Clinical Review Criteria Related to Infertility Treatment

Infertility Services

Massachusetts mandates certain health insurance coverage of non-experimental infertility procedures recognized by the American Society for Reproductive Medicine (ASRM) or the American College of Obstetrics and Gynecology (ACOG). In accordance with these mandates, Minuteman Health Insurance (MHI) will provide infertility benefits to medically infertile members with the goal of restoring normal reproductive capacity. Coverage for infertility services is available to members who meet the residency requirements, individual plan limitations, medical necessity and eligibility criteria outlined in this protocol.

Definition

Infertility is the condition of an individual who is unable to conceive or produce conception for a period of at least one year (if the female is age 35 or younger), or during a period of 6 months (if the female is over age 35).

For purposes of meeting MHI criteria, if a woman conceives but is unable to carry the pregnancy to live birth, the period of time spent attempting to conceive prior to achieving that pregnancy is included in the calculation of the one year (for females age 35 or younger) or 6 month period (for females over age 35 years) described above.

For women without male partners or exposure to sperm, infertility is the inability to conceive after 6 cycles of Artificial Insemination or Intrauterine Insemination performed by a qualified specialist using normal quality Donor Sperm.

- These 6 cycles (including Donor Sperm) are not cove**r**ed by MHI, as a diagnosis of infertility cannot be established until after the AI/IUI cycles have been completed.

Policy:

A. MHI Infertility benefits include coverage for non-experimental services that are medically necessary to diagnose and treat medical infertility when such treatment is likely to result in viable offspring. Covered services include, but are not limited to:

1. Specialist consultation.

2. Diagnostic services (e.g., lab work, hysterosalpingogram, laparoscopy, and ultrasound) that are medically necessary to assess infertility.

3. Assisted Reproductive Technology (ART) services including Artificial Insemination, Intrauterine Insemination, Frozen Embryo Transfer, Gamete Intra-Fallopian Transfer, and In-Vitro Fertilization.

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4. Prescription fertility drugs that are FDA approved, and cannot be self-administered.

5. Prescription fertility drugs that can be self-administered (e.g., ovulatory injections including HCG) are covered only for members with MHI prescription drug coverage who are in an active, authorized cycle of infertility treatment.

B. **See MHI's Medical Review Criteria for Preimplantation Genetic Diagnosis (PGD) for information regarding coverage and authorization requirements for PGD.**

C. **Medical Necessity:** Those Covered Services and supplies that are consistent with generally accepted principles of professional and medical practice as determined by whether the service is:

1. The most appropriate available supply or level of service for the Member in question, considering potential benefits and risks to the individual.

2. Known to be effective, based on scientific evidence, professional standards and expert opinion, in improving health outcomes.

3. Based on scientific evidence if the services and interventions are not in widespread use.

I. What is Covered:

- Artificial Insemination (AI) Intrauterine Insemination (IUI)
- Assisted Hatching
- Collection, storage cryopreservation and banking of sperm, eggs (oocytes), or embryos
- Donor eggs
- Donor sperm
- Embryo Transfer/Frozen Embryo Transfer (FET)
- Gamete-Intra-Fallopian Transfer (GIFT)
- Intra-Cytoplasmic Sperm Injection (ICSI)
- In-Vitro Fertilization (IVF) including conversion from IUI to an IVF cycle
- Microsurgical Epididymal Sperm Aspiration (MESA)
- Pre-implantation Genetic Diagnosis (please see separate policy)
- Testicular Sperm Extraction (TESE)
- Zygote Intra-Fallopian Transfer (ZIFT)

In-network providers should submit authorization requests utilizing MHI's Infertility Treatment Prior Approval Request Form. Forms can be found on MHI's Provider Site: https:// healtMHIwengland.org/forms

II. General Eligibility Criteria

A. Coverage for required infertility benefits will not be limited arbitrarily, but may be limited according to reasonable consideration of the individual member's medical history, hormone levels and age, medical necessity guidelines, provider standards and protocols, and legal requirements or limitations. Unless ineligible for reasons unrelated to this provision, and based upon the recommendation of the patient's clinician specialist, members who meet the

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residency requirements, the above definition of infertility, and the following criteria (where relevant) are eligible for ART services.

B. For a member to be considered for cycle initiation of a covered ART service:

1. The member must meet the definition of medical infertility (as defined above) and infertility may not be the result of a previous sterilization or unsuccessful reversal.

