BENEFIT PLAN

Prepared Exclusively For

Allina Health

Allina Elevate Open Access Aetna Select

What Your Plan Covers and How Benefits are Paid

Allina Health and Aetna Health Insurance Company

Booklet-Certificate

Open Access EPO Plus Medical Plan

Booklet

Prepared exclusively for:

Employer: Allina Health
Contract number: 109029
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Third Party Administrative Services provided by Allina Health and Aetna Insurance Company (Allina Health | Aetna)

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Welcome

Thank you for choosing **Allina Health | Aetna.**

This booklet contains a summary of the Allina Health Elevate Open Access Aetna Select Health Plan (called the or "plan" in this document) effective January 1, 2024. The plan is a component of the Allina Health Comprehensive Welfare Benefit Plan.

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

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

This plan, financed and administered by Allina Health, is a self-insured medical plan. Allina Health | Aetna is the medical Claims Administrator and provides medical administrative services only. Express Scripts, Inc. is the pharmacy Claims Administrator and provides outpatient 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 Program Option are contained in a separate booklet entitled "Allina Health Eligibility & Enrollment Booklet." To fully understand our benefits, you must carefully review this booklet together with the Allina Health Eligibility & Enrollment Booklet.

This booklet will tell you about your covered benefits – what they are and how you get them. It takes the place of all booklets describing similar coverage that were previously sent to you. The schedule of benefits at Exhibit A tells you how we share expenses for eligible health services and tells you about limits – like when your plan covers only a certain number of visits.

These documents may have amendments attached to them. They change or add to the documents, they amend.

Where to next? Flip through the table of contents or try the Let's get started! section right after it. The Let's get started! section gives you a thumbnail sketch of how your plan works. The more you understand, the more you can get out of your plan.

Welcome to your Employer's self-funded health benefit plan for in-network and out-of-network coverage.

Let's Get Started!

Here are some basics. First things first – some notes on how we use words. Then we explain how your plan works so you can get the most out of your coverage. But for all the details – and this is very important – you need to read this entire booklet and the schedule of benefits. And if you need help or more information, we tell you how to reach us.

Some notes on how we use words

- When we say "you" and "your", we mean both you and any covered dependents.
- When we say "us", "we", and "our", we mean **Allina Health | Aetna** when we are describing administrative services provided by **Allina Health | Aetna** as Third Party Administrator.
- Some words appear in **bold** type. We define them in the Glossary section.

Sometimes we use technical medical language that is familiar to medical providers.

What your plan does – covered benefits

Your plan provides **covered benefits**. These are **eligible health services** for which your plan has the obligation to pay.

This plan provides in-network coverage for medical, vision and pharmacy benefits.

What your plan doesn't do – exclusions

Your plan does not pay for benefits that are not covered under the terms of the plan. These are Exclusions and are described more in greater detail later in the document.

Many health care services and supplies are eligible for coverage under your plan in the Eligible health services under your plan section. However, some of those health care services and supplies have exclusions. For example, **physician care** is an eligible health service, but **physician care** for cosmetic surgery is never covered. This is an example of an exclusion.

The What your plan doesn't cover - some eligible health service exclusions section of this document also provides additional information.

The Plan does not cover any payments that are prohibited by the Federal Office of Foreign Asset Control.

How your plan works – starting and stopping coverage

Your coverage under the plan has a start and an end. You start coverage after you complete the eligibility and enrollment process. To learn more see the Who the plan covers section.

Your coverage typically ends when you leave your job. Family members can lose coverage for many reasons, such as growing up. To learn more see the When coverage ends section.

Ending coverage under the plan doesn't necessarily mean you lose coverage with us. See the Special coverage options after your plan coverage ends section.

How your plan works while you are covered in-network

Your in-network coverage:

- Helps you get and pay for a lot of – but not all – health care services. These are called **eligible health services**.
- Generally will pay only when you get care from providers in our network of doctors, **hospitals**, and other **providers**.
- You will pay less cost share when you use a **network provider**.

1. **Eligible health services**

   Doctor and **hospital** services are the foundation for many other services. You'll probably find the preventive care, **emergency services** and **urgent condition** coverage especially important. But the plan won't always cover the services you want. Sometimes it doesn't cover health care services your doctor will want you to have.

   So what are **eligible health services**? They are health care services that meet these three requirements:

- They are listed in the Eligible health services under your plan section.
- They are not carved out in the What your plan doesn't cover – some eligible health service exclusions section. (We refer to this section as the "exclusions" section.)
- They are not beyond any limits in the schedule of benefits.

2. **Providers**

   Allina Health | Aetna's network of doctors, hospitals and other health care **providers** are there to give you the care you need. You can find **network providers** and see important information about them most easily on our online **provider directory**. Just log into your Plan Benefits member website at www.allinahealthaetna.com. The **provider directory** is furnished automatically, without charge, upon request.

   You may choose a **primary care physician** (we call that doctor your **PCP**) to oversee your care. Your **PCP** will provide your routine care, and send you to other providers when you need specialized care. You don't have to access care through your **PCP**. You may go directly to network **specialists** and **providers** for **eligible health services**. Your plan often will pay a bigger share for **eligible health services** that you get through your **PCP**, so choose a **PCP** as soon as you can.

   For more information about the network and the role of your **PCP**, see the Who provides the care section.

3. **Service area**

   Your plan generally pays for **eligible health services** only within a specific geographic area, called a service area. There are some exceptions, such as for **emergency services** and urgent care. See the Who provides the care section.

4. **Paying for eligible health services– the general requirements**

   There are several general requirements for the plan to pay any part of the expense for an **eligible health service**. They are:

- The eligible health service is medically necessary, and
- You get your care from:
  - Your **PCP**, or
  - Another **network provider** after you get a **referral** from your **PCP**, and
- You or your provider precertifies the eligible health service when required.

  You will find details on medical necessity, referral and precertification requirements in the Medical necessity, referral and precertification requirements section. You will find the requirement to use a network provider and any exceptions in the Who provides the care section.

5. **Disagreements**

   We know that people sometimes see things differently.

   The plan tells you how we will work through our differences. And if we still disagree and your claim is eligible because it involves rescission of coverage, medical judgment, or whether the plan has complied with surprise billing and cost-sharing protections relating to (i) out-of-network emergency services; (ii) non-emergency services performed by out-of-network providers of participating facilities; or (iii) air ambulance services furnished by an out-of-network provider, an independent group of experts called an "external review organization" or ERO for short, will make the final decision for us.

   For more information see the Claim decisions and appeals procedures section.

How to contact us for help

We are here to answer your questions. Your plan of benefits includes the **Allina Health | Aetna** Concierge program. The program provides immediate access to healthcare resource consultants who have been specifically trained in the details of your plan. To contact an **Allina Health | Aetna** Concierge for questions on your plan, wherever you see the term Member Services within this booklet-certificate or your schedule of benefits, this is your **Allina Health | Aetna** Concierge team.

Register for Plan Benefits Navigator® at www.allinahealthaetna.com, our secure internet access to reliable health information, tools and resources. **Allina Health | Aetna** online tools will make it easier for

you to make informed decisions about your health care, view claims, research care and treatment options, and access information on health and wellness.

You can contact us by:

- Calling your **Allina Health | Aetna** Concierge at the toll-free number on your ID card from 8:00 a.m. to 6:00 p.m. Monday through Friday or
- Logging onto Plan Benefits Navigator® www.allinahealthaetna.com.

Your member ID card

Your member ID card tells doctors, **hospitals**, and other **providers** that you are covered by this plan. Show your ID card each time you get health care from a **provider** to help them bill us correctly and help us better process their claims.

Remember, only you and your covered dependents can use your member ID card. If you misuse your card we may end your coverage or take any other action allowed by law.

We will mail you your ID card. If you haven't received it before you need **eligible health services**, or if you've lost it, you can print a temporary ID card. Just log into your Plan Benefits Navigator® secure member website at www.allinahealthaetna.com.

Who the plan covers?

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
- General provisions

Medical Necessity and Precertification Requirements

The starting point for **covered benefits** under your plan is whether the services and supplies are **eligible health services**. See the *Eligible health services under your plan and exclusions* sections plus the schedule of benefits.

Your plan pays for its share of the expense for **eligible health services** only if the general requirements are met. Those general requirements are:

- The eligible health service is medically necessary.
- You or your **provider precertifies** the **eligible health** service when required.

This section addresses the **medical necessity** and **precertification** requirements.

Medically necessary; medical necessity

As we said in the Let's get started! section, **medical necessity** is a requirement for you to receive a **covered benefit** under this plan.

The **medical necessity** requirements are stated in the Glossary section, where we define "**medically necessary, medical necessity**." That is where we also explain what our medical directors or their **physician** designees consider when determining if an **eligible health service is medically necessary**.

Our clinical policy bulletins explain our policy for specific services and supplies. We use these bulletins and other resources to help guide individualized coverage decisions under our plans. You can find the bulletins and other information at https://www.aetna.com/health-care-professionals/clinical-policy-bulletins.html.

Precertification

You need pre-approval from us for some **covered services**. Pre-approval is also called **precertification**.

In-network

Your network **physician** is responsible for obtaining any necessary **precertification** before you get the care. **Network providers** cannot bill you if they fail to ask us for **precertification**. But if your **physician** requests **precertification** and we deny it, and you still choose to get the care, you will have to pay for it yourself.

Timeframes for **precertification** are listed below. For **emergency services**, **precertification** is not required, but you should notify us as shown.

To obtain **precertification**, contact us. You, your **physician** or the facility must call us within these timelines:

Type of care	Timeframe
Non-emergency admission	Call at least 14 days before the date you are scheduled to be admitted
Emergency admission	Call within 48 hours or as soon as reasonably possible after you have been admitted
Urgent admission	Call before you are scheduled to be admitted
Outpatient non-emergency medical services	Call at least 14 days before the care is provided, or the treatment or procedure is scheduled

An urgent admission is a **hospital** admission by a **physician** due to the onset of or change in an illness, the diagnosis of an illness, or injury.

We will tell you and your **physician** of the **precertification** decision orally, but will provide such notice in writing when required by law. An approval is valid for 180 days as long as you remain enrolled in the plan.

For an inpatient stay in a facility, we will tell you, your **physician** and the facility about your **precertified** length of **stay**. If your **physician** recommends that you stay longer, the extra days will need to be **precertified**. You, your **physician**, or the facility will need to call us as soon as reasonably possible, but no later than the final authorized day. We will tell you and your physician in writing of an approval or denial of the extra days.

If you or your **provider** request **precertification** and we don't approve coverage, we will tell you why and explain how you or your **provider** may request review of our decision. See the *Complaints, claim decisions and appeal procedures* section.

Types of services that require precertification

Precertification is required for inpatient stays and certain outpatient services and supplies.

Precertification is required for the following types of services and supplies:

Inpatient services and supplies	Outpatient services and supplies
Gene-based, cellular and other innovative therapies (GCIT)	Applied behavior analysis
Gender affirming treatment	ART services
Obesity (bariatric) **surgery**	Complex imaging
Stays in a **hospice** facility	Comprehensive infertility services
Stays in a **hospital**	**Cosmetic** and reconstructive **surgery**
Stays in a **rehabilitation facility**	Gene-based, cellular and other innovative therapies (GCIT)

Stays in a **residential treatment facility** for treatment of **mental health** disorders and **substance related disorders**	Gender affirming treatment
Stays in a **skilled nursing facility**	Injectables, (immunoglobulins, growth hormones, multiple sclerosis medications, osteoporosis medications, Botox, hepatitis C medications)
	Kidney dialysis
	Knee **surgery**
	Outpatient back **surgery** not performed in a **physician's** office
	Partial hospitalization treatment – **mental health disorders** and **substance related disorders** treatment
	Sleep studies
	Transcranial magnetic stimulation (TMS)
	Wrist **surgery**

Contact us to get a complete list of the services that require **precertification**. The list may change from time to time.

Sometimes you or your **provider** may want us to review a service that doesn't require **precertification** before you get care. This is called a predetermination, and it is different from **precertification**. Predetermination means that you or your **provider** requests the pre-service clinical review of a service that does not require **precertification**.

Our clinical policy bulletins explain our policy for specific services and supplies. We use these bulletins and other resources to help guide individualized coverage decisions under our plans. You can find the bulletins and other information at https://www.aetna.com/health-care-professionals/clinical-policy-bulletins.html.

Eligible Health Services Under Your Plan

The information in this section is the first step to understanding your plan's **eligible health services**.

Your plan covers many kinds of health care services and supplies, such as **physician** care and **hospital stays**. But sometimes those services are not covered at all or are covered only up to a limit.

For example,

- **Physician** care generally is covered but **physician** care for cosmetic surgery is never covered. This is an exception (exclusion).
- Home health care is generally covered but it is a **covered benefit** only up to a set number of visits a year. This is a limitation.

You can find out about these exceptions in the exceptions section, and about the limitations in the schedule of benefits.

We've grouped the health care services below to make it easier for you to find what you're looking for.

Important note:

Sex-specific **eligible health services** are covered when medically appropriate, regardless of identified gender.

Preventive care and wellness

This section describes the **eligible health** services and supplies available under your plan when you are well.

Important notes:

1. You will see references to the following recommendations and guidelines in this section:

   - Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention
   - United States Preventive Services Task Force
   - Health Resources and Services Administration
   - American Academy of Pediatrics/Bright Futures/Health Resources and Services Administration guidelines for children and adolescents

   These recommendations and guidelines may be updated periodically. When these are updated, they will be applied to this plan. The updates will be effective on the first day of the Calendar Year, one year after the updated recommendation or guideline is issued.

2. Diagnostic testing will not be covered under the preventive care benefit. For those tests, you will pay the cost sharing specific to **eligible health services** for diagnostic testing.

3. Gender-specific preventive care benefits include **eligible health services** described below regardless of the sex you were assigned at birth, your gender identity, or your recorded gender.

4. To learn what frequency and age limits apply to routine physical exams and routine cancer screenings, contact your **physician** or contact Member Services by logging on to your Plan Benefits secure member website at www.allinahealthaetna.com or at the toll-free number on your ID card. This information can also be found at the http://www.HealthCare.gov website.

Routine physical exams

Eligible health services include office visits to your **physician, PCP** or other **health professional** for routine physical exams. This includes routine vision and hearing screenings given as part of the exam. A routine exam is a medical exam given by a **physician** for a reason other than to diagnose or treat a suspected or identified **illness** or **injury**, and also includes:

- Evidence-based items that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force
- Services as recommended in the American Academy of Pediatrics/Bright Futures/Health Resources and Services Administration guidelines for children and adolescents.
- Screenings and counseling services as provided for in the comprehensive guidelines recommended by the Health Resources and Services Administration. These services may include but are not limited to:
  - Screening and counseling services on topics such as:
    - Interpersonal and domestic violence

    - Sexually transmitted diseases
    - Human Immune Deficiency Virus (HIV) infections
    - Screening for gestational diabetes for women
    - High risk Human Papillomavirus (HPV) DNA testing for women 30 and older
- Radiological services, lab and other tests given in connection with the exam
- For covered newborns, an initial hospital checkup

Preventive care immunizations

Eligible health services include immunizations for infectious diseases recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.

Your plan does not cover immunizations that are not considered preventive care, such as those required due to your employment or travel.

Well woman preventive visits

Eligible health services include your routine:

- Well woman preventive exam office visit to your **physician, PCP**, obstetrician (OB), gynecologist (GYN) or OB/GYN. This includes pap smears. Your plan covers the exams recommended by the Health Resources and Services Administration. A routine well woman preventive exam is a medical exam given for a reason other than to diagnose or treat a suspected or identified **illness** or **injury**.
- Preventive care breast cancer (BRCA) gene blood testing by a **physician** and lab.
- Preventive breast cancer genetic counseling provided by a genetic counselor to interpret the test results and evaluate treatment.
- Screening for diabetes after pregnancy for women with a history of diabetes during pregnancy.
- Screening for urinary incontinence.

Preventive screening and counseling services

Eligible health services include screening and counseling by your **health professional** for some conditions. These are obesity, misuse of alcohol and/or drugs, use of tobacco products, sexually transmitted infection counseling and genetic risk counseling for breast and ovarian cancer. Your plan will cover the services you get in an individual or group setting. Here is more detail about those benefits.

- Obesity and/or healthy diet counseling

Eligible health services include the following screening and counseling services to aid in weight reduction due to obesity:

- Preventive counseling visits and/or risk factor reduction intervention
- Nutritional counseling
- Healthy diet counseling visits provided in connection with Hyperlipidemia (high cholesterol) and other known risk factors for cardiovascular and diet-related chronic disease

- **Misuse of alcohol and/or drugs**

  Eligible health services include the following screening and counseling services to help prevent or reduce the use of an alcohol agent or controlled substance:

  - Preventive counseling visits
  - Risk factor reduction intervention
  - A structured assessment

- **Use of tobacco products**

  Eligible health services include the following screening and counseling services to help you to stop the use of tobacco products:

  - Preventive counseling visits
  - Treatment visits
  - Class visits;
  - Tobacco cessation prescription and over-the-counter drugs
    - **Eligible health services** include FDA- approved **prescription drugs** and over-the-counter (OTC) drugs to help stop the use of tobacco products, when prescribed by a prescriber and the prescription is submitted to the pharmacist for processing.

  Tobacco product means a substance containing tobacco or nicotine such as:

  - Cigarettes
  - Cigars
  - Smoking tobacco
  - Snuff
  - Smokeless tobacco

  - Candy-like products that contain tobacco

- **Sexually transmitted infection counseling**

  Eligible health services include the counseling services to help you prevent or reduce sexually transmitted infections.

- **Genetic risk counseling for breast and ovarian cancer**

  Eligible health services include counseling and evaluation services to help you assess whether or not you are at increased risk for breast and ovarian cancer.

Routine cancer screenings

Eligible health services include the following routine cancer screenings:

- Mammograms
- Prostate specific antigen (PSA) tests
- Digital rectal exams
- Fecal occult blood tests
- Sigmoidoscopies
- Double contrast barium enemas (DCBE)
- Colonoscopies which includes removal of polyps performed during a screening procedure, and a pathology exam on any removed polyps
- Lung cancer screenings

These benefits will be subject to any age, family history and frequency guidelines that are:

- Evidence-based items or services that have in effect a rating of A or B in the recommendations of the United States Preventive Services Task Force
- Evidence-informed items or services provided in the comprehensive guidelines supported by the Health Resources and Services Administration

If you need a routine gynecological exam performed as part of a cancer screening, you may go directly to a network provider OB, GYN or OB/GYN.

Prenatal care

Eligible health services include your routine prenatal physical exams as preventive care, which is the initial and subsequent history and physical exam such as:

- Maternal weight
- Blood pressure
- Fetal heart rate check
- Fundal height

You can get this care at your **physician's, PCP's**, OB's, GYN's, or OB/GYN's office.

Important note:

You should review the benefit under *Eligible health services under your plan Maternity and related newborn care* and the *exceptions* sections of this booklet for more information on coverage for pregnancy expenses under this plan.

Comprehensive lactation support and counseling services

Eligible health services include comprehensive lactation support (assistance and training in breast feeding) and counseling services during pregnancy or at any time following delivery for breast feeding. Your plan will cover this when you get it in an individual or group setting. Your plan will cover this counseling only when you get it from a certified lactation support provider.

Breast feeding durable medical equipment

Eligible health services include renting or buying **durable medical equipment** you need to pump and store breast milk as follows:

Breast pump

Eligible health services include:

- Renting a **hospital** grade electric pump while your newborn child is confined in a **hospital**.
- The buying of:
  - An electric breast pump (non-**hospital** grade). Your plan will cover this cost once every three years, or
  - A manual breast pump. Your plan will cover this cost once per pregnancy.

If an electric breast pump was purchased within the previous three year period, the purchase of another electric breast pump will not be covered until a three year period has elapsed since the last purchase.

Breast pump supplies and accessories

Eligible health services include breast pump supplies and accessories. These are limited to only one purchase per pregnancy in any year where a covered female would not qualify for the purchase of a new pump.

Coverage for the purchase of breast pump equipment is limited to one item of equipment, for the same or similar purpose, and the accessories and supplies needed to operate the item. You are responsible for the entire cost of any additional pieces of the same or similar equipment you purchase or rent for personal convenience or mobility.

Family planning services – female contraceptives

El**igible health services** include family planning services such as:

Counseling services

Eligible health services include counseling services provided by a **physician, PCP**, OB, GYN, or OB/GYN on contraceptive methods. These will be covered when you get them in either a group or individual setting.

Devices

Eligible health services include contraceptive devices (including any related services or supplies) when they are provided by, administered or removed by a **physician** during an office visit.

Voluntary sterilization

Eligible health services include charges billed separately by the **provider** for female voluntary sterilization procedures and related services and supplies. This also could include tubal ligation and sterilization implants.

Important note:

See the following sections for more information:

- *Family planning services - other*
- *Maternity and related newborn care*
- *Outpatient prescription drugs*
- *Treatment of basic infertility*

Physicians and other health professionals

Physician services

Eligible health services include services by your **physician** to treat an **illness** or **injury**. You can get those services:

- At the **physician's** office
- In your home

- In a **hospital**
- From any other inpatient or outpatient facility
- By way of **telemedicine**

Important note:

Your plan covers **telemedicine** only when you get your consult through a **provider** that has contracted with **Aetna** to offer these services.

All in-person office visits covered with a **behavioral health provider** are also covered if you use **telemedicine** instead.

Telemedicine may have different cost sharing. See the schedule of benefits for more information.

