KINGSTON TRUST FUND
ENROLLMENT APPLICATION FOR INFERTILITY PROGRAM

Infertility Benefits will not be available until your enrollment has been received and approved by the Pre-certification Office.

Plan:	**Kingston Trust Fund Health Plan**
Pre-certification Office:	**Hughes and Associates (Phone: (844) 583-3863 Fax: (601) 981-1778)**
Address:	**681 Towne Center Blvd Ste B, Ridgeland, MS 39157**

Member Name: _____ ID #: _____

Patient Name: _____ ID #: _____

Patient Date of Birth: _____ Date Covered by this Plan: _____

Do you have other insurance coverage? [ ] Yes [ ] No

If Yes, Name of Company: _____ ID#: _____

Phone: _____ If you are unavailable, can we leave a message? [ ] Yes [ ] No

Personal E-mail Address: _____

****Must be covered continuously for 18 months before benefits are available.****

Date Infertility Diagnosed: _____

Primary Physician (for infertility care): _____

Physician Address: _____

Phone: _____ Fax: _____ E-mail: _____

Is Dr. Board Certified in Reproductive Endocrinology? [ ] Yes [ ] No

Is doctor willing to Participate in Program? [ ] Yes [ ] No

Have you been previously treated for infertility? [ ] Yes [ ] No

If yes, please list dates of service and provider:

_____

Do you currently have a partner? [ ] Yes [ ] No

Are you trying to get pregnant right now? [ ] Yes [ ] No How long have you been trying? _____

Have you or your partner ever been sterilized? (Vasectomy, tubes tied/cut/clipped) [ ] Yes [ ] No

Have you been pregnant before? [ ] Yes [ ] No

Number of Pregnancies: _____ Dates: _____

Number of Deliveries: _____ Dates: _____

Number of Miscarriages: _____ Dates: _____

Number of Abortions: _____ Dates: _____

Disclosure: Benefits provided to members enrolled in this program are subject to verification that they have an infertility condition. This is a case management program with specialists who will track, monitor, and coordinate your treatment program with you and your providers.

Medical Release: I hereby authorize any health care facility, physician, surgeon, counselor, therapist, or insurance company to provide all information pertaining to me or any of my dependents or spouse who are covered regarding past or present medical or mental conditions, any examination or treatment, including treatment for alcohol abuse, substance abuse, mental or emotional disorders, AIDS, ARC (Aids Related Complex), HIV and to any illness, injury, or condition that I/We or my dependent(s) have had at any time in the past or in the future until the expiration of this authorization and/or coverage to the following authorized personnel of the individuals and companies responsible for the administration of this plan: Kingston Trust Fund, the Claims Supervisor, any third parties contracted to provide service for this plan (pre-certification firm, PPO, case manager, agent, or prescription benefit manager, etc.), and my employer only for purposes of eligibility and verification of benefits. No information will be used for any employment related matter. I understand this information is collected in connection with the evaluation and processing of any eligibility for benefits, determining medical necessity, and underwriting as required by the Plan. This authorization is valid as long as I am covered by this Plan or until changed in writing; and a photocopy is as valid as the original. I understand this information shall be treated with utmost confidentiality and will be separately maintained from my employment information accordingly to the Plan's HIPAA Privacy Policy.

Acceptance: As a participant in this program, you agree to all the conditions as outlined in this Plan for the treatment of infertility and understand that there are certain conditions and limitations. Failure to abide by the program rules and requirements will result in non-payment for those services which have not been pre-approved in advance of the treatment or in accordance with the plan rules.

Patient's Signature: _____ Date: _____

Spouse's Signature: _____ Date: _____

Call the Precertification or Compliance Office for any questions or general information on this program. This form may be returned via fax or mail to the Pre-Certification Office listed above.

KTF INFERTILITY BENEFITS SUMMARY
(INFERTILITY AND IVF PROGRAM (TO AGE 45)

Enrollment is required: You must be enrolled in this Plan for at least 18 months before you are eligible to enroll in the infertility program. You are responsible for enrolling in the Healthy Beginnings Program within 14 weeks of becoming pregnant.

Treatment Plan is required: The provider must submit a treatment plan, as well as any subsequent changes, for approval.

Provider Agreement and Qualifications: The primary doctor must be Board Certified in Gynecology with a Sub-Specialty in Reproductive Endocrinology.

Maximum Infertility Benefits: Effective 01/01/2023, the Plan will pay 90% of all covered charges up to a lifetime maximum of three cycles and $45,000.

Infertility drugs: Payable at 80% and included in the $45,000 lifetime maximum. It is recommended that you shop pharmacies and use coupons to maximize your benefits.

Member Coinsurance: Coinsurance is 10% for medical claims (20% for NPPO providers) and 20% for drugs. Coinsurance will not apply toward the medical or Rx out-of-pocket limits. Member is responsible for excess charges.

Genetic Testing: Genetic testing not included in the treatment plan or pre-approved will not be covered.

Excluded Treatment: Treatment outside the approved treatment plan is not covered.

Specifically excluded treatments include:

- treatment for infertility when the cause of the infertility was a previous sterilization;
- cryopreservation, storage, and thawing;
- elective preservation/retrieval of reproductive material prior to medical procedures or for later use;
- Intravaginal Culture of Oocytes (INVOCell);
- immune treatment;
- co-culturing of embryos/oocytes;
- Computer Assisted Sperm Motion Analysis (CASA);
- endometrial receptivity testing;
- fine needle aspiration mapping;
- hemizona test;
- Hyaluronan Binding Assay (HBA);
- sperm precursors;
- manual soft tissue therapy for pelvic adhesions;
- vaginal microbiome testing (SmartJane);
- uterine transplantation;
- inhibin B; and
- embryo glue.

This is a summary. Your Plan document contains complete information on the KTF Infertility Program. Please call the Compliance Office with any questions.