LISI CARRIERS' INFERTILITY COMPARISON

	AETNA	ANTHEM BLUE CROSS	BLUE SHIELD
STANDARD COVERAGE			
Coverage Definition	Diagnostic services for the diagnosis and treatment of the underlying medical condition, and: • Infertility Treatment - AI/OI • ART/GIFT	Coverage only to diagnose and treat the underlying medical condition.	Not covered. Optional rider available, see below.
Benefit	Cost share depends on place and type of service.	Standard plan benefits.	-
Lifetime Maximum	Coverage is limited to $2,000 maximum per lifetime, AI/OI & ART/GIFT combined.	N/A	-
Exclusions	N/A	N/A	-
OPTIONAL RIDERS			
Optional Rider	None available.	Coverage in and out-of-network for: • Medications administered in a Physician's office • Reconstructive Surgery, except for sterilization reversal • Artificial insemination • Supplies and appliances • In vitro, GIFT & ZIFT	Available on HMO and PPO plans; in-network coverage only: • Natural Artificial Insemination • Stimulated Artificial Insemination • GIFT • Cryopreservation • Prescription drugs HMO Plans: Coverage only for services authorized by the PCP. PPO Plans: Services covered only when authorized by Blue Shield and provided by a Preferred Provider.
Cost	N/A	$90 per employee per month, regardless of area or age.	$10.35 per enrolled member per month (including children). Families with 3+ children < age 21: only the 1st 3 children will be rated.
Rider Benefit	N/A	50% coinsurance (in and out-of-network).	50% coinsurance of allowed amount. **Full PPO Plans** Benefits not subject to medical ded and do not accrue to OOP Max. **Full PPO Savings Plans** Benefits are subject to medical ded and do not accrue to OOP Max.
Lifetime Maximum	N/A	$2,000 for services, and separate $1,500 for infertility drugs, per member.	Limited to 6 natural/3 stimulated AI, 1 GIFT, & Cryopreservation for a condition which the physician anticipates will cause infertility in the future - except when caused by elective chemical or surgical sterilization procedures (1 retrieval & 1 year storage per person/lifetime).
Exclusions	-	-	ZIFT; IVF; ICSI; surrogacy services; the collection, purchase, or storage of the sperm/eggs/frozen embryos from donors other than the member; and anything not specifically listed as a covered service in the Family Planning and Infertility Services section of the EOC.

Note: Rider cost is for comparison purposes only and is subject to change at any time.

	CALIFORNIA*CHOICE*®		
	ANTHEM BLUE CROSS	HEALTH NET	KAISER PERMANENTE OSCAR HEALTH SHARP HEALTH PLAN SUTTER HEALTH PLUS UNITEDHEALTHCARE WESTERN HEALTH ADVANTAGE
STANDARD COVERAGE			
Coverage Definition	Covered Services include diagnostic tests to find the cause of Infertility, such as diagnostic laparoscopy, endometrial biopsy, and semen analysis, and services to treat the underlying medical conditions that cause Infertility (e.g., endometriosis, obstructed fallopian tubes, and hormone deficiency).	**Gold HMO B and Silver HMO B** Not covered. **All Other Plans** Comprehensive Infertility benefits including treatment, infertility drugs and GIFT.	**Oscar** Basic infertility services (diagnosis) only for qualified members. **All Others** Not covered.
Benefit	Same share cost as doctor office visit copay.	**Gold HMO B and Silver HMO B** Not covered. **All Other Plans** 50% coinsurance	N/A
Lifetime Maximum	N/A	**Gold HMO B and Silver HMO B** Not Covered **All Other Plans** $8,500 for infertility services & $1,500 for infertility drugs.	N/A
Exclusions	Assisted reproductive technologies (ART) or the diagnostic tests and Drugs to support it. Examples of ART include artificial insemination, in-vitro fertilization (IVF), zygote intrafallopian transfer (ZIFT), or gamete intrafallopian transfer (GIFT).	IVF and ZIFT.	Services related to the diagnosis and treatment of infertility.
OPTIONAL RIDERS			
Optional Rider	N/A	N/A	N/A
Cost	N/A	N/A	N/A
Rider Benefit	N/A	N/A	N/A
Lifetime Maximum	N/A	N/A	N/A
Exclusions	-	-	-

