ALLINA HEALTH

BE FIT be you

2021 Benefit Description
Basic Health Savings Plan

Effective January 1, 2021

BlueCross BlueShield Minnesota

Blue Cross® and Blue Shield® of Minnesota and Blue Plus® are nonprofit independent licensees of the Blue Cross and Blue Shield Association

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, တၢ်ကဟ့ဉ်နၤကျိာ်တၢ်မၤစၢၤကလိတဖဉ်နှဉ်လီၤ. ကိး: 1-866-251-6744 လၢ TTYအဂီ, 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.

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

ຖ້າເຈົ້າເວົ້າພາສາລາວໄດ້, ມີການບໍລິການຊ່ວຍເຫຼືອພາສາໃຫ້ເຈົ້າຟຣີ. 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 áǫįęęǫįǫ́ǫǫąęįą́. 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:
  https://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 http://www.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 www.bluecrossmnonline.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

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INTRODUCTION

This Document contains a summary of the Allina Basic Health Savings Account (HSA) Medical and Prescription Drug plan (called the "plan" in this document) effective January 1, 2021. 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 care 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 under this plan. A charge shall be considered incurred on the date you receive the service or supply for which the charge is made.

Networks	
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 network for your particular plan. Not every provider is network for every plan. For a list of providers in the directory, visit www.myblueprintmn.com ("Member Sign in" then "Find a Doctor") or contact customer service at the telephone number listed on your member ID card.	
Participating network providers – medical • Allina First Network Providers (All Allina Health and affiliated providers and facilities) • Extended Network Providers (Providers and facilities that contract to be in the Blue Cross Extended Network, not including the Allina First Network) ▪ In Minnesota ▪ Outside Minnesota	 Aware network providers BlueCard PPO network providers

Benefits	Allina First Network Providers	Extended Network Providers	Out-of-Network Providers
Deductible (per calendar year) • Individual • Family	 You pay $2,000 You pay $4,000	 You pay $2,000 You pay $4,000	 You pay $6,000 You pay $12,000
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.			
The amounts accumulated toward the deductible are applied to covered services provided by Allina First Network, Extended Network and out-of-network providers. Amounts accumulated toward the Extended Network providers deductible also accumulate toward the Allina First Network providers deductible. When the Extended Network providers deductible is satisfied, covered services from both Extended Network providers and Allina First Network providers will be paid at the covered percentage. Amounts accumulated toward the out-of-network providers deductible also accumulate toward the Allina First Network providers and Extended Network providers deductible. When the out-of-network providers deductible is satisfied, covered services from both out-of-network providers and Allina First Network and Extended Network providers will be paid at the covered percentage.			
Coinsurance	Generally, you pay 15% coinsurance after deductible of the allowed amount until out-of-pocket limit is met; then you pay nothing to the end of the calendar year	Generally, you pay 15% coinsurance after deductible of the allowed amount until out-of-pocket limit is met; then you pay nothing to the end of the calendar year	Generally, you pay 40% coinsurance after deductible of the allowed amount until out-of-pocket limit is met; then you pay nothing to the end of the calendar year
Annual Out-of-Pocket Limits - eligible medical services including Pharmacy • Individual • Family	 You pay $5,000 You pay $10,000	 You pay $5,000 You pay $10,000	 You pay $12,000 Not applicable
The amounts accumulated toward the out-of-pocket limit are applied to covered services provided by Allina First Network, Extended Network and out-of-network providers. Amounts accumulated toward the Allina First Network out-of-pocket limit also accumulate toward the Extended Network out-of-pocket limit. When the Allina First Network out-of-pocket limit is satisfied, covered services from Allina First Network providers will be paid at 100% of the allowed amount. Amounts accumulated toward the Extended Network out-of-pocket limit also accumulate toward the Allina First Network out-of-pocket limit. When the Extended Network out-of-pocket limit is satisfied, covered services from Allina First Network providers and Extended Network providers will be paid at 100% of the allowed amount. Amounts accumulated toward the out-of-network out-of-pocket limit also accumulate toward the Allina First Network and the Extended Network out-of-pocket limits. When the out-of-network out-of-pocket limit is satisfied, the claims administrator considers the Allina First Network, Extended Network and out-of-network out-of-pocket limits satisfied and covered services from all providers will be paid at 100% of the allowed amount.			

Benefits	Allina First Network Providers	Extended Network Providers	Out-of-Network Providers
Amounts accumulated toward the combined Extended Network and out-of-network providers out-of-pocket limit also accumulate toward the Allina First Network providers out-of-pocket limit. When the combined Extended Network and out-of-network providers out-of-pocket limit is satisfied, covered services from Extended Network providers, out-of-network providers, and Allina First Network providers will be paid at 100% of the allowed amount.			
Lifetime Maximum (per person) • Palliative Care • Total benefits paid to all providers combined	$4,000 Not applicable		

BENEFIT CHART

The health care 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.

Prior authorization, admission notification, or emergency admission notification are required for specific services. Please refer to "Health Care Management."

Please refer to "Not Covered" sections of the Benefit Chart and “General Exclusions” for additional information.

Benefit Descriptions

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

AMBULANCE

The Plan Covers:	Allina First Network Providers	Extended Network Providers	Out-of-Network Providers
• Emergency medically necessary and appropriate service from the place of departure to the nearest medical facility equipped to treat the condition	You pay 15% coinsurance after deductible	You pay 15% coinsurance after deductible	Same as in-network services
• Non-emergency medically necessary and appropriate service from the place of departure to nearest medical facility equipped to treat the condition	You pay 15% coinsurance after deductible	You pay 15% coinsurance after deductible	Same as in-network services

NOTES:

- Ambulance service providing local transportation by means of a specially designed and equipped vehicle used only for transporting the sick and injured:
  - from your home, the scene of an accident or medical emergency to a hospital or skilled nursing facility provider;
  - 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.
- Transportation and related emergency service provided by an ambulance service will be considered emergency ambulance service if the injury or condition is considered emergency care. Use of an ambulance as transportation to an emergency room for an injury or condition that is not considered emergency care and will not be covered as emergency ambulance service. Please refer to "Terms You Should Know" for a definition of medical emergency.
- 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.

NOT COVERED:

- ambulance transportation costs that exceed the allowable cost applicable to transport from the place of departure to the nearest medical facility equipped to treat the condition (example: facility A is the closest medical facility equipped to treat the condition but you choose to be 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 choose to be 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)
- travel, transportation, or living expenses, whether or not recommended by a physician, except as provided herein
- ambulance transportation services that are not medically necessary and appropriate for basic or advanced life support
- transportation services, including ambulance services that are mainly for your convenience

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 age 18 and older:** You pay 10% coinsurance after deductible when you use A**llina Designated Bariatric Network Provider.**	**Eligible members age 18 and older:** You pay 20% coinsurance after deductible when you use **Blue Distinction Center for Bariatric Surgery** When you use an Out-of-Network Provider, there is **NO COVERAGE**
	Eligible members age 17 and younger: You pay 10% coinsurance after deductible when you use **Allina First Network Providers**	**Eligible members age 17 and younger:** You pay 20% coinsurance after deductible when you use **Blue Distinction Center for Bariatric Surgery** When you use an Out-of-Network Provider, there is **NO COVERAGE**

NOTES:

- **Members age 17 and younger have direct access to In-Network Providers for the highest level of benefits.**
- **For professional services related to eligible bariatric surgery services, refer to Office Visit and Professional Services.**
- Outpatient hospital/facilities including designated freestanding ambulatory surgical centers.
- Blue Distinction Centers for Bariatric Surgery are designated facilities within participating Blue Plans' service areas that have been selected after a rigorous evaluation of clinical data that provide insight into the facility's structures, processes, and outcomes of care. Nationally established evaluation criteria were developed with input from medical experts and organizations. These evaluation criteria support the consistent, objective assessment of specialty care capabilities. Blue Distinction Centers for Bariatric Surgery meet stringent quality criteria, as established by expert physician panels, surgeons, behaviorists, and nutritionists. The national Blue Distinction Centers for Bariatric Surgery have been developed in conjunction with other Blue Cross and Blue Shield Plans and the Blue Cross and Blue Shield Association.

NOT COVERED:

- 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 care 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:	Allina First Network Providers	Extended Network Providers	Out-of-Network Providers
• Outpatient health care professional services including: ▪ office visit ▪ telemedicine services ▪ individual/group/family therapy (office/in-home mental health services) ▪ all other professional services in an office or clinic ▪ all other professional services in an outpatient hospital/facility ▪ assessment and diagnostic services ▪ neuropsychological examinations • Outpatient hospital/outpatient behavioral health treatment facility services including: ▪ evaluation and diagnostic services ▪ individual/group therapy ▪ crisis evaluations ▪ observation beds ▪ family therapy • Professional health care services including: ▪ clinical based partial programs ▪ clinical based day treatment ▪ clinical based Intensive Outpatient Programs (IOP) • Facility health services including: ▪ hospital based partial programs ▪ hospital based day treatment ▪ hospital based intensive	Services in a physician's office: You pay 10% coinsurance after deductible Services in a hospital/facility: You pay 15% coinsurance after deductible	Services in a physician's office: You pay 20% coinsurance after deductible Services in a hospital/facility: You pay 15% coinsurance after deductible	You pay 40% coinsurance after deductible

The Plan Covers:	Allina First Network Providers	Extended Network Providers	Out-of-Network Providers
outpatient programs (IOP) • Inpatient health care professional services including: ▪ individual psychotherapy ▪ group psychotherapy ▪ psychological testing ▪ counseling with family members to assist in your diagnosis and treatment			
• Inpatient hospital/residential behavioral health treatment facility services including: ▪ all eligible inpatient services ▪ emergency holds	You pay 10% coinsurance after deductible	You pay 15% coinsurance after deductible	You pay 40% coinsurance after deductible

NOTES:

- Office visits may include medical history; medical examination; medical decision making; testing; counseling; coordination of care; nature of presenting problem; physician time; or psychotherapy.
- Court-ordered treatment for mental health care that is based on an evaluation and recommendation for such treatment or services by a physician or a licensed psychologist, is deemed medically necessary and appropriate.
- 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 care plan.
- 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.
- For home health related services, please refer to "Home Health Care."
- 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."
- Coverage is provided for crisis evaluations delivered by mobile crisis units.
- 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.
- Admissions that qualify as "emergency holds," as the term is defined in Minnesota statutes, are considered medically necessary and appropriate for the entire hold.
- 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.
- Coverage is provided for inpatient care and outpatient care for the treatment of serious mental illness. A serious 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. Serious mental illnesses include schizophrenia, schizoaffective disorder, major depressive disorder, bipolar disorder, obsessive-compulsive disorder, anorexia nervosa, bulimia nervosa and delusional disorder.

NOTES:

- 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:
  - mental health and substance use disorder services are to be covered on the same basis as similar medical services;
  - cost-sharing for mental health and substance use disorder services can be no more restrictive than cost-sharing for similar medical services; and
  - treatment restrictions and limitations such as prior authorization and medical necessity can be no more restrictive than for similar medical services.
- The plan covers telemedicine services, also referred to as televideo consultations or telehealth services, that provide real-time interaction between a physician/medical practitioner and the member both of whom are not in the same location, but are actively communicating through interactive audio and video channels.
- 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.
- Benefits are provided for autism treatment, including intensive behavioral therapy programs for the treatment of autism spectrum disorders including, but not limited to: Intensive Early Intervention Behavioral Therapy Services (EIBTS), Intensive Behavioral Intervention (IBI), and Lovaas Therapy. The diagnosis, evaluation, and assessment must include an assessment of the child's developmental skills, functional behavior, needs, and capacities. Treatment must be in accordance with an individualized treatment plan prescribed by the member's treating physician or mental health professional.

