



SPONSOR: Sen. Townsend & Rep. Longhurst
Sens. Cloutier, Ennis, Hansen, Henry, Lopez, Poore,
Simpson, Sokola; Reps. Baumbach, Bennett, Bentz,
Bolden, Brady, Carson, Heffernan, Hensley, Hudson,
Jaques, Keeley, Lynn, Matthews, Mitchell, Paradee,
M. Smith, K. Williams

DELAWARE STATE SENATE
149th GENERAL ASSEMBLY

SENATE BILL NO. 139
AS AMENDED BY
SENATE AMENDMENT NO. 1

AN ACT TO AMEND TITLE 18 OF THE DELAWARE CODE RELATING TO INSURANCE COVERAGE FOR OBSTETRICAL AND GYNECOLOGICAL SERVICES.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF DELAWARE:

Section 1. Amend § 3342, Title 18 of the Delaware Code by making deletions as shown by strike through and insertions as shown by underline as follows:

§ 3342. Obstetrical and gynecological coverage.

(i)(1) For purposes of this subsection:

a. "Iatrogenic infertility" means an impairment of fertility due to surgery, radiation, chemotherapy, or other medical treatment.

b. "Infertility" means a disease or condition that results in impaired function of the reproductive system whereby an individual is unable to procreate or to carry a pregnancy to live birth, including the following:

1. Absent or incompetent uterus.
2. Damaged, blocked, or absent fallopian tubes.
3. Damaged, blocked, or absent male reproductive tract.
4. Damaged, diminished, or absent sperm.
5. Damaged, diminished, or absent oocytes.
6. Damaged, diminished, or absent ovarian function.
7. Endometriosis.
8. Hereditary genetic disease or condition that would be passed to offspring.
9. Adhesions.
10. Uterine fibroids.

11. Sexual dysfunction impeding intercourse.

12. Teratogens or idiopathic causes.

13. Polycystic ovarian syndrome.

14. Inability to become pregnant or cause pregnancy of unknown etiology.

15. Two or more pregnancy losses, including ectopic pregnancies.

16. Uterine congenital anomalies, including those caused by diethylstilbestrol ("DES").

c. "Standard fertility preservation services" means procedures consistent with established medical practices and professional guidelines published by professional medical organizations, including the American Society for Clinical Oncology and the American Society for Reproductive Medicine.

(2) All individual health insurance policies, contracts, or certificates that are delivered, issued for delivery, renewed, extended, or modified in this State by any health insurer, health service corporation, or health maintenance organization and that provide for medical or hospital expenses shall include coverage for fertility care services, including in vitro fertilization services for individuals who suffer from a disease or condition that results in the inability to procreate or to carry a pregnancy to live birth and standard fertility preservation services for individuals who must undergo medically necessary treatment that may cause iatrogenic infertility. Such benefits must be provided to covered individuals, including covered spouses and covered non spouse dependents, to the same extent as other pregnancy-related benefits and include the following:

a. Intrauterine insemination.

b. Assisted hatching.

c. Cryopreservation and thawing of eggs, sperm, and embryos.

d. Cryopreservation of ovarian tissue.

e. Cryopreservation of testicular tissue.

f. Embryo biopsy.

g. Consultation and diagnostic testing.

h. Fresh and frozen embryo transfers.

i. Six completed egg retrievals per lifetime, with unlimited embryo transfers in accordance with the guidelines of the American Society for Reproductive Medicine, using single embryo transfer ("SET") when recommended and medically appropriate.

j. In vitro fertilization ("IVF"), including IVF using donor eggs, sperm, or embryos, and IVF where the embryo is transferred to a gestational carrier or surrogate.

k. Intra-cytoplasmic sperm injection (“ICSI”).

l. Medications.

m. Ovulation induction.

n. Storage of oocytes, sperm, embryos, and tissue.

o. Surgery, including microsurgical sperm aspiration.

p. Medical and laboratory services that reduce excess embryo creation through egg cryopreservation and thawing in accordance with an individual’s religious or ethical beliefs.

(3) An individual qualifies for coverage under this subsection if all of the following requirements are met:

a. A board-certified or board-eligible obstetrician-gynecologist, subspecialist in reproductive endocrinology, oncologist, urologist, or andrologist verifies that the covered individual is diagnosed with infertility or is at risk of iatrogenic infertility.

b. When the covered individual is diagnosed with infertility, the covered individual has not been able to obtain a successful pregnancy through reasonable effort with less costly infertility treatments covered by the policy, contract, or certificate, except as follows:

1. No more than 3 treatment cycles of ovulation induction or intrauterine inseminations may be required before in vitro fertilization services are covered.

2. If IVF is medically necessary, no cycles of ovulation induction or intrauterine inseminations may be required before in vitro fertilization services are covered.

3. IVF procedure must be performed at a practice that conforms to American Society for Reproductive Medicine and American Congress of Obstetricians and Gynecologists guidelines.

c. For IVF services, retrievals are completed before the individual is 45 years old and transfers are completed before the individual is 50 years old.

(4) A policy, contract, or certificate may not impose any exclusions, limitations, or other restrictions on coverage of fertility medications that are different from those imposed on any other prescription medications, nor may it impose deductibles, copayments, coinsurance, benefit maximums, waiting periods, or any other limitations on coverage for required fertility care services, which are different from those imposed upon benefits for services not related to infertility.

