blue of california

Assisted Reproductive Technology Rider

Group Rider
Effective January 1, 2025
HMO

San Francisco Health Service System Additional Blue Shield Infertility Benefits Summary of Benefits

This Summary of Benefits shows the amount you will pay for Covered Services under this Assisted Reproductive Technology (ART) Benefit.

Benefits	Your Payment	
	When using a Participating Provider	**When using a Non-Participating Provider**
Assisted reproductive technology (ART) procedures and associated services *Services are not subject to any applicable Deductible and do not count towards the Calendar Year Out-of-Pocket Maximum.*	50% of the Allowed Charges	Not covered
Assisted Reproductive Technology (ART) Procedures and Associated Services	**Benefit Maximums**	
Natural artificial inseminations *Without ovum [oocyte or ovarian tissue (egg)] stimulation*	6 procedures per lifetime	
Stimulated artificial inseminations *With ovum [oocyte or ovarian tissue] stimulation*	3 procedures per lifetime	
Gamete intrafallopian transfer (GIFT), Zygote intrafallopian transfer (ZIFT), or In-vitro fertilization (IVF)	2 procedures per lifetime	
Intracytoplasmic sperm injection (ICSI)	No benefit maximum	
Assisted embryo hatching	No benefit maximum	
Elective single embryo transfer, including preparation of embryo for transfer	No benefit maximum	
Embryo biopsy for preimplantation screening (PGS) or diagnosis (PGD)	No benefit maximum	
Cryopreservation of embryos, oocytes, ovarian tissue, sperm *Retrieved from a Subsriber, spouse or Domestic Partner. Includes one retrieval and one year of storage per person*	1 egg retrieval and 1 year of storage in a lifetime	

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.
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Introduction

Only the Subscriber, spouse or Domestic Partner is entitled to Benefits under this Assisted Reproductive Technology (ART) Benefit. Covered Services for Infertility include all professional, Hospital, Ambulatory Surgery Center, ancillary services and injectable drugs when authorized by the Primary Care Physician 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.

Benefits

Benefits are provided for a Subscriber, spouse or Domestic Partner who meets the definition of Infertility for a medically appropriate diagnostic work-up and ART 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 by the provider to induce fertilization. If your Employer selected the Outpatient Prescription Drug Rider as an optional Benefit, self-administered Drugs prescribed to induce fertilization are covered at the applicable Drug tier Copayment or Coinsurance. Procedures must be consistent with established medical practice for the treatment of Infertility and authorized by the Primary Care Physician.

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

Exclusions

No Benefits are provided for:

- Services received from Non-Participating Providers;
- Outpatient Prescription Drugs prescribed for self-administration, if your Employer did not select the Outpatient Prescription Drug Rider;
- 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 Assisted Reproductive Technology (ART) Benefit;
- Cryopreservation of embryos, oocytes, ovarian tissue, or sperm from donors other than the Subscriber, spouse or Domestic Partner entitled to Benefits under this Assisted Reproductive Technology (ART) 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; or
- Covered Services in excess of the lifetime Benefit maximums.

Benefits are limited to a Subscriber, spouse or Domestic Partner who meets the definition of 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.