Other services and supplies that your physician may provide:

- Allergy testing and allergy injections
- Radiological supplies, services, and tests
- Immunizations that are not covered as preventive care

Physician surgical services

Eligible health services include the services of:

- The surgeon who performs your surgery
- Your surgeon who you visit before and after the surgery
- Another surgeon who you go to for a second opinion before the surgery

Alternatives to physician office visits

Walk-in clinic

Eligible health services include, but are not limited to, health care services provided at a **walk-in clinic** for:

- Scheduled and unscheduled visits for **illnesses** and **injuries** that are not **emergency medical conditions**
- Preventive care immunizations administered within the scope of the clinic's license

Hospital and Other Facility Care

Hospital care

Eligible health services include inpatient and outpatient **hospital** care.

The types of **hospital** care services that are eligible for coverage include:

- Room and board charges up to the hospital's semi-private room rate. Your plan will cover the extra expense of a private room when appropriate because of your medical condition.
- Services of physicians employed by the hospital.
- Operating and recovery rooms.
- Intensive or special care units of a hospital.
- Administration of blood and blood derivatives, but not the expense of the blood or blood product.
- Radiation therapy.
- Cognitive rehabilitation.
- Speech therapy, physical therapy and occupational therapy.
- Oxygen and oxygen therapy.
- Radiological services, laboratory testing and diagnostic services.
- Medications.
- Intravenous (IV) preparations.
- Discharge planning.
- Services and supplies provided by the outpatient department of a hospital.
- Hospital and anesthesia charges if you are either:
    - A dependent child under age 5
    - Severely disabled
    - Have a medical condition that requires hospitalization or general anesthesia for dental care

Alternatives to hospital stays

Outpatient surgery and physician surgical services

Eligible health services include services provided and supplies used in connection with outpatient surgery performed in a **surgery center** or a **hospital's** outpatient department.

Important note:

Some **surgeries** can be done safely in a **physician's** office. For those **surgeries**, your plan will pay only for **physician or PCP** services and not for a separate fee for facilities.

Home health care

Eligible health services include home health care provided by a **home health care agency** in the home, but only when all of the following criteria are met:

- You are homebound.
- Your **physician** orders them.
- The services take the place of your needing to **stay** in a **hospital** or a **skilled nursing facility**, or needing to receive the same services outside your home.
- The services are a part of a **home health care plan**.
- The services are **skilled nursing services**, home health aide services or medical social services, or are short-term speech, physical or occupational therapy.
- If you are discharged from a **hospital** or **skilled nursing facility** after a **stay**, the intermittent requirement may be waived to allow coverage for continuous **skilled nursing services**. See the schedule of benefits for more information on the intermittent requirement.
- Home health aide services are provided under the supervision of a registered nurse.
- Medical social services are provided by or supervised by a **physician** or social worker.

If you are ventilator-dependent, **eligible health expenses** include 120 hours of services by a home care nurse or personal care assistant during the time you are in a **hospital**. The personal care assistant or home care nurse will serve as your communicator or interpreter to assure adequate training of the **hospital** staff to communicate with you and to understand your unique comfort, safety and personal care needs.

Short-term physical, speech and occupational therapy provided in the home are subject to the conditions and limitations imposed on therapy provided outside the home. See the *Short-term rehabilitation services and Habilitation therapy services* sections and the schedule of benefits.

Home health care services do not include **custodial care**.

Hospice care

Eligible health services include inpatient and outpatient **hospice care** when given as part of a **hospice care program**.

The types of **hospice care** services that are eligible for coverage include:

- Room and board
- Services and supplies furnished to you on an inpatient or outpatient basis
- Services by a hospice care agency or hospice care provided in a hospital
    - Bereavement counseling
    - Respite care

Hospice care services provided by the **providers** below may be covered, even if the **providers** are not an employee of the **hospice care agency** responsible for your care:

- A physician for consultation or case management
- A physical or occupational therapist
- A home health care agency for:
    - Physical and occupational therapy
    - Medical supplies
    - Outpatient prescription drugs
    - Psychological counseling
    - Dietary counseling

Skilled nursing facility

Eligible health services include inpatient **skilled nursing facility** care.

The types of **skilled nursing facility** care services that are eligible for coverage include:

- Room and board, up to the **semi-private room rate**
- Services and supplies that are provided during your stay in a **skilled nursing facility**

Emergency services

When you experience an **emergency medical condition**, you should go to the nearest emergency room. You can also dial 911 or your local emergency response service for medical and ambulance help.

Covered services include only outpatient services to evaluate and stabilize an **emergency medical condition** in a **hospital** emergency room. You can get **emergency services** from **network** or **out-of-network providers and will not be balance billed**. Refer to the emergency medical condition and emergency services definition in this SPD. See also the notice of "Your Rights and Protections Against Surprise Medical Billing under the Federal No Surprises Act" in the Important Health Care Reform Notices section of this SPD.

Your coverage for **emergency services** will continue until the following conditions are met:

- You are evaluated and your condition is stabilized and
- Your attending **physician** determines that you are medically able to travel or be transported, by non-medical or non-emergency transportation, to another **provider** if you need more care

If both of the above conditions are met and you continue to stay in the **hospital** (emergency admission) or receive follow-up care, these are not **emergency services**. Different benefits and requirements apply. Please refer to the *How your plan works – Medical necessity and precertification requirements* section and the *Coverage and exclusions* section that fits your situation (for example, *Hospital care or Physician services*). You can also contact us or your **network physician or primary care physician (PCP)**.

Non-emergency services

If you go to an emergency room for what is not an **emergency medical condition**, the plan may not cover your expenses. See the schedule of benefits for more information.

In case of an urgent condition

Urgent condition within the service area

If you need care for an **urgent condition** while within the **service area**, you should first seek care through your **physician**. If your **physician** is not reasonably available to provide services, you may access urgent care from an **urgent care facility** within the **service area**.

Urgent condition outside the service area

You are covered for urgent care obtained from a facility outside of the service area if you are temporarily absent from the service area and getting the health care service cannot be delayed until you return to the service area.

Non-urgent care

If you go to an **urgent care facility** for what is not an **urgent condition**, the plan may not cover your expenses. See the *exception –Emergency services and urgent care* section and the schedule of benefits for specific plan details.

Specific conditions

Autism spectrum disorder

Autism spectrum disorder is defined in the most recent edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) of the American Psychiatric Association.

Eligible health services include the services and supplies provided by a **physician** or **behavioral health provider** for the diagnosis and treatment of autism spectrum disorder. We will only cover this treatment if a **physician** or **behavioral health provider** orders it as part of a treatment plan.

We will cover early intensive behavioral interventions such as applied behavior analysis. Applied behavior analysis is an educational service that is the process of applying interventions:

- That systematically change behavior, and
- That is responsible for observable improvements in behavior.

Autism spectrum disorder

Autism spectrum disorder is defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) of the American Psychiatric Association.

Covered services include services and supplies provided by a **physician** or **behavioral health provider** for:

- The diagnosis and treatment of autism spectrum disorder
- Physical, occupational, and speech therapy associated with the diagnosis of autism spectrum disorder

Important note:

Applied behavior analysis requires **precertification** by **Allina Health|Aetna**. The **network provider** is responsible for obtaining **precertification**.

Birthing center

Eligible health services include prenatal and postpartum care and obstetrical services from your **provider**. After your child is born, **eligible health services** include:

- 48 hours of care in a birthing center after a vaginal delivery
- 96 hours of care in a birthing center after a cesarean delivery

A birthing center is a facility specifically licensed as a freestanding birthing center by applicable state and federal laws to provide prenatal care, delivery and immediate postpartum care.

Family planning services – other

Eligible health services include certain family planning services provided by your **physician** such as:

- Voluntary sterilization for males
- Abortion

Lyme disease

Eligible health services include the treatment of Lyme disease.

Maternity and related newborn care

Eligible health services include prenatal and postpartum care and obstetrical services. After your child is born, **eligible health services** include:

- 48 hours of inpatient care in a **hospital** after a vaginal delivery
- 96 hours of inpatient care in a **hospital** after a cesarean delivery
- A shorter **stay**, if the attending **physician**, with the consent of the mother, discharges the mother or newborn earlier
- The mother could be discharged earlier. If so, the plan will pay for 1 post-delivery home visits by a health care **provider**.

Coverage also includes the services and supplies needed for circumcision by a provider.

Gender affirming treatment

Covered services include certain services and supplies for gender affirming (sometimes called sex change) treatment.

Important note:

Just log into your **Aetna** website at https://www.aetna.com/health-care-professionals/clinical-policy-bulletins.html for detailed information about this **covered benefit**, including eligibility and medical necessity requirements. You can also call Member Services at the telephone number on the back of your I.D. card.

Port-wine stains

Eligible health services include the elimination or maximum feasible treatment of port-wine stains.

Mental health treatment

Eligible health services include the treatment of **mental disorders** provided by a **hospital**, **psychiatric hospital, residential treatment facility, physician** or **behavioral health provider** as follows:

- **Inpatient room and board** at the **semi-private room rate**, and other services and supplies related to your condition that are provided during your stay in a **hospital**, **psychiatric hospital**, or **residential treatment facility**

- Outpatient treatment received while not confined as an inpatient in a **hospital, psychiatric hospita**l or **residential treatment facility**, including:

    - Office visits to a **physician** or **behavioral health provider** such as a **psychiatrist**, psychologist, social worker, or licensed professional counselor (includes **telemedicine** consultation) and nutritional counseling as a result of a behavioral health condition (e.g., eating disorder)

    - Individual, group and family therapies for the treatment of mental health

    - Other outpatient mental health treatment such as:

    - **Partial hospitalization treatment** provided in a facility or program for mental health treatment provided under the direction of a **physician**

    - **Intensive outpatient program** provided in a facility or program for mental health treatment provided under the direction of a **physician**

    - Skilled behavioral health services provided in the home, but only when all the following criteria are met:

        - You are homebound

        - Your **physician** orders them

        - The services take the place of a **stay** in a **hospital** or a **residential treatment facility**, or you are unable to receive the same services outside your home

        - The skilled behavioral health care is appropriate for the active treatment of a condition, **illness** or disease to avoid placing you at risk for serious complications

    - Electro-convulsive therapy (ECT)

    - Transcranial magnetic stimulation (TMS)

    - Psychological testing

    - Neuropsychological testing

    - 23 hour observation

- Peer counseling support by a peer support specialist
    - A peer support **specialist** serves as a role model, mentor, coach, and advocate. They must be certified by the state where the services are provided or a private certifying organization recognized by us. Peer support must be supervised by a **behavioral health provider**.

- **Residential treatment facility**, licensed by the commissioner of human services, for the treatment of emotionally disabled children. "Emotionally disabled child" has the meaning set forth by the commissioner of human services in the rules relating to **residential treatment facilities**.

- Court-ordered **mental disorders** services to treat or improve an emotional, behavioral or psychiatric condition, otherwise covered under this **plan**. The court order must be issued based on a behavioral care evaluation performed by a licensed psychiatrist or a doctoral level licensed psychologist. The court order and behavioral care evaluation must:
    - Be provided to **Allina Health | Aetna**
    - Include a diagnosis and an individual treatment plan for care in the most appropriate and least restrictive environment.

Eligible health services include the:

- Evaluation if performed by an network provider
- Care included in the court-ordered individual treatment plan if the care is
    - A **covered benefit** under the plan
    - Ordered to be provided by a **network provider** or another **provider** as required by law.

We will not subject the court-ordered treatment to a separate medical necessity determination.

A party or interested person, including **Allina Health | Aetna** or its designee, may move to modify the court-ordered plan of care pursuant to the applicable rules of procedure for modification of a court order. The motion may include a request for a new behavioral care evaluation.

Mental health treatment

Eligible health services include the treatment of **mental disorders** provided by a **hospital, psychiatric hospital, residential treatment facility, physician** or **behavioral health provider** as follows:

- **Inpatient room and board** at the **semi-private room rate**, and other services and supplies related to your condition that are provided during your **stay** in a **hospital, psychiatric hospital**, or **residential treatment facility**.
- Outpatient treatment received while not confined as an inpatient in a **hospital**, **psychiatric hospital** or **residential treatment facility**, including:

- Office visits to a **physician** or **behavioral health provider** such as a psychiatrist, psychologist, social worker, or licensed professional counselor.

- Individual, group and family therapies for the treatment of mental health

- Other outpatient mental health treatment such as:

  - Partial hospitalization treatment provided in a facility or program for mental health treatment provided under the direction of a physician

  - Intensive outpatient program provided in a facility or program for mental health treatment provided under the direction of a physician

  - Skilled behavioral health services provided in the home, but only when all of the following criteria are met:

    - You are homebound

    - Your physician orders them

    - The services take the place of a stay in a hospital or a residential treatment facility, or you are unable to receive the same services outside your home

    - The skilled behavioral health care is appropriate for the active treatment of a condition, illness or disease to avoid placing you at risk for serious complications

  - Electro-convulsive therapy (ECT)

  - Transcranial magnetic stimulation (TMS)

  - Psychological testing

  - Neuropsychological testing

  - 23 hour observation

  - Peer counseling support by a peer support specialist

    - A peer support specialist serves as a role model, mentor, coach, and advocate. They must be certified by the state where the services are provided or a private certifying organization recognized by us. Peer support must be supervised by a behavioral health provider.

Substance related disorders treatment

Eligible health services include the treatment of **substance abuse** provided by a **hospital, psychiatric hospital, residential treatment facility, physician** or **behavioral health provider** as follows:

- **Inpatient room and board** at the **semi-private room rate**, and other services and supplies that are provided during your **stay** in a **hospital, psychiatric hospital** or **residential treatment facility**.

Treatment of **substance abuse** in a general medical **hospital** is only covered if you are admitted to the **hospital's** separate **substance abuse** section or unit, unless you are admitted for the treatment of medical complications of **substance abuse**.

As used here, "medical complications" include, but are not limited to, electrolyte imbalances, malnutrition, cirrhosis of the liver, delirium tremens and hepatitis.

- Outpatient treatment received while not confined as an inpatient in a **hospital, psychiatric hospital** or **residential treatment facility**, including:
    - Office visits to a **physician** or **behavioral health provider** such as a **psychiatrist**, psychologist, social worker, advanced practice registered nurse, or licensed professional counselor (includes **telemedicine** consultation)
    - Individual, group and family therapies for the treatment of **substance abuse**
    - Other outpatient **substance abuse** treatment such as:
        - Outpatient detoxification
        - **Partial hospitalization treatment** provided in a facility or program for treatment of **substance abuse** provided under the direction of a **physician**
        - **Intensive outpatient program** provided in a facility or program for treatment of **substance abuse** provided under the direction of a **physician**
        - Ambulatory detoxification which are outpatient services that monitor withdrawal from alcohol or other **substance abuse**, including administration of medications
        - Treatment of withdrawal symptoms
        - 23 hour observation
        - Peer counseling support by a peer support specialist
            - A peer support specialist serves as a role model, mentor, coach, and advocate. They must be certified by the state where the services are provided or a private certifying organization recognized by us. Peer support must be supervised by a behavioral health provider.

Obesity (bariatric) surgery

Eligible health services include obesity surgery, which is also known as "weight loss **surgery**." Obesity **surgery** is a type of procedure performed on people who are **morbidly obese**, for the purpose of losing weight.

Obesity is typically diagnosed based on your **body mass index (BMI).** To determine whether you qualify for obesity surgery, your doctor will consider your **BMI** and any other condition or conditions you may have. In general, obesity surgery will not be approved for any member with a **BMI** less than 35.

Your doctor will request approval in advance of your obesity **surgery**. The plan will cover charges made by a **network provider** for the following outpatient weight management services:

- An initial medical history and physical exam
- Diagnostic tests given or ordered during the first exam
- Outpatient **prescription drug** benefits included under the Outpatient prescription drugs section

Health care services include one obesity **surgical procedure**. However, **eligible health services** also include a multi-stage procedure when planned and approved by the plan. Your health care services include adjustments after an approved lap band procedure. This includes approved adjustments in an office or outpatient setting.

You may go to any of our **network** facilities that perform obesity **surgeries**.

Oral and maxillofacial treatment (mouth, jaws and teeth)

Eligible health services include the following oral and maxillofacial treatment (mouth, jaws and teeth) provided by a **physician**, a dentist and **hospital**:

- Non-surgical treatment of infections or diseases.
- Surgery needed to:
  - Treat a fracture, dislocation, or wound.
  - Cut out cysts, tumors, or other diseased tissues.
  - Cut into gums and tissues of the mouth. This is only covered when not done in connection with the removal, replacement or repair of teeth.
  - Alter the jaw, jaw joints, or bite relationships by a cutting procedure when appliance therapy alone cannot result in functional improvement.
- **Hospital** services and supplies received for a **stay** required because of your condition.
- Dental work, surgery and **orthodontic treatment** needed to remove, repair, restore or reposition:
  - Natural teeth damaged, lost, or removed. Your teeth must be free from decay or in good repair, and are firmly attached to your jaw bone at the time of your injury.
  - Other body tissues of the mouth fractured or cut due to **injury**.
- Crowns, dentures, bridges, or in-mouth appliances only for:
  - The first denture or fixed bridgework to replace lost teeth.
  - The first crown needed to repair each damaged tooth.

  - An in-mouth appliance used in the first course of **orthodontic treatment** after an **injury**.

- Accidental **injuries** and other trauma. Oral **surgery** and related dental services to return sound natural teeth to their pre-trauma functional state. These services must take place no later than 24 months after the **injury**.

  - Sound natural teeth are teeth that were stable, functional, and free from decay and advanced periodontal disease at the time of the trauma.

  - If a child needs oral **surgery** as the result of accidental **injury** or trauma, **surgery** may be postponed until a certain level of growth has been achieved.

Reconstructive surgery and supplies

Eligible health services include reconstructive **surgery** by your **provider** and related supplies provided in an inpatient or outpatient setting only in the following circumstances:

- Your **surgery** reconstructs the breast where a necessary mastectomy was performed, such as an implant and areolar reconstruction. It also includes **surgery** on a healthy breast to make it symmetrical with the reconstructed breast and physical therapy to treat complications of the mastectomy, including lymphedema.

- Your **surgery** is to implant or attach a covered prosthetic device.

- Your **surgery** corrects a gross anatomical defect present at birth. The **surgery** will be covered if:

  - The defect results in severe facial disfigurement or major functional impairment of a body part.

  - The purpose of the **surgery** is to improve function.

- Your **surgery** is needed because treatment of your **illness** resulted in severe facial disfigurement or major functional impairment of a body part, and your **surgery** will improve function.

Transplant services

Eligible health services include transplant services provided by a **physician** and **hospital**.

This includes the following transplant types:

- Solid organ

- Hematopoietic stem cell

- Bone marrow

- CAR-T and T Cell receptor therapy for FDA-approved treatments

Network of transplant facilities

We designate facilities to provide specific services or procedures. They are listed as **Institutes of Excellence™ (IOE) facilities** in your **provider directory**.

You must get transplant services from the **IOE facility** we designate to perform the transplant you need.

Important note:

- If there is no **IOE facility** for your transplant type in your network, the National Medical Excellence Program® (NME) will arrange for and coordinate your care at an **IOE facility** in another one of our networks. If you don't get your transplant services at the **IOE facility** we designate, they will not be **covered benefits**.
- Many pre and post-transplant medical services, even routine ones, are related to and may affect the success of your transplant. While your transplant care is being coordinated by the National Medical Excellence Program® (NME), all medical services must be managed through the NME so that you receive the highest level of benefits at the appropriate facility. This is true even if the **eligible health service** is not directly related to your transplant.

Specific therapies and tests

Outpatient diagnostic testing

Diagnostic complex imaging services

Eligible health services include complex imaging services by a provider, including:

- Computed tomography (CT) scans
- Magnetic resonance imaging (MRI) including magnetic resonance spectroscopy (MRS), magnetic resonance venography (MRV) and magnetic resonance angiogram (*MRA*)
- Nuclear medicine imaging including positron emission tomography (PET) scans
- Other outpatient diagnostic imaging service where the billed charge exceeds $500
- Complex imaging for preoperative testing is covered under this benefit

Diagnostic lab work and radiological services

Eligible health services include diagnostic radiological services (other than diagnostic complex imaging), lab services, and pathology and other tests, but only when you get them from a licensed radiological facility or lab.

Chemotherapy

Eligible health services for chemotherapy depends on where treatment is received. In most cases, chemotherapy is covered as outpatient care. However, your **hospital** benefit covers the initial dose of chemotherapy after a cancer diagnosis during a **hospital stay**.

Outpatient infusion therapy

Eligible health services include infusion therapy you receive in an outpatient setting including but not limited to:

- A free-standing outpatient facility
- The outpatient department of a **hospital**
- A **physician** in the office
- A home care **provider** in your home

Infusion therapy is the parenteral (e.g. intravenous) administration of prescribed medications or solutions.

When Infusion therapy services and supplies are provided in your home, they will not count toward any applicable **home health care** maximums.

Outpatient radiation therapy

Eligible health services include the following radiology services provided by a **health professional**:

- Radiological services
- Gamma ray
- Accelerated particles
- Mesons
- Neutrons
- Radium
- Radioactive isotopes

Specialty prescription drugs

Eligible health services include **specialty prescription drugs** when they are:

- Purchased by your provider, and

- Injected or infused by your provider in an outpatient setting such as:
  - A free-standing outpatient facility
  - The outpatient department of a **hospital**
  - A **physician** in the office
  - A home care **provider** in your home
- And, listed on our **specialty prescription drug** list as covered under this booklet.

You can access the list of **specialty prescription drugs** by contacting Member Services by logging onto your **Allina|Aetna** secure member website at www.allinahealthaetna.com or calling the number on your ID card to determine if coverage is available through **Allina|Aetna** or through the outpatient **prescription drug** benefit (administered through Express Scripts).

