Department of Origin: Integrated Healthcare Services	**Effective Date:** 03/20/24
Approved by: Chief Medical Officer	**Date Approved:** 03/14/24
Clinical Policy Document: Infertility Services	**Replaces Effective Clinical Policy Dated:** 03/14/23
Reference #: MP/I002	**Page:** 1 of 2

PURPOSE:
The intent of this clinical policy is to administer plan benefits for the diagnosis and treatment of infertility.

Please refer to the member's benefit document for specific information. To the extent there is any inconsistency between this policy and the terms of the member's benefit plan or certificate of coverage, the terms of the member's benefit plan document will govern.

POLICY:
Benefits must be available for health care services. Health care services must be ordered by a provider. Health care services must be medically necessary, applicable conservative treatments must have been tried, and the most cost-effective alternative must be requested for coverage consideration.

COVERAGE:

I. Coverage includes the professional services necessary to diagnose infertility and the related tests, facility charges, and laboratory work, such as, but not limited to, diagnostic radiology, laboratory services, semen analysis, and diagnostic ultrasounds, related to *covered services*.

II. When *infertility* treatment is a covered benefit, it includes, but is not limited to, artificial insemination (AI) and intrauterine insemination (IUI) procedures and/or prescription drugs.

   A. When covered, it is limited to a total of six cycles per confirmed pregnancy.

   B. A cycle is defined as one partial or complete fertilization attempt extending through the implantation phase only. Any attempt using artificial insemination, intrauterine insemination, and/or prescription drugs will be applied to the six-cycle maximum. If the member abandons a treatment regimen before the cycle is complete, the partial cycle is counted as one of the six cycles.

   C. Pregnancy must be confirmed by a live birth, an ultrasound, or by a spontaneous abortion/miscarriage documented by a pathology report.

   D. When covered, benefits will be renewed if successful pregnancy is attained.

III. No restriction is placed on the choice of a member as to where the member receives services related to the diagnosis of *infertility*.

IV. *Infertility* services for the spouse are not covered if he or she is not an eligible member of the applicable plan.

V. Medications used for the treatment of *infertility* are subject to the member's prescription drug services benefits.

EXCLUSIONS (not limited to):
Refer to member's Certificate of Coverage or Summary Plan Description

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Reference #: MP/I002	**Page:** 2 of 2

DEFINITIONS:

Covered Services:
Health care services that are provided by your provider or clinic and are covered by the Plan, subject to all of the terms, conditions, limitations and exclusions of the Plan.

Infertility:
Inability to become pregnant after the following periods of time of regular unprotected intercourse or therapeutic donor insemination:

1. One year, if member is a female under age 35 or a male of any age; or
2. Six months, if member is a female age 35 or older, provided that the infertility is not related to voluntary sterilization or failed reversal of voluntary sterilization; or

Inability or diminished ability to produce offspring, including but not limited to a woman's repeated failure to carry a pregnancy to fetal viability. Repeated failures to carry a pregnancy to fetal viability means three consecutive documented spontaneous abortions in the first or second trimester. Such inability must be documented by the member's provider.

Infertility Treatment/Fertility Treatment:
Health care service that is intended to (1) promote or preserve fertility; or (2) achieve and maintain a condition of pregnancy. For purposes of this definition, infertility treatment or fertility treatment includes, but is not limited to:

1. Fertility tests and prescription drugs.
2. Tests and exams done to prepare for or follow through with induced conception.
3. Surgical reversal of a sterilized state that was a result of a previous surgery.
4. Sperm enhancement procedures.
5. Direct attempts to cause or maintain pregnancy by any means, including, but not limited to: Hormone therapy or prescription drugs; artificial insemination; in vitro insemination; GIFT or ZIFT; embryo transfer; and freezing and/or storage of embryo, eggs, or semen.

REFERENCES:

1. Integrated Healthcare Services Process Manual UR015 Use of Medical Policy and Criteria
2. Clinical Policy: Coverage Determination Guidelines (MP/C009)
3. Clinical Policy: Genetic Testing, Hereditary and Somatic Conditions (MP/G001)
4. Clinical Policy: Investigative Services (MP/I001)
5. Clinical Policy: Genetic Testing, Preimplantation Genetic Diagnosis (MC/L026)
6. Clinical Policy: Genetic Testing, Reproductive Carrier Screening (MC/L017)
7. Pharmacy Policy: Quantity Limits (PP/Q003)

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Nondiscrimination & Language Access Policy

Aspirus Health Plan, Inc. complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, sexual orientation, or gender identity. *We* do not exclude people or treat them differently because of race, color, national origin, age, disability, sex, sexual orientation, or gender identity.

We will:
Provide free aids and services to people with disabilities to communicate effectively with us, such as:
- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)

Provide free language services to people whose primary language is not English, such as:
- Qualified interpreters
- Information written in other languages

If *you* need these services, contact *us* at the phone number shown on the inside cover of this *contract*, *your* id card, or aspirushealthplan.com.

If *you* believe that *we* have failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sex, sexual orientation, or gender identity, *you* can file a grievance with:

Nondiscrimination Grievance Coordinator
Aspirus Health Plan, Inc.
PO Box 1062
Minneapolis, MN 55440
Phone: 1.866.631.5404 (TTY: 711)
Fax: 763.847.4010
Email: customerservice@aspirushealthplan.com

You can file a grievance in person or by mail, fax, or email. If *you* need help filing a grievance, the Nondiscrimination Grievance Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Language Assistance Services

Albanian: KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë.Telefononi në 1.866.631.5404 (TTY: 711).

Arabic تنبيه: إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية متاحة لك مجاناً . اتصل بن اعلى رقم الهاتف 1.866.631.5404(رقم هاتف الصم والبك : 711)

French: ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelezle 1.866.631.5404 (ATS : 711).

German: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zurVerfügung. Rufnummer: 1.866.631.5404 (TTY: 711).

Hindi: _यान द_: य_द आप ि◌हंदी बोलते ह_ तो आपके ि◌लए मु_त म_ भाषा सहायता सेवाएं उपल_ध ह_। 1.866.631.5404 (TTY: 711) पर कॉल कर_।

Hmong: LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1.866.631.5404 (TTY: 711).

Korean: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1.866.631.5404 (TTY: 711)번으로 전화해 주십시오.

Polish: UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1.866.631.5404 (TTY: 711).

Russian: ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода.Звоните 1.866.631.5404 (телетайп: 711).

Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1.866.631.5404 (TTY: 711).

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nangwalang bayad. Tumawag sa 1.866.631.5404 (TTY: 711)

Traditional Chinese: 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請 致電 1.866.631.5404 (TTY:711).

Vietnamese: CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1.866.631.5404 (TTY: 711).

Pennsylvania Dutch: Wann du Deitsch (Pennsylvania German / Dutch) schwetzscht, kannscht du mitaus Koschte ebbergricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 1.866.631.5404 (TTY: 711).

Lao: ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ,ໂດຍບໍ່ເສັ້ງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1.866.631.5404 (TTY:711).