination of benefits, (b) a failure to provide or make payment (in whole or in part) for a benefit, or (c) a rescission of coverage. The claims administrator will provide the claimant written notice of the decision on a pre-service or urgent care claim whether or not the decision is adverse. The claims administrator may provide the claimant with oral notice of an adverse benefit determination on an urgent care claim, but written notice will be furnished no later than three (3) days after the oral notice.

Right of Examination

The claims administrator and the plan administrator each have the right to ask a claimant to be examined by a provider during the review of any claim. The plan pays for the examination whenever either the claims administrator or the plan administrator requests the examination. A claimant's failure to comply with this request may result in denial of the claimant's claim.

Appeals of Adverse Benefit Determinations

Appeal Procedures

A claimant has a right to appeal an adverse benefit determination under these claims procedures. These appeal procedures provide a claimant with a reasonable opportunity for a full and fair review of an adverse benefit determination.

The claims administrator will follow these procedures when deciding an appeal:

1. An adverse benefit determination includes a denial, reduction, termination of or failure to make a payment for a benefit, or a rescission of coverage;
2. A claimant must file an appeal within 180 days following receipt of a notice of an adverse benefit determination;
3. A claimant will have the opportunity to submit written comments, documents, records, other information, other evidence, and testimony relating to the claim for benefits;
4. The individual who reviews and decides the appeal will be a different individual than the individual who made the initial benefit decision and will not be a subordinate of that individual, and no individual who reviews and decides appeals is compensated or promoted based on the individual's support of a denial of benefits;
5. The claims administrator will give no deference to the initial benefit decision;
6. The claims administrator will 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 benefit decision;
7. The claims administrator will, in deciding an appeal of any adverse benefit determination that is based in whole or in part upon a medical judgment, consult with a health care professional with the appropriate training and experience who is neither the same individual who was consulted regarding the initial benefit decision nor a subordinate of that individual;
8. The claims administrator will provide the claimant, upon request, the names of any medical or vocational experts whose advice was obtained in connection with the initial benefit decision, even if the claims administrator did not rely upon their advice;
9. The claims administrator will provide the claimant, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim; any internal rule, guideline, protocol or other similar criterion relied upon in making the initial benefit decision; an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the claimant's medical circumstances; and information regarding any voluntary appeals offered by the plan;
10. The claims administrator will provide the claimant any new evidence considered, generated, or relied upon free of charge as soon as possible and with enough time before a final determination is required to be provided to the claimant (as described above) so that the claimant will have an opportunity to respond prior to making a final benefit determination;
11. The claims administrator will provide the claimant any new rationale for an adverse benefit determination prior to making a final benefit determination and with enough time before making a final determination so that the claimant will have an opportunity to respond; and

12. The claims administrator will provide required notices in a culturally and linguistically appropriate manner as directed by the plan administrator.

Filing Appeals

A claimant must file an appeal within 180 days following receipt of the notice of an adverse benefit determination. A claimant's failure to comply with this important deadline may cause the claimant to forfeit any right to any further review under these claims procedures or in a court of law. An appeal is filed when a claimant (or authorized representative) submits a written request for review to the claims administrator. A claimant is responsible for submitting proof that the claim for benefits is covered and payable under the plan.

Urgent Care Appeals

An urgent care appeal may be submitted to the claims administrator by telephone at 1-866-873-5943. The claims administrator will transmit all necessary information, including the claims administrator's determination on review, by telephone, fax, or other available similar methods.

Timeframes for Deciding Appeals

Urgent Care Claims

The claims administrator will decide the appeal of an urgent care claim and notify the claimant of the decision as soon as possible, taking into account the medical emergencies, but no later than 72 hours after receipt of the request for review.

Pre-Service Claims

The claims administrator will decide the appeal of a pre-service claim and notify the claimant of the decision within a reasonable time appropriate to the medical circumstances, but no later than 30 days after receipt of the written request for review.

Post-Service Claims

The claims administrator will decide the appeal of a post-service claim and notify the claimant of any adverse decision within a reasonable period, but no later than 60 days after receipt of the written request for review.

Concurrent Care Claims

The claims administrator will decide the appeal of a decision to reduce or terminate an initially approved course of treatment before the proposed reduction or termination takes place. The claims administrator will decide the appeal of a denied request to extend a concurrent care decision in the appeal timeframe for pre-service, urgent care, or post-service claims described above, as appropriate to the request.

Appeal Process

Notification of Appeal Decision

The claims administrator will provide the claimant with written notice of the appeal decision. The notification will include the reason for the final adverse benefit determination, reference to the relevant plan provision(s) and other information as required by ERISA. The claims administrator may provide the claimant with oral notice of an adverse decision on an urgent care claim appeal, but written notice will be furnished no later than three (3) days after the oral notice. Unless these procedures are deemed to be exhausted, the decision by the claims administrator on review will be final, binding and conclusive and will be afforded the maximum deference permitted by law. **These claims procedures (with the exception of a voluntary internal appeal and external review) must be exhausted before any legal action is commenced**.

Following notification of the appeal decision, a claimant may appeal further to a voluntary internal appeal or to an external appeal (for eligible claims). An adverse benefit determination relating to a claimant's failure to meet eligibility requirements is not eligible for external review.

Voluntary Appeals

A voluntary appeal may be available to a claimant receiving an adverse decision on a pre-service or post-service claim appeal. A claimant must file a voluntary appeal within 60 days following receipt of the adverse pre-service or post-service claim appeal decision. A voluntary appeal is filed when a claimant (or authorized representative) submits a written request for a voluntary appeal to the claims administrator. The claims administrator will provide the claimant with written notice of voluntary appeal decision. For more information on the voluntary appeal process, contact the claims administrator.

Special Rules for Claims Related to Rescissions

A rescission is a discontinuation of coverage with retroactive effect. Coverage may be rescinded because the individual or the person seeking coverage on behalf of the individual commits fraud or makes an intentional misrepresentation of material fact, as prohibited by the terms of the plan. However, some retroactive cancellations of coverage are not rescissions. Rescissions do not include retroactive cancellations of coverage for failure to pay required premiums or contributions toward the cost of coverage on time. A prospective cancellation of coverage is not a rescission. If your coverage is going to be rescinded, you will receive written notice 30 days before the coverage will be cancelled. A rescission will be considered a claim denial that can be appealed according to the rules described above for post-service claim denials.

External Review

Standard External Review

If your claim relates to medical judgment or rescission, or whether the plan has complied with surprise billing and cost-sharing protections relating to (i) out-of-network emergency services; (ii) non-emergency services performed by out-of-network providers of participating facilities; or (iii) air ambulance services furnished by an out-of-network provider, you may file a request for an external review within four (4) months after the date of receipt of a notice of an adverse benefit determination or final internal adverse benefit determination.

1. Within five (5) business days following the date of receipt of the external review request, the claims administrator will complete a preliminary review of the request to determine whether:
    a. you are or were covered under the plan at the time the health care item or service was requested or, in the case of a retrospective review, were covered under the plan at the time the health care item or service was provided;
    b. the adverse benefit determination or the final adverse benefit determination is based on medical judgment or rescission;
    c. you have exhausted the plan's internal appeal process (unless exhaustion is not required); and
    d. you have provided all the information and forms required to process an external review. You will be notified if the request is not eligible for external review. If your request is not complete, but eligible, the claims administrator will tell you what information or materials are needed to complete the request and will give you 48 hours (or more) to provide the required information.

2. Within 1 business day after completion of the preliminary review, the claims administrator will notify you in writing regarding whether your claim is eligible for external review. If your request was not complete, the notice will describe information or materials needed to complete request. You will have until the end of the 4-month period

you had to file a request for an external review or 48 hours (whichever is later) to complete your request. If your request is complete but not eligible for external review, the notice will include the reasons your request was ineligible and contact information for the Employee Benefits Security Administration.

3. The claims administrator will assign an accredited independent review organization (IRO) to conduct the external review.

   The IRO will utilize legal experts where appropriate to make coverage determinations under the plan and will notify you in writing of the request's eligibility and acceptance for external review. You may submit additional information in writing to the IRO within 10 business days that the IRO must consider when conducting the external review.

   The claims administrator will provide documents and any information considered in making the adverse benefit determination or final internal adverse benefit determination to the IRO.

   The IRO will review all of the information and documents timely received and is not bound by the claims administrator's prior determination. The IRO may consider the following in reaching a decision:
   a. your medical records;
   b. the attending health care professional's recommendation;
   c. reports from appropriate health care professionals and other documents submitted by the claims administrator, you, or your treating provider;
   d. the terms of the plan;
   e. evidence-based practice guidelines;
   f. any applicable clinical review criteria developed and used by the claims administrator; and
   g. the opinion of the IRO's clinical reviewer or reviewers after considering information noted above as appropriate.

   The IRO will provide written notice of the final external review decision within 45 days after the IRO receives the request for external review. The notice will contain a general description of the reason for the request for external review and 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.

Expedited External Review

1. You may request an expedited external review when you receive:
   a. an adverse benefit determination that involves a medical condition for which the timeframe for completion of an expedited internal appeal under the interim final regulations would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function and you have filed a request for an expedited internal appeal; or,
   b. a final internal adverse benefit determination, if you have a medical condition where the timeframe for completion of a standard external review would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function, or if the final internal adverse benefit determination concerns an admission, availability of care, continued stay, or health care item or service for which you received emergency services, but have not been discharged from a facility.

2. Immediately upon receipt of the request for expedited external review, the claims administrator will determine whether the request meets the reviewability requirements noted above for standard external review and will notify you of its eligibility determination.

3. When the claims administrator determines that your request is eligible for external review an IRO will be assigned. The claims administrator will provide all necessary documents and information considered in making the adverse benefit determination or final internal adverse benefit determination to the IRO by any available expeditious method.

   The IRO must consider the information or documents provided and is not bound by the claims administrator's prior determination.

4. The IRO will provide notice of the final external review decision as expeditiously as your medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited external review. If the IRO's notice is not in writing, the IRO must provide written confirmation of the decision within 48 hours to the claimant and the plan.

General Rules

1. The exhaustion of the claims procedures (with the exception of the voluntary appeal and external claim review process) is mandatory for resolving every claim and dispute arising under this plan. In any legal action brought after you have exhausted the administrative remedies, all determinations made by the claims administrator, Allina

Health or other fiduciary, shall be afforded the maximum deference permitted by law.

2. If you file your claim within the required time and complete the entire claims procedure (except for the voluntary appeal and external review), any lawsuit must be commenced within six months after the claim-and-review procedure is complete. In any event, you must commence the suit within two years after whichever is earliest – the date on which you were denied benefits or received benefits at a different level than you believed the plan provides; or the date you knew or reasonably should have known of the principal facts on which your claim is based.
3. Your initial claim, any request for review of an adverse benefit determination, and any request for external appeal must be made in writing, except for requests for review of adverse benefit determinations relating to urgent care claims, which may also be made orally.
4. You must follow the claims procedures contained in this SPD carefully and completely and you must file your claim before any applicable deadlines. If you do not do so, you may give up important legal rights.
5. Your casual inquiries and questions will not be treated as claims or requests for a review or submissions to the external appeal process.
6. You may have a lawyer or other representative help you with your claim at your own expense (the claims administrator or Allina Health may require written authorization to verify that an individual has been authorized to act on your behalf, except that for urgent care claims a health care professional with knowledge of the claimant's medical condition will be permitted to act as an authorized representative).
7. You are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to any adverse benefit determination. You will also be allowed to review the claim file and present evidence and testimony as part of the internal claims process.
8. You must comply with any additional requirements for filing a claim (e.g., using a specific claim form) imposed by the claims administrator.
9. Claims for services must be submitted within 90 days after the date services were first received for the injury or illness upon which the claim is based. Failure to file a claim within this period of time shall not invalidate nor reduce any claim if it was not reasonably possible to file the claim within that time. However, such claim must be filed as soon as reasonably possible, except in the absence of your legal capacity, within 12 months (or 90 days for administrative requests relating to eligibility or enrollment) after the earlier of the date on which: (1) you were denied benefits; (2) you received benefits at a different level than you believed the plan provides; or (3) you knew or reasonably should have known of the principal facts on which your claim is based.

Additional Provisions

Authorized Representative

A claimant may appoint an "authorized representative" to act on their behalf solely with respect to a claim or an appeal of an adverse benefit determination or an inquiry concerning an adverse benefit decision. To appoint an authorized representative, a claimant must complete a form that can be obtained from the claims administrator. However, in connection with an urgent care claim, the claims administrator will permit a health care professional with knowledge of the claimant's medical condition to act as the claimant's authorized representative without completion of this form. Once an authorized representative is appointed, all future communication from the claims administrator will be made with the representative rather than the claimant, unless the claimant provides specific written direction otherwise. An assignment for purposes of payment (e.g., to a health care professional) does not constitute an appointment of an authorized representative under these claims procedures. Any reference in these claims procedures to claimant is intended to include the authorized representative of such claimant.

A claimant may not assign to any other person or entity their right to legally challenge any decision, action, or inaction of the claims administrator or plan administrator.

Claims Payment

When a claimant uses in-network or out-of-network participating providers, the plan pays the provider. When a claimant uses a nonparticipating provider, the plan pays the claimant. A claimant may not assign their benefits to a nonparticipating provider, except when parents are divorced. In that case, the custodial parent may request, in writing, that the plan pay a nonparticipating provider for covered services for a child. When the plan pays the provider at the request of the custodial parent, the plan has satisfied its payment obligation. This provision may be waived for ambulance providers in Minnesota and certain institutional and medical/surgical providers outside the state of Minnesota at the discretion of the claims administrator.

The plan does not pay claims to providers or to employees for services received in countries that are sanctioned by the United States Department of Treasury's Office of Foreign Assets Control (OFAC), except for medical emergency services when payment of such services is authorized by OFAC. Countries currently sanctioned by OFAC include Cuba, Iran, and Syria. OFAC may add or remove countries from time to time.

No Third Party Beneficiaries

The plan benefits described in this benefit booklet are intended solely for the benefit of you and your covered dependents. No person who is not a plan participant or dependent of a plan participant may bring a legal or equitable claim or cause of action pursuant to this benefit booklet as an intended or third party beneficiary or assignee hereof.

Release of Records

Claimants agree to allow all health care providers to give the claims administrator needed information about the care that they provide to them. This includes information about care received prior to the claimants enrollment with the claims administrator where necessary. The claims administrator may need this information to process claims, conduct utilization review, care management, quality improvement activities, reimbursement and subrogation, and for other health plan activities as permitted by law. If a provider requires special authorization for release of records, claimants agree to provide this authorization. A claimant's failure to provide authorization or requested information may result in denial of the claimant's claim.

Right of Examination

The claims administrator and the plan administrator each have the right to ask a claimant to be examined by a provider during the review of any claim. The plan pays for the examination whenever either the claims administrator or the plan administrator requests the examination. A claimant's failure to comply with this request may result in denial of the claimant's claim.

Independent Dispute Resolution

If your plan and an out-of-network provider or facility that provided an item or service to you cannot agree on how much the provider or facility will be paid by the plan for the item or service, the dispute may be submitted by either the plan or the provider to Independent Dispute Resolution (IDR). As a plan participant, you are not involved in the IDR process (although your medical information will be shared with the certified IDR entity). Regardless of what the certified IDR entity decides, you will not have any additional cost-sharing under the plan, as your cost-sharing is limited to the in-network costs for the item or service. To the extent that you have a dispute about any adverse benefit determination you received relating to the item or service, you can appeal that decision under the plan's Appeal Process.

Employee Retirement Income Security Act (ERISA) Statement of Rights

For information regarding Employee Retirement Income Security Act (ERISA) Statement of Rights, please refer to the "ERISA Rights" section of the Eligibility & Enrollment Booklet.

Terms You Should Know

Admissions - A period of one (1) or more days and nights while you occupy a bed and receive inpatient care in a facility.

Advanced Practice Nurses - Licensed registered nurses who have gained additional knowledge and skills through an organized program of study and clinical experience that meets the criteria for advanced practice established by the professional nursing organization having the authority to certify the registered nurse in the advanced nursing practice. Advanced practice nurses include clinical nurse specialists (C.N.S.), nurse practitioners (N.P.), certified registered nurse anesthetists (C.R.N.A.), and certified nurse midwives (C.N.M.).

Aftercare/Continuing Care Services - The stage following discharge, when the patient no longer requires services at the intensity required during primary treatment.

Allowed Amount - The amount that payment is based on for a given covered service of a specific provider. The allowed amount may vary from one (1) provider to another for the same service. All benefits are based on the allowed amount, except as provided in "Benefit Overview." The allowed amount may include the provider's applicable taxes, for example, the MinnesotaCare tax.

The allowed amount for participating providers

For participating providers, the allowed amount is the negotiated amount of payment that the in-network provider has agreed to accept as full payment for a covered service at the time your claim is processed. The claims administrator periodically may adjust the negotiated amount of payment at the time your claim is processed for covered services at in-network providers as a result of expected settlements or other factors. The negotiated amount of payment with in-network providers for certain covered services may not be based on a specified charge for each service. Through annual or other global settlements, which may include an agreed upon fee schedule rate, case rate, withhold and/or capitation agreements, rebates, prospective payments or other methods, the claims administrator may adjust the amount due to in-network providers without reprocessing individual claims. These annual or other global adjustments will not cause any change in the amount you paid at the time your claim was processed. If the payment to the provider is decreased, the amount of the decrease is credited to the claims administrator, and the percentage of the allowed amount paid by the claims administrator is lower than the stated percentage for the covered service. If the payment to the provider is increased, the claims administrator pays that cost on your behalf, and the percentage of the allowed amount paid is higher than the stated percentage.

The allowed amount for all nonparticipating providers

For nonparticipating providers, the allowed amount may also be determined by the provider type, provider location, and the availability of certain pricing methods. The allowed amount may not be based upon or related to a usual, customary or reasonable charge. The claims administrator will pay the stated percentage of the allowed amount for a covered service. In most cases, the claims administrator will pay this amount to you. The determination of the allowed amount is subject to all business rules as defined in the claims administrator's Provider Policy and Procedure Manual. As a result, the claims administrator may bundle services, take multiple procedure discounts and/or other reductions as a result of the procedures performed and billed on the claim. No fee schedule amounts include any applicable tax.

The allowed amount for nonparticipating providers in Minnesota

For nonparticipating provider services within Minnesota, except those described in "Special Circumstances," the allowed amount will be based upon one (1) of the following payment options to be determined at the claims administrator's discretion: (1) a percentage, not less than 140%, of the Medicare allowed charge for the same or similar service; (2) a percentage of billed charges; (3) provider reimbursement databases, median costs from a benchmark of like claims, or fee negotiations; or, (4) as may be required by federal law. The payment option selected by the claims administrator may result in an allowed amount that is a lower amount than if calculated by another payment option. When the Medicare allowed charge is not available, the pricing method may also be determined by factors such as type of service, place of service, reason for care, and type of provider at the point the claim is received by the claims administrator.

