Your Progyny Benefit

Memorial Healthcare System Member Guide

2027 Plan Year

progyny

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Introduction to Progyny

Meet Progyny

Progyny is a transformative fertility, family building, and women's health benefits solution designed for you and your family. We envision a world where everyone can realize their dreams of family and ideal health. Your Progyny benefits include comprehensive coverage for the services you need, access to care from top providers, concierge support from your own care advocate or coach, and expert resources to empower a healthier journey across life's milestones.

To be eligible for Progyny benefits you must be enrolled in an eligible medical plan through your employer. Review this Member Guide to understand what services are covered under your benefit.

To learn more go to the Progyny Member Portal or call Progyny at **833.281.0088** to learn more.

Highlights of Your Benefit

Preconception and Trying to Conceive

Personalized clinical education, fertility and genetic testing coverage, and digital resources to optimize your reproductive health

Whether you're trying to conceive, planning to start trying soon, or looking to better understand your reproductive health, Progyny is here to support you every step of the way. Connecting with your own dedicated preconception coach and getting started with our exclusive digital resources are the first steps on your journey. Call Progyny and reference the *Preconception and Trying to Conceive* section to learn more.

Fertility and Family Building

Coverage for fertility and family building services from top fertility specialists paired with unlimited concierge support

Your benefit has been specifically designed to give you the best chance of fulfilling your dreams of family. With Progyny you have comprehensive fertility treatment coverage (including urology infertility services), with access to a premier network of top fertility specialists (reproductive endocrinologists and reproductive urologists). Progyny members receive unlimited support and guidance from a Progyny Care Advocate (PCA) with expertise to support all paths to parenthood, including adoption and surrogacy, dependent on coverage. Contact Progyny to activate your benefit and learn more about covered services in the *Fertility and Family Building* section.

Get Started

Contact Progyny to learn more about your benefit and start the program that is right for you.

- **Call Progyny at 833.281.0088.** You can reach your care team Monday to Friday from 9 am ET to 9 pm ET.
- **For digital access,** go to the Progyny Member Portal or download the app.

PCAs speak several languages, and we utilize a medical translation service for real-time (live) telephonic interpretation in over 200 languages.

If you have a hearing or speech impairment and use Telecommunications Relay Services (TRS) or Text Telephone (TTY), dial 711 to connect with a TRS operator. Oral interpretation services or alternative formats of materials are also available for members with special needs. Contact Progyny for assistance.



Fertility and Family Building



Preconception and Trying to Conceive

Preconception and Trying to Conceive

Personalized clinical education, testing coverage, and digital resources to optimize your reproductive health

Growing your family can feel overwhelming and we want to support you every step of the way. Whether you're trying to conceive, planning to start trying soon, or looking to better understand your reproductive health, we are here to help.

Progyny connects you with a preconception PCA from our team of nurses to provide clinical education, testing, and referral services wherever you are in your path to parenthood.

Eligibility

Progyny's Preconception and Trying to Conceive program is available to all benefit eligible employees and their eligible dependents. Contact Progyny to confirm eligibility and get started.

Personalized Coaching

Throughout the program, you will have regular check-ins with your preconception PCA who will provide you with personalized education and support. You can also reach out to your PCA whenever you need additional support through phone, email, and secure message. You also have access to support from Registered Dietitian Nutritionists (RDNs) who can help you explore your overall health and dietary habits, offer recommendations to support your goals, suggest meal ideas tailored to your preferences, and discuss general information on nutrients, calories, and supplements.

Educational Content and Resources

Your preconception PCA will send resources that include guidance and education including ovulation and intercourse timing, nutrition and wellness, and mental health support that you can also access from the Progyny app.

Testing and Referral Services

Your preconception PCA can help you access carrier screening (genetic testing) and/or fertility testing. This testing is part of your covered services. You should expect to have financial responsibility for services you receive through your Progyny benefit.

Your preconception PCA can also provide referral services offered through your employer for nutrition support, behavioral health, leave benefits, and legal services to support your preconception journey.

Get Started

Contact Progyny to confirm eligibility and start using your benefit.

- **Call Progyny at 833.281.0088.** You can reach your care team Monday to Friday from 9 am ET to 9 pm ET.
- **For digital access,** visit the Progyny member portal.



Eligibility for the Fertility and Family Building Benefit

Eligibility for the Fertility and Family Building Benefit

Eligibility

Employees and their covered spouse or domestic partner enrolled in an eligible plan have access to the Progyny benefit. Dependent children are not eligible for the Progyny benefit.*

To verify eligibility and learn more about covered services, please contact your Progyny Care Advocate. You must meet eligibility criteria at time services are provided to utilize the Progyny benefit.

The lifetime Smart Cycle benefit is per family not per member.

*In the event of medical treatment for a current cancer diagnosis or in cases of gender dysphoria, that may impact future fertility, fertility preservation is covered for members, partners, and dependent children under 26. Contact your PCA for more information.

If you are the primary subscriber and your partner is not a claimed dependent on your primary medical insurance plan, your partner's services, including testing and treatment, will not be covered. Your partner must be a claimed dependent on your plan in order to receive coverage under your Progyny benefit.

If you and your partner 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.

COBRA

If you leave your current employer:

- If you receive treatment after you have left your employer, you may be able to enroll in COBRA. If you would like to extend your coverage, please speak with your HR department and employer to see if COBRA is available. If COBRA is offered, you may be able to continue your current Progyny coverage by completing all required enrollment steps. Be sure to connect with your employer to understand your options and the actions you need to take to extend your coverage under COBRA. 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.
- You must supply your COBRA enrollment letter and proof of coverage to your PCA each month you are enrolled in COBRA and utilize Progyny.
- To continue to use your Progyny benefits, your COBRA coverage must be active on each individual day you receive treatment or date of services. This applies even if your treatment cycle spans multiple days or weeks. If you receive care on a day your COBRA coverage isn't active, you'll be responsible for the full out-of-pocket cost of all services in that cycle.
- If you're leaving an employer that offers Progyny and you choose COBRA coverage, but then start a new job and enroll in a new medical plan, your new plan will become your primary insurance. Before

you can continue to use your Progyny benefit you'll need to contact both insurance providers to coordinate your benefits and ensure your coverage is set up correctly.

Coordination of Benefits

Members who are seeking Progyny-covered fertility services and have more than one health insurance plan may be required to complete Coordination of Benefits.

Before Progyny can authorize eligible fertility treatment, your insurance companies may need to confirm how your plans work together with a process called **Coordination of Benefits (COB).**

Understanding your insurance plans

Coordination of Benefits determines which health insurance plan pays first and what the other plan may cover.

In many cases:

- **Primary insurance** is the plan where you are the **subscriber**, meaning you have coverage through your own employer or policy.
- **Secondary insurance** is the plan where you are a **dependent**, meaning you are covered through someone else's plan, such as a spouse, partner, or parent.

Your primary and secondary plans may be different from the examples above, since your insurance companies make the final determination.

What do I need to do?

If the health insurance plan associated with your Progyny benefit is your **secondary plan**, the COB process must be completed before Progyny can authorize treatment.

The required documentation will depend on the rules of both insurance plans. You may be asked to provide one or more of the following:

- **Letter of Exclusion:** A letter from your primary health insurance company confirming that a service or benefit is not covered.
- **Letter of Exhaustion:** A letter from your primary health insurance company confirming that you have used all available coverage for a service or benefit.
- **Denied Explanation of Benefits (EOB):** A statement from your primary health insurance company showing that a claim was denied and explaining why.

Your Progyny team is here to walk you through the entire process and let you know what is needed along the way.

Here are the general steps:

1. Send your health insurance information to the Progyny COB team at cob@progyny.com.
2. A Progyny COB Specialist will review your coverage and determine which pathway applies to you.

3. Your COB Specialist will explain exactly what documentation to request from your primary health insurance company, if needed.
4. After you submit the required documentation, Progyny will work with your secondary health insurance company to complete the COB process.

Important: *Progyny cannot authorize treatment until the COB process is complete, and your insurance companies have confirmed how your fertility coverage works across both plans.*

Coordination of Benefit Scenarios:

During your journey there will be different scenarios that may apply and require different steps. Progyny is here to help walk you through the process after you send in your health insurance information. Contact the Coordination of Benefits team at cob@progyny.com if you're not sure which situation applies to you. We're here to guide you through the process.

Review the scenarios below to find the one that best matches your health insurance coverage. Each scenario explains the possible pathway you may need to follow and what steps to take next.

My primary health insurance does not cover fertility treatment, or I have used all of my fertility benefits.

Your Progyny COB Specialist will review your coverage and tell you which of the following options apply to you. The documentation depends on the requirements of your health insurance plans.

Option 1: Letter of Exclusion or Exhaustion

Obtain a letter of exclusion or exhaustion and send it to the COB team at cob@progyny.com. Here's how:

Contact your primary health insurance company (the health plan that is not associated with your Progyny benefit) and request one of the following:

- A **Letter of Exclusion** confirming that fertility treatment is not covered
- A **Letter of Exhaustion** confirming that you have used all available fertility benefits

The letter must be issued on your primary health insurance company's official letterhead and include:

- The date
- Your name
- Your member ID
- The coverage period
- **Coverage determination** (a clear statement of non-covered fertility services or that your fertility benefits have been exhausted)

The letter must be from your primary health insurance company. We cannot accept a letter from your employer or Human Resources department, or a Summary of Benefits (which provides general plan information and does not confirm your individual fertility coverage).

Send the letter to the COB team at cob@progyny.com.

How often do I need to submit a letter? *These letters are typically valid for 1 plan year. In most cases, you will need to submit a new letter once every plan year.*

Option 2: Denied Explanation of Benefits (EOB)

Sometimes, it's necessary to submit fertility services to your primary insurance to generate a denied Explanation of Benefits (EOB). For example, your carrier may not accept letters which will require you to submit for a denied EOB. Here's how:

1. Ask your fertility provider to submit claims for any completed services to your primary health insurance company (the health plan that is not associated with your Progyny benefit).

a. If your provider cannot submit a claim to your primary health insurance, you may submit the claim to your insurance company.

2. Your insurance company will process the claim and send you an EOB showing how the claim was processed and why it was denied.

3. Either you or your fertility provider may send the denied EOB to the COB team at cob@progyny.com.

In some cases, you may need to pay for services upfront. If the service is eligible, you may submit a reimbursement request after the Coordination of Benefits process is approved.

How often do I need to submit an EOB? *You will need to submit a denied EOB for each new fertility service you receive. Each treatment or procedure is reviewed separately by your insurance companies.*

Next steps for the COB process

1. Progyny reviews your documentation (letter or denied EOB).

2. Progyny sends the documentation to your secondary health insurance plan (the health plan associated with your Progyny benefit).

