

# DRAFT

## Comparison of Infertility Benefits by 2017 Oregon EHB Benchmark Option

DRAFT for April 21, 2015 Meeting



<b>Small Group Plans</b>	<b>Pacific-Source</b>	<p><b><u>Not Covered</u></b>                      Excludes coverage for: Services and supplies, diagnostic laboratory and x-ray studies, surgery, treatment, or prescriptions to diagnose, prevent, or cure infertility or to induce fertility (including Gamete and/or Zygote Interfallopian Transfer; i.e. GIFT or ZIFT), except for medically necessary medication to preserve fertility during treatment with cytotoxic chemotherapy.</p>
	<b>HealthNet</b>	<p><b>Coverage only</b> for Medically Necessary services and supplies for standard fertility preservation treatments are covered when a cancer treatment may directly or indirectly cause iatrogenic infertility. Iatrogenic infertility is infertility that is caused by a medical intervention, including reactions from prescribed drugs or from medical or surgical procedures that may be provided for cancer treatment.</p>
	<b>United</b>	<p><b><u>Not Covered</u></b>                      Excluded services:                      1. Health services and associated expenses for infertility treatments, including assisted reproductive technology, regardless of the reason for the treatment. This exclusion does not apply to services required to treat or correct underlying causes of infertility.                      2. Surrogate parenting, donor eggs, donor sperm and host uterus.                      3. Storage and retrieval of all reproductive materials. Examples include eggs, sperm, testicular tissue and ovarian tissue.                      4. The reversal of voluntary sterilization.</p>

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<b>State Employee Plans</b>	<b>PEBB Providence Statewide</b>	<p><u>Covered Services include the following:</u></p> <ul style="list-style-type: none"> <li>• Diagnostic testing and associated office visits to determine the cause of infertility. This includes physical examination, related laboratory testing, instruction, and medical/surgical procedures when preformed for the sole purpose of diagnosing and treating an infertile state. Diagnostic Services for the treatment of infertility include, but are not limited to hysterosalpingogram, laparoscopy, and pelvic ultrasound;</li> <li>• Artificial insemination, limited to a lifetime maximum of six cycles and sperm wash;</li> <li>• Cost of acquiring semen; and</li> <li>• Covered infertility-related supplies.</li> </ul> <p><u>Covered Services do NOT include:</u></p> <ul style="list-style-type: none"> <li>• Charges for donor semen from donor banks or other providers;</li> <li>• Charges for harvesting and storage of semen other than for immediate use;</li> <li>• Infertility drugs or medications;</li> <li>• Infertility Services not resulting from a medical condition;</li> <li>• All Services for non-Participant surrogate mothers;</li> <li>• Infertility resulting from the aging process as confirmed by elevated follicle stimulating hormone (FSH); and</li> <li>• In vitro and in vivo fertilization including services related to or supporting in vitro fertilization, GIFT, ZIFT, reversals of voluntary sterilization and procedures determined to be experimental or investigational.</li> </ul>
	<b>PEBB Providence Choice</b>	<p><u>Covered Services include the following:</u></p> <ul style="list-style-type: none"> <li>• Diagnostic testing and associated office visits to determine the cause of infertility. This includes the physical examination, related laboratory testing, instruction, and medical/surgical procedures when preformed for the sole purpose of diagnosing and treating an infertile state. Diagnostic Services for the treatment of infertility include, but are not limited to hysterosalpingogram, laparoscopy and pelvic ultrasound.</li> <li>• Artificial insemination, limited to a lifetime maximum of six cycles and sperm wash;</li> <li>• Cost of acquiring semen;</li> <li>• Infertility related drugs or injectables</li> <li>• Covered infertility-related supplies.</li> </ul> <p><u>Covered Services do NOT include:</u></p> <ul style="list-style-type: none"> <li>• Charges for donor semen from donor banks or other providers;</li> <li>• Charges for harvesting and storage of semen other than for immediate use;</li> <li>• Infertility Services not resulting from a medical condition;</li> <li>• All Services for non-Participant surrogate mothers;</li> <li>• Infertility resulting from the aging process as confirmed by elevated FSH; and</li> <li>• In vitro and in vivo fertilization including Services related to or supporting in vitro fertilization, GIFT, ZIFT, reversals of voluntary sterilization and procedures determined to be experimental or investigational.</li> </ul>
	<b>Kaiser Permanente</b>	<p>Diagnosis and treatment of involuntary infertility and artificial insemination are covered.</p> <p>The following are not covered:</p> <ul style="list-style-type: none"> <li>• Donor semen, donor eggs (including the Member's own eggs), and Services related to their procurement and storage.</li> <li>• Oral and injectable drugs used to treat infertility.</li> <li>• Services for conception by artificial means, such as in vitro fertiliation (IVF), ovum transplants, gamete intrafallopian transfer (GIFT), and zygote intrafallopian transfer (ZIFT), except artificial insemination.</li> <li>• Services to reverse voluntary, surgically induced infertility</li> </ul>

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<b>Federal Employee Plans</b>	<b>BCBS Standard Option</b>	<p>Diagnosis and treatment of infertility, except</p> <ul style="list-style-type: none"> <li>• Assisted reproductive technology (ART) and assisted insemination procedures, including but not limited to:               <ul style="list-style-type: none"> <li>– Artificial insemination (AI)</li> <li>– In vitro fertilization (IVF)</li> <li>– Embryo transfer and Gamete Intrafallopian Transfer (GIFT)</li> <li>– Zygote Intrafallopian Transfer (ZIFT)</li> <li>– Intravaginal insemination (IVI)</li> <li>– Intracervical insemination (ICI)</li> <li>– Intracytoplasmic sperm injection (ICSI)</li> <li>– Intrauterine insemination (IUI)</li> </ul> </li> </ul>
	<b>BCBS Basic Option</b>	<ul style="list-style-type: none"> <li>• Services and supplies related to ART and assisted insemination procedures</li> <li>• Cryopreservation or storage of sperm (sperm banking), eggs, or embryos</li> <li>• Infertility drugs used in conjunction with ART and assisted insemination procedures</li> <li>• Services, supplies, or drugs provided to individuals not enrolled in this Plan</li> </ul>
	<b>GEHA</b>	<p>Diagnosis and treatment of infertility, except</p> <ul style="list-style-type: none"> <li>• Infertility services after voluntary sterilizations</li> <li>• Fertility drugs</li> <li>• Genetic counseling and genetic screening</li> <li>• Preimplantation genetic diagnosis (PGD)</li> <li>• Assisted reproductive technology (ART) procedures, such as:               <ul style="list-style-type: none"> <li>- Artificial insemination</li> <li>- In vitro fertilization</li> <li>- Embryo transfer and gamete intrafallopian transfer (GIFT)</li> <li>- Intravaginal insemination (IVI)</li> <li>- Intracervical insemination (ICI)</li> <li>- Intrauterine insemination (IUI)</li> </ul> </li> <li>• Services and supplies related to ART procedures</li> <li>• Cost of donor sperm</li> <li>• Cost of donor egg</li> </ul>