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SYNOPSIS
Revises health insurance coverage requirements for treatment of infertility.

CURRENT VERSION OF TEXT
As reported by the Assembly Appropriations Committee on January 4, 2024, with amendments.

(Sponsorship Updated As Of: 1/8/2024)
AN ACT concerning health insurance coverage requirements for
infertility treatment and amending [and supplementing]¹
various parts of the statutory law.

BE IT ENACTED by the Senate and General Assembly of the State
of New Jersey:

1. Section 1 of P.L.2001, c.236 (C.17:48-6x) is amended to
read as follows:

1. a. A hospital service corporation contract which provides
hospital or medical expense benefits for groups with more than 50
persons, which includes pregnancy-related benefits, shall not be
delivered, issued, executed or renewed in this State, or approved for
issuance or renewal in this State by the Commissioner of Banking
and Insurance on or after the effective date of this act unless the
contract provides coverage for persons covered under the contract
for medically necessary expenses, as determined by a physician,
incurred in the diagnosis and treatment of infertility as provided
pursuant to this section. The hospital service corporation contract
shall provide coverage for any services related to infertility [that is
recommended] in accordance with American Society for
Reproductive Medicine guidelines and as determined¹ by a
physician, which includes, but is not limited to: the following
services related to infertility: diagnosis and diagnostic tests;
medications; surgery; intruterine insemination; in vitro
fertilization², including in vitro fertilization using donor eggs and in
vitro fertilization where the embryo is transferred to a gestational
carrier or surrogate²: genetic testing; [embryo transfer;]² artificial
insemination: [gamete intra fallopian transfer; zygote intra
fallopian transfer;] intracytoplasmic sperm injection; [and] four
completed egg retrievals [per lifetime of the covered person];
[and]² unlimited embryo transfers, in accordance with guidelines
from the American Society for Reproductive Medicine, using single
embryo transfer when recommended and deemed medically
appropriate by a physician²; and medical costs of egg or sperm
donors, including office visits, medications, laboratory and
radiological procedures and retrieval, shall be covered until the
donor is released from treatment by the reproductive
endocrinologist². The hospital service corporation may provide that
coverage for in vitro fertilization[,] gamete intra fallopian transfer
and zygote intra fallopian transfer] shall be limited to a covered
person who[:] a.] has used all reasonable, less expensive and
medically appropriate treatments, as determined by a licensed

EXPLANATION – Matter enclosed in bold-faced brackets [thus] in the above bill is
not enacted and is intended to be omitted in the law.

Matter underlined thus is new matter
Matter enclosed in superscript numerals has been adopted as follows:
¹Assembly AFI committee amendments adopted December 11, 2023.
²Assembly AAP committee amendments adopted January 4, 2024.
A physician, and is still unable to become pregnant or carry a pregnancy; b. has not reached the limit of four completed egg retrievals; and c. is 45 years of age or younger to a live birth.

Coverage for infertility services provided to partners of persons who have successfully reversed a voluntary sterilization shall not be excluded. A contract shall not impose any restriction concerning the coverage of infertility services based on age.

For purposes of this section:
"Infertility" means a disease or condition that results in the abnormal function of the reproductive system, as determined pursuant to American Society for Reproductive Medicine practice guidelines by a physician who is Board Certified or Board Eligible in Reproductive Endocrinology and Infertility or in Obstetrics and Gynecology or that the patient has met one of the following conditions:

(1) A male is unable to impregnate a female;
(2) A female with a male partner and under 35 years of age is unable to conceive after 12 months of unprotected sexual intercourse;
(3) A female with a male partner and 35 years of age and over is unable to conceive after six months of unprotected sexual intercourse;
(4) A female without a male partner and under 35 years of age who is unable to conceive after 12 failed attempts of intrauterine insemination under medical supervision;
(5) A female without a male partner and over 35 years of age who is unable to conceive after six failed attempts of intrauterine insemination under medical supervision;
(6) Partners are unable to conceive as a result of involuntary medical sterility;
(7) A person is unable to carry a pregnancy to live birth; or
(8) A previous determination of infertility pursuant to this section, or status characterized by any of the following:

(1) the failure to establish a pregnancy or carry a pregnancy to term inability to achieve a successful pregnancy based on a patient’s medical, sexual, and reproductive history, age, physical findings, diagnostic testing, or any combination of those factors;
(2) a person’s inability to reproduce as a single individual or with a partner of the individual without medical intervention the need for medical intervention, including, but not limited to, the use of donor gametes or donor embryos in order to achieve a successful pregnancy either as an individual or with a partner; or
(3) a physician’s recommendation, diagnosis, treatment plan, or prescription based on a patient’s medical, sexual, and reproductive history, age, physical findings or diagnostic testing in patients having regular, unprotected intercourse and without any known etiology for either partner suggestive of impaired
reproductive ability, evaluation should be initiated at 12 months when the female partner is under 35 years of age and at 6 months when the female partner is 35 years of age or older.

Nothing in this definition shall be used to deny or delay treatment to any individual, regardless of relationship status or sexual orientation.

“Treatment of infertility” means the recommended treatment plan or prescribed procedures, services, and medications as directed by a licensed physician for infertility as defined in this section.

The benefits shall be provided to the same extent as for other pregnancy-related procedures under the contract, except that the services provided for in this section shall be performed at facilities that conform to standards established by the American Society for Reproductive Medicine or the American College of Obstetricians and Gynecologists. The same copayments, deductibles and benefit limits shall apply to the diagnosis and treatment of infertility pursuant to this section as those applied to other medical or surgical benefits under the contract. [Infertility resulting from voluntary sterilization procedures shall be excluded under the contract for the coverage required by this section] Infertility resulting from a voluntary unreversed sterilization procedure may be excluded if the voluntary unreversed sterilization is the sole cause of infertility, provided, however, that coverage for infertility services shall not be excluded if the voluntary sterilization is successfully reversed. 2[A contract shall not impose any exclusions, limitations, or restrictions on coverage of any fertility services provided by or to a third party.] 2

b. A religious employer may request, and a hospital service corporation shall grant, an exclusion under the contract for the coverage required by this section for in vitro fertilization, embryo transfer, artificial insemination, zygote intra fallopian transfer and intracytoplasmic sperm injection, if the required coverage is contrary to the religious employer's bona fide religious tenets. The hospital service corporation that issues a contract containing such an exclusion shall provide written notice thereof to each prospective subscriber or subscriber, which shall appear in not less than 10 point type, in the contract, application and sales brochure. For the purposes of this subsection, "religious employer" means an employer that is a church, convention or association of churches or any group or entity that is operated, supervised or controlled by or in connection with a church or a convention or association of churches as defined in 26 U.S.C. s.3121(w)(3)(A), and that qualifies as a tax-exempt organization under 26 U.S.C. s.501(c)(3).

c. This section shall apply to those hospital service corporation contracts in which the hospital service corporation has reserved the right to change the premium.
d. The provisions of this section shall not apply to a hospital service corporation contract which, pursuant to a contract between the hospital service corporation and the Department of Human Services, provides benefits to persons who are eligible for medical assistance under P.L.1968, c.413 (C.30:4D-1 et seq.), the NJ FamilyCare Program established pursuant to P.L.2005, c.156 (C.30:4D-8 et al.), or any other program administered by the Division of Medical Assistance and Health Services in the Department of Human Services.

e. Nothing in this section shall preclude the hospital service corporation from performing utilization review, including periodic review of the medical necessity of a particular service, provided all utilization review decisions are consistent with American Society for Reproductive Medicine guidelines.