3. Your secondary health insurance plan determines if the documentation meets its Coordination of Benefits requirements.

4. Progyny notifies you of the decision and, if approved, authorizes your eligible treatment.

Estimated timeline: The COB process typically takes about **4 to 6 weeks**.

My primary health insurance plan covers fertility treatment.

If your primary health insurance plan covers all or part of your fertility treatment, you may be able to request reimbursement for eligible out-of-pocket costs through your secondary health insurance plan (the health plan associated with your Progyny benefit).

Your primary health insurance plan will process your fertility services first. You will pay the amount you are responsible for directly to your provider. This may include:

- Your deductible, copay, or coinsurance
- Costs for services your primary insurance plan doesn't cover

To be eligible for reimbursement:

1. The services must be covered by your Progyny benefit.
2. The services must be provided by a Progyny in-network provider.
3. Eligible out-of-pocket costs may include amounts you paid to your provider that were applied to your primary insurance deductible, copay, or coinsurance.

Reimbursement coverage is not guaranteed. Before you submit your request, please note:

- The health insurance plan associated with your Progyny benefit may reimburse eligible out-of-pocket costs, minus any cost share required under your Progyny benefit (such as deductible or coinsurance).
- Smart Cycles may be deducted based on the reimbursement amount.

How will reimbursement affect my Smart Cycles?

If you receive a reimbursement, Smart Cycles may be deducted based on the amount reimbursed.

Amount reimbursed	Smart Cycles deducted
Less than $2,000	None
$2,000–$3,999	¼ Smart Cycle
$4,000 or more	½ Smart Cycle

What happens next?

If you choose to request reimbursement for your eligible out-of-pocket costs to Progyny:

1. Contact your Progyny Care Advocate (PCA) to confirm that the services are eligible under your Progyny benefit and meet any applicable in-network requirements.
2. After you've paid your portion, submit the following to Progyny to request a reimbursement:
    - Explanation of Benefits (EOB) from your primary health insurance plan

- Proof of payment
- Itemized invoice from your provider

3. Progyny will review your documentation and work with your health insurance plan to confirm all requirements have been met.
4. Progyny will notify you when the review is complete and, when applicable, move your request to the reimbursement process.

Your Progyny Care Advocate is available to answer questions and help you submit any documentation.

Estimated timeline: This process typically takes about **90 days**. It may vary based on the health plan and whether any additional documentation is requested.

I have Progyny benefits through two health insurance plans (dual coverage).

What is dual coverage?

Dual coverage means you have access to Progyny benefits through two different health insurance plans. This can happen when:

- You have Progyny benefits through your own employer-sponsored health insurance plan, and
- You are also covered as a spouse or dependent under another health insurance plan that includes Progyny benefits.

In many cases:

- The plan where you are the subscriber (you're covered through your own employer or policy) is your primary health insurance plan.
- The plan where you are a dependent (you're covered through someone else's plan, such as a spouse, partner, or parent) is your secondary health insurance plan.

This may vary, since your health insurance plans make the final determination based on their Coordination of Benefits rules.

How does this affect me?

If you're eligible for Progyny benefits under both health insurance plans, you must use Progyny benefits available through your primary health insurance plan first.

Your secondary Progyny benefits may become available after you have used all available benefits under your primary health insurance plan.

Until then, your secondary Progyny account will remain unavailable.

Why do I need to use my primary health insurance plan first?

Coordination of Benefits rules require your primary health insurance plan to be used before your secondary health insurance plan.

This means:

- Your primary health insurance plan's eligibility rules apply first.
- Any waiting period or employment requirement under your primary health insurance plan must be completed.
- Once eligible, you must use the Progyny benefits available through your primary health insurance plan before requesting access to your secondary Progyny benefits.
- Your secondary health insurance plan cannot be used to bypass your primary health insurance plan's eligibility requirements, waiting period, or benefit structure.
- Using your secondary health insurance plan before you are eligible may cause claims to be reversed. You could then be responsible for the cost of those services.

What if my primary health insurance plan has a waiting period or tenure requirement?

Some employer-sponsored health insurance plans require you to complete a waiting period or work for your employer for a certain amount of time before you become eligible for Progyny benefits.

Here's an example:

- Primary plan: Progyny benefits become available after one year of employment.
- Secondary plan: Progyny benefits are available immediately because you are covered as a dependent under a spouse's or partner's health insurance plan.

Even if your secondary health insurance plan offers Progyny benefits sooner, you generally cannot use that plan first.

- You must meet the eligibility requirements of your primary health insurance plan before using Progyny benefits.
- Once you become eligible, you must use the Progyny benefits under your primary health insurance plan first.
- Your secondary benefits may become available after your primary benefits have been used.

What happens next?

Once you've used the Progyny benefits available through your primary health insurance plan:

- Progyny sends documentation to your secondary health insurance plan confirming that your primary Progyny benefits have been used.

- Your secondary health insurance plan reviews the documentation and determines if your secondary Progyny benefits can be activated.
- Progyny notifies you of the decision. If approved, your secondary Progyny account will be made available for use.

I terminated my coverage under my former primary health insurance plan.

If your previous primary health insurance coverage has ended and you do not have another active health insurance plan, you must notify the health insurance company associated with your Progyny benefit that your former primary plan has ended.

This allows them to update your Coordination of Benefits record and recognize their plan as your primary health insurance.

What you need to do

Call the health insurance plan associated with your Progyny benefit and ask them to:

- Remove your former primary health insurance plan from your Coordination of Benefits record.
- Confirm that their plan is now listed as your primary health insurance.

During the call, please request:

- The representative's name
- A reference number for the call
- Confirmation that your former primary health insurance plan has been removed from your Coordination of Benefits record

Send this information to us at *cob@progyny.com.*

What happens next?

1. Progyny reviews the information you provide.
2. If needed, Progyny confirms with the health insurance plan associated with your Progyny benefit that your Coordination of Benefits record has been updated and their plan is listed as your primary insurance.
3. Progyny notifies you when the Coordination of Benefits review is complete and whether treatment can be authorized.

Your Progyny COB Specialist will guide you through the process and let you know if any additional information is needed.



Fertility and Family Building Benefit Highlights

Highlights of Your Fertility and Family Building Benefit

At Progyny, we know the road to parenthood can be challenging, and we are here to support you through each phase of your family building journey. We partner with the nation's top fertility specialists to bring you a smarter approach with better care, more successful outcomes, and treatment options to support all paths to parenthood. Unlike other fertility solutions, the Progyny benefit has removed barriers to care to ensure equitable and inclusive access for all Progyny members.

Your Progyny benefit includes **comprehensive treatment coverage** (up to your Smart Cycle limit, as applicable), concierge support from dedicated **Progyny Care Advocates** (PCAs), and access to high-quality care through a **network of top fertility specialists.**

The Progyny benefit provides coverage for eligible services. You should expect to have financial responsibility for services you receive through your Progyny benefit. This means you may receive bills for services provided under your authorized Smart Cycle, including your initial consultation and diagnostics, medications, tissue storage, donor tissue, and fertility treatment. The amount you are responsible for will depend on your specific benefit and plan coverage. Please see the *Understanding Your Financial Responsibility* section of this guide or speak with your PCA for more information.

Highlights of Your Fertility and Family Building Benefit	Effective 01/01/2027
1*	Smart Cycle per family per lifetime
2	Initial consultations bundles per year
Progyny Rx	Fertility medication coverage
Fertility preservation	Egg and sperm freezing coverage
Donor tissue	Egg and sperm coverage
Tissue storage	Tissue storage is included for the first year in applicable treatment cycles

*You have access to an additional Smart Cycle if your first does result in a live birth.

To learn more and activate your benefit, go to the Progyny member portal or call: 833.281.0088

Concierge Support

Your Care Team

As a Progyny member, you'll be matched to a PCA who will provide unlimited educational and emotional support throughout your entire journey. After onboarding, you will be matched with your PCA team based on your fertility and family building goals. PCAs are fertility support specialists trained to support all paths to parenthood, including surrogacy and adoption. Your PCA can provide guidance on available treatment options and possible outcomes, prepare you for all of your appointments, and answer questions about your benefit.

Your PCA is also your connection to a team of Clinical Educators, made up of clinicians in the fertility space (including registered nurses and embryologists) who can answer any detailed clinical questions you may have about your care. All members are encouraged to speak with a Clinical Educator prior to and after receiving services, and as you are making important decisions during your treatment journey. Connecting with a Clinical Educator is included within your Smart Cycles and will not impact your balance. You can request to be connected with a Clinical Educator at any time, or your PCA may connect you with one, to receive additional guidance.

If you are interested in exploring other paths to parenthood like surrogacy or adoption, your PCA can also connect you to our surrogacy and adoption focused PCAs. Contact your PCA to learn more.

Digital Tools

Progyny Member Portal and App

In addition to the personalized support from your PCA, you have access to the Progyny member portal, available on the web and as a mobile app. You can download the Progyny app from the Apple App Store for iPhone or Google Play for Android. With the member portal, you can review your benefit details, upcoming authorizations, account and claims information, communicate directly with your PCA, and access educational resources. Access will be granted after you activate your benefit. To activate the benefit you can enroll in the Progyny Member Portal or contact Progyny for support.

Educational Resources

We know how confusing the world of fertility can be, and we want to ensure you have access to resources for every step of your family building journey.

- Visit https://member.progyny.com/login to browse articles, videos, infographics, webinars, and more
- Listen to Progyny's *This Is Infertility* podcast to hear personal stories and guidance from experts to understand what it's like to go through a family building journey
- Subscribe to Progyny's YouTube channel for expert education on key fertility and family building topics

Top Fertility Specialists

Progyny has created a network of top fertility specialists, including reproductive endocrinologists and reproductive urologists, connecting you to high-quality care across the United States.

Our fertility specialists use advanced, evidence-based science and technology to increase the chances of a healthy and successful pregnancy. With Progyny's comprehensive benefit design, your provider can work with you to create the customized treatment plan that is best for you.

To utilize your benefit, Progyny covered treatments and services must be performed by an authorized in-network provider affiliated with a Progyny in-network clinic. You can search for an in-network fertility specialist at progyny.com/find-a-provider. The search tool includes detailed information for each Progyny network clinic, including provider profiles with demographics, sub-specialties, and other unique practice characteristics. To search for in-network laboratories and ancillary partners, please visit progyny.com/labs. For questions about network coverage or participating providers, please contact your Progyny Care Advocate

Progyny works in tandem with our in-network clinics to ensure a seamless experience for all members. Progyny will authorize covered services that are provided by our in-network clinics and then bill you directly for any financial responsibility as applicable. Please refer to the *Authorization and Financial Responsibility* section to learn more.

Check out frequently asked questions about providers and lab facilities here.

Tips for Using Your Fertility and Family Building Benefit

As you get started with Progyny, review these tips for the top things to know when utilizing your fertility and family building coverage. Review the full member guide for all important information relevant to your benefit.