NOT COVERED:

- services for 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)*
- custodial care, nonskilled care, adult daycare or personal care attendants
- 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; education classes for DUI or DWI offences; competency evaluations; adoption home status; parental competency; and domestic violence programs
- services for or related to room and board for foster care, group homes, shelter care and lodging programs, halfway house services, and skills training
- services for or related to marriage/couples training for the primary purpose of relationship enhancement including, but not limited to: premarital education; or, marriage/couples retreats, encounters, or seminars
- 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
- 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)
- services for the treatment of learning disabilities
- services for therapeutic day care and therapeutic camp services
- court-ordered services or confinements by a court or law enforcement officer that are not based on a behavioral health care evaluation performed by a licensed psychiatrist or doctoral level licensed psychologist as provided under Minnesota law
- services for or related to marriage/couples counseling

BEHAVIORAL HEALTH SUBSTANCE USE CARE

The Plan Covers:	Allina First Network Providers	Extended Network Providers	Out-of-Network Providers
• Outpatient health care professional services including: ▪ office visit ▪ telemedicine services ▪ individual and family therapy ▪ all other professional services in an office or clinic ▪ all other professional services in an outpatient hospital/facility ▪ assessment and diagnostic services ▪ opioid treatment • Inpatient health care professional services	Services in a physician's office: You pay 10% coinsurance after deductible Services in a hospital/facility: You pay 15% coinsurance after deductible	Services in a physician's office: You pay 20% coinsurance after deductible Services in a hospital/facility: You pay 15% coinsurance after deductible	You pay 40% coinsurance after deductible
• Inpatient hospital/residential behavioral health treatment facility services	You pay 10% coinsurance after deductible	You pay 15% coinsurance after deductible	You pay 40% coinsurance after deductible

NOTES:

- Office visits may include medical history; medical examination; medical decision making; testing; counseling; coordination of care; nature of presenting problem; physician time; or psychotherapy.
- 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.
- Benefits are provided for individual and group counseling and psychotherapy, psychological testing, and family counseling for the treatment of substance use disorder include the following:
  - inpatient hospital or substance use disorder treatment facility provider services for detoxification
  - substance use disorder treatment facility provider services for non-hospital inpatient residential treatment and rehabilitation services
  - outpatient hospital/facility or substance use disorder treatment facility provider or outpatient substance use disorder treatment facility provider services for rehabilitation therapy
  - 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
  - admissions that qualify as "emergency holds," as the term is defined in Minnesota statutes, are considered medically necessary and appropriate for the entire hold
  - coverage includes medication assisted treatment (MAT) for opioid use disorder.
- 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.
- 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."
- For home health related services, please refer to "Home Health Care."
- For medical stabilization during detoxification services billed by a facility, please refer to "Hospital Inpatient Care" or "Hospital Outpatient Care."

NOTES:

- 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:
  - mental health and substance use disorder services are to be covered on the same basis as similar medical services;
  - cost-sharing for mental health and substance use disorder services can be no more restrictive than cost-sharing for similar medical services; and
  - treatment restrictions and limitations such as prior authorization and medical necessity can be no more restrictive than for similar medical services.
- The plan covers telemedicine services, also referred to as televideo consultations or telehealth services, that provide real-time interaction between a physician/medical practitioner and the member both of whom are not in the same location, but are actively communicating through interactive audio and video channels.

NOT COVERED:

- services for substance use disorder or additions not listed in the most recent editions of the *International Classification of Diseases (ICD)* and *Diagnostic and Statistical Manual for Mental Disorders (DSM)*
- custodial care, nonskilled care, adult daycare or personal care attendants
- services or confinements ordered by a court or law enforcement officer that are not medically necessary and appropriate
- 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; education classes for Driving Under the Influence (DUI)/Driving While Intoxicated (DWI) offenses; competency evaluations; adoption home status; and parental competency and domestic violence programs
- services for or related to room and board for foster care, group homes, shelter care, and lodging programs, halfway house services, and skills training
- 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
- services provided during a telemedicine 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
- services for therapeutic day care and therapeutic camp services
- services for hippotherapy (equine movement therapy)
- court-ordered services or confinements by a court or law enforcement officer that are not based on a behavioral health care evaluation performed by a licensed psychiatrist or doctoral level licensed psychologist as provided under Minnesota law

CHIROPRACTIC CARE

The Plan Covers:	Allina First Network Providers	Extended Network Providers	Out-of-Network Providers
• Spinal manipulations - includes office visit • Other chiropractic services including therapies	You pay 15% coinsurance after deductible	You pay 15% coinsurance after deductible	You pay 40% coinsurance after deductible
• Acupuncture services for the treatment of chronic pain, nausea associated with surgery, chemotherapy or pregnancy	Services in a physician's office: You pay 10% coinsurance after deductible Services in a hospital/facility: You pay 15% coinsurance after deductible	Services in a physician's office: You pay 20% coinsurance after deductible Services in a hospital/facility: You pay 15% coinsurance after deductible	You pay 40% coinsurance after deductible

NOTES:

- 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.
- For laboratory and diagnostic imaging services billed by a health care professional, please refer to "Office Visits and Professional Services." For laboratory and diagnostic imaging services billed by a facility, please refer to "Hospital Inpatient Care" or "Hospital Outpatient Care."
- Office visits may include medical history; medical examination; medical decision making; testing; counseling; coordination of care; nature of presenting problem and chiropractor time.

NOT COVERED:

- 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
- 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
- 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; etc.; and all related material and products for these programs
- services for or related to therapeutic massage
- maintenance services

NOT COVERED:

- 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
- custodial care

DENTAL CARE

The Plan Covers:	Allina First Network Providers	Extended 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 and healthy natural teeth (see NOTES) • Treatment of cleft lip and palate when services are scheduled or initiated prior to the member turning age 19 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 • Surgical and nonsurgical treatment of Temporomandibular Joint (TMJ) disorder and craniomandibular disorder including: ▪ orthognathic surgery ▪ related orthodontia • Tooth extraction when due to a medical diagnosis (see NOTES)	You pay 10% coinsurance after deductible	You pay 20% coinsurance after deductible	You pay 40% coinsurance after deductible
• Services for the treatment of ectodermal dysplasia including: ▪ orthodontia ▪ bone grafts ▪ dental implants ▪ dentures ▪ bridgework	You pay 10% coinsurance after deductible	You pay 20% coinsurance after deductible	You pay 20% coinsurance after deductible

NOTES:

- For medical services, please refer to "Hospital Inpatient Care," "Hospital Outpatient Care," "Office Visit and Professional Services," etc.

NOTES:

- 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.
- 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.
- Mandibular staple implant is covered, provided the procedure is not done to prepare the mouth for dentures.
- Bone grafts 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.
- A sound and healthy natural tooth is a viable tooth (including natural supporting structures) that is free from disease that would prevent continual function of the tooth for at least one (1) year. In the case of primary (baby) teeth, the tooth must have a life expectancy of one (1) year. A dental implant is not a sound and healthy natural tooth.
- Accident-related dental services, treatment and/or restoration of a sound and healthy 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 and healthy natural teeth, crowns, fillings and bridges.
- The health care plan covers anesthesia and inpatient and outpatient hospital charges when necessary to provide dental care to a covered person 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.
- Services for surgical and nonsurgical treatment of temporomandibular joint 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.

NOT COVERED:

- services for or related to orthodontia, except as provided herein
- oral surgery procedures, except as provided herein
- dental services to treat an injury from biting or chewing
- dentures, regardless of the cause or the condition, and any associated services including bone grafts
- dental implants, and associated services, except when related to services for cleft lip and palate that are scheduled or initiated prior to the member turning age 19
- removal of impacted teeth and/or tooth extractions and any associated charges including but not limited to imaging studies and pre-operative examinations, except as provided herein
- services for or related to replacement of a damaged dental bridge from an accident-related injury
- osteotomies and other procedures associated with the fitting of dentures or dental implants, except as provided herein
- services for or related to dental or oral care, treatment, orthodontics, surgery, supplies, anesthesia, or facility charges, except as provided herein
- services, including dental splints, to treat bruxism
- charges for routine dental care, except as provided herein

EMERGENCY CARE

The Plan Covers:	Allina First Network Providers	Extended Network Providers	Out-of-Network Providers
• Outpatient health care professional services to treat a medical emergency • Outpatient hospital/facility services to treat a medical emergency	You pay 25% coinsurance after Allina First Network providers deductible		

NOTES:

- 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. Once the crisis has passed, call your physician to receive appropriate follow-up care.
- Please refer to "Terms You Should Know" for a definition of medical emergency.
- For inpatient services, please refer to "Hospital Inpatient Care" and "Office Visit and Professional Services."
- For urgent care visits, please refer to "Hospital Outpatient Care" and "Office Visit and Professional Services."

GENDER CONFIRMATION CARE

The services outlined on this page are for the treatment of gender dysphoria. Gender dysphoria refers to the distress that may accompany the incongruence between one's experienced or expressed gender and one's assigned gender. The therapeutic approach to gender dysphoria, as outlined by the Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People, from the World Professional Association for Transgender Health (WPATH), may consist of several interventions with the type and sequence of interventions differing from person to person.

The Plan Covers:	Allina First Network Providers	Extended Network Providers	Out-of-Network Providers
• Outpatient health care professional services including: ▪ office visit • Professional services for gender affirming procedures for the treatment of gender dysphoria	Services in a physician's office: You pay 10% coinsurance after deductible Services in a hospital/facility: You pay 15% coinsurance after deductible	Services in a physician's office: You pay 20% coinsurance after deductible Services in a hospital/facility: You pay 15% coinsurance after deductible	You pay 40% coinsurance after deductible

NOTES:

- Services include related preparation and follow-up treatment care.
- For outpatient counseling services, please refer to "Behavioral Health Mental Health Care."
- Office visits may include medical history; medical examination; medical decision making; testing; counseling; coordination of care; nature of presenting problem; physician time; or psychotherapy.
- For hospital/facility services, please refer to "Hospital Inpatient Care" and "Hospital Outpatient Care."
- 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."
- For therapeutic injections, please refer to "Hospital Outpatient Care" or "Office Visit and Professional Services."
- For more information contact customer service at the telephone number on the back of your member ID card or visit www.myblueprintmn.com.
- Coverage includes cosmetic surgery related to sex transformation surgery only.

NOT COVERED:

- treatment, services or supplies that are not medically necessary and appropriate

HOME HEALTH CARE

The Plan Covers:	Allina First Network Providers	Extended Network Providers	Out-of-Network Providers
• Home health care agency or hospital program for home health care 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 dietician ▪ 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 services provided by the above listed agency employees ▪ 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 15% coinsurance after deductible	You pay 15% coinsurance after deductible	You pay 40% coinsurance after deductible

NOTES:

- Health aide services when you are also receiving covered nursing services or therapy and rehabilitation services.
- Benefits for home/suite infusion therapy and related home health care are listed under "Infusion Therapy."
- For supplies and durable medical equipment billed by a home health agency, please refer to "Medical Equipment and Supplies."
- 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.