2. Documentation (i.e., clinical history including: diagnosis, menopausal status, response to and outcomes of previous infertility treatment) confirms that infertility treatment using the female partner's eggs will result in a live birth.

   a. For women with a diagnosis of premature ovarian failure (POF), premature diminished ovarian reserve, or premature menopause, documentation must confirm that, absent such a diagnosis, the member would be an individual in whom fertility would naturally be expected.

3. Documentation of ovarian reserve assessment results obtained within the past year are submitted.

   a. For women ages 40 and older, documentation of adequate ovarian reserve, confirmed by ANY of the following, is required:

      i. Clomiphene Citrate Challenge Test (CCCT) needs to be completed annually with the day 3 FSH test repeated every 6 months for any woman >/= 40 years of age performed:

         - Day 3 and Day 10 FSH levels less than 15 milli international units per milliliter (mIU/ml) and

         - Day 3 Estradiol level less than 100 picograms per milliliter (pg/ml)

   b. Abnormal CCCT Results in women aged 40 years or older:

      i. When Day 3 Estradiol (basal labs or CCCT) is found to be over 100 pg/ml, and all FSH values are under 15 mIU/ml, the Day 3 Estradiol and FSH should be repeated prior to determining eligibility for IVF or other infertility treatment. To meet Criteria, repeat values must meet the criteria above.

      ii. At any time when any Day 3 or Day 10 FSH is >/= 15 mIU/ml, infertility services are not authorized.

         - Documentation confirming the member is unable to take (or tolerate) Clomid with a normal Anti-Mullerian Hormone (AMH) level will be considered.

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4. Women over age 40 with ANY history of Day 3 or Day 10 FSH >15 remain eligible for coverage of the transfer of frozen embryos created prior to the abnormal test finding, but are not eligible for ANY further assisted reproduction treatments.

5. If a woman has a history of an abnormal CCCT, plans to use donor egg and is under age 40, this test does not need to be repeated

6. Diagnosing Male Infertility, the following documentation is required:

    a. Medical and reproductive history (including substance use)

    b. Results of a semen analysis performed within the past year demonstrating normal fertility must be submitted:

        i. If the initial semen analysis is abnormal, a second sample must be submitted;

        ii. If the second sample is abnormal, work-up by an urologist or other specialist in male reproduction (to evaluate and treat reversible causes) should be done and precede any invasive procedures of the female partner.

            - Documentation for the specialist will need to be submitted for review.

    c. If the male partner has previously undergone vasectomy reversal, results of 2 consecutive semen analyses demonstrating a normal fertility threshold, and performed within 3 months of the initial request, must be submitted.

        i. The couple must also meet Service-Specific Criteria for Reversal or Prior Sterilization (below).

        ii. Normal fertility threshold is defined as: semen volume 1.5 ml, sperm concentration 15 million/ml, sperm total 40 million, 40% motility, and 4% normal morphology by Krüger classification, or morphology of 30% by WHO 3rd edition classification (based on World Health Organization 5th edition 2010).

7. Substance Use

    a. Tobacco - due to the toxic effects of tobacco on female and male fertility and in pregnancy, both members of the couple must be non-smokers. If either member of the couple has smoked within the past 6 months:

        - Urine or serum cotinine levels, obtained within the month of the requested service, for all members and their partners who acknowledged smoking within the past year.
        - No infertility services will be approved if cotinine is found in the member or the member's partner.

    b. Other – Due to the known negative effects related to fertility and/or fetal

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development, if either member of a couple is abusing alcohol, consuming substances that are against medical advice or using illegal substances, such as marijuana, opiates, or cocaine, results of serum or urine drug screening may be requested before infertility services are authorized.

8. Body Mass Index (BMI) - Due to the association of obesity and infertility (live birth rate in IVF - 9% lower when BMI > 30), the increased risks associated with infertility treatments in obese patients (up to 31% when BMI > 35), and the increased risk to the mother, pregnancy, and baby associated with maternal obesity, the obese female patient must optimize her health status prior to receiving infertility therapy.

    a. If reported **BMI ≥ 30,** the member must be counseled regarding weight loss and educated about the risks associated with excess weight (e.g., impact on fertility and fertility treatment success, obstetrical risks including diabetes and hypertension, potential anesthesia complications, poorer fetal outcomes) **with documentation of counseling in the medical record.**

    b. If reported **BMI is 35** or higher, **documentation of a nutrition consult with weight loss recommendations and history of previous weight loss attempts within the past 6 months is required.**

