Benefit Payment Guidelines are developed by HealthyCT to assist in administering plan benefits and constitute neither offers of coverage nor medical advice. This Guideline may contain only a partial, general description of plan or program benefits and does not constitute a contract. This Guideline may be updated and therefore is subject to change.

Infertility Benefit Payment Guideline 2016

Infertility
(Artificial Insemination, IVF, GIFT, ZIFT)

Benefit Policy Statement:
Per Public Act 05-196 ("Act") - An Act Concerning Health Insurance Coverage for Infertility

This Act defines infertility as, "the condition of a presumably healthy individual who is unable to conceive or produce conception or sustain a successful pregnancy during a one year period".

HCT covers the medical necessary expenses for the diagnosis of infertility for both males and females

HCT provides coverage for medically necessary expenses for the treatment of infertility including, but not limited to, ovulation induction, intrauterine insemination, in-vitro fertilization, uterine embryo lavage, embryo transfer, gamete intra-fallopian transfer, zygote intra-fallopian transfer and low tubal ovum transfer.

HealthyCT can apply policy limitations, maximums and requirements that are not in conflict with the Act.

The benefit limits, as per the Act, include:
1. Ovulation induction (to a maximum of four cycles);
2. Intrauterine insemination (to a maximum of three cycles per recipient, regardless of source);
3. Uterine embryo lavage, in-vitro fertilization (IVF), gamete intra-fallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT) or low tubal ovum transfer (to a maximum of two cycles combined for all procedures, with not more than two embryo implantations per cycle). These cycles are only covered when the Member has been unable to conceive or produce conception or sustain a successful pregnancy through the less expensive and medically appropriate treatments covered by HealthyCT.
4. Limit coverage for in-vitro fertilization, gamete intra-fallopian transfer, zygote intra-fallopian transfer and low tubal ovum transfer to those individuals who have been unable to conceive or produce conception or sustain a successful pregnancy through less expensive and medically viable infertility treatment or procedures.

Infertility treatment or procedures must be performed at facilities that conform to the standards and guidelines developed by the American Society of Reproductive Medicine or the Society of Reproductive Endocrinology and Infertility;
Benefit Policy Guidelines:

Summary

<table>
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<tr>
<th>Service</th>
<th>Coverage Limitations</th>
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| Infertility treatment                        | • Member was unable to achieve pregnancy after 12 months of unprotected intercourse  
• The condition of a presumably healthy individual who is unable to conceive or produce conception or sustain a successful pregnancy during a one year period                                                                                                                                       |
| Diagnosis and treatment of the underlying medical condition causing the infertility | • Payable in accordance with the type of expense incurred and the place where the service is provided.                                                                                                                                                                                                                                                   |
| Artificial Insemination (IUI)                 | • 3 cycles                                                                                                                                                                                                                                                                                                                                          |
| Ovulation Induction                          | • 4 cycles                                                                                                                                                                                                                                                                                                                                          |
| In-vitro fertilization (IVF), gamete intra-fallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT) or low tubal ovum transfer | • 2 cycles combined for all procedures  
• No more than two embryo implantations per cycle  
• Only used if unable to conceive or produce conception or sustain a successful pregnancy through less expensive and medically viable infertility treatment or procedures.                                                                                                                                                                                                 |
| Procurement, processing, and temporary storage (associated with each IVF attempt) of donor sperm. | • Only covered while the member is in active infertility treatment.                                                                                                                                                                                                                   |

Infertility Criteria:  
Definition of infertility: the condition of a presumably healthy individual who is unable to conceive or produce conception or sustain a successful pregnancy during a one year period

Note: Women who have had a tubal ligation are not eligible for infertility treatments since she does not meet the definition of infertility: the condition of a presumably healthy individual who is unable to conceive or produce conception or sustain a successful pregnancy during a one year period

Preimplantation Genetic Diagnosis (PGD) (requires PA)  
PGD involves analysis of biopsied cells as part of an assisted reproductive procedure. Preimplantation genetic diagnosis (PGD) is used to detect a specific inherited disorder and aims to prevent the birth of affected children in couples at high risk of transmitting a disorder. PGD is covered when one or more genetic parents carry a gene mutation or a balanced chromosomal rearrangement and testing is performed to determine whether that specific mutation or an unbalanced chromosomal complement has been transmitted to the oocyte or embryo.
Preimplantation Genetic Screening for Aneuploidy (not covered)
The term "preimplantation genetic screening" (PGS) applies when the genetic parents are known or presumed to be chromosomally normal and their embryos are screened for aneuploidy. This is used in conjunction with in vitro fertilization.

