# INFERTILITY BENEFIT

## COPAYMENT SUMMARY

### Infertility Services

Covered Infertility services generally include consultations, examinations, diagnostic services whether performed in a physician's office or in a hospital or other facility, and medications. All covered Infertility services must receive prior authorization and are subject to the exclusions and limitations set forth in this Copayment Summary.

"Infertility" is defined as a condition of being infertile. A member is considered infertile if there is a presence of a demonstrated condition recognized by a licensed physician and surgeon as a cause of infertility, or the member is unable to conceive a pregnancy or to carry a pregnancy to a live birth after one (1) year of regular unprotected intercourse, or if the female partner is over age 35 years, after 6 months of regular unprotected intercourse. A member not having regular unprotected intercourse may be considered infertile if conception does not occur after at least 12 cycles of supervised artifical/donor insemination (6 cycles for women 35 years or older).

| cost to member | Covered Sevices — Services and supplies for diagnosis and treatment of involuntary infertility |
| ---: | --- |
| $10 per visit* | Office visits |
| $10 per procedure* | Outpatient surgery and outpatient procedure |
| none | Outpatient imaging and laboratory tests |
| none | Artificial insemination (except for donor semen or eggs, and services and supplies related to their procurement and storage) |
| none | Medications for the treatment of Infertility when received and administered in a physician office |
| $5, $10, $20* | Other medications for the treatment of Infertility (see Prescription Copayment Summary) |
| 50% copayment* | One Gamete Intra-Fallopian Transfer (GIFT) per Lifetime+ |

Hospitalization services are covered the same as the medical benefit.

Genetic testing and counseling are covered benefits when medically indicated and are not subject to the Infertility Benefit copayments.

### Exclusions and Limitations

In addition to exclusions and limitations described under Covered Services, the following apply:

- The member must be diagnosed with "Infertility" as defined in this Copayment Summary.
- All covered Infertility services must be prior authorized by WHA.
- Services and supplies to reverse voluntary, surgically induced infertility are excluded.
- All services involved in surrogacy, including but not limited to embryo transfers, services and supplies related to donor sperm or sperm preservation for artificial insemination, are excluded.
- Services and medication for In Vitro Fertilization (IVF) are excluded.
- Frozen embryo transfers and Zygote Intra-Fallopian Transfer (ZIFT) are excluded.
- Intracytoplasmic Sperm Injection (ICSI) is excluded.
- Ova sticks (a self-test for infertility) are excluded.
- Ovum transfer/transplants or uterine lavage as part of infertility diagnosis or treatment is excluded.
- All services related to the sperm donor, including the collection of the sperm, are excluded.
- Sperm storage is excluded.
- Treatment of infertility as a result of previous/prevailing elective vasectomy or tubal ligation, including, but not limited to, procedure reversal attempts and infertility treatment after reversal attempts, is excluded.
- Artificial insemination in the absence of a diagnosis of Infertility is excluded.
- Treatment of female sterility in which a donor ovum would be necessary (e.g., post-menopausal syndrome) is excluded.
- Experimental and/or investigational diagnostic studies, procedures or drugs used to treat or determine the cause of infertility are excluded.
- Laboratory medical procedures involving the freezing or storing of sperm, ovum and/or pre-embryos are excluded.
- Inoculation of a woman with partner's white cells is excluded (considered experimental).

* Copayments for covered Infertility services do not contribute to the annual out-of-pocket maximum of your Western Health Advantage medical plan.

+ "Lifetime" refers to services obtained during the member's life, including services provided under any other health insurance or HMO.