Assisted Reproductive Technology (ART) Benefit FAQ

What is the ART benefit?

Eligible insured members on a County medical plan may receive:

- Up to a $4,000 reimbursement for qualified Assisted Reproductive Technology (ART) expenses

Who is eligible?

To qualify, members must:

- Be enrolled in a County medical plan with ART as a covered benefit (see your Benefits Summary for details)
- Meet age requirements:
    - Under age 40 if using own oocytes (eggs)
    - Under age 46 if using donor oocytes — donor must be under age 36
- Not be using a surrogate
- Not receive coverage for donor charges (however, once an embryo is created, the qualifying ART procedure becomes eligible)

Eligible individuals include the subscriber, spouse, and dependent children.

Note - This benefit is not eligible for members who are incapable of bearing a child through lack of female reproductive organs, members who are post-menopausal or have premature ovarian failure (and would require donor eggs), members requesting another person become pregnant with the member's embryo, or members requesting this benefit for reasons other than infertility.

What procedures are covered?

Coverage is limited to single embryo/gamete/zygote transfers:

- In Vitro Fertilization (IVF), including:
    - Intracytoplasmic sperm injection (ICSI)
    - Frozen embryo transfer (FET)
- Gamete intrafallopian transfer (GIFT) — criteria must be met

- Zygote intrafallopian transfer (ZIFT), Tubal embryo transfer (TET), Pronuclear stage tubal embryo transfer (PROUST) — criteria must be met
- Specialized sperm retrieval procedures such as:
    - MESA, PESA, TESA, TESE, TEFNA

Are there restrictions?

Yes:

- Only one embryo may be transferred per attempt
- Surrogates are not eligible
- Donor expenses are not covered (until embryo exists)
- Member must be capable of bearing a child and have female reproductive organs
- Services must be rendered through a designated provider

How does reimbursement work?

- Members pay the clinic up front
- Clinic submits:
    - Receipt confirming member's payment
    - Physician Verification Form
    - Procedure note documenting single embryo transfer
- Reimbursement is issued directly to the member
- Claims are processed under the patient receiving services

Is pre-authorization required?

Yes.

- Must use a designated, in-network ART provider
- Provider submits verification and proof of payment before claim processing

Is there a limit on attempts?

No. There are no lifetime attempt limits.

However:

- Benefit is paid once per attempt
- $4,000 max per attempt, even if dual coverage exists

Can multiple eggs be fertilized?

Yes. Members may harvest and fertilize multiple oocytes, but:

- Only one embryo may be transferred per attempt

Can the benefit be used for embryo storage?

Yes. Storage costs are included within the $4,000 maximum.

Are experimental procedures covered?

Only procedures listed under covered ART services qualify. Anything experimental or not best practice is excluded.

Are services required to be in-network?

Yes. This benefit is limited to designated in-network providers.

What services are excluded?

Common exclusions include:

1. Multiple-embryo transfers
2. ART procedures completed before the medical carrier receives verification forms
3. Surrogacy and donor-related charges
4. Situations where infertility is not the reason for treatment

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This FAQ is intended to address common questions about the Assisted Reproductive Technology (ART) benefit. For specific questions or unique circumstances, please contact your medical carrier and review the Summary Plan Document (SPD). If there is any discrepancy between this document and the official plan documents, the plan documents will prevail.