Article - Insurance

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§15–810.

(a) This section applies to:

(1) insurers and nonprofit health service plans that provide hospital, medical, or surgical benefits to individuals or groups on an expense–incurred basis under health insurance policies that are issued or delivered in the State; and

(2) health maintenance organizations that provide hospital, medical, or surgical benefits to individuals or groups under contracts that are issued or delivered in the State.

(b) An entity subject to this section that provides coverage for infertility benefits other than in vitro fertilization may not require as a condition of that coverage, for a patient who is married to an individual of the same sex:

(1) that the patient's spouse's sperm be used in the covered treatments or procedures; or

(2) that the patient demonstrate infertility exclusively by means of a history of unsuccessful heterosexual intercourse.

(c) (1) This subsection does not apply to insurers, nonprofit health service plans, and health maintenance organizations that provide hospital, medical, or surgical benefits under health insurance policies or contracts:

(i) that are issued or delivered to a small employer in the State; and

(ii) for which the Administration has determined that in vitro fertilization procedures are not essential health benefits, as determined under § 31–116 of this article.

(2) An entity subject to this section that provides pregnancy–related benefits may not exclude benefits for all outpatient expenses arising from in vitro fertilization procedures performed on a policyholder or subscriber or on the dependent spouse of a policyholder or subscriber.

(3) The benefits under this subsection shall be provided:

(i) for insurers and nonprofit health service plans, to the same extent as the benefits provided for other pregnancy–related procedures; and

(ii) for health maintenance organizations, to the same extent as the benefits provided for other infertility services.

(d) Subsection (c) of this section applies if:

(1) the patient is the policyholder or subscriber or a covered dependent of the policyholder or subscriber;

(2) for a married patient whose spouse is of the opposite sex, the patient's oocytes are fertilized with the patient's spouse's sperm, unless:

(i) the patient's spouse is unable to produce and deliver functional sperm; and

(ii) the inability to produce and deliver functional sperm does not result from:

1. a vasectomy; or

2. another method of voluntary sterilization;

(3) (i) for a married patient, the patient and the patient's spouse have a history of involuntary infertility, which may be demonstrated by a history of:

1. if the patient and the patient's spouse are of opposite sexes, intercourse of at least 1 year's duration failing to result in pregnancy; or

2. if the patient and the patient's spouse are of the same sex, three attempts of artificial insemination over the course of 1 year failing to result in pregnancy; or

(ii) the infertility of the patient or the patient's spouse is associated with any of the following medical conditions:

1. endometriosis;

2. exposure in utero to diethylstilbestrol, commonly known as DES;

3. blockage of, or surgical removal of, one or both fallopian tubes (lateral or bilateral salpingectomy); or

4. abnormal male factors, including oligospermia, contributing to the infertility;

(4) for an unmarried patient:

(i) the patient has had three attempts of artificial insemination over the course of 1 year failing to result in pregnancy; or

(ii) the infertility is associated with any of the following medical conditions of the patient:

1. endometriosis;

2. exposure in utero to diethylstilbestrol, commonly known as DES;

3. blockage of, or surgical removal of, one or both fallopian tubes (lateral or bilateral salpingectomy); or

4. abnormal male factors, including oligospermia, contributing to the infertility;

(5) the patient has been unable to attain a successful pregnancy through a less costly infertility treatment for which coverage is available under the policy or contract; and

(6) the in vitro fertilization procedures are performed at medical facilities that conform to applicable guidelines or minimum standards issued by the American College of Obstetricians and Gynecologists or the American Society for Reproductive Medicine.

(e) An entity subject to this section may limit coverage of the benefits for in vitro fertilization required under this section to three in vitro fertilization attempts per live birth, not to exceed a maximum lifetime benefit of $100,000.

(f) An entity subject to this section is not responsible for any costs incurred by a policyholder or subscriber or a dependent of a policyholder or subscriber in obtaining donor sperm.

(g) A denial of coverage for in vitro fertilization benefits required under this section by an entity subject to this section constitutes an adverse decision under Subtitle 10A of this title.

(h) This section may not be construed to require an entity subject to this section to provide coverage for a treatment or a procedure that would not treat a diagnosed medical condition of a patient.

(i) Notwithstanding any other provision of this section, if the coverage required under this section conflicts with the bona fide religious beliefs and practices of a religious organization, on request of the religious organization, an entity subject to this section shall exclude the coverage otherwise required under this section in a policy or contract with the religious organization.

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