When injectable or infused services and supplies are provided in your home, they will not count toward any applicable home health care maximums.

Short-term cardiac and pulmonary rehabilitation services

Eligible health services include the cardiac and pulmonary rehabilitation services listed below.

Cardiac rehabilitation

Eligible health services include cardiac rehabilitation services you receive at a **hospital, skilled nursing facility or physician's** office, but only if those services are part of a treatment plan determined by your risk level and ordered by your **physician**.

Pulmonary rehabilitation

Eligible health services include pulmonary rehabilitation services as part of your inpatient **hospital stay** if it is part of a treatment plan ordered by your **physician**.

A course of outpatient pulmonary rehabilitation may also be eligible for coverage if it is performed at a **hospital, skilled nursing facility**, or **physician's** office, is used to treat reversible pulmonary disease states, and is part of a treatment plan ordered by your **physician**.

Short-term rehabilitation services

Short-term rehabilitation services help you restore or develop skills and functioning for daily living.

Eligible health services include short-term rehabilitation services your **physician** prescribes. The services have to be performed by:

- A licensed or certified physical, occupational or speech therapist
- A **hospital, skilled nursing facility**, or **hospice facility**

- A **home health care agency**
- A **physician**

Short-term rehabilitation services have to follow a specific treatment plan.

Short-term physical, speech and occupational therapy services provided in an outpatient setting are subject to the same conditions and limitations for outpatient short-term rehabilitation services. See the *Short-term rehabilitation services* section in the schedule of benefits.

Outpatient cognitive rehabilitation, physical, occupational, and speech therapy

Eligible health services include:

- Physical therapy, but only if it is expected to significantly improve or restore physical functions lost as a result of an acute **illness**, **injury** or **surgical procedure**.
- Occupational therapy (except for vocational rehabilitation or employment counseling), but only if it is expected to:
  - Significantly improve, develop or restore physical functions you lost as a result of an acute **illness, injury** or **surgical procedure**, or
  - Relearn skills so you can significantly improve your ability to perform the activities of daily living.
- Speech therapy, but only if it is expected to:
  - Significantly improve or restore the speech function or correct a speech impairment as a result of an acute **illness, injury** or **surgical procedure**, or
  - Improve delays in speech function development caused by a gross anatomical defect present at birth.

  Speech function is the ability to express thoughts, speak words and form sentences. Speech impairment is difficulty with expressing one's thoughts with spoken words.
- Cognitive rehabilitation associated with physical rehabilitation, but only when:
  - Your cognitive deficits are caused by neurologic impairment due to trauma, stroke, or encephalopathy and
  - The therapy is coordinated with us as part of a treatment plan intended to restore previous cognitive function.

Habilitation therapy services

Habilitation therapy services are services that help you keep, learn, or improve skills and functioning for daily living (e.g. therapy for a child who isn't walking or talking at the expected age).

Eligible health services include habilitation therapy services your **physician** prescribes. The services have to be performed by:

- A licensed or certified physical, occupational or speech therapist
- A **hospital, skilled nursing facility**, or **hospice facility**
- A **home health care agency**
- A **physician**

Habilitation therapy services have to follow a specific treatment plan, ordered by your **physician**.

Outpatient physical, occupational, and speech therapy

Eligible health services include:

- Physical therapy, if it is expected to develop any impaired function.
- Occupational therapy (except for vocational rehabilitation or employment counseling), if it is expected to:
  - Develop any impaired function, or
  - Relearn skills to significantly develop your ability to perform the activities of daily living.
- Speech therapy is covered provided the therapy is expected to:
  - Develop speech function as a result of delayed development

  (Speech function is the ability to express thoughts, speak words and form sentences).

Other services

Acupuncture

Eligible health services include the treatment by the use of acupuncture (manual or electroacupuncture) provided by your **physician**, if the service is performed:

- As a form of anesthesia in connection with a covered surgical procedure and
- To alleviate chronic pain or to treat:
  - Postoperative and chemotherapy-induced nausea and vomiting
  - Nausea of pregnancy
  - Postoperative dental pain
  - Temporomandibular disorders (TMD)

- Migraine headache
- Pain from osteoarthritis of the knee or hip (adjunctive therapy).

Ambulance service

Eligible health services include transport by professional ground **ambulance** services:

- To the first **hospital** to provide **emergency services**.
- From one **hospital** to another **hospital** if the first **hospital** cannot provide the **emergency services** you need.
- From a **hospital** to your home or to another facility if an **ambulance** is the only safe way to transport you.
- From your home to a **hospital** if an **ambulance** is the only safe way to transport you. Transport is limited to 100 miles.

Your plan also covers transportation to a hospital by professional air or water ambulance when:

- Professional ground **ambulance** transportation is not available.
- Your condition is unstable, and requires medical supervision and rapid transport.
- You are travelling from one **hospital** to another and
  - The first **hospital** cannot provide the **emergency services** you need, and
  - The two conditions above are met.

Clinical trial therapies (experimental or investigational)

Eligible health services include **experimental or investigational** drugs, devices, treatments or procedures from a **provider** under an “approved clinical trial” only when you have cancer or terminal illnesses and all of the following conditions are met:

- Standard therapies have not been effective or are not appropriate.
- We determine based on published, peer-reviewed scientific evidence that you may benefit from the treatment.

An "approved clinical trial" is a clinical trial that meets all of these criteria:

- The FDA has approved the drug, device, treatment, or procedure to be investigated or has granted it investigational new drug (IND) or group c/treatment IND status. This requirement does not apply to procedures and treatments that do not require FDA approval.

- The clinical trial has been approved by an Institutional Review Board that will oversee the investigation.
- The clinical trial is sponsored by the National Cancer Institute (NCI) or similar federal organization.
- The trial conforms to standards of the NCI or other, applicable federal organization.
- The clinical trial takes place at an NCI-designated cancer center or takes place at more than one institution.
- You are treated in accordance with the protocols of that study.

Clinical trials (routine patient costs)

Eligible health services include "routine patient costs" incurred by you from a **provider** in connection with participation in an "approved clinical trial" as a “qualified individual” for cancer or other life-threatening disease or condition, as those terms are defined in the federal Public Health Service Act, Section 2709.

As it applies to in-network coverage, coverage is limited to benefits for routine patient services provided within the network.

COVID-19 Benefits

The Plan will cover 100% of the cost for (i) an item, service or immunization that 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.

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

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

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

1. **Participating Pharmacy**

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

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

2. **Non-Participating Pharmacy**

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

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

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

Allina Health Pharmacy will mail COVID-19 over-the-counter tests directly to your home at no cost, subject to the rules and limitations set forth above. To request tests, please call your local Allina Health Pharmacy or go to www.express-scripts.com/allinahealth and click "Find a Pharmacy." For assistance in receiving this benefit at an in-network pharmacy or submitted a receipt for reimbursement, contact Express Scripts at 1-800-509-5310.

Durable medical equipment (DME)

Eligible health services include the expense of renting or buying **DME** and accessories you need to operate the item from a **DME** supplier. Your plan will cover either buying or renting the item, depending on which we think is more cost efficient. If you purchase **DME**, that purchase is only eligible for coverage if you need it for long-term use.

Coverage includes:

- One item of **DME** for the same or similar purpose.
- Repairing **DME** due to normal wear and tear. It does not cover repairs needed because of misuse or abuse.
- A new **DME** item you need because your physical condition has changed. It also covers buying a new **DME** item to replace one that was damaged due to normal wear and tear, if it would be cheaper than repairing it or renting a similar item.

Your plan only covers the same type of **DME** that Medicare covers. But there are some **DME** items Medicare covers that your plan does not. We list examples of those in the exclusions section.

Hearing aids and exams

Eligible health services include hearing care that includes hearing exams, prescribed hearing aids and hearing aid services as described below.

Hearing aid means:

- Any wearable, non-disposable instrument or device designed to aid or make up for impaired human hearing
- Parts, attachments, or accessories

Hearing aid services are:

- Audiometric hearing exam and evaluation for a hearing aid **prescription** performed by:
  - A **physician** certified as an otolaryngologist or otologist
  - An audiologist who is legally qualified in audiology, or holds a certificate of Clinical Competence in Audiology from the American Speech and Hearing Association in the absence of any licensing requirements; and who performs the exam at the written direction of a legally qualified otolaryngologist or otologist
- Electronic hearing aids, installed in accordance with a **prescription** written during a covered hearing exam
- Any other related services necessary to access, select and adjust or fit a hearing aid

Non-routine/non-preventive care hearing exams

Eligible health services for adults and children include charges for an audiometric hearing exam for evaluation and treatment of **illness, injury** or hearing loss, if the exam is performed by:

- A **physician** certified as an otolaryngologist or otologist
- An audiologist who is legally qualified in audiology; or holds a certificate of Clinical Competence in Audiology from the American Speech and Hearing Association (in the absence of any applicable licensing requirements); and who performs the exam at the written direction of a legally qualified otolaryngologist or otologist.

Nutritional supplements

Eligible health services include formula and low protein modified food products ordered by a **physician** for the treatment of phenylketonuria or an inherited disease of amino and organic acids.

For purposes of this benefit, “low protein modified food product” means foods that are specifically formulated to have less than one gram of protein per serving and are intended to be used under the direction of a physician for the dietary treatment of any inherited metabolic disease. Low protein modified food products do not include foods that are naturally low in protein.

Prosthetic devices

Eligible health services include the initial provision and subsequent replacement of a prosthetic device that your **physician** orders and administers.

Prosthetic device means:

- A device that temporarily or permanently replaces all or part of an external body part lost or impaired as a result of illness or injury or congenital defects.

Coverage includes:

- Repairing or replacing the original device you outgrow or that is no longer appropriate because your physical condition changed
- Replacements required by ordinary wear and tear or damage
- Instruction and other services (such as attachment or insertion) so you can properly use the device

Spinal manipulation

Eligible health services include spinal manipulation to correct a muscular or skeletal problem, but only if your **provider** establishes or approves a treatment plan that details the treatment, and specifies frequency and duration.

Vision care

Routine vision exams

Eligible health services include a routine vision exam provided by an ophthalmologist or optometrist. The exam will include refraction and glaucoma testing.

Eligible health services include 100% coverage up to $250 for glasses or contacts every calendar year per covered person at Allina Health Eye Clinics.

Outpatient prescription drugs

Preventive contraceptives

For females who are able to reproduce, your plan covers certain drugs and devices that the U.S. Food and Drug Administration (FDA) has approved to prevent pregnancy when prescribed by a **prescriber** and the **prescription** is submitted to the pharmacist for processing. Your outpatient **prescription drug** plan also covers related services and supplies needed to administer covered devices. At least one form of contraception in each of the methods identified by the FDA is included. You can access the list of contraceptive drugs by logging onto your secure member website at www.allinahealthaetna.com or www.express-scripts.com/allinahealth or calling Express Scripts customer service at 1-800-509-5310, select prompt 2.

The plan covers over-the-counter (OTC) and **generic prescription drugs** and devices for each of the methods identified by the FDA at no cost share. If a **generic prescription drug** or device is not available for a certain method, you may obtain certain **brand-name prescription drug** for that method at no cost share.

Important Note: You may qualify for a medical exception if your **provider** determines that the contraceptives covered standardly as preventive are not medically appropriate. Your prescriber may request a medical exception and submit the exception to us.

Preventive care drugs and supplements

Eligible health services include preventive care drugs and supplements (including over-the-counter drugs and supplements) as required by the Affordable Care Act (ACA) guidelines when prescribed by a **prescriber** and the **prescription** is submitted to the pharmacist for processing.

Risk reducing breast cancer prescription drugs

Eligible health services include **prescription drugs** used to treat people who are at:

- Increased risk for breast cancer, and
- Low risk for adverse medication side effects

Tobacco cessation prescription and over-the-counter drugs

Eligible health services include FDA-approved **prescription drugs** and over-the-counter (OTC) drugs to help stop the use of tobacco products, when prescribed by a **prescriber** and the **prescription** is submitted to the pharmacist for processing.

Tenex

Plan covers Percutaneous Tenotomy (Tenex) if an Allina Health physician both determines the member is a candidate for the procedure and performs the procedure, subject to member cost sharing that applies for outpatient procedures/surgery under the Plan.

Exclusions: What Your Plan Doesn’t Cover

We already told you about the many health care services and supplies that are eligible for coverage under your plan in the Eligible health services under your plan section. And we told you there, that some of those health care services and supplies have exclusions. For example, **physician** care is an **eligible health service** but **physician** care for **cosmetic surgery** is never covered. This is an exclusion.

In this section we tell you about the exclusions. We've grouped them to make it easier for you to find what you want.

- Under "General exclusions" we've explained what general services and supplies are not covered under the plan.
- Below the general exclusions, in “Exclusions under specific types of care,” we've explained what services and supplies are exceptions under specific types of care or conditions.

Please look under both categories to make sure you understand what exclusions may apply in your situation.

And just a reminder, you'll find coverage limitations in the schedule of benefits.

General exclusions

Blood, blood plasma, synthetic blood, blood derivatives or substitutes

Examples of these are:

- The provision of blood to the hospital, other than blood derived clotting factors.
- Any related services including processing, storage or replacement expenses.
- The services of blood donors, apheresis or plasmapheresis.

For autologous blood donations, only administration and processing expenses are covered.

Behavioral health treatment

Services for the following categories (or equivalent terms as listed in the most recent version of the Diagnostic and Statistical Manual of Mental Disorders (DSM) of the American Psychiatric Association):

- **Stay** in a facility for treatment for dementias and amnesia without a behavioral disturbance that necessitates mental health treatment
- School and/or education service, including special education, remedial education, wilderness treatment programs, or any such related or similar programs.
- Services provided in conjunction with school, vocation, work or recreational activities
- Transportation

Cosmetic services and plastic surgery

- Any treatment, **surgery (cosmetic** or plastic), service or supply to alter, improve or enhance the shape or appearance of the body, whether or not for psychological or emotional reasons. This **cosmetic** services exclusion does not apply to **surgery** after an accidental **injury** when performed as soon as medically feasible. **Injuries** that occur during medical treatments are not considered accidental **injuries**, even if unplanned or unexpected.

Cost share waived

- Any cost for a service when any **out-of-network provider** waives all or part of your **copayment, coinsurance, deductible**, or any other amount

Counseling

- Marriage, religious, family, career, social adjustment, pastoral, or financial counseling.

Court-ordered services and supplies

This includes those court-ordered services and supplies, or those required as a condition of parole, probation, release or because of any legal proceeding, unless they are a covered benefit under your plan.

*Note: Contact your **Allina Health | Aetna** Concierge at the toll-free number on your ID card to confirm coverage.

Custodial care

Examples are:

- Routine patient care such as changing dressings, periodic turning and positioning in bed
- Administering oral medications
- Care of a stable tracheostomy (including intermittent suctioning)
- Care of a stable colostomy/ileostomy
- Care of stable gastrostomy/jejunostomy/nasogastric tube (intermittent or continuous) feedings
- Care of a bladder catheter (including emptying/changing containers and clamping tubing)
- Watching or protecting you
- Respite care, adult (or child) day care, or convalescent care
- Institutional care. This includes room and board for rest cures, adult day care and convalescent care

- Help with walking, grooming, bathing, dressing, getting in or out of bed, toileting, eating or preparing foods
- Any other services that a person without medical or paramedical training could be trained to perform
- Any service that can be performed by a person without any medical or paramedical training

Dental care except as covered in the Eligible health services under your plan Oral and maxillofacial treatment section.

Dental services related to:

- The care, filling, removal or replacement of teeth and treatment of injuries to or diseases of the teeth
- Dental services related to the gums
- Apicoectomy (dental root resection)
- Orthodontics
- Root canal treatment
- Soft tissue impactions
- Bony impacted teeth
- Alveolectomy
- Augmentation and vestibuloplasty treatment of periodontal disease
- False teeth
- Prosthetic restoration of dental implants
- Dental implants

This exclusion does not include bone fractures, removal of tumors, and odontogenic cysts.

Educational services

Examples of those services are:

- Any service or supply for education, training or retraining services or testing, except where described in the Eligible health services under your plan – Diabetic equipment, supplies and education. This exclusion includes:
    - Special education

- Remedial education
- Wilderness treatment programs (whether or not the program is part of a residential treatment facility or otherwise licensed institution)
- Job training
- Job hardening programs

Educational services, schooling or any such related or similar program, including therapeutic programs within a school setting.

Examinations

Any health examinations needed:

- Because a third party requires the exam. Examples are, examinations to get or keep a job, or examinations required under a labor agreement or other contract.
- Because a law requires it.
- To buy insurance or to get or keep a license.
- To travel.
- To go to a school, camp, or sporting event, or to join in a sport or other recreational activity.

Experimental or investigational

Experimental or investigational drugs, devices, treatments or procedures unless otherwise covered under Clinical trial therapies (experimental or investigational) or covered under Clinical trials (routine patient costs). See the *Eligible health services under your plan – Other services* section.

Facility charges

For care, services or supplies provided in:

- Rest homes
- Assisted living facilities
- Similar institutions serving as a persons' main residence or providing mainly custodial or rest care
    - Health resorts
    - Spas or sanitariums
    - Infirmaries at schools, colleges, or camps

Foot care

Services and supplies for:

- The treatment of calluses, bunions, toenails, hammertoes, fallen arches
- The treatment of weak feet, chronic foot pain or conditions caused by routine activities, such as walking, running, working or wearing shoes
- Supplies (including orthopedic shoes), foot orthotics, arch supports, shoe inserts, ankle braces, guards, protectors, creams, ointments and other equipment, devices and supplies
- Routine pedicure services, such as routine cutting of nails, when there is no **illness** or **injury** in the nails

Growth/height care

- A treatment, device, drug, service or supply to increase or decrease height or alter the rate of growth
- **Surgical procedures**, devices and growth hormones to stimulate growth

Jaw joint disorder

- Non-surgical treatment of **jaw joint disorder** (TMJ)
- **Jaw joint disorder** treatment (TMJ) performed by prosthesis placed directly on the teeth, surgical and non-surgical medical and dental services, and diagnostic or therapeutics services related to TMJ

Maintenance care

- Care made up of services and supplies that maintain, rather than improve, a level of physical or mental function, except for habilitation therapy services. See the Eligible health services under your plan – Habilitation therapy services section.

Medical supplies – outpatient disposable

- Any outpatient disposable supply or device. Examples of these are:
  - Sheaths
  - Bags
  - Elastic garments
  - Support hose
  - Bandages

- Bedpans
- Syringes
- Blood or urine testing supplies
- Other home test kits
- Splints
- Neck braces
- Compresses
- Other devices not intended for reuse by another patient

Other primary payer

- Payment for a portion of the charge that Medicare or another party is responsible for as the primary payer.

Outpatient prescription or non-prescription drugs and medicines

- Outpatient **prescription** or non-**prescription drugs** and medicines provided by the employer or through a third party vendor contract with the employer.

Personal care, comfort or convenience items

- Any service or supply primarily for your convenience and personal comfort or that of a third party.

Pregnancy charges

- Charges in connection with pregnancy care other than for complications of pregnancy and other covered expenses as specifically described in the *Eligible health services under your plan* section.

Routine exams

- Routine physical exams, routine eye exams, routine dental exams, routine hearing exams and other preventive services and supplies, except as specifically provided in the Eligible health services under your plan section.

Services provided by a family member

- Services provided by a spouse, parent, child, step-child, brother, sister, in-law or any household member.

Services, supplies and drugs received outside of the United States

- Non-emergency medical services, outpatient prescription drugs or supplies received outside of the United States. They are not covered even if they are covered in the United States under this booklet.

Sexual dysfunction and enhancement

- Any treatment, **prescription drug**, service, or supply to treat sexual dysfunction, enhance sexual performance or increase sexual desire, including:
  - **Surgery, prescription drugs**, implants, devices or preparations to correct or enhance erectile function, enhance sensitivity, or alter the shape or appearance of a sex organ
  - Sex therapy, sex counseling, marriage counseling, or other counseling or advisory services

Strength and performance

- Services, devices and supplies such as drugs or preparations designed primarily for enhancing your:
  - Strength
  - Physical condition
  - Endurance
  - Physical performance

Telemedicine

- Services given when you are not present at the same time as the provider
- Services including:
  - Telephone calls
  - Telemedicine kiosks
  - Electronic vital signs monitoring or exchanges, (e.g. Tele-ICU, Tele-stroke)

Therapies and tests

- Full body CT scans
- Hair analysis
- Hypnosis and hypnotherapy

- Massage therapy, except when used as a physical therapy modality
- Sensory or auditory integration therapy

Tobacco cessation

- Any treatment, drug, service or supply to stop or reduce smoking or the use of other tobacco products or to treat or reduce nicotine addiction, dependence or cravings, including, medications, nicotine patches and gum unless recommended by the United States Preventive Services Task Force (USPSTF). This also includes:
  - Counseling, except as specifically provided in the Eligible health services under your plan – Preventive care and wellness section
  - Hypnosis and other therapies
  - Medications, except as specifically provided in the *Eligible health services under your plan – Outpatient prescription drugs* section
  - Nicotine patches
  - Gum

Treatment in a federal, state, or governmental entity

- Any care in a **hospital** or other facility owned or operated by any federal, state or other governmental entity, except to the extent coverage is required by applicable laws

Wilderness treatment programs

See Educational services within this section.

Work related illness or injuries

- Coverage available to you under worker's compensation or under a similar program under local, state or federal law for any **illness** or **injury** related to employment or self-employment.
- A source of coverage or reimbursement will be considered available to you even if you waived your right to payment from that source. You may also be covered under a workers' compensation law or similar law. If you submit proof that you are not covered for a particular **illness** or **injury** under such law, then that **illness** or **injury** will be considered "non-occupational" regardless of cause.

