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California Health Care Coverage Summary: Treatment for Infertility Including In Vitro Fertilization

California Senate Bill (SB) 729 expands required coverage for infertility diagnosis and treatment, including in vitro fertilization (IVF), for certain health plans.

- Prior law: Required coverage for infertility diagnosis and treatment but excluded IVF.
- SB 729: Removes the IVF exclusion and establishes minimum coverage standards for certain fully insured health plans..
- Fully insured large group health plans, including disability policies, must provide coverage for the diagnosis and treatment of infertility and fertility services including coverage for IVF.
 - Includes at least three attempts to collect/retrieve sperm and three completed oocyte retrievals, with unlimited embryo transfers (single embryo transfer when recommended).
- Fully insured small group health plans including disability policies may offer coverage for diagnosis and treatment of infertility and fertility services including coverage for IVF, when purchased.
 - According to guidance from the California Department of Managed Health Care, minimum retrieval and storage periods differ for small group fully insured products, at least one attempt to collect/retrieve sperm and oocytes must be included when coverage is purchased.
 - Rider “adds” fertility/IVF benefits to the plan. Without the rider, a small group plan may not include IVF coverage.
- The requirements do not apply to ASO plans, specialized plans, or religious employer’s groups.

Effective Dates

The following distinction is critical and must be applied consistently:

- **CA-situs fully insured large group policies:**
UnitedHealthcare has implemented coverage as a Benefit Standard for plans new or renewing on or after **July 1, 2025**
- **Non-California situs policies covering California residents (extraterritorial application):**
Coverage is required beginning **January 1, 2026**, consistent with SB 729

These effective dates apply to different scenarios and should not be used interchangeably.

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Rev June 1, 2026

- Effective January 1, 2026, fully insured small group plans in California, fertility benefits will be available for policies that are new or renewing only if the optional infertility rider is purchased.

Key Points for SB 729 law

- Under SB 729, coverage for infertility diagnosis and treatment, including IVF, is required for fully insured, large group plans issued, amended, or renewed on or after January 1, 2026. UnitedHealthcare has implemented this requirement earlier as a Benefit Standard effective for large group California-situs policies that are new or renewing on or after 7/1/2025.
- Effective January 1, 2026, fully insured small group plans in California, fertility benefits will be available for policies that are new or renewing only if the optional infertility rider is purchased.
- Ends the prior exclusion of IVF from required coverage for applicable plans.

Where clinically appropriated, large group fully insured plans are required to cover:

- At least three (3) completed oocyte retrievals, and
- At least three (3) sperm collection/retrieval attempts
- Plans may apply lifetime limits, provided they are not less than these minimum requirements.

Embryo transfers are not subject to a numerical limit when performed in accordance with clinical guidelines, including single embryo transfer when medically appropriate and consistent with ASRM guidelines.

Small group: If coverage is offered, benefit design must comply with applicable regulatory guidance. Retrieval minimums and storage requirements may differ from large group requirements.

- Services obtained under small group or other non-DMHC-regulated coverage do not count toward DMHC-regulated large group lifetime limits..
- Prohibits discrimination in infertility and fertility coverage based on protected characteristics, including sexual orientation, gender identity, and marital status.
- Insurance contracts may not put extra restrictions (exclusions, limitations, deductibles, copays, benefit maximums, waiting periods or other restrictions) on fertility services, treatment, diagnosis, or medications that are more restrictive than those applied to other covered services or prescriptions.
- Coverage cannot be denied for infertility services that involve sperm donors, egg donors, or surrogates when medically necessary.
- Coverage cannot be denied based on “a covered individual’s participation in fertility services provided by or to a third party.”

Key Points for UHC approach

- Coverage for IVF aligns with the group’s plan year, not calendar year.
- Infertility injectable medications, will be paid under the pharmacy benefit and will be subject to the applicable pharmacy benefit cost-sharing requirements. Oral medications are already processed under the pharmacy benefit.
- Specific Group exemption for CalPERS until 2027.

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Rev June 1, 2026

Note: LACERA does not have a specific exemption and should follow the Benefit Standard requirements unless otherwise indicated.