1. **Activate your benefit**
   Before receiving services or beginning treatment, call Progyny or visit the Progyny Member Portal to activate your benefit. Please be prepared to provide insurance details to verify you're enrolled in an eligible medical insurance plan or complete an attestation form to confirm eligibility. Connecting with your team of PCAs is an important first step as they will be there to provide unlimited support to you throughout your journey, which is part of the services included within your Smart Cycle. Contact your PCA with any questions or if there are any changes to your insurance.
2. **Review your financial responsibility**
   All covered and authorized services are subject to member financial responsibility, as determined by your health plan. Depending on your plan, you may receive a bill for your portion of the cost. Speak to your PCA prior to starting treatment to understand your potential costs. You can also explore the Cost Estimator Tool on Progyny's website to help understand what your financial responsibility may be. Reference the *Understanding Your Financial Responsibility* section to learn more.
3. **Select a Progyny in-network clinic**
   Any treatments and services covered by Progyny must be performed by a Progyny in-network provider at a Progyny in-network clinic to utilize your benefit. To search for an in-network clinic, visit progyny.com/find-a-provider or contact your PCA. When contacting a clinic to schedule an appointment let them know you have Progyny and provide your Progyny ID (provided at onboarding and available on the member portal).
4. **Ensure there is an authorization in place BEFORE receiving services**
   An authorization must be requested by your clinic and approved by Progyny before the start of any treatment or service. Coverage is subject to your eligibility on the date of service for the claim. Your clinic will handle the authorization request and confirm the details on your behalf. Once the authorization is approved, you will receive a Confirmation Statement, which serves as your proof of coverage. Prior to any procedure, be sure to review your app to confirm that the requested authorization is in place. The authorization confirms that the service is covered under your benefit, but an authorization is not a guarantee of coverage and claim payment. Coverage is subject to your eligibility on the date of service for the claim. For select services, authorization may be denied based on Progyny's Utilization Management policies. Reference the *Authorization for Covered Services* section to learn more.
5. **List Progyny as your primary insurance provider and provide your Progyny ID**
   To avoid billing issues, when you register at your clinic be sure to list Progyny as your insurance for all services listed as covered in this member guide. You will need to provide your Progyny ID to your in-network clinic and labs where you receive services. Your Progyny ID will be provided to you at onboarding, and you can access your Progyny ID via the member portal.

We're here to help! Call 833.281.0088 if you have questions along the way.



The Smart Cycle

Understanding Your Smart Cycle Benefit

To make your fertility benefit easier to use, we've bundled all the individual services, tests, technology, and treatments into the Progyny Smart Cycle. The Progyny Smart Cycle is a benefit currency that is expressed in fractions. Each treatment or service type, such as IVF or IUI, is valued as a fraction of a Smart Cycle. You can mix and match Smart Cycle treatments until you max out your Smart Cycle balance.

If you are using your Smart Cycle balance for select services, you may be subject to utilization management. Please refer to the *Utilization Management section* or https://nputilizationalliance.com/policies/ for more information on which services may require authorization through NPUA.

Please note, you will have financial responsibility for covered services included within your Smart Cycles as determined by your medical insurance plan, and some services may have tax considerations. Financial responsibility may include a deductible, coinsurance, or copayment depending on your specific plan. To learn more, visit the *Understanding Your Financial Responsibility* section or contact your PCA.

Common Ways to Use a Smart Cycle:

Progyny Smart Cycles can be mixed and matched to create a customized treatment path that works best for you. The below treatments are covered under your Progyny fertility and family building benefit and will deduct from your total Smart Cycle balance.

Visit the *Explanation of Covered Treatments & Services* section of the Member Guide to learn more about what's included in each Smart Cycle and additional covered services. Unless specified, the stated Smart Cycle value for treatment is applied in full, even if you choose to forego any included services. For a full explanation of what's covered under each Smart Cycle, visit the *Glossary of Services*.



Fertility Treatment Coverage

Explanation of Covered Treatments & Services

Progyny offers the following covered services. If a service or procedure is not listed, you should assume that it is not covered by Progyny but may be covered through your medical insurance. Always confirm specific benefits and requirements with your dedicated team of PCAs prior to treatment or testing.

Initial Consultation and Diagnostic Testing

Your coverage includes 2 initial consultations per year, until you've exhausted your Smart Cycle balance. There is no impact to your Smart Cycle balance for your initial consultations, however all covered services are subject to your financial responsibility. Your initial consultation and diagnostic testing bundle includes, but is not limited to: three office visits, two ultrasounds, hormone testing, infectious disease testing, genetic carrier screening, and two semen analyses. Depending on your specific circumstances, there may be some diagnostic tests ordered by your provider that are not covered by Progyny but may be covered by your medical insurance. For example, cholesterol, Pap smear, HPV, and other tests that are not specific to fertility, and are not covered under Progyny, but are likely covered under your regular medical insurance. Reach out to your medical carrier if you have questions about coverage for these services. You can always contact your PCA to clarify if a specific test is covered by Progyny.

Reference the Initial Consultation and Diagnostic Testing appendix for a full list of covered tests and procedures, their medical CPT codes, and additional information.

Covered services are subject to your financial responsibility. See the *Understanding Your Financial Responsibility* section for more information. Please note, your covered services may be billed via several invoices.

Partial Initial Consultation and Diagnostic Testing

In certain instances, your provider may recommend a portion of services for your initial consultation and diagnostic testing rather than the comprehensive bundle of services.

Examples include:

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

All providers in the Progyny network are instructed to bill only for the partial services utilized in these circumstances. Please note, the examples above are for illustrative purposes only and are not comprehensive.

Mock Cycle

A mock cycle occurs when the patient is prescribed medication and monitored as if they were preparing for an embryo transfer. Instead of transferring an embryo, a biopsy of the uterine lining is performed to check the receptivity of the endometrium. Progyny provides coverage for the mock cycle for members with approved medical indications such as a history of previously failed embryo transfers, only one frozen embryo, or the use of donor tissue.

The following services are covered:

- Bloodwork related to the mock cycle
- Endometrial biopsy
- Office visits
- Ultrasound
- Endometrial receptivity pathology at an in-network laboratory (Note, ALICE/EMMA/ReceptivaDX tests are not covered)

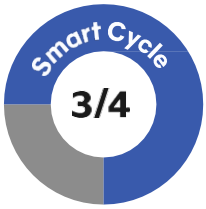
Medications necessary for the mock cycle will also be covered as listed in the Progyny Rx formulary.

This service will require specific authorization. To learn more about services that require specific authorization under utilization management, please visit https://nputilizationalliance.com/policies/ or talk to your PCA. Request for authorization for covered services will be reviewed based on your individual submission and our written clinical policy. The request will be timely adjudicated and based on that review may be approved, denied, or partially approved or partially denied.

Fertility Treatments Covered Under Your Progyny Benefit:

IVF Fresh Cycle

An IVF fresh cycle starts by stimulating the ovaries with a course of medications. Following stimulation, the provider retrieves the eggs, which are taken to the lab and fertilized. After three to five days, an embryo is 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. PGT-A screens each sample for genetic abnormalities, allowing the fertility specialist to ensure that the most viable embryo is chosen for transfer. Please note, the use of PGT-A does not impact your Smart Cycle balance.



IVF Fresh Cycle

The following procedures are covered:

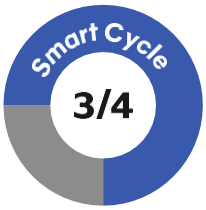
- Anesthesia (for egg retrieval)
- Assisted hatching
- Blastocyst culture
- Cycle management
- Embryo biopsy
- Embryo culture lab
- Embryo transfer w/ultrasound guidance
- Intracytoplasmic sperm injection (ICSI)
- Office visits
- Oocyte fertilization/insemination
- Oocyte identification
- Preimplantation 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)
- Sperm wash & prep (simple* or complex preparation)
- Sperm cryopreservation (sperm storage is authorized and billed separately)
- Tissue storage (1 year)

- Ultrasounds & in-cycle bloodwork (E2, P4, beta hCG, FSH, LH)

*Sperm wash and prep may not be covered if person giving the sample is not on the health plan.

Standard coverage is for a single embryo transfer. If you and your doctor are interested in the transfer of more than one embryo, please refer to the Utilization Management section to learn more about available options as this service will require a specific authorization. To learn more about the single embryo transfer, please find the description in the glossary. This service may require specific authorization. To learn more about services that require specific authorization steps, please visit https://nputilizationalliance.com/policies/ or talk to your PCA. Request for authorization for covered services will be reviewed based on your individual submission and our written clinical policy. The request will be timely adjudicated and based on that review may be approved, denied, or partially approved or partially denied.

IVF Freeze-All



IVF Freeze-All Cycle

An IVF freeze-all cycle is similar to an IVF fresh cycle but may increase the chances of success. An IVF freeze-all starts by stimulating the ovaries with a course of medications. Following the course of stimulation medications, the provider retrieves the eggs, which are taken to the laboratory 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 laboratory 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, and until you choose to use at a later date. Please note, a frozen embryo transfer Is a separate authorization that requires an additional Smart Cycle deduction.

The following procedures are covered:

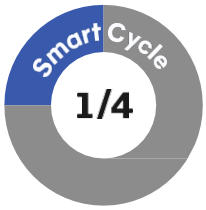
- Anesthesia (for egg retrieval)
- Assisted hatching
- Blastocyst culture
- Cycle management
- Embryo biopsy
- Embryo culture lab
- Intracytoplasmic sperm injection (ICSI)
- Office visits
- Oocyte fertilization/insemination
- Oocyte identification
- Preimplantation genetic testing for aneuploidy (PGT-A)
- Preparation and cryopreservation of extra embryo(s)
- Retrieval (follicular aspiration, to include ultrasound guidance)
- Sperm wash & prep (simple* or complex preparation)
- Sperm cryopreservation (sperm storage is authorized and billed separately)
- Tissue storage (1 year)
- Ultrasounds & in-cycle bloodwork (E2, P4, beta hCG, FSH, LH)

*Sperm wash and prep may not be covered if person giving the sample is not on the health plan.

If you have used two IVF cycles, all subsequent IVF cycles will require prior authorization through Progyny's Utilization Management policies. You can learn more about the policies at https://nputilizationalliance.com/policies/.

Frozen Embryo Transfer (FET)

Embryos that have been preserved during an IVF freeze-all, frozen oocyte transfer, or previous IVF fresh 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 screens each sample for genetic abnormalities, allowing the fertility specialist to ensure that the most viable embryo is chosen for transfer. Please note, FETs performed on a gestational carrier are standardly not a covered service. Contact your PCA for more information.



Frozen Embryo Transfer (FET)

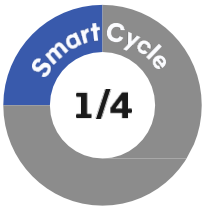
Standard coverage is for a single embryo transfer. If you and your doctor are interested in the transfer of more than one embryo, please refer to the Utilization Management section to learn more about available options as this service will require a specific authorization. To learn more about the single embryo transfer, please find the description in the glossary.