2. Section 2 of P.L.2001, c.236 (C.17:48A-7w) is amended to read as follows:

  2. a. A medical service corporation contract which provides hospital or medical expense benefits for groups with more than 50 persons, which includes pregnancy-related benefits, shall not be delivered, issued, executed or renewed in this State, or approved for issuance or renewal in this State by the Commissioner of Banking and Insurance on or after the effective date of this act unless the contract provides coverage for persons covered under the contract for medically necessary expenses, as determined by a physician, incurred in the diagnosis and treatment of infertility as provided pursuant to this section. The medical service corporation contract shall provide coverage for any services related to infertility [that is recommended], in accordance with American Society for Reproductive Medicine guidelines and as determined by a physician, which includes, but is not limited to, the following services related to infertility: diagnosis and diagnostic tests; medications; surgery; intruterine insemination; in vitro fertilization; in vitro fertilization using donor eggs and in vitro fertilization where the embryo is transferred to a gestational carrier or surrogate; genetic testing; embryo transfer; artificial insemination; gamete intra fallopian transfer; zygote intra fallopian transfer; intracytoplasmic sperm injection; and four completed egg retrievals per lifetime of the covered person; unlimited embryo transfers, in accordance with guidelines from the American Society for Reproductive Medicine, using single embryo transfer when recommended and deemed medically appropriate by a physician; and medical costs of egg or sperm donors, including office visits, medications, laboratory and radiological procedures and retrieval, shall be covered until the donor is released from treatment by the reproductive endocrinologist. The medical service corporation may provide that coverage for in vitro fertilization, gamete intra
fallopian transfer and zygote intra fallopian transfer shall be limited to a covered person who: a. has used all reasonable, less expensive and medically appropriate treatments, as determined by a licensed physician, and is still unable to become pregnant or carry a pregnancy to a live birth; b. has not reached the limit of four completed egg retrievals; and c. is 45 years of age or younger. Coverage for infertility services provided to partners of persons who have successfully reversed a voluntary sterilization shall not be excluded. A contract shall not impose any restriction concerning the coverage of infertility services based on age.

[For purposes of this section,] "Infertility" means a disease or condition, or status characterized by any of the following:

1. A male is unable to impregnate a female;
2. A female with a male partner and under 35 years of age is unable to conceive after 12 months of unprotected sexual intercourse;
3. A female with a male partner and 35 years of age and over is unable to conceive after six months of unprotected sexual intercourse;
4. A female without a male partner and under 35 years of age who is unable to conceive after 12 failed attempts of intrauterine insemination under medical supervision;
5. A female without a male partner and over 35 years of age who is unable to conceive after six failed attempts of intrauterine insemination under medical supervision;
6. Partners are unable to conceive as a result of involuntary medical sterility;
7. A person is unable to carry a pregnancy to live birth; or
8. A previous determination of infertility pursuant to this section;

1. Failure to establish a pregnancy or carry a pregnancy to term inability to achieve a successful pregnancy based on a patient’s medical, sexual, and reproductive history, age, physical findings, diagnostic testing, or any combination of those factors;
2. A person’s inability to reproduce as a single individual or with a partner of the individual without medical intervention the need for medical intervention, including, but not limited to, the use of donor gametes or donor embryos in order to achieve a successful pregnancy either as an individual or with a partner; or
3. A physician’s recommendation, diagnosis, treatment plan, or prescription based on a patient’s medical, sexual, and reproductive history, age, physical findings or diagnostic testing in patients having regular, unprotected intercourse and without any known etiology for
either partner suggestive of impaired reproductive ability, evaluation should be initiated at 12 months when the female partner is under 35 years of age and at 6 months when the female partner is 35 years of age or older.

Nothing in this definition shall be used to deny or delay treatment to any individual, regardless of relationship status or sexual orientation.

“Treatment of infertility” means the recommended treatment plan or prescribed procedures, services, and medications as directed by a licensed physician for infertility as defined in this section.

The benefits shall be provided to the same extent as for other [pregnancy-related procedures] medical conditions under the contract, except that the services provided for in this section shall be performed at facilities that conform to standards established by the American Society for Reproductive Medicine or the American College of Obstetricians and Gynecologists. The same copayments, deductibles and benefit limits shall apply to the diagnosis and treatment of infertility pursuant to this section as those applied to other medical or surgical benefits under the contract. [Infertility resulting from voluntary sterilization procedures shall be excluded under the contract for the coverage required by this section] Infertility resulting from a voluntary unreversed sterilization procedure may be excluded if the voluntary unreversed sterilization is the sole cause of infertility, provided, however, that coverage for infertility services shall not be excluded if the voluntary sterilization is successfully reversed. 2 [A contract shall not impose any exclusions, limitations, or restrictions on coverage of any fertility services provided by or to a third party.] 2