Additional exclusions for specific types of care preventive care and wellness

- Services for diagnosis or treatment of a suspected or identified **illness** or **injury**
- Exams given during your **stay** for medical care

- Services not given by or under a **physician's** direction
- Psychiatric, psychological, personality or emotional testing or exams

Family planning services

- Any contraceptive methods that are only "reviewed" by the FDA and not "approved" by the FDA
- The reversal of voluntary sterilization procedures, including any related follow-up care
- Voluntary sterilization procedures that were not billed separately by the **provider** or were not the primary purpose of a confinement

Physicians and other health professionals

There are no additional exclusions specific to physicians and other health professionals.

Hospital and other facility care

Alternatives to facility stays

Outpatient surgery and physician surgical services

- The services of any other **physician** who helps the operating **physician**
- A **stay** in a **hospital (Hospital stays** are covered in the *Eligible health services under your plan – Hospital and other facility care* section.)
- A separate facility charge for **surgery** performed in a **physician's** office
- Services of another **physician** for the administration of a local anesthetic

Home health care

- Services for infusion therapy
- Services provided outside of the home (such as in conjunction with school, vacation, work or recreational activities)
- Transportation
- Services or supplies provided to a minor or dependent adult when a family member or caregiver is not present

Hospice care

- Funeral arrangements

- Pastoral counseling
- Financial or legal counseling. This includes estate planning and the drafting of a will
- Homemaker or caretaker services. These are services which are not solely related to your care and may include:
  - Sitter or companion services for either you or other family members
  - Transportation
  - Maintenance of the house

Outpatient private duty nursing

(See home health care in the *Eligible health services under your plan and Outpatient and inpatient skilled nursing care* sections regarding coverage of nursing services).

Emergency services and urgent care

- **Non-emergency care** in a **hospital** emergency room facility
- Non-urgent care in an **urgent care facility**(at a non-hospital freestanding facility)

Specific conditions

Autism spectrum disorder

- Early intensive behavioral interventions (including Denver, LEAP, TEACCH, Rutgers, floor time, Lovaas and similar programs) and other intensive educational interventions.

Family planning services - other

- Reversal of voluntary sterilization procedures including related follow-up care
- Family planning services received while confined as an inpatient in a hospital or other facility

Maternity and related newborn care

- Any services and supplies related to births that take place in the home or in any other place not licensed to perform deliveries.

Mental health and substance related disorders treatment

The following conditions/diagnoses (or equivalent terms as listed in the most recent edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) of the American Psychiatric Association) are not covered by the plan:

- Sexual deviations and disorders except for Gender Dysphoria and Transgender services

- Tobacco use disorders and nicotine dependence, except as described in the Eligible health services -Preventive care section
- Pathological gambling, kleptomania, and pyromania
- Specific developmental disorders of scholastic skills (Learning Disorders/Learning Disabilities)
- Specific developmental disorder of motor functions
- Specific developmental disorders of speech and language
- Other disorders of psychological development

Substance related disorders treatment

- Except as provided in the *Eligible health services under your plan – Substance related disorders treatment* section alcoholism or drug abuse rehabilitation treatment on an inpatient or outpatient basis

Oral and maxillofacial treatment (mouth, jaws and teeth)

- Dental implants

Transplant services

- Services and supplies furnished to a donor when the recipient is not a covered person
- Harvesting and storage of organs, without intending to use them for immediate transplantation for your existing **illness**
- Harvesting and/or storage of bone marrow, hematopoietic stem cells or other blood cells without intending to use them for transplantation within 12 months from harvesting, for an existing **illness**

Specific therapies and tests

Outpatient infusion therapy

- Enteral nutrition
- Blood transfusions and blood products
- Dialysis

Specialty prescription drugs

- **Specialty prescription drugs** and medicines provided by your employer or through a third party vendor contract with your employer.

- Drugs that are included on the list of **specialty prescription drugs** as covered under your outpatient **prescription drug** plan.

Other services

Ambulance services

- Fixed wing air ambulance from an out-of-network provider

Clinical trial therapies (experimental or investigational)

- Your plan does not cover clinical trial therapies (experimental or investigational), except as described in the *Eligible health services under your plan - Clinical trial therapies (experimental or investigational)* section.

Clinical trial therapies (routine patient costs)

- Services and supplies related to data collection and record-keeping that is solely needed due to the clinical trial (i.e. protocol-induced costs)
- Services and supplies provided by the trial sponsor without charge to you
- The experimental intervention itself (except **medically necessary** Category B investigational devices and promising experimental and investigational interventions for **terminal illnesses** in certain clinical trials in accordance with **Allina Health | Aetna's** claim policies).

Durable medical equipment (DME)

Examples of these items are:

- Whirlpools
- Portable whirlpool pumps
- Massage table
- Sauna baths
- Message devices (personal voice recorder)
- Over bed tables
- Elevators
- Communication aids
- Vision aids
- Telephone alert systems

Hearing aids and exams

The following services or supplies:

- A replacement of:
  - A hearing aid that is lost, stolen or broken
  - A hearing aid installed within the prior 12 period
- Replacement parts or repairs for a hearing aid
- Batteries or cords
- A hearing aid that does not meet the specifications prescribed for correction of hearing loss
- Any ear or hearing exam performed by a **physician** who is not certified as an otolaryngologist or otologist
- Hearing exams given during a **stay** in a **hospital** or other facility, except those provided to newborns as part of the overall **hospital stay**
- Any tests, appliances and devices to:
  - Improve your hearing. This includes hearing aid batteries and auxiliary equipment.
  - Enhance other forms of communication to make up for hearing loss or devices that simulate speech.

Nutritional supplements

- Any food item, including infant formulas, nutritional supplements, vitamins, plus **prescription** vitamins, medical foods and other nutritional items, even if it is the sole source of nutrition, except as covered in the *Eligible health services under your plan – Other services* section.

Prosthetic devices

- Services covered under any other benefit
- Orthopedic shoes, therapeutic shoes, foot orthotics, or other devices to support the feet, unless required for the treatment of or to prevent complications of diabetes, or if the orthopedic shoe is an integral part of a covered leg brace
- Trusses, corsets, and other support items
- Repair and replacement due to loss, misuse, abuse or theft

Vision Care

Adult vision care

- Office visits to an ophthalmologist, optometrist or optician related to the fitting of **prescription** contact lenses

- Eyeglass frames and contacts (except as described herein), non-**prescription** lenses and non-**prescription** contact lenses that are for cosmetic purposes

Vision care services and supplies

Your plan does not cover vision care services and supplies, except as described herein.

- Special supplies such as non-**prescription** sunglasses

- Special vision procedures, such as orthoptics or vision therapy

- Eye exams during your stay in a **hospital** or other facility for health care

- Eye exams for contact lenses or their fitting

- Eyeglasses or duplicate or spare eyeglasses or lenses or frames

- Replacement of lenses or frames that are lost or stolen or broken

- Acuity tests

- Eye **surgery** for the correction of vision, including radial keratotomy, LASIK and similar procedures

- Services to treat errors of refraction

Outpatient prescription drugs

Preventive contraceptives

- **Brand-name prescription drug** forms of contraception in each of the methods identified by the FDA

Who Provides the Care?

Just as the starting point for coverage under your plan is whether the services and supplies are **eligible health services**, the foundation for getting covered care is the network. This section tells you about **network** and **out-of-network providers**.

Just as the starting point for coverage under your plan is whether the services and supplies are **eligible health services**, the foundation for getting covered care is the network. This section tells you about **network providers**, referral network providers and out-of-network providers.

Network providers

The **network providers** are those **providers** set forth below, as such list may be amended from time to time in the on-line **directory** available at www.allinahealthaetna.com/ah under the Best Results for Your Plan tab. These **providers** make up the network for your plan. For you to receive benefits under the plan, for **eligible health** services you must use **network providers**. There are some exceptions:

- **Emergency services** – refer to the description of **emergency services** and urgent care in the *Eligible health services under your plan* section.

- Urgent care – refer to the description of emergency services and urgent care in the *Eligible health services under your plan* section.

- Referral network services – only when the **eligible health services** to which you need access cannot be provided by a **network provider**, and it is decided by Allina Health|Aetna through the claim decisions and appeals procedures that it is medically necessary for you to obtain **eligible health services** from a non-network provider, then **eligible health** services can be obtained from a referral network provider, which is a provider with a contract with Aetna. Refer to the description of referral network providers in the *Referral network providers* section.

- Out-of-network services – only when the **eligible health** services to which your need access cannot be provided by either a **network provider** or referral network provider, and it is determined by Allina Health|Aetna through the claim decisions and appeals procedures that it is medically necessary to you to obtain **eligible health services** from an out-of-network provider, the **eligible health services** can be obtained from an out-of-network provider. Refer to the description of out-of-network providers in the *Out-of-network providers* section.

You may select a **network provider** from the **directory** through your plan benefits secure member website at http://www.allinahealthaetna.com/. You can search our online **directory**, DocFind®, for names and locations of **network providers**.

You will not have to submit claims for treatment received from **network providers**. Your **network provider** will take care of that for you. And we will directly pay the **network provider** for what the plan owes.

Your PCP

We encourage you to access **eligible health services** through a **PCP**. They will provide you with primary care.

A **PCP** can be any of the following **providers** available under your plan:

- General practitioner
- Family **physician**
- Internist
- Pediatrician
- OB, GYN, and OB/GYN
- Medical group (primary care office)

How do you choose your PCP?

You can choose a **PCP** from the list of **PCPs** in our **directory**. See the *Who provides the care, Network providers* section. For more information on how to select a PCP, and for a list of the participating PCPs, contact Allina Health | Aetna at:

Allina Health | Aetna
2825 Chicago Ave. South
Minneapolis, MN 55407
Telephone: (612) 262-4531
Online: www.allinahealthaetna.com

Each covered family member is encouraged to select their own **PCP**. You may each select your own **PCP**. You should select a **PCP** for your covered dependent if they are a minor or cannot choose a **PCP** on their own.

What will your PCP do for you?

Your **PCP** will coordinate your medical care or may provide treatment. They may send you to other network **providers**.

Your **PCP** can also:

- Order lab tests and radiological services.
- Prescribe medicine or therapy.
- Arrange a **hospital stay** or a **stay** in another facility.

How do I change my PCP?

You may change your **PCP** at any time. You can call us at the toll-free number on your ID card or log on to your Plan Benefits secure member website at www.allinahealthaetna.com to make a change.

Referral network providers

A referral network provider is a provider who is not a **network provider**, but who has a contract with Aetna. Except in the case of emergency, you will only have access to a referral network provider if Allina Health|Aetna determines it is medically necessary because the **eligible health services** cannot be obtained through a **network provider**. If you believe that **eligible health services** cannot be obtained through a **network provider**, you can make request for a referral to a referral network provider who you believe can provide you with medically necessary **eligible health services**, using the rules set forth in the Claim decisions and appeals procedures section. If you use a referral network provider to receive services that Allina Health|Aetna determines are **eligible health services** and cannot be obtained from a **network provider**, such provider is called a referral network provider and you will be subject to the same cost-sharing as if you had received care at a **network provider**.

Out-of-network providers

If you use an **out-of-network provider** to receive services that could have been obtained through a **network provider** or referral network provider, you will have no coverage even if the services you received would have otherwise been **eligible health services**. **Eligible health services** obtained from an **out-of-network provider** are only covered by the plan if Allina Health|Aetna determines it is medically necessary because the **eligible health services** cannot be obtained through a **network provider** or a referral network provider. When you must use an out-of-network provider to receive **eligible health services**, you are subject to a higher out-of-pocket expense and are responsible for:

- Your out-of-network **payment percentage**
- Any charges over our **recognized charge**
- Submitting your own claims and getting **precertification**

Keeping a Provider You Go to Now (continuity of care)

In the event you must change your current primary care physician, specialty care physician or general hospital provider because that provider or facility leaves the network or because the network changes, you may have the right to continue receive in-network benefits for services from such current provider or facility for a period of time. Some services provided by an out-of-network provider or facility may be treated as a covered in-network benefit under the Plan for the earlier of 90 days or when you are no longer a Continuing Care Patient if you qualify for continuity of care benefits under federal law and, in such case, the provider or facility cannot send you a balance bill. A “Continuing Care Patient” is a person who is:

- undergoing a course of treatment for a serious and complex condition from the provider or facility;

- undergoing a course of institutional or inpatient care from the provider or facility;
- scheduled to undergo non-elective surgery from the provider or facility;
- pregnant and undergoing a course of treatment for pregnancy from the provider or facility; or
- determined to be terminally ill and receiving treatment for such illness from the provider or facility.

Continuity of care benefits may not be available or may be discontinued if the provider or facility is terminated from the network for misconduct.

What the Plan Pays and What You Pay

Who pays for your **eligible health services** – this plan, both of us, or just you? That depends. This section gives the general rule and explains these key terms:

- Your **copayments/payment percentage**
- Your **maximum out-of-pocket limit**

We also remind you that sometimes you will be responsible for paying the entire bill: for example, if you get care that is not an **eligible health service**.

The general rule

When you get **eligible health services**:

- The plan and you share the expense. The schedule of benefits lists how much your plan pays and how much you pay for each type of health care service. Your share is called a **copayment/payment percentage**.

  And then

- The plan pays the entire expense after you reach any **maximum out-of-pocket limit**.

When we say "expense" in this general rule, we mean the **negotiated charge** for a **network provider**. See the *Glossary* section for what these terms mean.

Important exception – when your plan pays all

Under the in-network level of coverage, your plan pays the entire expense for all eligible health services under the preventive care and wellness benefit.

Important exceptions – when you pay all

You pay the entire expense for an eligible health service:

- When you get a health care service or supply that is not **medically necessary**. See the *Medical necessity and precertification requirements* section.
- When your plan requires **precertification**, your **physician** requested it, we refused it, and you get an eligible health service without **precertification**. See the *Medical necessity and precertification requirements* section.
- Usually, when you get an **eligible health service** from someone who is not an **Allina Health | Aetna Health provider**. See the *Who provides the care* section.

In all these cases, the **provider** may require you to pay the entire charge. Any amount you pay will not count towards your **maximum out-of-pocket limit**.

Special financial responsibility

You are responsible for the entire expense of:

- Cancelled or missed appointments

Neither you nor we are responsible for:

- Charges for which you have no legal obligation to pay
- Charges that would not be made if you did not have coverage
- Charges, expenses, or costs in excess of the **negotiated charge**

Where your schedule of benefits fits in

How your copayment/ payment percentage works

Your **copayment/payment percentage** is the amount you pay for **eligible health services**. Your schedule of benefits shows you which **copayments/ payment percentage** you need to pay for specific **eligible health services**.

You will pay the **physician, PCP copayment/payment percentage** when you receive **eligible health services** from any **PCP**.

How your maximum out-of-pocket limit works

You will pay your **copayments/payment percentage** up to the **maximum out-of-pocket limit** for your plan. Your schedule of benefits shows the **maximum out-of-pocket limits** that apply to your plan. Once you reach your **maximum out-of-pocket limit**, your plan will pay for **covered benefits** for the remainder of that **Calendar Year**.

Important note:

See the schedule of benefits for any **copayments/ payment percentage, maximum out-of-pocket limit** and maximum age, visits, days, hours, admissions that may apply.

Claim Decisions and Appeals Procedures

In the previous section, we explained how you and the plan share responsibility for paying for your eligible health services.

When a claim comes in, you will receive a decision on how you and the plan will split the expense. We also explain what you can do if you think we got it wrong.

Claims are processed in the order in which they are received and in the time and manner required by applicable law.

Claim procedures

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 SPD 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 medical benefits under this plan. If Allina Health | Aetna, 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 Allina Health | Aetna.

Referral claim procedures

If you believe you cannot obtain **eligible health services** from a **network provider** and you wish to obtain such services, you must submit a request for referral to a referral network provider (a non-network provider who nevertheless has a contract in place with Aetna) by submitting a Pre-service Claim to Allina Health|Aetna at **1-800-343-9264**. If Allina Health|Aetna, in its sole discretion, determines the **eligible health services** you are requesting can be obtained from a **network provider**, so that it is not medically necessary for you to obtain care from a referral network provider, no benefits will be payable under this plan (except in the case of emergency or urgent care needs). Except in the event of emergency or urgent care needs, only if Allina Health|Aetna, in its sole discretion, determines that the **eligible health services** you are requesting cannot be obtained from either a network provider or referral **network provider**, and that it is medically necessary for you to obtain care from an out-of-service provider, then the plan will pay for **eligible health services** but your out-of-pocket costs will be higher. All claims and questions regarding referral to a non-network provider should be directed to Allina Health|Aetna. The general claims procedures below apply to requests for referral to a non-network provider.

For claims involving out-of-network providers:

Notice	Requirement	Deadline
Submit a claim	• You should notify and request a claim form from Allina Health | Aetna • The claim form will provide instructions on how to	• Within 15 working days of your request. • If the claim form is not sent on time, we will accept a written description that is the

Notice	Requirement	Deadline
	complete and where to send the form(s).	basis of the claim as proof of loss. It must detail the nature and extent of loss within 90 days of your loss.
Proof of loss (claim)	• A completed claim form and any additional information required by your employer.	• You must submit proof of loss to Allina Health | Aetna no later than 90 days after you have incurred expenses for covered benefits. • We won't void or reduce your claim if you can't send us notice and proof of loss within the required time. But, you must send us notice and proof as soon as reasonably possible. • Proof of loss may not be given later than 2 years after the time proof is otherwise required, except if you are legally unable to notify us.
Benefit payment	• Written proof must be provided for all benefits. • If any portion of a claim is contested by us, the uncontested portion of the claim will be paid promptly after the receipt of proof of loss.	• Benefits will be paid as soon as the necessary proof to support the claim is received.

Types of claims and communicating our claim decisions

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 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.

You or your provider are required to send us a claim in writing. You can request a claim form from us. And we will review that claim for payment to the provider.

There are different types of claims. The amount of time that we have to tell you about our decision on a claim depends on the type of claim. The section below will tell you about the different types of claims.

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. In other words, a Pre-service claim is a claim that involves services you have not yet received and which we will pay for only if we precertify them. If the plan does not require a claimant to obtain approval of a medical service prior to getting treatment, then it is not a "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. If you are pregnant, an urgent claim also includes a situation that can cause serious risk to the health of your unborn baby. Allina Health | Aetna 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 Allina Health | Aetna for prior approval. The claimant should obtain such care without delay.

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, or a claim that involves health care services you have already received.

Concurrent Care Claim

A “Concurrent Care Claim" arises when Allina Health | Aetna has approved an ongoing course of treatment to be provided over a period of time or number of treatments, and either (a) Allina Health | Aetna 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 has been 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 Allina Health | Aetna 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.

If we decide to reduce or stop payment for an already approved course of treatment, we will notify you of such a determination and you will have enough time to file an appeal. Your coverage for the service or supply will continue until you receive a final appeal decision from us or an external review organization if the situation is eligible for external review.

During this continuation period, you are still responsible for your share of the costs, such as copayments/payment percentage that apply to the service or supply. If we uphold our decision at the final internal appeal, you will be responsible for all of the expenses for the service or supply received during the continuation period.

We may need to tell your physician about our decision on some types of claims, such as a Concurrent Care Claim, or a claim when you are already receiving the health care services or are in the hospital.

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 Allina Health | Aetna.

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 Allina Health | Aetna. A claimant is not responsible for submitting claims for services received from network providers or referral network providers. These providers will submit claims directly to the plan on the claimant's behalf and payment will be made directly to these providers. If a claimant receives services from out-of-network 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 Allina Health | Aetna at the address on the back of your card. The necessary forms may be obtained by contacting Allina Health | Aetna at 800-343-9264. 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.

Urgent Care Claims

An Urgent Care Claim may be submitted to Allina Health | Aetna at 800-343-9264.

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 Allina Health | Aetna at 800-343-9264.

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, Allina Health | Aetna 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, Allina Health | Aetna 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

Type of notice	Urgent Care Claim	Pre-service Claim	Post-service Claim	Concurrent Care Claim
Initial determination (by us) and notification of determination	As soon as possible, but no later than 72 hours after claim received	No later than 15 days after claim received	No later than 30 days after claim received	24 hours for urgent request* 15 calendar days for non-urgent request
Extensions	None	15 days	15 days	Not applicable
Additional information request (us)	72 hours	15 days	30 days	Not applicable
Response to additional information request (you)	48 hours	45 days	45 days	Not applicable

*We have to receive the request at least 24 hours before the previously approved health care services end.

Extensions of Time

If Allina Health | Aetna is not able to decide a Pre-service or Post-service Claim and notify you 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 you are notified in writing prior to the expiration of the initial timeframe applicable to the claim. The notice will describe the matters beyond Allina Health | Aetna's control that justify the extension and the date by which it expects to render a decision. No extension of time is permitted for Urgent Care Claims. In addition, you may voluntarily agree to extend the timeframes described above.

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, Allina Health | Aetna 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. Allina Health | Aetna 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, Allina Health | Aetna 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. Allina Health | Aetna 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.

Adverse benefit determinations

Benefits under the plan will be paid only if Allina Health | Aetna decides in its discretion that the claimant is entitled to them. All determinations, interpretations, rules, and decisions of Allina Health | Aetna shall be made in its sole discretion and shall be conclusive and binding upon all persons having or claiming to have any interest or right under the plan.

We pay many claims at the full rate negotiated charge with a network provider and the recognized amount with an out-of-network provider, except for your share of the costs. But sometimes we pay only some of the claim. And sometimes we deny payment entirely. Any time we deny even part of the claim that is an “adverse benefit determination” or “adverse decision.” It is also an “adverse benefit determination” if we rescind your coverage entirely.