The allowed amount for nonparticipating provider services outside Minnesota

For nonparticipating provider physician or clinic services outside of Minnesota, except those described in "Special Circumstances," the allowed amount will be based upon one (1) of the following payment options to be determined at the claims administrator's discretion: (1) a percentage, not less than 140%, of the Medicare allowed charge for the same or similar service; (2) a percentage of billed charges; (3) pricing determined by another Blue Cross or Blue Shield plan; (4) provider reimbursement databases, median costs from a benchmark of like claims, or fee negotiations; or, (5) as may be required by federal law. The payment option selected by the claims administrator may result in an allowed amount that is a lower amount than if calculated by another payment option. When the Medicare allowed charge is not available, the pricing method may also be determined by factors such as type of service, place of service, reason for care, and type of provider at the point the claim is received by the claims administrator.

Applied Behavioral Analysis - The design, implementation and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior or to prevent loss of attained skill or function, including the use of direct observation, measurement and functional analysis of the relations between environment and behavior.

Artificial Insemination (AI) - A procedure in which semen is placed in a vagina, cervix, or uterus.

Assisted Reproductive Technology - Treatments or procedures that are done to start a pregnancy. This may include handling eggs and sperm or embryos.

Attending Health Care Professional - A health care professional with primary responsibility for the care provided to a sick or injured person.

Autism Spectrum Disorders - Any of the pervasive developmental disorders defined by the most recent edition of the *Diagnostic and Statistical Manual of Mental Disorders (DSM)*, or its successor, including autistic disorder, Asperger's disorder and pervasive developmental disorder not otherwise specified.

Behavioral Health Care Treatment - Treatment for mental health disorders and substance use disorder/addiction diagnoses as listed in the most recent editions of the *International Classification of Diseases (ICD)* and *Diagnostic and Statistical Manual for Mental Disorders (DSM)*. Does not include developmental disability.

Biological Products - Products that are regulated by the Food and Drug Administration (FDA) and are medicines made from living organisms through highly complex manufacturing processes and must be handled and administered under carefully monitored conditions. There are a wide variety of biological products such as drugs, gene and cellular therapies and vaccines.

Biosimilars - Products that are regulated by the Food and Drug Administration (FDA) and are highly similar to the reference biological brand name product in terms of safety, purity and potency, but may have minor differences in clinically inactive components.

BlueCard Program - A Blue Cross and Blue Shield program which allows you to access covered health care services while traveling outside of your service area. You must use in-network providers of a Host Blue and show your member ID card to secure BlueCard program access.

Board-Certified - A designation given to those physicians who, after meeting strict standards of knowledge and practices, are certified by the professional board representing their specialty.

Calendar Year - The period starting on January 1st of each year and ending at midnight December 31st of that year.

Care Coordination - Organized, information-driven patient care activities intended to facilitate the appropriate responses to your health care needs across the continuum of care.

Care/Case Management Plan - A plan for health care services developed for a specific patient by a care/case manager after an assessment of the patient's condition in collaboration with the patient and the patient's health care

team. The plan sets forth both the immediate and the ongoing skilled health care needs of the patient to sustain or achieve optimal health status.

Cellular Therapy - The transfer of cells into a person with the goal of improving a disease. Gene modified cell therapy removes the cells from a person's body and alters the genetic material of the cell. The modified cells are then reintroduced into the body.

Chronic Condition - Any physical or mental condition that requires long-term monitoring and/or management to control symptoms and to shape the course of the disease.

Claim - A request for prior approval of a covered service or for the payment or reimbursement of the charges or costs associated with a covered service. Claims include:
- **Pre-service claim -** A request for prior approval of a covered service which under the terms of your coverage must be approved before you receive the covered service.
- **Urgent care claim -** A pre-service claim which, if decided within the time periods established for making non-urgent care pre-service claim decisions, could seriously jeopardize your life, health or ability to regain maximum function or, in the opinion of a physician with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without the service. Whether a request involves an urgent care claim will be determined by your attending health care provider.
- **Post-service claim -** A request for payment or reimbursement of the charges or costs associated with a covered service that you have received.

Claims Administrator - Blue Cross and Blue Shield of Minnesota (Blue Cross).

Coinsurance - The percentage of the allowed amount you must pay for certain covered services after you have paid any applicable deductibles and copays until you reach your out-of-pocket limits. For covered services from participating providers, coinsurance is calculated based on the lesser of the allowed amount or the billed charge. Because payment amounts are negotiated to achieve overall lower costs, the allowed amount for participating providers is generally lower than the billed charge. However, the amount used to calculate your coinsurance will not exceed the billed charge. When your coinsurance is calculated on the billed charge rather than the allowed amount for participating providers, the percentage of the allowed amount paid by us will be greater than the stated percentage.

For covered services from nonparticipating providers, coinsurance is calculated based on the allowed amount. In addition, you are responsible for any excess charge over the allowed amount.

Your coinsurance and deductible amount will be based on the negotiated payment amount we have established with the provider or the provider's charge, whichever is less. The negotiated payment amount includes discounts that are known and can be calculated when the claim is processed. In some cases, after a claim is processed, that negotiated payment amount may be adjusted at a later time if the agreement with the provider so provides. Coinsurance calculation will not be changed by such subsequent adjustments or any other subsequent reimbursements we may receive from other parties.

Coinsurance Example:
You are responsible for payment of any applicable coinsurance amounts for covered services. The following is an example of how coinsurance would work for a typical claim:

For instance, when Blue Cross pays 80% of the allowed amount for a covered service, you are responsible for the coinsurance, which is 20% of the allowed amount. In addition, you would be responsible for any excess charge over our allowed amount when a nonparticipating provider is used. For example, if a nonparticipating provider ordinarily charges $100 for a service, but our allowed amount is $95, Blue Cross will pay 80% of the allowed amount ($76). You must pay the 20% coinsurance on the Blue Cross allowed amount ($19), plus the difference between the billed charge and the allowed amount ($5), for a total responsibility of $24.

Remember, if participating providers are used, your share of the covered charges (after meeting any deductibles) is limited to the stated coinsurance amounts based on the Blue Cross allowed amount. If nonparticipating providers are used, your out-of-pocket costs will be higher as shown in the example above.

Continued Stay - A continuation of inpatient care services for a member with an existing prior authorization. A continued stay review determines if continued inpatient care is medically necessary and/or if the current health care

facility is still the most appropriate to provide the level of care required for the patient. Also known as concurrent review.

Copay - The dollar amount you must pay for certain covered services. The "Benefit Overview" lists the copays and services that require copays. A negotiated payment amount with the provider for a service requiring a copay will not change the dollar amount of the copay.

Cosmetic Services - Surgery and other services performed primarily to enhance or otherwise alter physical appearance without correcting or improving a physiological function.

Covered Services - A health service or supply that is eligible for benefits when performed and billed by an eligible provider. You incur a charge on the date a service is received or a supply or a drug is purchased.

Custodial Care - Care provided primarily for maintenance of the member or which is designed essentially to assist the member in meeting activities of daily living and which is not primarily provided for its therapeutic value in the treatment of an illness, disease, bodily injury, or condition.

Cycle - One (1) partial or complete fertilization attempt extending through the implantation phase only.

Day Treatment - Behavioral health services that may include a combination of group and individual therapy or counseling for a minimum of three (3) hours per day, three (3) to five (5) days per week.

Deductible - The deductible is a specified dollar amount you must pay for most covered services each calendar year before the health plan begins to provide payment for benefits. Services such as prenatal care, pediatric preventive care, and primary network preventive care services for adults are not subject to the deductible. Please refer to "Benefit Overview" for the deductible amount.

Dental Implant - Metal, screwlike posts surgically inserted in the jawbone to replace damaged or missing teeth with artificial teeth that look and function like real ones.

Dependent - Your spouse, child or dependent child as specified in the “Eligibility” section of the Eligibility and Enrollment Booklet.

Designated Agent - An entity that has contracted, either directly or indirectly, with the claims administrator to perform a function and/or service in the administration of this health plan. Such function and/or service may include, but is not limited to, medical management and provider referral.

Diabetes Self-Management Education (DSME) - The process of facilitating the knowledge, skill, and ability necessary for diabetes self-care. Diabetes self-management support (DSMS) refers to the support that is required for implementing and sustaining coping skills and behaviors needed to self-manage on an ongoing basis. The overall objectives are to support informed decision making, self-care behaviors, problem solving, and active collaboration with the health care team and to improve clinical outcomes, health status, and quality of life. Support can be behavioral, educational, psychosocial, or clinical. DSMES will be provided by one (1) or more instructors. The instructors will have recent educational and experiential preparation in education and diabetes management or will be a certified diabetes educator. The instructor(s) will obtain regular continuing education in the field of diabetes management and education. At least one (1) of the instructors will be a registered nurse, dietitian, or pharmacist. DSMES must be consistent with the National Standards for Diabetes Self-Management Education.

Durable Medical Equipment - Medical equipment prescribed by a physician that meets each of the following requirements:

1. able to withstand repeated use;
2. used primarily for a medical purpose;
3. generally not useful in the absence of illness or injury;
4. determined to be reasonable and necessary; and
5. represents the most cost-effective alternative.

E-Visit - A member-initiated, limited online evaluation and management health care service provided by a physician or other qualified health care provider using the internet or similar secure communications network to communicate with an established member.

Experimental/Investigative - The use of any treatment, service, procedure, facility, equipment, prescription drug, device or supply (intervention) which is not determined by the claims administrator to be medically effective for the condition being treated. The claims administrator will consider an intervention to be experimental/investigative if: the intervention does not have Food and Drug Administration (FDA) approval to be marketed for the specific relevant indication(s); or available scientific evidence does not permit conclusions concerning the effect of the intervention on health outcomes; or the intervention is not proven to be as safe and as effective in achieving an outcome equal to or exceeding the outcome of alternative therapies; or the intervention does not improve health outcomes; or the intervention is not proven to be applicable outside the research setting. If an intervention, as defined above, is determined to be experimental/investigative at the time of the service, it will not receive retroactive coverage, even if it is found to be in accordance with the above criteria at a later date. Medical researchers constantly experiment with new medical equipment, prescription drugs and other technologies. In turn, health plans must evaluate these technologies. The claims administrator believes that decisions for evaluating new technologies, as well as new applications of existing technologies, for medical and behavioral health procedures, pharmaceuticals and devices should be made by medical professionals. Certain routine patient costs for participation in an approved clinical trial will not be considered experimental/investigative. Routine patient costs include items and services that would be covered if the member was not enrolled in an approved clinical trial.

Extended Hours Skilled Nursing Care (Private Duty Nursing) - Extended hours home care are continuous and complex skilled nursing services greater than two (2) consecutive hours per date of service in the member's home. Extended hours services provide complex, direct, skilled nursing care to develop caregiver competencies through training and education to optimize the member's heath status and outcomes. The frequency of the nursing tasks is continuous and temporary in nature and is not intended to be provided on a permanent, ongoing basis.

Facility - A provider that is a hospital, skilled nursing facility, residential behavioral health treatment facility, or outpatient behavioral health treatment facility licensed under state law in the state in which it is located to provide the health services billed by that facility. Facility may also include a licensed home/suite infusion therapy provider, freestanding ambulatory surgical center, a home health agency, or freestanding birthing center when services are billed on a facility claim.

Foot Orthoses - Appliances or devices used to stabilize, support, align, or immobilize the foot in order to prevent deformity, protect against injury, or assist with function. Foot orthoses generally refer to orthopedic shoes, and devices or inserts that are placed in shoes including heel wedges and arch supports. Foot orthoses are used to decrease pain, increase function, correct some foot deformities, and provide shock absorption to the foot. Orthoses can be classified as pre-fabricated or custom-made. Pre-fabricated orthoses are manufactured in quantity and are not designed for a specific member. Custom-fitted orthoses are specifically made for an individual member.

Freestanding Ambulatory Surgical Center - A provider that facilitates medical and surgical services to sick and injured persons on an outpatient basis. Such services are performed by, or under the direction of, a staff of licensed doctors of medicine (M.D.) or osteopathy (D.O.) and/or registered nurses (R.N.). A freestanding ambulatory surgical center is not part of a hospital, clinic, doctor's office, or other health care professional's office.

Gene Therapy - The introduction, removal, or change in the content of a person's genetic material with the goal of treating or curing a disease. It includes therapies such as gene transfer, gene modified cell therapy, and gene editing.

Habilitative Services - Services, including devices, that are expected to make measurable or sustainable improvement within a reasonable period of time and assist a member to attain, maintain, or improve daily living skills or functions never learned or acquired due to a disabling condition.

Halfway House - Specialized residences for individuals who no longer require the complete facilities of a hospital or institution but are not yet prepared to return to independent living.

Health Care Provider - A health care professional, licensed for independent practice, certified or otherwise qualified under state law, in the state in which the services are rendered, to provide the health services billed by that health care

professional. Health care professionals include only physicians, chiropractors, mental health professionals, advanced practice nurses, physician assistants, audiologists, physical, speech, and occupational therapists, licensed nutritionists, licensed registered dieticians, and licensed acupuncture practitioners. Health care professional also includes supervised employees of: Minnesota Rule 29 behavioral health treatment facilities licensed by the Minnesota Department of Human Services and doctors of medicine, osteopathy, chiropractic, or dental surgery.

Home Health Agency - A preapproved facility that sends health care professionals and home health aides into a person's home to provide health services.

Hospice Care - A coordinated set of services provided at home or in an inpatient hospital setting for covered individuals diagnosed with a terminal disease or condition.

Hospital - A facility that provides diagnostic, therapeutic and surgical services to sick and injured persons on an inpatient or outpatient basis. Such services are performed by or under the direction of a staff of licensed doctors of medicine (M.D.), or osteopathy (D.O.). A hospital provides 24-hour-a-day professional registered nursing (R.N.) services.

Host Blue - A Blue Cross and/or Blue Shield licensee outside of Minnesota that has contractual relationships with providers in its designated service area that deliver the benefit of its arrangements with its local and ancillary providers eligible for Inter-Plan Programs, on behalf of Control/Home Licensee Members who incur claims within its service area.

Illness - A sickness, injury, pregnancy, mental illness, substance use disorder, or condition involving a physical disorder.

Immediate Family - Your spouse, child, stepchild, parent, brother, sister, mother-in-law, father-in-law, brother-in-law, sister-in-law, daughter-in-law, son-in-law, grandchild, grandparent, stepparent, stepbrother or stepsister.

Infertility - The medically documented inability to conceive with unprotected sexual intercourse between partners for a period of at least 12 months. The inability to conceive may be due to either partner.

In-network - Depending on where you receive services, the in-network is designated as one (1) of the following:

- When you receive services within the health plan service area, the designated in-network for professional providers and facility providers is the network.
- When you receive services within the claims administrator’s service area, the designated in-network for professional providers and facility providers is the network.
- When you receive services outside Minnesota, the designated participating in-network for professional providers and facility providers is the local BlueCard PPO network.

In-network Provider - Elevate Network providers and referral network providers.

Inpatient Care - Care that provides 24-hour-a-day professional registered nursing (R.N.) services for short-term medical and behavioral health services in a hospital setting.

Intensive Outpatient Programs (IOPs) - A behavioral health care service setting that provides structured, multidisciplinary diagnostic and therapeutic services. IOPs operate at least three (3) hours per day, three (3) days per week. Substance use disorder treatment is typically provided in an IOP setting. Some IOPs provide treatment for mental health disorders.

Intermittent Skilled Nursing Care - Services consisting of up to two (2) consecutive hours per date of service in the member's home provided by a licensed registered nurse or licensed practical nurse who are employees of an approved home health care agency.

Lifetime Maximum - The cumulative maximum payable for specified covered services incurred by a member during their lifetime or by each covered dependent during their lifetime under all health plans with the employer. The lifetime maximum does not include amounts which are the member’s responsibility, such as deductibles, coinsurance, copays, and other amounts. Please refer to "Benefit Overview" for specific dollar maximums on certain services.

Maintenance Services - Services that are neither habilitative nor rehabilitative that are not expected to make measurable or sustainable improvement within a reasonable period of time.

Marriage/Couples Counseling - Behavioral health care services for the primary purpose of working through relationship issues.

Marriage/Couples Training - Services for the primary purpose of relationship enhancement including, but not limited to: premarital education; or marriage/couples retreats, encounters, or seminars.

Medical Emergency - Medically necessary and appropriate care which a reasonable layperson believes is immediately necessary to preserve life, prevent serious impairment to bodily functions, organs, or parts, or prevent placing the physical or mental health of the member in serious jeopardy.

Medically Necessary and Appropriate (Medical Necessity and Appropriateness) - Services, supplies or covered medications that a provider, exercising prudent clinical judgment, would provide to a member for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are: (i) in accordance with generally accepted standards of medical practice; and (ii) clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the member's illness, injury or disease; and (iii) not primarily for the convenience of the member, physician, or other health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that member's illness, injury or disease. The claims administrator reserves the right, utilizing the criteria set forth in this definition, to render the final determination as to whether a service, supply or covered medication is medically necessary and appropriate. No benefits will be provided unless the claims administrator determines that the service, supply or covered medication is medically necessary and appropriate.

With respect to mental health care services: services appropriate, in terms of type, frequency, level, setting, and duration, to the member's diagnosis or condition, and diagnostic testing and preventive services. Medically necessary and appropriate care must be consistent with generally accepted practice parameters as determined by health care providers in the same or similar general specialty as typically manages the condition, procedure, or treatment at issue and must:

(1) help restore or maintain the member's health; or
(2) prevent deterioration of the member's condition.

Medicare - A federal health insurance program established under Title XVIII of the Social Security Act. Medicare is a program for people age 65 or older; some people with disabilities under age 65; and people with end-stage renal disease. The program includes Part A, Part B, and Part D. Part A generally covers some costs of inpatient care in hospitals and skilled nursing facilities. Part B generally covers some costs of physician, medical, and other services. Part D generally covers outpatient prescription drugs defined as those drugs covered under the Medicaid program plus insulin, insulin-related supplies, certain vaccines, and smoking cessation agents. Medicare Parts A, B, and D do not pay the entire cost of services and are subject to cost-sharing requirements and certain benefit limitations.

Mental Illness - A mental disorder as defined in the *International Classification of Diseases (ICD)* and *Diagnostic and Statistical Manual for Mental Disorders (DSM)*. It does not include substance dependence, nondependent substance use disorder, or developmental disability.

Nonparticipating Provider - A provider who has not entered into a network contract with the claims administrator or the local Blue Cross and/or Blue Shield plan.

Opioid Treatment - Treatment that uses Medication Assisted Treatment (MAT) to control withdrawal symptoms of opioid addiction.

