



# Illinois Insurance Facts

## Illinois Department of Insurance

### Insurance Coverage for Infertility Treatment

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**Note:** This information was developed to provide consumers with general information and guidance about insurance coverages and laws. It is not intended to provide a formal, definitive description or interpretation of Department policy. For specific Department policy on any issue, regulated entities (insurance industry) and interested parties should contact the Department.

Infertility is a medical condition of the reproductive system that impairs the conception of a child. Approximately 10% of the reproductive age population is affected by infertility. Illinois law requires certain group insurance plans and health maintenance organizations (HMOs) to provide coverage for the diagnosis and treatment of 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?

Any woman who receives coverage under a fully-insured group policy of accident and health insurance or HMO contract for a group larger than 25 who:

1. Is unable to conceive after one year of unprotected sexual intercourse;
2. Is unable to sustain a successful pregnancy;
3. Has been diagnosed by a physician as having a medical condition that renders conception impossible through unprotected sexual intercourse; **or**
4. Has undergone one year of medically based and supervised methods of conception, including artificial insemination, which a physician has determined to have failed and are not likely to lead to a successful pregnancy.

**NOTE:** Each of these four categories of infertility is independent of the other. For example, if a physician determines that one year of artificial insemination has failed and is not likely to lead to a successful pregnancy a woman shall be considered infertile for purposes of this coverage, regardless of whether she satisfies any of the other three categories of infertility.

## **What is Covered?**

Illinois law requires that coverage for the diagnosis and treatment of infertility be the same as coverage for any other condition covered by the policy. For example, a policy may not apply any unique co-payments or deductibles for infertility coverage. If the policy does not contain a prescription drug benefit it must establish one solely for coverage of prescription drug therapies for infertility.

Benefits required to be covered include, but are not limited to:

- Testing.
- Prescription drugs.
- Artificial insemination.
- In vitro fertilization (IVF).
- Uterine embryo lavage.
- Embryo transfer.
- Zygote intrafallopian tube transfer.
- Low tubal ovum transfer.
- 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.
- Associated donor medical expenses, including but not limited to physical examination, laboratory screening, psychological screening, and prescription drugs if established as prerequisites to donation by the insurer.

## **What are the Limits?**

Coverage for treatments that include oocyte retrievals is required only if 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. This requirement shall be waived in the event that the covered individual or partner has a medical condition that renders such treatment useless.

Coverage for such treatments is limited to 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 such 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 may but does not have to pay for:

- Costs incurred for reversing a voluntary 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.
- Experimental treatments.
- Costs for procedures which violate the religious and moral teachings or beliefs of the insurance company or covered group.
- Certain travel costs.
- Infertility treatments rendered to dependents under the age of 18.

### **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 <http://insurance.illinois.gov>