The following procedures are covered:

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

Intrauterine Insemination (IUI)

Intrauterine insemination (IUI), or artificial insemination, is when sperm is inserted directly into the uterus through a catheter following monitoring. Sometimes a course of medication is used prior to insemination to stimulate the ovaries and increase the likelihood of pregnancy.



Intrauterine Insemination (IUI)

The following procedures are covered:

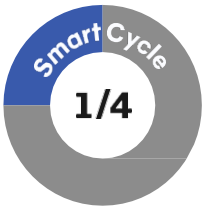
- Sperm wash & prep (simple* or complex preparation)
- Cycle management
- Insemination
- Office visits
- Ultrasounds & in-cycle bloodwork (E2, P4, beta hCG, FSH, LH)

*Sperm wash and prep may not be covered if the person giving the sample is not on the health plan.

This authorization includes oral medications and a trigger shot. If your IUI cycle involves injectable stimulation hormone shots, you will need prior authorization through Progyny's partner, NPUA. Please refer to our Utilization Management policies at https://nputilizationalliance.com/policies/.

Timed Intercourse (TIC)

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



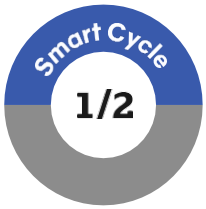
Timed Intercourse (TIC)

The following procedures are covered:

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

Fertility Preservation (Egg Freezing)

Egg freezing, or oocyte cryopreservation, allows a member to preserve their fertility as they plan for the future. An egg freezing cycle starts by stimulating the ovaries with a course of medication. Following stimulation, the provider retrieves eggs from the ovaries and freezes them using vitrification.



Egg Freezing

The following procedures are covered:

- Anesthesia (for egg retrieval)
- Cycle management
- Oocyte identification
- Office visits
- Preparation and cryopreservation of egg(s)
- Retrieval (follicular aspiration, to include ultrasound guidance)
- Tissue storage (1 year)
- Ultrasounds & in-cycle bloodwork (E2, P4, beta hCG, FSH, LH)

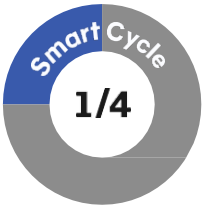
While your employer offers fertility preservation, it may be considered a taxable benefit. Contact a trusted tax advisor for more information regarding the tax treatment of Smart Cycles under this benefit.

If you have used two egg freezing cycles, all subsequent egg freezing cycles will require prior authorization through Progyny's Utilization Management policies. You can learn more about the policies at https://nputilizationalliance.com/policies/.

Fertility Preservation (Sperm Freezing)

Although sperm freezing is less common than egg freezing, there are situations in which a provider may advise banking sperm.

As with other services, your portion of financial responsibility will apply to each production of a sample. If you prefer to preserve your Smart Cycle balance for treatment, you can always opt to pay for these services out-of-pocket.



Sperm Freezing

The following procedures are covered:

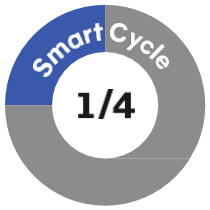
- Office visits
- Semen analysis

- Semen cryopreservation
- Tissue storage (1 year)

[Sperm Freezing DisclaimerWhile your employer offers fertility preservation, it may be considered a taxable benefit. Contact a trusted tax advisor for more information regarding the tax treatment of Smart Cycles under this benefit.

Split Cycle

A split cycle is comprised of splitting the cryopreservation of the tissue between eggs and embryos. A split cycle may only be added to an authorized IVF fresh or IVF freeze-all cycle.



Split Cycle (Egg & Embryo Freezing)
When paired with IVF cycle

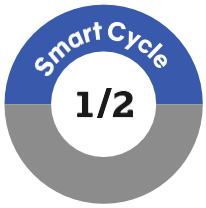
The following procedures are covered:

- Oocyte cryopreservation

Frozen Oocyte Transfer (FOT)

A frozen oocyte transfer cycle can be scheduled when a member is previously frozen eggs to attempt pregnancy. Eggs are thawed and fresh embryo transfer takes place three to five days after fertilization. embryos may undergo preimplantation genetic testing for aneuploidy being frozen via vitrification.

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Frozen Oocyte Transfer (FOT)

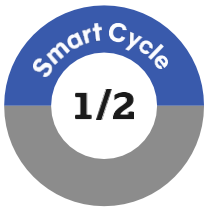
The following procedures are covered:

- Assisted hatching
- Blastocyst culture
- Cycle management
- Embryo biopsy
- Embryo culture lab
- Embryo transfer 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
- Sperm wash & prep (simple* or complex preparation)
- Tissue storage (1 year)
- Ultrasounds & in-cycle bloodwork (E2, P4, beta hCG, FSH, LH)

*Sperm wash and prep may not be covered if person giving the sample is not on the health plan.

Pre-Transfer Embryology Services

Progyny's fertility benefit covers pre-transfer embryology services including diagnostic testing, fertilization, preimplantation genetic testing, and cryopreservation for the covered member who is the intended parent. This cycle includes all the embryology services for the creation of embryos from previously frozen or donor eggs. The services begin once the eggs have been retrieved or thawed. If this service is being authorized using a gestational carrier or surrogate, please be aware Progyny's fertility benefit does not cover services on a gestational carrier or surrogate, so the subsequent frozen embryo transfer is an out-of-pocket cost.



Pre-Transfer Embryology Services

The following procedures are covered:

- Assisted hatching
- Blastocyst culture
- Cycle management
- Embryo biopsy
- Embryo culture lab
- 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)
- Sperm wash & prep (intended parent's sperm) for simple** or complex preparation
- Sperm cryopreservation (sperm storage is billed and authorized separately)
- Tissue storage (1 year)*
- Ultrasounds & in-cycle bloodwork (E2, P4, beta hCG, FSH, LH)**

*Sperm wash and prep may not be covered if the person giving the sample is not on the health plan.

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

Donor Eggs (Oocyte)

A cohort typically includes 6-8 oocytes (eggs); however the cohort will ultimately be determined by the contracted egg bank you select. Progyny only includes single egg cohort authorizations and not any specialty packages. Tissue transportation from the tissue bank to your in-network clinic is also covered. The authorization of donor tissue must be at an in-network egg bank where members can use their Smart Cycles to purchase donor eggs directly after an authorization is issued. Visit progyny.com/labs to search for in-network egg banks. You can choose to pay out-of-pocket for additional oocytes outside the standard cohort. Contact your PCA if you have questions.



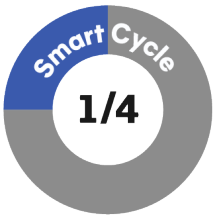
1 Cohort of Donor Eggs
6–8 eggs

After your initial donor tissue authorization, utilization management will apply for all consecutive authorizations for donor tissue. You can learn more about the policies at https://nputilizationalliance.com/policies/.

While your benefit includes donor tissue, it may be considered a taxable benefit. Please contact a trusted tax advisor for more information regarding the tax treatment of Smart Cycles under this benefit.

Donor Sperm

Donor sperm includes up to four vials per authorization. All vials must be obtained via authorization the same day. Tissue transportation from the tissue bank to your in-network clinic is also covered. The authorization of donor tissue must be at an in-network sperm bank where members can use Smart Cycles to purchase donor sperm directly after an authorization is issued. Visit progyny.com/labs to search for in-network sperm banks. Contact your PCA if you have questions.



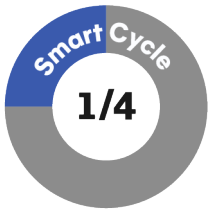
Donor Sperm
4 vials

You may also elect to purchase donor sperm without utilizing your Smart Cycle benefit. In this case, you would pay out-of-pocket for the donor sperm (purchase or known donor expenses) as well as transportation. These costs would not contribute to your medical insurance plan cost share. Contact your PCA if you have questions.

While your benefit includes donor tissue, it may be considered a taxable benefit. Please contact a trusted tax advisor for more information regarding the tax treatment of Smart Cycles under this benefit.

FET for Donor Embryo

Some members may choose embryo donation to build their families. Embryo donation, which is sometimes referred to as embryo adoption, is the process of receiving an embryo created by another individual or couple who donated their remaining embryos. Following testing, the recipient undergoes a frozen embryo transfer (FET). The FET is covered as part of the Progyny benefit. Donor embryos typically include agency/administration fees. These fees will be an out-of-pocket cost. Please contact your PCA for more information.



Frozen Embryo Transfer (FET) for Donor Embryo

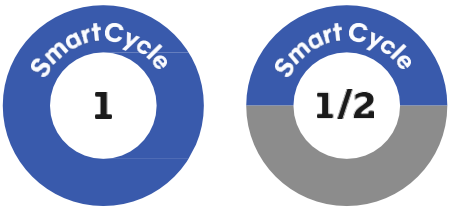
Standard coverage is for a single embryo transfer. If you or your provider are interested in transfer of more than one embryo, please refer to our Utilization Management section to learn more about available options as this service will require a specific authorization. To learn more about the single embryo transfer, please find the description in the glossary.

The following procedures are covered:

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

Live Donor IVF Fresh

Live donor IVF fresh refers to egg retrieval services performed on an egg donor. Once the eggs are retrieved, they are fertilized with sperm to create embryos, and one embryo is transferred to the uterus. Please note, the fresh embryo transfer (transferring the tissue to the uterus of the intended parent) is covered. Sperm may be either donor tissue or tissue from the intended parent(s). Please note, Progyny's fertility benefit does not cover services on a gestational carrier or surrogate.



IVF Live Donor Fresh
Donor services and creation of embryos including transfer to member

Standard coverage is for a single embryo transfer. If you and your doctor are interested in the transfer of more than one embryo, please refer to the Utilization Management section to learn more about available options as this service will require a specific authorization. To learn more about the single embryo transfer, please find the description in the glossary.

The following procedures are covered for the donor:

- Anesthesia for retrieval
- Cycle management
- Education and instruction for donor
- FDA testing on donor (blood draw and lab tests)
- Office visits
- Physical examination and consultation of donor (includes psychological consultation and testing on donor, physical evaluation on donor—which includes ultrasounds and blood tests, genetic screening, and consultation on donor)
- Retrieval (follicular aspiration, to include ultrasound guidance)
- Ultrasounds & in-cycle bloodwork (E2, P4, beta hCG, FSH, LH)

The following procedures are covered for the recipient:

- Assisted hatching (blast culture)
- Cycle management
- Education and instruction for recipient
- Embryo culture
- Embryo transfer with ultrasound guidance
- Insemination and fertilization of oocytes
- Intracytoplasmic sperm injection (ICSI)
- Office visits
- PGT-A biopsy (PGT-A managed through Progyny in-network lab)
- Preparation of embryos for transfer
- Preparation or cryopreservation of embryos, if applicable
- Psychological consultation for recipient (via reimbursement)
- Semen cryopreservation, if applicable
- Semen thaw, if applicable
- Semen wash and prep (simple* or complex preparation)

- Tissue storage (1 year) if balance of embryos remaining
- Ultrasounds & in-cycle bloodwork (E2, P4, beta hCG, FSH, LH)

*Sperm wash and prep may not be covered if the person giving the sample is not on the health plan.