Out-of-network Participating Provider - Providers who have a contract with the claims administrator or the local Blue Cross and/or Blue Shield plan (participating providers), but are not in-network providers because the contract is not specific to this plan.

Out-of-network Provider - A provider with a Blue Cross contract that is not specific to this plan; and nonparticipating providers.

Out-of-pocket Limit - The out-of-pocket limit refers to the specified dollar amount of member cost-sharing incurred for covered services in a calendar year. When the specified dollar amount is attained, the claims administrator begins to pay 100% of the allowed amount for all covered expenses. Please refer to "Benefit Overview" for the out-of-pocket limit.

Outpatient Behavioral Health Treatment Facility - A facility that provides outpatient treatment by, or under the direction of, a licensed mental health care professional for mental health disorders, or a licensed substance use professional for substance use disorders.

Outpatient Care - Services received without being admitted for an inpatient stay. Services received at an ambulatory surgery center are considered outpatient care.

Palliative Care - Services specifically designed to alleviate the physical, psychological, psychosocial, or spiritual impact of a disease, rather than providing a cure for members with a new or established diagnosis of a progressive, debilitating illness. Services are focused on improving quality of life by enabling a patient to address social, emotional and spiritual needs, and supporting the patient and family.

Partial Hospitalization - The provision of medical, nursing, counseling or therapeutic mental health care services or substance use disorder services on a planned and regularly scheduled basis in a facility provider designed for a member or client who would benefit from more intensive services than are generally offered through outpatient treatment but who does not require inpatient care.

Partial Programs - An intensive, structured behavioral health care setting that provides medically supervised diagnostic and therapeutic services. Partial programs operate five (5) to six (6) hours per day, five (5) days per week although some patients may not require daily attendance.

Participating Provider - A provider who has entered into either a specific network contract or a general broader network contract with the claims administrator or the local Blue Cross and/or Blue Shield plan.

Physician - A doctor of medicine (M.D.), osteopathy (D.O.), dental surgery (D.D.S.), medical dentistry (D.M.D.), podiatric medicine (D.P.M.), or optometry (O.D.) practicing within the scope of his or her license.

Place of Service - Clinic and hospital providers submit claims using national standards established by the Centers for Medicare & Medicaid Services (CMS) and state guidelines. The benefit paid for a service is based on provider billing and the place of service. For example, the benefits for diagnostic imaging performed in a physician's office may be different than diagnostic imaging delivered in an outpatient facility setting.

Plan - The plan of benefits established by the plan sponsor.

Plan Year - A 12-month period which begins on the effective date of the plan and each succeeding 12-month period thereafter.

Provider - A health care professional or facility licensed, certified or otherwise qualified under state law, in the state in which the services are rendered, to provide the health services billed by that provider. Provider also includes home/suite infusion therapy providers, pharmacies, medical supply companies, independent laboratories and ambulances.

Rehabilitative Services - Services, including devices, that are expected to make measurable or sustainable improvement within a reasonable period of time and assist a member to regain, maintain, or prevent deterioration of daily living skills or functions acquired but then lost or impaired due to an illness, injury, or disabling condition.

Residential Behavioral Health Treatment Facility - A facility licensed under state law in the state in which it is located that provides residential treatment under the direction of, a licensed mental health professional for mental health disorders, or a licensed substance use professional for substance use disorders. The facility provides

continuous, 24-hour supervision by a skilled staff who are directly supervised by health care professionals. Skilled nursing and medical care are available each day.

Respite Care - Short-term inpatient or home care provided when necessary to relieve family members or other persons caring for the member.

Retail Health Clinic - A clinic located in a retail establishment or worksite. The clinic provides medical services for a limited list of eligible symptoms (e.g., sore throat, cold).

Services - Health care services, procedures, treatments, durable medical equipment, medical supplies, and prescription drugs, including specialty drugs.

Skilled Care - Services rendered that are medically necessary and appropriate and provided by a licensed nurse or other licensed health care provider. A service shall not be considered skilled care merely because it is performed by, or under the direct supervision of, a licensed health care provider. Services such as tracheotomy suctioning or ventilator monitoring, that can be safely and effectively performed by a non-medical person (or self-administered) without direct supervision of a licensed health care provider, shall not be regarded as skilled care, whether or not a licensed health care provider actually provides the service. The unavailability of a competent person to provide a non-skilled service shall not make it skilled care when a licensed health care provider provides the service. Only the skilled care component(s) of combined services that include non-skilled care are covered under the plan.

Skilled Nursing Facility - A Medicare-approved facility that provides skilled transitional care by, or under the direction of a doctor of medicine (M.D.) or osteopathy (D.O.). A skilled nursing facility provides 24-hour-a-day professional registered nursing (R.N.) services.

Skills Training - Training of basic living and social skills that restore a patient's skills essential for managing their illness, treatment, and the requirements of everyday independent living.

Specialist/Specialist Physician - A physician who limits their practice to a particular branch of medicine or surgery.

Specialty Drugs - Specialty drugs are designated complex injectable and oral drugs that have very specific manufacturing, storage, and dilution requirements that are subject to restricted distribution by the U.S. Food and Drug Administration (FDA); or require special handling, provider coordination, or patient education that cannot be provided by a retail pharmacy.

Specialty Pharmacy Network Supplier - A pharmaceutical specialty provider that has an agreement with the claims administrator pertaining to the payment and exclusive dispensing of selected specialty prescription drugs provided to you.

Step Therapy - Step therapy includes, but is not limited to, drugs in specific categories or drug classes. If your health care provider prescribes one (1) of these drugs, there must be documented evidence that you have tried another eligible drug(s) that is safe, more clinically effective, and in some cases more cost-effective before the drugs subject to step therapy medication will be paid under the drug benefit.

Substance Use Disorder and/or Addictions - Alcohol, drug dependence or other addictions as defined in the most current editions of the *International Classification of Diseases (ICD)* and *Diagnostic and Statistical Manual for Mental Disorders (DSM)*.

Supervised Employees - Health care professionals employed by a doctor of medicine, osteopathy, chiropractic, dental surgery, or a Minnesota Rule 29 behavioral health treatment facility licensed by the Minnesota Department of Human Services. The employing M.D., D.O., D.C., D.D.S., or mental health professional must be physically present and immediately available in the same office suite more than 50% of each day when the employed health care professional is providing services. Independent contractors are not eligible.

Supplies - Health care materials prescribed by a physician that are not reusable. They are used primarily for a medical purpose and are generally not useful in the absence of illness or injury.

Supplies include, but are not limited to:
1. ostomy supplies;
2. catheters;
3. oxygen; and
4. diabetic supplies.

Surrogate Pregnancy - An arrangement in which a person agrees to carry a pregnancy for another person.

Telehealth Services - The delivery of health care services or consultations through the use of real time two-way interactive audio and visual communications to provide or support health care delivery and facilitate the assessment, diagnosis, consultation, treatment, education, and care management of a member’s health care. Telehealth includes the application of secure video conferencing, store-and-forward technology, and synchronous interactions between a member located at an originating site and a provider located at a distant site. Originating site means a site where the member is located at the time health care services are provided to the member by means of telehealth. Coverage is provided for health care services delivered through telehealth by means of the use of audio-only communication if the communication is a scheduled appointment and the standard of care for that particular service can be met through the use of audio-only communication. Telehealth does not include communication between providers that consists solely of a telephone conversation, e-mail, or facsimile transmission. Telehealth does not include communication between a provider and a member that consists solely of an e-mail or facsimile transmission.

Tobacco Cessation Drugs and Products - Prescription drugs and over-the-counter products that aid in reducing or eliminating the use of nicotine.

Treatment - The management and care of a patient for the purpose of combating illness or injury. Treatment includes medical care, surgical care, diagnostic evaluation, giving medical advice, monitoring and taking medication.

Value-Based Program - An outcomes-based payment arrangement and/or a coordinated care model facilitated with one (1) or more local providers that is evaluated against cost and quality metrics/factors and is reflected in provider payment.

The Blue Cross® and Blue Shield® Association is an association of independent Blue Cross and Blue Shield plans.

You are hereby notified, your health care benefit program is between the employer, on behalf of itself and its employees and Blue Cross and Blue Shield of Minnesota. Blue Cross is an independent corporation operating under licenses from the Blue Cross and Blue Shield Association ("the Association"), which is a national association of independent Blue Cross and Blue Shield companies throughout the United States. Although all of these independent Blue Cross and Blue Shield companies operate from a license with the Association, each of them is a separate and distinct operation. The Association allows Blue Cross Blue Shield to use the familiar Blue Cross and Blue Shield words and symbols. Blue Cross Blue Shield shall be liable to the employer, on behalf of itself and its employees, for any Blue Cross Blue Shield obligations under your health care benefit program.

Prescription Drug Appendix

Benefit Chart for prescription drugs

This section lists covered services and the benefits the Plan pays for prescription drugs. The prescription drug benefit is administered by Express Scripts.

Benefit Features, Limitations, and Maximums

Networks

- Allina Elevate Network (Allina Health Pharmacy)
- National Network (Express Scripts Network Pharmacies), which does not include Walgreens. NOTE: The National Network is only available for the urgent first fill or if an override was approved by the Allina Health Pharmacy.

Benefit Features	Your Liability
Deductible	
The deductibles under the Allina Elevate Network and National Network are combined.	
• Allina Elevate Network	$2,000 for individual coverage per calendar year $4,000 per family per calendar year
• National Network	$2,000 per person per calendar year $4,000 per family per calendar year

Deductible - Non-embedded
If you have other family members on the plan, the overall family deductible must be met before the plan begins to pay. The individual deductible applies to individual coverage only.

Benefit Features	Limitations and Maximums
Out-of-Pocket Maximums	
The out-of-pocket limits under the Allina Elevate Network and National Network are combined.	
• Allina Elevate Network	$2,000 per person per calendar year $4,000 per family per calendar year
• National Network	$2,000 per person per calendar year $4,000 per family per calendar year

Out-of-pocket Limit - Non-embedded
If you have other family members on the plan, the overall family out-of-pocket limit must be met. The individual out-of-pocket limit applies to individual coverage only.

The following items are applied toward the out-of-pocket maximum:
1. prescription drug coinsurance
2. prescription drug copay
3. prescription drug deductible
4. medical coinsurance;
5. medical deductible;
6. diabetic supplies

The following items are NOT applied toward the out-of-pocket maximum:

1. excess charges for purchasing brand-name prescription drugs when there is a generic drug equivalent available
2. special dietary treatment for Phenylketonuria (PKU)
3. amino acid based elemental formula
4. charges for non-covered items

Refer to the following pages for a more detailed description of Prescription Drug benefits.

Prescription Drugs

The Plan Covers:	Allina Elevate Network	National Network (for urgent first fills and overrides approved by the Allina health Pharmacy only)	Out-of-Network Providers
• Retail (up to 31-day supply) ▪ Generic ▪ Preferred-brand name ▪ Non-Preferred	You pay nothing after deductible .	You pay nothing after deductible	**NO COVERAGE.**
• Mail order (up to 93-day supply) ▪ Generic ▪ Preferred-brand name ▪ Non-Preferred	You pay nothing after deductible	**NO COVERAGE.**	**NO COVERAGE.**
• Insulin	100%	**NO COVERAGE.**	**NO COVERAGE**.
• Insulin Pump	100%	**NO COVERAGE**.	**NO COVERAGE.**
• Insulin Pump Supplies and Equipment	100%	**NO COVERAGE.**	**NO COVERAGE.**
• Diabetic Supplies and Equipment	100%	**NO COVERAGE.**	**NO COVERAGE.**
• Ostomy Supplies	100%	**NO COVERAGE.**	**NO COVERAGE.**
• Drugs for Treatment of sexual dysfunction ▪ Generic ▪ Preferred-brand name ▪ Non-Preferred	100% after you pay the deductible. 100% after you pay the deductible. 100% after you pay the deductible.	100% after you pay the deductible. 100% after you pay the deductible. 100% after you pay the deductible.	**NO COVERAGE.**
• Tobacco cessation products	100%	**NO COVERAGE.**	**NO COVERAGE.**
• Specialty drugs (31 day supply) ▪ Drugs for the treatment of growth deficiency ▪ Drugs for treatment of infertility (Non-Essential Benefit) ▪ All Other Specialty drugs	100% after you pay the deductible. 100% after you pay the deductible. See Allina Elevate Network - Retail.	**NO COVERAGE.**	**NO COVERAGE.**

NOTES:

- The prior authorization program monitors certain prescription drugs and their costs. You may call Express Scripts customer service at 1-800-509-5310, and select prompt 2 or visit www.express-scripts.com/allinahealth for a current list of prescription drugs that require prior authorization.
- The urgent first fill of any medication can be filled at any Express Scripts Network pharmacy (except Walgreens); however, any subsequent fills would need to go through Allina Health Pharmacy
- Specialty drugs are limited to drugs on the specialty drug list and must be obtained from an Allina Health Pharmacy.
- If an Allina Health Pharmacy is unable to fill a specialty drug you must receive an override from the Allina Health Pharmacy to fill the drug with the Express Scripts specialty drug pharmacy, Accredo.
- For the treatment of sexual dysfunction/erectile dysfunction, all drugs are subject to quantity limits. Call the Express Scripts customer service at 1-800-509-5310 to learn about the limits.
- Tobacco cessation products must be prescribed by a licensed provider.
- Unless otherwise specified in the Prescription Drug section, you may receive up to a 31-day supply per prescription. All drugs are subject to Express Scripts utilization review process and quantity limits. In addition, certain drugs may be subject to quantity limits applied as part of the trial program. No more than a 31-day supply of specialty drugs will be covered and dispensed at a time.
- Drugs for the treatment of infertility and growth deficiency are subject to the deductible.
- Drugs for the treatment of infertility are subject to a $5,000 maximum benefit per calendar year.
- If there is a generic equivalent and you request the brand-name drug, you must pay the copay for the brand name drug plus the amount that the cost of the brand-name drug exceeds the cost of the generic drug.
- The Plan covers certain prescription female contraceptive drugs which meet the recommendations and criteria established by the United States Preventive Services Task Force (USPSTF), Advisory Committee on Immunizations Practices (ACIP) of the Centers for Disease Control and the Health Resources and Services Administration (HRSA) effective no later than January 1 of the year following the year the recommendation was issued.
- Present your medical ID card to ensure proper submission of your claim. Pharmacy information is on the front of the medical ID card.

At-Home Over-The-Counter COVID-19 Tests

The Plan will cover up to four (4) over-the-counter (OTC) COVID-19 tests at $0 copay for each covered person per 30 rolling days, as long as such tests will be used for personal use and not employment use (i.e., the test is not used by a covered person who needs a negative COVID-19 test to access the employer's worksite). This means, for example, that a family of four (4) covered persons under the Plan, can receive up to sixteen (16) OTC COVID-19 tests per 30 rolling days for $0 copay, as long as they will be used for personal and not employment reasons.

You have the following options for purchase of an OTC COVID-19 test kit:

1. **Participating Pharmacy**

   If you present your prescription drug card at the pharmacy counter (not general check-out register) of a participating pharmacy when purchasing COVID-19 tests for personal use, they should adjudicate at the point of sale for $0, meaning you would not have to pay for the tests out-of-pocket and you would not need to submit a manual claim for reimbursement to the Plan. If the participating pharmacy requires payment from you for the COVID-19 test that is eligible for reimbursement from the Plan, you can submit a claim for reimbursement to the Plan.

   To submit a manual claim for reimbursement, you will need to complete a Prescription Drug Reimbursement Claim Form. You can download the form at https://www.express-scripts.com/art/BOB_ClaimForm.pdf?t1=t1 and submit it by mail or fax with your pharmacy receipt to the address/number specified in the form by the claim filing deadline described in the Plan's summary plan description.

2. **Non-Participating Pharmacy**

   You can purchase a COVID-19 OTC test at a non-participating pharmacy or outside of the direct-to-home shipping program, but you will only be reimbursed up to $12 per test (or the actual cost of the test if less).

   To submit a claim for reimbursement, you will need to complete a Prescription Drug Reimbursement Claim Form. You can down download the form at https://www.express-scripts.com/art/BOB_ClaimForm.pdf?t1=t1 and submit it by mail or fax with your pharmacy receipt to the address/number specified in the form by the claim filing deadline described in the General Rules section of the Prescription Drug Claims Procedures.

3. **Direct-to-Home Shipping Program**

   Allina Health Pharmacy will mail COVID-19 over-the-counter tests directly to your home at no cost, subject to the rules and limitations set forth above. To request tests, please call your local Allina Health Pharmacy or go to www.express-scripts.com/allinahealth and click "Find a Pharmacy."

For assistance in receiving this benefit at an in-network pharmacy or submitted a receipt for reimbursement, contact Express Scripts at 1-800-509-5310.

Specialty Drugs

Specialty medications are drugs that are used to treat complex conditions, such as cancer, growth hormone deficiency, hemophilia, hepatitis C, immune deficiency, multiple sclerosis, and rheumatoid arthritis. Whether they're administered by a healthcare professional, self-injected, or taken by mouth, specialty medications require an enhanced level of service.

You are required to obtain specialty drugs from an Allina Health Pharmacy, except where an override was approved by Allina Health Pharmacy..

Mail Order

Benefit-eligible employees enrolled in an Allina Health medical plan have a lower co-pays when using an Allina Health Pharmacy. Online ordering through MyChart is convenient and fast, especially for maintenance medications. You may order online through MyChart at www.allinahealth.org/mychart and pick them up in person at one of the many Allina Health Pharmacy locations, or have them mailed to you at no additional cost.

While a 93 day supply of your medication is available at any Allina Health Pharmacy location, the primary site for employee mail order is the Allina Health Heart Hospital Pharmacy.

The first time you use the mail order pharmacy benefit, you must call the Allina Health Heart Hospital Pharmacy to ensure they have all your up-to-date information.

Your prescription will be processed and mailed to the designated address within four business days free of any shipping charges.

Prescriptions may be ordered using the following methods:

- online request through MyChart (For new prescriptions, the original prescription must be submitted using one of the methods below.)
- electronically sent or faxed from your physician's office
- telephone submission by your physician
- hard copy prescription dropped off or mailed in to the pharmacy

Locating a Network Pharmacy

To locate an Allina Health Pharmacy, visit www.allinahealth.org/pharmacy or call Express Scripts at 1-800-509-5310, and select prompt 2.