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	COVERED CA FOR SMALL BUSINESS	
	BLUE SHIELD	CCHP
STANDARD COVERAGE		
Coverage Definition	Not covered. Optional rider available, see below.	The following covered services in the physician's office or facility for involuntary infertility are, but not limited to: • Services for diagnosis & treatment of involuntary INF • Diagnostic tests • Medication • Surgery • Artificial insemination (AI) • Gamete intrafallopian transfer (GIFT)
Benefit	-	Refer to plan coinsurance. Prescriptions related to infertility covered under the applicable outpatient copay.
Lifetime Maximum	-	N/A
Exclusions	-	• In vitro fertilization (IVF) - including the pre-IUI sperm washing and necessary screening tests, ovum transplants, donor semen or eggs, services related to procurement and storage of donor semen or eggs. • Zygote intrafallopian transfer (ZIFT) • Infertility treatment to treat or reverse voluntary vasectomy or tubal ligation. • In vitro fertilization (IVM)
OPTIONAL RIDERS		
Optional Rider	Available on HMO and PPO plans; In-net coverage only: • Natural Artificial Insemination • Stimulated Artificial Insemination • GIFT • Cryopreservation • Prescription drugs HMO Plans: Coverage only for services authorized by the Primary Care Physician. PPO Plans: Services covered only when authorized by Blue Shield and provided by a Preferred Provider.	None available.
Cost	$10.35 per member per month. All members, including children, are individually rated. Families with more than 3 children under age 21, only the 1st 3 children will be rated.	N/A
Rider Benefit	50% coinsurance of allowed amount. **<u>Full PPO Plans</u>** Benefits are not subject to the medical deductible and do not accrue to OOP Max. **<u>Full PPO Savings Plans</u>** Benefits are subject to the medical deductible and do not accrue to OOP Max.	N/A
Lifetime Maximum	Benefits limited to 6 natural AI, 3 stimulated AI, 1 GIFT, and Cryopreservation for a condition which the treating physician anticipates will cause infertility in the future - except when the infertile condition is caused by elective chemical or surgical sterilization procedures (1 retrieval and 1 year of storage per person per lifetime).	N/A
Exclusions	ZIFT; IVF; ICSI; surrogacy services; the collection, purchase, or storage of the sperm/eggs/frozen embryos from donors other than the member; and anything not specifically listed as a covered service in the Family Planning and Infertility Services section of the EOC. Please refer to the plan contract and the Evidence of Coverage (EOC) for a detailed description of covered benefits, limitations and exclusions.	-