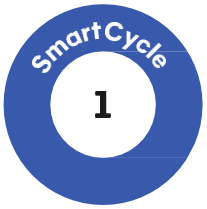
Non-covered services include (but are not limited to) donor agency fees, donor compensation, and donor medications. Contact your PCA to learn more.

The Progyny benefit does not cover shared/split live donor IVF cycles. For any questions about your cycle coverage, please reach out to your PCA.

While your benefit includes donor services, it may be considered a taxable benefit. Please contact a trusted tax advisor for more information regarding the tax treatment of Smart Cycles under this benefit.

Live Donor IVF Freeze-All

Live donor IVF freeze-all refers to egg retrieval services performed on an egg donor for fertilization and embryo-banking purposes. Sperm may be donor tissue or tissue from the intended parent(s). Please note, a frozen embryo transfer requires a separate authorization and an additional Smart Cycle deduction.



IVF Live Donor Freeze-All
Donor services and creation of embryos not including frozen embryo transfer

The following procedures are covered for the donor:

- Anesthesia for retrieval
- Cycle management
- Education and instruction for donor
- FDA testing on donor (blood draw and lab tests)
- Physical examination and consultation of donor (includes psychological consultation and testing on donor, physical evaluation on donor—which includes ultrasounds and blood tests, genetic screening, and consultation on donor)
- Office visits
- Retrieval (follicular aspiration, to include ultrasound guidance)
- Ultrasounds & in-cycle bloodwork (E2, P4, beta hCG, FSH, LH)

The following procedures are covered for the recipient:

- Assisted hatching (blast culture)
- Cryopreservation of embryos
- Cycle management
- Education and instruction for recipient
- Embryo culture
- Insemination and fertilization of oocytes
- Intracytoplasmic sperm injection (ICSI)
- Office visits
- Semen cryopreservation, if applicable
- Semen thaw, if applicable
- Semen wash and prep (simple* or complex preparation)

- PGT-A biopsy & testing (PGT-A managed through Progyny in-network lab)
- Psychological consultation for recipient (via reimbursement)
- Tissue storage (1 year)
- Ultrasounds & in-cycle bloodwork (E2, P4, beta hCG, FSH, LH)

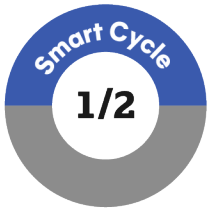
*Sperm wash and prep may not be covered if the person giving the sample is not on the health plan.

Non-covered services include (but are not limited to) donor agency fees, donor compensation, and donor medications. Contact your PCA to learn more.

While your benefit includes donor services, it may be considered a taxable benefit. Please contact a trusted tax advisor for more information regarding the tax treatment of Smart Cycles under this benefit.

Known/Directed Sperm Donor

Some members may choose to utilize a known sperm donor for their family building needs. When utilizing a known or directed donor, specific testing is required. Sperm donors can visit one of our in-network sperm banks, and your PCA will create an authorization. The authorization will also include one year of storage. If the donor must use an out of network sperm bank, you may pay the upfront costs and submit for reimbursement, which will impact your Smart Cycle balance. Speak to your PCA about what out-of-pocket costs may occur (for example the fees associated with a legal agreement, psychological evaluation, and genetic counseling services). Your PCA will also be able to direct you to Progyny in-network labs for testing.



Known/Directed Sperm Donor

The following procedures are covered:

- Banking attempt(s)
- Office visits
- Physical exam
- Risk assessment(s)
- Expanded carrier screening
- Screening bloodwork
- Consultation, semen analysis, processing, and freeze
- Tissue storage (1 year)
- Final serology test & donor eligibility determination testing
- Karyotyping (separate authorization)

Partial Cycle = 1/4 or 1/2 Smart Cycle

If you only have 1/4 or 1/2 of a Smart Cycle remaining, you may be eligible to utilize your remaining balance toward IVF for partial cycle coverage. Any services not included in the partial cycle will be a full out-of-pocket cost. All partial cycles are subject to provider approval. Contact your PCA to confirm eligibility and learn more about your options.

PGT-M/SR Biopsy

Preimplantation genetic testing for monogenic/single gene diseases (PGT-M) or Preimplantation genetic testing for structural rearrangements (PGT-SR) are both used when medically indicated and require a separate authorization outside of a treatment cycle. There is no Smart Cycle deduction but you may have financial responsibility depending on your plan. For more information on what these tests cover, please reference the glossary section.

What happens if I don't use all aspects of the treatment?

If you choose not to use all services included in your treatment plan, your Smart Cycle usage will still reflect the full treatment for which authorization was granted. For example, if your provider recommends services such as ICSI or PGT-A and you elect not to proceed with them, your Smart Cycle count will not be adjusted.

Medical decisions, including whether to proceed with recommended services, are made solely between you and your provider. Progyny's Smart Cycle benefit is designed to make covered services available when recommended by your provider, but coverage remains subject to the terms and conditions of your plan. Specific services will be subject to utilization management. You can learn more about the policies at https://nputilizationalliance.com/policies/

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.

If you already have tissue in storage that was not created or retrieved with the Progyny benefit, Progyny will cover one year of storage in an in-network clinic or storage facility.

Tissue storage is subject to your financial responsibility. If you choose to discontinue storage or move your tissue before the end of the first year, billing will not be pro-rated, and you will be charged for the full year.

Tissue Transportation

Tissue transportation within or into an in-network clinic or storage facility is covered by Progyny. Coverage only applies to standard shipping, and when possible, members should use an in-network tissue transportation solution. If eligible to use an out-of-net network transport company, reimbursements must be submitted based on your timely filling limit. Contact your PCA for more information and to confirm reimbursement eligibility and processing details.

Remote monitoring

When choosing a clinic, it's important to select a fertility clinic that will both meet your personal needs and be easily accessible, as your treatment will include numerous visits to your clinic for testing such as bloodwork and ultrasounds. These tests are designed to ensure you are responding to the medication prescribed by your provider. All services, including monitoring, are authorized at your primary clinic and typically cannot be covered if performed at outside clinics or labs. If you choose to pursue these services outside of your primary clinic, this is referred to as remote monitoring (or outside monitoring) and it is not covered by your benefit. The tests will have an out-of-pocket expense.

Reproductive Urology Services

Progyny covers sperm-related infertility, which often means there is an issue with sperm production or delivery, motility or the shape of sperm, or blockage in the reproductive tract. While treatment will vary, an individual will typically need to see a reproductive urologist who specializes in sperm-related health. The Progyny benefit provides treatment coverage for these services when performed by an in-network provider from our curated network of reproductive urologists. Most of these services, other than fertility preservation, do not reduce your Smart Cycle balance when utilized but you may have financial responsibility. While services may not use Smart Cycles, you will not be able to access urology services if you have exhausted your Smart Cycle balance. Contact your PCA for more information.

Sperm Retrieval Procedures

Sperm retrieval procedures involve procuring sperm for storage or use in fertility treatment. Please note that the sperm retrieval will require a separate authorization. These include:

Testicular Sperm Aspiration (TESA) is a procedure often performed for obstructive azoospermia and involves the insertion of a needle into the testicle and tissue/sperm are aspirated.

All of the following services are covered for a TESA:

- Office visits
- Scrotal ultrasound
- Rectal ultrasound
- Biopsy of the testis, needle
- Sperm aspiration
- Sperm identification from testis tissue*
- Cytopathology: evaluation of fine needle aspirate
- Cytopathology: fluids, washings, or brushings
- Cytopathology: concentration technique
- Level IV surgical pathology
- Facility fees and anesthesia

*May require additional authorization.

Percutaneous Epididymal Sperm Aspiration (PESA) is a procedure often performed for obstructive azoospermia from either a prior vasectomy or infection which involves the insertion of a needle through the skin of the scrotum into the epididymis to aspirate sperm.

All of the following services are covered for a PESA:

- Office visits
- Scrotal ultrasound
- Rectal ultrasound
- Biopsy of the testis, needle
- Sperm aspiration
- Sperm identification from epididymal or vasal fluid*
- Cytopathology: evaluation of fine needle aspirate
- Cytopathology: fluids, washings, or brushings
- Cytopathology: concentration technique

- Level IV surgical pathology
- Facility fees and anesthesia

*May require additional authorization.

Testicular Sperm Extraction (TESE) or Microdissection TESE (MicroTESE) is a procedure often performed when there is a sperm production problem and there are few or no sperm present in the ejaculate. A small incision is made in the testis to examine the tubules for the presence of sperm.

All of the following services are covered for a TESE:

- Office visits
- Scrotal ultrasound
- Rectal ultrasound
- Biopsy of the testis, incisional
- Sperm identification from testis tissue*
- Cytopathology: fluids, washings, or brushings
- Cytopathology: concentration technique
- Level IV surgical pathology
- Facility fees and anesthesia

All of the following services are covered for a MicroTESE:

- Office visits
- Scrotal ultrasound
- Rectal ultrasound
- Biopsy of the testis, incisional
- Sperm identification from testis tissue*
- Level IV surgical pathology
- Cytopathology: fluids, washings, or brushings
- Cytopathology: concentration technique
- Facility fees and anesthesia

*May require additional authorization.

Micro Epididymal Sperm Aspiration (MESA) is a procedure performed for vasal or epididymal obstruction and allows for an extensive collection of mature sperm. Often through use of an operating microscope, a fine needle is inserted into the epididymis to aspirate sperm and fluid directly from the epididymal tubules.

All of the following services are covered for a MESA:

- Office visits
- Scrotal ultrasound
- Rectal ultrasound
- Biopsy of the testis, needle
- Biopsy of the testis, incisional
- Sperm aspiration
- Sperm identification from epididymal or vasal fluid*
- Cytopathology: evaluation of fine needle aspirate
- Cytopathology: fluids, washings, or brushings
- Cytopathology: concentration technique
- Level IV surgical pathology
- Facility fees and anesthesia

*May require additional authorization.

Percutaneous Vasal Sperm Aspiration/Vasal Sperm Aspiration (PVSA/VASA) is a sperm retrieval process that gathers mature sperm cells found in the vas deferens. This approach may be an option for those who have normal sperm production but have some kind of blockage or condition that impedes sperm transport from the testicle to the ejaculate.