- Self-insured (ASO) groups are not required by law to provide the IVF benefit.
- UnitedHealthcare encourages members to use Fertility Solutions (Centers of Excellence (CoE)) to access infertility nurses, guidance, and a network of fertility Centers of Excellence.
 - A list or link to verified Centers of Excellence will not be made available as it is proprietary in nature.

Questions and Answers

Overview of SB 729 law

When will the small and large groups plans include the new coverage for fertility or infertility?

- **CA-situs fully insured large group policies:**
UnitedHealthcare has implemented coverage as a Benefit Standard for plans new or renewing on or after **July 1, 2025**
- **Non-California situs policies covering California residents (extraterritorial application):**
Coverage is required beginning **January 1, 2026**, consistent with SB 729

These effective dates apply to different scenarios and should not be used interchangeably.

- Effective January 1, 2026, fully insured small group plans in California, fertility benefits will be available for policies that are new or renewing only if the optional infertility rider is purchased.

Feature	Large Group Plans (101+ employees)	Small Group Plans (≤100 employees)
Coverage Requirement	Benefit Standard	Optional Infertility Rider (may be offered but is not required)
Infertility Diagnosis	Covered	Optional Infertility Rider (may be offered but is not required)
IVF Coverage	Covered	Optional Infertility Rider (may be offered but is not required)
Semen/Egg Retrievals	At least three (3) completed oocyte retrievals and three (3) sperm collection/retrieval attempts (lifetime maximums)	Offered if employer opts in/purchases the optional infertility rider - subject to plan terms
Embryo Transfers	Not subject to a numerical limit when performed in accordance with clinical guidelines, including ASRM recommendations	Offered if employer opts in/purchases the optional infertility rider - subject to plan terms

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Rev June 1, 2026

Cost-Sharing Rules	Cannot impose higher cost-sharing than other medical services	If included, must follow same cost-sharing rules as place of service
Effective Date	New and renewing CA-situs large group plans on or after July 1, 2025 New and renewing non-California situs policies covering California residents on or after January 1, 2026,	Offered for new and renewing plans as of January 1, 2026, if the group has purchased the infertility rider

What services are covered under SB 729 for members?

Coverage for diagnosis and treatment of infertility and fertility services. Additionally, members will have access to:

- In vitro fertilization for 3 attempts to procure semen/oocytes/embryos retrievals per lifetime and unlimited embryo transfers.
- Unlimited embryo transfers using single embryo transfer when recommended and medically appropriate.
- The American Society for Reproductive Medicine (ASRM) guidelines apply.
- Artificial insemination
- Allows for sperm donors, egg donors, or surrogates.
- Includes medically necessary services to enable use of donor gametes/embryos and surrogate services (e.g., procurement of donor semen/oocytes/embryos, testing, screening, transfer), subject to retrieval attempt limits and other APL provisions.
- Prohibits discrimination in coverage for medical and disability plans based on age, ancestry, color, disability, domestic partner status, gender, gender expression, gender identity, genetic information, marital status, national origin, race, religion, sex, or sexual orientation.
- Removes extra restrictions (for example: exclusions, limitations, deductibles, copays, benefit maximums, waiting periods or other restrictions) on fertility services, treatment, diagnosis, or medications that aren't imposed on other services or prescriptions.
- Allows a covered individual's participation in fertility services provided by or to a third party.

What does California SB 729 do?

1) Large fully insured group health plan contracts, including disability insurance policies.

Plans must

- Provide coverage for the diagnosis and treatment of infertility and fertility services.
- At least three completed oocyte or semen retrievals for large group products. Plans may set this as a lifetime limit. Embryo transfers remain unlimited using single embryo transfer when clinically appropriate.
- The American Society for Reproductive Medicine (ASRM) guidelines apply.

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2) **Small group health plan contracts including disability insurance policies.** Benefit design must comply with applicable regulatory guidance; requirements may differ from large group standards. Plans may

- Offer coverage for the diagnosis and treatment of infertility and fertility services.
- The American Society for Reproductive Medicine (ASRM) guidelines apply.

