2023 Blue Cross and Blue Shield Service Benefit Plan - Standard and Basic Option
Section 5. Benefits
Section 5(a). Medical Services and Supplies Provided by Physicians and Other Healthcare Professionals
Reproductive Services

Note: For Standard Option, we state whether or not the calendar year deductible applies for each benefit listed in this Section. There is no calendar year deductible under Basic Option.

Benefit Description

Reproductive Services
Diagnosis and treatment of infertility including covered:

- Diagnostic and treatment services
- Laboratory tests
- Diagnostic tests
- Surgical procedures
- Prescription drugs

Note: We cover one year of sperm and egg storage for individuals facing iatrogenic infertility, once per lifetime. We provide the benefits seen here when billed by a facility. See page 22 for prior approval requirements. See Section 10 for our definition of iatrogenic infertility.

Note: See Section 5(a) for covered labs, diagnostic tests, and X-rays.

Note: See Section 5(b) for covered surgical services.

Note: See Section 5(f) for covered prescription drugs.

Note: See below for a list of services not covered as treatments for infertility or as alternatives to conventional conception.

Standard Option - You Pay
Preferred: 15% of the Plan allowance (deductible applies)

Participating: 35% of the Plan allowance (deductible applies)

Non-participating: 35% of the Plan allowance (deductible applies), plus any difference between our

allowance and the billed amount

Basic Option - You Pay
Preferred primary care provider or other healthcare professional: $30 copayment per visit

Preferred specialist: $40 copayment per visit

Note: You pay 30% of the Plan allowance for sperm and egg storage, agents, drugs, and/or supplies administered or obtained in connection with your care. (See page 152 for more information about "agents.")

Participating/Non-participating: You pay all charges (except as noted below)

Note: For services billed by Non-participating laboratories or radiologists, you pay any difference between our allowance and the billed amount.

Benefit Description
The services listed below are not covered as treatments for infertility or as alternatives to conventional conception:

- *Assisted reproductive technology (ART) and assisted insemination procedures, including but not limited to:*
    - *Artificial insemination (AI)*
    - *In vitro fertilization (IVF)*
    - *Embryo transfer and gamete intrafallopian transfer (GIFT) and zygote intrafallopian transfer (ZIFT)*
    - *Intravaginal insemination (IVI)*
    - *Intracervical insemination (ICI)*
    - *Intracytoplasmic sperm injection (ICSI)*
    - *Intrauterine insemination (IUI)*
- *Services, procedures, and/or supplies that are related to ART and/or assisted insemination procedures*
- *Cryopreservation or storage of sperm (sperm banking), eggs, or embryos except as described above*

- *Preimplantation diagnosis, testing, and/or screening, including the testing or screening of eggs, sperm, or embryos*
- *Drugs used in conjunction with ART and assisted insemination procedures*
- *Services, supplies, or drugs provided to individuals not enrolled in this Plan*

Standard Option - You Pay
All charges

Basic Option - You Pay
All charges