**Section 2015.50 Minimum Benefit Standards**

a) All diagnosis and treatment for infertility, including ART, shall be covered the same as any other illness or condition under the contract. Except as provided in this Part and permitted under Section 356m of the Code, a unique copayment, coinsurance, deductible, benefit maximum, waiting period, exclusion, restriction, or other limitation shall not be applied to the coverage for the diagnosis or treatment of infertility, including, but not limited to, ART or prescription drug therapy, nor to the coverage for standard fertility preservation services required under Section 356z.32 of the Code. 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. Except as otherwise provided in this Part, infertility coverage shall include services to a surrogate and to a covered individual or the covered individual’s donor when a surrogate is arranged. Fertility services rendered to a surrogate or donor to treat the covered individual's infertility shall be subject to and count toward the covered individual's cost-sharing requirements, benefit maximum, waiting period, network-based, and other exclusions, restrictions, or limitations.

b) Nothing in this Part shall be construed to prohibit the use of the same medical management techniques and medical necessity criteria with a surrogate that the policy would apply to a covered individual for the same service, nor to prohibit the collection of the same information about the surrogate that would be collected about a covered individual for medical management of the service.

(Source: Amended at 47 Ill. Reg. 143, effective December 20, 2022)