Per ACOG’s Committee on genetics:
ABSTRACT: Preimplantation genetic screening differs from preimplantation genetic diagnosis for single gene disorders and was introduced for the detection of chromosomal aneuploidy. Current data does not support a recommendation for preimplantation genetic screening for aneuploidy using fluorescence in situ hybridization solely because of maternal age. Also, preimplantation genetic screening for aneuploidy does not improve in vitro fertilization success rates and may be detrimental. At this time there are no data to support preimplantation genetic screening for recurrent unexplained miscarriage and recurrent implantation failures; its use for these indications should be restricted to research studies with appropriate informed consent.

Artificial Insemination (IUI)
Used for infertile couples with mild male-factor fertility problems, unexplained infertility problems, minimal to mild endometriosis, low sperm count, low sperm motility, medically refractory erectile dysfunction or vaginismus preventing intercourse, couples where the man is HIV positive and undergoing sperm washing, or couples undergoing menotropin (human menopausal gonadotropin or hMG) ovarian stimulation.
Note: See sperm washing under IVG

Assisted Reproductive Technologies (ART)
I. In Vitro Fertilization (IVF);
II. Zygote Intrafallopian Transfer (ZIFT);
III. Gamete Intra-Fallopian Transfer (GIFT); and
IV. Intracytoplasmic Sperm Injection (ICSI); or Ovum Microsurgery
V. Microsurgical Epididymal Sperm Aspiration (MESA) and Testicular Sperm Aspiration (TESA)
VI. Assisted Hatching and Mechanically Assisted Fertilization (MAF)

The definition of ART according to the American Society of Reproductive Medicine (ASRM) and the Center for Disease Control (CDC) is fertility treatment in which both eggs and sperm are handled. An ART cycle is a process over an interval of approximately 2 weeks, rather than a procedure at a single point in time, in which: (1) an ART procedure is carried out; or (2) a woman has undergone ovarian stimulation or monitoring with the intent of having an ART procedure; or (3) frozen embryos have been thawed with the intent of transferring them to a woman. A cycle begins when a woman begins taking fertility drugs or having her ovaries monitored for follicle production.
A canceled cycle (incomplete cycle) is an ART cycle in which ovarian stimulation was carried out but which was stopped before eggs were retrieved, or in the case of frozen embryo cycles, before embryos were transferred. This is not counted as a cycle for purposes of determining the benefit.

I. In Vitro Fertilization (IVF)

IVF involves controlled ovarian hyperstimulation, which is aimed at producing multiple oocytes. Once the oocytes are mature, human chorionic gonadotropin (hCG) is administered, and 34 to 36 hours later they are retrieved under ultrasound guidance with the patient under light general anesthesia. The oocytes are then combined with sperm in a Petri dish to allow for fertilization. The embryos are incubated in growth medium and then transferred back into the female partner’s uterus three to five days later.

Sperm Washing and Preparation Techniques for Artificial Insemination and IVF (covered):
Sperm washing is a form of sperm preparation that is required prior to intrauterine insemination or IVF because it removes chemicals from the semen, which may cause adverse reactions in the uterus. During the sperm washing process sperm is separated from the seminal fluid. This procedure enhances the fertilizing capacity of the sperm and is thus recommended in cases with immune system disorders, male-factor or unexplained infertility.

II. Zygote Intrafallopian Transfer (ZIFT)

This procedure is usually performed when there is a need to document fertilization because of male factor infertility. Zygote Intrafallopian transfer (ZIFT) or In Vitro Fertilization with Pronuclear Stage Embryo Transfer (PROST) - in some cases it is desirable to document that fertilization is taking place (which is not known when GIFT is done unless pregnancy results). As with GIFT or IVF, ovaries are stimulated to produce multiple eggs, which are retrieved with ultrasound guidance. Fertilization is accomplished in vitro when one pronucleus contains the genetic material from the sperm and the other pronuclear containing the genetic material from the oocyte fuse into a one cell zygote. Normal fertilization is confirmed by observation of two pronuclei. Shortly after normal fertilization is confirmed, the embryos are loaded into a catheter and transferred to the fallopian tube by laparoscopy.

III. Gamete Intrafallopian Transfer (GIFT)

The GIFT procedure is similar to IVF. With GIFT, however, fertilization occurs in the body, as opposed to IVF where fertilization occurs outside the body in a Petri dish. Ovaries are stimulated to produce multiple eggs, which are retrieved with ultrasound guidance. Eggs and sperm are transferred to the Fallopian tube by laparoscopy immediately following aspiration of all follicles. A catheter is threaded into the outer opening of the tube, into which up to four mature eggs and 300,000 motile sperm are deposited. If the number of mature eggs retrieved exceeds the desired number for the GIFT procedure, the extra eggs may be inseminated in vitro and resulting embryos can be frozen for a future treatment cycle.

IV. Intracytoplasmic Sperm Injection (ICSI)

Used to improve fertilization in couples with male factor infertility undergoing IVF or in couples with fertilization failure in a prior IVF cycle without detectable abnormalities of semen parameters.
The routine use of ICSI for all oocytes does not appear to be justified in cases without male factor infertility or a history of prior fertilization failure based on available evidence.

