

Infertility Benefits

Definition of Infertility		
Maroon Plans	BCBS HMO	UCHP
<p>Infertility is a disease, condition, or status characterized by:</p> <ol style="list-style-type: none"> 1. The inability to conceive a child or to carry a pregnancy to live birth after one year of regular unprotected sexual intercourse for a woman 35 years of age or younger, or after 6 months for a woman over 35 years of age (conceiving but having a miscarriage does not restart the 12 month or 6-month term for determining Infertility); 2. A person’s inability to reproduce either as a single individual or with a partner without medical intervention; or 3. A licensed Physician’s findings based on a patient’s medical, sexual, and reproductive history, age, physical findings, or diagnostic testing. 	<p>Infertility means a disease, condition, or status characterized by:</p> <ol style="list-style-type: none"> 1. The inability to conceive a child or to carry a pregnancy to live birth after one year of regular unprotected sexual intercourse for a woman 35 years of age or younger, or after 6 months for a woman over 35 years of age (conceiving but having a miscarriage does not restart the 12 month or 6-month term for determining Infertility), 2. A person’s inability to reproduce either as a single individual or with a partner without medical intervention, or 3. A licensed Physician’s findings based on a patient’s medical, sexual, and reproductive history, age, physical findings, or diagnostic testing. 	<p>Infertility means a disease, condition, or status characterized by:</p> <ol style="list-style-type: none"> 1. A failure to establish a pregnancy or to carry a pregnancy to live birth after 12 months of regular, unprotected sexual intercourse if the woman is 35 years of age or younger, or after 6 months of regular, unprotected sexual intercourse if the woman is over age 35; conceiving but having a miscarriage does not restart the 12-month or 6-month term for determining infertility; 2. An inability to reproduce either as a single individual or with a partner without medical intervention; or 3. A licensed physician’s findings based on a patient’s medical, sexual, and reproductive history, age, physical findings, or diagnostic testing. <p>Call National Infertility Unit (NIU) at 1-800-575-5999 to enroll and determine your eligibility for services under the plan.</p>

Other Definitions:

A “**cycle**” is an attempt at a particular type of infertility treatment (e.g., GIFT, ZIFT, cryopreserved embryo transfers). The cycle begins with the initiation of therapy and ends when the treatment is followed by confirmation of non-pregnancy (either a negative pregnancy test or a menstrual period). In the case of the achievement of pregnancy, a cycle is considered completed at 6 weeks following a positive pregnancy test. Each treatment type is counted as a separate cycle.

Coverage by Medical Plan			
Covered Services	Maroon Plans	BCBS HMO	UCHP
Infertility Treatments	<p>Benefits will be provided the same as benefits for any other condition for covered services rendered in connection with the diagnosis and/or treatment of Infertility, including, but not limited to:</p> <ul style="list-style-type: none"> • In vitro fertilization (IVF) • Uterine embryo lavage • Zygote intrafallopian transfer (ZIFT) • Gamete intrafallopian transfer (GIFT) • Low tubal ovum transfer • Cryopreserved (frozen) embryo transfers (FET) • Intracytoplasmic sperm injection (ICSI) or ovum microsurgery • Cryopreservation (freezing) of eggs, embryos, or sperm including non-experimental or investigational procedures that use the cryopreserved eggs, embryos or sperm provided you are in active infertility treatment 	<p>Benefits will be provided for Covered Services rendered in connection with the diagnosis and/or treatment of Infertility including, but not limited to:</p> <ul style="list-style-type: none"> • In vitro fertilization (IVF) • Uterine embryo lavage. • Zygote intrafallopian transfer (ZIFT) • Gamete intrafallopian transfer (GIFT) • Low tubal ovum transfer • Cryopreserved (frozen) embryo transfers (FET) • Intracytoplasmic sperm injection (ICSI) or ovum microsurgery 	<p>Assisted Reproductive Technology (ART) ART services include:</p> <ul style="list-style-type: none"> • In vitro fertilization (IVF) • Uterine embryo lavage • Zygote intrafallopian transfer (ZIFT) • Gamete intrafallopian transfer (GIFT) • Low tubal ovum transfer • Cryopreserved (frozen) embryo transfers (FET) • Cryopreservation (freezing) of eggs, embryos, or sperm including non-experimental or investigational procedures that use the cryopreserved eggs, embryos or sperm provided you are in active infertility treatment • Intracytoplasmic sperm injection (ICSI) or ovum microsurgery • Charges associated with your care when you receive a donor egg or embryo in a donor IVF cycle. These services include culture and fertilization of the egg from the donor and transfer of the embryo into you. • Charges associated with your care when using a gestational carrier including egg retrieval and culture and fertilization of your eggs that will be transferred into a gestational carrier. Services for the gestational carrier, including transfer of the embryo into the carrier, are not covered. • Medical costs of oocytes or sperm donors for ART procedures used to retrieve oocytes or sperm and includes the cost of the procedure used to transfer oocytes or sperm to the covered recipient. We will also cover associated donor medical expenses, established by us, as a prerequisite to donation. • The procedures are done while not confined in a hospital or any other facility as an inpatient.