	COVERED CA FOR SMALL BUSINESS		
	HEALTH NET	KAISER PERMANENTE	SHARP HEALTH PLAN
STANDARD COVERAGE			
Coverage Definition	Coverage only to diagnose and treat the underlying medical condition.	**HMO Plans:** Not covered. **PPO Plans:** In-net for treatment of infertility, including GIFT.	Coverage only to diagnose and treat the underlying medical condition.
Benefit	-	**PPO Plat 90, Gold 80, & Silver 70:** 50% **PPO Bronze 60:** Member pays 100% after deductible up to out of pocket max.	50% coinsurance
Lifetime Maximum	-	**PPO Plans:** Benefits payable for treatment of infertility are limited to $1,000 per cal year for services provided by PHCS providers.	N/A
Exclusions	-	Services to reverse voluntary, surgically induced infertility, IVF and ZIFT. Semen & eggs (& services related to procurement & storage).	-
OPTIONAL RIDERS			
Optional Rider	Available on all plans. Coverage in network for: • Infertility services and supplies (all covered services that diagnose, evaluate or treat infertility) • Prescription drugs • Professional services • Inpatient and outpatient care • Treatment by injections • AI and GIFT Infertility benefits do not apply to the OOP Max on HSP or PPO plans.	All HMO plans. Available to groups with 20+ eligible employees. Kaiser must be the sole carrier. Services include: • Services for diagnosis and treatment of infertility. • Artificial Insemination • Services for GIFT, limited to one treatment cycle per lifetime. Benefits not subject to deductible and do not accrue to the OOP Max, except for HSA plans.	Available to groups with 20+ eligible employees. For diagnosed Infertility, the following are covered benefits: • Artificial Insemination • Assisted Reproductive Technologies (ART) procedures (GIFT)
Cost	$5.64 per employee per month, regardless of area or age.	Cost built into lan and varies by age/ plan design. HMO plans with INF are not avail in HC; must quote direct.	$15.09 per member per month
Rider Benefit	50% coinsurance (in network only).	50% coinsurance	50% coinsurance (in network only).
Lifetime Maximum	**HMO/HSP Plans** $8,500 for medical benefits, $1,500 for prescription benefits. **PPO Plans** $2,000 for medical benefits, $2,000 for prescription benefits.	None.	• AI services lifetime up to a maximum of 3 inseminations • ART procedures up to lifetime max of 3 cycles for any combo of procedures. • Covered ART procedures are limited to GIFT.
Exclusions	Conception by medical procedures (IVF and ZIFT).	• Services to reverse voluntary, surgically induced infertility. • Except for GIFT services and retrieval of your eggs for GIFT treatment cycle or artificial insemination services, all other services related to assisted reproductive technology services such as ovum transplants, procurement and storage of semen and eggs, IVF, and ZIFT.	• The collection, preservation or purchase of sperm, ova or embryos. • Services relating to cryo preservation. • Reversal of voluntary sterilization. • Surrogacy services or supplies. • ART procedures other than GIFT. • Procedures that are not covered include, but are not limited to, Assisted Hatching, blastocyst transfer, ICSI, TET, ZIFT, and other procedures that may be employed to bring about conception without sexual intercourse. • Any service, procedure or process that prepares the member for non-covered ART procedures. • Outpatient prescription drugs (may be available through a separate supplemental plan)

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	HEALTH NET	KAISER PERMANENTE	OSCAR HEALTH
STANDARD COVERAGE			
Coverage Definition	Coverage only to diagnose and treat the underlying medical condition.	**HMO Plans:** Not covered. **PPO Plans:** In-network coverage for treatment of infertility, including GIFT.	**Standard Plans:** Not covered. **INF Plans:** Services include, but are not limited to, diagnosis, diagnostic tests, medication, surgery, and GIFT.
Benefit	-	**PPO Plat 90, Gold 80, & Silver 70:** 50%. **PPO Bronze 60:** Member pays 100% after deductible up to out of pocket max.	Cost-share based on type of service.
Lifetime Maximum	-	**PPO Plans:** Benefits payable for treatment of infertility are limited to $1,000 per calendar year for services provided by PHCS network providers.	N/A. An In-Network Physician determines the appropriate number of drug-induced ovulation attempts for the GIFT treatment cycle.
Exclusions	-	Services to reverse voluntary, surgically induced infertility, IVF and ZIFT. Semen & eggs (& services related to procurement & storage).	Services for IVF are not covered.
OPTIONAL RIDERS			
Optional Rider	Available on all plans. Coverage in network for: • Infertility services and supplies (all covered services that diagnose, evaluate or treat infertility) • Prescription drugs • Professional services • Inpatient and outpatient care • Treatment by injections • AI and GIFT Infertility benefits do not apply to the OOP Max on HSP or PPO plans.	All HMO plans. Available to groups with 20+ eligible employees. Kaiser must be the sole carrier. Services include: • Services for diagnosis and treatment of infertility. • Artificial Insemination • Services for GIFT, limited to one treatment cycle per lifetime. Benefits not subject to deductible and do not accrue to the OOP Max, except for HSA plans.	None available.
Cost	$5.64 per employee per month, regardless of area or age.	Cost is built into the plan and varies by age and plan design. HMO plans with Infertility are not available in HealthConnect; must quote direct.	N/A
Rider Benefit	50% coinsurance (in network only).	50% coinsurance	N/A
Lifetime Maximum	**HMO/HSP Plans** $8,500 for medical benefits, $1,500 for prescription benefits. **PPO Plans** $2,000 for medical benefits, $2,000 for prescription benefits.	None.	N/A
Exclusions	Conception by medical procedures (IVF and ZIFT).	• Services to reverse voluntary, surgically induced infertility. • Except for GIFT services and retrieval of your eggs for GIFT treatment cycle or artificial insemination services, all other services related to assisted reproductive technology services such as ovum transplants, procurement and storage of semen and eggs, IVF, and ZIFT.	-