NOTES:

- **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.**
- 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 her newborn child.

NOT COVERED:

- homemaker services
- maintenance services
- services for dialysis treatment you receive from a home health care agency
- services for custodial care you receive from a home health care agency
- services for food or home-delivered meals you receive from a home health care agency
- services for or related to care that is custodial or not normally provided as preventive care or for treatment of an illness/injury (please refer to "Custodial Care" and "Skilled Care" in the "Terms You Should Know")
- services for or related to skilled nursing care - extended hours, also referred to as private-duty nursing care

HOSPICE CARE

The Plan Covers:	Allina First Network Providers	Extended Network Providers	Out-of-Network Providers
• Hospice care for terminal condition provided by a Medicare approved hospice provider or other preapproved hospice provider	You pay 15% coinsurance after deductible	You pay 15% coinsurance after deductible	You pay 40% coinsurance after deductible

NOTES:

- 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.
- Benefits for hospice care are limited to members with a terminal condition (i.e., life expectancy of six (6) months or less). The member's primary physician must certify, in writing, a life expectancy of six (6) months or less. Hospice benefits begin on the date of admission to a hospice program.
- **Inpatient respite care is for the relief of the patient's primary caregiver and is limited to a maximum of five (5) consecutive days at a time up to a maximum of 30 days during the episode of hospice care.**
- **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.**
- Hospice program general inpatient care is for control of pain or other symptom management that cannot be managed in a less intense setting.
- Benefits include family counseling related to the member's terminal condition.
- Medical care services unrelated to the terminal condition under the hospice program are covered, but are separate from the hospice benefit.

NOT COVERED:

- services for respite care, except as provided herein
- room and board expenses in a residential hospice facility
- services for dialysis treatment you receive from hospice or a hospital program for hospice care
- services for custodial care you receive from hospice or a hospital program for hospice care
- services for food or home-delivered meals you receive from hospice or a hospital program for hospice care

HOSPITAL INPATIENT CARE

The Plan Covers:	Allina First Network Providers	Extended 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 and medicines provided to you while you are inpatient in a facility • Whole blood, administration of blood, blood processing, and blood derivatives • Diagnostic services • Telemedicine 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 10% coinsurance after deductible	You pay 20% coinsurance after deductible	You pay 40% coinsurance after deductible
• Magnetic esophageal ring surgery services (see NOTES)	You pay 10% coinsurance after deductible	NO COVERAGE	NO COVERAGE

NOTES:

- **Coverage for magnetic esophageal ring surgery services is limited to services provided by Surgical Specialists of MN and Abbott Northwestern Hospital.**
- The health care 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.
- The plan covers kidney and cornea transplants. For kidney transplants done in conjunction with an eligible major organ transplant or other kinds of transplants, please refer to "Transplant."
- The plan covers the following kidney donor services when billed under the donor recipient's name and the donor recipient is covered for the kidney transplant under the plan:
  - potential donor testing;
  - donor evaluation and work-up; and
  - hospital and professional services related to organ procurement.
- Diagnostic services include the following when ordered by a health care provider:
  - diagnostic imaging consisting of radiology, magnetic resonance imaging (MRI), ultrasound and nuclear medicine;
  - diagnostic pathology consisting of laboratory and pathology tests;
  - 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
  - allergy testing consisting of percutaneous, intracutaneous, and patch tests.
- The health care plan covers anesthesia and inpatient hospital services when necessary to provide dental care to a covered person 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.
- The plan covers telemedicine services, also referred to as televideo consultations or telehealth services, that provide real-time interaction between a physician/medical practitioner and the member both of whom are not in the same location, but are actively communicating through interactive audio and video channels.

NOT COVERED:

- charges for inpatient admissions which are primarily for diagnostic studies
- personal comfort items such as telephone, television
- travel expenses for a kidney donor
- kidney donor expenses for complications incurred after the organ is removed if the donor is not covered under this plan
- kidney donor expenses when the recipient is not covered for the kidney transplant under this plan
- communication services provided on an outpatient basis or in the home
- services for or related to skilled nursing care - extended hours, also referred to as private-duty nursing care

HOSPITAL OUTPATIENT CARE

The Plan Covers:	Allina First Network Providers	Extended Network Providers	Out-of-Network Providers
• Outpatient hospital/facility services, except as noted below • 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 • Prescription drugs and medicines provided to you while you are outpatient in a facility • Whole blood, administration of blood, blood processing, and blood derivatives • The plan covers telemedicine services, also referred to as televideo consultations or telehealth services, that provide real-time interaction between a distant site physician/medical practitioner and the member who is present and participating in the televideo visit at a remote facility. • Facility billed freestanding ambulatory surgical center services	You pay 10% coinsurance after deductible	You pay 20% coinsurance after deductible	You pay 40% coinsurance after deductible
• Laboratory services, except as listed below • Diagnostic imaging services	You pay 15% coinsurance after deductible	You pay 15% coinsurance after deductible	You pay 40% coinsurance after deductible
• Laboratory screening for cotinine alkaloid	You pay nothing	You pay nothing	NO COVERAGE

The Plan Covers:	Allina First Network Providers	Extended Network Providers	Out-of-Network Providers
• Resiliency training (see NOTES) • Magnetic esophageal ring surgery services (see NOTES)	You pay 10% coinsurance after deductible	NO COVERAGE	NO COVERAGE
• Palliative care	You pay 15% coinsurance after deductible	NO COVERAGE	NO COVERAGE
• Urgent care center visits ▪ facility billed services	You pay 10% coinsurance after deductible	You pay 20% coinsurance after deductible	You pay 40% coinsurance after deductible
• Urgent care center visits ▪ Facility laboratory services ▪ Facility diagnostic imaging services	You pay 15% coinsurance after deductible	You pay 15% coinsurance after deductible	You pay 40% coinsurance after deductible

NOTES:

- **Coverage for magnetic esophageal ring surgery services is limited to services provided by Surgical Specialists of MN and Abbott Northwestern Hospital.**
- **Palliative care is limited to a maximum benefit of $4,000 per person per lifetime.**
- **Resiliency training is limited to one assessment and one training program per person per lifetime, with payment conditioned upon completion of the program.**
- 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.
- 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.
- 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.
- 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.
- The health care plan covers anesthesia and outpatient hospital services when necessary to provide dental care to a covered person 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.
- The plan covers telemedicine services, also referred to as televideo consultations or telehealth services, that provide real-time interaction between a physician/medical practitioner and the member both of whom are not in the same location, but are actively communicating through interactive audio and video channels.

NOT COVERED:

- Services and prescription drugs for or related to assisted fertilization, except as described in the Fertility Benefit Appendix.

INFUSION THERAPY

The Plan Covers:	Allina First Network Providers	Extended 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 15% coinsurance after deductible	You pay 15% coinsurance after deductible	You pay 40% coinsurance after deductible

NOTES:

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

NOT COVERED:

- home/suite infusion services or supplies not specifically listed as covered services
- 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:	Allina First Network Providers	Extended Network Providers	Out-of-Network Providers
• Prenatal hospital/facility provider services • Prenatal professional services • Family planning services	You pay nothing	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	NO COVERAGE
• Health care professional services for: ▪ delivery in a hospital/facility ▪ examination of the newborn infant while the mother is an inpatient ▪ postpartum care ▪ office visit ▪ all other eligible services	Services in a physician's office: You pay 10% coinsurance after deductible Services in a hospital/facility: You pay 15% coinsurance after deductible	Services in a physician's office: You pay 20% coinsurance after deductible Services in a hospital/facility: You pay 15% coinsurance after deductible	You pay 40% coinsurance after deductible
• Acupuncture services for the treatment of chronic pain, nausea associated with surgery, chemotherapy or pregnancy	You pay nothing after deductible	You pay nothing after deductible	You pay 40% coinsurance after deductible

NOTES:

- For hospital/facility services, please refer to "Hospital Inpatient Care" and "Hospital Outpatient Care."
- 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."
- 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 her newborn child.
- 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.
- Normal pregnancy – normal pregnancy includes any condition usually associated with the management of a difficult pregnancy but is not considered a complication of pregnancy.
- Hospital, medical and surgical services rendered by a facility provider or professional provider for:
  - 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, including conditions related to ectopic pregnancy or those that require cesarean section.

NOTES:

- Prenatal care - the comprehensive package of medical and psychosocial support provided throughout the pregnancy, includes risk assessment, 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.

- 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:
  - inpatient hospital coverage for the mother (to the extent the mother is covered under this health care 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 care plan. Please refer to "Home Health Care."
  - inpatient hospital coverage for the newborn (to the extent the newborn is covered under this health care 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."
- Under federal law, the health care plan may require that a provider obtain authorization from the health care plan for prescribing a length of stay greater than the 48 hours (or 96 hours) mentioned above.

NOT COVERED:

- health care professional services for childbirth deliveries in the home
- services for or related adoption fees
- services for or related to surrogate pregnancy including: diagnostic screening, physician services, assisted fertilization, 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
- services for childbirth classes
- 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
- services for donor ova or sperm
- services for or related to elective cesarean (C)-section for the purpose of convenience
- services and prescription drugs for or related to the selection of gender in embryos

MEDICAL EQUIPMENT AND SUPPLIES

The Plan Covers:	Allina First Network Providers	Extended Network Providers	Out-of-Network Providers
• Durable medical equipment (DME), except as noted below • Amino acid-based elemental formula • Corrective lenses, frames and contact lenses after cataract surgery • Scalp hair prostheses (wigs) for hair loss due to alopecia areata • Hearing aids for children age 18 and younger who have a hearing loss that cannot be corrected by other covered procedures. Maximum of one (1) hearing aid for each ear every three (3) years • Custom foot orthoses if you have a diagnosis of diabetes with neurological manifestations of one (1) or both feet • Prosthetics, including breast prosthesis, artificial limbs, and artificial eyes • Cochlear implants • Non-investigative bone conductive hearing devices	You pay 15% coinsurance after deductible	You pay 15% coinsurance after deductible	You pay 40% coinsurance after deductible
• Insulin infusion devices • Blood glucose monitors • Ostomy supplies • Diabetic supplies, including: cotton balls; alcohol swabs; and other diabetic supplies	You pay nothing after deductible	You pay 20% coinsurance after deductible	You pay 40% coinsurance after deductible

NOTES:

- Coverage includes the 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.
- 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:
  - 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.

NOTES:

- The rental or, upon approval by the claims administrator, the purchase, adjustment, repairs and replacement of durable medical equipment for therapeutic use when prescribed by a health care provider within the scope of his/her license. Rental costs cannot exceed the total cost of purchase.
- Amino acid-based elemental formula is 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 if he/she is 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.
- Coverage for eligible orthotic devices includes purchase, fitting, necessary adjustment, repairs and replacement of a rigid or semi-rigid supportive device which restricts or eliminates motion of a weak or diseased body part.
- Hearing aids for children age 18 and younger who have a hearing loss that cannot be corrected by other covered procedures. Maximum of one (1) hearing aid for each ear every three (3) years.
- You are required to obtain prior authorization for durable medical equipment when you use nonparticipating providers in Minnesota or any provider outside of Minnesota. Please refer to www.myblueprintmn.com (click on "For Providers" at the bottom of the page, then "Medical Policy" under "Tools and Resources") or contact customer service at the telephone number on the back of your member ID card.

