



Illinois Insurance Facts

Illinois Department of Financial and Professional Regulation
Division of Insurance

Insurance Coverage for Infertility Treatment

Revised
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Infertility is a condition that strikes hundreds of couples in Illinois. Illinois law requires group insurance plans and health maintenance organizations (HMOs) to provide coverage for infertility. Here are the basic facts about the law.

Who Must Offer the Coverage?

Illinois law requires insurance companies and HMOs to provide coverage for infertility to employee groups of more than 25. The law does not apply to self-insured employers or to trusts or insurance policies written outside Illinois. However, for HMOs, the law does apply in certain situations to contracts written outside of Illinois if the HMO member is a resident of Illinois and the HMO has established a provider network in Illinois. To determine if your HMO provides infertility benefits, you should contact the HMO directly or check your certificate of coverage.

Who is Covered?

To receive infertility coverage, you must:

- live in Illinois
- be covered by a fully insured Illinois group policy through an employer with more than 25 full-time employees
- have been unable to conceive after one year of unprotected sexual intercourse between a male and female or have been unable to sustain a successful pregnancy

What is Covered?

Illinois requires group insurance and HMO plans to cover the diagnosis and treatment of infertility the same as all other conditions. For example, they may not apply any unique co-payments or deductibles for infertility coverage. Benefits shall include, but not be limited to:

- testing
- prescription drugs
- artificial insemination
- invitro fertilization (IVF)
- gamete intrafallopian tube transfer (GIFT)
- intracytoplasmic sperm injection (ICSI)
- donor sperm and eggs (medical costs)
 - procedures utilized to retrieve oocytes or sperm and subsequent procedures used to transfer the oocytes or sperm to the covered recipient are covered
 - Associated donor expenses medical expense, including but not limited to physical examination, laboratory screening, psychological screening, and prescription drugs, are covered if established as prerequisites to donation by the insurer

What are the Limits?

Benefits for advanced procedures such as IVF, GIFT, ZIFT or ICSI are required only if you have been unable to attain or sustain a successful pregnancy through reasonable, less costly medically appropriate infertility treatments for which coverage is available under the policy.

The benefits for advanced procedures required by the law are four completed oocyte retrievals per lifetime of the individual, except that two completed oocyte retrievals are covered after a successful live birth is achieved as a result of an artificial reproductive transfer of oocytes. For example, if a successful live birth takes place as a result of the first completed oocyte retrieval, then two more completed oocyte retrievals for a maximum of three are covered under the law. If a live birth takes place as a result of the fourth completed oocyte retrieval, then two more completed oocyte retrievals for a maximum of six are covered. The maximum number of completed oocyte retrievals that can be covered under the law is six.

One completed oocyte retrieval could result in many IVF, GIFT, ZIFT or ICSI procedures. There is no limit on the number of procedures, including less invasive procedures such as artificial insemination. The only limitations are on the number of completed oocyte retrievals.

NOTE: Once the final covered oocyte retrieval is completed, one subsequent procedure (IVF, GIFT, ZIFT, or ICSI) used to transfer the oocytes or sperm is covered. After that, the benefit is maxed out and no further benefits are available under the law.

NOTE: Oocyte retrievals are per lifetime of the individual. If you had a completed oocyte retrieval in the past that was paid for by another carrier, or not covered by insurance, it still counts toward your lifetime maximum under the law.

What is Not Covered?

Your group insurance or HMO plan does not have to pay for:

- costs incurred for reversing a tubal ligation or vasectomy
- costs for services rendered to a surrogate, however, costs for procedures to obtain eggs, sperm or embryos from a covered individual shall be covered if the individual chooses to use a surrogate and if the individual has not exhausted benefits for completed oocytes retrievals
- costs of preserving and storing sperm, eggs and embryos
- costs for an egg or sperm donor which are not medically necessary; any fees for non-medical services paid to the donor are not covered under the law
- experimental treatments
- costs for procedures which violate the religious and moral teachings or beliefs of the insurance company or covered group

For More Information

Call our Consumer Services Section at (312) 814-2427 or
our Office of Consumer Health Insurance toll free at (877) 527-9431
or visit us on our website at www.ins.state.il.us

Text of the Illinois Infertility Law (215 ILCS 5/356m)

Sec. 356m. Infertility coverage.

(a) No group policy of accident and health insurance providing coverage for more than 25 employees that provides pregnancy related benefits may be issued, amended, delivered, or renewed in this State after the effective date of this amendatory Act of 1991 unless the policy contains coverage for the diagnosis and treatment of infertility including, but not limited to, in vitro fertilization, uterine embryo lavage, embryo transfer, artificial insemination, gamete intrafallopian tube transfer, zygote intrafallopian tube transfer, and low tubal ovum transfer.

