

This Summary of Benefits shows the amount you will pay for Covered Services under this assisted reproductive technology Benefit. Please refer to your medical *Summary of Benefits* for more information about your Calendar Year Deductible (CYD).

Benefits		Your Payment		
	When using a Participating Provider	CYD applies	When using a Non-Participating Provider	CYD applies
Assisted reproductive technology (ART) procedures and associated services	35% of the allowable amount	✓	50% of the allowable amount	✓

Assisted Reproductive Technology (ART) Procedures and Associated Services	Lifetime Benefit Maximums
Natural artificial inseminations <i>Without ovum [oocyte or ovarian tissue (egg)] stimulation</i>	6/lifetime
Stimulated artificial inseminations <i>With ovum [oocyte or ovarian tissue] stimulation</i>	3/lifetime
Oocyte (egg) retrieval	1/lifetime
Gamete intrafallopian transfer (GIFT)	1/lifetime
Cryopreservation of embryos, oocytes, sperm, reproductive tissue <i>Retrieved from a Member. Includes one year of storage per person</i>	1/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.

Introduction

The Member is entitled to Benefits under this assisted reproductive technology Benefit. Covered Services for Infertility include all professional, Hospital, Ambulatory Surgery Center, ancillary services and injectable drugs to a Member for the inducement of fertilization as described herein.

For the purposes of this Benefit, Infertility is:

- A licensed Physician's findings, based on a patient's medical, sexual, and reproductive history, age, physical findings, diagnostic testing, or any combination of those factors. This definition shall not prevent testing and diagnosis of Infertility before the 12-month or 6-month period to establish Infertility in paragraph (3);
- A person's inability to reproduce either as an individual or with their partner without medical intervention; or
- The failure to establish a pregnancy or to carry a pregnancy to live birth after regular, unprotected sexual intercourse. For purposes of this definition, "regular, unprotected sexual intercourse" means no more than 12 months of unprotected sexual intercourse for a person under 35 years of age or no more than 6 months of unprotected sexual intercourse for a person 35 years of age or older. Pregnancy resulting in miscarriage does not restart the 12-month or 6-month time period to qualify as having Infertility.

Benefits

Benefits are provided for a Member who meets the definition of Infertility for a medically appropriate diagnostic work-up and ART procedures.

The Member 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 a Participating Provider to induce fertilization. Self-administered Drugs prescribed to induce fertilization are covered at the applicable Drug tier Copayment or Coinsurance under the *Prescription Drug Benefits* section of the Evidence of Coverage. Procedures must be consistent with established medical practice for the treatment of Infertility and authorized by Blue Shield of California.

These Covered Services are subject to the Calendar Year Medical Deductible. Cost Share for these Covered Services applies towards the Out-of-Pocket Maximum.

Exclusions

No Benefits are provided for:

- ART and associated services related to intracytoplasmic sperm injection (ICSI);
- ART and associated services related to zygote intrafallopian transfer (ZIFT);
- ART and associated services related to in vitro fertilization (IVF);
- 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 Member entitled to Benefits under this assisted reproductive technology Benefit;

- Cryopreservation of embryos, oocytes, ovarian tissue, or sperm from donors other than the Member entitled to Benefits under this assisted reproductive technology 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 Member 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 Member 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.