V. Microsurgical Epididymal Sperm Aspiration (MESA) and Testicular Sperm Aspiration (TESA)
HCT considers microsurgical epididymal sperm aspiration medically necessary for congenital absence or congenital obstruction of the vas deferens only. It is not covered status-post vasectomy or attempted/actual reversal of vasectomy.

VI. Assisted Hatching and Mechanically Assisted Fertilization (MAF)
Assisted hatching is covered to improve embryonic implantation rates in women who:
- Have thick zona pellucidae or
- Have failed to achieve embryonic implantation after several IVF cycles

The embryo is surrounded by a soft shell called the zona pellucida. The zona pellucida protects the embryo during early development. As the embryo develops, the zona pellucida thins. The embryo must hatch out of the zona pellucida prior to implantation into the uterine wall. It has been suggested that some unsuccessful cycles of assisted reproduction are due to the inability of the embryo to hatch out of the zona pellucida or delayed hatching which prevents the embryo from subsequently implanting into the uterine wall during the implantation "window of opportunity". Assisted hatching is a form of embryo micromanipulation in which a small hole is created in the zona pellucida of the embryo to enhance the probability of achieving pregnancy. In addition, hatching can be achieved by thinning the zona with chemicals.

Mechanically Assisted Fertilization (MAF) may be performed as part of an IVF procedure. Such procedures include an intracytoplasmic sperm insertion (ICSI).

LOB:
Commercial – On exchange and off exchange
- Large group
- Small group
- Individual

Exclusions/Limitations
Not covered per the member’s certificate of Coverage:
- Any Assisted Reproductive Technology (ART) procedure or related treatments that HCT deems experimental or investigative;
• All other genetic testing services, as well as genetic testing panels not endorsed by ACOG or ACMG;

• Genetic testing kits available either direct to the consumer or via a physician prescription;

• Home ovulation prediction kits or home pregnancy tests;

• Genetic testing only for the benefit of another family member;

• Genetic testing to guide personalized medicine: Preimplantation Genetic Diagnosis (PGD) to select embryos with particular traits, such as; sex selection, personality traits, physical traits and sexual orientation; unless the sex of the embryo is related to a particular birth defect such as a risk for an x-linked disorder

• Recruitment, selection and screening and any other expenses of donors (donors of eggs, embryos or sperm); examples:
  o the purchase of donor sperm and any charges for the storage of sperm;
  o the purchase of donor eggs
  o any charges associated with care of the donor required for donor egg retrievals or transfers
  o thawing of cryopreserved eggs, embryos, or sperm
  o fees associated with donor egg programs
  o donor egg retrieval or, including but not limited to fees for laboratory tests and thawing

• Cryopreservation (freezing) or banking of eggs, embryos, or sperm;

• Drugs and devices for sexual dysfunction;

• Reversal of surgical sterilization;

• Pre Implantation Genetic Screening (PGS) to screen for potential genetic abnormalities in conjunction with in vitro fertilization for couples without a specific known inherited disorder

• Surrogacy and all charges associated with surrogacy such as prescription drugs or egg harvesting, fertilization or implantation, except when the egg harvesting is performed on the Member.

Not a covered benefit per the definition of infertility as defined in the Per Public Act 05-196 ("Act") - An Act Concerning Health Insurance Coverage for Infertility. The definition is: the condition of a presumably healthy individual who is unable to conceive or produce conception or sustain a successful pregnancy during a one year period

• Infertility treatment requested solely for the convenience, lifestyle, personal or religious preference of the member in the absence of medical necessity;

• Intrauterine insemination (IUI) or Assisted Reproductive Technology (ART) in the absence of male factor infertility or the absence of a male partner, until the female meets the definition of infertility;
- Coverage of infertility services for persons who have undergone sterilization. This would include sperm retrieval for men who have undergone vasectomy and women who have undergone tubal ligation.

- The routine use of ICSI for all oocytes does not appear to be justified in cases without male factor infertility or a history of prior fertilization failure based on available evidence;

- MESA and TESA It is not covered status-post vasectomy or attempted/actual reversal of vasectomy.

References
3. The members Certificate of Coverage

Document History
<table>
<thead>
<tr>
<th>Date</th>
<th>Description</th>
</tr>
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<tbody>
<tr>
<td>7/8/2015</td>
<td>Initial Version</td>
</tr>
<tr>
<td>1/1/2016</td>
<td>Removed age limitation as per Bulletin HC-104: requiring carriers to remove the age limits on infertility benefits for policies issued or renewed on or after January 1, 2016.</td>
</tr>
<tr>
<td>6/28/2016</td>
<td>Annual Review. No new changes</td>
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