(b) The coverage required under subsection (a) is subject to the following conditions:

(1) Coverage for procedures for in vitro fertilization, gamete intrafallopian tube transfer, or zygote intrafallopian tube transfer shall be required only if:

(A) The covered individual has been unable to attain or sustain a successful pregnancy through reasonable, less costly medically appropriate infertility treatments for which coverage is available under the policy, plan, or contract;

(B) the covered individual has not undergone 4 completed oocyte retrievals, except that if a live birth follows a completed oocyte retrieval, then 2 more completed oocyte retrievals shall be covered; and

(C) the procedures are performed at medical facilities that conform to the American College of Obstetric and Gynecology guidelines for in vitro fertilization clinics or to the American Fertility Society minimal standards for programs of in vitro fertilization.

(2) the procedures required to be covered under this Section are not required to be contained in any policy or plan issued to or by a religious institution or organization or to or by an entity sponsored by a religious institution or organization that finds the procedures required to be covered under this Section to violate its religious and moral teachings and beliefs.

(c) For purpose of this Section, "infertility" means the inability to conceive after one year of unprotected sexual intercourse or the inability to sustain a successful pregnancy.

(Source: P.A. 89-669, effective 1-1-97.)

TITLE 50: INSURANCE
PART 2015 INFERTILITY COVERAGE
CHAPTER I: DEPARTMENT OF INSURANCE

Section 2015.10 Purpose

The purpose of this Part is to establish uniform definitions of terms associated with infertility coverage and to establish minimum benefit standards for infertility coverage to be provided in this State.

Section 2015.20 Applicability and Scope

This Part shall apply to all group accident and health insurance policies and health maintenance organization group contracts that are issued, amended, delivered or renewed in this State on or after the effective date of this Part which provide pregnancy related benefits for employees of an employer which has more than 25 full-time employees at the time of issue or renewal thereof.

Section 2015.30 Definitions

Artificial Insemination (AI) means the introduction of sperm into a woman's vagina or uterus by noncoital methods, for the purpose of conception.

Assisted Reproductive Technologies (ART) means treatments and/or procedures in which the human oocytes and/or sperm are retrieved and the human oocytes and/or embryos are manipulated in the laboratory. ART shall include prescription drug therapy used during the cycle where an oocyte retrieval is performed.

Donor means an oocyte donor or sperm donor.

Embryo means a fertilized egg that has begun cell division and has completed the pre-embryonic stage.

Embryo Transfer means the placement of the pre-embryo into the uterus or, in the case of zygote intrafallopian tube transfer, into the fallopian tube.

Gamete means a reproductive cell. In a man, the gametes are sperm; in a woman, they are eggs or ova.

Gamete Intrafallopian Tube Transfer (GIFT) means the direct transfer of a sperm/egg mixture into the fallopian tube. Fertilization takes place inside the tube.

Infertility means the inability to conceive after one year of unprotected sexual intercourse or the inability to sustain a successful pregnancy. In the event a physician determines a medical condition exists that renders conception impossible through unprotected sexual intercourse, including but not limited to congenital absence of the uterus or ovaries, absence of the uterus or ovaries due to surgical removal due to a medical condition, or involuntary sterilization due to chemotherapy or radiation treatments, the one year requirement shall be waived.

Infertility Coverage means insurance or health maintenance organization coverage required by Section 356m of the Illinois Insurance Code [215 ILCS 5/356m] for the diagnosis and treatment, including prescription drug therapy, of infertility.

In Vitro Fertilization (IVF) means a process in which an egg and sperm are combined in a laboratory dish where fertilization occurs. The fertilized and dividing egg is transferred into the woman's uterus.

Low Tubal Ovum Transfer means the procedure in which oocytes are transferred past a blocked or damaged section of the fallopian tube to an area closer to the uterus.

Oocyte means the female egg or ovum, formed in an ovary.

Oocyte Donor means a woman determined by a physician to be capable of donating eggs in accordance with the standards recommended by the American Society for Reproductive Medicine.

Oocyte Retrieval means the procedure by which eggs are obtained by inserting a needle into the ovarian follicle and removing the fluid and the egg by suction. Also called ova aspiration.

Pregnancy Related Benefit means benefits that cover any related medical condition that may be associated with pregnancy, including complications of pregnancy.

Surrogate means a woman who carries a pregnancy for a woman who has infertility coverage.

Unprotected Sexual Intercourse means sexual union between a male and a female, without the use of any process, device or method that prevents conception, including but not limited to oral contraceptives, chemicals, physical or barrier contraceptives, natural abstinence or voluntary permanent surgical procedures.

Uterine Embryo Lavage means a procedure by which the uterus is flushed to recover a preimplantation embryo.

Zygote means a fertilized egg before cell division begins.