All of the following services are covered for a PVSA/VASA:

- Office visits
- Scrotal ultrasound
- Rectal ultrasound
- Biopsy of the testis, needle
- Sperm aspiration
- Sperm identification from epididymal or vasal fluid*
- Cytopathology: evaluation of fine needle aspirate
- Cytopathology: fluids, washings, or brushings
- Cytopathology: concentration technique
- Level IV surgical pathology
- Facility fees and anesthesia

*May require additional authorization.

Other Reproductive Urology (sperm-related) Treatments

In addition to sperm retrieval procedures, Progyny also covers several other treatments. These include:

- Fine needle aspiration biopsy (testes mapping)
- Electroejaculation (rectal probe) or Penile Vibratory Stimulation (PVS)
- Varicocelectomy (unilateral or bilateral)
- Cystoscopy and transrectal ultrasound-guided seminal vesicle aspiration and chromotubation
- Transurethral resection of the ejaculatory ducts (TURED)
- Cytopathology: evaluation of fine needle aspirate
- Cytopathology: fluids, washings, or brushings
- Sperm DNA fragmentation
- Cytopathology: concentration technique
- Level IV surgical pathology
- Vasography
- Orchidopexy
- Scrotal exploration and microsurgical reconstruction for idiopathic or defined excurrent duct obstruction (cannot be authorized for vasectomy reversal procedures)
- Inguinal exploration

If you have any questions about coverage and services please view our frequently asked questions here. To see what is covered for labs, procedures, and diagnostic tests, view here.

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. Your treatment and medications are authorized through a single authorization process. Progyny partners with leading mail order specialty fertility pharmacies to bring you clinical support and overnight delivery of your medications. Each medication delivery includes an UnPack It Call and concierge support. Pharmacy clinicians are available during regular business hours to answer routine questions, with 24/7 support for emergency needs.

Here's How It Works:

Progyny Rx works by authorizing medications at the same time as your treatment. Reference the confirmation statement for your approved authorization to identify your assigned Progyny Rx pharmacy. Please share this information with your clinic to ensure prescriptions are sent to the correct pharmacy.

1. Once the authorization is processed, your doctor will send your prescription(s) to our Progyny Rx pharmacy partner.
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, discuss any allergies and health conditions, review dispensing protocols and how medication is dispensed, and address any questions you may have about your medication shipment. You will also receive guidance on which medications within your order are for Progyny Rx-covered medications (fertility medications) versus medications covered by your pharmacy benefit manager (PBM) (ancillary medications). You may need to pay a copayment for any ancillary medications as determined by your medical plan.
3. Once your medication is fulfilled, your fertility medication is submitted as a claim to be processed. You will receive an invoice from Progyny for any out-of-pocket responsibility as determined by your medical insurance plan.
4. The pharmacy will fill your prescriptions and deliver to your preferred address before the start of your treatment cycle. You will receive your fertility medications and ancillary medications in the same shipment. Compounded medications may arrive separately.
5. Once you have your medications, a Progyny Rx specialist will be available to conduct an UnPack It Call to walk you through your medications and how to properly store and administer them.

Here's What's Included in Your Delivery:

1. All medications, compounds, ancillary medications, and supplies required for treatment.
2. Inside your delivery you will find a Progyny Rx placemat that shows the medication and supplies included in your order and how to properly store them. The placemat includes the phone number for the Progyny Rx pharmacy that will conduct your UnPack It Call.

3. Your Progyny Rx UnPack It Call connects you with a trained pharmacy clinician who will walk you through your delivery, explain how to store and administer each medication, and answer any additional questions you may have.

4. Additionally, you can view Progyny Rx video tutorials on medication administration at progyny.com/rx.

The Progyny Rx pharmacy will ensure only the necessary amount of medication is dispensed to prevent you from having extra medication that goes unused (which can be costly to you). Medications are sent using next-day delivery (or same day, if necessary) to ensure they arrive on time for your treatment. You must confirm delivery with the Progyny Rx pharmacy before the shipment can occur. The Progyny Rx pharmacy will contact you throughout your treatment for any additional medication deliveries that may be required. Please note, once medication has been dispensed, you may not return it for reimbursement. In the event that your medications cannot be delivered for treatment, please contact your Progyny Rx pharmacy and PCA for next steps.

If you have questions about your delivery, how to take your medication, possible side effects, or other clinical concerns, contact your Progyny Rx pharmacy using the phone number provided on your Confirmation Statement. Emergency support is available 24/7.

Please reference the Progyny Rx Formulary for a list of covered medications.

Note: Medication covered under Progyny Rx is subject to your financial responsibility as determined by your medical insurance plan. Ancillary medications fall under your medical insurance plan and may require a copayment. See the *Understanding Your Financial Responsibility* section for more information about how your out-of-pocket costs are determined.

Certain medications may require specific authorization, and coverage may be subject to utilization management review. To learn more about services that require specific authorization under utilization management, please visit http://nputilizationalliance.com/ or contact your PCA. Authorization requests will be reviewed according to the applicable written clinical policy. If a request is denied based on the clinical review, coverage for the medication may be denied, and you may be responsible for paying the full cost out of pocket. Please refer to the *Utilization Management section* for additional information.

Please reference Progyny Rx frequently asked questions here.

Utilization Management

Utilization management is the process of evaluating the medical necessity, appropriateness, and efficiency of healthcare services. Progyny works alongside the National Programmatic Utilization Alliance to review services related to fertility and family building care. The NPUA is URAC accredited. To learn more about the NPUA and policies that may impact your coverage, please reference https://nputilizationalliance.com/.

Prior Authorization Process

The prior authorization process complies with applicable law and regulations, as well as written clinical and internal policies for performing utilization review. The application of criteria to an individual situation requires consideration of all factors relevant to the criteria, including age, co-morbid conditions, prior history and progress of treatment, and may include other social factors.

The request will be timely adjudicated and based on that review may be approved, denied, or partially approved or partially denied. Authorization is not a guarantee of payment.

NPUA reviewers are experienced fertility nurses and board-certified Reproductive Endocrinology and Infertility (REI) physicians who review cases using evidence-based medical guidelines and best practices to support high-quality fertility care decisions.

If Your Request Is Denied

If your request for authorization is denied or partially denied, you or your provider are able to appeal. For information on your right to appeal, please reference https://nputilizationalliance.com/appeals-process/.

Non-Covered Services

Services not listed in the Member Guide are not covered. Standard exclusions include services and supplies furnished by an out-of-network provider, and treatments, including medication, considered experimental or non-standard 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.

If your provider recommends services that are not listed in this guide, or that require specific prior authorization, 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 insurance plan. **Costs associated with non-covered services are your responsibility. Please check with your medical insurance plan to confirm coverage and for more information.**

Examples of these services may include surgical procedures. Examples of non-covered surgical procedures include laparoscopies, myomectomies, and tubal ligation reversals. Please contact your medical plan to inquire about coverage for surgical procedures.

Services provided without an authorization will be your responsibility. Always connect with your PCA prior to beginning treatment or receiving services to understand what is covered and if any additional authorization procedures are required. Request for authorization of covered services will be reviewed based on the clinic's submission and our written clinical policy. Even if you receive an authorization, you may also need utilization management approval to move forward with specific services. Authorization requests will be reviewed according to the applicable written clinical policy. If a request is denied based on the clinical review, coverage for the service or medication may be denied, and you may be responsible for paying the full cost out of pocket. Please refer to the *Utilization Management section* for additional information. To learn more about those policies, visit https://nputilizationalliance.com/policies/.

ERISA Claims and Appeals Process

Progyny Claims and Appeals Procedures

Per the U.S Department of Labor, federal law requires that each welfare plan (i.e., medical plan) subject to Employee Retirement Income Security Act of 1974 ("ERISA") must set up reasonable rules for filing a claim for benefits. The following procedures apply to the fertility benefit offered through Progyny for the employee benefits plan offered by your employer, which throughout this document will be referred to as the Plan ("Plan"). Although Progyny is not the Plan Administrator under ERISA, Progyny serves as the claims fiduciary with discretionary authority solely to administer the Plan's claims and appeals processes related to Progyny services in accordance with ERISA's claims and appeals rules.

The description of the benefits in your benefits booklet includes specific explanations of each benefit. This member guide describes the general rules and procedures, as well as your rights under ERISA, that relate to filing an appeal for the denial of fertility claims under your Plan. It also describes the procedure for you to follow if your appeal is denied and you wish to appeal the decision through an independent review organization. This document and the procedures it describes are provided in accordance with ERISA requirements and pertain only to the fertility benefits under your Plan.

Under U.S. Department of Labor (DOL) regulations, you are entitled to full and fair review of any claim for benefits made under the Plan. The procedures described here are intended to comply with DOL regulations and these procedures describe how benefit claims and appeals for fertility benefits are made and decided.

Authorized Representative

If needed, you can designate an authorized representative to act on your behalf with respect to a benefit claim or appeal under these claims procedures. You must submit a signed Progyny approved form designating your authorized representative before Progyny will recognize your authorized representative. You can obtain an authorized representative form from Progyny. All completed forms must be submitted to:

Progyny 1359 Broadway, 2nd floor, New York, NY 10018
Email: legalnotices@progyny.com
Phone: 877.762.5012

As part of your benefit, you may be eligible for medical reimbursement benefits. This will be paid directly to you, as the ERISA participant, and not to your provider. The Plan Administrator and its delegates have a fiduciary duty only to you and your covered dependents.

Types of Group Health Claims

For all ERISA plans, the law allows a reasonable amount of time for the Progyny, as the claims fiduciary for these benefits, to evaluate a claim and decide whether to pay benefits. Under the ERISA Claims and Appeals rules, these times are dictated by the type of claim and whether you followed the proper procedures, as described below. The claims procedures will vary depending on whether your claim is for a Pre-Service Claim, an Urgent Care Claim, or a Post-Service Claim.

Pre-Service Claims

Pre-service claims are claims for benefits that must be approved before the medical care of service is provided.

Urgent Care Claim

An urgent care claim is a type of claim where there is a sudden and urgent need for such benefits or services. A claim will be considered to be urgent care if the claims fiduciary or a physician with knowledge of your condition determines that a delay (1) could seriously jeopardize your life or your health, or your ability to regain maximum function, or (2) in your physician's opinion would subject you to severe pain that cannot adequately be managed without the care or treatment that is the subject of the claim.

Post-Service Claim

A post-service claim is a claim for a benefit under the Plan after the benefit or service has been provided. All claims for fertility benefits must be submitted within one year after the date you receive the service.

All claims must be sent to:

Progyny 1359 Broadway, 2nd floor, New York, NY 10018
Email: legalnotices@progyny.com
Phone: 877.762.5012

Your Plan does not require prior authorization to begin to use your fertility benefits for initial diagnostic services. All decisions regarding your fertility treatments will be made by you in consultation with your doctor. Progyny does not make medical necessity determinations of your diagnosis of infertility, and Progyny will not deny your initial claim or your appeal for diagnostic services on the basis of medical necessity or medical appropriateness. Progyny will process your claim after the services are rendered.