Allina Health | Aetna will provide the claimant with written notice of an adverse benefit determination on a claim. Allina Health | Aetna will provide the claimant written notice of the decision on a Pre-service or Urgent Care Claim whether or not the decision is adverse. We 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.

The difference between a complaint and an appeal

A Complaint

You may not be happy about a provider or an operational issue, and you may want to complain. You can call or write Member Services. Your complaint should include a description of the issue. You should include copies of any records or documents that you think are important. We will review the information and provide you with a written response within 30 calendar days of receiving the complaint. We will let you know if we need more information to make a decision.

An Appeal

You can ask us to re-review an adverse benefit determination. This is called an appeal. You can appeal to us verbally or in writing at 800-343-9264.

Appeals of Adverse Benefit Determinations

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

adverse benefit determination. We will assign your appeal to someone who was not involved in making the original decision, and who is not a subordinate of the original decisionmaker.

You must file an appeal within 180 calendar days from the time you receive the notice of an adverse benefit determination. You can appeal by sending a written appeal to Allina Health | Aetna at the address on the notice of adverse benefit determination. Or you can call Allina Health | Aetna at the number on your ID card. You need to include:

- Your name
- The employer's name
- A copy of the adverse benefit determination
- Your reasons for making the appeal
- Any other information you would like us to consider

Another person may submit an appeal for you, including a provider. That person is called an authorized representative. You need to tell us if you choose to have someone else appeal for you (even if it is your provider). You should fill out an authorized representative form telling us that you are allowing someone to appeal for you. You can get this form by contacting us. You can use an authorized representative at any level of appeal.

You can appeal two times under this plan. If you appeal a second time you must present your appeal within 60 calendar days from the date you receive the notice of the first appeal decision.

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 Allina Health | Aetna. A claimant is responsible for submitting proof that the claim for benefits is covered and payable under the plan.

Urgent Care and Pre-service Claim Appeals

If your claim is an Urgent Care Claim or a Pre-service Claim, your provider may appeal for you without having to fill out a form.

Additionally, an urgent care appeal may be submitted to Allina Health | Aetna at 800-343-9264. Allina Health | Aetna will transmit all necessary information, including the determination on review, by telephone, fax, or other available similar methods.

Timeframes for Deciding Appeals

The amount of time that we have to tell you about our decision on an appeal depends on the type of claim. The chart below shows a timetable view of the different types of claims and how much time we have to tell you about our decision for each appeal.

Type of notice	Urgent Care Claim	Pre-service Claim	Post-service Claim	Concurrent Care Claim
Deadline to notify you of appeal determinations at each level of appeal (us)	No later than 36 hours after appeal received	No later than 15 days after appeal received	No later than 30 days after appeal received	As appropriate to type of claim
Extensions	None	None	None	

Notification of Appeal Decision

Allina Health | Aetna will provide the claimant with written notice of the appeal decision. The notification will include the content required by law.

Allina Health | Aetna 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. Unless these procedures are deemed to be exhausted, the decision by Allina Health | Aetna on review will be final, binding and conclusive and will be afforded the maximum deference permitted by law.

Exhaustion of Appeals Process

You must complete the two levels of appeal with us before you can take these other actions:

- Appeal through an external review process (if eligible for external review).
- Pursue litigation.

But sometimes you do not have to complete the two levels of appeals process before you may take other actions. These situations are:

- You have an urgent claim or a claim that involves ongoing treatment. You can have your claim reviewed internally and at the same time through the external review process.
- We did not follow all of the claim determination and appeal requirements of the Federal Department of Health and Human Services. But, you will not be able to proceed directly to external review if:
  - The rule violation was minor and not likely to influence a decision or harm you.
  - The violation was for a good cause or beyond our control.
  - The violation was part of an ongoing, good faith exchange between you and us.

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

External review is a review done by people in an organization outside of Allina Health | Aetna. This is called an external review organization (ERO).

You have a right to external review only if the adverse determination (i) involved, medical judgment (e.g., we decided the service or supply is not medically necessary or not appropriate; or we decided the service or supply is experimental or investigational); (ii) your coverage was rescinded; or (iii) or whether the plan has complied with surprise billing and cost-sharing protections relating to (i) out-of-network emergency services; (ii) non-emergency services performed by out-of-network providers of participating facilities; or (iii) air ambulance services furnished by an out-of-network provider.

If our claim decision is one for which you can seek external review, we will say that in the notice of adverse benefit determination or final adverse benefit determination we send you. That notice also will describe the external review process. It will include a copy of the Request for External Review form at the final adverse determination level.

You must submit the Request for external review Form:

- To Allina Health | Aetna
- Within 123 calendar days (four months) of the date you received the adverse decision from us
- And you must include a copy of the notice from us and all other important information that supports your request

You will pay for any information that you send and want reviewed by the ERO. We will pay for information we send to the ERO plus the cost of the review.

Allina Health | Aetna will:

- Contact the ERO that will conduct the preliminary review of your claim to determine its eligibility for external review.
- If the appeal is eligible for external review, assign it to one or more independent clinical reviewers that have the proper expertise to do the review.

- Consider appropriate credible information that you sent.
- Follow our contractual documents and your plan of benefits.
- Send notification of the decision within 45 calendar days of the date we receive your request form and all the necessary information.

We will stand by the decision that the ERO makes, unless we can show conflict of interest, bias or fraud.

How long will it take to get an ERO decision?

We will tell you of the ERO decision not more than 45 calendar days after we receive your Notice of External Review Form with all the information you need to send in.

But sometimes you can get a faster external review decision. Your provider must call us or send us a Request for External Review Form.

There are two scenarios when you may be able to get a faster external review:

For initial adverse determinations

Your provider tells us that a delay in your receiving health care services would:

- Jeopardize your life, health or ability to regain maximum function, or
- Be much less effective if not started right away (in the case of experimental or investigational treatment)

For final adverse determinations

Your provider tells us that a delay in your receiving health care services would:

- Jeopardize your life, health or ability to regain maximum function
- Be much less effective if not started right away (in the case of experimental or investigational treatment), or
- The final adverse determination concerns an admission, availability of care, continued stay or health care service for which you received emergency services, but have not been discharged from a facility

If your situation qualifies for this faster review, you will receive a decision within 72 hours of us getting your request.

General Rules

- The exhaustion of the claims procedures (with the exception of external review) 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 Allina Health | Aetna or another 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 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 (Allina Health | Aetna 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. A document, record, or other information shall be considered “relevant” to a claim if the document, record, or other information: (i) was relied upon in making the benefit determination; (ii) was submitted, considered, or generated in the course of making the benefit determination, without regard to whether such document, record, or other information was relied upon in making the benefit determination; (iii) demonstrates compliance with the required administrative processes and safeguards in making the benefit determination; or (iv) constitutes a statement of policy or guidance with respect to the plan concerning the denied treatment option or benefit for the claimant’s diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.

- You must comply with any additional requirements for filing a claim (e.g., using a specific claim form) imposed by Allina Health | Aetna.

- 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.

- We do not pay any fees or expenses incurred by you in pursuing a complaint or appeal.

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 Allina Health | Aetna. However, in connection with an Urgent Care Claim, Allina Health | Aetna 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 Allina Health | Aetna 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 the 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 Allina Health | Aetna or the Plan Administrator.

Claims Payment

When a claimant uses Network providers or referral network providers, the plan pays the provider. A claimant may not assign his or her benefits to a provider.

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 SPD 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 SPD as an intended or third-party beneficiary or assignee hereof.

Release of Records

Claimants agree to allow all health care providers to give Allina Health | Aetna needed information about the care that they provide to them. This includes information about care received prior to the claimant's enrollment with Allina Health | Aetna where necessary. Allina Health | Aetna 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

Allina Health | Aetna 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 exam whenever either Allina Health | Aetna or the Plan Administrator requests the exam. A claimant's failure to comply with this request may result in denial of the claimant's claim.

Coordination of Benefits

Some people have health coverage under more than one health plan. If you do, we will work together with your other plan(s) to decide how much each plan pays. This is called coordination of benefits (COB).

Key terms

Here are some key terms we use in this section. These terms will help you understand this COB section.

In this section when we talk about a “plan” through which you may have other coverage for health care expenses, we mean:

- Group or non-group, blanket, or franchise health insurance policies issued by insurers, HMOs, or health care service contractors
- Labor-management trustee plans, labor organization plans, employer organization plans, or employee benefit organization plans
- An automobile insurance policy
- Medicare or other governmental benefits
    - Any contract that you can obtain or maintain only because of membership in or connection with a particular organization or group

Here’s how COB works

- When this is the primary plan, we will pay your medical claims first as if the other plan does not exist.
- When this is the secondary plan, we will pay benefits after the primary plan and will reduce the benefits to the lesser of:
    - What the plan would have paid if it had been primary
    - What the plan would have paid less the primary plans payment.

Determining who pays

Reading from top to bottom the first rule that applies will determine which plan is primary and which is secondary.

A plan that does not contain a COB provision is always the primary plan.

If you are covered as a:	Primary plan	Secondary plan
Non-dependent or Dependent	The plan covering you as an employee or retired employee.	The plan covering you as a dependent.
Exception to the rule above when you are eligible for Medicare	If you or your spouse have Medicare coverage, the rule above may be reversed. If you have any questions about this you can contact us: • **Online**: Log on to your **Allina|Aetna** secure member website at www.allinahealthaetna.com. Select Find a Form, then select Your Other Health Plans. • **By phone:** Call the toll-free Member Services number on your ID card.	
COB rules for dependent children		
Child of: • Parents who are married or living together	The "birthday rule" applies. The plan of the parent whose birthday* (month and day only) falls earlier in the **calendar year.** *Same birthdays--the plan that has covered a parent longer is primary	The plan of the parent born later in the year (month and day only)*. *Same birthdays--the plan that has covered a parent longer is primary
Child of: • Parents separated or divorced or not living together • With court-order	The plan of the parent whom the court said is responsible for health coverage. But if that parent has no coverage then the other spouse's plan.	The plan of the other parent. But if that parent has no coverage, then his/her spouse's plan is primary.
Child of: • Parents separated or divorced or not living together – court-order states both parents are responsible for coverage or have joint custody	Primary and secondary coverage is based on the birthday rule.	
Child of: • Parents separated or divorced or not living together and there is no court-order	The order of benefit payments is: • The plan of the custodial parent pays first • The plan of the spouse of the custodial parent (if any) pays second • The plan of the noncustodial parents pays next • The plan of the spouse of the noncustodial parent (if any) pays last	
Active or inactive employee	The plan covering you as an active employee (or as a dependent of an active employee) is primary to a plan	A plan that covers the person as a laid off or retired employee (or as a dependent of a former employee) is secondary to a

	covering you as a laid off or retired employee (or as a dependent of a former employee).	plan that covers the person as an active employee (or as a dependent of an active employee).
COBRA or state continuation	The plan covering you as an employee or retiree or the dependent of an employee or retiree is primary to COBRA or state continuation coverage.	COBRA or state continuation coverage is secondary to the plan that covers the person as an employee or retiree or the dependent of an employee or retiree.
Longer or shorter length of coverage	If none of the above rules determine the order of payment, the plan that has covered the person longer is primary.	
Other rules do not apply	If none of the above rules apply, the plans share expenses equally.	

How are benefits paid?

Primary plan	The primary plan pays your claims as if there is no other health plan involved.
Secondary plan	The secondary plan calculates payment as if the primary plan did not exist and we compare that benefit to the primary plan's benefit. If the primary plan's benefit is equal to or more than our benefit, we don't pay a benefit. If the primary plan's benefit is less than our benefit, we pay the difference between the primary plan's benefit and our benefit.

How COB works with Medicare

This section explains how the benefits under this plan interact with benefits available under Medicare.

Medicare, when used in this plan, means the health insurance provided by Title XVIII of the Social Security Act, as amended. It also includes Health Maintenance Organization (HMO) or similar coverage that is an authorized alternative to Parts A and B of Medicare.

You are eligible for Medicare when you are covered under it by reason of:

- Age, disability, or
- End stage renal disease

You are also eligible for Medicare even if you are not covered if you:

- Refused it,
- Dropped it, or
- Did not make a proper request for it

When you are eligible for Medicare, the plan coordinates the benefits it pays with the benefits that Medicare pays. In the case of someone who is eligible for Medicare but not covered by Medicare, the plan may pay as if you are covered by Medicare and coordinates benefits with the benefits Medicare would have paid had you enrolled in Medicare. Sometimes, this plan is the primary plan, which means that the plan pays benefits before Medicare pays benefits. Sometimes, this plan is the secondary plan, and pays benefits after Medicare or after an amount that Medicare would have paid had you been covered by Medicare.

Who pays first?

If you are eligible due to age and have group health plan coverage based on your or your spouse's current employment and:	**Primary plan**	**Secondary plan**
You are retired	Medicare	Your plan
If you have Medicare because of:		
End stage renal disease (ESRD)	Your plan will pay first for the first 30 months. Medicare will pay first after this 30 month period.	Medicare Your Plan
A disability other than ESRD	Your plan	Medicare
Note regarding ESRD: If you were already eligible for Medicare due to age and then became eligible due to ESRD, Medicare will remain your primary plan and this **plan** will be secondary to the maximum extent allowed by Medicare Secondary Payer rules.		

This plan is secondary to Medicare in all other circumstances.

How are benefits paid?

The plan is primary	The plan pays your claims as if there is no Medicare coverage.
Medicare is primary	We calculate our benefit based on any remaining charges after Medicare has paid. Any member cost share under the plan will be applied to the remaining charges before the plan will pay.

Charges that satisfy your Part B deductible will be applied in the order received. We will apply the largest charge first when two or more charges are received at the same time.

Other health coverage updates – contact information

You should contact us if you have any changes to your other coverage. We want to be sure our records are accurate so your claims are processed correctly.

- **Online:** Log on to your Allina|Aetna secure member website at www.allinahealthaetna.com. Select Find a Form, then select Your Other Health Plans.

- **By phone:** Call the toll-free Member Services number on your ID card.

Right to receive and release needed information

We have the right to release or obtain any information we need for COB purposes. That includes information we need to recover any payments from your other health plans.

Right to pay another carrier

Sometimes another plan pays something we would have paid under your plan. When that happens, we will pay your plan benefit to the other plan.

Right of recovery

If we pay more than we should have under the COB rules, we may recover the excess from any means allowed by law:

- Any person we paid or for whom we paid, or

- Any other plan that is responsible under these COB rules.

Outpatient Prescription Drug Information

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

Outpatient Prescription Drugs Benefits

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

Benefit Features, Limitations, and Maximums

Networks

Allina Elevate Network (Allina Health Pharmacy)

National Network (Express Scripts Network Pharmacies)

Benefit Features **Limitations and Maximums**

Out-of-Pocket Maximums

The out-of-pocket limits for medical and prescription drug expenses under the Elevate Network are combined.

Allina Elevate Network	$3,500 per person per calendar year
	$7,000 per family per calendar year

The following items are applied toward the out-of-pocket maximum:

1. prescription drug coinsurance
2. prescription drug copay
3. medical coinsurance
4. 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. charges for non-covered items

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

Prescription Drugs

The Plan Covers:	**Allina Elevate Network**
Retail (31 day supply)	
Generic	$5 copay
Preferred-brand name	$25 copay
Non-Preferred	$60 copay
Mail Order (93 day supply)	
Generic	$10 copay
Preferred-brand name	$50 copay
Non-Preferred	$120 copay
Insulin	100%
Insulin Pump	100%
Insulin Pump Supplies and Equipment	100%
Diabetic Supplies and Equipment	100%

Ostomy Supplies	100%
Drugs for Treatment of sexual dysfunction (Non-Essential Benefit) Generic Preferred-brand name Non-Preferred Tobacco cessation products	 $5 copay $25 copay $60 copay 100%
Specialty drugs (31 day supply) Drugs for the treatment of growth deficiency Drugs for treatment of infertility (Non-Essential Benefit) All Other Specialty drugs	 $25 copay $25 copay $25 copay

Notes:

The prior authorization program monitors certain prescription drugs and their costs. You may call Express Scripts customer service at 1-800-509-5310, and select prompt 2 or visit www.express-scripts.com/allinahealth for a current list of prescription drugs that require prior authorization.

The first fill of any medication can be filled at any Express Scripts network pharmacy (except Walgreens); however, any subsequent fills would need to go through Allina pharmacies.

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.

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 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, the primary site for employee mail order is the Allina Health Heart Hospital Pharmacy.

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

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

Prescriptions may be ordered using the following methods:

- online request through MyChart (For new prescriptions, the original prescription must be submitted using one of the methods below.)

- electronically sent or faxed from your physician's office
- telephone submission by your physician
- hard copy prescription dropped off or mailed in to the pharmacy

Locating a Network Pharmacy

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

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

Formulary Information

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

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

- A drug may be moved to a higher or lower cost-sharing Formulary tier.
- Additional drugs may be excluded from the Formulary.
- A restriction may be added on coverage for a Formulary-covered drug (e.g., prior authorization).
- A Formulary-covered brand name drug may be replaced with a Formulary-covered generic drug.

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

Clinical Programs

The Prescription Drug Plan uses pharmacy management programs for safety, quality, and cost reasons. The programs include Step Therapy, Prior Authorization and Quantity Management.

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

Outpatient 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. 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:

Express Scripts
ATTN: Clinical Appeals Department
P.O. Box 66588
St. Louis, MO 63166-6588
Fax: 1-877-852-4070

Administrative coverage appeal requests:

Express Scripts
ATTN: Administrative Appeals Department
P.O. Box 66587
St. Louis, MO 63166-6588
Fax: 1-877-328-9660

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

- If new information provided: If there is an approval granted based on the new information provided, an override or payment is issued and a letter is mailed to you. If the new information still results in a denial, a denial reconsideration letter is mailed with further appeal rights with Express Scripts' address.

- If no new information provided from original denial: The appeal is sent to MCMC for review. MCMC is not affiliated with Express Scripts and it independently reviews previously denied services. MCMC reviews the case information and provides Express Scripts with the decision, and a letter is sent to you based on determination. If the appeal is approved, the necessary overrides are entered into the Express Scripts' system. If the appeal is denied, MCMC sends a denial letter to you explaining further appeal rights.

Urgent Care Appeals

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

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

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

Timeframes for Deciding Appeal

Urgent Care Claims

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

Pre-Service Claims

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

Post-service Claims

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

Notification of Appeal Decision

ESI will provide the claimant with written notice of the appeal decision. The notification will include 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, rescission or whether the plan has complied with surprise billing and cost-sharing protections relating to (i) out-of-network emergency services; (ii) non-emergency services performed by out-of-network providers of participating facilities; or (iii) air ambulance services furnished by an out-of-network provider, you may file a request for an external review within four (4) months after the date of receipt of a notice of 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, rescission or whether the plan has complied with surprise billing and cost-sharing protections relating to (i) out-of-network emergency services; (ii) non-emergency services performed by out-of-network providers of participating facilities; or (iii) air ambulance services furnished by an out-of-network provider;

    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.

When Coverage Ends

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

- When coverage ends
- COBRA continuation coverage

Additional information

We gathered a number of additional provisions here.

Administrative information

Who's responsible to you

We are responsible to you for what our employees and other agents do.

We are not responsible for what is done by your providers. Even network providers are not our employees or agents.

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

Coverage and services

Your coverage can change

Your coverage is defined by the group health plan. This document may have amendments too. Under certain circumstances, your employer or the law may change your plan.

If a service cannot be provided to you

Sometimes things happen that are outside of our control. These are things such as natural disasters, epidemics, fire and riots.

We will try hard to get you access to the services you need even if these things happen.

Legal action

You must complete the internal appeal process before you take any legal action against us, your employer or the plan for any expense or bill. See the Claim decisions and appeal procedures section.

You must commence any lawsuit under the plan within 2 years after you knew or reasonably should have known of the facts behind your claim or, if earlier, within 6 months after the claims procedure is completed.

Claims venue

Any claim or action brought with respect to this plan shall be brought in the federal courts located in Minneapolis in the District of the State of Minnesota.

Physical examinations and evaluations

At our expense, we have the right to have a **physician** of our choice examine you. This will be done at all reasonable times while certification or a claim for benefits is pending or under review.

Records of expenses

You should keep complete records of your expenses. They may be needed for a claim.

Things that would be important to keep are:

- Names of **physicians**, dentists and others who furnish services
- Dates expenses are incurred
- Copies of all bills and receipts

Intentional deception

Intentional deception

If we learn that you defrauded us or you intentionally misrepresented material facts, we can take actions that can have serious consequences for your coverage. These serious consequences include, but are not limited to:

- Loss of coverage, starting at some time in the past. This is called rescission.
- Loss of coverage going forward.
- Denial of benefits.
- Recovery of amounts we already paid by any method allowed by law.

We also may report fraud to criminal authorities.

Rescission means you lose coverage both going forward and going backward. If we paid claims for your past coverage, we will want the money back.

You have special rights if we rescind your coverage.

- We will give you 30 days' advanced written notice of any rescission of coverage.
- You have the right to an **Allina Health | Aetna** appeal.
- You have the right to a third party review conducted by an independent external review organization if your appeal is denied.

Financial information

Assignment of benefits

When you see a **network provider** they will usually bill us directly. When you see an **out-of-network provider**, we may choose to pay you or to pay the **provider** directly. However, assignment of benefits under this plan is prohibited.