b. A religious employer may request, and a hospital service corporation shall grant, an exclusion under the contract for the coverage required by this section for in vitro fertilization, embryo transfer, artificial insemination, zygote intra fallopian transfer and intracytoplasmic sperm injection, if the required coverage is contrary to the religious employer's bona fide religious tenets. The hospital service corporation that issues a contract containing such an exclusion shall provide written notice thereof to each prospective subscriber or subscriber, which shall appear in not less than 10 point type, in the contract, application and sales brochure. For the purposes of this subsection, "religious employer" means an employer that is a church, convention or association of churches or any group or entity that is operated, supervised or controlled by or in connection with a church or a convention or association of churches as defined in 26 U.S.C. s.3121(w)(3)(A), and that qualifies as a tax-exempt organization under 26 U.S.C. s.501(c)(3).

c. This section shall apply to those medical service corporation contracts in which the medical service corporation has reserved the right to change the premium.
d. The provisions of this section shall not apply to a medical service corporation contract which, pursuant to a contract between the medical service corporation and the Department of Human Services, provides benefits to persons who are eligible for medical assistance under P.L.1968, c.413 (C.30:4D-1 et seq.), the NJ FamilyCare Program established pursuant to P.L.2005, c.156 (C.30:4J-8 et al.), or any other program administered by the Division of Medical Assistance and Health Services in the Department of Human Services.

2e. Nothing in this section shall preclude the medical service corporation from performing utilization review, including periodic review of the medical necessity of a particular service, provided all utilization review decisions are consistent with American Society for Reproductive Medicine guidelines.²

(cf: P.L.2017, c.48, s.2)

3. Section 3 of P.L.2001, c.236 (C.17:48E-35.22) is amended to read as follows:

3. a. A health service corporation contract which provides hospital or medical expense benefits for groups with more than 50 persons, which includes pregnancy-related benefits, shall not be delivered, issued, executed or renewed in this State, or approved for issuance or renewal in this State by the Commissioner of Banking and Insurance on or after the effective date of this act unless the contract provides coverage for persons covered under the contract for medically necessary expenses, as determined by a physician, incurred in the diagnosis and treatment of infertility as provided pursuant to this section. The health service corporation contract shall provide coverage for any services related to infertility¹ that is recommended in accordance with American Society for Reproductive Medicine guidelines and as determined¹ by a physician, which includes, but is not limited to, the following services related to infertility¹: diagnosis and diagnostic tests; medications; surgery; intrauterine insemination; in vitro fertilization², including in vitro fertilization using donor eggs and in vitro fertilization where the embryo is transferred to a gestational carrier or surrogate²; genetic testing;²[embryo transfer.²] artificial insemination; [gamete intra fallopian transfer; zygote intra fallopian transfer;] intracytoplasmic sperm injection; [and] four completed egg retrievals [per lifetime of the covered person];²[and]² unlimited embryo transfers, in accordance with guidelines from the American Society for Reproductive Medicine, using single embryo transfer when recommended and deemed medically appropriate by a physician²; and medical costs of egg or sperm donors, including office visits, medications, laboratory and radiological procedures and retrieval, shall be covered until the donor is released from treatment by the reproductive endocrinologist². The health service corporation may provide that coverage for in vitro fertilization¹, gamete intra fallopian transfer and zygote intra fallopian transfer shall be limited to a
covered person who: a. has used all reasonable, less expensive and medically appropriate treatments, as determined by a licensed physician, and is still unable to become pregnant or carry a pregnancy to a live birth; b. has not reached the limit of four completed egg retrievals; and c. is 45 years of age or younger. Coverage for infertility services provided to partners of persons who have successfully reversed a voluntary sterilization shall not be excluded.