	Urgent Care Claims	"Pre-Service"	"Post-Service" Claims
Time frame for Providing Notice	See Memorial Healthcare System Summary Plan Description for Time Frame	See Memorial Healthcare System Summary Plan Description for Time Frame	Notice of adverse determination (the denial or limited authorization of a requested service) must be provided as soon as possible, and no later than 30 days of receipt of the claim.
Extensions	See Memorial Healthcare System Summary Plan Description for Time Frame	See Memorial Healthcare System Summary Plan Description for Time Frame	Progyny has up to 15 days, if necessary due to matters beyond the Plan's control, and must provide extension notice before the initial 30-day period ends.
Period for Claimant to Complete Claim	See Memorial Healthcare System Summary Plan Description for Time Frame	See Memorial Healthcare System Summary Plan Description for Time Frame	You have at least 45 days to provide any missing information. Progyny will provide a benefit determination (decision to approve or deny a request) within 15 days of receipt of the requested information, or if no information is received, within 15 days of the end of the claimant's 45-day period.

Other Related Notices	See Memorial Healthcare System Summary Plan Description for Time Frame	See Memorial Healthcare System Summary Plan Description for Time Frame	N/A

Your Right to Appeal a Decision

- You have a right to appeal an adverse decision under these claims procedures. Your appeal must be submitted within 180 days of the adverse benefit determination.
- You have the right to submit documents, written comments, or other information in support of your appeal.
- You may request reasonable access to, and copies of all documents, records, and other information relevant to your claim for benefits, including (to the extent applicable) the names of any experts consulted in an explanation of the scientific or clinical judgment that serves as the basis for the determination. This information is free of charge.

How Your Appeal Will Be Decided

If your initial claim is denied and you submit an appeal, your appeal will be reviewed and decided by an individual designated by Progyny who is different from and not a subordinate of the person who made the initial benefit determination. This reviewer will act impartially and independently.

The Progyny claims fiduciary will take into account all information you have submitted, even if it was not presented or available at the initial benefit decision. During your appeal, the claims fiduciary will not defer to the initial benefit determination.

Before issuing any new determination, Progyny will provide you, free of charge, with the new rationale for the decision, if any, along with any additional evidence. You will have no less than 45 days to review and respond to this new rationale or evidence prior to a final decision.

Neither Progyny nor your Plan will retaliate or take any discriminatory action against you for filing an appeal. Your appeal will be handled fairly and will not affect any other part of your health coverage.

Notification of Initial Decision and Appeal Benefit Decision by Plan

You will receive written notice of the decision, as applicable, on your claim. For initial decisions, you will only receive notice if your claim is denied. For appeals, you will receive notice of either a denial or approval.

Notification of Benefit Decision

If your claim or appeal is denied you will receive notice of that denial and it will include:

- Information sufficient to identify the claim (including the date of service, the health care provider, the claim amount)
- Reference(s) to the specific Plan provision(s) on which the decision is based

- A description of any additional material or information necessary to adjust the claim and why such information is necessary
- A statement disclosing any internal rule, guidelines, protocol or similar criterion relied on in making the adverse decision (or a statement that such information will be provided free of charge upon request), and an explanation of the scientific or clinical judgement for the determination to the extent applicable (or a statement that such information will be provided free of charge upon request)
- A statement describing the reason or reasons for the adverse determination including the denial code, and its corresponding meaning and description of the standard used to deny the claim to the extent applicable
- A statement describing the availability of the diagnosis and treatment codes, with their corresponding meanings, upon request
- A statement indicating entitlement to receive on request, and without charge, reasonable access to or copies of all documents, records or other information relevant to the determination
- A description of procedures and time limits for appeal of the decision, and the right to obtain information about those procedures, and the right to sue in federal court

For appeals, you will also receive notice if your appeal is approved.

If your claim is denied in whole or in part, and you decide to file suit in federal court, you must file suit within 365 days of the date of the letter denying your appeal.

	Urgent Care Claims	Non-Urgent "Pre-Service"	Non-Urgent "Post Service"
Period for Filing Appeal	See Memorial Healthcare System Summary Plan Description for Time Period	See Memorial Healthcare System Summary Plan Description for Time Period	You have at least 180 days to file.
Time frame for Providing Notice of Benefit Determination on Review	See Memorial Healthcare System Summary Plan Description for Time Period	See Memorial Healthcare System Summary Plan Description for Time Period	Within a reasonable period of time, but not later than 60 days after receipt of request for review.
Extension	None	None	None

External Claims Procedures

- External review of denied claims is available for claims should the service be denied by us, as not medically necessary, or denied as experimental or investigational, or for any other reason required by law.

Independent Review Organization (IRO)

Members can choose to utilize an Independent Review Organization to review their claim.

Progyny will engage an independent review organization (IRO) that is accredited by the Utilization Review Accreditation Commission (URAC) or by a similar nationally recognized accrediting organization, to conduct any external reviews under these claim procedures. Progyny will take actions to guard against bias in favor of denial of external review claims and to ensure independence.

More About the IRO Review

Progyny will rotate external claim assignments among various IROs (or incorporate other independent, unbiased methods for selection of IROs, such as random selection). Any IRO will not be eligible for any financial incentives based on the likelihood that the IRO will support the denial of benefits.

You or your representative may request a standard external review by sending a written request to the address set out in the determination letter. A request must be made within four months after the date you received Progyny's decision.

An external review request should include all of the following:

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

Standard External Review

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

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

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

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

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

The IRO will notify you in writing of the request's eligibility and acceptance for external review. You may submit in writing to the IRO within ten business days following the date of receipt of the notice additional information that

the IRO will consider when conducting the external review. The IRO is not required to, but may, accept and consider additional information submitted by you after ten business days.

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

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

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

Upon receipt of a Final External Review Decision reversing Progyny determination, Progyny will immediately provide coverage or payment for the benefit claim at issue in accordance with the terms and conditions of the Plan benefit plan, and any applicable law regarding plan remedies.

If the Final External Review Decision is that payment or referral will not be made, Progyny will not be obligated to provide for the health care service or procedure.

Limitation on When a Lawsuit May be Started

You may not start a lawsuit related to a claim until you have requested an appeal and a final decision has been rendered, or until all applicable time frames have elapsed since you filed your request for appeal. If you fail to timely file a claim for benefits or fail to timely file a request for review, your claim will be deemed abandoned and you will be precluded from reasserting it and you (and any other interested party) may not bring a suit or other legal action in a court of law.

You may also pursue remedies under ERISA section 502(a) without exhausting these appeals procedures if we have failed to follow them. Any suit or legal action must be filed no later than one year following the final determination by the claims fiduciary regarding the claim for benefits. If you do not file your suit or legal action within this one-year period, your benefit claim will be deemed abandoned.



Additional Family Building Support

Surrogacy Support

Surrogacy Counseling

Progyny members looking to grow their family through surrogacy have access to surrogacy-focused PCAs to provide support and resources throughout the process. Whether you're just starting to think about surrogacy, have already reached out to a few agencies, or have even met your surrogate, your dedicated team of PCAs can connect you with personalized surrogacy support and guidance on next steps, including:

- Details on the process and average cost of surrogacy
- Explanation of various processes and pathways
- Resources to find legal advice for state-specific laws that impact your options
- Specific counseling for LGBTQ+ individuals and couples

Surrogacy Services

You can utilize your Smart Cycles to cover the below services as part of your surrogacy journey. Please note, your Smart Cycle allowance cannot be used for the surrogate, as they are not a claimed dependent. Reference the *Explanation of Covered Treatments & Services* section and contact your PCA to learn more.

- Pre-transfer Embryology Services: includes diagnostic testing, fertilization, preimplantation genetic testing, and cryopreservation for the covered member who is the intended parent. This cycle includes all the embryology services for the creation of embryos from previously frozen or donor 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, so the frozen embryo transfer is not covered under the Smart Cycle.
- Donor Tissue Authorization: your Smart Cycle allowance can be utilized to purchase donor tissue (egg and sperm tissue). Tissue transportation from the tissue bank to your in-network clinic is also covered. The authorization of donor tissue must be at an in-network bank where members can purchase tissue directly after an authorization is issued. Visit progyny.com/labs to search for in-network donor tissue banks. Contact a trusted tax advisor if you have questions and to learn more about tax treatment, if applicable.

Adoption Support

Adoption Counseling

Progyny members looking to grow their family through adoption have access to adoption-focused PCAs to provide support and resources throughout the process. Whether you're just starting your research, ready to begin the process, or are well on your way in your adoption journey, your dedicated team of PCAs can connect you to personalized adoption support and guidance, including:

- Details on the process and average cost of adoption
- Explanation of various processes and pathways
- Resources to find legal advice for state-specific laws that impact your options
- Specific counseling for LGBTQ+ individuals and couples



Authorization & Financial Responsibility

Authorization for Covered Services

An authorization is required before coverage for services or treatment can be determined. Your provider will request an authorization before your first appointment and again before you begin each service or treatment cycle. Once an authorization is approved, you'll receive a Confirmation Statement. This is important because it confirms your Progyny coverage for specific treatments and is sent to your clinic to ensure proper billing. For certain services, additional information may be needed from your provider to authorize and provide a Confirmation Statement. Learn more below.

When do I need an authorization?

Authorization is required before most fertility services, including your initial consultation and each new treatment cycle which may include IVF, IUI, and the purchase or use of donor tissue. Your clinic will request your authorization. Once the authorization is approved, you will receive a copy of your Confirmation Statement. It's important that you obtain an authorization and Confirmation Statement prior to your appointments. Your confirmation statement will include your Progyny ID which your clinic will need. This ensures you are eligible for services and that you understand your treatment plan.

What is a Confirmation Statement and why do I need it?

A Confirmation Statement is a document that confirms your Progyny coverage for a specific treatment bundle or covered service. Once an authorization request is approved, you and your clinic will receive a Confirmation Statement as proof of coverage. The best way to prevent billing errors or delays in treatment is to ensure you have received a Confirmation Statement before your first appointment and again before you begin each treatment cycle.

What do I need to know about the authorization process and confirmation statements?

1. Your clinic will handle the authorization request and confirm the details on your behalf. This should be done prior to all scheduled treatment start dates. We encourage you to check with your clinic to ensure they will submit the request.

2. Once your authorization is approved, Progyny will send your Confirmation Statement to the clinic and will also send it to you for your records. Certain services do require specific authorization and may require more information from you or your provider. Your PCA will let you know if additional information is needed.

3. The authorization will be processed a few days before your appointment to confirm you are still eligible for the benefit. If you are ineligible, you will be responsible for all costs incurred at your appointment. Authorizations are only valid for their specific date range and all treatment or testing must be completed within the authorization date range.