To locate an Express Scripts National Network pharmacy anywhere in the country, visit www.express-scripts.com/allinahealth or call Express Scripts at 1-800-509-5310, and select prompt 2. **The Express Scripts National Network does not include Walgreens.**

Formulary Information

The Plan includes a list of preferred drugs that are either more effective at treating a particular condition than other drugs in the same class of drugs, or as effective as and less costly than similar medications. Non-preferred drugs may also be covered under the Plan, but at a higher cost-sharing tier. Collectively, these lists of drugs make up the Plan's Formulary. The Plan's Formulary is updated periodically and subject to change, so to get the most up-to-date list go online to www.express-scripts.com/allinahealth. Drugs that are excluded from the Plan's Formulary are not covered under the Plan unless approved in advance through a Formulary exception process managed by Express Scripts on the basis that the drug requested is (1) medically necessary and essential to your health and safety and/or (2) all Formulary drugs comparable to the excluded drug have been tried by you. If approved through that process, the applicable Formulary co-pay would apply for the approved drug based on the Plan's cost sharing structure. Absent such approval, if you select drugs excluded from the Formulary you will be required to pay the full cost of the drug without any reimbursement under the Plan. If your physician believes that an excluded drug meets the requirements described above, he or she should take the necessary steps to initiate a Formulary exception review.

The Formulary will continue to change from time to time. For example:

- A drug may be moved to a higher or lower cost-sharing Formulary tier.

- Additional drugs may be excluded from the Formulary.
- A restriction may be added on coverage for a Formulary-covered drug (e.g., prior authorization).
- A Formulary-covered brand name drug may be replaced with a Formulary-covered generic drug.

Please be sure to check before the drug is purchased to make sure it is covered on the Formulary, as you may not have received notice that a drug has been removed from the Formulary. Certain drugs even if covered on the Formulary will require prior authorization in advance of receiving the drug. Other Formulary-covered drugs may not be covered under the Plan unless an established protocol is followed first; this is known as Step-Therapy. As with all aspects of the Formulary, these requirements may also change from time to time.

Clinical Programs

The Prescription Drug Plan uses pharmacy management programs for safety, quality, and cost reasons. The programs include Step Therapy, Prior Authorization and Quantity Management. **The Express Scripts National Network (which is available only for urgent first fills and for overrides approved by Allina Health Pharmacy) does not include Walgreens.**

Step Therapy

Step Therapy is a program for people who take prescription drugs regularly to treat ongoing medical conditions, such as arthritis, asthma or high blood pressure. In Step Therapy, the covered drugs are organized in a series of "steps," with the doctor approving and writing prescriptions.

- The program usually starts with generic drugs in the "first step." Rigorously tested and approved by the U.S. Food & Drug Administration (FDA), the generics covered by your plan have been proven to be effective in treating many medical conditions. This first step allows patients to begin or continue treatment with safe, effective prescription drugs that are also affordable.
- The doctor is consulted and then approves prescriptions in writing based on the list of Step Therapy drugs covered by the plan. For instance, the doctor must write your new prescription when patients change from a second-step drug to a first-step drug.

You may call Express Scripts customer service at 1-800-509-5310, and select prompt 2 or visit www.express-scripts.com/allinahealth for a current list of prescription drugs subject to Step Therapy.

Prior Authorizations

The prior authorization program monitors certain prescription drugs and their costs so you can get the right drug at the right cost. If a patient is prescribed a certain medicine, that drug may need a "prior authorization". You may call Express Scripts customer service at 1-800-509-5310, and select prompt 2 or visit www.express-scripts.com/allinahealth for a current list of prescription drugs that require prior authorization.

Prior Authorization also ensures that covered drugs are used for treating medical problems rather than for other purposes. A prior authorization is used to make sure the medicine is covered for the medical condition but not for cosmetic purposes. For more information on requesting a prior authorization, see the *Prescription Drug Claims Procedures* section below.

Drug Quantity Management

The Drug Quantity Management program is designed to support safe, effective, and economic use of drugs while providing you access to quality care. Express Scripts' clinicians maintain a list of medication quantity limits, which are based upon FDA-approved dosing guidelines and medical literature.

Should patients need additional quantities of medications; criteria have been established for overrides in selected situations.

Drugs Excluded

The following list of excluded drugs is not all inclusive and is subject to change at any time and without notice. You may call Express Scripts customer service at 1-800-509-5310, and select prompt 2 or visit www.express-scripts.com/allinahealth for a current list of prescription drug excluded under the Plan.

- Non-Federal Legend Drugs
- Federal Legend Non-Drugs
- Non Federal Legend Non-Drugs
- Investigational Drugs
- Std Rx/OTC Equivalents
- Diagnostics
- Homeopathic Drugs
- Abortifacients Mifeprex
- Nutritional Supplements and Combo Nutritional Products
- Infant Formulas – Rx & OTC
- Enteral Nutritional Medications
- [OTC and Legend] Smoking Deterrents unless purchased from Allina Health Pharmacy
- Respigam and Synagis
- Cosmetic Drugs ALL (examples include drugs for Hypopigmentation, Renova, Vaniqa)
- Hair Growth Stimulants and other products indicated only for cosmetic use
- Biologicals, Allergy Sera, Blood Products
- Vitamins (OTC)
- Peak Flow Meter (OTC & Rx)
- Injectable Medications administered at Physician's Office

PRESCRIPTION DRUG CLAIMS PROCEDURES

Claims

All claims are treated as filed on the date they are received. Either you or your authorized representative may file a claim for Prescription Drug Plan benefits. An "authorized representative" means a person you authorize, in writing, to act on your behalf. The Prescription Drug Plan will also recognize a court order giving a person authority to submit claims on your behalf. In the case of an Urgent Care Claim, a health care professional with knowledge of your condition may always act as your authorized representative. All communications from the Plan will be directed to your authorized representative unless your written designation provides otherwise.

You have the right to request that a prescription drug be covered or be covered at a higher benefit (e.g. lower copay, higher quantity, etc.). The first request for coverage is called an initial coverage review. Express Scripts reviews both clinical and administrative claims coverage review requests:

> Clinical coverage review request: A request for coverage of a medication that is based on clinical conditions of coverage that are set by the Plan. For example, medications that require a prior authorization.
>
> Administrative coverage review request: A request for coverage of a medication that is based on the Plan's benefit design.

Requesting Prior Authorization

To request an initial clinical coverage review, also called prior authorization (also called initial clinical coverage review), your participating provider submits the request electronically. Information about electronic options can be found at www.express-scripts.com/PA.

To request an initial administrative coverage review, you or your representative must submit the request in writing, using a Benefit Coverage Request Form available by calling the ESI customer service phone number on the back of your prescription card. Complete the form and mail or fax it to:

> Express Scripts
> ATTN: Benefit Coverage Review Department
> P.O. Box 66587
> St. Louis, MO 63166-6587
> Fax: 877 328-9660.

If you use a participating pharmacy (Elevate Network Pharmacy or a National Network Pharmacy for urgent first fills or for overrides approved by Allina Health Pharmacy only), and have your ID card on file with that pharmacy, your claim will be submitted for you automatically. In the event you need to submit a claim yourself, you may obtain a claim form by calling ESI Member Services at 1-800-509-5310 or online at www.express-scripts.com. Send your completed form to:

> Express Scripts
> ATTN: Commercial Claims
> P.O. Box 14711
> Lexington, KY 40512-4711

Timeframes for Deciding Claims

Urgent Care Claims

ESI will decide an Urgent Care Claim (as defined in the Medical Claims Procedures section) and notify you of the decision as soon as possible, taking into account the medical exigencies, but no later than 72 hours after receipt of the claim. If you or your provider believes your situation is urgent, the expedited review must be requested by your provider by phone at 1-800-753-2851.

Pre-service Claims/Prior Authorization/Clinical Coverage Review

ESI will decide a Pre-service Claim (as defined in the Medical Claims Procedures section) and notify you of the decision within a reasonable time appropriate to the medical circumstances, but no later than 15 days after receipt of the claim.

Post-Service Claims

Claims must be filed no later than 12 months after the date of receipt of the treatment or product to which the claim relates. ESI will decide a Post-service Claim (as defined in the Medical Claims Procedures section) and notify you of any adverse decision within a reasonable time, but no later than 30 days after receipt of the claim.

Extensions of Time

You may voluntarily agree to extend the timeframes described above. In addition, if ESI is not able to decide a Pre-service or Post-service Claim within the timeframes described above due to matters beyond its control, these timeframes may be extended for up to 15 days, provided you are notified in writing prior to the expiration of the initial timeframe applicable to the claim. The notice will describe the matters beyond ESI's control that justify the extension and the date by which ESI expects to render a decision. No extension of time is permitted for Urgent Care Claims.

Incomplete Claims

If any information needed to process a claim is missing, the claim will be treated as an incomplete claim. If an Urgent Care Claim is incomplete, ESI will notify the claimant as soon as possible, but no later than 24 hours following receipt of the incomplete claim. The notice will explain that the claim is incomplete, describe the information necessary to complete the claim and specify a reasonable time, no less than 48 hours, within which the claim must be completed. The notice may be oral unless the claimant specifically requests written notice. ESI will decide the claim and notify you of the decision as soon as possible but no 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 submit the specified information.

If a Pre-service or Post-service Claim is incomplete, ESI will notify the claimant as soon as possible. The notice will explain that the claim is incomplete and describe the information needed to complete the claim. You will have 45 days from the date you received the notice to provide the missing information. The timeframe for deciding the claim will be suspended from the date the claimant receives the notice until the date the necessary information is provided to ESI. ESI will decide the claim following receipt of the requested information and provide the claimant with written notice of the decision within the time period required by the Department of Labor claims procedure regulations.

Notification of Initial Benefit Decision

If your claim is denied in whole or in part, you will receive a written notice of the denial directly from ESI. The notice will explain the reason for the denial and the review procedures. A decision on a claim is an "adverse benefit determination" if it is (a) a denial, reduction, or termination of benefits, or (b) a failure to provide or make payment (in whole or in part) for a benefit, or (c) a rescission of coverage. ESI will provide the claimant written notice of the decision on a Pre-service or Urgent Care Claim whether or not the decision is adverse. ESI may provide the claimant with oral notice of an adverse benefit determination on an Urgent Care Claim, but written notice will be furnished no later than three (3) days after the oral notice.

Appeals

Appeal Procedures

ESI will follow these procedures when deciding an appeal:

1. An adverse benefit determination includes a denial, reduction, termination of or failure to make a payment for a benefit, a denial of coverage, or a rescission of coverage;

2. A claimant must file an appeal within 180 days to ESI at the appropriate address below following receipt of a notice of an adverse benefit determination;

3. The following information must be included with the request for appeal:

   - Claimant name;
   - Claimant member ID;
   - Claimant phone number;
   - The drug name for which benefit coverage has been denied;
   - Brief description of why you disagree with the initial adverse benefit determination; and
   - Any additional information that may be relevant to the appeal, including provider statements/letters, bills or any other documents.

4. A claimant will have the opportunity to submit written comments, documents, records, other information, other evidence, and testimony relating to the claim for benefits;

5. The individual who reviews and decides the appeal will be a different individual than the individual who made the initial benefit decision and will not be a subordinate of that individual, and no individual who reviews and decides appeals is compensated or promoted based on the individual's support of a denial of benefits;

6. ESI will give no deference to the initial benefit decision;

7. ESI will 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 benefit decision;

8. ESI will, in deciding an appeal of any adverse benefit determination that is based in whole or in part upon a medical judgment, consult with a health care professional with the appropriate training and experience who is neither the same individual who was consulted regarding the initial benefit decision nor a subordinate of that individual;

9. ESI will provide you, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim; any internal rule, guideline, protocol or other similar criterion relied upon in making the initial benefit decision; an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances; and information regarding any external review offered by the Plan;

10. ESI will provide you any new evidence considered, generated, or relied upon free of charge as soon as possible and with enough time before a final determination is required to be provided to you (as described above) so that you will have an opportunity to respond prior to making a final benefit determination;

11. ESI will provide you any new rationale for an adverse benefit determination prior to making a final benefit determination and with enough time before making a final determination so that you will have an opportunity to respond; and

12. ESI will provide required notices in a culturally and linguistically appropriate manner.

Filing of Appeals

Appeal requests should be sent to:

Clinical coverage appeal requests:	Administrative coverage appeal requests:
Express Scripts ATTN: Clinical Appeals Department P.O. Box 66588 St. Louis, MO 63166-6588 Fax: 1-877-852-4070	Express Scripts ATTN: Administrative Appeals Department P.O. Box 66587 St. Louis, MO 63166-6588 Fax: 1-877-328-9660

The appeal is reviewed by a pharmacist to determine if the request has any additional information, or if it is the same information in the initial request.

- If new information provided: If there is an approval granted based on the new information provided, an override or payment is issued and a letter is mailed to you. If the new information still results in a denial, a denial reconsideration letter is mailed with further appeal rights with Express Scripts' address.
- If no new information provided from original denial: The appeal is sent to MCMC for review. MCMC is not affiliated with Express Scripts and it independently reviews previously denied services. MCMC reviews the case information and provides Express Scripts with the decision, and a letter is sent to you based on determination. If the appeal is approved, the necessary overrides are entered into the Express Scripts' system. If the appeal is denied, MCMC sends a denial letter to you explaining further appeal rights.

Urgent Care Appeals

An urgent care appeal may be submitted to ESI using the appropriate telephone or fax number listed below. ESI will transmit all necessary information, including ESI's determination on review, by telephone, fax, or other available similar methods.

Clinical Coverage Review and Claim Appeal Requests: Phone: 1-800-753-2851, Fax: 1-877-852-4070

Administrative Coverage Review Appeal Requests: Phone: 1-800-946-3979, Fax: 1-877-328-9660

Timeframes for Deciding Appeal

Urgent Care Claims

ESI will decide the appeal of an Urgent Care Claim and notify you of the decision as soon as possible, taking into account the medical exigencies, but no later than 72 hours after receipt of the request for review.

Pre-Service Claims

ESI or MCMC (for 2nd level appeals) will decide the appeal of a Pre-service Claim and notify you of the decision no later than 15 days after receipt of the written request for review.

Post-service Claims

ESI or MCMC (for 2nd level appeals) will decide the appeal of a Post-service Claim and notify you of the decision no later than 30 days after receipt of the written request for review.

Notification of Appeal Decision

ESI will provide the claimant with written notice of the appeal decision. The notification will include the information required by law.

ESI may provide you with oral notice of an adverse decision on an Urgent Care Claim appeal, but written notice will be furnished no later than three (3) days after the oral notice. The decision by ESI on review will be final, binding and conclusive and will be afforded the maximum deference permitted by law. **These claims procedures (with the exception of the voluntary second level appeal and an external review) must be exhausted before any legal action is commenced.**

Following notification of a non-urgent coverage or Claim appeal decision, you may appeal further to a voluntary internal appeal or to an external appeal (for eligible claims). In urgent care situations, there is only one level of appeal prior to an external review.

Special Rules for Claims Related to Rescissions

A rescission is a discontinuation of coverage with retroactive effect. Coverage may be rescinded because the individual or the person seeking coverage on behalf of the individual commits fraud or makes an intentional misrepresentation of material fact, as prohibited by the terms of the Plan. However, some retroactive cancellations of coverage are not rescissions. Rescissions do not include retroactive cancellations of coverage for failure to pay required premiums or contributions toward the cost of coverage on time. A prospective cancellation of coverage is not a rescission. If your coverage is going to be rescinded, you will receive written notice 30 days before the coverage will

be cancelled. A rescission will be considered a claim denial that can be appealed according to the rules described above for Post-service Claim denials.

MCMC then reviews the case and provides Express Scripts with a determination. If the appeal is denied, MCMC sends a denial letter to you explaining further appeal rights.

Voluntary Second Level Appeal

If you are not satisfied with the decision of your initial appeal, you may request a second level appeal to ESI by mail or fax using the appropriate address listed above, based on the type of initial appeal you requested (except that voluntary appeal is not available for urgent care claims). You must request a second level appeal within 90 days of your receipt of an adverse initial appeal decision.

The following information must be included with the request for a second level appeal:

- Claimant name;
- Claimant member ID;
- Claimant phone number;
- The drug name for which benefit coverage has been denied;
- Brief description of why you disagree with the initial adverse benefit determination; and
- Any additional information that may be relevant to the appeal, including provider statements/letters, bills or any other documents.

ESI will forward your request for a second level appeal to MCMC. If approved, the information is entered into the Express Scripts system. If the determination results in denial, the denial is entered into the Express Scripts system, and a final denial is mailed to you.

The procedure and timeframes for deciding a second level appeal, are the same as those for initial appeals. Please refer to those specific sections for additional information on the appeals process.

Voluntary External Review

If you are not satisfied with the final internal review decision on your first level appeal, and your claim involved medical judgment or rescission, including determinations involving treatment that is considered experimental or investigational, you may submit a request for an external review. Generally, all internal appeal rights must be exhausted prior to requesting an external review. To submit a request for an external review, you must mail or fax your request to:

MCMC LLC
ATTN: Express Scripts Appeal Program
300 Crown Colony Drive. Suite 203
Quincy, MA 02169-0929
Phone: 1-617-375-7700 ext. 28253
Fax: 1-617-375-7683

External Review

Standard External Review

For claims involving medical judgment or rescission or whether the Plan has complied with surprise billing and cost-sharing protections relating to (i) out-of-network emergency services; (ii) non-emergency services performed by out-of-network providers of participating facilities; or (iii) air ambulance services furnished by and out-of-network provider, you may file a request for an external review within four (4) months after the date of receipt of a notice of a final internal adverse benefit determination.

1. Within five (5) business days following the date of receipt of the external review request, MCMC will complete a preliminary review of the request to determine whether:

a. you are or were covered under the Plan at the time the health care item or service was requested or, in the case of a retrospective review, were covered under the Plan at the time the health care item or service was provided;

b. the final adverse benefit determination is based on medical judgment or rescission;

c. you have exhausted the Plan's internal appeal process other than any voluntary appeal (unless exhaustion is not required); and

d. you have provided all the information and forms required to process an external review. You will be notified if the request is not eligible for external review. If your request is not complete, but eligible, MCMC will tell you what information or materials are needed to complete the request and will give you 48 hours (or more) to provide the required information.

2. Within 1 business day after completion of the preliminary review, MCMC will notify you in writing regarding whether your claim is eligible for external review. If your request was not complete, the notice will describe information or materials needed to complete request. You will have until the end of the 4-month period you had to file a request for an external review or 48 hours (whichever is later) to complete your request. If your request is complete but not eligible for external review, the notice will include the reasons your request was ineligible and contact information for the Employee Benefits Security Administration.

3. MCMC will assign an accredited independent review organization (IRO) to conduct the external review.
The IRO will utilize legal experts where appropriate to make coverage determinations under the Plan and will notify you in writing of the request's eligibility and acceptance for external review. You may submit additional information in writing to the IRO within 10 business days that the IRO must consider when conducting the external review. MCMC will provide documents and any information considered in making the final internal adverse benefit determination to the IRO.
The IRO will review all of the information and documents timely received and is not bound by ESI's or MCMC's prior determination. The IRO may consider the following in reaching a decision:

a. your medical records;

b. the attending health care professional's recommendation;

c. reports from appropriate health care professionals and other documents submitted by ESI or MCMC, you, or your treating provider;

d. the terms of your Plan;

e. evidence-based practice guidelines;

f. any applicable clinical review criteria developed and used by ESI or MCMC; and

g. the opinion of the IRO's clinical reviewer or reviewers after considering information noted above as appropriate.