NOT COVERED:

- foot orthoses, except as provided herein
- services for or related to hearing aids or devices, except as provided herein
- solid or liquid food, standard and specialized infant formula, banked breast milk, nutritional supplements and electrolyte solution, except when administered by tube feeding and as specified in the "Benefit Chart"
- personal and convenience items or items provided at levels which exceed our determination of medically necessary and appropriate for durable medical equipment, supplies, and prosthetics
- 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
- modifications to home, vehicle, and/or workplace, including vehicle lifts and ramps
- blood pressure monitoring devices
- replacement of properly functioning durable medical equipment
- duplicate equipment, prosthetics, or supplies
- communication devices, except when exclusively used for the communication of daily medical needs and without such communication the patient's medical condition would deteriorate
- charges for devices for maintenance services
- scalp hair prostheses (wigs) for any diagnosis other than alopecia areata
- charges for the rental of a manual breast pump
- charges for an electric breast pump
- services for eyeglasses or contact lenses for prescribing or fitting eyeglasses or contact lenses (except for the initial pair of contact lenses/glasses prescribed following cataract extraction in place of surgically implanted lenses, or sclera shells intended for use in the treatment of disease or injury)

OFFICE VISIT AND PROFESSIONAL SERVICES

The Plan Covers:	Allina First Network Providers	Extended Network Providers	Out-of-Network Providers
• Physician office visits • Specialty physician office visits	You pay 10% coinsurance after deductible	You pay 20% coinsurance after deductible	You pay 40% coinsurance after deductible
• E-visits • Telephone consultations • Retail health clinic ▪ retail health clinic office visit ▪ laboratory services ▪ all other professional services	Allina Health Everyday Online: You pay nothing after deductible Allina Health Everyday Clinic and St. Francis Express Clinics: You pay nothing after deductible Minute Clinic: You pay 5% coinsurance after deductible Retail Health: You pay 5% coinsurance after deductible	You pay 10% coinsurance after deductible	You pay 40% coinsurance after deductible
• Urgent care center visits for illness/injury ▪ office visit for urgent care ▪ professional laboratory services for urgent care ▪ professional diagnostic imaging services for urgent care ▪ all other professional services for urgent care	You pay 15% coinsurance after deductible	You pay 15% coinsurance after deductible	Services in a physician's office: You pay 25% coinsurance after deductible Services in a hospital/facility: You pay 40% coinsurance after deductible
• Outpatient allergy testing • Professional laboratory services, except as listed below • Professional diagnostic imaging services, except as listed below • Hearing aid exam/fittings/adjustment for children age 18 and younger • Inpatient hospital/facility visits during a covered admission • Outpatient hospital/facility visits	You pay 15% coinsurance after deductible	You pay 15% coinsurance after deductible	You pay 40% coinsurance after deductible

The Plan Covers:	Allina First Network Providers	Extended Network Providers	Out-of-Network Providers
• Outpatient allergy serum and injections	You pay nothing after deductible	You pay nothing after deductible	You pay 40% coinsurance after deductible
• Outpatient sleep studies	You pay 10% coinsurance after deductible	You pay 20% coinsurance after deductible	You pay 40% coinsurance after deductible
• Bariatric surgery to correct morbid obesity including: ▪ Anesthesia ▪ assistant surgeon	You pay 15% coinsurance after deductible	You pay 15% coinsurance after deductible	NO COVERAGE
• Palliative care • Magnetic esophageal ring surgery services (see NOTES)	You pay 15% coinsurance after deductible	NO COVERAGE	NO COVERAGE
• Resiliency training (see NOTES)	You pay 10% coinsurance after deductible	NO COVERAGE	NO COVERAGE
• 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	You pay nothing	NO COVERAGE
• Inpatient hospital facility within 24 hours of an emergency department visit for the same illness	You pay 15% coinsurance after deductible	You pay 15% coinsurance after deductible	You pay 15% coinsurance after deductible
• Injectable drugs administered by a health care professional • Kidney and cornea transplants • Diabetes outpatient self-management training and education, including medical nutrition therapy • Chemotherapy administration • Professional billed services	<u>Services in a physician's office:</u> You pay 10% coinsurance after deductible <u>Services in a hospital/facility:</u> You pay 15% coinsurance after deductible	<u>Services in a physician's office:</u> You pay 20% coinsurance after deductible <u>Services in a hospital/facility:</u> You pay 15% coinsurance after deductible	You pay 40% coinsurance after deductible

The Plan Covers:	Allina First Network Providers	Extended Network Providers	Out-of-Network Providers
received at a freestanding ambulatory surgical center • Acupuncture services for the treatment of chronic pain, nausea associated with surgery, chemotherapy or pregnancy • All other professional services			

NOTES:

- Through the end of the COVID-19 national emergency, the Plan will cover 100% of the cost of:
  - diagnostic testing for the detection of SARS-CoV-2 or the virus that causes COVID-19 (as long as such test is FDA-approved or otherwise required by federal law to be covered at no cost-sharing including serological testing to detect antibodies against COVID-19 when required by law);
  - health care items and services necessary for such testing (including the provider visit as long as such testing is ordered or administered during such visit or where the visit results in a COVID-19 diagnosis code);
  - items, services and the provider visit where the participant is being evaluated for the need for such diagnostic testing; and
- During 2021, the Plan will cover 100% of the cost of treatment for COVID-19 at an in-network provider, subject to normal Plan rules.
- Through the date required by law, the Plan will cover 100% of the cost for an item, service or immunization that (i) has an "A" or "B" rating from the United States Preventive Services Task Force and is intended to prevent or mitigate 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.
- **Palliative care is limited to a maximum benefit of $4,000 per person per lifetime.**
- **Resiliency training is limited to one assessment and one training program per person per lifetime, with payment conditioned upon completion of the program.**
- **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**.**
- **Coverage for magnetic esophageal ring surgery services is limited to services provided by Surgical Specialists of MN and Abbott Northwestern Hospital.**
- For members diagnosed with End Stage Renal Disease (ESRD), your provider is required to complete the Centers for Medicare and Medicaid Services (CMS) form CMS-2728-U3 ESRD Medical Evidence Report Medicare Entitlement and/or Patient Registration. Your provider must send the completed form to CMS and the claims administrator. Please verify with your provider that form CMS-2728-U3 has been completed and submitted.
- 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. 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.
- 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:
  - Diabetes Education Program*: When your health care provider certifies that you require diabetes education as an outpatient, coverage is provided for the following when rendered through a diabetes education program:
    - visits medically necessary and appropriate upon the diagnosis of diabetes

NOTES:

- subsequent visits under circumstances whereby your physician: a) identifies or diagnoses a significant change in your symptoms or conditions that necessitates changes in your self-management, or b) identifies, as medically necessary and appropriate, a new medication or therapeutic process relating to your treatment and/or management of diabetes

*Diabetes Education Program – an outpatient program of self-management, training and education, including medical nutrition therapy, for the treatment of diabetes. Such outpatient program must be conducted under the supervision of a licensed health care provider working in a program consistent with the national standards of diabetes self-management education as established by the American Diabetes Association with expertise in diabetes.

- 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.
- Physician services include services of an optometrist and an advanced practice nurse when performed within the scope of their licensure.
- The plan covers treatment of diagnosed Lyme disease on the same basis as any other illness.
- Office visits may include medical history; medical examination; medical decision making; testing; counseling; coordination of care; nature of presenting problem; physician time; and psychotherapy.
- 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.
- The plan covers kidney and corneal transplants. For kidney transplants done in conjunction with an eligible major organ transplant, please refer to "Transplant."
- The plan covers the following kidney donor services when billed under the donor recipient's name and the donor recipient is covered for the kidney transplant under the plan:
  - potential donor testing;
  - donor evaluation and workup; and
  - hospital and professional services related to organ procurement.
- 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.
- Diagnostic services include the following when ordered by a health care provider:
  - diagnostic imaging consisting of radiology, magnetic resonance imaging (MRI), ultrasound and nuclear medicine;
  - diagnostic pathology consisting of laboratory and pathology tests;
  - 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
  - allergy testing consisting of percutaneous, intracutaneous, and patch tests.
- Eligible therapeutic injections, 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.
- 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.

NOTES:

- 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 care plan.
- Please refer to “Preventive Care” for female sterilization.
- You are entitled to receive care at the in-network level from out-of-network providers if these services are covered under your plan:
  - the voluntary planning of the conception and bearing of children;
  - the diagnosis of infertility;
  - the testing and treatment of a sexually transmitted disease; or,
  - the testing of AIDS or other HIV-related conditions.
- 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.
- The plan covers telemedicine services, also referred to as televideo consultations or telehealth services. These services provide real-time interaction between a distant site physician/medical practitioner and the member who is present and participating in the televideo visit at a remote facility.
- The plan covers hearing aid examinations/fitting/adjustments for children age 18 and younger.

NOT COVERED:

- out-of-network provider-initiated communications
- charges for giving injections that can be self-administered
- self-administered drugs that are available for coverage under the pharmacy/prescription drug benefit
- services for autopsies
- 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
- separate services for pre-operative and post-operative care for surgery billed by an out-of-network provider
- travel expenses for a kidney donor
- kidney donor expenses for complications incurred after the organ is removed if the donor is not covered under this plan
- kidney donor expenses when the recipient is not covered under this plan
- services and supplies for or related to weight reduction programs, including all diagnostic testing related to weight reduction programs, except as provided herein
- services for routine or periodic physical examinations, the completion of forms, and the preparation of specialized reports solely for insurance, licensing, employment or other non-preventive purposes, such as pre-marital examinations, physicals for school, camp, sports or travel, which are not medically necessary and appropriate, except as provided herein
- services for educational classes or programs, except as required by law
- 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
- 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

NOT COVERED:

- 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
- services provided during a telemedicine 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
- services and prescription drugs for or related to assisted fertilization, except as described in the Fertility Benefit Appendix
- services for or related to reversal of sterilization

PHYSICAL, OCCUPATIONAL, AND SPEECH THERAPY

The Plan Covers:	Allina First Network Providers	Extended Network Providers	Out-of-Network Providers
• Habilitative and rehabilitative office visits and therapies from a physical therapist	You pay 15% coinsurance after deductible	You pay 15% coinsurance after deductible	You pay 40% coinsurance after deductible
• Habilitative and rehabilitative office visits and therapies from an occupational therapist	You pay 15% coinsurance after deductible	You pay 15% coinsurance after deductible	You pay 40% coinsurance after deductible
• Habilitative and rehabilitative office visits and therapies from a speech or language pathologist	You pay 15% coinsurance after deductible	You pay 15% coinsurance after deductible	You pay 40% coinsurance after deductible

NOTES:

- 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.
- For physical, occupational and speech therapy services billed by a hospital/facility, please refer to "Hospital Inpatient Care" and "Hospital Outpatient Care."
- Office visits may include an evaluation or re-evaluation of the following therapies:
  - physical
  - occupational
  - speech
  - swallowing
- 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."