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	SHARP HEALTH PLAN	SUTTER HEALTH PLUS
STANDARD COVERAGE		
Coverage Definition	Coverage only to diagnose and treat the underlying medical condition.	HMO plans: Not covered. HMO Plus plans Diagnostic services for the diagnosis and treatment of the underlying medical condition, infertility treatment and advanced reproductive technology (AI/OI/GIFT).
Benefit	50% coinsurance	HMO plans: Not covered. HMO Plus plans Cost share of all services medically necessary and clinically appropriate to diagnose and treat involuntary infertility is 50% coinsurance of contracted prices. Medications prescribed for the treatment of infertility are covered at 50% of the contracted prescription cost. Does not apply to annual Out of Pocket max.
Lifetime Maximum	N/A	HMO plans: Not covered. HMO Plus plans Coverage is limited to three (3) cycles of Intrauterine Insemination (IUI) per Member's lifetime, and one (1) In-Vitro Fertilization (IVF) per Member's lifetime. Member's lifetime is defined as a recipient of Infertility Services including all treatments provided to the member under any health care coverage plan in which the Member participated.
Exclusions	-	Excludes ZIFT, ICSI, ovum microsurgery, and cryopreserved embryo transfers.
OPTIONAL RIDERS		
Optional Rider	Available to groups with 20+ eligible employees. For diagnosed Infertility, the following are covered benefits: • Artificial Insemination • Assisted Reproductive Technologies (ART) procedures (GIFT)	None available.
Cost	$15.09 per member per month	N/A
Rider Benefit	50% coinsurance (in network only).	N/A
Lifetime Maximum	• Artificial Insemination services up to a Lifetime maximum of three inseminations • Assisted Reproductive Technologies (ART) procedures up to a combined Lifetime maximum of three cycles for any combination of procedures. • Covered ART procedures are limited to Gamete Intrafallopian Transfer (GIFT)	N/A
Exclusions	• The collection, preservation or purchase of sperm, ova or embryos. • Services relating to cryo preservation. • Reversal of voluntary sterilization. • Surrogacy services or supplies. • ART procedures other than GIFT. • Procedures that are not covered include, but are not limited to, Assisted Hatching, blastocyst transfer, ICSI, TET, ZIFT, and other procedures that may be employed to bring about conception without sexual intercourse. • Any service, procedure or process that prepares the member for non-covered ART procedures. • Outpatient prescription drugs (may be available through a separate supplemental plan)	-