Note: This is not an inclusive summary of benefits, nor does it constitute a contract. See the [Summary Plan Description](#) for the coverage details, limits, and exclusions.

Coverage by Medical Plan			
Covered Services	Maroon Plans	BCBS HMO	UHP
Treatment Limits	Benefits for treatments that include oocyte retrievals are limited to four completed oocyte retrievals per benefit period, except that if a live birth follows a completed oocyte retrieval, then two more completed oocyte retrievals shall be covered per benefit period.	Benefits for treatments that include oocyte retrievals are limited to four completed oocyte retrievals per calendar year, except that if a live birth follows a completed oocyte retrieval, then two more completed oocyte retrievals shall be covered per calendar year.	Your benefits for assisted reproductive technologies (ART) and all related services and supplies are subject to a lifetime maximum 4 complete oocyte retrieval cycles, unless a live birth follows a completed oocyte retrieval cycle, in which case 2 more oocyte retrieval cycles will be covered.
Infertility Drugs	Benefits are available under the CVS pharmacy benefit for fertility drugs in connection with the diagnosis and/or treatment of Infertility which are self-administered that require a written prescription by federal law.	Benefits are available for fertility drugs in connection with the diagnosis and/or treatment of Infertility which are self-administered that require a written prescription by federal law.	<ul style="list-style-type: none"> • Prescription drug therapy used during an oocyte retrieval cycle. • Oral prescription drugs used: <ul style="list-style-type: none"> ○ To stimulate the ovaries ○ Primarily for treating the underlying cause of infertility • Benefits are available under the CVS pharmacy benefit for fertility drugs in connection with the diagnosis and/or treatment of Infertility which are self-administered that require a written prescription by federal law.

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Special Limitations		
Maroon Plans	BCBS HMO	UCHP
<p>Benefits will not be provided for the following:</p> <ol style="list-style-type: none"> 1. Services or supplies rendered to a surrogate, except that costs for procedures to obtain eggs, sperm or embryos from you will be covered if you choose to use a surrogate. 2. Non-medical costs of an egg or sperm donor. 3. Travel costs for travel within 100 miles of your home or travel costs not Medically Necessary or required by the Claim Administrator. 4. Infertility treatments which are deemed Investigational, in writing, by the American Society for Reproductive Medicine or the American College of Obstetricians or Gynecologists. 5. Infertility treatment rendered to your dependents under age 18. <p>In addition to the above provisions, in-vitro fertilization, gamete intrafallopian tube transfer, zygote intrafallopian tube transfer, low tubal ovum transfer and intracytoplasmic sperm injection procedures must be performed at medical facilities that conform to the American College of Obstetricians and Gynecologists guidelines for in-vitro fertilization clinics or to the American Society for Reproductive Medicine minimal standards for programs of in-vitro fertilization.</p>	<p>Benefits under this Infertility Treatment provision will not be provided for the following:</p> <ol style="list-style-type: none"> 1. Services or supplies rendered to a surrogate, except that costs for procedures to obtain eggs, sperm or embryos from you will be covered if you choose to use a surrogate. 2. Cryo-preservation or storage of sperm, eggs or embryos, except for those procedures which use a cryo-preserved substance. Please note that benefits may be provided for fertility preservation as set forth in the Fertility Preservation provision of this Certificate. 3. Non- medical costs of an egg or sperm donor. 4. Travel costs for travel within 100 miles of the Enrollee's home or which is not medically necessary or which is not required by the Plan. 5. Infertility treatments which are determined to be Investigational, in writing, by the American Society for Reproductive Medicine or American College of Obstetrics and Gynecology. 6. Infertility treatment rendered to your dependents under the age of 18 7. Reversal of voluntary sterilization. However, in the event a voluntary sterilization is successfully reversed, benefits will be provided if your diagnosis meets the definition of "Infertility" as stated above. <p>In addition to the above provisions, in vitro fertilization, gamete intrafallopian tube transfer, zygote intrafallopian tube transfer, low tubal ovum transfer and intracytoplasmic sperm injection procedures must be performed at medical facilities that conform to the American College of Obstetrics and Gynecology guidelines for in vitro fertilization clinics or to the American Society for Reproductive Medicine minimal standards for programs of in vitro fertilization.</p>	<p>The following are not covered services:</p> <ol style="list-style-type: none"> 1. Travel costs within 100 miles of your home or travel cost not required by Aetna. 2. Treatment for covered dependents under age 18 3. Non-medical costs of an egg or sperm donor 4. Selected termination of an embryo, unless the life of the mother would be in danger if all embryos were carried to full term 5. Experimental or investigational treatment as determined by the American Society for Reproductive Medicine 6. Services to the surrogate. If you choose to use a surrogate, this does not apply to the cost for procedures to obtain the eggs, sperm or embryo from a covered individual.

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