NOT COVERED:

- 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
- 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:	Allina First Network Providers	Extended Network Providers	Out-of-Network Providers
Preventive care services from health care professionals, outpatient hospitals/facilities, and medical equipment suppliers in accordance with a predefined schedule based on age, sex and certain risk factors which are the 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), and the Internal Revenue Service (IRS) for:			
Adults and children age 6 and older			
• Routine physical examinations	You pay nothing	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	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	You pay nothing	NO COVERAGE
• Vision examination (glaucoma, acuity, refraction)	You pay nothing	You pay nothing	NO COVERAGE
• Routine gynecological examinations, including a Papanicolaou (PAP) test	You pay nothing	You pay nothing	NO COVERAGE
• mammograms, 2 dimensional (2D) or 3 dimensional (3D), annual routine and medically necessary and appropriate	You pay nothing	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	You pay nothing	NO COVERAGE
Pediatric			
• Routing physical examinations from birth to age 6	You pay nothing	You pay nothing	NO COVERAGE
• Pediatric immunizations from birth to age 18	You pay nothing	You pay nothing	NO COVERAGE
• Diagnostic services and procedures from birth to age 6	You pay nothing	You pay nothing	NO COVERAGE

NOTES:

- 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.
- Routine physical examinations including a complete medical history for adults, and other items and services.
- For more information regarding preventive care services, please visit www.mybluepprintmn.com (choose "Live Healthy" then "Preventive Care") or contact customer service at the telephone number listed on the back of your member ID card.
- Pediatric preventive care services are limited to those on the health care plan's preventive schedule. Gender, age and frequency limits may apply.
- 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 www.mybluepprintmn.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.
- Benefits are provided for "child health supervision services," which means pediatric preventive services, appropriate immunizations, developmental assessments, and laboratory services appropriate to the age of a child from birth to age 6, and appropriate immunizations from ages six (6) to 18, as defined by Standards of Child Health Care issued by the American Academy of Pediatrics. We will reimburse five (5) child health supervision visits from birth to 12 months, three (3) child health supervision visits from 12 months to 24 months, and once a year from 24 months to 72 months.
- Well-woman benefits are provided for female members for items and services including, but not limited to, an initial physical examination to confirm pregnancy, screening for gestational diabetes, coverage for contraceptive methods and counseling and breastfeeding support and counseling.
- You are entitled to receive care at the in-network level for screening for sexually transmitted disease or HIV.
- Adult preventive care services are limited to those on the health care plan's preventive schedule and the women's health preventive schedule. Gender, age and frequency limits may apply.
- Pediatric preventive care services are limited to those on the health care plan's preventive schedule. Gender, age and frequency limits may apply.
- Benefits are provided for surgical implants and tubal ligation for elective sterilization for females which meet the recommendations and criteria established by the USPSTF, ACIP of the Centers for Disease Control, and the HRSA. For more information regarding elective sterilization coverage, please visit www.mybluepprintmn.com (choose "Live Healthy" then "Preventive Care") or contact customer service at the telephone number listed on the back of your member ID card.
- 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.
- Services for complications related to female contraceptive drugs, devices, and services for women of 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.
- Services to treat an illness/injury diagnosed as a result of preventive care services or preventive care services in excess of USPSTF, ACIP of the Centers for Disease Control, HRSA, or the IRS recommendations and criteria 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.

NOTES:

- All female members, regardless of age, are covered for routine gynecological examinations, including a pelvic and clinical breast examination.
- Benefits are provided to eligible dependent children for pediatric immunizations.
- Benefits are provided for the following tests or procedures when ordered by a physician for the purpose of early detection of colorectal cancer:
  - diagnostic laboratory and pathology screening services such as a fecal-occult blood or fecal immunochemical test
  - diagnostic imaging screening services such as barium enema
  - surgical screening services such as flexible sigmoidoscopy and colonoscopy and hospital services related to such surgical screening services
  - 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
- If you are determined to be at high or increased risk, benefits are provided for a colonoscopy or any other combination of covered services related to colorectal cancer screening when prescribed by a physician. Colorectal cancer screening services which are otherwise not described herein and are prescribed by a physician for a symptomatic member are not considered preventive care services. The payment for these services will be consistent with similar medically necessary and appropriate covered services.

NOT COVERED:

- services for routine or periodic physical examinations, the completion of forms, and the preparation of specialized reports solely for insurance, licensing, employment or other non-preventive purposes, such as pre-marital examinations, physicals for school, camp, sports or travel, which are not medically necessary and appropriate, except as provided herein

RECONSTRUCTIVE SURGERY

The Plan Covers:	Allina First Network Providers	Extended 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	Services in a physician's office: You pay 10% coinsurance after deductible Services in a hospital/facility: You pay 15% coinsurance after deductible	Services in a physician's office: You pay 20% coinsurance after deductible Services in a hospital/facility: You pay 15% coinsurance after deductible	You pay 40% coinsurance after deductible
• Treatment of cleft lip and palate when services are scheduled or initiated prior to the member turning age 19 including: ▪ dental implants ▪ removal of impacted teeth or tooth extractions ▪ related orthodontia ▪ related oral surgery ▪ bone grafts	You pay 10% coinsurance after deductible	You pay 20% coinsurance after deductible	You pay 40% coinsurance after deductible

NOTES:

- 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.
- Congenital means present at birth.
- For hospital/facility services, please refer to "Hospital Inpatient Care" and "Hospital Outpatient Care."

NOT COVERED:

- repairs of scars and blemishes on skin surfaces
- oral surgery procedures, except as provided herein
- dentures, regardless of the cause or condition, and any associated services including bone grafts
- dental implants, and associated services, except when related to services for cleft lip and palate that are scheduled or initiated prior to the member turning age 19

SKILLED NURSING FACILITY CARE

The Plan Covers:	Allina First Network Providers	Extended Network Providers	Out-of-Network Providers
• Skilled care ordered by a physician and eligible under Medicare guidelines • Room and board • General nursing care • Prescription drugs used during a covered admission • Take home prescription drugs • Physical, occupational, and speech therapy	You pay 15% coinsurance after deductible	You pay 15% coinsurance after deductible	You pay 40% coinsurance after deductible

NOT COVERED:

- custodial care, nonskilled care, adult daycare or personal care attendants
- 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
- services when confinement is intended solely to assist you with the activities of daily living or to provide an institutional environment for your convenience
- treatment, services or supplies that are not medically necessary and appropriate
- services for or related to skilled nursing care - extended hours, also referred to as private-duty nursing care

TRANSPLANT

The Plan Covers:	Allina Designated Transplant Providers	Out-of-Network Providers
• Benefits may be provided for covered services furnished by a hospital which are directly and specifically related to the transplantation of the following: medically necessary and appropriate human organ, bone marrow, cord blood, and peripheral stem cell transplant procedures: ▪ allogeneic and syngeneic bone marrow transplant and peripheral stem cell and umbilical cord blood transplant procedures ▪ autologous bone marrow transplant and peripheral blood stem cell transplant procedures ▪ heart ▪ heart-lung ▪ kidney-pancreas transplant performed simultaneously (SPK) ▪ liver - deceased donor and living donor ▪ liver-kidney ▪ lung - single or double ▪ pancreas transplant - deceased donor and living donor segmental • Pancreas Transplant Alone (PTA) • Simultaneous Pancreas-Kidney (SPK) transplant • Pancreas After Kidney (PAK) transplant ▪ small-bowel and small-bowel/liver	You pay 10% coinsurance of the Transplant Payment Allowance after deductible for the transplant admission	**Blue Distinction Centers for Transplant (BDCT) Provider:** You pay 20% coinsurance of the Transplant Payment Allowance after deductible for the transplant admission **Non-Blue Distinction Centers for Transplant (BDCT) Provider:** You pay 40% coinsurance of the Transplant Payment Allowance after deductible for the transplant admission

NOTES:

- **BDCT Provider** means a hospital or other institution that has a contract with the Blue Cross and Blue Shield Association[1] to provide human organ, bone marrow, cord blood, and peripheral stem cell transplant procedures. These providers have been selected to participate in this nationwide transplant network based on their ability to meet defined clinical criteria that are unique for each type of transplant. Once selected for participation, institutions are re-evaluated annually to insure that they continue to meet the established criteria for participation in this network.
- For members diagnosed with End Stage Renal Disease (ESRD), your provider is required to complete the Centers for Medicare and Medicaid Services (CMS) form CMS-2728-U3 ESRD Medical Evidence Report Medicare Entitlement and/or Patient Registration. Your provider must send the completed form to CMS and the claims administrator. Please verify with your provider that form CMS-2728-U3 has been completed and submitted.
- Kidney transplants when not done in conjunction with an eligible major organ transplant noted above, and cornea transplants are eligible procedures that are covered on the same basis as any other illness. Please refer to "Hospital Inpatient Care," "Office Visit and Professional Services," etc.
- If a human organ, bone, tissue or blood stem cell transplant is provided from a living donor to a human transplant recipient:
  - when both the recipient and the donor are members, each is entitled to the benefits of their health care plan;
  - when only the recipient is a member, both the donor and the recipient are entitled to the benefits of this health care plan subject to the following additional limitations: 1) the donor benefits are limited to only those not provided or available to the donor from any other source, including, but not limited to, other insurance coverage, other Blue Cross or Blue Shield coverage or any government program; and 2) benefits provided to the donor will be charged against the recipient's coverage under this health care plan to the extent that benefits remain and are available under this health care plan after benefits for the recipient's own expenses have been paid;
  - when only the donor is a member, the donor is entitled to the benefits of this health care plan, subject to the following additional limitations: 1) the benefits are limited to only those not provided or available to the donor from any other source in accordance with the terms of this health care plan; and 2) no benefits will be provided to the non-member transplant recipient; and
  - if any organ, tissue or blood stem cell is sold rather than donated to the member recipient, no benefits will be payable for the purchase price of such organ, tissue or blood stem cell; however, other costs related to evaluation and procurement are covered up to the member recipient's health care plan limit.
- 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.
- Prior authorization is required for human organ, bone marrow, cord blood and peripheral stem cell transplant procedures, and should be submitted in writing to the Transplant Coordinator at P.O. Box 64179, St. Paul, Minnesota 55164, or faxed to 651-662-1624.
- Eligible transplant services provided by participating transplant providers will be paid at the Blue Distinction Centers for Transplant (BDCT) providers level of benefits when the transplant services are not available at a BDCT provider.

NOT COVERED:

- services, supplies, drugs, and aftercare for or related to artificial or nonhuman organ implants
- services, chemotherapy, radiation therapy (or any therapy that results in marked or complete suppression of blood producing organs), supplies, drugs and aftercare for or related to bone marrow and peripheral stem cell transplant procedures that are considered investigative or not medically necessary and appropriate
- living donor organ and/or tissue transplants, except as provided herein
- benefits for travel expenses when you are using a Non-BDCT provider

[1] An association of independent Blue Cross and Blue Shield Plans.