Service-Specific Criteria

SERVICE	CRITERIA
Advanced Maternal Age	Advanced Maternal Age will be considered the following way: A. For women ages 40 to 42, an ART cycle will be approved one cycle at a time after meeting the above-listed criteria including a normal CCCT, HSG, and at least two medicated IUI cycles. 1. It is expected that an ART cycle will be cancelled if there are fewer than 3 follicles developed and/or the E2 level ≤500 pg/ml. 2. A repeat cycle may be approved after review of the prior cycles' outcome; at a minimum, it is expected that an ART cycle will have had more than 3 follicles developed and an estradiol level > 500 MIU/mil in order to offer a reasonable chance of success. B. For women age 42, up to the member's 44th birthday, a single ART cycle may be approved for coverage using her own eggs based on her history and prior ART attempts including: 1. Normal CCCT, 2. Development of 4 or more follicles (>15mm) and Estradiol > 500 m IU/ml

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	following gonadotropin stimulation or prior ART cycle with transfer of at least 4 embryos of reasonable quality, and 3. Fewer than 3 ART cycles prior to the woman's 42nd birthday C. For women ages ≥ 44: Fertility is not considered a natural state due to age-related decline in oocyte number and quality at or beyond age 44 regardless of hormonal testing. Infertility is not considered a disease process at or after 44 y/o though a member's individual medical history will be considered in making coverage decisions.
Artificial Insemination (AI) **Intrauterine Insemination (IUI)**	Medically necessary AI or IUI services are authorized when applicable eligibility criteria are met, and documentation includes: A. Results of a uterine cavity evaluation (sonohysterogram, hysterosalpingography, or hysteroscopy) within the past 2 years confirming the presence of ALL the following: • At least one patent Fallopian tube • Normal ipsilateral ovary • Normal endometrial cavity B. Confirmation of spontaneous ovulation, or normal ovarian reserve testing; C. Evidence of ANY of the following: • Unexplained infertility • Polycystic Ovary Syndrome (PCOS), anovulation, or oligo ovulation • Mild to moderate endometriosis • Cervical factors • Mild to moderate male factor infertility (abnormal semen analysis with at least a sperm concentration 10 million/ml) • Documentation of urology consult must be submitted, and include evidence that infertility cannot be improved through standard conservative treatment. • Use of stored sperm from male members who, subsequent to active infertility treatment, required sperm banking/storage as a result of medical treatment (e.g., cancer treatment) likely to cause infertility.
Assisted Hatching (AH)	Assisted Hatching may be authorized as part of an IVF or Frozen Embryo Transfer (FET procedure when there is documentation of ANY of the following:

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	A. Women with a history of 2 or more embryo transfers without a pregnancy B. History of a prior pregnancy as a result of IVF and AH C. Planned transfer of a frozen-thawed embryo; or Thick Zonae in prior IVF for a woman over age 35.
Conversion from IUI to IVF	Conversion from IUI to IVF cycle may be authorized when the current IUI cycle has resulted in an Estradiol level of ≥800 pg/ml and production of at least 5 follicles >12 mm in diameter.
Cryopreservation of Eggs and/or Embryos	For women in **active** (authorized) infertility treatment: A. MHI covers retrieval, cryopreservation, and up to one year of storage, of any embryos remaining after an authorized IVF cycle, or cryopreservation, and up to one year of storage, of mature eggs from an authorized IVF cycle when there is an unexpected lack of sperm for fertilization. 1. Cryopreserved embryos (or eggs) must be used before additional (fresh) IVF cycles using the member's or a donor's eggs are authorized if: • A woman up to age 35 years has 2 or more cryopreserved embryos or eggs; or • A woman age 35 years or older has 4 or more cryopreserved embryos or eggs. 2. This is restricted for women 40 years of age and younger. 3. Requests for authorization of a Thaw Cycle (using frozen eggs or embryos) must meet General Eligibility Criteria (above) at the time of the request. For women who are **not in active** infertility treatment: A. MHI covers retrieval, cryopreservation, and storage (up to one year) of eggs or embryos when documentation confirms a female member who is not in active treatment for infertility will be undergoing medical treatment (e.g., chemotherapy, radiation therapy) that is likely to result in infertility:

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	1. The member is not required to meet MHI's General Eligibility Criteria for Infertility Services. 2. For members not in active infertility treatment, who are requesting fertilization of eggs and cryopreservation of embryos: • Results of ovarian testing, and the male partner's semen analysis, must be submitted to assess the likelihood of embryo creation.
Cryopreservation and Sperm Collection	Sperm collection, cryopreservation (including up to one year of storage) is authorized for male members when: A. There is a need for frozen back-up sperm because of unreliable ability to produce adequate or useful sperm on the day of ovulation; or B. Sperm was recovered through MESA or TESE; or C. Documentation confirms that the member is undergoing medical treatment (e.g., cancer treatment) that is likely to result in infertility.
Cryopreservation of Eggs or Sperm (including retrieval and up to one year of storage) for members undergoing Gender Reassignment Treatment	Covered when documentation confirms a member with Gender Dysphoria will be undergoing covered Gender Reassignment treatment that is likely to result in infertility. A. Documentation must confirm that member and provider (s) have discussed the impact of Gender Reassignment treatment on fertility and family planning. B. No coverage for cost associated with any form of Surrogacy including gestational carriers.
Donor Eggs (Donor Oocyte) **Non-medical services related to donor egg procurement (e.g., finder fees, broker fees, legal fees) are not covered.**	Donor egg procedures are authorized for women under age 40 years when General Eligibility Criteria (above) are met, and there is documentation of ANY of the following: A. Congenital or surgical absence of ovaries B. Premature ovarian failure or premature menopause in women under age 40 years C. Premature diminished ovarian reserve (i.e., FSH

	≥15 in women under age 40 years D. Inadequate ovarian response (i.e., fewer than 3 follicles >12mm diameter), or inadequate embryo numbers and quality, during authorized IVF cycle within the prior 6 months When donor egg criteria are met, a donor egg cycle is authorized for up to 6 months. A. If the donor egg procedure is not performed within 6 months, the member must be reevaluated and continue to meet MHI criteria for infertility services and donor egg procedures before additional services are authorized. B. Medications for the member-recipient will only be covered if the member has an MHI pharmacy benefit. Medication for the anonymous or designated donor in an approved cycle will not be covered. C. For women age 40 up to the 42nd birthday, donor egg is covered when fertility is expected (normal ovarian reserves). The member will demonstrate normal ovarian reserves with a normal CCCT and at least one failed IVF attempt within the prior 6 months. D. Donor egg is not authorized for women aged > 43 as they are experiencing an age-related decline in fertility that is normal and expected, and not consistent with disease process. While these individuals may require donor egg/embryo to achieve a positive birth outcome, the need is secondary to an age-related decline in fertility that is normal and expected After proceeding to a donor egg cycle, further IVF cycles using the member's eggs are not authorized.
Donor Sperm	A. Normal quality donor sperm (from an accredited sperm bank) is authorized when there is documentation (by ANY of the following) confirming male factor infertility: B. Bilateral Congenital Absence of Vas Deferens (BCAVD) C. Non-obstructive Azoospermia confirmed through MESA/TESE results

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	E. Previous radiation or chemotherapy treatment resulting in abnormal semen analyses F. Two or more abnormal semen analyses at least 30 days apart G. Inadequate fertilization rates despite use of ICSI. Normal quality donor sperm may also be authorized in lieu of PGD for couples who meet MHI's PGD Medical Review Criteria due to the male partner's genetic abnormality. A diagnosis of infertility is not required if PGD criteria are met.
Frozen Embryo Transfer (FET)	FET will be approved for members who meet the definition of infertility, expect fertility as a natural state, and have a normal uterine cavity evaluation within two years. A normal uterine cavity evaluation is required after a pregnancy or pregnancy loss. Under the following conditions, cryopreserved embryos must be used prior to authorization for an additional fresh cycle: A. For a woman < 35 years old with at least 2 embryos cryopreserved of the same developmental stage B. For a woman ≥ 35 with at least four embryos cryopreserved at the same developmental stage C. A member requesting FET before or instead of a fresh cycle, regardless of the number of available embryos, will be approved for an FET as long as she is eligible for infertility treatment.
Gamete-Intra-Fallopian Transfer (GIFT)	GIFT procedures are authorized for members who have one normal patent Fallopian tube, and meet IVF criteria above.
Intra-Cytoplasmic Sperm Injection (ICSI) **ICSI is not authorized for any IVF cycle involving use of donor sperm, or solely to perform PGD when MHI's PGD criteria are not met.**	ICSI using the male partner's fresh or frozen sperm is authorized (in conjunction with IVF) to treat sperm-related infertility problems in the male partner when the use of ICSI is expected to result in a live birth, and there is documentation of ANY of the following: A. Severe male factor infertility that cannot be overcome by IVF less than 10 million total motile sperm per ejaculate (unprocessed semen analysis) or < 3 million total motile sperm on

	prepared specimen on two separate occasions at least 2 weeks apart B. Less than 50% fertilization (for mature eggs) or failed fertilization on a prior IVF C. Sperm retrieved via Microsurgical Epididymal Sperm Aspiration (MESA) or Testicular Sperm Extraction (TESE) due to abnormalities of the male reproductive tract.