Zygote Intrafallopian Tube Transfer (ZIFT) means a procedure by which an egg is fertilized in vitro and the zygote is transferred to the fallopian tube at the pronuclear stage before cell division takes place. The eggs are harvested and fertilized on one day and the embryo is transferred at a later time.

Section 2015.35 Benefit Limitation/Oocyte Retrieval Limitation

- a) For treatments that include oocyte retrievals, coverage for such treatments shall be required only if the covered individual has been unable to attain or sustain a successful pregnancy through reasonable, less costly medically appropriate infertility treatments. This requirement shall be waived in the event that the covered individual or partner has a medical condition that renders such treatment useless.
- b) For treatments that include oocyte retrievals, coverage for such treatments is not required if the covered individual has already undergone four completed oocyte retrievals, except that if a live birth follows a completed oocyte retrieval, then coverage shall be required for a maximum of two additional completed oocyte retrievals. Such coverage applies to the covered individual per lifetime of that individual, for treatment of infertility, regardless of the source of payment.

- 1) Following the final completed oocyte retrieval for which coverage is available, coverage for one subsequent procedure used to transfer the oocytes or sperm to the covered recipient shall be provided.
 - 2) The maximum number of completed oocyte retrievals that shall be eligible for coverage is six.
- c) When the maximum number of completed oocyte retrievals has been achieved, except as provided by subsection (b)(1) above, infertility benefits required under this Part shall be exhausted.

Section 2015.40 Oocyte Retrieval Limitation (Repealed)

Section 2015.43 Donor Expenses

- a) The medical expenses of an oocyte or sperm donor for procedures utilized to retrieve oocytes or sperm, and the subsequent procedure used to transfer the oocytes or sperm to the covered recipient shall be covered. Associated donor medical expenses, including but not limited to physical examination, laboratory screening, psychological screening, and prescription drugs, shall also be covered if established as prerequisites to donation by the insurer.
- b) No group accident and health policy or health maintenance organization group contract which provides coverage as required by this Part shall exclude coverage for a known donor. In the event the insured or member does not have arrangements with a known donor, the health plan may require the use of a contracted facility. If the insured or member uses a known donor, the health plan may require the use of contracted providers by the donor for all medical treatment including, but not limited to, testing, prescription drug therapy and ART procedures, if benefits are contingent upon the use of such contracted providers.
- c) If an oocyte donor is used, then the completed oocyte retrieval performed on the donor shall count against the insured or member as one completed oocyte retrieval.

Section 2015.50 Minimum Benefit Standards

All diagnosis and treatment for infertility, including ART, shall be covered the same as any other illness or condition under the contract. A unique copayment or deductible shall not be applied to the coverage for infertility, including, but not limited to, ART or prescription drug therapy. If the policy or contract does not contain a prescription drug benefit, then one shall be established solely for coverage of prescription drug therapies for infertility.

Section 2015.60 Permissible Exclusions

- a) Reversal of voluntary sterilization; however, in the event a voluntary sterilization is successfully reversed, infertility benefits shall be available if the covered individual's diagnosis meets the definition of "infertility" as set forth in Section 2015.30 of this Part.
- b) Payment for services rendered to a surrogate (however, costs for procedures to obtain eggs, sperm or embryos from a covered individual shall be covered if the individual chooses to use a surrogate);

- c) Costs associated with cryo preservation and storage of sperm, eggs, and embryos; provided, however, subsequent procedures of a medical nature necessary to make use of the cryo preserved substance shall not be similarly excluded if deemed non-experimental and non-investigational;
- d) Selected termination of an embryo; provided, however, that where the life of the mother would be in danger were all embryos to be carried to full term, said termination shall be covered;
- e) Non-medical costs of an egg or sperm donor;
- f) Travel costs for travel within 100 miles of the insured's or member's home address as filed with the insurer or health maintenance organization, travel costs not medically necessary, not mandated or required by the insurer or health maintenance organization;
- g) Infertility treatments deemed experimental in nature. However, where infertility treatment includes elements which are not experimental in nature along with those which are, to the extent services may be delineated and separately charged, those services which are not experimental in nature shall be covered. No insurer or HMO required to provide infertility coverage shall deny reimbursement for an infertility service or procedure on the basis that such service or procedure is deemed experimental or investigational unless supported by the written determination of the American Society for Reproductive Medicine (formerly known as the American Fertility Society or the American College of Obstetrics). These entities will provide such determinations for specific procedures or treatments only and will not provide determinations on the appropriateness of a procedure or treatment for a specific individual. Coverage is required for all procedures specifically listed in Section 356m of the Illinois Insurance Code, entitled Infertility Coverage [215 ILCS 5/356m], regardless of experimental status;
- h) Infertility treatments rendered to dependents under the age of 18.

(Source: Amended at 28 Ill. Reg. 12992, effective September 9, 2004)