2 A contract shall not impose any restriction concerning the coverage of infertility services based on age.

[For purposes of] As used in this section: "Infertility" means a disease, condition, or status characterized by any of the following:

1. That results in the abnormal function of the reproductive system, as determined pursuant to American Society for Reproductive Medicine practice guidelines by a physician who is Board Certified or Board Eligible in Reproductive Endocrinology and Infertility or in Obstetrics and Gynecology or that the patient has met one of the following conditions:

   (1) A male is unable to impregnate a female;
   (2) A female with a male partner and under 35 years of age is unable to conceive after 12 months of unprotected sexual intercourse;
   (3) A female with a male partner and 35 years of age and over is unable to conceive after six months of unprotected sexual intercourse;
   (4) A female without a male partner and under 35 years of age who is unable to conceive after 12 failed attempts of intrauterine insemination under medical supervision;
   (5) A female without a male partner and over 35 years of age who is unable to conceive after six failed attempts of intrauterine insemination under medical supervision;
   (6) Partners are unable to conceive as a result of involuntary medical sterility;
   (7) A person is unable to carry a pregnancy to live birth; or
   (8) A previous determination of infertility pursuant to this section.

   (1) the failure to establish a pregnancy or carry a pregnancy to term inability to achieve a successful pregnancy based on a patient’s medical, sexual, and reproductive history, age, physical findings, diagnostic testing, or any combination of those factors;
   
   (2) A person’s inability to reproduce as a single individual or with a partner of the individual without medical intervention the need for medical intervention, including, but not limited to, the use of donor gametes or donor embryos in order to achieve a successful pregnancy either as an individual or with a partner;
   
   (3) A physician’s recommendation, diagnosis, treatment plan, or prescription based on a patient’s medical, sexual, and reproductive history, age, physical findings or diagnostic testing in patients having regular, unprotected intercourse and without any known etiology for either partner suggestive of impaired reproductive ability, evaluation
should be initiated at 12 months when the female partner is under 35 years of age and at 6 months when the female partner is 35 years of age or older.

Nothing in this definition shall be used to deny or delay treatment to any individual, regardless of relationship status or sexual orientation.

"Treatment of infertility" means the recommended treatment plan or prescribed procedures, services, and medications as directed by a licensed physician for fertility as defined in this section.

The benefits shall be provided to the same extent as for other pregnancy-related procedures under the contract, except that the services provided for in this section shall be performed at facilities that conform to standards established by the American Society for Reproductive Medicine or the American College of Obstetricians and Gynecologists. The same copayments, deductibles and benefit limits shall apply to the diagnosis and treatment of infertility pursuant to this section as those applied to other medical or surgical benefits under the contract. [Infertility resulting from voluntary sterilization procedures shall be excluded under the contract for the coverage required by this section] Infertility resulting from a voluntary unreversed sterilization procedure may be excluded if the voluntary unreversed sterilization is the sole cause of infertility, provided, however, that coverage for infertility services shall not be excluded if the voluntary sterilization is successfully reversed. 2

b. A religious employer may request, and a hospital service corporation shall grant, an exclusion under the contract for the coverage required by this section for in vitro fertilization, embryo transfer, artificial insemination, zygote intra fallopian transfer and intracytoplasmic sperm injection, if the required coverage is contrary to the religious employer's bona fide religious tenets. The hospital service corporation that issues a contract containing such an exclusion shall provide written notice thereof to each prospective subscriber or subscriber, which shall appear in not less than 10 point type, in the contract, application and sales brochure. For the purposes of this subsection, "religious employer" means an employer that is a church, convention or association of churches or any group or entity that is operated, supervised or controlled by or in connection with a church or a convention or association of churches as defined in 26 U.S.C. s.3121(w)(3)(A), and that qualifies as a tax-exempt organization under 26 U.S.C. s.501(c)(3).

c. This section shall apply to those health service corporation contracts in which the health service corporation has reserved the right to change the premium.

d. The provisions of this section shall not apply to a health service corporation contract which, pursuant to a contract between the health
service corporation and the Department of Human Services, provides benefits to persons who are eligible for medical assistance under P.L.1968, c.413 (C.30:4D-1 et seq.), the NJ FamilyCare Program established pursuant to P.L.2005, c.156 (C.30:4I-8 et al.), or any other program administered by the Division of Medical Assistance and Health Services in the Department of Human Services.