(5) A policy, contract, or certificate is not required to cover experimental fertility care services, monetary payments to gestational carriers or surrogates, or the reversal of voluntary sterilization undergone after the covered individual successfully procreated with the covered individual’s partner at the time the reversal is desired.

Section 2. Amend § 3556, Title 18 of the Delaware Code by making deletions as shown by strike through and insertions as shown by underline as follows:

§ 3556. Obstetrical and gynecological coverage.

(i)(1) For purposes of this subsection:

a. “Iatrogenic infertility” means an impairment of fertility due to surgery, radiation, chemotherapy, or other medical treatment.

b. “Infertility” means a disease or condition that results in impaired function of the reproductive system whereby an individual is unable to procreate or to carry a pregnancy to live birth, including the following:

1. Absent or incompetent uterus.
2. Damaged, blocked, or absent fallopian tubes.
3. Damaged, blocked, or absent male reproductive tract.
4. Damaged, diminished, or absent sperm.
5. Damaged, diminished, or absent oocytes.
6. Damaged, diminished, or absent ovarian function.
7. Endometriosis.
8. Hereditary genetic disease or condition that would be passed to offspring.
9. Adhesions.
10. Uterine fibroids.
11. Sexual dysfunction impeding intercourse.
12. Teratogens or idiopathic causes.
13. Polycystic ovarian syndrome.
14. Inability to become pregnant or cause pregnancy of unknown etiology.
15. Two or more pregnancy losses, including ectopic pregnancies.
16. Uterine congenital anomalies, including those caused by diethylstilbestrol (“DES”).

c. “Standard fertility preservation services” means procedures consistent with established medical practices and professional guidelines published by professional medical organizations, including the American Society for Clinical Oncology and the American Society for Reproductive Medicine.

(2) All group and blanket health insurance policies, contracts, or certificates that are delivered, issued for delivery, renewed, extended, or modified in this State by any health insurer, health service corporation, or health

maintenance organization and that provide for medical or hospital expenses shall include coverage for fertility care services, including in vitro fertilization services for individuals who suffer from a disease or condition that results in the inability to procreate or to carry a pregnancy to live birth and standard fertility preservation services for individuals who must undergo medically necessary treatment that may cause iatrogenic infertility. Such benefits must be provided to covered individuals, including covered spouses and covered non spouse dependents, to the same extent as other pregnancy-related benefits and include the following:

- a. Intrauterine insemination.
 - b. Assisted hatching.
 - c. Cryopreservation and thawing of eggs, sperm, and embryos.
 - d. Cryopreservation of ovarian tissue.
 - e. Cryopreservation of testicular tissue.
 - f. Embryo biopsy.
 - g. Consultation and diagnostic testing.
 - h. Fresh and frozen embryo transfers.
 - i. Six completed egg retrievals per lifetime, with unlimited embryo transfers in accordance with the guidelines of the American Society for Reproductive Medicine, using single embryo transfer (“SET”) when recommended and medically appropriate.
 - j. In vitro fertilization (“IVF”), including IVF using donor eggs, sperm, or embryos, and IVF where the embryo is transferred to a gestational carrier or surrogate.
 - k. Intra-cytoplasmic sperm injection (“ICSI”).
 - l. Medications.
 - m. Ovulation induction.
 - n. Storage of oocytes, sperm, embryos, and tissue.
 - o. Surgery, including microsurgical sperm aspiration.
 - p. Medical and laboratory services that reduce excess embryo creation through egg cryopreservation and thawing in accordance with an individual’s religious or ethical beliefs.
- (3) An individual qualifies for coverage under this subsection if all of the following requirements are met:
- a. A board-certified or board-eligible obstetrician-gynecologist, subspecialist in reproductive endocrinology, oncologist, urologist, or andrologist verifies that the covered individual is diagnosed with infertility or is at risk of iatrogenic infertility.

b. When the covered individual is diagnosed with infertility, the covered individual has not been able to obtain a successful pregnancy through reasonable effort with less costly infertility treatments covered by the policy, contract, or certificate, except as follows:

1. No more than 3 treatment cycles of ovulation induction or intrauterine inseminations may be required before in vitro fertilization services are covered.

2. If IVF is medically necessary, no cycles of ovulation induction or intrauterine inseminations may be required before in vitro fertilization services are covered.

3. IVF procedure must be performed at a practice that conforms to American Society for Reproductive Medicine and American Congress of Obstetricians and Gynecologists guidelines.

c. For IVF services, retrievals are completed before the individual is 45 years old and transfers are completed before the individual is 50 years old.

(4) A policy, contract, or certificate may not impose any exclusions, limitations, or other restrictions on coverage of fertility medications that are different from those imposed on any other prescription medications, nor may it impose deductibles, copayments, coinsurance, benefit maximums, waiting periods, or any other limitations on coverage for required fertility care services, which are different from those imposed upon benefits for services not related to infertility.

(5) A religious employer may request and an entity subject to this subsection shall grant an exclusion from coverage for the coverage required under this subsection in a policy, contract, or certificate if the required coverage conflicts with the religious organization's bona fide religious beliefs and practices. A religious employer that obtains an exclusion under this subsection shall provide its employees reasonable and timely notice of the exclusion.

(6) Employers who self-insure or who have fewer than 50 employees are exempt from the requirements of this subsection.

(7) A policy, contract, or certificate is not required to cover experimental fertility care services, monetary payments to gestational carriers or surrogates, or the reversal of voluntary sterilization undergone after the covered individual successfully procreated with the covered individual's partner at the time the reversal is desired.