What are the rules for lifetime limits?

Large group: plans may impose lifetime limits not less than three attempts for sperm collection/retrieval and oocyte retrievals, and not less than five years for cryopreservation storage.

Small group: plans may not impose lifetime limits. Services obtained under small group or other non-DMHC large group coverage do not count toward DMHC-regulated large group lifetime limits.

How do the requirements apply to large and small group plans?

Large group products must cover the diagnosis and treatment of infertility, including at least three attempts to collect/retrieve sperm and three completed oocyte retrievals, with unlimited embryo transfers (single embryo transfer when recommended).

Small group products must offer coverage when purchased; minimum retrieval and storage periods do not apply to small group products, except that at least one attempt to collect/retrieve sperm and oocytes must be included.

What is the optional infertility rider (IVF rider) that is available to small groups?

An infertility rider (IVF rider) is an optional add-on to a health insurance plan that provides coverage for infertility treatment, including in vitro fertilization (IVF), when that coverage is not automatically included in the base plan.

In the context of the FAQ:

- For California fully insured small group plans, IVF/infertility coverage is not automatically required the same way it is for large group plans.
- Beginning January 1, 2026, small group plans may offer fertility benefits only if the employer purchases the optional infertility rider.
- The rider essentially “adds” fertility/IVF benefits to the plan.
- Without the rider, a small group plan may not include IVF coverage.

A few key distinctions:

CA fully insured large group plans: IVF coverage is required as part of the benefit standard; it is not optional in the same way.

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Rev June 1, 2026

CA fully insured small group plans: IVF/fertility coverage is available only if the employer purchases the optional infertility rider (IVF rider).

Non-CA situs policies covering CA residents: The California mandate may still apply starting Jan. 1, 2026, but only for fully insured large group plans when the extraterritorial criteria are met. The California IVF benefit can apply beyond employees physically located in California, but it depends on the policy situs and effective date.

ASO/self-funded plans: The CA mandate does not apply.

**the rider itself is mainly relevant to California small group fully insured plans; the broader IVF mandate applies in specific California-related fully insured large group situations.

Are any groups exempt from the California SB 729 law?

The law does provide an exemption for certain groups, including a religious employers or other specialized health care plan service contracts. Specific Group exemption for CalPERS until July 2027

Does SB 729 apply to self-funded or level funded/alternate funded groups?

Fully insured plans are required to follow state insurance laws.

Self-funded health care plans including Level Funded plans are exempt from state law and employers do not have to follow the California SB 729 insurance law.

Does California IVF mandate apply to employers situs outside California?

California's IVF mandate includes an extraterritorial component. Members must meet **all** of the following criteria:

- California resident
- Enrolled in a fully insured large group plan
- Plan is new or renewing on or after January 1, 2026

How should brokers guide members with questions about eligibility?

If the extraterritorial criteria are met, the member may qualify for coverage under California's IVF mandate even when the employer is headquartered outside California.

- Brokers should direct members to contact Member Services, as eligibility determinations are member- and plan-specific.
- Member Services will review residency status, plan funding, and renewal date to determine eligibility.
- If a member meets eligibility requirements Member Services will refer the member to Fertility Solutions who complete the evaluation, confirm medical criteria, and support the member throughout the process including care coordination.

Does the provider or facility have to be located in California?

No. The provider is not required to be located in California for the coverage to apply based on plan benefits.

For cryopreservation storage, plans may use an out-of-state storage vendor if the vendor holds a California Department of Public Health human tissue bank license..

At this time, is SB 729 considered an Essential Health Benefit (EHB)?

No. Therefore, annual and lifetime dollar limits are permitted.

Are there dollar limits for IVF retrieval or for treatment or diagnosis?

No. However, for large group products, plans may impose lifetime limits on attempts to collect/retrieve sperm and on completed oocyte retrievals (not less than three), and a lifetime limit on cryopreservation storage duration (not less than five years).

SB 729 mandates unlimited embryo transfers, including using single embryo transfer when recommended and **medically appropriate**.