NOT COVERED:

- travel expenses for a kidney donor
- kidney donor expenses for complications incurred after the organ is removed if the donor is not covered under this plan
- kidney donor expenses when the recipient is not covered for the kidney transplant under this plan

GENERAL EXCLUSIONS

Except as specifically provided in this health care plan or as the plan is mandated to provide under 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. Court-ordered services or confinements by a court or law enforcement officer that are not based on a behavioral health care evaluation performed by a licensed psychiatrist or doctoral level licensed psychologist as provided under Minnesota law.
2. Custodial care, nonskilled care, adult daycare or personal care attendants.
3. Services rendered prior to your effective date of coverage.
4. Services which are experimental/investigative in nature, except for certain routine care for approved clinical trials.
5. Treatments, services or supplies which are not medically necessary and appropriate based on the definition of “Medically Necessary and Appropriate” in “Terms You Should Know.”
6. Any portion of a charge for a covered service or supply that exceeds the allowed amount, except as provided herein.
7. 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.
8. 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, toe nails (except surgery for ingrown toe nails), fallen arches, weak feet, chronic foot strain, and symptomatic complaints of the feet, except when such devices or services are related to the treatment of diabetes.
9. Services for or related to hearing aid devices and tinnitus maskers for adults age 19 and older.
10. 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.
11. 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.
12. 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 care plan and you elect this coverage as primary.
13. 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.
14. Charges for the covered patient’s failure to keep a scheduled visit.
15. Charges billed by your provider for the completion of a claim form.
16. Any other medical or dental service or treatment or prescription drug, except as provided herein.
17. 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.
18. Fees, dues, nutritional supplements, food, vitamins, and exercise therapy for or related to weight loss programs.

19. Services for or related to care that is custodial or not normally provided as preventive care or for treatment of an illness/injury.
20. Services which are not prescribed by or performed by or upon the direction of a professional provider.
21. Services rendered by other than ancillary providers, facility providers or professional providers.
22. 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.
23. 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.
24. Services rendered by a provider who is a member of your immediate family.
25. Services performed by a professional provider enrolled in an education or training program when such services are related to the education or training program.
26. 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.
27. Services for or related to tobacco cessation program fees and/or supplies, except as provided herein.
28. Services incurred after the date of termination of your coverage, except as provided herein.
29. Services for or related to weight reduction programs, including all diagnostic testing related to weight reduction programs, unless medically necessary and appropriate.
30. 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.
31. Services that are provided without charge, including services of the clergy.
32. Expenses incurred for services, supplies, medical care or treatment received at a health care provider that represents to a patient that he or she will not owe the required cost-sharing amount (including, for example, deductibles, copays, and coinsurance) described in this plan.
33. 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.
34. 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; etc., and all related material and products for these programs.
35. Services for dependents if you have employee-only coverage.
36. Services that are not within the scope of licensure or certification of a provider.
37. Services that are prohibited by law or regulation.
38. Services for furnishing medical records or reports and associated delivery services.
39. 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.
40. 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.
41. Services for or related to therapeutic massage.

42. 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.
43. Charges for donor ova or sperm, except as described in the Fertility Benefit Appendix.
44. 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.
45. Services and prescription drugs for or related to reproduction treatment including Assisted Reproductive Technology (ART), Artificial Insemination (AI), and IntraUterine Insemination (IUI) procedures, except as described in the Fertility Benefit Appendix.
46. 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.
47. Services provided during a telemedicine 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.
48. Services and fees for or related to health clubs and spas.
49. Services for or related to the repair of scars and blemishes on skin surfaces.
50. Services for hippotherapy (equine movement therapy).
51. Maintenance services.
52. Services that do not involve direct patient contact such as delivery services and recordkeeping billed by an out-of-network provider.
53. Services for educational classes or programs, except as required by law.
54. Services for or related to functional capacity evaluations for vocational purposes or the determination of disability or pension benefits.
55. Services for or related to gene therapy (for those considered experimental) as a treatment for inherited or acquired disorders.
56. 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 for cancer and/or allergy testing and/or treatment; services for or related to homeopathy, or chelation therapy that is not medically necessary and appropriate.
57. Charges for growth hormone replacement therapy, except for services that meet medical necessity and appropriateness criteria.
58. Services for or related to fetal tissue transplantation.
59. Charges for services: (a) for which a charge would not have been made in the absence of insurance or medical plan coverage; or, (b) which the covered person in not legally obligated to pay; and, (c) from providers who waive copayment, deductible, and coinsurance payments by the covered person.
60. Services that are rendered to a covered person, who also has other primary insurance coverage for those services and who does not provide the plan the necessary information to pursue coordination of benefits as required under the plan.
61. Services needed because you engaged in an illegal occupation, or committed or attempted to commit a felony, unless the services are related to an act of domestic violence or the illegal occupation or felonious act is related to a physical or mental health condition.
62. Services for or related to root canal therapy.

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. 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.

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. 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 policy. 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 www.bluecrossmnonline.com or contact customer service at the telephone number listed on the back of your member ID card. They will direct your call.

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 working 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 working 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 (e.g., long-term acute care, acute rehabilitation, skilled nursing facility, residential treatment or half-way house). 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. They will direct your call.

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 working 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.

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 working 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 working 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.

Your health care 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 three (3) levels of health care services: **Allina First Network, Extended Network** or **out-of-network.**

Network Care

Network care is care you receive from providers in the health care plan's Allina First Network or Extended Network.

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

When you receive health care within the Extended Network, in most cases you receive a reduced level of coverage than if you used Allina First Network providers. 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 First Network or Extended Network.

Even when you go outside the network, you will still be covered for eligible services. However, your 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 providers compared to the cost of receiving care from Allina First Network or Extended Network providers. If you receive 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.

Out-of-Area Care

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

Services received from providers across the country who are part of the local Blue Cross and Blue Shield PPO network will be covered at the Extended Network level of benefits. If you receive covered services from a provider who is not part of the local Blue Cross and Blue Shield PPO network, these services will be covered at the lower, out-of-network level of benefits.

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 First 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 an emergency, you are required to use providers in the local Blue Cross and Blue Shield PPO network in order to be covered at the Extended Network level. If you receive care from an out-of-network provider, benefits for eligible services will be provided at the lower, out-of-network level of benefits.

General Provider Payment Methods

Participating Providers

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 care 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 care plan. Please refer to "How Your Plan Works" for additional detail on covered services received in the in-network and out-of-network.

- Non-Institutional or Professional (i.e., doctor visits, office visits) Participating Provider Payments
  - **Fee-for-Service -** Providers are paid for each service or bundle of services. Payment is based on the amount of the provider's billed charges.
  - **Discounted Fee-for-Service -** Providers are paid a portion of their billed charges for each service or bundle of services. Payment may be a percentage of the billed charge or it may be based on a fee schedule that is developed using a methodology similar to that used by the federal government to pay providers for Medicare services.
  - **Discounted Fee-for-Service, Withhold and Bonus Payments -** Providers are paid a portion of their billed charges for each service or bundle of services, and a portion (generally 5-20%) of the provider's payment 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 provider's care. In order to determine cost-effectiveness, a per person per month target is established. The target is established by using historical payment information to predict average costs. If the provider's costs are below this target, providers are eligible for a return of all or a portion of the withhold amount and may also qualify for an additional bonus payment.

  In addition, as an incentive to promote high quality care and as a way to recognize those providers that participate in certain quality improvement projects, providers may be paid a bonus based on the quality of the provider's care to its members. In order to determine quality of care, certain factors are measured, such as member/patient satisfaction feedback on the provider, compliance with clinical guidelines for preventive services or specific disease management processes, immunization administration and tracking, and tobacco cessation counseling.

  Payment for high cost cases and selected preventive and other services may be excluded from the discounted fee-for-service and withhold payment. When payment for these services is excluded, the provider is paid on a discounted fee-for-service basis, but no portion of the provider's payment is withheld.
- Institutional (i.e., Hospital and other Facility provider) Participating Provider Payments
  - Inpatient care
    - **Payments for each Case (case rate) -** Providers are paid a fixed amount based upon the member's diagnosis at the time of admission, regardless of the number of days that the member is hospitalized. This payment amount may be adjusted if the length of stay is unusually long or short in comparison to the average stay for that diagnosis ("outlier payment"). This method is similar to the payment methodology used by the federal government to pay providers for Medicare services.
    - **Payments for each Day (per diem) -** Providers are paid a fixed amount for each day the member spends in the hospital or facility provider.
    - **Percentage of Billed Charges** - Providers are paid a percentage of the hospital's or facility provider's billed charges for inpatient or outpatient services, including home services.
  - Outpatient care
    - **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 in an outpatient or home setting during one (1) visit.
- **Payments for each Patient** - Providers are paid a fixed amount per person per calendar year for certain categories of outpatient services.

Special Incentive Payments

As an incentive to promote high quality, cost-effective care and as a way to recognize that those providers participate in certain quality improvement projects, providers may be paid extra amounts following the initial adjudication of a claim based on the quality of the provider's care to their members and further based on claims savings that the provider may generate in the course of rendering cost-effective care to its member. Certain providers also may be paid in advance of a claim adjudication in recognition of their efficiency in managing the total cost of providing high quality care to members and for implementing quality improvement programs. In order to determine quality of care, certain factors are measured to determine a provider's compliance with recognized quality criteria and quality improvement. Areas of focus for quality may include, but are not limited to: services for diabetes care; tobacco cessation; colorectal cancer screening; and breast cancer screening, among others. Cost of care is measured using quantifiable criteria to demonstrate that a provider is meeting specific targets to manage claims costs. These quality and cost of care payments to providers are determined on a quarterly or annual basis and will not directly be reflected in a claims payment for services rendered to an individual member. Payments to providers for meeting quality improvement and cost of care goals and for recognizing efficiency are considered claims payment.

Pharmacy Payment

Four (4) kinds of pricing are compared and the lowest amount of the four (4) is paid:

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

Nonparticipating Providers

Nonparticipating providers are not network providers. Payment for covered services provided by a nonparticipating provider will be at the out-of-network level. Please refer to "How Your Plan Works" for additional detail on covered services received in the in-network and out-of-network.

When you use a nonparticipating provider, benefits are substantially reduced and you will likely incur significantly higher out-of-pocket expenses. A nonparticipating provider does not have any agreement with Blue Cross or another Blue Cross and/or Blue Shield plan. For services received from a nonparticipating provider (other than those described under "Special Circumstances" below), the allowed amount will be based upon one of the following payment options to be determined at the claims administrators' discretion: (1) 140% of the Medicare Allowed Charge for the same or similar service; (2) 140% of the Medicare Advantage Allowed Charge for the same or similar service; (3) a percentage of billed charges; (4) pricing determined by another Blue Cross or Blue Shield plan; or, (5) pricing based on: provider reimbursement databases, median costs from a benchmark of claims, or fee negotiations. The payment option selected by the claims administrator may result in an allowed amount that is a lower amount than calculated by another payment option. When the Medicare Allowed Charge or Medicare Advantage 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 a nonparticipating provider is usually less than the allowed amount for a participating provider for the same service and can be significantly less than the nonparticipating provider's billed charges. You will be paid the benefit under the health care plan and you are responsible for paying the nonparticipating provider. The only exception to this is stated in "Claims Procedures," "Claims Payment." The amount you pay does not apply toward any out-of-pocket limit contained in the plan.

In determining the allowed amount for nonparticipating providers, the claims administrator makes no representations that the allowed amount is a usual, customary or reasonable charge from a provider. Please refer to "Allowed Amount" under "Terms You Should Know" for a more complete description of how payments will be calculated for services provided by nonparticipating providers.

