

A Review on the Illinois Infertility Mandate

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.

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, unique co-payments or deductibles cannot apply to 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 medical expense, including but not limited to physical examination, laboratory screening, psychological screening, and prescription drugs, are covered if established as prerequisites

What are the Limits?

Benefits for advanced procedures such as IVF, GIFT, ZIFT or ICSI are required only when a successful pregnancy through reasonable, less costly medically appropriate infertility treatments for which coverage is available under the policy is not successful..

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 live birth is achieved as a result of an artificial reproductive transfer of oocytes. For example, if a 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

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".
- 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.