Transfers are in accordance with the American Society for Reproductive Medicine's (ASRM) guidelines.

Lifetime limits may not be imposed on small group coverage.

What is the difference between coverage for large groups or small groups for infertility or fertility services including IVF?

California fully insured large groups are required to comply with the requirements under CA SB 729 for new, renewing or plan changes beginning on and after January 1, 2026. UnitedHealthcare has designated this as a Benefit Standard effective for California policies that are new or renew on and after July 1, 2025.

Small groups may offer these services to members. Coverage offered follows the same requirements as infertility coverage and fertility services available for a large group when the Rider has been purchased.

When a California resident is covered by a policy issued in a state where the fertility services mandates benefits are more generous than the CA SB 729 benefits, the group would be required to meet the requirements in that state.

Under California law what characteristics define infertility as a condition?

- 1) A licensed physician's findings, based on a patient's medical, sexual, and reproductive history, age, physical findings, diagnostic testing, or any combination of those factors.
 - Testing and diagnosis of infertility may occur before the 12-month, or 6-month period to establish infertility.
- 2) A person's inability to reproduce either as an individual or with their partner without medical intervention.

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Rev June 1, 2026

- 3) The failure to establish a pregnancy or to carry a pregnancy to live birth after regular, unprotected sexual intercourse.
- "Regular, unprotected sexual intercourse" means no more than 12 months of unprotected sexual intercourse for a person under 35 years of age or no more than 6 months of unprotected sexual intercourse for a person 35 years of age or older.
 - Pregnancy resulting in miscarriage does not restart the 12-month or 6-month period to qualify as having infertility.

What may not be included in the Evidence of Coverage (EOC) or COC contract?

The contract may not include any of the following.

- 1) Any exclusion, limitation, or other restriction on coverage of fertility medications that are different from those imposed on other prescription medications.
- 2) Any exclusion or denial of coverage of any fertility services based on a covered individual's participation in fertility services provided by or to a third party including an oocyte, sperm, or embryo donor, gestational carrier, or surrogate that enables an intended recipient to become a parent.
- 3) Any deductible, copayment, coinsurance, benefit maximum, waiting period, or any other limitation on coverage for the diagnosis and treatment of infertility, (except as provided above) that are different from those imposed upon benefits for services not related to infertility.

How are infertility benefits paid? Does a cost share apply?

Infertility benefits must be covered at the same cost share as other medical services. Place of service is dominant. This means that copays, coinsurance, and deductibles for infertility services cannot differ from those applied to comparable medical services such as inpatient care, office visits, lab work, or radiology.

Important Note:

- Place of service is dominant, therefore, the member's out-of-pocket costs may vary based on the place of service (e.g., hospital, outpatient clinic, physician's office) and the type of provider delivering the care.
- Plans cannot impose additional limitations or higher cost sharing for infertility services compared to other covered medical services.

Will UnitedHealthcare cover the medications for IVF under medical or pharmacy fully insured benefits?

IVF/infertility injectable medications will be paid under the pharmacy benefit. Oral medications are already processed under the pharmacy benefit.

How are members charged for fertility drugs including injectables under the new SB 729 rule?

Fertility injectable drugs, will be paid under the pharmacy benefit and will be subject to the member's applicable pharmacy benefit cost-sharing requirements. Oral medications are already processed under the pharmacy benefit.

Does the new law require IVF coverage for surrogates?

The enrollee's plan covers medically necessary health testing of the surrogate prior to embryo transfer for each attempt. The enrollee's plan is not responsible for the surrogate's post-transfer maternity services, except as required under the surrogate's own health plan contract.

What are the cryopreservation requirements under the new law?

Although SB 729, does not directly mandate cryopreservation coverage, the APL requires that large group health plan products include a benefit for the cryopreservation and storage of sperm, oocytes, and embryos for a period of at least five years from the time the genetic material is first cryopreserved. The small group offer of coverage must include coverage of cryopreservation and storage of sperm, oocytes, and embryos for a period of at least one year from the time the genetic material is first cryopreserved.