The IRO will provide written notice of the final external review decision within 45 days after the IRO receives the request for external review. The notice will contain a general description of the reason for the request for external review and 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.

Expedited External Review

1. You may request an expedited external review when you receive:
   a. an adverse benefit determination that involves a medical condition for which the timeframe for completion of an expedited internal appeal under the interim final regulations would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function and you have filed a request for an expedited internal appeal; or
   b. a final internal adverse benefit determination, if you have a medical condition where the timeframe for completion of a standard external review would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function, or if the final internal adverse benefit determination concerns an

admission, availability of care, continued stay, or health care item or service for which you received emergency services, but have not been discharged from a facility.

2. Immediately upon receipt of the request for expedited external review, ESI will determine whether the request meets the reviewability requirements noted above for standard external review and will notify you of its eligibility determination.

3. When ESI determines that your request is eligible for external review an IRO will be assigned. ESI will provide all necessary documents and information considered in making the adverse benefit determination or final internal adverse benefit determination to the IRO by any available expeditious method.

   The IRO must consider the information or documents provided and is not bound by ESI's prior determination.

4. The IRO will provide notice of the final external review decision as expeditiously as your medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited external review. If the IRO's notice is not in writing, the IRO must provide written confirmation of the decision within 48 hours to you and the Plan.

General Rules

- The exhaustion of the claims procedures (with the exception of the voluntary second level appeal and external review process) is mandatory for resolving every claim and dispute arising under this Plan. In any legal action brought after you have exhausted the administrative remedies, all determinations made by ESI, Allina Health or other fiduciary, shall be afforded the maximum deference permitted by law.
- If you file your claim within the required time and complete the entire claims procedure (except for the voluntary second level appeal and external review), any lawsuit must be commenced within six months after the claim-and-review procedure is complete. In any event, you must commence the suit within two years after whichever is earliest – the date on which you were denied benefits or received benefits at a different level than you believed the Plan provides; or the date you knew or reasonably should have known of the principal facts on which your claim is based.
- Your initial claim, any request for review of an adverse benefit determination, and any request for external appeal must be made in writing, except for requests for review of adverse benefit determinations relating to urgent care claims, which may also be made orally.
- You must follow the claims procedures contained in this SPD carefully and completely and you must file your claim before any applicable deadlines. If you do not do so, you may give up important legal rights.
- Your casual inquiries and questions will not be treated as claims or requests for a review or submissions to the external appeal process.
- You may have a lawyer or other representative help you with your claim at your own expense (ESI or Allina Health may require written authorization to verify that an individual has been authorized to act on your behalf, except that for urgent care claims a health care professional with knowledge of the claimant's medical condition will be permitted to act as an authorized representative).
- You are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to any adverse benefit determination. You will also be allowed to review the claim file and present evidence and testimony as part of the internal claims process.
- You must comply with any additional requirements for filing a claim (e.g., using a specific claim form) imposed by ESI.

Fertility Benefit Appendix

Understanding Your Progyny Benefit

MEMBER GUIDE | 2024 PLAN YEAR

TABLE OF CONTENTS

Introduction to Your Benefit

Access to High Quality Care 5

Personalized Support 5

Getting Started 6

The Progyny Smart Cycle

Understanding your Smart Cycle Benefit 8

Understanding Your Coverage

Explanation of Covered Treatments & Services 11

Also Included in Your Coverage 18

Fertility Medications 21

Transition to Pregnancy 22

Non-Covered Services 22

Authorization & Financial Responsibility

Authorization/Patient Confirmation Statement 24

Understanding Your Financial Responsibility 25

FAQs

Benefit 29

Eligibility 33

Provider and Lab Facility 35

Medication.. 37

Billing and Claims 40

Appendix

Initial Consultation and Diagnostic Testing 43

Progyny Rx Formulary.. 46

INTRODUCTION TO YOUR BENEFIT

YOUR GUIDE TO PROGYNY'S FERTILITY AND FAMILY BUILDING BENEFIT

At Progyny, we know the road to parenthood can be challenging. That's why we partner with the nation's leading fertility specialists to bring you a smarter approach with better care, more successful outcomes, and more options available to anyone who wants to have a child, no matter their path to parenthood. Our mission is to make your dream of parenthood come true through a healthy, timely, and supported family building journey.

We created this guide to provide you with all the information you'll need to get the most out of your benefit. We understand the journey to become a parent can be physically, emotionally, and financially challenging. With this in mind, the Progyny benefit includes comprehensive treatment coverage leveraging the latest technologies and treatments, access to high-quality care through a premier network of fertility specialists, and personalized emotional support and guidance from dedicated Patient Care Advocates (PCAs). Your coverage includes:

Highlights of Your Progyny Benefit	Effective 01/01/2024
1*	Smart Cycle per family (employee and spouse)
2	Initial consultations per year
Progyny Rx	Fertility medication coverage
Tissue storage	Tissue storage is included in applicable treatment cycles for the first year

*You have access to an additional Smart Cycle if your first is not successful.

To learn more and activate your benefit, call: 833.205.4001

ACCESS TO HIGH QUALITY CARE

Progyny has created a premier network of fertility specialists, with rigorous provider inclusion standards connecting you to high quality specialists across the US. Our network of 800 doctors across 600 clinic locations includes nationally recognized providers, many of whom do not contract broadly with national carrier networks. You can search for an in-network provider and find our list of in-network labs at progyny.com/find-a-provider.

Our Medical Advisory Board continually looks at the latest science and research to make sure that your benefit allows your doctor to utilize the best clinical practices and latest technologies, ensuring you receive the highest level of care.

Our fertility specialists use the latest advancements in science and technology to increase the chances of a healthy and successful pregnancy. And because the Progyny benefit design is comprehensive, your doctor is able to work with you to create the customized treatment plan that is best for you, based on clinical criteria, not costs.

PERSONALIZED SUPPORT

Personalized Support from a Patient Care Advocate

As a Progyny member, you have unlimited access to a dedicated PCA, who will be there to provide clinical and emotional support throughout your entire fertility journey. This includes guidance on available treatment options and outcomes, coordination and preparation for all your appointments, and support throughout your journey to parenthood. Call your PCA to learn more about your benefit and to get started.

Easy Access to Information and Education

In addition to the personalized support from your PCA, you also have access to our member portal. Our member portal provides you with educational resources to better understand your benefit and the fertility process. Through the portal, you'll also be able to view coverage details, review appointments, view account and claims information, and communicate directly with your PCA, keeping all the information you need in one place. Contact your PCA to initiate the member portal login process.

GETTING STARTED

Call Progyny to activate your benefit at 833.205.4001

During your first call your PCA will:

Check your eligibility

The person(s) receiving treatment must be enrolled in an eligible medical plan to have access to the Progyny benefit. Note: Your Progyny benefit coverage is per family (employee and covered spouse).

Help you to understand

your financial responsibility.

Help you choose the in-network provider that is right for you. If you already have a provider, let your PCA know.

Answer any questions you have about starting or continuing your family building journey.

THE PROGYNY SMART CYCLE

UNDERSTANDING YOUR SMART CYCLE BENEFIT

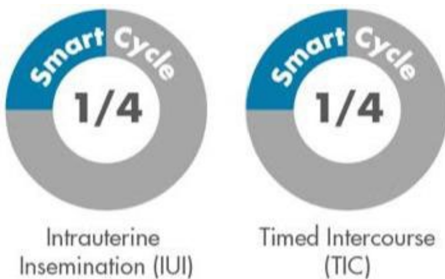
It all starts with the Progyny Smart Cycle. To make your fertility benefit easier to use, we've bundled all of the individual services, tests, and treatments into the Progyny Smart Cycle. Some treatment types will use only a portion of a Smart Cycle, while other more comprehensive treatments will require the use of an entire Smart Cycle.

The Progyny Smart Cycle is designed for comprehensive coverage. All standard of care services and technology needed for a treatment cycle are covered within the Smart Cycle. From in-cycle monitoring and anesthesia, to the latest technology like assisted hatching, genetic testing and ICSI, and even the first year of storage, it's all included. That means you won't run out of coverage mid-cycle and you can focus on the most effective treatment, regardless of cost. Please note, covered services include financial responsibility depending on your medical plan. To learn more, visit the *Understanding Your Financial Responsibility* section.

For a full explanation of what's covered under each Smart Cycle, visit the *Also Included in Your Coverage* section.

Common Ways to Use a Smart Cycle:

Visit the *Explanation of Covered Treatments & Services* section of the Member Guide to see all ways to use your Smart Cycle.



IVF Fresh Cycle

IVF Freeze-All Cycle

Frozen Embryo Transfer (FET)

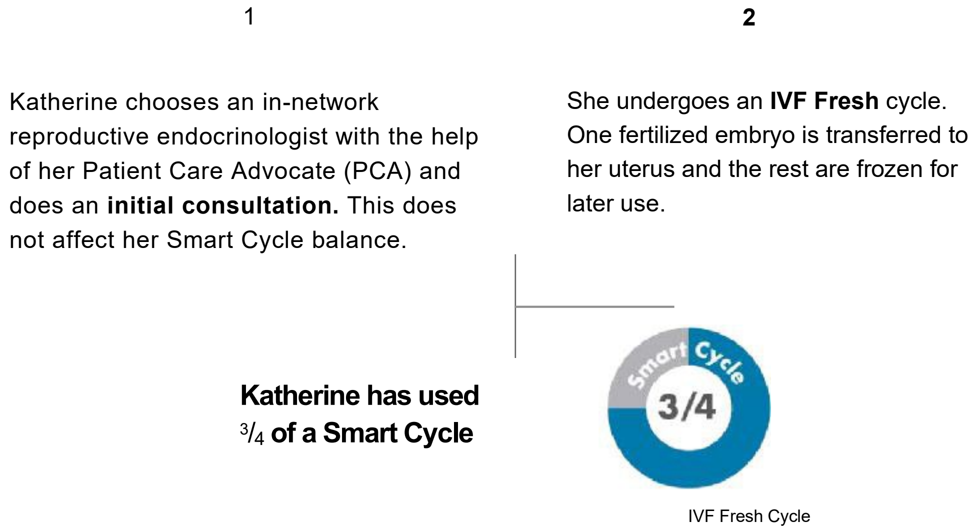
Frozen Oocyte Transfer (FOT)

Surrogacy Embryology Services
Pre-transfer services

Examples of How to Use Your Smart Cycle Benefit:

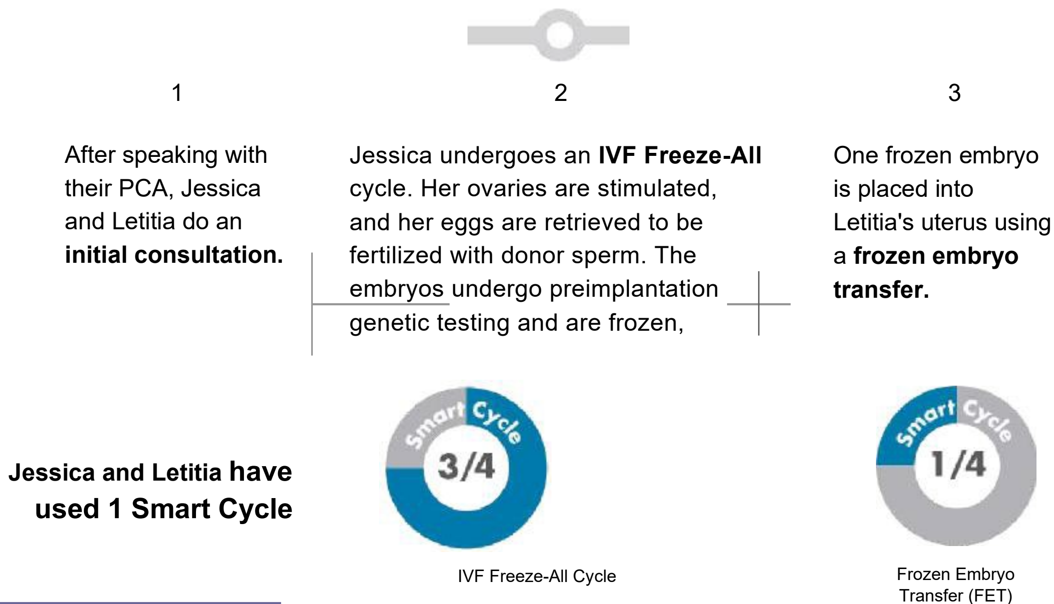
IVF Fresh Cycle

Katherine and her husband Tom have had trouble conceiving. Katherine discovers she has diminished ovarian reserve and decides to pursue IVF. Her treatment is as follows:



Reciprocal IVF Cycle

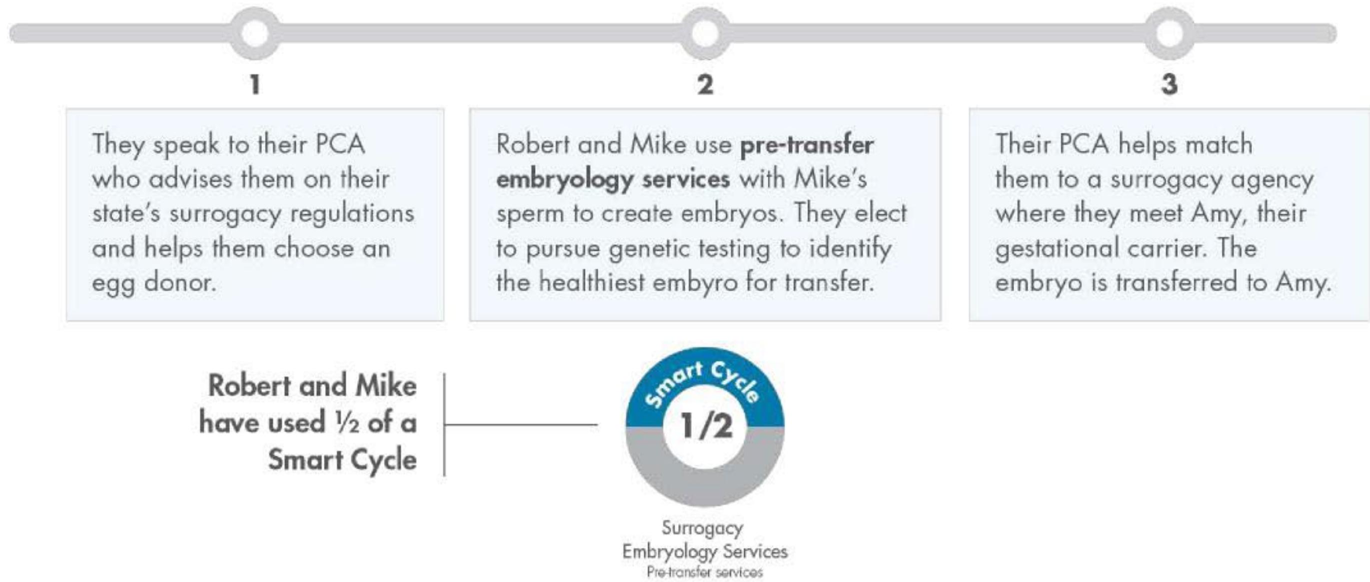
Jessica and Letitia are a same-sex female couple that would like to expand their family. Both partners would like to be involved in the family building process, so they elect to do reciprocal IVF. Letitia will carry a baby created from Jessica's egg.



Progyny Member Guide
Prepared for Allina Health

Surrogacy

Robert and Mike want to expand their family and are interested in exploring surrogacy.



UNDERSTANDING YOUR COVERAGE

EXPLANATION OF COVERED TREATMENTS & SERVICES

Progyny offers the following covered services, but please always confirm specific benefits with your dedicated PCA prior to treatment.

Initial Consultation and Diagnostic Testing

Your coverage includes 2 initial consultations per year, until you've exhausted your Smart Cycle balance. There is no Smart Cycle deduction for your initial consultations. Depending on your provider and your specific circumstances, there may be some tests performed by your provider that are not covered by Progyny. For example, cholesterol, pap smear, HPV, and other tests that are not specific to fertility are not covered under Progyny but are likely covered under your regular medical insurance. Please be mindful of this possibility before moving forward with specific testing. You can always contact your PCA to clarify if a specific test is covered by Progyny before proceeding.

Please see the *Initial Consultation and Diagnostic Testing* section for a full list of covered tests and procedures, their CPT codes, and more information.

Covered services are subject to your financial responsibility. Please see the *Understanding Your Financial Responsibility* section for more information.

Partial Initial Consultation and Diagnostic Testing

In certain instances, your physician may recommend a subset of services for your initial consultation and diagnostic testing. To accommodate these instances, Progyny utilizes partial initial consultations and diagnostic testing services.

A few examples include:

- If you seek a second opinion, a visit only may be appropriate.
- If you have recently completed diagnostic testing, a visit only may be appropriate.
- If you only require partial testing, e.g. a semen analysis or SHG only.

Please note, the examples above are for illustrative purposes only and are not comprehensive. All providers in the Progyny network are instructed to bill for partial services in these circumstances. You may always consult with your PCA to ensure appropriate authorization and billing.

Mock Cycle

A mock cycle occurs when the patient is prescribed medication and monitored as if they were preparing for an embryo transfer. The mock cycle is performed to ensure the body, specifically the endometrium lining, can support a pregnancy. Progyny provides coverage for the mock cycle for members with approved indications such as a history of previously failed embryo transfers or the use of donor tissue.

The following services are covered:

- Blood work related to the mock cycle
- Endometrial biopsy
- Office visits
- Ultrasound

Not covered under the Mock Cycle authorization:

- Pathology bloodwork, sometimes referred to as the ERA or Endometrial Receptivity Array. Please consult with your provider for a detailed estimate of out of pocket costs.

A Smart Cycle Can Be Used for the Following Treatments:

IVF Fresh Cycle = 3/4 Smart Cycle

An IVF fresh cycle starts by stimulating the ovaries with a course of medications. Following stimulation, the doctor will retrieve the eggs, which are then taken to the lab and fertilized. After three to five days, an embryo will be transferred into the uterus in the hopes of achieving pregnancy. Any remaining embryos may be biopsied for preimplantation genetic testing for aneuploidy (PGT-A) before being frozen using vitrification. The biopsy tissue is sent to an in-network genetic lab for testing. PGT-A tests each sample for genetic abnormalities, ensuring that only chromosomally normal embryos are eligible for transfer. Any additional, genetically normal embryos will remain cryopreserved until needed.