Financial sanctions exclusions

If coverage provided under this booklet violates or will violate any economic or trade sanctions, the coverage will be invalid immediately. For example, we cannot pay for **eligible health services** if it violates a financial sanction regulation. This includes sanctions related to a person or a country under sanction by the United States, unless it is allowed under a written license from the Office of Foreign Asset Control (OFAC). You can find out more by visiting http://www.treasury.gov/resource-center/sanctions/Pages/default.aspx.

Recovery of overpayments

If a benefit payment is made by the Plan, to you or on your behalf, which exceeds the benefit amount that you are entitled to receive, the Plan has the right to require the return of the overpayment by any method allowed by law. The Plan has the right to reduce by the amount of the overpayment, any future benefit payment made to or on behalf of a Participant in the Plan. Another way that overpayments are recovered is by reducing future payments to the provider by the amount of the overpayment. These future payments may involve this Plan or other health plans that are administered by the Plan's third-party administrator - Aetna. Under this process, Aetna reduces future payments to providers by the amount of the overpayment they received, and then credit the recovered amount to the plan that overpaid the provider. Payments to providers under this Plan are subject to this same process when Aetna recovers overpayments for other plans administered by Aetna.

This right does not affect any other right of recovery the Plan may have with respect to overpayments.

Subrogation and Right of Recovery

For information regarding subrogation and right of recovery, please refer to the Subrogation and Reimbursement provisions in the “Plan Administration” section of the Eligibility & Enrollment Booklet.

Continuation of coverage for other reasons

Health coverage under this plan will continue uninterrupted as to your dependent college student who takes a medically necessary leave of absence from school. See the Special coverage options after your plan coverage ends – How can you extend coverage for a child in college on medical leave? section.

Sutter Health and Affiliates Services

Sutter Health and Affiliates, the dominant health system in much of northern California, uses its bargaining power to insist on unique requirements to participate in the Aetna network. Aetna’s contract with Sutter requires payment of claims that would otherwise be denied, such as those not medically necessary or experimental or investigational (but does not require payment for services the Plan expressly excludes from coverage, such as for cosmetic surgery). The Plan for these claims in order to be able to continue providing Plan Participants with access to Sutter’s services on an in-network basis.

Glossary

Aetna

Aetna Life Insurance Company, an affiliate, or a third party vendor under contract with **Aetna**.

Allina Health | Aetna

Allina Health and Aetna Insurance Company, an affiliate, or a third party vendor under contract with Allina Health | Aetna.

Ambulance

A vehicle staffed by medical personnel and equipped to transport an ill or injured person.

Behavioral health provider

An individual professional that is properly licensed or certified to provide diagnostic and/or therapeutic services for mental disorders and substance abuse under the laws of the jurisdiction where the individual practices.

Body mass index

This is a degree of obesity and is calculated by dividing your weight in kilograms by your height in meters squared.

Brand-name prescription drug

A U.S. Food and Drug Administration (FDA) approved prescription drug marketed with a specific brand name by the company that manufactures it, usually by the company which develops and patents it.

Copay/Copayments

The specific dollar amount or percentage you have to pay for a health care service listed in the schedule of benefits.

Cosmetic

Services, drugs or supplies that are primarily intended to alter, improve or enhance your appearance.

Covered benefits

Eligible health services that meet the requirements for coverage under the terms of this plan, including:

1. They are **medically necessary**.

2. You received **precertification** and/or a **referral, if required.**

Custodial care

Services and supplies mainly intended to help meet your activities of daily living or other personal needs. Care may be custodial care even if it is prescribed by a physician or given by trained medical personnel.

Deductible

The amount you pay for eligible health services per Calendar Year before your plan starts to pay as listed in the schedule of benefits.

Designated network provider

A network provider listed in the directory under the Best results for your plan tab as an Allina Tier 1 provider for your plan.

Detoxification

The process where an alcohol or drug intoxicated, or alcohol or drug dependent, person is assisted through the period of time needed to eliminate the:

- Intoxicating alcohol or drug
- Alcohol or drug-dependent factors
- Alcohol in combination with drugs

This can be done by metabolic or other means determined by a physician, or a nurse practitioner working within the scope of their license. The process must keep the physiological risk to the patient at a minimum. And if it takes place in a facility, the facility must meet any applicable licensing standards established by the jurisdiction in which it is located.

Directory

The list of **network providers** for your plan. The most up-to-date **directory** for your plan appears at http://www.aetna.com under the Provider search label. When searching Provider search, you need to make sure that you are searching for **providers** that participate in your plan. Provider lists are finished automatically, without charge, upon request.

Durable medical equipment (DME)

Equipment and the accessories needed to operate it, that is:

- Made to withstand prolonged use
- Mainly used in the treatment of an illness or injury
- Suited for use in the home

- Not normally used by people who do not have an illness or injury
- Not for altering air quality or temperature
- Not for exercise or training

Effective date of coverage

The date your coverage begins under this booklet-certificate as noted in Allina Health | Aetna's records.

Eligible health services

The health care services and supplies listed in the Eligible health services under your plan section and not carved out or limited in the exclusions section or in the schedule of benefits.

Emergency admission

An admission to a **hospital** or treatment facility ordered by a **physician** within 24 hours after you receive **emergency services**.

Emergency medical condition

A medical condition, including a mental health condition or substance use disorder, with symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention and treatment would reasonably be expected to result in: (a) serious jeopardy to the health of the individual (or, with respect to a pregnant woman, the woman's unborn child); (b) serious impairment to bodily functions; or (c) serious dysfunction of any bodily organ or part.

Emergency services

Emergency services with respect to an emergency medical condition can be provided by the emergency department of a hospital or by an independent freestanding emergency department and include an appropriate medical screening examination, ancillary services routinely available to evaluate such emergency medical condition and such further medical examination and treatment as are required to stabilize the patient (regardless of the department of the hospital in which such further examination or treatment is furnished). Post-stabilization services, such as an inpatient hospital stay or outpatient observation, are emergency services for which an out-of-network provider or facility cannot balance bill unless the provider or facility provides notice to you of treatment by a nonparticipating provider or facility, you provide written consent for balance billing and you give up your balance billing protections.

Experimental or investigational

A drug, device, procedure, or treatment that is found to be **experimental or investigational** because:

- There is not enough outcome data available from controlled clinical trials published in the peer-reviewed literature to validate its safety and effectiveness for the **illness** or **injury** involved

- The needed approval by the FDA has not been given for marketing
- A national medical or dental society or regulatory agency has stated in writing that it is **experimental or investigational** or suitable mainly for research purposes
- It is the subject of a Phase I, Phase II or the experimental or research arm of a Phase III clinical trial. These terms have the meanings given by regulations and other official actions and publications of the FDA and Department of Health and Human Services
- Written protocols or a written consent form used by a facility **provider** state that it is **experimental or investigational**.

Generic prescription drug

A **prescription drug** with the same dosage, safety, strength, quality, performance and intended use as the brand name product. It is defined as therapeutically equivalent by the U.S. Food and Drug Administration (FDA) and is considered to be as effective as the brand name product.

Health professional

A person who is licensed, certified or otherwise authorized by law to provide health care services to the public. For example, **physicians**, nurses, and physical therapists.

Home health care agency

An agency licensed, certified or otherwise authorized by applicable state and federal laws to provide home health care services, such as skilled nursing and other therapeutic services.

Home health care plan

A plan of services prescribed by a **physician** or other health care practitioner to be provided in the home setting. These services are usually provided after your discharge from a **hospital** or if you are homebound.

Hospice care

Care designed to give supportive care to people in the final phase of a **terminal illness** and focus on comfort and quality of life, rather than cure.

Hospice care agency

An agency or organization licensed, certified or otherwise authorized by applicable state and federal laws to provide **hospice care**. These services may be available in your home or inpatient setting.

Hospice care program

A program prescribed by a **physician** or other **health professional** to provide **hospice care** and supportive care to their families.

Hospice facility

An institution specifically licensed, certified or otherwise authorized by applicable state and federal laws to provide **hospice care**.

Hospital

An institution licensed as a **hospital** by applicable state and federal laws, and accredited as a **hospital** by The Joint Commission (TJC).

Hospital does not include a:

- Convalescent facility
- Rest facility
- Nursing facility
- Facility for the aged
- **Psychiatric hospital**
- **Residential treatment facility** for **substance abuse**
- **Residential treatment facility** for **mental disorders**
- Extended care facility
- Intermediate care facility
- **Skilled nursing facility**

Illness

Poor health resulting from disease of the body or mind.

Infertile/infertility

A disease defined by the failure to become pregnant:

- For a female with a male partner, after:
    - 1 year of frequent, unprotected heterosexual sexual intercourse if under the age of 35
    - 6 months of frequent, unprotected heterosexual sexual intercourse if age 35 or older
- For a female without a male partner, after:
    - At least 12 cycles of donor insemination if under the age of 35

  - 6 cycles of donor insemination if age 35 or older

- For a male without a female partner, after:
  - At least 2 abnormal semen analyses obtained at least 2 weeks apart

Injury

Physical damage to a person or part of their body.

Institutes of Excellence™ (IOE) facility

A facility designated by **Allina Health | Aetna** in the **provider directory** as **Institutes of Excellence network provider** for specific services or procedures.

Intensive Outpatient Program (IOP)

Clinical treatment provided must be no more than 5 days per week, no more than 19 hours per week and a minimum of 2 hours each treatment day of **medically necessary** services delivered by an appropriately licensed or credentialed practitioner. Services are designed to address a **mental disorder** or **substance abuse** issue and may include group, individual, family or multi-family group psychotherapy, psycho educational services, and adjunctive services such as medication monitoring.

Jaw joint disorder

This is:

- A temporomandibular joint (TMJ) dysfunction or any similar disorder of the jaw joint,
- A myofascial pain dysfunction (MPD) of the jaw, or
- Any similar disorder in the relationship between the jaw joint and the related muscles and nerves.

L.P.N.

A licensed practical nurse or a licensed vocational nurse.

Mail order pharmacy

A pharmacy where **prescription drugs** are legally dispensed by mail or other carrier.

Maximum out-of-pocket limit

The maximum out-of-pocket amount for payment of **copayments** and **payment percentage** and **deductible**, to be paid by you or any covered dependents per Calendar Year for **eligible health services**.

Medically necessary/Medical necessity

Health care services that a **provider** exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an **illness, injury**, disease or its symptoms, and that are:

- In accordance with generally accepted standards of medical practice
- Clinically appropriate, in terms of level of care, type, frequency, extent, site and duration, and considered effective for the patient's **illness, injury** or disease
- Not primarily for the convenience of the patient, **physician**, or other health care **provider**
- 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 patient's **illness, injury** or disease

Generally accepted standards of medical practice means:

- Standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community.
- Consistent with the standards set forth in policy issues involving clinical judgment.

Mental disorder

A **mental disorder** is in general, a set of symptoms or behavior associated with distress and interference with personal function. A complete definition of **mental disorder** is in the most recent edition of The International Classification of Diseases, Tenth Edition (ICD-10).

Morbid obesity/morbidly obese

This means the **body mass index** is well above the normal range and severe medical conditions may also be present, such as:

- High blood pressure;
- A heart or lung condition;
- Sleep apnea; or
- Diabetes

Negotiated charge

For health coverage, this is either:

- The amount a **network provider** has agreed to accept

- The amount we agree to pay directly to a **network provider** or third-party vendor (including any administrative fee in the amount paid)

for providing services, **prescription drugs** or supplies to plan members. This does not include **prescription drug** services from a **network pharmacy**.

Some providers are part of **Allina Health | Aetna's** network for some **Allina Health | Aetna** plans but are not considered **network providers** for your plan. For those **providers**, the **negotiated charge** is the amount that **provider** has agreed to accept for rendering services or providing **prescription drugs** to members of your plan.

We may enter into arrangements with **network providers** or others related to:

- The coordination of care for members
- Improving clinical outcomes and efficiencies

Some of these arrangements are called:

- Value-based contracting
- Risk sharing
- Accountable care arrangements

These arrangements will not change the **negotiated charge** under this plan.

*For **prescription drug** services from a **network pharmacy**:*

The amount we established for each **prescription drug** obtained from a **network pharmacy** under this plan. This **negotiated charge** may reflect amounts we agreed to pay directly to the **network pharmacy** or to a third-party vendor for the **prescription drug**, and may include a rebate, an additional service or risk charge set by us.

We may receive or pay additional amounts from or to third parties under price guarantees. These amounts may not change the negotiated charge under this plan.

Network provider

A **provider** listed in the **directory** for your plan. However, a NAP provider listed in the NAP directory is not a **network provider**.

Non-designated network provider

A **network provider** listed in the **directory** under the *All other results* tab as a **provider** for your plan.

Out-of-network provider

A provider who is not a network provider.

Partial hospitalization treatment

Clinical treatment provided must **medically necessary** and provided by a **behavioral health provider** with the appropriate license or credentials. Services are designed to address a **mental disorder** or **substance abuse** issue and may include:

- Group, individual, family or multi-family group psychotherapy
- Psycho-educational services
- Adjunctive services such as medication monitoring

Care is delivered according to accepted medical practice for the condition of the person.

Payment Percentage

The specific percentage the plan pays for a health care service listed in the schedule of benefits.

Pharmacy

An establishment where **prescription drugs** are legally dispensed. This includes a **network retail pharmacy, mail order pharmacy** and **specialty pharmacy**.

Physician

A skilled health care professional trained and licensed to practice medicine under the laws of the state where they practice; specifically, doctors of medicine or osteopathy.

Precertification, precertify

A requirement that you or your **physician** contact **Allina Health | Aetna** before you receive coverage for certain services. This may include a determination by us as to whether the service is **medically necessary** and eligible for coverage.

Prescriber

Any **provider** acting within the scope of his or her license, who has the legal authority to write an order for outpatient **prescription drugs**.

Prescription

A written order for the dispensing of a **prescription drug** by a **prescriber**. If it is a verbal order, it must promptly be put in writing by the **network pharmacy**.

Prescription drug

An FDA approved drug or biological which can only be dispensed by **prescription**.

Primary care physician (PCP)

A **physician** who:

- The directory lists as a **PCP**
- Is selected by a person from the list of **PCPs** in the **directory**
- Supervises, coordinates and provides initial care and basic medical services to a person as a family care **physician**, an internist, a pediatrician
- Is shown on **Allina Health | Aetna's** records as your **PCP**

Provider(s)

A **physician**, other **health professional, hospital, skilled nursing facility, home health care agency** or other entity or person licensed or certified under applicable state and federal law to provide health care services to you. If state law does not specifically provide for licensure or certification, the entity must meet all Medicare accreditation standards (even if it does not participate in Medicare).

Psychiatric hospital

An institution specifically licensed or certified as a **psychiatric hospital** by applicable state and federal laws to provide a program for the diagnosis, evaluation, and treatment of alcoholism, drug abuse, **mental disorders** (including substance-related disorders) or mental illnesses.

Psychiatrist

A **psychiatrist** generally provides evaluation and treatment of mental, emotional, or behavioral disorders.

R.N.

A registered nurse.

Referral

This only applies to in-network coverage and is a written or electronic authorization made by your **PCP** to direct you to a **network provider** for **medically necessary** services and supplies.

Residential treatment facility (mental disorders)

- An institution specifically licensed as a **residential treatment facility** by applicable state and federal laws to provide for mental health residential treatment programs and credentialed by **Allina Health | Aetna** or is accredited by one of the following agencies, commissions or committees for the services being provided:
    - The Joint Commission (TJC)

- The Committee on Accreditation of Rehabilitation Facilities (CARF)
- The American Osteopathic Association's Healthcare Facilities Accreditation Program (HFAP)
- The Council on Accreditation (COA)

In addition to the above requirements, an institution must meet the following for residential treatment programs treating **mental disorders**:

- A **behavioral health provider** must be actively on duty 24 hours per day for 7 days a week.
- The patient must be treated by a psychiatrist at least once per week.
- The medical director must be a psychiatrist.
- Is not a wilderness treatment program (whether or not the program is part of a licensed residential treatment **facility** or otherwise licensed institution).

Residential treatment facility (substance abuse)

- An institution specifically licensed as a **residential treatment facility** by applicable state and federal laws to provide for **substance abuse** residential treatment programs and is credentialed by **Allina Health | Aetna** or accredited by one of the following agencies, commissions or committees for the services being provided:
  - The Joint Commission (TJC)
  - The Committee on Accreditation of Rehabilitation Facilities (CARF)
  - The American Osteopathic Association's Healthcare Facilities Accreditation Program (HFAP)
  - The Council on Accreditation (COA)

In addition to the above requirements, an institution must meet the following for chemical dependence residential treatment programs:

- A **behavioral health provider** or an appropriately state certified professional (CADC, CAC, etc.) must be actively on duty during the day and evening therapeutic programming.
- The medical director must be a **physician**.
- Is not a wilderness treatment program (whether or not the program is part of a licensed **residential treatment facility** or otherwise licensed institution).

In addition to the above requirements, for chemical dependence detoxification programs within a residential setting:

- An **R.N.** must be onsite 24 hours per day for 7 days a week within a residential setting.

- Residential care must be provided under the direct supervision of a **physician**.

Residential treatment facility

An institution specifically licensed by applicable laws to provide residential treatment programs for **mental health disorders, substance related disorders**, or both. It is credentialed by us or is accredited by one of the following agencies, commissions or committees for the services being provided:

- The Joint Commission (TJC)
- The Committee on Accreditation of Rehabilitation Facilities (CARF)
- The American Osteopathic Association's Healthcare Facilities Accreditation Program (HFAP)
- The Council on Accreditation (COA)

In addition to the above requirements, an institution must meet the following:

For residential treatment programs treating **mental health disorders**:

- A **behavioral health provider** must be actively on duty 24 hours/day for 7 days/week
- The patient must be treated by a psychiatrist at least once per week
- The medical director must be a psychiatrist
- It is not a wilderness treatment program (whether or not the program is part of a licensed **residential treatment facility** or otherwise licensed institution)

For residential treatment programs treating substance related disorders:

- A **behavioral health provider** or an appropriately state certified professional (CADC, CAC, etc.) must be actively on duty during the day and evening therapeutic programming
- The medical director must be a **physician**
- It is not a wilderness treatment program (whether or not the program is part of a licensed **residential treatment facility** or otherwise licensed institution)

For **detoxification** programs within a residential setting:

- An R.N. must be onsite 24 hours/day for 7 days/week within a residential setting
- Residential care must be provided under the direct supervision of a **physician**

Room and board

A facility's charge for your overnight **stay** and other services and supplies expressed as a daily or weekly rate.

Semi-private room rate

An institution's **room and board** charge for most beds in rooms with 2 or more beds. If there are no such rooms, **Allina Health | Aetna** will calculate the rate based on the rate most commonly charged by similar institutions in the same geographic area.

Skilled nursing facility

A facility specifically licensed as a **skilled nursing facility** by applicable state and federal laws to provide skilled nursing care.

Skilled nursing facilities also include rehabilitation **hospitals**, and portions of a rehabilitation **hospital** and a **hospital** designated for skilled or rehabilitation services.

Skilled nursing facility does not include institutions that provide only:

- Minimal care
- **Custodial care** services
- Ambulatory care
- Part-time care services

It does not include institutions that primarily provide for the care and treatment of **mental disorders** or **substance abuse**.

Skilled nursing services

Services provided by an R.N. or L.P.N. within the scope of his or her license.

Specialist

A **physician** who practices in any generally accepted medical or surgical sub-specialty.

Specialty prescription drugs

These are **prescription drugs** that include typically high-cost drugs that require special handling, special storage or monitoring and may include things such as oral, topical, inhaled and injected routes of administration.

You can access the list of these **specialty prescription drugs** by calling the toll-free number on your ID card or by logging on to your Plan Benefits secure member website at www.allinahealth.com.

Stay

A full-time inpatient confinement for which a **room and board** charge is made.

Substance abuse

This is a physical or psychological dependency, or both, on a controlled substance or alcohol agent. These are defined in the Diagnostic and Statistical Manual of Mental Disorders (DSM) published by the American Psychiatric Association. This term does not include conditions that you cannot attribute to a **mental disorder** that are a focus of attention or treatment, or an addiction to nicotine products, food or caffeine intoxication.

Surgery center

A facility specifically licensed as a freestanding ambulatory surgical facility by applicable state and federal laws to provide outpatient **surgery** services. If state law does not specifically provide for licensure as an ambulatory surgical facility, the facility must meet all Medicare accreditation standards (even if it does not participate in Medicare).

Surgery or surgical procedures

The diagnosis and treatment of **injury**, deformity and disease by manual and instrumental means, such as cutting, abrading, suturing, destruction, ablation, removal, lasering, introduction of a catheter (e.g., heart or bladder catheterization) or scope (e.g., colonoscopy or other types of endoscopy), correction of fracture, reduction of dislocation, application of plaster casts, injection into a joint, injection of sclerosing solution, or otherwise physically changing body tissues and organs.

Telemedicine

A consultation between you and a **provider** who is performing a clinical medical or behavioral health service.

Services can be provided by:

- Two-way audiovisual teleconferencing;
- Telephone calls
- Any other method required by applicable law

Terminal illness

A medical prognosis that you are not likely to live more than 12 months.

Urgent care facility

A facility licensed as a freestanding medical facility by applicable state and federal laws to treat an **urgent condition**.

Urgent condition

An **illness** or **injury** that requires prompt medical attention but is not an **emergency medical condition**.