In-Vitro Fertilization (IVF) **NOTE: IVF cycles using a member's own eggs are not authorized for members who have undergone previous donor egg cycles.**	IVF services are authorized when relevant General Eligibility Criteria (above) are met, and there is documentation of ANY of the following: A. Documented history of failed medicated IUI cycles (as follows) when IUI criteria have been met: • For female members under 40 years-old, there must be documentation confirming a history of 3 failed medicated IUI cycles • For female members age 40 or older, documentation confirming a history of 2 failed medicated IUI cycles. B. The female member has ANY of the following: • Bilateral Fallopian tube absence (excluding prior elective sterilization) or bilateral Fallopian tube obstruction due to prior tubal disease. (Documentation confirming failure of conventional therapy is required.) • Severe endometriosis. (Documentation confirming failure of surgical and medical therapy is required.) C. The male member has severe male factor infertility, and has been evaluated by an urologist. • There must be documentation confirming that the condition cannot be improved by standard conservative treatment(s), and cannot be addressed via IUI. D. Results of prior IUI cycles must be submitted with each IVF request (initial and subsequent requests). Results must demonstrate an adequate response to each cycle (i.e., at least 3 follicles >12 mm diameter for ICD, and adequate embryo numbers and quality for transfer), and adequate fresh semen and post-wash semen parameters. • Documentation confirming the female member requesting IVF has undergone hysterosalpingogram, sonohystogram, or hysteroscopy (to establish uterine contours) within the past 2 years is required. E. An IVF cycle will be approved one cycle at a time to determine that the probability of a live birth remains using one's own eggs.

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IVF FOR Women Without Male Partners or Exposure to Sperm	To establish a diagnosis of infertility, there must be documentation confirming the woman without a male partner or exposure to sperm has failed to conceive after 6 AI/IUI cycles, performed by a qualified specialist, using normal donor sperm. To qualify for IVF services, the woman must also meet Service-Specific Criteria for IVF including documentation of an age-specific number of failed medicated IUI cycles: A. For female members up to 40 years old, there must be documentation confirming a history of 3 failed medicated IUI cycles; B. For female members age 40 or older, documentation confirming 2 failed medicated IUI cycles.
IUI After In-Vitro Fertilization (IVF)	IUI after IUI-to-IVF conversion for hyperstimulation if the stimulation that was initially given is reduced. IUI after IVF/ICSI/Preimplantation Genetic Testing (PGT) may be authorized for couples with a male genetic disorder who opt to use donor sperm after IVF/ICSI/PGT if the female member meets IUI criteria. (Coverage for IUI is limited to 6 cycles with documented ovulation.) In the absence of an intervening live birth, subsequent IUI cycles are not authorized for members who have already undergone IVF if further IVF cycles do not meet MHI's IVF criteria.
Microsurgical Epididymal Sperm Aspiration (MESA)	Microsurgical Epididymal Sperm Aspiration is authorized for male members with documented congenital absence or obstruction, or traumatic obstruction, of the vas deferens. A. This does not include obstruction resulting from prior sterilization or sterilization reversal procedures.
Reversal of Sterilization	For members who have undergone previous sterilization procedures (e.g., tubal ligation or vasectomy) and subsequent surgical reversal, infertility services are authorized only when there is clinical documentation confirming ALL the following: A. The member/couple meets all applicable medical necessity criteria in this policy, and the member has undergone a successful reversal procedure;

	B. The member's infertility is independent of the previous sterilization procedure, and the successful reversal procedure has been followed by at least 6 months of attempting natural conception; C. There is documentation of either: 1. For males, two consecutive semen analyses within 3 months of the request for infertility services demonstrating a normal fertility threshold (as noted in General Eligibility Criteria) and continued success of the reversal; 2. For females, post-surgery hysterosalpingogram (HSG) or chromotubation demonstrate unilateral or bilateral free spill tubal patency, and results of an HSG or chromotubation performed within the six months of the request for infertility services demonstrate that post-operative scarring and tubal blockage have not occurred.
Testicular Sperm Extraction (TESE)	Testicular Sperm Extraction or Micro-TESE is authorized for male members with documented non-obstructive azoospermia, or those who have failed a MESA procedure.
Zygote Intra-Fallopian Transfer (ZIFT)	ZIFT procedures are authorized for members who have one normal patent Fallopian tube, and meet IVF criteria above.