The following procedures are covered:

- Anesthesia (for egg retrieval)
- Assisted hatching
- Blastocyst culture
- Complex sperm wash & prep
- Cycle management
- Embryo biopsy
- Embryo culture lab
- Embryo transfer (eSET) w/ultrasound
- Oocyte identification
- Preimplantation genetic testing for aneuploidy (PGT-A)
- Preparation and cryopreservation of extra embryo(s)
- Preparation of embryo(s) for transfer
- Retrieval (follicular aspiration, to include ultrasound guidance)
- Simple sperm wash & prep

IVF fresh can also be used with donor egg and/or sperm.

IVF Freeze-All = 3/4 Smart Cycle

The IVF freeze-all process differs from an IVF fresh cycle and may increase the chances of success. An IVF freeze-all starts by stimulating the ovaries with a course of medication. Following a course of stimulation medications, your doctor will retrieve the eggs, which are then taken to the lab and fertilized. The resultant embryos continue to develop until day five when they may be biopsied before being frozen using vitrification. The biopsy of the embryo tissue is sent to a genetic lab for preimplantation genetic testing for aneuploidy (PGT-A). PGT-A screens each sample for genetic abnormalities, allowing the fertility specialist to ensure that the most viable embryo is chosen for transfer. The embryos remain frozen in storage while the PGT-A testing takes place. During this time, the body has an opportunity to return to its pre-treatment state before a frozen embryo transfer is performed at a later date.

The following procedures are covered:

- Anesthesia (for egg retrieval)
- Assisted hatching
- Blastocyst culture
- Complex sperm wash & prep
- Cycle management
- Embryo biopsy
- Embryo culture lab
- Oocyte identification
- Preimplantation genetic testing for aneuploidy (PGT-A)
- Preparation and cryopreservation of extra embryo(s)
- Retrieval (follicular aspiration, to include ultrasound guidance)
- Simple sperm wash & prep
- Tissue storage (1 year)

IVF freeze-all can also be used with donor egg and/or sperm.

Frozen Embryo Transfer (FET) = 1/4 Smart Cycle

Embryos that have been preserved during an IVF freeze-all, frozen oocyte transfer, or previous fresh IVF cycle can be thawed and transferred into the uterus. A frozen embryo transfer is commonly performed following an IVF freeze-all cycle to allow for preimplantation genetic testing for aneuploidy (PGT-A) on the resultant embryos. PGT-A testing ensures that only a genetically or chromosomally normal embryo is chosen for transfer.

The following procedures are covered:

- Cycle management
- Embryo thaw
- Embryo transfer (eSET) w/ultrasound guidance
- Office visits
- Preparation of embryo(s) for transfer
- Ultrasounds & in-cycle bloodwork (E2, P4, beta hCG, FSH, LH)

Intrauterine Insemination (IUI) = 1/4 Smart Cycle

Intrauterine insemination (IUI), also called artificial insemination, is a process in which, either with or without a course of medication, and after monitoring, sperm is inserted directly into the uterus through the use of a catheter.

The following procedures are covered:

- Complex sperm wash & prep
- Cycle management

- Insemination
- Office visits
- Simple sperm wash & prep
- Ultrasounds & in-cycle bloodwork (E2, P4, beta hCG, FSH, LH)

Timed Intercourse (TIC) = 1/4 Smart Cycle

Timed intercourse (TIC) may be recommended when irregular or missing ovulation is the cause for infertility. A TIC cycle will typically involve monitoring via ultrasound at the clinic and may also involve the use of medication to trigger ovulation. When ovulation is about to occur, the doctor will instruct the couple to have timed intercourse at home.

The following procedures are covered:

- Cycle management
- Office visits
- Ultrasounds & in-cycle bloodwork (E2, P4, beta hCG, FSH, LH)

Frozen Oocyte Transfer = 1/2 Smart Cycle

A frozen oocyte transfer cycle can be scheduled when a member is ready to use their previously frozen eggs to attempt pregnancy. Eggs will be thawed and fertilized in the lab. A fresh embryo transfer will take place three to five days after fertilization. Any remaining embryos may undergo preimplantation genetic testing for aneuploidy (PGT-A) prior to being frozen via vitrification.

The following procedures are covered:

- Assisted hatching
- Blastocyst culture
- Complex sperm wash & prep
- Cycle management
- Embryo biopsy
- Embryo culture lab
- Embryo transfer (eSET) w/ ultrasound guidance
- Intracytoplasmic sperm injection (ICSI)
- Office visits

- Oocyte fertilization/insemination

- Oocyte identification
- Oocyte thaw
- Preimplantation genetic testing for aneuploidy (PGT-A)
- Preparation and cryopreservation of extra embryo(s)
- Preparation of embryo(s) for transfer
- Simple sperm wash & prep
- Tissue storage (1 year)
- Ultrasounds & in-cycle bloodwork (E2, P4, beta hCG, FSH, LH)

Pre-Transfer Embryology Services = 1/2 Smart Cycle

If you are unable to carry a pregnancy, utilizing a gestational carrier, or surrogate, may be helpful in building your family. Progyny's fertility benefit covers pre-embryo transfer services including diagnostic testing, fertilization, preimplantation genetic testing, and cryopreservation for the intended parent who is a covered member. This cycle includes all the embryology services for the creation of embryos from eggs. The services begin once the eggs have been retrieved or thawed. Progyny's fertility benefit does not cover services on a gestational carrier, or surrogate.

The following procedures are covered:

- Assisted hatching
- Blastocyst culture
- Complex sperm wash & prep
- Cycle management
- Embryo biopsy
- Embryo culture lab
- Intracytoplasmic sperm injection (ICSI)
- Preimplantation genetic testing for aneuploidy (PGT-A)
- Preparation and cryopreservation of extra embryo(s)
- Retrieval (follicular aspiration, to include ultrasound guidance) when using member oocytes*
- Simple sperm wash & prep
- Tissue storage (1 year)

*These services are included for those using their own eggs to create embryos. If you are utilizing donor eggs these services are not included.

Standalone Preimplantation Genetic Testing for Aneuploidy (PGT-A) = 1/4 Smart Cycle

Standalone reimplantation genetic testing for aneuploidy (PGT-A) may be performed outside of traditional IVF cycle, for example, if you have already created and cryopreserved embryos for future use. PGT-A involves testing a small embryo biopsy for chromosomal abnormalities. Only euploid embryos (those with the correct number of chromosomes) are preserved and saved for future transfer.

PGT-A testing greatly reduces the risk of miscarriage and increases the probability of a successful pregnancy. Furthermore, elective single embryo transfer (eSET) is recommended, thus nearly eliminating the risk of a multiple pregnancy

FET for Donor Embryo = 1/4 Smart Cycle

Some members may choose embryo donation to build their families. Donor embryo is the process of receiving an embryo created from another individual or couple who completes their family and donates their leftover embryos. The recipient undergoes a frozen embryo transfer (FET) following testing. The FET is covered as

part of your Progyny benefit. Donor embryo typically includes agency/admin fees as well. These fees will be an out of pocket cost. Please contact your PCA for more information.

The following procedures are covered:

- Cycle management
- Embryo thaw
- Embryo transfer (eSET) w/ultrasound guidance
- Office visits
- Preparation of embryo(s) for transfer
- Ultrasounds & in-cycle bloodwork (E2, P4, beta hCG, FSH, LH)

Partial Cycle = 1/4 Smart Cycle

You may be eligible for coverage of a partial cycle if you are pursuing IVF and have only 1/4 Smart Cycle remaining. While 1/4 Smart Cycle is not sufficient to cover a full IVF cycle, the partial cycle authorization will provide coverage for all standard covered services up to and including egg retrieval. Any services following the retrieval are not included in this authorization and will remain a full out of pocket cost.

The following procedures are covered:

- Abdominal or endoscopic aspiration of eggs from ovaries
- Abdominal ultrasound
- Cycle management
- Office visits
- Oocyte identification from follicular fluid
- Retrieval (follicular aspiration, to include ultrasound guidance)
- Ultrasounds & in-cycle bloodwork (E2, P4, beta hCG, FSH, LH)

ALSO INCLUDED IN YOUR COVERAGE

Anesthesia for Egg Retrieval

Egg retrievals are not typically performed without an anesthetic of some kind, so anesthesia (deep sedation) is generally used during this procedure.

Assisted Hatching

In order for the advanced embryo to implant in the uterine wall and to continue development, it must hatch out of its shell, which is called the zona pellucida.

Some embryos grown in the laboratory may have a harder shell than normal or may lack the energy requirements needed to complete the hatching process. Embryologists can help these embryos achieve successful implantation through a technique called assisted hatching.

On the third or fifth day of laboratory growth and shortly prior to uterine transfer, a small hole is made in the zona pellucida of the embryo with a specially fitted laser microscope. Through this opening, the cells of the embryo can escape from the shell and implant at a somewhat earlier time of development, when the uterine lining may be more favorable.

Cryopreservation

Cryopreservation is the process of freezing tissue to sub-zero temperatures for later use. When the tissue is needed, it is thawed and used in a treatment cycle.

Embryo Culture

Embryo culture is a component of in vitro fertilization (IVF) when resultant embryos are allowed to grow for some time in the lab.

FDA Workup

FDA-approved lab testing is required for any member or dependent who is using a gestational carrier or surrogate.

Fertilization

Fertilization refers to the process in which eggs are combined with sperm in the laboratory by adding sperm to the dish containing the egg, in order to create embryos.

In-Cycle Monitoring/Management

During a treatment cycle your clinic will monitor your progress through pelvic ultrasounds and blood work every other day or so. This will help shed light on the development of your follicles and the thickness of your endometrium, both of which are essential measures in the stimulation process.

Intracytoplasmic Sperm Injection (ICSI)

Intracytoplasmic sperm injection (ICSI), also known as micro manipulation, is a laboratory technique that is performed in about 70% of IVF cases in the United States. Once the eggs are ready for insemination, a micropipette—or tiny needle—is used to inject a single, normal-appearing, living sperm directly into the center of an egg to promote fertilization. ICSI is most often used in cases of male factor infertility such as low sperm count; poor sperm morphology (shape) or motility (movement); or if the sperm have trouble attaching to the egg—however many clinics now perform it in most or all IVF cycles.

Preimplantation Genetic Testing for Aneuploidy (PGT-A)

Preimplantation genetic testing for aneuploidy (PGT-A) may be performed in conjunction with IVF treatment and involves testing a small embryo biopsy for chromosomal abnormalities. Only euploid embryos (those with the correct number of chromosomes) are preserved and saved for future transfer.

PGT-A testing greatly reduces the risk of miscarriage and increases the probability of a successful pregnancy. Furthermore, elective single embryo transfer (eSET) is recommended, thus nearly eliminating the risk of a multiple pregnancy.

PGT-A can be performed during any cycle where embryos are created in the lab—frozen oocyte transfer, IVF freeze-all, or IVF fresh cycles (of note, because it can take several days to get the PGT-A test results from the lab, the embryo(s) transferred during a fresh IVF Cycle will likely not be PGT-A tested). Your Progyny coverage also allows for untested, previously frozen embryos to be thawed, biopsied for PGT-A testing, and refrozen prior to transfer.

Preimplantation Genetic Testing for Monogenic/Single Gene Diseases (PGT-M)

Preimplantation genetic testing for monogenic/single gene diseases (PGT-M) is a procedure used prior to implantation to help identify genetic defects within embryos. This serves to prevent certain genetic diseases or disorders from being passed on to the child.

Preimplantation Genetic Testing for Structural Rearrangements (PGT-SR)

Preimplantation genetic testing for structural rearrangements (PGT-SR) is utilized when one or both intended parents may have a balanced chromosome or structural rearrangement (inversions or translocations). PGT-SR reduces the risk of having a pregnancy or child with an unbalanced structural abnormality, which involves extra or missing genetic material and typically results in pregnancy loss.

Sperm Wash and Preparation

Sperm washing is a form of sperm preparation that is required prior to intrauterine insemination or IVF because it removes chemicals from the semen, which may cause adverse reactions in the uterus.

Telehealth

A telehealth appointment is a one-on-one video meeting with your physician. You can utilize telehealth for an initial consultation with your provider, for example, enabling you to meet your doctor, discuss your medical history and explore possible treatments, just like you would for an in-person visit. Progyny members have coverage for telehealth within their Smart Cycles. Just like an in-person office visit, your member financial responsibility for a telehealth visit will be applied according to your medical plan.

Tissue Storage

Storage for tissue retrieved or created using the Progyny benefit is covered for the first year. Additional years of storage will be an out-of-pocket cost to you.

Tissue Transportation

Tissue transportation within or into an in-network clinic or storage facility is covered by Progyny. Contact your PCA for more information on reimbursement.

FERTILITY MEDICATIONS

Fertility medications are essential to your treatment. Your medication is covered under Progyny Rx, which is designed to work seamlessly with your treatment coverage. There is only one authorization process, so your treatment and your medication will be authorized at the same time. Progyny partners with leading mail order specialty fertility pharmacies to bring you a concierge experience and overnight delivery of your medications. An UnPack It call and concierge support is included with every medication delivery and you have access to a pharmacy clinician for any questions you may have, 7 days a week.

Here's How It Works:

Once your prescription has been received from your provider, you will receive a call from a Progyny Rx pharmacist to schedule your medication delivery.

Inside your order you will find a Progyny Rx placemat that depicts the medication and equipment included in your order and how to properly store them. All medications, compounds, ancillary medications, and equipment required for treatment will be included in your shipment. The placemat includes the phone number to the Progyny Rx pharmacy to conduct your UnPack It Call. Your Progyny Rx UnPack It Call connects you to a trained pharmacy clinician who will walk you through your order, explain how to store and administer each medication, and answer any additional questions you may have. Additionally, you can view Progyny Rx video tutorials on medication administration at progyny.com/rx.

The Progyny Rx pharmacy will be applying thoughtful dispensing protocols to your order to ensure only the necessary amount is dispensed to prevent possible unused medications, which can be costly to you. Medications are sent using next day delivery (or same day, if necessary) to ensure they arrive for your treatment. The Progyny Rx pharmacy will contact you throughout your treatment for additional medication deliveries that may be required.

If you have any questions relating to your medication, the Progyny Rx pharmacy is available 7 days a week by calling the number noted in your medication delivery.

Please reference the *Progyny Rx Formulary* section of the Member Guide for a list of covered medications.

Note: Medication covered under Progyny Rx is subject to your financial responsibility as determined by your medical plan. You may be responsible for out-of-pocket costs for any applicable copayment, coinsurance and/or deductible. Any ancillary medications fall under your medical plan and will require a copayment over the phone via credit card. Please see the *Understanding Your Financial Responsibility* section for more information about how your out-of-pocket costs are determined.

TRANSITION TO PREGNANCY

Your Progyny benefit includes coverage through your second positive pregnancy test. However, your reproductive endocrinologist may not refer you to your OB-GYN until week eight of your pregnancy. Pregnancy monitoring after that time should be billed as medical to your medical plan. However, if it is billed as fertility and denied by your medical carrier, your pregnancy monitoring will be covered by Progyny's pregnancy gap coverage. If pregnancy monitoring is deemed as medical, coverage will vary depending upon your health plan. Contact your medical plan to confirm coverage in advance. You may have to pay out-of-network rates or the full cost for pregnancy monitoring services if your Progyny provider is not in-network with your medical plan. Contact your PCA for specific details about your medical vs. fertility benefit coverage.

NON-COVERED SERVICES

Services not listed in the member guide are not covered. There are some services that are not covered by Progyny; however, they may be covered by your medical plan (e.g., corrective surgeries like hysteroscopies, laparoscopies, myomectomies, and testicular sperm extractions). Costs will otherwise be your responsibility. Please check with your medical plan to confirm coverage and ensure your fertility doctor is in-network with your medical insurance.

AUTHORIZATION &
FINANCIAL RESPONSIBILITY

AUTHORIZATION/PATIENT CONFIRMATION STATEMENT

What Is a Patient Confirmation Statement (Authorization) and Why Do I Need It?

A Patient Confirmation Statement (authorization) is a document that confirms your Progyny coverage for a specific treatment. The best way to prevent errors or delays in treatment is to request an authorization before your first appointment and again before you begin each treatment cycle. Progyny sends an authorization to your clinic confirming coverage for your treatment, which facilitates an error-free billing process.

Contact your dedicated PCA when you schedule an initial consultation or treatment cycle so that an authorization is generated prior to your appointment. Your PCA will obtain the authorization, providing you with a seamless experience. Obtaining an authorization prior to treatment ensures that you are eligible for services and that you understand the treatment plan indicated by your physician. Once your authorization is complete, you will receive a Patient Confirmation Statement. The Patient Confirmation Statement works in place of a Progyny ID card and includes your Progyny member ID number, the dates that your authorization is valid, and the procedure codes to be used by the clinic. Although your clinic will receive a copy of your statement automatically, we recommend printing a copy and bringing it with you to your appointment to make sure your clinic has the correct information listed in your account.

During your initial consultation you may be asked to get blood work done at a lab outside of the clinic where you are receiving treatment. A list of in-network laboratory partners can be found at progyny.com/labs. Please bring a copy of your Patient Confirmation Statement with you as it has all the necessary information for the lab to bill Progyny. Please note, this is the ONLY time blood work performed outside of your clinic will be covered by Progyny. Once treatment begins, all lab draws must take place at your clinic.

If you choose to pursue preimplantation genetic testing on your embryos, you will want to share a copy of your Patient Confirmation Statement with the genetic lab performing the testing so that they bill Progyny directly. On this statement you will find the list of in-network reference labs, preconception carrier screening labs, and preimplantation genetic testing labs for this genetic testing, as well as contact information for your specialty pharmacy.

Authorizations for initial consultations are valid for 90 days. Authorizations for treatment are valid for 60 days. The authorization alone is not a guarantee of coverage. You must also be active on an eligible medical plan on the date of service reported by your fertility provider, and this date of service must be within the valid date range of your authorization for coverage to apply.

UNDERSTANDING YOUR FINANCIAL RESPONSIBILITY

Why Am I Getting a Bill from Progyny?

Progyny works side-by-side with your medical plan to administer your Progyny fertility benefit. As a result, your member financial responsibility—which may include coinsurance, copayment, and/or out-of-pocket maximum, depending on your medical plan—is applied to your fertility treatment in the same way a surgery or treatment for a broken bone would be. Insurance terminology can be confusing, so here's the best way to think about it:

- Your premium is the amount deducted from your pay for your medical coverage. There is no additional premium through Progyny.

- At the start of each plan year, you will pay for all medical services (including fertility services).

- You and your medical plan both pay a percentage of your covered healthcare services. This is called coinsurance. You may also be responsible for a copayment, which is a flat fee for certain services or prescriptions determined by your medical plan.

- You and your medical plan continue to split the costs of your covered healthcare services (according to the coinsurance percentage) until you reach your out-of-pocket maximum.

- After you reach your out-of-pocket maximum, your medical plan will pay 100% of the costs of your covered healthcare services for the rest of the plan year.