Walk-in clinic

A health care facility that provides limited medical care on a scheduled and unscheduled basis. A **walk-in clinic** may be located in, near, or within a:

- Drug store
- **Pharmacy**
- Retail store
- Supermarket

The following are not considered a **walk-in clinic**:

- Ambulatory surgical center
- Emergency room
- **Hospital**
- Outpatient department of a **hospital**
- **Physician's** office
- **Urgent care facility**

Discount programs

Wellness and other incentives

We may encourage you to access certain medical services, use tools (online and others) that enhance your coverage and services, and continue participation as an **Allina Health | Aetna** member through incentives. You and your doctor can talk about these medical services and tools and decide if they are right for you. In connection with a wellness or health improvement program, we may provide incentives based on your participation and your results. Any incentives are described in the Eligibility & Enrollment Booklet.

Additional Information Provided by Allina Health

The following information is provided to you in accordance with the Employee Retirement Income Security Act of 1974 (ERISA).

Name of Plan:

Allina Health Comprehensive Welfare Benefit Plan

Employer Identification Number:

36-3261413

Plan Number:

501

Type of Plan:

Welfare

Type of Administration:

Administrative Services Contract with:

Allina Health and Aetna Insurance Company
Mail Route 13303
800 East 28th Street
Minneapolis, MN 55407

Claims Administrator:

Allina Health and Aetna Insurance Company is the Claims Administrator and named claims fiduciary of the plan. Claims must be addressed to:

Claims Address:

Allina Health and Aetna Insurance Company
P.O. Box 981106
El Paso, TX 79998-1106

Plan Sponsor/Plan Administrator/Employer:

Allina Health System is the Plan Sponsor/Plan Administrator/Employer and a named fiduciary of the plan. Its address is:

Appeals address:

Allina Health and Aetna Insurance Company
P.O. Box 14079
Lexington, KY 40512-4079

Agent For Service of Legal Process:

Allina Health
Attn: Vice President, Total Rewards
Mail Route 10707
P.O. Box 1469
Minneapolis, MN 55440-1469

Service of legal process may also be made upon the Plan Administrator

End of Plan Year:

December 31

Source of Contributions:

Employer and Employee

Collectively-Bargained Plan:

The plan is maintained under a collectively-bargained agreement. A copy of the agreement may be obtained by participants and beneficiaries upon written request to the Plan Administrator. The agreement is also available for examination by participants and beneficiaries.

Procedure for Amending the Plan:

The Employer may amend the Plan from time to time by a written instrument signed by the person designated by the Plan Administrator.

ERISA 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.

Statement of Rights under the Newborns' and Mothers' Health Protection Act

Under federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider (e.g., your physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under federal law, require that you, your physician, or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, you may be required to obtain precertification for any days of confinement that exceed 48 hours (or 96 hours). For information on precertification, contact your plan administrator.

Notice Regarding Women's Health and Cancer Rights Act

Under this health plan, as required by the Women's Health and Cancer Rights Act of 1998, coverage will be provided to a person who is receiving benefits in connection with a mastectomy and who elects breast reconstruction in connection with the mastectomy for:

(1) all stages of reconstruction of the breast on which a mastectomy has been performed;

(2) surgery and reconstruction of the other breast to produce a symmetrical appearance;

(3) prostheses; and

(4) treatment of physical complications of all stages of mastectomy, including lymphedemas.

This coverage will be provided in consultation with the attending physician and the patient, and will be provided in accordance with the plan design, limitations, copays, deductibles, and referral requirements, if any, as outlined in your plan documents.

If you have any questions about our coverage of mastectomies and reconstructive surgery, please contact the Member Services number on your ID card.

For more information, you can visit this U.S. Department of Health and Human Services website, http://www.cms.gov/home/regsguidance.asp, and this U.S. Department of Labor website, https://www.dol.gov/agencies/ebsa/employers-and-advisers/plan-administration-and-compliance/health-plans.

Important Health Care Reform Notices

Choice of Provider

You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact your Employer or, if you are a current member, your Aetna contact number on the back of your ID card.

You may designate a pediatrician as the primary care provider.

YOUR RIGHTS AND PROTECTIONS AGAINST SURPRISE MEDICAL BILLS UNDER THE FEDERAL NO SURPRISES ACT

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing. In these cases, you shouldn't be charged more than your plan's copayments, coinsurance and/or deductible.

What is Balance Billing (sometimes called Surprise Billing)

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

"Out-of-network" describes providers and facilities that haven't signed a contract with your health plan to provide services. Out-of-network providers may be allowed to bill you for the difference between what your plan pays and the full amount charged for a service. This is called "balance billing." This amount is likely more than in-network costs for the same service and might not count toward your plan's deductible or annual out-of-pocket limit.

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

You Are Protected from Balance Billing for:

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

The Plan may, at its discretion, request satisfactory proof that an emergency medical condition did exist. When reviewing claims for coverage of emergency services, the Plan will take into consideration (1) whether a reasonable layperson would believe that the circumstances required immediate medical care; and (2) the presenting symptoms, including but not limited to severe pain, to ensure that the decision to

reimburse the emergency services is not made solely on the basis of the actual diagnosis or diagnostic code.

Certain Services at an In-Network Hospital or Ambulatory Surgical Center. When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers may bill you is your Plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers can't balance bill you and may not ask you to give up your protections not to be balance billed. If you get other types of services at these in-network facilities by out-of-network providers (e.g., ancillary but not unforeseen urgent services), out-of-network providers can't balance bill you, unless the provider provides notice to you of treatment by a nonparticipating provider, you give written consent for balance billing and give up your balance billing protections.

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

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

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

State balance billing laws and protections are inapplicable to your Plan, unless the state has an All-Payer Model Agreement with Centers for Medicare & Medicaid Services (CMS) that applies to the Plan with respect to the services at issue (e.g., in Maryland, Vermont and Pennsylvania).

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

(1) You are only responsible for paying your share of the cost for such services (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). The Plan will pay any additional costs to the out-of-network providers and facilities directly, based on the allowed amount as determined by the Plan in accordance with the federal no surprise billing law. Your cost-sharing for such services will be based on the in-network cost-sharing and the amounts you pay will accumulate toward the in-network deductibles and in-network out-of-pocket maximums.

(2) Your Plan generally must:

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

Independent Dispute Resolution. When required by the federal No Surprises Act, if the Plan and an out-of-network provider or facility that provided an item or service to you cannot agree on how much the provider or facility will be paid by the Plan for the item or service, the dispute may be submitted by either the Plan or the provider to Independent Dispute Resolution (IDR). As a Plan member, you are not involved in the IDR process (although your medical information will be shared with the certified IDR entity). Regardless of what the certified IDR entity decides, you will not have any additional cost-sharing under the Plan, as your cost-sharing is limited to the in-network costs for the item or service. To the extent that you have a dispute about any adverse benefit determination you received relating to the item or service, you can appeal that decision under the Plan's benefit claim appeal process and you also have the right to external review of a balance billing adverse benefit determination.

If you believe you've been wrongly billed under the Plan, you may contact the Employee Benefits Security Administration at 866-444-3272 or you may call the No Surprise Billing Help Desk 800-985-3059. Visit www.dol.gov/ebsa or www.cms.gov/nosurprises for more information about your rights under the federal No Surprises Act. If an All-Payer Model Agreement with Centers for Medicare & Medicaid Services (CMS) applies to the Plan with respect to the services at issue (e.g., in Maryland, Vermont and Pennsylvania), you may call that applicable state Department of Insurance for more information about your rights under such state law.

Maryland:

Maryland Insurance Administration

200 Saint Paul Place, Suite 2700
Baltimore, Maryland 21202-2272
Phone: (410) 468-2000

Pennsylvania:

Pennsylvania Insurance Department
1326 Strawberry Square
Harrisburg, Pennsylvania 17120
Phone: (717) 787-7000

Vermont:

Vermont Department of Financial Regulation
89 Main Street
Montpelier, Vermont 05620-3101
Phone: (802) 828-3301

Open Access EPO Plus Medical Plan

Schedule of Benefits

Prepared exclusively for:

Employer: **ALLINA HEALTH**

Contract number: **109029**

Schedule of Benefits 1A

Plan effective date: **January 1, 2024**

These benefits are not insured with Aetna but will be paid from the Employer's funds. Aetna will provide certain administrative services under the Aetna medical benefits plan.

**See How to read your schedule of benefits at the beginning of this schedule of benefits*

Schedule of Benefits

This schedule of benefits lists the **copayments/payment percentage**, if any, that apply to the services you receive under this plan. You should review this schedule to become familiar with your **copayments/payment percentage** and any limits that apply to the services.

How to read your schedule of benefits

- When we say:
  - "In-network coverage", we mean you get care from a **network provider**.
- The **copayments/payment percentage** listed in the schedule of benefits below reflect the **copayment/payment percentage** amounts under your plan.
- Any **payment percentage** listed in the schedule of benefits reflects the plan **payment percentage**. This is the amount the Plan pays. You are responsible to pay any **copayments** and the remaining **payment percentage**.
- This plan has maximums for specific **covered benefits**. For example, these could be visit, day or dollar maximums.
- At the end of this schedule you will find detailed explanations about your:
  - **Maximum out-of-pocket limits**

Important note:

All **covered benefits** are subject to the **copayment/payment percentage** unless otherwise noted in the schedule of benefits below.

We are here to answer any questions. Contact Member Services by logging onto your Plan Benefits Aetna secure member website at www.allinahealthaetna.com or at the toll-free number on your ID card.

This schedule of benefits replaces any schedule of benefits previously in effect under your plan of benefits. Keep this schedule of benefits with your booklet.

Per admission copayment

Per admission **copayment**	$750 per admission
Inpatient copay when engaged with Complex Care Management (CCM)	$250

Maximum out-of-pocket limit

Maximum out-of-pocket limit per Calendar Year (medical and prescription drug expenses combined).	
Individual	$3,500 per Calendar Year
Family	$7,000 per Calendar Year

Eligible health services	**In-network coverage***
Preventive care and wellness	

Routine physical exams	
Performed at a **physician's, PCP** office	100% per visit No **deductible** applies.
Covered persons through age 21:	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the American Academy of Pediatrics/Bright Futures/Health Resources and Services Administration guidelines for children and adolescents. For details, contact your physician or Member Services by logging onto your Plan Benefits Aetna's secure member website at www.allinahealthaetna.com or calling the number on your ID card.
Covered persons age 22 and over	Unlimited

Children's health supervision	
Covered according to the type of benefit and the place where the service is received	
Maximum visits	1 visit to 1 **provider** for all of the services provided at each visit
Maximum visits from birth to 12 months	5 visits
Maximum visits from 12 months to 24 months	3 visits

Maximum visits from 24 months to 72 months per year	1 visit

Preventive care immunizations	
Performed in a facility or at a **physician's** office	100% per visit No **deductible** applies
	Subject to any age limits provided for in the comprehensive guidelines supported by Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention. For details, contact your physician or Member Services by logging onto your Plan Benefits Aetna's secure member website at www.allinahealthaetna.com or calling the number on your ID card.

Well woman preventive visits **Routine gynecological exams (including pap smears)**	
Performed at a **physician's, PCP**, obstetrician (OB), gynecologist (GYN) or OB/GYN office	100% per visit No **deductible** applies
Maximums	Subject to any age limits provided for in the comprehensive guidelines supported by the Health Resources and Services Administration.
Maximum visits per Calendar Year	Unlimited

Preventive screening and counseling services

Office visits • Obesity and/or healthy diet counseling • Misuse of alcohol and/or drugs • Use of tobacco products • Sexually transmitted infection counseling • Genetic risk counseling for breast and ovarian cancer	100% per visit No **deductible** applies

Obesity and/or healthy diet counseling maximums:

Maximum visits per Calendar Year (This maximum applies only to covered persons age 22 and older.)	Unlimited
*Note: In figuring the maximum visits, each session of up to 60 minutes is equal to one visit.	

Misuse of alcohol and/or drugs maximums:

Maximum visits per Calendar Year	Unlimited visits*
*Note: In figuring the maximum visits, each session of up to 60 minutes is equal to one visit.	

Use of tobacco products maximums:

Maximum visits per Calendar Year	Unlimited visits*
*Note: In figuring the maximum visits, each session of up to 60 minutes is equal to one visit.	

Sexually transmitted infection counseling maximums:

Maximum visits per Calendar Year	Unlimited visits*
*Note: In figuring the maximum visits, each session of up to 60 minutes is equal to one visit.	

Genetic risk counseling for breast and ovarian cancer maximums:

Genetic risk counseling for breast and ovarian cancer	Not subject to any age or frequency limitations

Routine cancer screenings

(applies whether performed at a physician's, PCP, specialist office or facility)

Routine cancer screenings	100% per visit No deductible applies

Maximums	Subject to any age, family history, and frequency guidelines as set forth in the most current: Evidence-based items that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force; and The comprehensive guidelines supported by the Health Resources and Services Administration For details, contact your **physician** or Member Services by logging onto your Plan Benefits Aetna's secure member website at www.allinahealthaetna.com or calling the number on your ID card
Lung cancer screening maximums from age 55	1 screening every 12 months*
Important note: Any lung cancer screenings that exceed the lung cancer screening maximum above are covered under the *Outpatient diagnostic testing* section.	

Prenatal care

Prenatal care services (provided by an obstetrician (OB), gynecologist (GYN), and/or OB/GYN)

Preventive care services only	100% per visit No **deductible** applies
Important note: You should review the *Maternity and related newborn care* sections. They will give you more information on coverage levels for maternity care under this plan.	

Comprehensive lactation support and counseling services

Lactation counseling services – facility or office visits	100% per visit No **deductible** applies
Lactation counseling services maximum per 12 months either in a group or individual setting	6 visits*
***Important note:** Any visits that exceed the lactation counseling services maximum are covered under Physician services office visits.	

Breast feeding durable medical equipment

Breast pump supplies and accessories	100% per item No **deductible** applies
Important note: See the *Breast feeding durable medical equipment* section of the booklet-certificate for limitations on breast pump and supplies.	

Family planning services – female contraceptives

Counseling services

Female contraceptive counseling services office visit	100% per visit No **deductible** applies
Contraceptive counseling services maximum visits per 12 months either in a group or individual setting	2 visits*
***Important note:** Any visits that exceed the contraceptive counseling services maximum are covered under **Physician** services office visits.	

Devices

Female contraceptive device provided, administered, or removed, by a **physician** during an office visit	100% per item No **deductible** applies

Female voluntary sterilization

Inpatient	100% per admission No **deductible** applies
Outpatient	100% per visit No **deductible** applies

Eligible health services	**In-network coverage***
Physicians and other health professionals	

Physicians and specialists office visits (non-surgical)	
Physician services	
Office hours visits (non-surgical) non preventive care	$10 then the plan pays 100% (of the balance of the **negotiated charge**) per visit thereafter No **deductible** applies

Allergy injections	
Performed at a **physician's, PCP** or specialist office when you do not see the **physician**	100% (of the **negotiated charge**) per visit No **deductible** applies

Immunizations that are not considered preventive care	
Immunizations that are not considered preventive care	100% (of the negotiated charge) per visit No **deductible** applies

Specialist	
Specialist office visits	
Office hours visits (non-surgical)	$50 then the plan pays 100% (of the balance of **the negotiated charge**) per visit thereafter No **deductible** applies

Physician Surgical services	
Physician and specialist office visits	
Performed at a **physician's, PCP** office	$10 then the plan pays 100% (of the balance of the **negotiated charge)** per visit thereafter No **deductible** applies
Performed at a **specialist's** office	$50 then the plan pays 100% (of the balance of the **negotiated charge**) per visit thereafter No **deductible** applies

Alternatives to physician office visits	
Walk-in clinic visits	
Walk-in clinic non-emergency visit (includes coverage for immunizations)	Plan pays 100% (of the **negotiated charge**) per visit if at an Allina Health Everyday Clinic, Allina Health Everyday Online clinic, and St. Francis Express Care $5 then the plan pays 100% (of the balance of the **negotiated charge**) per visit thereafter at Minute Clinics $10 then the plan pays 100% (of the balance of the **negotiated charge**) per visit thereafter No **deductible** applies Subject to any age limits provided for in the comprehensive guidelines supported by Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention. For details, contact your **physician** or Member Services by logging onto your Plan Benefits secure member website at www.allinahealthaetna.com or calling the number on your ID card.

Eligible health services	**In-network coverage***
Hospital and other facility care	

Hospital care	
Inpatient **hospital** **Cost share when engaged with CCM** **Outpatient hospital (Ancillary charges)**	$750 then the plan pays 100% (of the balance of the **negotiated charge)** per admission No **deductible** applies $250 then the plan pays 100% (of the balance of the negotiated charge) per admission No **deductible** applies $50 then the plan pays 100% (of the balance of the **negotiated charge**) per admission No **deductible** applies

Alternatives to hospital stays	
Outpatient surgery and physician surgical services	
	$150 then the plan pays 100% (of the balance of the **negotiated charge**) per visit thereafter No **deductible** applies

Home health care	
Outpatient	100% (of the **negotiated charge**) per visit No deductible applies
Maximum visits per Calendar Year	120 Limited to: 1 intermittent visit per day provided by a participating **home health care agency**; 1 visit equals a period of 4 hours or less. Intermittent visits are considered periodic and recurring visits that skilled nurses make to ensure your proper care The intermittent requirement may be waived to allow coverage for up to 12 hours with a daily maximum of 3 visits. Services must be provided within 10 days of discharge

Hospice care	
Inpatient facility	$750 then the plan pays 100% (of the balance of the **negotiated charge**) per admission No **deductible** applies
Maximum days per lifetime	Unlimited
Outpatient	100% (of the **negotiated charge**) per visit No **deductible** applies Part-time or intermittent nursing care by an **R.N.** or **L.P.N.** for up to 8 hours a day Part-time or intermittent home health aide services to care for you up to 8 hours a day

Skilled nursing facility	
Inpatient facility	$750 then the plan pays 100% (of the balance of the **negotiated charge**) per admission No **deductible** applies

Eligible health services	In-network coverage*	Out-of-network coverage*
Emergency services and urgent care		

Emergency services		
Hospital emergency room	$300 then the plan pays 100% (of the balance of the **negotiated charge**) per visit No **deductible** applies	Paid the same as in-network coverage
Non-emergency care in a **hospital** emergency room	Not covered	Not covered

- Refer to the "Your Rights and Protections Against Surprise Medical Billing under the Federal No Surprises Act" Notice in this SPD.
- **Out-of-network providers** do not have a contract with us. The **provider** may not accept payment of your cost share as payment in full. You may receive a bill for the difference between the amount billed by the **provider** and the amount paid by the plan. If the **provider** bills you for an amount above your cost share, you are not responsible for payment of that amount. You should send the bill to the address on your ID card and we will resolve any payment issue with the **provider**. Make sure the member ID is on the bill.
- In the case of a surprise bill from an out-of-network provider, where you had no control of their participation in your **covered services**, you will pay the same cost share you would have if the **covered services** were received from a **network provider**. The cost share will be based on the median contracted rate. Contact us immediately if you receive such a bill.
- If you are admitted to the **hospital** for an inpatient stay right after you visit the emergency room, you will not pay your emergency room cost share if you have one. You will pay the inpatient **hospital** cost share, if any.

Urgent care		
Urgent medical care (at a non-**hospital** free standing facility)	$10 then the plan pays 100% (of the balance of the **negotiated charge**) per visit thereafter No **deductible** applies	$100 then the plan pays 100% per visit thereafter No **deductible** applies
Non-urgent use of **urgent care provider** (at a non-**hospital** free standing facility)	Not covered	

Eligible health services	In-network coverage*

Specific conditions

Autism spectrum disorder	
Autism Spectrum Disorder Behavioral Therapy	$10 then the plan pays 100% (of the balance of the **negotiated charge**) per visit thereafter No **deductible** applies
Applied behavior analysis	100% (of the **negotiated charge**) per visit No **deductible** applies Your plan will cover the extra expense of a private room when appropriate because of your medical condition.
Physical, occupational, and speech therapy associated with diagnosis of autism spectrum disorder	$10 then the plan pays 100% (of the balance of the **negotiated charge**) per visit thereafter No **deductible** applies

Birthing Center	
Inpatient Cost share when engaged with CCM	$750 then the plan pays 100% (of the balance of the **negotiated charge**) per admission No **deductible** applies $250 then the plan pays 100% (of the balance of the negotiated charge) per admission No **deductible** applies
The per admission **copayment** amount for newborns will be waived for nursery charges for the duration of the newborn's initial facility stay. The nursery charges waiver will not apply for non-routine facility stays	

Diabetic equipment, supplies and education	
Diabetic equipment, supplies and education	100% (of the **negotiated charge**) per item No **deductible** applies

Family planning services - other

Voluntary sterilization for males	
Outpatient	100% (of the **negotiated charge**) per visit No **deductible** applies

Abortion	
Outpatient	100% (of the **negotiated charge**) per visit No **deductible** applies

Maternity and related newborn care	
Inpatient	$750 then the plan pays 100% (of the **negotiated charge**) per admission No **deductible** applies
Cost share when engaged with CCM	$250 then the plan pays 100% (of the balance of the negotiated charge) per admission No **deductible** applies
*The per admission **copayment** amount for newborns will be waived for nursery charges for the duration of the newborn's initial routine facility stay. The nursery charges waiver will not apply for non-routine facility stays.*	

Delivery services and postpartum care services	
Performed in a facility or at a **physician's** office	100% (of the **negotiated charge**) per visit No **deductible** applies
Other prenatal care services	Covered according to the type of benefit and the place where the service is received.