2e. Nothing in this section shall preclude the health service corporation from performing utilization review, including periodic review of the medical necessity of a particular service, provided all utilization review decisions are consistent with American Society for Reproductive Medicine guidelines.²

(cf: P.L.2017, c.48, s.3)

4. Section 4 of P.L.2001, c.236 (C.17B:27-46.1x) is amended to read as follows:

4. a. A group health insurance policy which provides hospital or medical expense benefits for groups with more than 50 persons, which includes pregnancy-related benefits, shall not be delivered, issued, executed or renewed in this State, or approved for issuance or renewal in this State by the Commissioner of Banking and Insurance on or after the effective date of this act unless the policy provides coverage for persons covered under the policy for medically necessary expenses, as determined by a physician, incurred in the diagnosis and treatment of infertility as provided pursuant to this section. The policy shall provide coverage for any services related to infertility that is recommended in accordance with American Society for Reproductive Medicine guidelines and as determined by a physician, which includes, but is not limited to, the following services related to infertility: diagnosis and diagnostic tests; medications; surgery; intrauterine insemination; in vitro fertilization, including in vitro fertilization using donor eggs and in vitro fertilization where the embryo is transferred to a gestational carrier or surrogate; genetic testing; artificial insemination; [gamete intra fallopian transfer; zygote intra fallopian transfer;] intracytoplasmic sperm injection; [and] four completed egg retrievals per lifetime of the covered person; unlimited embryo transfers, in accordance with guidelines from the American Society for Reproductive Medicine, using single embryo transfer when recommended and deemed medically appropriate by a physician; and medical costs of egg or sperm donors, including office visits, medications, laboratory and radiological procedures and retrieval, shall be covered until the donor is released from treatment by the reproductive endocrinologist. The policy may provide that coverage for in vitro fertilization, gamete intra fallopian transfer and zygote intra fallopian transfer shall be limited to a covered person who has used all reasonable, less expensive and medically appropriate
treatments, as determined by a licensed physician, and is still unable to become pregnant or carry a pregnancy to a live birth; b. has not reached the limit of four completed egg retrievals; and c. is 45 years of age or younger. Coverage for infertility services provided to partners of persons who have successfully reversed a voluntary sterilization shall not be excluded. A policy shall not impose any restriction concerning the coverage of infertility services based on age.

For purposes of, As used in this section:

“Infertility” means a disease or condition, or status characterized by any of the following:

1. A male is unable to impregnate a female;
2. A female with a male partner and under 35 years of age is unable to conceive after 12 months of unprotected sexual intercourse;
3. A female with a male partner and 35 years of age and over is unable to conceive after six months of unprotected sexual intercourse;
4. A female without a male partner and under 35 years of age who is unable to conceive after 12 failed attempts of intrauterine insemination under medical supervision;
5. A female without a male partner and over 35 years of age who is unable to conceive after six failed attempts of intrauterine insemination under medical supervision;
6. Partners are unable to conceive as a result of involuntary medical sterility;
7. A person is unable to carry a pregnancy to live birth; or
8. A previous determination of infertility pursuant to this section

1. the failure to establish a pregnancy or carry a pregnancy to term inability to achieve a successful pregnancy based on a patient’s medical, sexual, and reproductive history, age, physical findings, diagnostic testing, or any combination of those factors;
2. a person’s inability to reproduce as a single individual or with a partner of the individual without medical intervention the need for medical intervention, including, but not limited to, the use of donor gametes or donor embryos in order to achieve a successful pregnancy either as an individual or with a partner; or
3. a physician’s recommendation, diagnosis, treatment plan, or prescription based on a patient’s medical, sexual, and reproductive history, age, physical findings or diagnostic testing in patients having regular, unprotected intercourse and without any known etiology for either partner suggestive of impaired reproductive ability, evaluation should be initiated at 12 months when the female partner is under 35
years of age and at 6 months when the female partner is 35 years of age or older.

Nothing in this definition shall be used to deny or delay treatment to any individual, regardless of relationship status or sexual orientation. "Treatment of infertility" means the recommended treatment plan or prescribed procedures, services, and medications directed by a licensed physician for infertility as defined in this section.