4. Your Confirmation Statement includes everything you need, such as 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 Confirmation Statement automatically, we recommend having a copy at your appointment to make sure your clinic has the correct information listed in your account.

5. Your clinic will determine the date of services which doesn't always align with the start of treatment. You will need to be eligible for the duration of the treatment. If you change health plans before the end of treatment, you may become financially responsible.

How do I know which services require additional information for authorization?

To learn more about services that require specific authorization under utilization management, please visit http://nputilizationalliance.com/ or talk to your PCA. Authorization requests will be reviewed according to the applicable written clinical policy. If a request is denied based on the clinical review, coverage for the service or medication may be denied, and you may be responsible for paying the full cost out of pocket. Please refer to the *Utilization Management section* for additional information.

Do I need to obtain an authorization for lab work?

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

Additionally, if you choose to pursue preimplantation genetic testing on your embryos, share a copy of your Confirmation Statement with the genetic laboratory performing the testing so that they can bill Progyny directly. On your Confirmation Statement you will find a link to the list of in-network laboratories, preconception carrier screening laboratories, and preimplantation genetic testing laboratories for this genetic testing, as well as contact information for your specialty pharmacy.

How long is each authorization valid?

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 a benefit eligible 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.

If you have any questions related to providers and lab facilities, reference the frequently asked questions here.

Understanding Your Financial Responsibility

Your Progyny benefit covers eligible fertility services. Any out-of-pocket costs will depend on your specific coverage and cost-sharing requirements. Financial responsibility means you will be expected to pay for a portion of your covered services under your Progyny benefit. The amount you should expect to pay is determined by the medical plan you're enrolled in through your employer. This means you should expect bills for all covered and authorized services including your initial consultation and diagnostics, medication, tissue storage, donor tissue, and fertility treatment. Your PCA team can help you understand or help estimate your expected financial responsibility for services at any time.

Why Am I Getting a Bill from Progyny?

Progyny coordinates with your medical insurance plan to administer your Progyny fertility benefit. This means your Progyny member financial responsibility cross accumulates with medical services and is calculated in the same way a surgery or treatment for a broken bone would be. Member financial responsibility is determined by your medical insurance plan and may include deductible, coinsurance, copayment, and/or out-of-pocket maximum.

Important Reminders

When scheduling with your provider, you must list Progyny as your medical plan and your Progyny ID as your member ID at your clinic and laboratories to avoid significant billing issues and incorrect financial responsibility. Your clinic will submit a claim directly to Progyny for payment. Progyny, in turn, processes the claim according to your plan and applies your financial responsibility. You will receive a bill from Progyny reflecting the amount as determined by your medical insurance plan. For most treatments and services, you are billed in bundles aligned with your Smart Cycle or treatment authorization, and not in a fee for service manner. If you choose to forego any services listed as covered within an authorization, the stated Smart Cycle value and bundle is applied in full. For example, your Initial Consultation and Diagnostic bundle is billed based on the services included within the authorization. Please note, although your services are typically authorized as a treatment bundle, you may receive several bills related to your treatment. When you receive your Progyny bill, you can submit payment by credit card, over the phone, via the member portal, by mailing a check to the address on your bill, or at progyny.com/payment.

Note: You should never receive a bill from the clinic or pay the clinic directly for services covered by Progyny. You should only receive a bill from Progyny after the claim has been processed to determine your financial responsibility. If you are asked to pay at the clinic or receive a bill from the clinic, please contact your PCA.

Receiving and paying a bill

While you have coverage for authorized services, you may have financial responsibility. Your individual costs will be determined by several factors, including: the medical insurance plan or option that you enrolled in and its corresponding financial responsibility, your treatment plan, and the center directing your care.

Your clinic will bill Progyny directly throughout your treatment. Progyny will process claims and apply member responsibility to these paid services. You will receive a bill from Progyny that indicates your portion of the financial responsibility. Note, although your services are typically authorized as a treatment bundle, you may receive several bills related to your treatment. If you believe that you have received a bill in error, contact your PCA.

To avoid significant billing issues, you must obtain an authorization and corresponding Confirmation Statement prior to receiving services, and list Progyny as your primary insurance with your clinic, lab, pharmacy, etc., including your Progyny member ID. Your medical insurance should be listed as secondary insurance to be billed for any services not covered by Progyny.

You will receive a bill via email and/or text with instructions to pay the bill online. You can also pay your bill in the member portal. Payments can be made via check, by ACH, or credit card.

Utilizing services that may require reimbursement

In some cases, Progyny reimburses members for covered medical services. These covered medical services are still subject to financial responsibility. To ensure eligibility, reimbursements must be discussed with your dedicated team of PCAs in advance. You will need to save all invoices and proof-of-payments. When you're ready to initiate your reimbursement, contact your PCA. Reimbursements must be submitted to Progyny within the time frame that complies with timely filing rules. Your PCA will send you a reimbursement form via DocuSign to complete and you will attach all relevant documents listed prior to submitting your reimbursement request for processing. Your reimbursement will be the cost of service minus your financial responsibility. Not all services are eligible for reimbursement, please check with your PCA on your specific case. Note, reimbursements may take up to 90 days to process. If your expenses are related to adoption or surrogacy, contact your PCA.

Timely Filing

Timely filing is the timeframe within which a claim must be submitted to your insurance carrier. Your timely filing limit is determined by your insurance carrier and is based on the date of service rendered. The date of service is determined by the clinic.

Progyny is unable to authorize a service, reimburse for covered services, or submit a claim for processing that is past the timely filing date. If a claim is submitted for processing after the specified timely filing date, the claim will be denied by your carrier. This pertains to all services that require a claim to be processed, including reimbursements. Please submit as soon as possible to avoid timely filing issues or delays.

Contact your PCA if you have any questions regarding your carrier's timely filing limit.



Glossary of Services

Glossary of Services

Anesthesia for Egg Retrieval

Egg retrievals are typically performed with anesthesia (deep sedation).

Assisted Hatching

For the embryo to implant in the uterine wall and 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.

D&C

Occasionally, a minor surgical procedure called a D&C is needed in a fertility setting. Typically, this procedure is billed to your medical insurance and is covered.

Embryo Culture

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

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 the laboratory where sperm is added to a dish containing the egg to create embryos.

Genetic Counseling

Genetic Counseling is sometimes required as part of your fertility journey to review your preconception carrier screening and/or PGT-A/M/SR results. Typically, genetic counseling is covered by your medical insurance.

In-Cycle Monitoring/Management

During a treatment cycle, the clinic will monitor progress through pelvic ultrasounds and bloodwork throughout your treatment cycle. This helps to assess the development of follicles and the thickness of the 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 most 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 sperm-related infertility such as low sperm count; poor sperm morphology (shape); 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), also called CCS and NGS, may be performed in conjunction with IVF treatment and involves testing embryo biopsy tissue for chromosomal abnormalities.

PGT-A testing greatly reduces the risk of miscarriage and increases the probability of a successful and healthy pregnancy. Furthermore, providers in Progyny's network will only perform a single embryo transfer (SET), 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 (because it can take several days to get the PGT-A test results from the lab, the embryo(s) transferred during an IVF fresh cycle are unlikely to be PGT-A tested).

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.

Single Embryo Transfer (SET)

At Progyny, our goal is your goal: healthy pregnancies and healthy babies. Progyny is committed to providing our members with access to the best care to ensure the best outcomes. While we do not determine care, we require that all providers in our network follow the American Society for Reproductive Medicine (ASRM) guidelines.

SET or single embryo transfer is the preferred process where one embryo is transferred at a time. Fertility providers and the specialty overwhelmingly prefer SET to reduce the risk of multiple pregnancy and miscarriage.

Transferring more than one embryo does not significantly increase pregnancy rates and can increase the chance of poor outcomes including miscarriage, high-risk pregnancy, and pre-term birth.

If the ordering physician believes that transfer of multiple embryos is indicated, they must attest that the transfer follows current published evidence-based guidelines.

If the recommended multiple embryo transfer does not meet ASRM guidelines, our Medical Advisory Board will review the recommendation including any supporting medical records.

If approved, you may move forward with the transfer.

If the transfer of multiple embryos is denied by Progyny's Medical Advisory Board, you and your provider should discuss your next steps. If you choose to move forward with SET, your transfer will be covered as normal (assuming eligibility and sufficient benefit remaining). If you and your provider elect to move forward with the transfer of multiple embryos, the entire cycle will be an out-of-pocket cost that is not covered under your benefit.

Contact your PCA for more information.

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 provider. Telehealth can be utilized for an initial consultation, for example, enabling you to meet your provider virtually, discuss your medical history and explore possible treatments, just like you would during an in-person visit.

Pregnancy Monitoring

Pregnancy monitoring is a maternity service that involves checking the health of the unborn baby during pregnancy and labor.

National Programmatic Utilization Alliance LLC offers an interpreter service so that you can ask a question in Spanish or other various languages. If the representative that speaks your language is not available, an interpreter can be connected on the line to be able to assist you with your question.

National Programmatic Utilization Alliance LLC ofrece un servicio de intérprete para que pueda hacer una pregunta en español o en otros idiomas. Si el representante que habla su idioma no está disponible, un intérprete puede estar conectado en la línea para poder ayudarle con su pregunta.

National Programmatic Utilization Alliance LLC offre un service d'interprète afin que vous puissiez poser une question en français ou dans d'autres langues différentes. Si le représentant qui parle votre langue n'est pas disponible, un interprète peut être connecté en ligne pour pouvoir vous assister dans votre question.

National Programmatic Utilization Alliance LLC bietet einen Dolmetscherservice an, damit Sie eine Frage in deutscher oder anderer Sprache stellen können. Wenn der Vertreter, der Ihre Sprache spricht, nicht verfügbar ist, kann ein Dolmetscher auf der Leitung angeschlossen werden, um Ihnen bei Ihrer Frage behilflich zu sein.

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National Programmatic Utilization Alliance LLC nudi uslugu tumača kako biste mogli postaviti pitanje na svom jeziku ili na drugim jezicima. Ako predstavnik koji govori vaš jezik nije dostupan, tumač se može povezati na liniji kako bi vam pomogao u vašem pitanju.

Naghahandog ang National Programmatic Utilization Alliance LLC ng serbisyo ng interpreter upang maaari kang magtanong sa Tagalog o iba pang iba't ibang wika. Kung walang kinatawan na nagsasalita ng iyong wika na maaaring makipag-usap sa iyo, may isang interpreter na maaaring i-konekta sa linya upang matulungan ka sa iyong tanong.

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National Programmatic Utilization Alliance LLC предлагает услугу переводчика, чтобы вы могли задать вопрос на русском или других языках. Если представитель, который говорит на вашем языке, недоступен, на линии может быть подключен переводчик, чтобы помочь вам в решении вопроса.



For more information about your Progyny benefit,
explore the Progyny member portal or call: 833.281.0088