Please note that a separate regulation (28 CCR §1300.74.551) requires coverage for fertility preservation due to **iatrogenic infertility** (e.g., chemotherapy and gender affirming care). Duration is based on the enrollee's age at the time of first preservation. All eligible individuals receive a minimum of 3 years of storage, with extended coverage up to age 26 for those who begin preservation before age 26.

What are the cryopreservation and storage standards under SB729?

Large group: cover cryopreservation and storage of sperm, oocytes, and embryos for at least five (5) years from first cryopreservation.

Small group (if purchased): at least one (1) year. If an enrollee changes plans during the storage period and the new plan requires transfer, the new plan covers transport and the remaining storage; for embryo cryopreservation, transport/storage costs must be paid by the new plan covering the enrollee receiving infertility treatment.

What required cryopreservation notices must be provided to Enrollees?

Within 30 business days after receipt of a cryopreservation claim, plans must provide written notice explaining the covered storage period; and at least 90 calendar days before the storage period expires, plans must provide written notice of termination and options/costs for continued storage.

What happens to stored genetic material if plan enrollment changes?

A plan has no obligation to continue to cover storage of genetic material for an individual who is no longer enrolled with the plan. If an enrollee changes health plans during the covered storage period and the new plan deems it necessary to transport the sperm, oocytes, or embryos to a different storage facility, the enrollee's new health plan shall be responsible for transportation costs of genetic material to the new health plan's storage facilities. The new plan shall cover storage for the remainder of the applicable storage time frame. With respect to embryo cryopreservation, the transportation and

storage costs must be paid by the new health plan providing coverage to the enrollee that received or is receiving infertility treatment.

Does infertility and fertility services comply with nondiscrimination guidance?

Coverage for the treatment of infertility and fertility services shall be provided without discrimination based on age, ancestry, color, disability, domestic partner status, gender, gender expression, gender identity, genetic information, marital status, national origin, race, religion, sex, or sexual orientation.

The clinical judgment of a physician and surgeon would not be construed as discriminatory.

UnitedHealthcare Approach

Based on UnitedHealthcare medical policy, what benefits are standard for large fully insured groups, or must be offered for small fully insured groups based on California law SB 729?

Services to diagnose and treat infertility and the underlying condition causing infertility are a Benefit Standard on the UHC fully insured certificates.

Certain services to “create” a pregnancy are a Benefit Standard in the California situs UHC generic fully insured certificates of coverage (COC) beginning upon plan renewal on or after July 1, 2025. This includes assisted reproductive technologies such as Artificial Insemination (AI), In Vitro Fertilization (IVF), and other related services.

- Legislation formally indicates that benefits are required on or after renewal, January 1, 2026, for Large Group, but UnitedHealthcare has designated this as a Benefit Standard effective for policies new or renewing on and after 7/1/2025.
- For small groups it will be available for policies new or renewing only if purchased.

Drugs that are administered as part of the physician’s office are covered as part of that office visit.

What is not included as part of the standard coverage under SB 729?

Donor fees are excluded.

Coverage includes medically necessary services to enable use of donor gametes/embryos (e.g., procurement, lab, testing, screening) when treating the enrollee’s infertility; compensation to donors or surrogates beyond medical services remains excluded.

Only medical services related to third-party services would be covered (e.g., procuring a donated oocyte, embryo transfer to the gestational carrier); additional service fees paid to surrogates or gestational carriers, or for biologic donor materials would not be covered. The provision does not extend coverage to individuals that are not enrolled in the health plan coverage, for example: maternity coverage.

How should new or renewal business be handled beginning on and after 7/1/25?

HMO

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- For your large group renewals 7/1/2025 and after, for NICE HMO include only the new plan code IXZ.
- No longer to list IBD or ART for NICE HMO.

PPO

- PPO the information will be silent on the UAF, as all plans are to standardly include infertility services with no \$ limits for medical and pharmacy.
- Note in SOAR comments — as a reminder to your IMO and BC.

How will the additional benefit be added to customer plans?

For HMO Plans

HMO plans have existing rider and bracketed language now.

Under the new law, UHC will include a notice of coverage in the HMO large group fully insured California situs evidence of coverage (EOC).