Example

The following table 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 care plan covers 80% for participating providers and 60% for nonparticipating providers. It also presumes that the allowed amount for a nonparticipating provider will be less than for a participating provider. The difference in the allowed amount between a Participating and nonparticipating provider could be more or less than the 20% difference in the example below.

	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

There may be circumstances where you require medical or surgical care and you do not have the opportunity to select the provider of care. For example, some hospital-based providers (e.g., anesthesiologists) or independent laboratory providers may not be participating providers. Typically, when you receive care from nonparticipating providers, you are responsible for the difference between the allowed amount and the provider's billed charges. However, in circumstances where you needed care such as in a participating hospital and were not able to choose the provider who rendered such care (nonparticipating providers in a participating hospital or your physician sending laboratory samples to a nonparticipating lab), the plan may pay an additional amount, unless you gave advance written consent to the nonparticipating provider. 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 nonparticipating provider's services, you should submit the bill to the claims administrator for processing. If you have questions, please contact customer service at the telephone number listed on the back of your member ID card. The extent of reimbursement in certain medical emergency circumstances may also be subject to federal law – please refer to "Emergency Care" for coverage of benefits.

The above is a general summary of our provider payment methodologies only. Further, while efforts are made to keep this form as up-to-date as possible, provider payment methodologies may change from time to time and every current provider payment methodology may not be reflected in this summary.

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. prosthesis 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 sex, to a transgender individual based on the fact that the individual's sex 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 medical policy and/or federal law.

Inter-Plan Arrangements

Out-of-Area Services

Overview

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 of these inter-plan arrangements. The inter-plan arrangements are described below.

When you receive care outside of the claims administrator's service area, you will receive it from one 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 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 admission notification 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 www.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 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 Extended Network level of coverage.

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 First Network providers are all Allina Health and affiliated providers and facilities. Your Extended Network includes: thousands of physicians; a wide range of specialists; a wide variety of mental health and substance use disorder providers; community and specialty hospitals; and laboratories in the Aware network and BlueCard PPO network, not including the Allina First Network.

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 care 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 to enjoy 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.myblueprintmn.com ("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.myblueprintmn.com, 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 care 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 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
7. continuation through the postpartum period (six (6) weeks post-delivery) for a pregnancy beyond the first trimester.

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 care plan, does not extend benefits beyond any existing limits, dollar maximums, or coverage termination dates, and does not extend benefits from one 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.

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 care 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 care 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 First and Blue Cross Extended 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. You are required to pay the following amounts:

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.

Tolled Plan Deadlines relating to COVID-19 Pandemic

In response to the proclamation declaring that the coronavirus disease (COVID-19) constitutes a National Emergency, federal agencies issued rules extending various deadlines. Under the guidance, during the COVID-19 Outbreak Period, which began on March 1, 2020, and will end the earlier of 60 days after the National Emergency officially ends or one year from the date of the event or such other date as the federal agencies later provide, the Outbreak Period is disregarded when calculating (i) the deadline of the Plan Administrator or its delegate to notify you of the right to elect COBRA after a COBRA qualifying event; and (ii) your deadline associated with the following:

- Requesting HIPAA special enrollment under this plan
- Electing COBRA
- Making COBRA premium payments
- Notifying the Plan Administrator of a COBRA qualifying event
- Notifying the Plan Administrator of the Social Security Administration's determination of disability
- Filing an ERISA claim for benefits
- Filing an appeal of an ERISA adverse benefit determination
- Filing a request for external review under this plan
- Perfecting a request for external review upon a finding that the request was not complete under this plan

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 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.

Termination of Your Coverage

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

Continuation of 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.

COORDINATION OF BENEFITS

This section applies when you have health care coverage under more than one (1) plan, as defined below. If this section applies, you should look at the Order of Benefits Rules first to determine which plan determines benefits first. Your benefits under this plan are not reduced if the Order of Benefits Rules require this plan to pay first. Your benefits under this plan may be reduced if another plan pays first.

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

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;
   c. individual coverage; or,
   d. the medical payment ("medpay") or personal injury protection benefit available to you under an automobile insurance policy.

   "Plan" does not include:

   a. 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);
   b. any benefits that, by law, are excess to any private or other nongovernmental program;
   c. 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" is determined by the Order of Benefits Rules.

   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.

   a. NOTES: If you are covered under this plan and Medicare: this plan will comply with the Medicare Secondary Payor ("MSP") provisions of federal law, rather than the Order of Benefits Rules in this section, to determine which plan is a primary plan and which is a Secondary plan. Medicare will be primary and this plan will be secondary only to the extent permitted by MSP rules. When Medicare is the primary plan, this plan will coordinate benefits up to Medicare's allowed amount.
   b. If you are covered under this plan and TRICARE: this plan will comply with the TRICARE provisions of federal law, rather than the Order of Benefits Rules in this section, to determine which plan is a primary plan and which is a secondary plan. TRICARE will be primary and this plan will be secondary only to the extent permitted by TRICARE rules. When TRICARE is the primary plan, this plan will coordinate benefits up to TRICARE'S allowed amount.

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 (see number 3 above).

   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

1. General: When a claim is filed under this plan and another plan, this plan is a Secondary plan and determines benefits after the other plan, unless:
   a. the other plan has rules coordinating its benefits with this plan's benefits; and
   b. the other plan's rules and this plan's rules, in part 2. below, require this plan to determine benefits before the other plan.

2. Rules: This plan determines benefits using the first of the following rules that applies:
   a. The plan that covers a person as automobile insurance medical payment ("medpay") or personal injury protection coverage determines benefits before a plan that covers a person as a group health plan enrollee.
   b. Non-dependent/dependent: The plan that covers the person as an employee, member, or subscriber (that is, other than as a dependent) determines its benefits before the plan that covers the person as a dependent.
   c. Dependent child of parents not separated or divorced: When this plan and another plan cover the same child as a dependent of different persons, called "parents":
      1) the plan that covers the parent whose birthday falls earlier in the year determines benefits before the plan that covers the parent whose birthday falls later in the year; but,
      2) if both parents have the same birthday, the plan that has covered the parent longer determines benefits before the plan that has covered the other parent for a shorter period of time.

      However, if the other plan does not have this rule for children of married parents, and instead the other plan has a rule based on the gender of the parent, and if as a result the plans do not agree on the order of benefits, the rule in the other plan determines the order of benefits.
   d. Dependent child of parents divorced or separated: If two (2) or more plans cover a dependent child of divorced or separated parents, this plan determines benefits in this order:
      1) first, the plan of the parent with physical custody of the child;
      2) then, the plan that covers the spouse of the parent with physical custody of the child;
      3) finally, the plan that covers the parent not having physical custody of the child; or,
      4) in the case of joint physical custody, c. above applies.

      However, if the court decree requires one (1) of the parents to be responsible for the health care expenses of the child, and the plan that covers that parent has actual knowledge of that requirement, that plan determines benefits first. This does not apply to any claim determination period or plan year during which any benefits are actually paid or provided before the plan has that actual knowledge.
   e. Active/inactive employee: The plan that covers a person as an employee who is neither laid-off nor retired (or as that employee's dependent) determines benefits before a plan that covers that person as a laid-off or retired employee (or as that employee's dependent). If the other plan does not have this rule, and if as a result the plans do not agree on the order of benefits, then this rule is ignored.
   f. Longer/shorter length of coverage: If none of the above determines the order of benefits, the plan that has covered an employee, member, or subscriber longer determines benefits before the plan that has covered that person for a shorter time.

Effect on Benefits of This Health Care Plan

When this section applies:

1. When the Order of Benefits Rules require this health care plan to be a secondary plan, this part applies. Benefits of this health care 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 care 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 care 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 care plan are reduced each benefit is reduced in proportion and charged against any applicable benefit limit of this health care 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

A payment made under another plan may include an amount that should have been paid under this plan. If this happens, 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. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means reasonable cash value of the benefits provided in the form of services.

Right of Recovery

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; and
3. other organizations.

The 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.myblueprintmn.com.

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.

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 his or her 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 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.

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, 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 his or her behalf 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 his or her right to legally challenge any decision, action, or inaction of the claims administrator or plan administrator.

Claims Payment

When a claimant uses 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 his or her 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.

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.

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 provider to another for the same service. All benefits are based on the allowed amount, except as provided in "Benefit Overview." For in-network 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, 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 plan will pay the stated percentage of the allowed amount for a covered service. In most cases, the plan 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 under special circumstances below, the allowed amount will be based upon one 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; or, (3) pricing based upon a nationwide provider reimbursement database. 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 under special

circumstances below, the allowed amount will be based upon one 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; or, (4) fee negotiations. 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.

Special circumstances

There may be circumstances where you require immediate medical or surgical care and you do not have the opportunity to select the provider of care, such as in the event of a medical emergency. Some hospital-based providers (e.g., anesthesiologists) may not be participating providers. Typically, when you receive care from nonparticipating providers, you are responsible for the difference between the allowed amount and the provider's billed charges. However, in circumstances where you needed care, and were not able to choose the provider who rendered such care, the plan may pay an additional amount. The extent of reimbursement in these circumstances may also be subject to federal law. 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.

If you have questions about the benefits available for services to be provided by a nonparticipating provider, you will need to speak with your provider and you may contact customer service at the telephone number listed on the back of your member ID card for more information.

Artificial Insemination (AI) - The introduction of semen from a donor (which may have been a preserved specimen), into a woman's vagina, cervical canal, or uterus by means other than sexual intercourse.

Assisted Fertilization - Any method used to enhance the possibility of conception through retrieval or manipulation of the sperm or ovum. This includes, but is not limited to, artificial insemination, In Vitro Fertilization (IVF), Gamete Intra-Fallopian Transfer (GIFT), Zygote Intra-Fallopian Transfer (ZIFT), Tubal Embryo Transfer (TET), Peritoneal Ovum Sperm Transfer, Zona Drilling, and sperm microinjection.

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, 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.

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.

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.

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.

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 participating provider's billed charge. Because payment amounts are negotiated with in-network providers to achieve overall lower costs, the allowed amount for participating providers is generally, but not always, 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.

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 care 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.

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

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 care 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.

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 infusion therapy provider, freestanding ambulatory surgical center, a home health care 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. A custom-fitted orthosis is 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.

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 Care Agency - A Medicare-approved or other 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 suffering from 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 organization outside of Minnesota that has contractual relationships with in-network providers in its designated service area that require such in-network providers to provide services to members of other Blue Cross and/or Blue Shield organizations.

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 a male and female partner for a period of at least 12 months. The inability to conceive may be due to either the male or female partner.

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

- When you receive services within the health care 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 - An ancillary provider, professional provider or facility provider who has entered into an agreement, either directly or indirectly, the claims administrator or with any licensee of the Blue Cross and Blue Shield Association located out-of-area, pertaining to payment as a participant in a network for covered services rendered to a member.

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.

Lifetime Maximum - The cumulative maximum payable for covered services incurred by a member during their lifetime or by each covered dependent during their lifetime under all health care 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, unless they are medically necessary and appropriate and part of specialized therapy for the member's condition.

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

Marital/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 an in-network contract with the claims administrator or the local Blue Cross and/or Blue Shield plan.