During your treatment, you must list Progyny as your medical plan in order to avoid significant billing issues and financial responsibility on your part. Your clinic will submit a claim directly to Progyny for payment. Progyny, in turn, submits the claim to your medical plan to be processed and your financial responsibility applied, as applicable. Once your medical plan has finished processing your claim, they will notify Progyny of your financial responsibility. You will receive an invoice from Progyny reflecting this amount. When you receive your Progyny invoice, you can submit payment by mailing a check to the address on your invoice, by credit card, Health Savings Account (HSA), over the phone, via the member portal, or at progyny.com/payment.

Note: You should *never* receive an invoice from the clinic or pay the clinic directly. You should *only* receive an invoice from Progyny once the treatment is complete and we have worked with your medical plan to determine your financial responsibility. If you are asked to pay at the clinic or receive an invoice from the clinic, please contact your PCA.

Fertility treatment costs do not accumulate toward MOOP. Members will need to pay coinsurance for all

fertility treatments.

What's on My Bill?

Insurance statements can be difficult to read. To help make them a little easier to understand, please see the sample bill and guide below for reference:

A. Invoice Number: You will need your specific invoice number when you pay your invoice.

B. Account Number: Identifies the specific claim submitted to Progyny for the service(s) referenced in the "Description" box.

C. Member ID: Your unique Progyny member ID number.

D. Procedure Code: Each covered test and procedure has a unique billing code. Your clinic submits claims to Progyny using this code.

E. Description: The test, treatment, or procedure connected to the procedure code.

F. Total Charges: The full cost of your treatment as billed to Progyny by your clinic.

G. Insurance Payment: The amount of your treatment covered under your Progyny benefit, as determined by your medical plan.

H. Coinsurance: The percentage of cost for a covered healthcare service you are financially responsible for paying. For example, if your coinsurance is 10%, you will pay 10% of the cost of treatment and your medical plan will pay 90%. You will continue to have a cost share until your out-of-pocket maximum is met. These costs are determined by your medical plan.

I. Copayment: You may be responsible for a fixed copayment amount per appointment. The amount is determined by your medical plan.

J. Patient Balance Due: You are responsible for paying the total amount, for each line item listed on your invoice, to Progyny.

FAQS

BENEFIT

1. What family building options are available through Progyny?

Progyny understands that there are many ways to grow a family. We're here to support you—however you choose to grow your family. Under your Progyny benefit, a Smart Cycle can be broken up, mixed, or matched to cover your fertility treatment. You may pursue timed intercourse (TIC), intrauterine insemination (IUI), in vitro fertilization (IVF), or any combination that you and your specialist think is best. If surrogacy or adoption is the path you choose, your dedicated PCA can offer you support and education through this process as well.

2. What does Progyny cover?

Under a Smart Cycle, Progyny covers standard of care fertility treatment, including timed intercourse (TIC), intrauterine insemination (IUI), frozen oocyte transfer (FOT), IVF freeze-all, frozen embryo transfer (FET), and fresh IVF. Initial consultation and some stand-alone services, such as preimplantation genetic testing for aneuploidy (PGT-A), are also covered. For a more detailed review of your plan coverage options, please refer to the *Explanation of Covered Treatments & Services* section of your Member Guide. You can also learn about different types of treatments directly from reproductive endocrinologists in the Progyny network by visiting **progyny.com/education**. Please note, covered services include financial responsibility depending on your medical plan. To learn more, visit the *Understanding Your Financial Responsibility* section.

3. Is Progyny's benefit inclusive of all unique paths to parenthood?

Yes, Progyny's family building benefit was specifically designed to support all and not exclude anyone in benefit coverage, including single parents by choice and LGBTQ+ individuals and couples. Please contact your PCA to learn more about options available to you on your personal family building journey.

4. How many Smart Cycles do I have left and how should I use them?

Please contact your dedicated PCA for more information regarding your Smart Cycle balance and to discuss your options for utilizing the remainder of your benefit.

5. What's covered in my initial consultation?

Your initial consultation includes, but is not limited to, three office visits, two ultrasounds, hormone testing, infectious disease testing, and two semen analyses. For a detailed list of coverage, please refer to the *Explanation of Covered Treatments & Services* section of your Member Guide.

The initial consultation and diagnostic bundle is designed to provide you access to all standard of care services necessary to provide you and your physician with all of the diagnostic information you need.

6. What if I don't need the full initial consultation and diagnostic workup?

In certain instances, your physician may recommend a portion of the services included in the initial consultation bundle. For example, you may be seeking a second opinion, or you may have recently completed diagnostic testing. To accommodate these instances, Progyny has created partial initial consult and diagnostic testing services. All providers in the Progyny network are instructed to bill for partial services in these circumstances. You may always consult with your PCA to ensure appropriate authorization and billing.

7. What's covered under my Smart Cycle authorizations?

Each treatment authorization is valid for 60 days and covers your baseline blood test, ultrasound and monitoring appointments. Anesthesia for egg retrieval, fertilization (including ICSI), assisted hatching, preimplantation genetic testing for aneuploidy (PGT-A), cryopreservation, and embryo transfer are also covered, where applicable. To learn more about what is included in each treatment cycle, please refer to the *Explanation of Covered Treatments & Services* section of your Member Guide.

8. What is ICSI and is it covered?

Intracytoplasmic sperm injection (ICSI) is a procedure that uses a micropipette, or a tiny needle, to inject a single sperm into an egg to facilitate fertilization. ICSI is covered as part of your Smart Cycle.

9. What is PGT-A and is it covered?

Preimplantation genetic testing for aneuploidy (PGT-A) is a test performed on embryo biopsy tissue to test each embryo for chromosomal abnormalities in conjunction with IVF. All embryos from an IVF freeze-all and any resultant embryos remaining from the frozen oocyte transfer and Fresh IVF cycles are eligible for PGT-A testing. PGT-A is also available for embryos that were frozen prior to the commencement of your Progyny coverage. This testing is a covered service included as part of a Smart Cycle and will not affect your balance; however if performed as a standalone service 1/4 Smart Cycle will be deducted.

10. What is PGT-M and is it covered?

Preimplantation genetic testing for monogenic/single gene disease (PGT-M) is a test that is performed on an embryo biopsy at the same time as preimplantation genetic testing for aneuploidy (PGT-A). PGT-M tests for specific single gene mutations and is used if you carry a genetic mutation, such as cystic fibrosis, Tay-Sachs, or Huntington's disease. This is a covered standalone service under your benefit and will not impact your Smart Cycle balance.

11. What is PGT-SR and is it covered?

Preimplantation genetic testing for structural rearrangements (PGT-SR) is utilized when one or both intended parents may have a balanced chromosome or structural rearrangement (inversions or translocations). PGT-SR reduces the risk of having a pregnancy or child with an unbalanced structural abnormality, which involves extra or missing genetic material and typically results in pregnancy loss. This is a covered standalone service under your benefit and will not impact your Smart Cycle balance.

12. What if my authorized IVF freeze-all or fresh IVF cycle is converted into a timed intercourse cycle (TIC)?

If your IVF freeze-all or fresh IVF treatment cycle is converted into a TIC by your provider, please contact your PCA immediately so that a new authorization can be issued. This change will impact your Smart Cycle balance and out-of-pocket financial responsibility. If your treatment is converted into a TIC and you do not want this service counted toward your Smart Cycle balance, you have the option to pay for the service out-of-pocket. However, you will need to notify your PCA of this decision prior to the completion of your treatment. Progyny is unable to cancel authorizations once a claim from the clinic has been received.

13. What if my authorized fresh IVF cycle is converted into an IVF freeze-all cycle?

If your fresh IVF cycle is converted into an IVF freeze-all cycle, please notify your PCA of the cycle conversion as quickly as possible, as we will need to cancel or update the original authorization on file. This change will also impact your out-of-pocket financial responsibility. If you have any questions about the impact this will have, please reach out to your dedicated PCA.

14. What if my treatment is cancelled? Will it count toward my Smart Cycle balance?

In rare cases, a treatment cycle will need to be cancelled prior to completion. The following cases may arise:

- Cycles cancelled prior to retrieval (or aspiration) will not be counted against your Smart Cycle balance but will be subject to financial responsibility as determined by your medical plan.

- Cycles cancelled after retrieval (or aspiration), 1/4 Smart Cycle will be deducted from your balance.

- Cycles cancelled after fertilization due to immature or non-viable embryos prior to transfer, 1/2 Smart Cycle will be deducted from your balance.

- Cycles converted to IUI or Timed Intercourse, 1/4 Smart Cycle will be deducted from your balance. If you have further questions regarding cycle cancellation, contact your PCA.

15. What if my doctor requests a test that is not covered under Progyny?

If your doctor requests that you undergo a test that is not listed as a covered service under Progyny, please contact your dedicated PCA to confirm your coverage and discuss next steps regarding how to proceed. If the test is not covered under Progyny, you may be financially responsible.

For example, cholesterol, pap smear, HPV, and other tests that are not specific to fertility are not covered under Progyny but are likely covered under your regular medical insurance.

16. Are there any exclusions I should be aware of?

Standard exclusions include home ovulation prediction kits, services and supplies furnished by an out-of-network provider, and treatments considered experimental by the American Society of Reproductive Medicine. All charges associated with services for a gestational carrier, including but not limited to fees for laboratory tests, are not covered. Purchase of donor egg or sperm is not covered by your Progyny benefit.

If your doctor requests services that are not listed in this guide, please check with your PCA to confirm coverage. There are some services that do not fall under Progyny's coverage; however, they may be provided through your medical plan.

- Surgical procedures, except for egg retrievals, are not covered by your Progyny benefit. Examples of non-covered surgical procedures include hysteroscopies, laparoscopies, myomectomies, and testicular sperm extractions. Please contact your medical plan to inquire about coverage for surgical procedures.

- Pregnancy monitoring is a maternity service and therefore should be provided by your medical insurance carrier. Your Progyny benefit covers your fertility treatment until your second positive pregnancy test.

Costs will otherwise be your responsibility. Please check with your medical plan to confirm coverage.

17. What if I want to pay out-of-pocket for a service to save my Smart Cycle balance?

You have the option to opt out of the use of your Smart Cycle benefit and pay out of pocket for a service in order to save your Smart Cycle balance. Please contact your PCA if you are planning to pay out of pocket for a service, as your PCA will work with your provider to arrange payment. You cannot retroactively request that authorizations be cancelled in order to self-pay for services and conserve Smart Cycles. Please be sure to check your email and alert us immediately if your clinic requests an authorization for a service for which you wish to self-pay. In most cases, self-payment for treatment also means self-payment for medication, for those members who have coverage through Progyny Rx. Once a claim is in process for medication and treatment we are not able to cancel the authorization.

18. What happens when I've exhausted my benefit?

When you have used your full Smart Cycle allowance, your lifetime benefits are considered exhausted. Initial consultations and other services can no longer be accessed, with the exception of any remaining storage

renewals as determined by your plan. Additionally, you will continue to have ongoing access to your dedicated PCA as long as you remain an employee under an eligible plan. Progyny can continue to provide assistance by coordinating care as you move forward with your family building journey. If you would like to continue treatment, your PCA will help coordinate your appointments, speak to schedulers, labs, and clinics on your behalf, as well as continue to provide emotional support and guidance throughout your family building journey. However, once your Smart Cycle benefit has been exhausted, treatment costs will be incurred as an out of pocket cost to you.

19. Does the Progyny benefit include coverage if I want to be a donor or surrogate?

Your Progyny benefit does not cover services for you to act as a donor or gestational surrogate for another person. Donors are those donating their eggs, sperm, or embryos to another person or couple. They are not the intended parent, not an intimate partner, and not carrying the pregnancy. Gestational carriers or surrogates are also not an intimate partner and not the intended parent.

20. When do I stop using Progyny and start using my maternity coverage?

Your Progyny benefit includes coverage through your second positive pregnancy test. However, your reproductive endocrinologist may not refer you to your OB-GYN until week eight of your pregnancy. Pregnancy monitoring after that time should be billed as medical to your medical plan. However, if it is billed as fertility and denied by your medical carrier, your pregnancy monitoring will be covered by Progyny's pregnancy gap coverage.

If pregnancy monitoring is deemed as medical, coverage will vary depending upon your health plan. Contact your medical plan to confirm coverage in advance. You may have to pay out-of-network rates or the full cost for pregnancy monitoring services if your Progyny provider is not in network with your medical plan. Contact your PCA for specific details about your medical vs. fertility benefit coverage.

ELIGIBILITY

21. Is the Progyny Smart Cycle benefit per member or per family?

The lifetime Smart Cycle benefit is per family (employee and covered spouse), not per member.

22. What if my partner is not a claimed dependent on my plan?

If you are the primary subscriber and your partner is not a claimed dependent on your primary medical insurance plan, Progyny will not be able to cover any services performed on your partner. Your partner must be a claimed dependent on your plan in order to receive coverage under your Progyny benefit.

23. What is primary and secondary insurance?

A primary insurance is the plan that is billed first for medical services and the secondary insurance is billed for the remaining cost.

24. How do I know if Progyny is my primary insurance for fertility coverage?

If your employer-sponsored medical plan is your primary medical plan, then Progyny is likely your primary insurance for fertility. If you have another medical plan as your primary, Progyny may be your secondary insurance for fertility coverage. Contact your PCA to confirm.

25. What happens when one partner has the Progyny benefit and one partner has fertility coverage through another carrier?

If you and/or your partner have medical coverage through more than one insurer (i.e., covered under two different employers), it is imperative that you reach out to a Progyny PCA to understand how the coordination of benefits applies before you receive treatment.

Your indication of primary insurance coverage for medical benefits will be used in Progyny's treatment authorization process. If your indication of primary coverage is not correct it may lead to significant billing issues and financial responsibility on your part. If you're not sure of your coverage details, please reach out to your medical carrier to confirm your coverage. You can then discuss this information with your PCA.

If you do not have fertility coverage under your primary medical insurance and are a dependent on the Progyny benefit, you must receive services from a Progyny in-network provider for your services to be covered under Progyny. Your PCA can help you select an in-network provider. All claims for fertility treatment for the person receiving services must be submitted to the primary insurance first (even though it will be denied). You must submit your Explanation of Benefits (EOB) from your primary insurance (which shows that the services were denied) to your PCA. Progyny will then work with your provider to process the claim successfully, subject to the specific coverage details of your Progyny benefit.

If you have fertility coverage under your primary medical insurance and are a dependent on the Progyny benefit, you can submit the EOB from your primary insurance, which details your out-of-pocket responsibility, to Progyny for reimbursement until your primary insurance coverage is exhausted. Your reimbursement will be deducted from your Smart Cycle balance, subject to your member responsibility under your fertility benefit with Progyny, as applicable. Your PCA can provide you with more detail on how your reimbursement will impact your Smart Cycle balance. After your primary insurance coverage is exhausted, you must receive any additional fertility services from a Progyny in-network provider for those services to be covered under Progyny. Your PCA can help you select an in-network provider. Even though your primary insurance coverage has been exhausted, all claims for fertility treatment for the person receiving services must still be submitted to the primary insurance first. You will then receive an EOB from your primary insurance (which will show that the services were denied) and you must submit this to your PCA. Progyny will then process the claim, subject to the specific coverage details of your Progyny benefit. Note, coinsurance from

your medical plan are not reimbursable expenses.

If Progyny is included in your primary medical insurance and you are a dependent on another plan that has fertility coverage, you may be able to submit your EOB from Progyny, which details your out-of-pocket responsibility, to your secondary coverage carrier for reimbursement. Please contact your secondary insurance carrier with any questions.

26. What happens when both partners have the Progyny benefit through separate employers?

The person receiving services must be a covered employee on their employer's Progyny benefit (primary) as well as a covered dependent on their partner's Progyny benefit (secondary) in order to access coverage on both plans. Services will be processed through the patient's primary Progyny benefit until it is exhausted. Prior to the benefit being exhausted, you may request that any out-of-pocket responsibility be deducted from your secondary Smart Cycle balance, subject to your member responsibility, as applicable. Your PCA can provide you with more detail on how this will impact your secondary Smart Cycle balance. Once your primary Progyny benefit is exhausted, your remaining Smart Cycle balance under your secondary Progyny benefit will then be utilized for coverage of services.

27. How many Smart Cycles do I get if my partner and I are both employed at the same company?

Your Progyny benefit is per family, even if each member is enrolled separately on an eligible plan. If you and your partner are both employed at the same company, your Progyny benefit does not double.

28. How long does my Progyny coverage last?

Your Progyny Smart Cycle coverage lasts as long as you have a Smart Cycle balance available and are enrolled in a qualifying medical plan through your employer, or you elect COBRA upon leaving your employer. Should you leave your employer and not elect COBRA, your Progyny Smart Cycle coverage will expire on the date your medical plan will be terminated. If you receive an authorization but coverage lapses before you receive services, your claim will be denied and you will be financially responsible.

29. Does my Progyny coverage still apply if I leave my current employer?

If you receive treatment after you have left your employer, you must enroll in COBRA. The process of enrolling in COBRA may take time. Please contact your HR department directly for more information regarding your specific COBRA coverage options. Please advise your PCA of any coverage changes. You forgo any remaining Progyny benefits if you choose not to enroll in COBRA and are subsequently responsible for any further treatment expenses.

PROVIDER AND LAB FACILITY

30. How do I schedule an appointment?

When you're ready to schedule an initial consultation, please notify your dedicated PCA. Your PCA will send a referral with your Progyny member ID and contact information to the clinic. The clinic will then reach out to you directly to schedule a consultation. If you are an existing patient at a Progyny in-network clinic, you can schedule directly with the clinic. You must notify your PCA of all new appointments to ensure an authorization is processed in a timely manner.

31. What is an authorization and why do I need it?

An authorization is a document that confirms your coverage. Progyny sends the authorization to your clinic, which allows the clinic to bill Progyny directly. Prior authorization is the best way to prevent errors or delays in treatment. Please contact your dedicated PCA to request an authorization before your first appointment and before you begin any treatment cycle.

32. How do I prepare for my initial consultation appointment?

Before your appointment:

- Print your Progyny Confirmation Statement so that you can provide a copy to your clinic and to any diagnostic testing facility, if needed. In-network labs are listed on your Confirmation Statement; please provide them a copy of your confirmation in lieu of your medical insurance card.

- Request any relevant medical records from previous clinics/appointments and bring these with you to your appointment. If you have any questions on how to initiate this, your PCA will be happy to guide you through the process.

- Arrive early to fill out any paperwork or visit the clinic website to see if there's paperwork you can print and fill out prior to your appointment.

At your appointment:

- Please ensure the clinic has Progyny listed as your primary insurance, including your Progyny member ID number.

- You will also be asked for your primary insurance card for procedures not managed by Progyny (e.g. certain blood tests, pregnancy monitoring, and surgeries such as laparoscopies and other non-covered services).