III. Residency Requirements and Individual Plan Limitations

A. **Fully Funded health plan members:** MHI covers infertility services in accordance with the terms of this protocol for Massachusetts residents only.

B. **Self-Funded Group members:** Self-funded plans are not required to provide mandated infertility services. If a self-funded group offers infertility coverage, benefits will be provided to all members subject to the defined plan limitations, regardless of their state of residency, as outlined in the group's Summary Plan Description, which may reference this protocol.

IV. What is Not Covered:

MHI does not cover Infertility Services when criteria above are not met.

A. In addition, MHI does not cover Infertility services for ANY of the following:

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1. Members without MHI Infertility benefits

2. Members who are not medically infertile unless the member meets other MHI criteria (e.g., PGD, sperm/egg banking and storage for a member who is undergoing medical treatment that is likely to result in infertility); Individuals who are not members (including partners, dependents, or other third parties), or services in which the member is not treated, or is not the intended recipient of the infertility services

3. Individuals who are not members (including partners, dependents, or other third parties), or services in which the member is not treated, or is not the intended recipient of the infertility services

4. Infertility services (including but not limited to consultations, labs, radiology studies, infertility drugs, ART cycles, and other services to assess and/or treat infertility in a member or a member's partner) requested as a result of a prior voluntary sterilization or unsuccessful sterilization reversal procedure unless there is documentation that criteria (above) are met

5. Infertility services requested to treat effects that are due to natural aging, or for women who are menopausal

6. Donor sperm:

    a. In the absence of documented male factor infertility, or for genetic sperm defects in the male partner when the male partner is not an MHI member

    b. In the absence of a male partner

    c. When the male partner has undergone vasectomy reversal and fails to meet the medical necessity criteria for infertility services for males with prior vasectomy with reversal

    d. Chromosome studies of a donor (sperm or egg)

7. Infertility services in cases in which normal embryos have been or will be discarded because of gender selection

8. ICSI for any IVF cycle involving use of donor sperm

9. Any Advanced Reproductive Technology requested solely for PGD (e.g., IVF, ICSI) when PGD is not a covered benefit, or PGT criteria (above) are not met.

10. When PGD is not covered or not authorized, medically necessary Infertility services (including IVF and ICSI) may be authorized for members with Infertility benefits if service-specific criteria (above) are met.

11. Treatments requested solely for the convenience, lifestyle, personal or religious preference of the member in the absence of medical necessity

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12. Treatment to reverse voluntary sterilization, or MESA/TESE, for a member who has undergone prior sterilization

13. Supplies that may be purchased without a physician's written order (e.g., ovulation test kits)

14. Monitoring of non-authorized IUI cycles

15. Services related to achieving pregnancy through a surrogate or gestational carrier

16. Implantation or other services provided to a gestational carrier, including but not limited to transfer, impending pregnancy costs or cryopreservation of embryos, whether or not the gestational carrier is an MHI member

17. Use of donor egg with gestational carrier even when the surrogate is a member of the health plan

18. Charges for the storage of eggs, sperm or embryos that remain in storage after the completion of an approved series of infertility cycles, or more than 1 year after the cryopreservation (whichever is shorter)

19. Service fees, charges or compensation for the recruitment of egg donors

20. This exclusion does not include the charges related to the medical procedure of removing an egg for the purpose of donation when the recipient is a member of the Plan.

21. Infertility services when clinical documentation confirms an individual or couple are using illicit substances or abusing substances known to negatively interfere with fertility or fetal development (e.g., cigarettes, marijuana, opiates, cocaine, or alcohol).

References:

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Summary of Changes:
02/09/2017

- Updated website information - page 2
- Revised information for CCCT - page 3
- Added the definition of normal fertility threshold - page 4
- Added a new category: Gender Reassignment tx - page 8
- Donor egg added age requirements - page 9
- Added a line in what's not covered (#4) re: individuals that are not covered - page 15

HNE Review Dates: 6/11/13; 9/10/13; 9/9/14; 9/8/15; 10/13/15, 2/9/16, 1/10/17
MHI Review Dates: 01/01/14, 10/23/14, 10/07/15, 4/21/2016, 02/09/2017