For PPO Plans

PPO has bracketed embedded language now.

Under the new law, UHC will include a notice of coverage in the PPO large group fully insured California situs EOC/COC.

What role will the Fertility Solutions program play in medical management of IVF for PPO and HMO? Does this vary by platform?

There is no platform variation, members will get the same experience regardless of platform. It is encouraged that members use Fertility Solutions to get the best and most supportive experience.

There are several components:

- **Member Services.** Member may call the number on their ID Card, and a member meets eligibility requirements, an Advocate will transfer the member to Fertility Solutions or members may call Fertility Solutions directly at **866-774-4626**, and get a nurse who will:
 - Assess the member's needs
 - Provide a high-level overview of the member's fertility benefit
 - Handle medical management and case management
 - Direct the member to high quality in-network providers or a Center of Excellence (CoE) as they are available
 - Offer support and resources based on member and family needs
 - No additional cost for these services
- **Claim Processing.** Claim payment will come from UnitedHealthcare unless a CoE is used. For CoE, claims are paid through Fertility Solutions.

- **Plan and Provider Medical Management Coordination.**
 - For HMO Provider Medical Groups (PMG), they should provide a referral with proper coding to an in-network fertility specialist.
 - Reproductive Endocrinology & Infertility (REI) providers submit prior authorization via Provider portal, fax, or email
 - Fertility Solutions will do medical review
 - UnitedHealthcare will manage appeals

How does Fertility Solutions support fully insured members?

It is encouraged that members use Fertility Solutions to get the best and most supportive experience. There is no platform variation, members will get the same experience regardless of platform.

- **Member support.** Member may call the number on their ID Card, and a member meets eligibility requirements, an Advocate will transfer the member to Fertility Solutions or members may call Fertility Solutions directly at **866-774-4626**, and get a nurse who will:
 - Assess the member's needs
 - Provide a high-level overview of the member's fertility benefit
 - Handle medical management and case management
 - Direct the member to high quality in-network providers or a Center of Excellence (CoE) as they are available
 - Offer support and resources based on member and family needs
 - No additional cost for these services
- **Claim support.** Claim payment will come from UnitedHealthcare unless a CoE is used. For CoE claims are paid through Fertility Solutions.

Does UnitedHealthcare cover insemination as part of treatment for infertility?

. Insemination is covered as a basic medical procedure of infertility treatment when medically appropriate and consistent with ASRM guidelines.

For IVF, how does UnitedHealthcare oversee delegated providers?

Delegated providers are required to provide referrals, so they refer based on the member's benefit plan. Communications and education/training will support clarity of UnitedHealthcare's process requirements for delegated providers. For HMO Provider Medical Groups (PMG), they should provide a referral with proper coding to an in-network fertility specialist. Reproductive Endocrinology & Infertility (REI) providers submit prior authorization via Provider portal, fax or email.

Does coverage for IVF and related services align with the plan year or calendar year?

Coverage aligns with plan year.

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Fertility Medications and Cost Share

How are members charged for fertility drugs (especially injectables) under current benefit rules?

IVF/infertility medications remain under the medical benefit (ICCOP) until further notice. This is subject to change.

How are members charged for fertility drugs including injectables under the new SB 729 rule?

At this time, coverage for fertility drugs and injectables remains unchanged unless their medical or pharmacy drug coverage is modified by the employer.

Is hormone replacement therapy included in the standard plans?

Yes.

Injectable Drug Coverage

- Refer to the plan's EOC/COC for the specific member cost share.
- Outpatient injectable medication and self-injectable medication – subject to change
 - Applies to dollar copayment only
 - In instances where the negotiated rate is less than a member's copayment, the member would only pay the negotiated rate.
 - FDA approved contraceptive methods and procedures recommended by the Health Resources and Service Administration (HRSA) as preventive are covered at 100%.
 - Copayment applies to contraceptive methods and procedures that are NOT defined as Covered Services under the Preventive Care Services and Family Planning benefit as specified in the Combined Evidence of Coverage and Disclosure Form.