blue of california

Group Rider

Infertility Services Rider

Additional Assisted Reproductive Technology Benefits Rider 50%

Summary of Benefits

This Summary of Benefits shows the amount you will pay for Covered Services under this Infertility services Benefit.

Benefits	Your Payment	
	When using a Participating Provider	When using a Non-Participating Provider
Infertility Services	50% of the allowable amount	Not covered
Services are not subject to the Calendar Year Medical Deductible and do not count towards the Calendar Year Out-of-Pocket Maximum.		

Assisted Reproductive Technology (ART) Procedures and Associated Services	Benefit Maximums
Natural artificial inseminations	6/lifetime
Without ovum [oocyte or ovarian tissue (egg)] stimulation	
Stimulated artificial inseminations	3/lifetime
With ovum [oocyte or ovarian tissue] stimulation	
Gamete intrafallopian transfer (GIFT)	1/lifetime
Zygote intrafallopian transfer (ZIFT)	2/lifetime
In-vitro fertilization (IVF)	2/lifetime
Intracytoplasmic sperm injection (ICSI)	2/lifetime
Cryopreservation of embryos, oocytes, ovarian tissue, sperm	1/lifetime
Retrieved from the Subscriber, spouse or Domestic Partner. Includes one retrieval and three years of storage per person	

Lifetime Benefit Maximum

Lifetime Benefit maximums for the above described procedures apply to all services related to or performed in conjunction with such procedures, such that once the maximums for the above procedures have been reached, no services related to or performed in conjunction with the procedures will be covered.

Benefit Plans may be modified to ensure compliance with State and Federal Requirements.

PENDING REGULATORY APPROVAL

Introduction

Only the Subscriber, spouse or Domestic Partner is entitled to Benefits under this Infertility Benefit. Covered Services for Infertility include all professional, Hospital, Ambulatory Surgery Center, ancillary services and injectable drugs administered or prescribed by a Participating Provider to a Subscriber, spouse or Domestic Partner for the inducement of fertilization as described herein.

For the purposes of this Benefit, Infertility is:

- a demonstrated condition recognized by a licensed physician and surgeon as a cause for infertility; or
- the inability to conceive a pregnancy or to carry a pregnancy to a live birth after a year of regular sexual relations without contraception.

Benefits

Benefits are provided for a Subscriber, spouse or Domestic Partner who has a current diagnosis of Infertility for a medically appropriate diagnostic work-up and ART procedures.

Benefits include cryopreservation services for a condition which the treating Physician anticipates will cause Infertility in the future (except when the infertile condition is caused by elective chemical or surgical sterilization procedures). The Subscriber, spouse or Domestic Partner is responsible for the Copayment or Coinsurance listed for all professional and Hospital services, Ambulatory Surgery Center and ancillary services used in connection with any procedure covered under this Benefit, and injectable drugs administered or prescribed by a Participating Provider to induce fertilization. Procedures must be consistent with established medical practice for the treatment of Infertility and authorized by Blue Shield of California.

No Benefits are provided for services received from Non-Participating Providers.

The Calendar Year Medical Deductible does not apply to these Covered Services, and Coinsurance for these Covered Services do not apply towards the Out-of-Pocket Maximum responsibility.

Exclusions

No Benefits are provided for:

- Services received from Non-Participating Providers;
- Services for or incident to sexual dysfunction and sexual inadequacies, except as provided for treatment of organically based conditions, for which Covered Services are provided only under the medical Benefits portion of the Evidence of Coverage (EOC);
- Services incident to or resulting from procedures for a surrogate mother. However, if the surrogate mother is enrolled in a Blue Shield of California health Plan, Covered Services for pregnancy and maternity care for the surrogate mother will be covered under that health Plan;
- Services for collection, purchase or storage of embryos, oocytes, ovarian tissue, or sperm from donors other than the Subscriber, spouse or Domestic Partner entitled to Benefits under this Infertility Benefit;
- Cryopreservation of embryos, oocytes, ovarian tissue, or sperm from donors other than the Subscriber, spouse or Domestic Partner entitled to Benefits under this Infertility Benefit;
- Home ovulation prediction testing kits or home pregnancy tests;
- Microsurgical epididymal sperm aspiration (MESA), percutaneous epididymal sperm aspiration (PESA), and testicular sperm aspiration (TESA) if the Subscriber, spouse or Domestic Partner had a previous vasectomy;
- Reversal of surgical sterilization and associated services;
- Any services not specifically listed as a Covered Service, above;
- Covered Services in excess of the lifetime Benefit maximums; or
- Services for or incident to a condition which the Subscriber, spouse or Domestic Partner anticipates may cause Infertility in the future except as described in the Benefit for cryopreservation of embryos, oocytes, ovarian tissue, or sperm.

Benefits are limited to a Subscriber, spouse, or Domestic Partner who has diagnosed Infertility as defined at the time services are provided.

See the Grievance Process portion of your EOC for information on filing a grievance, your right to seek assistance from the Department of Managed Health Care, and your rights to independent medical review.

Please be sure to retain this document. It is not a contract but is a part of your EOC.