

Infertility Benefits

Supplement to Your Blue Shield PPO Plan Evidence of Coverage

Summary of Benefits

Member Benefit Lifetime Maximum	Maximum Blue Shield Payment
	Covered Services by Preferred & Participating Providers ¹
Covered Infertility Benefits up to the lifetime maximum	None
Infertility Benefits	Blue Shield Payment
Covered Infertility Benefits up to the lifetime benefit maximums as described in this Supplement	50% of the Allowable Amount

¹ Infertility Benefits are only covered when provided by Preferred or Participating Providers. There are no Benefits for Infertility services provided by Non-Preferred or Non-Participating Providers.

Introduction

Only the Member is entitled to Benefits under this Infertility Benefit. Covered Services for Infertility include all professional, Hospital, ambulatory surgery center, and ancillary services and injectable drugs administered or prescribed by a Preferred or Participating Provider to a Member covered hereunder to diagnose and treat the cause of Infertility including inducement of fertilization as described herein.

For the purposes of this Benefit, Infertility means the Member must be actively trying to conceive and has, with respect to a Subscriber, spouse or Domestic Partner covered hereunder:

1. the presence of a demonstrated condition recognized by a licensed Doctor of Medicine as a cause of not being able to conceive; or
2. for women age 35 and less, failure to achieve a successful pregnancy (live birth) after 12 months or more of regular unprotected intercourse; or
3. for women over age 35, failure to achieve a successful pregnancy (live birth) after 6 months or more of regular unprotected intercourse; or

4. failure to achieve a successful pregnancy (live birth) after six cycles of artificial insemination supervised by a physician. (The initial six cycles are not a Benefit of this Plan); or
5. three or more pregnancy losses.

Benefits

Benefits are provided for a Member who has a current diagnosis of Infertility for a medically appropriate diagnostic work-up and the procedures listed below which have the following per Member Benefit Lifetime Maximums:

1. Six natural (without ovum (oocyte or ovarian tissue (egg)) stimulation) artificial inseminations;
2. Three stimulated (with ovum [oocyte or ovarian tissue] stimulation) artificial inseminations;
3. One gamete intrafallopian transfer (GIFT).

4. Cryopreservation of sperm/ oocytes /embryos when retrieved from a Member. 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). Benefits are limited to one retrieval and one year of storage per person per lifetime.

Note: the lifetime benefit maximum 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.

The Member is responsible for the Copayment 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 Preferred or Participating Provider during a course of treatment to diagnose Infertility or induce fertilization. Procedures must be consistent with established medical practice in the treatment of Infertility and authorized by Blue Shield of California.

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

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

No Benefits are provided for:

1. Services received from Non-Preferred or Non-Participating Providers;
2. 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;
3. 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;

4. Services for collection, purchase or storage of sperm/eggs/frozen embryos from donors other than the Member;
5. Intracytoplasmic sperm injection (ICSI);
6. Zygote intrafallopian transfer (ZIFT) and in vitro fertilization (IVF);
7. Any services not specifically listed as a Covered Service, above;
8. Covered Services in excess of the Lifetime Benefit Maximums per Member;
9. Services for or incident to a condition which the person anticipates may cause Infertility in the future except as described in the Benefit for cryopreservation of sperm/oocytes/ovarian tissue/embryos.

Benefits are limited to a Member who has diagnosed Infertility as defined at the time services are provided.

Please be sure to retain this document. It is not a contract but is a part of your *Blue Shield of California PPO Plan Evidence of Coverage*.