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	UNITEDHEALTHCARE
STANDARD COVERAGE	
Coverage Definition	<u>PPO Plans</u> Services for the treatment of infertility when provided by or under the direction of a Physician, limited to the following procedures: • Ovulation Induction • Insemination procedures (artificial insemination (AI), and intrauterine insemination (IUI)) • Assisted Reproductive Technologies (ART). • Pharmaceutical Products for the treatment of infertility that are administered on an outpatient basis in a Hospital, Alternate Facility, Physician's office, or in a Covered Person's home. <u>All other plans</u> Infertility services are not covered.
Benefit	<u>PPO Plans</u> Refer to plan coinsurance. Prescriptions covered under Specialty Prescription Drug benefit.
Lifetime Maximum	<u>PPO Plans</u> $2,000 per covered person.
Exclusions	<u>PPO Plans</u> • In vitro fertilitization that is not part of Assisted Reproductive Technology. • Cryo-preservation and other forms of preservation of reproductive materials. • Long-term storage of reproductive materials such as sperm, eggs, embryos, ovarian tissue and testicular tissue. • Donor services. Surrogate parenting, donor eggs, donor sperm and host uterus. • The reversal of voluntary sterilization.
OPTIONAL RIDERS	
Optional Rider	Available on all HMO plans. Coverage for basic diagnosis and treatment of infertility: • Insemination procedures, limited to 6 procedures per lifetime, unless the Member conceives, in which case the benefit renews. • Gamete Intrafallopian Transfer (GIFT). Benefits are limited to three (3) cycles or one live birth per lifetime. • Clomid used during the covered periods of infertility is covered as part of this Supplemental Benefit and is not a covered pharmaceutical through UnitedHealthcare's supplemental pharmacy coverage. • Injectable medications and syringes for the treatment of infertility are covered as part of this Supplemental Infertility Benefit and are not a covered pharmaceutical through UnitedHealthcare's supplemental pharmacy coverage. Coverage for injectable drugs other than the following will be reviewed based on medical necessity: Pergonal, Profasi, Metrodin, and Urofollitropin.
Cost	4.8% premium increase
Rider Benefit	50% coinsurance
Lifetime Maximum	N/A
Exclusions	Including but not limited to the following: • Advanced infertility procedures, as well as IVF, and ZIFT and procedures performed in conjunction with advanced infertility procedures, IVF, and ZIFT. • Intravenous Gamma Globulin (IVIG). • Infertility service after a previous elective vasectomy or tubal ligation, whether or not a reversal has been attempted or completed. Reversal of a previous elective vasectomy or tubal ligation. • All Medical and Hospital infertility services and supplies for a Member whose fertility is impaired due to an elective sterilization. This includes any supplies, medications, services and/or procedures used for an excluded benefit, e.g., ZIFT or IVF. • Treatment of sterility in which a donor ovum would be necessary (e.g., post-menopausal syndrome). • Microdissection of the zona or sperm microinjection.

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	WESTERN HEALTH ADVANTAGE
STANDARD COVERAGE	
Coverage Definition	Not covered.
Benefit	N/A
Lifetime Max	N/A
Exclusions	Infertility services to diagnose, evaluate or treat infertility are not covered.
OPTIONAL RIDERS	
Optional Rider	Available on all plans with 20+ eligible employees. • Services and supplies for diagnosis and treatment of involuntary infertility • Artificial insemination (except for donor semen or eggs, and services and supplies related to their procurement and storage), subject to a maximum of one treatment period of up to three (3) cycles per Lifetime+ • One Gamete Intra-Fallopian Transfer (GIFT) or In Vitro Fertilization per Lifetime+ • Medications for the treatment of Infertility • Genetic testing and counseling are covered benefits when medically indicated and are not subject to the Infertility Benefit copayments.
Cost	$12.50 per member per month
Rider Benefit	50% copay on services, supplies and medication; subject to limitations. Does not contribute to OOP max.
Lifetime Max	• Artificial insemination: 3 cycles per lifetime • GIFT or In Vitro Fertilization: 1 per lifetime "Lifetime" refers to services obtained during the member's life, including services provided under any other health insurance or HMO.
Exclusions	• The member must be diagnosed with "Infertility" as defined in the 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. • 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).

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CONTACT ANY OF OUR FULLY-STAFFED OFFICES:

San Mateo • Sacramento • Fresno • Los Angeles • Orange • San Diego

866.570.LISI (5474) • WWW.LISIBROKER.COM