- In addition to meeting with the doctor, you should expect to have blood work and an ultrasound performed.

As a reminder, your authorization for your initial consultation and all standard of care fertility-related diagnostic testing is valid for 90 days. Authorizations cannot be extended. Any testing performed outside the

90-day authorization window will be an out-of-pocket expense.

33. How do I prepare for my treatment cycle appointment?

Before your appointment:

- Notify your PCA about the first day of your upcoming treatment cycle to ensure an authorization is in place prior to starting treatment.

- Print your Progyny Confirmation Statement so you can provide a copy to your clinic and to any in-network preimplantation genetic testing facility, if needed. In-network labs for preimplantation genetic testing are listed on your Confirmation Statement. Please provide the lab with a copy of your Progyny Confirmation Statement. There is no need for payment at this time since your member responsibility will be calculated after the lab has submitted the claim to Progyny.

When you arrive:

- Please ensure the clinic has Progyny listed as the primary insurance, including your Progyny member ID number.

- Typically, you can expect to have blood work and an ultrasound performed at every appointment during in-cycle monitoring. Please note that this protocol may vary depending on the treatment plan.

As a reminder, your authorization for your treatment cycle and standard of care fertility-related testing is valid for 60 days.

34. How can I check if my provider is in-network?

You can search for your clinic by visiting **progyny.com/find-a-provider** or contact your dedicated PCA.

35. What do I do if the nearest in-network provider is more than 60 miles from my location?

Please contact your PCA to discuss options and next steps.

36. How do I transition to an in-network Progyny provider?

After you've reviewed Progyny's in-network list and selected a new clinic, please notify your dedicated PCA. Your PCA will send the clinic a referral including your Progyny member ID and contact information. The clinic will then reach out to you to schedule your initial consultation. Once you've scheduled an appointment, your PCA can walk you through the process of transferring your medical records to your new clinic.

37. How do I transfer tissue from an out-of-network clinic to an in-network clinic?

Transporting tissue between clinics requires precise timing. You will need to coordinate with both clinics simultaneously and likely a third-party transfer company. Please contact your PCA for more information on how to get started.

38. Which labs are in-network for PGT-A or PGT-M testing?

Please refer to **progyny.com/labs** for our growing list of in-network labs for PGT-A and PGT-M testing.

MEDICATION

39. What is Progyny Rx?

Progyny Rx is an integrated fertility medication program designed to work seamlessly with your Progyny benefit. Progyny Rx will supply your fertility medication throughout your fertility treatment.

40. What are the benefits of Progyny Rx?

Progyny Rx offers several advantages over typical medication providers:

- Progyny Rx works seamlessly with your fertility benefit, requiring a single authorization for both your fertility treatment and your related medications.

- Next day medication delivery ensures that you have your medication when you need it. Same day medication delivery is available, if necessary.

- A pharmacy clinician is available 7 days a week to review your medication and usage as well as offer training and support for every medication delivery.

- Pharmacy clinicians are available by phone to answer any questions you have about your fertility medication.

- Information about medications and your fertility treatment plan will be seamlessly coordinated between Progyny Rx and your PCA.

41. How does Progyny Rx work?

Progyny Rx works by authorizing medications at the same time as your treatment:

1. Once the authorization is processed, your doctor will send your prescription(s) to our pharmacy fulfillment partner for Progyny Rx.

2. Before your medications can be shipped, a Progyny Rx specialist from our pharmacy partner will call you to complete a consultation call. On this call, you will confirm your preferred shipping address, schedule your delivery date, document any allergies and health conditions, review waste management protocols and how much medication will be dispensed, and ask any questions you may have about your medication shipment. You will also receive a verbal explanation of financial responsibility for Progyny Rx-covered medications (fertility medication) vs. medications covered by your Pharmacy Benefit Manager (PBM) (ancillary medication). You will pay a copayment for any ancillary medications over the phone via credit card.

3. Once your medication is fulfilled, your fertility medication is submitted as a claim to your medical carrier. Once processed, you will receive an invoice from Progyny for any out-of-pocket responsibility according to your medical carrier.

4. The pharmacy will fill your prescriptions and deliver to your preferred address on the day required for your treatment. You will receive your fertility medications and ancillary medications in the same shipment.

5. Once you have your medications, a Progyny Rx specialist from our pharmacy partner will be available to walk you through your medications and how to properly store and administer them.

42. Where is the Progyny Rx pharmacy?

The Progyny Rx network contains fertility specialty pharmacies throughout the United States that provide mail order services to anywhere in the U.S. with clinical and order support 7 days a week. Your Progyny Rx in-network pharmacy will be indicated on the bottom left hand corner of the Patient Confirmation Statement that authorizes your treatment. The Progyny Rx in-network pharmacy is determined by your provider's geographical location.

43. What medications are covered under Progyny Rx?

Please refer to the medications covered under Progyny Rx in the *Progyny Rx Formulary* section.

Note: While ancillary medications (such as antibiotics) may be included in your fertility medication shipment, ancillary medications are not covered by Progyny Rx. Coverage for these medications falls under your pharmacy benefit manager (PBM). You will pay any applicable fees (copayment and/or coinsurance) directly to the pharmacy during your consultation call.

44. How do I get my medication for treatment?

Prescriptions for your fertility treatment must be sent by your doctor to the pharmacy indicated on your Patient Confirmation Statement. Once the prescription is received by our pharmacy partner, a Progyny Rx specialist will reach out to you to schedule the delivery. Medications are sent overnight.

45. Why am I receiving multiple shipments of medication instead of receiving it all at once?

Progyny Rx will provide the quantity of fertility medication that is required for your treatment. However, your combination and dosage of medications may change throughout the course of your treatment. In order to minimize waste and ensure that you are only paying for the medication you need, Progyny Rx will deliver your medication in multiple shipments. You should expect a 7-day supply of fertility medication on the initial fill and a 3-day supply of fertility medication on subsequent refills. The Progyny Rx in-network pharmacy will schedule a follow up call with you prior to your last day of fertility medication supply to check-in and determine if the refill is required. If your dosage increases mid-cycle, your provider should inform Progyny of this change, but just to ensure we are aware, please contact your Progyny Rx in-network pharmacy immediately. The Progyny Rx in-network pharmacy can provide next day delivery and same day delivery or local pharmacy pick up when necessary to ensure you receive your medication when you need it for treatment.

46. How do I store my medications when I receive my shipment?

Some fertility medications require refrigeration. Medication(s) that require refrigeration will be marked with a blue border and snowflake icon on your Progyny Rx Placemat. Other medications may have additional storage requirements that will be discussed during your UnPack It Call with your pharmacy clinician. Please call the Progyny Rx in-network pharmacy and conduct your Unpack It Call after your package arrives by calling the number on your Progyny Rx Placemat. A pharmacy clinician will walk you through your shipment and explain how to properly administer and store the medication during your UnPack It Call. The UnPack It Call is available 7 days a week.

47. How do I administer my medications?

You will have a call with a Progyny Rx specialist after you receive your medication shipment. Together, you will review each medication's usage and dosage. You also have access to a pharmacy clinician for any questions you may have after your call. Additionally, you can view Progyny Rx video tutorials on medication administration at **progyny.com/rx**.

48. How do cancelled treatments impact my prescription?

It is important to notify your dedicated PCA about a cancelled treatment to ensure additional medication is not shipped to you. If Progyny is not aware that your treatment is cancelled, additional packages may be shipped to you and your medical carrier will be billed. Progyny will send you an invoice reflecting any member financial responsibility, which may include coinsurance, copayment, and/or out-of-pocket maximum, depending on your medical plan.

49. What if my doctor orders medications not on the formulary?

Progyny only covers specialty fertility medications that are on the formulary. Any prescribed medication that is not on the formulary will be substituted for the alternative covered by Progyny. Compounds that consist of the

medication on the formulary are covered by Progyny. All ancillary medications, such as antibiotics, are not covered by Progyny but are typically covered by your primary pharmacy benefit manager (PBM). These are subject to financial responsibility, which may include deductible, coinsurance, copayment, and/or out-of-pocket maximum depending on your medical plan.

BILLING AND CLAIMS

50. What is an authorization and why do I need it?

Progyny sends an authorization (Patient Confirmation Statement) to your clinic confirming your coverage, which allows the clinic to bill Progyny directly. Prior authorization is the best way to prevent errors or delays in treatment. Please contact your dedicated PCA to request an authorization before your first appointment and before you begin any treatment cycle.

51. Why am I receiving a bill?

Progyny works side-by-side with your primary medical plan to administer your Progyny fertility benefit. You should expect out-of-pocket expenses for services rendered. Your individual costs will be determined by several factors, including: the plan that you enrolled in and its fixed copayment amount (if applicable), your maximum out-of-pocket expense, your treatment plan, and the center directing your care.

You may have to pay coinsurance (percentage of cost-share). Your coinsurance will be applied until you hit your out-of-pocket maximum for your current plan year. Your plan may also include copayments, which vary depending on service and plan type and will help you meet your out-of-pocket maximum. Once you have hit your out-of-pocket maximum for the year, all standard of care treatment will be covered at 100% for the remainder of the plan year, until your Progyny benefit is exhausted. Once you have exhausted the benefit, your health plan will no longer provide financial assistance; however, you will still have access to the support and guidance of your PCA.

Your clinic will bill Progyny directly throughout your treatment. Progyny will process claims through your primary medical carrier and apply member responsibility to these paid services. You will receive an invoice from Progyny that indicates your portion of the financial responsibility, which you can pay via check or by credit card. If you believe that you have received a bill in error, please contact your PCA.

52. What is on my invoice?

Refer to the *Understanding Your Financial Responsibility* section of the Member Guide for a sample bill.

53. What if I utilize a service that requires reimbursement?

In some cases, Progyny reimburses members for covered medical services. To ensure eligibility, reimbursements must be discussed with your dedicated PCA in advance. You will need to save all invoices and proofs-of-payment. When you're ready to initiate your reimbursement, please contact your PCA.

Reimbursements must be submitted to Progyny within 30 days of payment to comply with timely filing rules. Your PCA will send you a DocuSign or paper copy to complete and you will attach all relevant documents prior to submitting your reimbursement request for processing. Your reimbursement will be the cost of service minus your financial responsibility (coinsurance). Not all services are eligible for reimbursement, please check with your PCA on your specific case. Please note, reimbursements may take up to 90 days to process. If your expenses are related to adoption or surrogacy, please contact your PCA.

54. How can I pay my invoice?

When you receive your Progyny invoice, you can submit payment by mailing a check to the address on your invoice, by credit card, Health Savings Account (HSA), over the phone, via the member portal, or at **progyny.com/payment.**

55. What is the Progyny claims and appeals process?

After a member's services are rendered, Progyny processes the claim and provides the member the initial benefit determination within 30 days after receipt of claim. If such determination is an adverse benefit determination, the member would be appropriately notified in writing of the opportunity for an internal appeal and external review process, including information on how to initiate an appeal. Progyny would provide members at least 180 days following receipt of notification of adverse benefit determination within which to appeal the determination.

Progyny maintains a two-level review process—each level would be conducted by individuals who would not have been responsible for the initial denial. The first level of review would be conducted by Progyny's Head of Claims and Provider Service. The second level of review would be conducted by a member of Progyny's legal department, which includes the General Counsel and Associate General Counsel. With respect to any one of such two appeals, Progyny would provide notification of benefit determination on review no later than 30 days after receipt by Progyny of the member's request for review of the adverse benefit determination. If a member receives an adverse benefit determination, the member would be further instructed on how to request an external review by an independent third party and their rights to bring action under section 502(a) of ERISA as required by law.

APPENDIX

INITIAL CONSULTATION AND DIAGNOSTIC TESTING

Below is the list of authorized tests and associated codes that may be ordered by your doctor during your initial consultation(s). The bolded tests below are standard protocol for your reproductive endocrinologist to order prior to undergoing any fertility treatment. The other tests listed are also covered by Progyny and may be ordered by your physician.

Lab/ Procedure/ Diagnostic Test	99499 Bundled CPT Codes	Max Per Authorization
Antibody screen, RBC each serum tech	86850	1
Assay of estradiol (E2)	82670	2
Assay of follicle-stimulating hormone (FSH) (testing covered for females only)	83001	2
Assay of free thyroxine; T4 free (FT4)	84439	1
Assay of luteinizing hormone (LH) (testing covered for females only)	83002	2
Assay of progesterone (P4)	84144	2
Assay of prolactin (testing covered for females only)	84146	2
Assay of thyroid (T3 OR T4); thyroid panel: T3 uptake; T4 (thyroxine), total; free T4 index, and TSH	84479	1
Assay thyroid stim hormone (TSH)	84443	2
Assay of thyroxine T4	84436	2
Assay of vitamin D; 25-OH (hydroxy) vitamin D	82306	1
Blood typing, ABO or ABO group and RH type	86900, 86901	2
Chemiluminescent assay - inhibin B	82397	1
Chorionic gonadotropin test - (hCG), total, quantitative (hCG) pregnancy test; beta (hCG)	84702	2
Chlamydia trachomatis (culture), RNA, TMA; chlamydia trachomatis	87491	1
Complete CBC w/auto diff WBC; CBC including differential and platelets	85025, 85027	1
Culture - ureaplasma/mycoplasma; mycoplasma hominis/ureaplasma culture	87109	1
Cytomegalovirus	86644, 86645, 87497, 87496, 87252, 87254, 86777	2
Glucose	82947	1
Glycosylated hemoglobin test; HgA1C (hemoglobin A1C)	83036	1

Gonadotropin (FSH) (testing covered for females only)	83001	2

Lab/ Procedure/ Diagnostic Test	99499 Bundled CPT Codes	Max Per Authorization
Gonadotropin (LH) (testing covered for females only)	83002	2
Hemoglobin chromatography; hemoglobin electrophoresis	83021	2
Hepatitis B surface AG, EIA	87340	2
hepatitis B surface AB	86706	2
Hepatitis B core AB	86705	2
Hepatitis C AB TEST (anti-HCV)	86803	2
HIV I (if 87389 comes back positive)	86701	2
HIV II (if 87389 comes back positive)	86702	2
HIV-1/HIV-2, single assay; HIV 1/2 antigen and antibodies 4th gen with reflexes	87389	2
HTLV 1&2; HTLV I & II antibody screen (human t-cell lymphoma virus 1 & 2)	36175, 86790	2
Hysterosalpingogram - HSG (global)	58340	1
Hysterosalpingogram - HSG (global) (Facility)	58340	1
Hysterosalpingogram - HSG (global) (radiology charge)	74740-00	1
Hysterosalpingogram - HSG (hospital) (radiology charge)	74740-TC	1
Hysterosalpingogram - HSG (physician bill) (radiology charge)	74740-26	1
In-office hysteroscopy (non-surgical HSC)	58555	1
Immunoassay, RIA; anti-Mullerian hormone, AMH/MIS	83520	2
Karyotype	88230, 88261, 88262, 88280, 88291	2
Mock cycle	58100	1
Molecular pathology procedure level 2; spinal muscular atrophy (SMA)	81401	2
N.gonorrhoeae (culture), RNA, TMA; Neisseria gonorrhoeae	87591	1
Obstetric panel, (which includes all of the following: prenatal panel with HIV ABO, antibody screen, CBC w/ Platelet and Differential, Hepatitis B surface antigen, RH, syphilis screen IgG, rubella antibody IgG, HIV Type 1/2 (HIV-1, HIV-2) antibodies, reflex western blot 800)	80081	1
Obstetric panel, (which includes the following: ABO, antibody screen, CBC w/ platelet and differential, hepatitis B surface antigen, RH, syphilis screen IgG, rubella antibody IgG)	80055	1

Office visits	99205, 99213, 99214	3
Ovarian assessment report (oar)	S6600	2

Lab/ Procedure/ Diagnostic Test	99499 Bundled CPT Codes	Max Per Authorization
Pre-conception carrier screening (genetic tests)*	Various	2
RBC sickle cell test	85660	2
Routine venipuncture	36415	2
RPR (syphilis) VDRL; blood serology, qualitative; includes RPR (syphilis) screen	86592	2
Rubella antibody; rubella IgG antibody; Rubella Immune status	86762	1
Saline infusion sonohysterography (SHG) sis (saline infusion sonogram)	76831	1
Semen analysis	89325, 89322	2
Semen culture	87070	1
Ultrasound trans vaginal non-OB	76830	2
Urine (hCG) (UPT), Qualitative	81025	2
Varicella-zoster antibody; varicella zoster (VZV) IgG Antibody	86787	1
Virus antibody test NOS	Various	2

*Pre-conception carrier screening (genetic tests) includes: RBC sickle cell test; Horizon panels; FANCC, gene analysis; G6PC, gene analysis; GBA, gene analysis; HBA1/HBA2, gene analysis; IKBKAP, gene analysis; MCOLN1, gene analysis; SMPD1, gene analysis; CFTR gene com variants; CFTR gene full sequence; CFTR intron 8 POLY (T) analysis; FMR1 gene detection; FMR1 gene characterization; HEXA gene, Tay Sachs enzyme

PROGYNY RX FORMULARY

The fertility medications below are covered under the Progyny Rx pharmacy benefit. Progyny Rx coverage includes compounds of the raw ingredients of the formulary medications below. If you have any questions about the medications listed, please ask your medical provider. Ancillary medications, such as antibiotics, are not covered by Progyny Rx, but are typically covered by your primary pharmacy benefit manager (PBM), subject to all applicable coinsurance, and copayment amounts. As a convenience to you, ancillary medications can be filled by our pharmacy partner and delivered to you with your fertility medication(s).

Medication Name	Category
Leuprolide/2-week kit	Agonist
Lupron Depot 3.75	Agonist
Cetrotide 0.25mg	Antagonist
Clomiphene 50mg	Anti-estrogen
Letrozole 2.5mg	Anti-estrogen
Estradiol Valerate 20mg/cc	Estrogen
Estradiol Valerate 40mg/cc	Estrogen
Estradiol 2mg	Estrogen
Estradiol 1 mg	Estrogen
Estradiol 0.5mg	Estrogen
Estradiol Patch 0.1mg/24hr	Estrogen
Delestrogen 10mg/cc	Estrogen
Delestrogen 20mg/cc	Estrogen
Delestrogen 40mg/cc	Estrogen
Menopur 75iu	hMG
Gonal F 300iu pen	FSH
Gonal F 450iu pen	FSH

Gonal F 900iu pen	FSH
Gonal F 75iu vial	FSH
Gonal F 450iu vial	FSH
Gonal F 1050iu vial	FSH
Pregnyl 10,000iu	hCG
Novarel 5,000iu	hCG
Ovidrel 250mcg	hCG
Progesterone 50mg/cc Sesame oil	Progesterone
Endometrin 100mg vaginal insert	Progesterone

For more information on your fertility benefits, call: 833.205.4001