Mental health treatment - inpatient	
Inpatient mental health treatment Inpatient **residential treatment facility** Coverage is provided under the same terms, conditions as any other **illness**.	$750 then the plan pays 100% (of the balance of the **negotiated charge**) per admission No **deductible** applies

Mental health treatment - outpatient	
Outpatient office visit to a physician or behavioral health provider Includes telemedicine consultation Coverage is provided under the same terms, conditions as any other **illness**.	$10 then the plan pays 100% (of the balance of the **negotiated charge**) per visit thereafter No **deductible** applies
Outpatient mental health telemedicine cognitive therapy consultations by a physician or behavioral health provider	$10 then the plan pays 100% (of the balance of the **negotiated charge**) per visit thereafter No **deductible** applies
Other outpatient services including: • Behavioral health services in the home • **Partial hospitalization treatment** • **Intensive outpatient program** The cost share doesn't apply to in-network peer counseling support services	100% (of the **negotiated charge**) per visit No **deductible** applies

Substance related disorders treatment - inpatient	
Inpatient **substance abuse detoxification** during a **hospital** confinement Inpatient **substance abuse** rehabilitation during a hospital confinement Inpatient **residential treatment facility** during a **hospital** confinement Coverage is provided under the same terms, conditions as any other **illness**.	$750 then the plan pays 100% (of the balance of the **negotiated charge**) per admission No **deductible** applies

Substance related disorders treatment - outpatient: detoxification and rehabilitation	
Outpatient office visit to a physician or behavioral health provider Includes telemedicine consultation Coverage is provided under the same terms, conditions as any other **illness**.	$10 then the plan pays 100% (of the balance of the **negotiated charge**) per visit thereafter No deductible applies
Outpatient mental health telemedicine cognitive therapy consultations by a physician or behavioral health provider Coverage is provided under the same terms, conditions as any other **illness**.	$10 then the plan pays 100% (of the balance of the **negotiated charge**) per visit thereafter No **deductible** applies
Other outpatient services including: Behavioral health services in the home • **Partial hospitalization treatment** • **Intensive outpatient program**	100% (of the **negotiated charge**) per visit No **deductible** applies

The cost share doesn't apply to in-network peer counseling support services	

Obesity (bariatric) surgery	
Inpatient **hospital** (includes **surgical procedure** and acute **hospital** services) Cost share when engaged with CCM	$750 then the plan pays 100% (of the balance of the **negotiated charge**) per admission No **deductible** applies $250 then the plan pays 100% (of the balance of the negotiated charge) per admission No **deductible** applies

Outpatient obesity (bariatric) surgery	
	$150 then the plan pays 100% (of the balance of the **negotiated charge**) per visit thereafter No deductible applies

Oral and maxillofacial treatment (mouth, jaws and teeth)	
Oral and maxillofacial treatment (mouth, jaws and teeth)	Covered according to the type of benefit and the place where the service is received

Reconstructive breast surgery	
Reconstructive breast **surgery**	Covered according to the type of benefit and the place where the service is received

Eligible health services	**Network (IOE facility)**	**Network (Non-IOE facility)**
Transplant services facility and non-facility		
Inpatient **hospital** transplant services Cost share when engaged with CCM	$750 then the plan pays 100% (of the balance of the **negotiated charge**) per transplant	Not covered

	$250 then the plan pays 100% (of the balance of the **negotiated charge**) per transplant. No **deductible** applies	
Physician services including office visits	Covered according to the type of benefit and the place where the service is received	Not covered

Eligible health services	(IOE facility)	Non-IOE facility

Transplant services facility and non-facility		
Maximum per transplant occurrence	Unlimited*	Not covered
*This maximum applies to all transplant services you receive while covered under any **Allina Health | Aetna** or **Allina Health | Aetna** affiliated plan.		

Eligible health services	(IOE facility)	Non-IOE facility

Transplant services facility and non-facility		
Transplant services and supplies	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
*This maximum applies to all transplant services you receive while covered under any **Allina Health | Aetna** or **Allina Health | Aetna** affiliated plan.		

Eligible health services	In-network coverage*

Specific therapies and tests
Outpatient diagnostic testing

Diagnostic complex imaging services	
Free standing facility	$50 then the plan pays 100% (of the balance of the **negotiated charge**) per visit thereafter. No **deductible** applies
Outpatient, Independent lab	$100 then the plan pays 100% (of the balance of the **negotiated charge**) per visit thereafter No **deductible** applies

Diagnostic lab work	
	100% (of the **negotiated charge**) per visit. No **deductible** applies.

Diagnostic radiological services	
	100% (of the **negotiated charge**) per visit No **deductible** applies
Chemotherapy	
	Covered according to the type of benefit and the place where the service is received

Outpatient infusion therapy	
	Covered according to the type of benefit and the place where the service is received.

Outpatient radiation therapy	
	Covered according to the type of benefit and the place where the service is received.

Short-term cardiac and pulmonary rehabilitation services	
Cardiac rehabilitation	
Cardiac rehabilitation	Covered according to the type of benefit and the place where the service is received

Pulmonary rehabilitation	
Pulmonary rehabilitation	Covered according to the type of benefit and the place where the service is received

Short-term rehabilitation services	
Outpatient Physical and Occupational Therapies	
	$15 then the plan pays 100% (of the balance of the **negotiated charge**) per visit thereafter No **deductible** applies

Outpatient Speech Therapy	
	$15 then the plan pays 100% (of the balance of the **negotiated charge**) per visit thereafter No **deductible** applies

Habilitation therapy services	
Outpatient physical and occupational therapy	
	$15 then the plan pays 100% (of the balance of the **negotiated charge**) per visit thereafter No **deductible** applies

Allina Spine Center of Excellence	You pay nothing for physical therapy For more information regarding eligible services provided by Allina Spine Center of Excellence and to determine if you meet criteria call toll free at 1-800-827-8313.

Outpatient speech therapy	
	$15 then the plan pays 100% (of the balance of the **negotiated charge**) per visit thereafter No deductible applies

Eligible health services	**In-network coverage***
Other services	

Acupuncture	
Acupuncture	$15 copay then the plan pays 100% (of the balance of the **negotiated charge**) per visit thereafter in a professional setting/doctor's office No **deductible** applies

Ambulance service	
Ground, air or water **ambulance**	$150 then the plan pays 100% (of the balance of the **negotiated charge**) per trip thereafter No **deductible** applies.

Clinical trial therapies (experimental or investigational)	
Clinical trial therapies	Covered according to the type of benefit and the place where the service is received

Clinical trials (routine patient costs)	
Clinical trial (routine patient costs)	Covered according to the type of benefit and the place where the service is received

Durable medical equipment (DME)	
DME Includes Wigs	100% (of the **negotiated charge**) per item No deductible applies.

Hearing aids and exams	
Hearing aid exams	Covered according to the type of benefit and the place where the service is received
Hearing aids	100% (of the **negotiated charge**) per item No **deductible** applies.
Hearing aids	One per ear every 3 years. $3,000 limit every 3 years.

Non-preventive hearing exams	
For adults and children	100% (of the **negotiated charge**) per visit thereafter No **deductible** applies.

Prosthetic devices	
Prosthetic devices	Covered according to the type of benefit and the place where the service is received

Spinal manipulation	
Spinal manipulation	$15 then the plan pays 100% (of the balance of the **negotiated charge**) per visit thereafter No **deductible** applies

Vision care	
Routine vision care	
Routine vision exams (including refraction)	
Performed by a legally qualified ophthalmologist or optometrist	100% per visit No **deductible** applies

Vision hardware	
Allina Health Eye Clinics	100% coverage for up to $250 for glasses or contacts every calendar year per covered person at Allina Health Eye Clinics

	No **deductible** applies

Eligible health services*	

Family planning services - female contraceptives	
Female contraceptives that are **generic prescription drugs**: • Oral drugs • Injectable drugs • Vaginal rings • Transdermal contraceptive patches	100% per **prescription** or refill No **deductible** applies
Female contraceptives that are **brand-name prescription drugs:** • Oral drugs • Injectable drugs • Vaginal rings • Transdermal contraceptive patches	100% per prescription or refill No **deductible** applies.
Female contraceptive generic devices and brand-name devices	100% per **prescription** or refill No **deductible** applies

Preventive care drugs and supplements	
Preventive care drugs and supplements filled at a **pharmacy**	100% per **prescription** or refill No **deductible** applies

Risk reducing breast cancer prescription drugs	
Risk reducing breast cancer **prescription drugs** filled at a **pharmacy**	100% per **prescription** or refill No **deductible** applies
Maximums:	Coverage will be subject to any sex, age, medical condition, family history, and frequency guidelines in the recommendations of the United States Preventive Services Task Force. For details on the guidelines and the current list of covered preventive care

	drugs and supplements, contact Member Services by logging onto your secure member website at www.allinahealthaetna.com or calling the number on your ID card.

Tobacco cessation prescription and over-the-counter drugs	
Tobacco cessation **prescription drugs** and OTC drugs filled at a **pharmacy** for each 90 day supply	$0 per **prescription** or refill No **deductible** applies
Maximums:	Coverage is permitted for two 90-day treatment regimens only. Any additional treatment regimens will be subject to the cost sharing in your schedule of benefits below. Coverage will be subject to any sex, age, medical condition, family history, and frequency guidelines in the recommendations of the United States Preventive Services Task Force. For details on the guidelines and the current list of covered tobacco cessation **prescription drugs** and OTC drugs, contact Member Services by logging onto your secure member website at www.allinahealthaetna.com or calling the number on your ID card.

General coverage provisions

This section provides detailed explanations about the **Maximum out-of-pocket limits** that are listed in the first part of this schedule of benefits.

Copayments
Copayment
As it applies to in-network coverage, this is a specified dollar amount or percentage that must be paid by you at the time you receive **eligible health services** from a **network provider**.

Per Admission Copayment
A per admission **copayment** is an amount you are required to pay when you or a covered dependent have a **stay** in an inpatient facility.
Separate copayments may apply per facility. These **copayments** are in addition to any other **copayments** applicable under this plan. They may apply to each **stay** or they may apply on a per day basis up to a per admission maximum amount.
The per admission **copayment** amount is equal to a facility's **semi-private room rate** for one day. However, for the **stay** of a well newborn baby (starting at birth), the per admission **copayment** amount will not exceed the **hospital's** actual **room and board** charge on the first day of the **stay**.

Payment percentage
The specific percentage you have to pay for a health care service listed in the schedule of benefits.

Maximum out-of-pocket limits provisions
Eligible health services that are subject to the **maximum out-of-pocket limit** include **prescription drug eligible health services** provided under the medical plan outpatient **prescription drug** plan.
The **maximum out-of-pocket limit** is the maximum amount you are responsible to pay for **copayments**/payment percentage for **eligible health services** during the Calendar Year. This plan has an individual and family maximum out-of-pocket limit. As to the individual **maximum out-of-pocket limit** each of you must meet your **maximum out-of-pocket limit** separately.

Individual
Once the amount of the **copayments**/payment percentage you and your covered dependents have paid for **eligible health services** during the Calendar Year meets the individual **maximum out-of-pocket limit**, this plan will pay 100% of the **negotiated charge** for **covered benefits** that apply toward the limit for the rest of the Calendar Year for that person.

Family
Once the amount of the **copayments/payment percentage** you and your covered dependents have paid for **eligible health services** during the Calendar Year meets this family **maximum out-of-pocket limit**, this plan will pay 100% of the **negotiated charge** for such **covered benefits** that apply toward the limit for the remainder of the Calendar Year for all covered family members.
To satisfy this family maximum out of pocket limit for the rest of the Calendar year, the following must happen: • The family **maximum out-of-pocket limit** is a cumulative **maximum out-of-pocket limit** for all family members. The family **maximum out-of-pocket limit** can be met by a combination of family members with no single individual within the family contributing more than the individual **maximum out-of-pocket limit** amount in a Calendar Year.
The **maximum out-of-pocket limit** may not apply to certain **eligible health services**. If the **maximum out-of-pocket limit** does not apply to a covered benefit, your **copayment/payment percentage** for that covered benefit will not count toward satisfying the **maximum out-of-pocket limit** amount.
Certain costs that you incur do not apply toward the maximum out-of-pocket limit. These include: • All costs for non-covered services • All costs for non-emergency use of the emergency room • All costs incurred for non-urgent use of an **urgent care provider**

Calculations; determination of benefits provisions
Your financial responsibility for the costs of services will be calculated on the basis of when the service or supply is provided, not when payment is made. Benefits will be prorated to account for treatment or portions of stays that occur in more than one Calendar Year. Determinations regarding when benefits are covered are subject to the terms and conditions of the booklet.

Fertility Benefit Appendix

Understanding Your Progyny Benefit

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progyny
Smarter Fertility Benefits

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INTRODUCTION TO YOUR BENEFIT

YOUR GUIDE TO PROGYNY'S FERTILITY AND FAMILY BUILDING BENEFIT

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

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

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

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

To learn more and activate your benefit, call: 833.205.4001

ACCESS TO HIGH QUALITY CARE

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

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

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

PERSONALIZED SUPPORT

Personalized Support from a Patient Care Advocate

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

Easy Access to Information and Education

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

Progyny Member Guide 3

GETTING STARTED

Call Progyny to activate your benefit at 833.205.4001

During your first call your PCA will:

Check your eligibility

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

Help you to understand your financial responsibility.

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

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

THE PROGYNY SMART CYCLE

UNDERSTANDING YOUR SMART CYCLE BENEFIT

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

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

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

Common Ways to Use a Smart Cycle:

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

IVF Fresh Cycle

IVF Freeze-All Cycle

Frozen Embryo Transfer (FET)

Frozen Oocyte Transfer (FOT)

Surrogacy Embryology Services
Pre-transfer services

Intrauterine Insemination (IUI)

Timed Intercourse (TIC)

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.

Katherine has used ¾ of a Smart Cycle

2

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

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)

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 guidance
- Intracytoplasmic sperm injection (ICSI)
- Office visits
- Oocyte fertilization/insemination
- Oocyte identification
- Preimplantation genetic testing for aneuploidy (PGT-A)
- Preparation and cryopreservation of extra embryo(s)
- Preparation of embryo(s) for transfer
- Retrieval (follicular aspiration, to include ultrasound guidance)
- Simple sperm wash & prep
- Tissue storage (1 year)
- Ultrasounds & in-cycle bloodwork (E2, P4, beta hCG, FSH, LH)

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
- Embryo transfer (eSET) w/ultrasound guidance
- Intracytoplasmic sperm injection (ICSI)
- Office visits
- Oocyte fertilization/insemination
- Oocyte identification
- Preimplantation genetic testing for aneuploidy (PGT-A)
- Preparation and cryopreservation of extra embryo(s)
- Retrieval (follicular aspiration, to include ultrasound guidance)
- Simple sperm wash & prep
- Tissue storage (1 year)
- Ultrasounds & in-cycle bloodwork (E2, P4, beta hCG, FSH, LH)

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

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

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

The following procedures are covered:

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

Intrauterine Insemination (IUI) = 1/4 Smart Cycle

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

The following procedures are covered:

- Complex sperm wash & prep
- Insemination
- Office visits
- Simple sperm wash & prep
- Cycle management
- 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.

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

Frozen Oocyte Transfer = 1/2 Smart Cycle

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

The following procedures are covered:

- Assisted hatching
- Blastocyst culture
- Complex sperm wash & prep
- Cycle management
- Embryo biopsy
- Embryo culture lab
- Embryo transfer (eSET) w/ ultrasound guidance
- Intracytoplasmic sperm injection (ICSI)
- Office visits
- Oocyte fertilization/insemination
- Oocyte identification
- Oocyte thaw
- Preimplantation genetic testing for aneuploidy (PGT-A)
- Preparation and cryopreservation of extra embryo(s)
- Preparation of embryo(s) for transfer
- Simple sperm wash & prep
- Tissue storage (1 year)
- Ultrasounds & in-cycle bloodwork (E2, P4, beta hCG, FSH, LH)

Pre-Transfer Embryology Services = 1/2 Smart Cycle

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

The following procedures are covered:

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

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

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

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

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

FET for Donor Embryo = 1/4 Smart Cycle

Some members may choose embryo donation to build their families. Donor embryo is the process of receiving an embryo created from another individual or couple who completes their family and donates their leftover embryos. The recipient undergoes a frozen embryo transfer (FET) following testing. The FET is covered as part of your Progyny benefit. Donor embryo typically includes agency/admin fees as well. These fees will be an out of pocket cost. Please contact your PCA for more information.

- 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
- Oocyte identification from follicular fluid
- Retrieval (follicular aspiration, to include ultrasound guidance)
- Ultrasounds & in-cycle bloodwork (E2, P4, beta hCG, FSH, LH)

ALSO INCLUDED IN YOUR COVERAGE

Anesthesia for Egg Retrieval

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

Assisted Hatching

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

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

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

Cryopreservation

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

Embryo Culture

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

FDA Workup

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

Fertilization

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

In-Cycle Monitoring/Management

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

Intracytoplasmic Sperm Injection (ICSI)

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

Preimplantation Genetic Testing for Aneuploidy (PGT-A)

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

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

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

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

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

Preimplantation Genetic Testing for Structural Rearrangements (PGT-SR)

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

Sperm Wash and Preparation

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

Telehealth

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

Tissue Storage

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

Tissue Transportation

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

FERTILITY MEDICATIONS

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

Here's How It Works:

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

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

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

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

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

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

TRANSITION TO PREGNANCY

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

NON-COVERED SERVICES

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

AUTHORIZATION &FINANCIAL RESPONSIBILITY

AUTHORIZATION/PATIENT CONFIRMATION |STATEMENT

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

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

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

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

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

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

UNDERSTANDING YOUR FINANCIAL RESPONSIBILITY

Why Am I Getting a Bill from Progyny?

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

- Your premium is the amount deducted from your pay for your medical coverage. There is no additional premium through Progyny.
- At the start of each plan year, you will pay for all medical services (including fertility services).
- You and your medical plan both pay a percentage of your covered healthcare services. This is called coinsurance. You may also be responsible for a copayment, which is a flat fee for certain services or prescriptions determined by your medical plan.
- You and your medical plan continue to split the costs of your covered healthcare services (according to the coinsurance percentage) until you reach your out-of-pocket maximum.
- After you reach your out-of-pocket maximum, your medical plan will pay 100% of the costs of your covered healthcare services for the rest of the plan year.

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

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

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

What's on My Bill?

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

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

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

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

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

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

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

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

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

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

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

FAQS

BENEFIT

1. What family building options are available through Progyny?

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

2. What does Progyny cover?

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

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

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

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

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

5. What's covered in my initial consultation?

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

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

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

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

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

Each treatment authorization is valid for 60 days and covers your baseline blood test, ultrasound and monitoring appointments. Anesthesia for egg retrieval, fertilization (including ICSI), assisted hatching, preimplantation genetic testing for aneuploidy (PGT-A), cryopreservation, and embryo transfer are also covered, where applicable.

To learn more about what is included in each treatment cycle, please refer to the *Explanation of Covered Treatments & Services* section of your Member Guide.

8. What is ICSI and is it covered?

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

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

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

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

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

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

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

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

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

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

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

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

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

- Cycles cancelled prior to retrieval (or aspiration) will not be counted against your Smart Cycle balance but will be subject to financial responsibility as determined by your medical plan.
- Cycles cancelled after retrieval (or aspiration), 1/4 Smart Cycle will be deducted from your balance.
- Cycles cancelled after fertilization due to immature or non-viable embryos prior to transfer, 1/2 Smart Cycle will be deducted from your balance.
- Cycles converted to IUI or Timed Intercourse, 1/4 Smart Cycle will be deducted from your balance. If you have further questions regarding cycle cancellation, contact your PCA.

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

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

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

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

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

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

- Surgical procedures, except for egg retrievals, are not covered by your Progyny benefit. Examples of non-covered surgical procedures include hysteroscopies, laparoscopies, myomectomies, and testicular sperm extractions. Please contact your medical plan to inquire about coverage for surgical procedures.
- Pregnancy monitoring is a maternity service and therefore should be provided by your medical insurance carrier. Your Progyny benefit covers your fertility treatment until your second positive pregnancy test.

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

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

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

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

When you have used your full Smart Cycle allowance, your lifetime benefits are considered exhausted. Initial consultations and other services can no longer be accessed, with the exception of any remaining storage renewals as determined by your plan. Additionally, you will continue to have ongoing access to your dedicated PCA as long as you remain an employee under an eligible plan. Progyny can continue to provide assistance by coordinating care as you move forward with your family building journey. If you would like to continue treatment, your PCA will help coordinate your appointments, speak to schedulers, labs, and clinics on your behalf, as well as continue to provide emotional support and guidance throughout your family building journey. However, once your Smart Cycle benefit has been exhausted, treatment costs will be incurred as an out of pocket cost to you.

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

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

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

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

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

ELIGIBILITY

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

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

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

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

23. What is primary and secondary insurance?

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

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

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

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

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

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

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

If you have fertility coverage under your primary medical insurance and are a dependent on the Progyny benefit, you can submit the EOB from your primary insurance, which details your out-of-pocket responsibility, to Progyny for reimbursement until your primary insurance coverage is exhausted. Your reimbursement will be deducted from your Smart Cycle balance, subject to your member responsibility under your fertility benefit with Progyny, as applicable. Your PCA can provide you with more detail on how your reimbursement will impact your Smart Cycle balance. After your primary insurance coverage is exhausted, you must receive any additional fertility services from a Progyny in-network provider for those services to be covered under Progyny. Your PCA can help you select an in-network provider. Even though your primary insurance coverage has been exhausted, all claims for fertility treatment for the person receiving services must still be submitted to the primary insurance first. You will then receive an EOB from your primary insurance (which will show that the services were denied) and you must submit this to your PCA. Progyny will then process the claim, subject to the specific coverage details of your Progyny benefit. Note, coinsurance from your medical plan are not reimbursable expenses.

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

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

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

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

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

28. How long does my Progyny coverage last?

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

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 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

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Smarter Fertility Benefits

For more information on your fertility benefits, call: 833.205.4001