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 doctor of medicine (M.D.) or osteopathy (D.O.) for mental health disorders, alcoholism, substance use disorder, or addiction. An outpatient behavioral health treatment facility does not, other than incidentally, provide educational or recreational services as part of its treatment program.

Outpatient Care - Health services a patient receives without being admitted to a facility as an inpatient. Care received at ambulatory surgery centers is considered outpatient care.

Palliative Care - Any eligible treatment or service 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 may include medical, spiritual, or psychological interventions focused on improving quality of life by reducing or eliminating physical symptoms, enabling a patient to address psychological and spiritual problems, 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.

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 - Industry standard claim submission standards (established by the Medicare program) used by clinic and hospital providers.

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

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 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 inpatient treatment by, or under the direction of, a doctor of medicine (M.D.) or osteopathy (D.O.) for mental health disorders, alcoholism, substance use disorder, or substance addiction. 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. A residential behavioral health treatment facility does not, other than incidentally, provide educational or recreational services as part of its treatment program.

Respite Care - Short-term inpatient or home care provided to the member 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 that 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 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.

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

Skilled Care - Services rendered other than in a skilled nursing facility that are medically necessary and appropriate and provided by a licensed nurse or other licensed health care professional. A service shall not be considered skilled care merely because it is performed by, or under the direct supervision of, a licensed nurse. 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 nurse, shall not be regarded as skilled care, whether or not a licensed nurse 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 nurse provides the service. Only the skilled care component(s) of combined services that include non-skilled care are covered under the plan.

Skilled Nursing Care - Extended Hours - Extended hours home care (skilled nursing services) are continuous and complex skilled nursing services greater than two (2) consecutive hours per date of service in the member's home. skilled nursing care - 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.

Skilled Nursing Care - Intermittent Hours - Intermittent skilled nursing services consist 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.

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.), after a hospital/facility stay. 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 his or her illness, treatment, and the requirements of everyday independent living.

Specialist/Specialty Physician - A physician who limits his or her 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 drugs are drugs including, but not limited to drugs used for: growth hormone treatment; multiple sclerosis; rheumatoid arthritis; hepatitis C; and hemophilia.

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, medications in specific categories or drug classes. If your physician prescribes one of these medications, there must be documented evidence that you have tried another eligible medication that is safe, more clinically effective, and in some cases more cost-effective before the 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.

Supply - Equipment that must be medically necessary and appropriate for the medical treatment or diagnosis of an illness or injury or to improve functioning of a malformed body part. Supplies are not reusable, and usually last for less than one (1) year.

Supplies do not include such things as:
1. alcohol swabs;
2. cotton balls;
3. incontinence liners/pads;
4. Q-tips;
5. adhesives; and
6. informational materials.

Surrogate Pregnancy - An arrangement whereby a woman who is not covered under this plan becomes pregnant for the purpose of gestating and giving birth to a child for others to raise.

Telemedicine Services - Telemedicine services may also be referred to as televideo consultations or telehealth services. These services provide real-time interaction between a distant site physician/medical practitioner and the member both of whom are not in the same location but are actively communicating through interactive audio and video channels.

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

Totally Disabled (or Total Disability) - A condition resulting from illness or injury as a result of which, and as certified by a physician, for an initial period of 24 months, you are continuously unable to perform all of the substantial and material duties of your regular occupation. However: (i) after 24 months of continuous disability, "totally disabled" (or total disability) means your inability to perform all of the substantial and material duties of any occupation for which you are reasonably suited by education, training or experience; (ii) during the entire period of total disability, you may not be engaged in any activity whatsoever for wage or profit and must be under the regular care and attendance of a physician, other than your Immediate Family. If you do not usually engage in any occupation for wages or profits, "totally disabled" (or total disability) means you are substantially unable to engage in the normal activities of an individual of the same age and sex.

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 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 First Network (Allina Health Pharmacy)
- National Network (Express Scripts Network Pharmacies), which does not include Walgreens.

Benefit Features	Your Liability
Deductible	
The deductibles under the Allina First Network, National Network and Out-of-Network are combined.	
• Allina First Network	$1,400 per person per calendar year $2,800 per family per calendar year
• National Network	$1,400 per person per calendar year $2,800 per family per calendar year
• Out-of-Network	$3,000 per person per calendar year $6,000 per family per calendar year
Benefit Features	**Limitations and Maximums**
Out-of-Pocket Maximums	
The out-of-pocket limits under the Allina First Network, National Network and Out-of-Network are combined.	
• Allina First Network	$5,000 per person per calendar year $10,000 per family per calendar year
• National Network	$5,000 per person per calendar year $10,000 per family per calendar year
• Out-of-Network	$12,000 per person per calendar year

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.

The Plan Covers:	Allina First Network	National Network	Out-of-Network Providers
• Retail (up to 31-day supply)			
▪ Generic	$5 copay after you pay the deductible.	$10 copay after you pay the deductible.	60% after you pay the deductible.
▪ Preferred-brand name	75% after you pay the deductible.	60% after you pay the deductible.	60% after you pay the deductible.
▪ Non-Preferred	50% after you pay the deductible.	40% after you pay the deductible.	40% after you pay the deductible.
• Mail order (up to 93-day supply)			
▪ Generic	$5 copay after you pay the deductible.	**NO COVERAGE.**	**NO COVERAGE.**
▪ Preferred-brand name	75% after you pay the deductible.		
▪ Non-Preferred	50% after you pay the deductible.		
• Insulin	85% after you pay the deductible.	85% after you pay the deductible.	60% after you pay the deductible.
• Insulin Pump	100%	80% after you pay the deductible.	60% after you pay the deductible.
• Insulin Pump Supplies and Equipment	100%	80% after you pay the deductible.	60% after you pay the deductible.
• Diabetic Supplies and Equipment	100%	80% after you pay the deductible.	60% after you pay the deductible.
• Ostomy Supplies	100%	80% after you pay the deductible.	60% after you pay the deductible.
• Drugs for Treatment of sexual dysfunction (Non-Essential Benefit)			
▪ Generic	85% after you pay the deductible.	85% after you pay the deductible.	60% after you pay the deductible.
▪ Preferred-brand name	75% after you pay the deductible.	75% after you pay the deductible.	60% after you pay the deductible.
▪ Non-Preferred	50% after you pay the deductible.	50% after you pay the deductible.	40% after you pay the deductible.
• 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	80% after you pay the deductible. 75% after you pay the deductible. See Allina First 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.
- 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 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.

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.

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 Ritchie Pharmacy.

The first time you use the mail order pharmacy benefit, you must call the Allina Health Ritchie 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 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 current a 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, 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	Express Scripts
ATTN: Clinical Appeals Department	ATTN: Administrative Appeals Department
P.O. Box 66588	P.O. Box 66587
St. Louis, MO 63166-6588	St. Louis, MO 63166-6588
Fax: 1-877-852-4070	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, 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 | 2021 PLAN YEAR

progyny
Smarter Fertility Benefits

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Appendix

INTRODUCTION TO YOUR BENEFIT

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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 01/01/2021
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

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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

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UNDERSTANDING YOUR SMART CYCLE BENEFIT

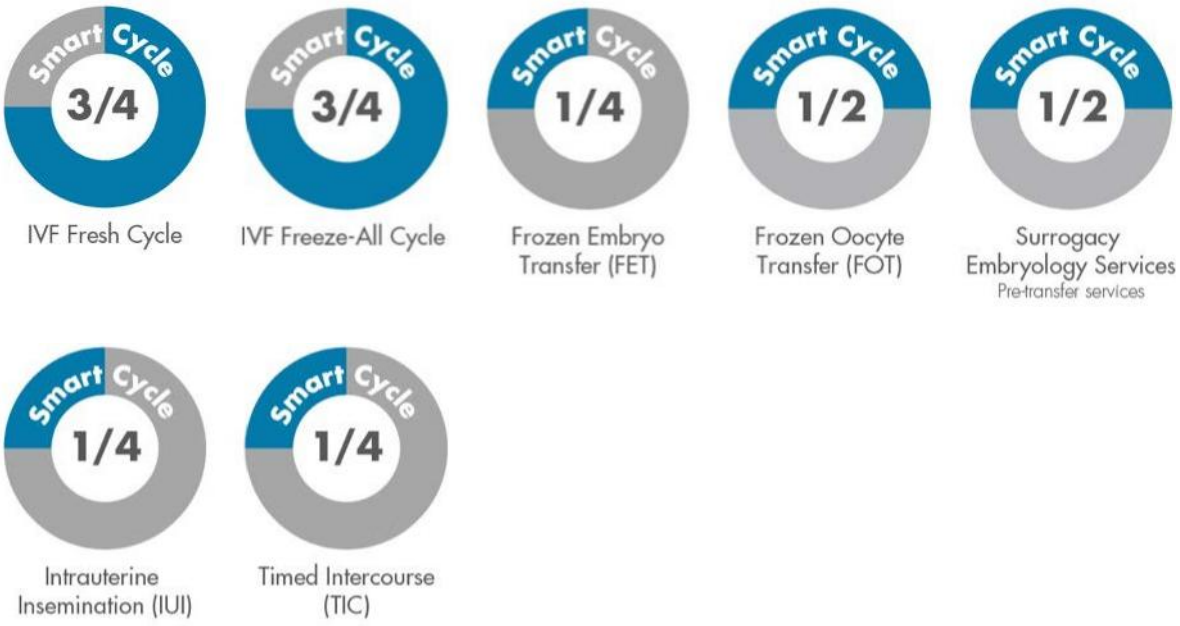
It all starts with the Progyny Smart Cycle. To make your fertility benefit easier to use, we've bundled all of the individual services, tests, and treatments into the Progyny Smart Cycle. Some treatment types will use only a portion of a Smart Cycle, while other more comprehensive treatments will require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



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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:

1

Katherine chooses an in-network reproductive endocrinologist with the help of her Patient Care Advocate (PCA) and does an **initial consultation.** This does not affect her Smart Cycle balance.

2

She undergoes an **IVF Fresh** cycle. One fertilized embryo is transferred to her uterus and the rest are frozen for later use.

Katherine has used ¾ of a Smart Cycle

IVF Fresh Cycle

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.

1

After speaking with their PCA, Jessica and Letitia do an **initial consultation.**

2

Jessica and Letitia have used 1 Smart Cycle

3

Jessica undergoes an **IVF Freeze-All** cycle. Her ovaries are stimulated, and her eggs are retrieved to be fertilized with donor sperm.

The embryos undergo preimplantation genetic testing and are frozen,

IVF Freeze-All Cycle

One frozen embryo is placed into Letitia's uterus using a **frozen embryo transfer.**

Frozen Embryo Transfer (FET)

Progyny Member Guide
Prepared for Allina Health

Surrogacy

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

1

They speak to their PCA who advises them on their state's surrogacy regulations and helps them choose an egg donor.

2

Robert and Mike use **pre-transfer embryology services** with Mike's sperm to create embryos. They elect to pursue genetic testing to identify the healthiest embyro for transfer.

3

Their PCA helps match them to a surrogacy agency where they meet Amy, their gestational carrier. The embryo is transferred to Amy.

Robert and Mike have used ½ of a Smart Cycle

Surrogacy
Embryology Services
Pre-transfer services

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)

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

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:

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- 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

*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)

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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.

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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.

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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 be 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