The benefits shall be provided to the same extent as for other medical conditions under the policy, except that the services provided for in this section shall be performed at facilities that conform to standards established by the American Society for Reproductive Medicine or the American College of Obstetricians and Gynecologists. The same copayments, deductibles and benefit limits shall apply to the diagnosis and treatment of infertility pursuant to this section as those applied to other medical or surgical benefits under the contract. Infertility resulting from voluntary sterilization procedures shall be excluded under the contract for the coverage required by this section. Infertility resulting from a voluntary unreversed sterilization procedure may be excluded if the voluntary unreversed sterilization is the sole cause of infertility, provided, however, that coverage for infertility services shall not be excluded if the voluntary sterilization is successfully reversed. A policy shall not impose any exclusions, limitations, or restrictions on coverage of any fertility services provided by or to a third party.

b. A religious employer may request, and a hospital service corporation shall grant, an exclusion under the contract for the coverage required by this section for in vitro fertilization, embryo transfer, artificial insemination, zygote intra fallopian transfer and intracytoplasmic sperm injection, if the required coverage is contrary to the religious employer's bona fide religious tenets. The hospital service corporation that issues a contract containing such an exclusion shall provide written notice thereof to each prospective subscriber or subscriber, which shall appear in not less than 10 point type, in the contract, application and sales brochure. For the purposes of this subsection, "religious employer" means an employer that is a church, convention or association of churches or any group or entity that is operated, supervised or controlled by or in connection with a church or a convention or association of churches as defined in 26 U.S.C. s.3121(w)(3)(A), and that qualifies as a tax-exempt organization under 26 U.S.C. s.501(c)(3).

c. This section shall apply to those insurance policies in which the insurer has reserved the right to change the premium.

d. The provisions of this section shall not apply to a group health insurance policy which, pursuant to a contract between the insurer and the Department of Human Services, provides benefits to persons who are eligible for medical assistance under P.L.1968, c.413 (C.30:4D-1 et
seq.), the NJ FamilyCare Program established pursuant to P.L.2005, c.156 (C.30:4J-8 et al.), or any other program administered by the Division of Medical Assistance and Health Services in the Department of Human Services.

e. Nothing in this section shall preclude the insurer from performing utilization review, including periodic review of the medical necessity of a particular service, provided all utilization review decisions are consistent with American Society for Reproductive Medicine guidelines.²

(cf: P.L.2017, c.48, s.4)

5. Section 5 of P.L.2001²[c.236 (C.26:2J-4.23) is amended to read as follows:

5. a. No certificate of authority to establish and operate a health maintenance organization in this State shall be issued or continued on or after the effective date of this act unless the health maintenance organization provides health care services, to groups of more than 50 enrollees, for medically necessary expenses, as determined by a physician, incurred in the diagnosis and treatment of infertility as provided pursuant to this section. A health maintenance organization shall provide enrollee coverage for any services related to infertility that is recommended in accordance with American Society for Reproductive Medicine guidelines and as determined by a physician, which includes, but is not limited to, the following services related to infertility: diagnosis and diagnostic tests; medications; surgery; intrauterine insemination; in vitro fertilization², including in vitro fertilization using donor eggs and in vitro fertilization where the embryo is transferred to a gestational carrier or surrogate²; genetic testing; ²[embryo transfer;]² artificial insemination; [gamete intra fallopian transfer; zygote intra fallopian transfer;] intracytoplasmic sperm injection; [and] four completed egg retrievals [per lifetime of the covered person]; ²[and]² unlimited embryo transfers, in accordance with guidelines from the American Society for Reproductive Medicine, using single embryo transfer when recommended and deemed medically appropriate by a physician²; and medical costs of egg or sperm donors, including office visits, medications, laboratory and radiological procedures and retrieval, shall be covered until the donor is released from treatment by the reproductive endocrinologist². A health maintenance organization may provide that coverage for in vitro fertilization¹, gamete intra fallopian transfer and zygote intra fallopian transfer¹ shall be limited to a covered person who¹: a. has used all reasonable, less expensive and medically appropriate treatments, as determined by a licensed physician, and is still unable to become pregnant or carry a pregnancy to a live birth¹; b. has not reached the limit of four completed egg retrievals; and c. is 45 years of age or younger¹. Coverage for
infertility services provided to partners of persons who have successfully reversed a voluntary sterilization shall not be excluded.

A contract shall not impose any restriction concerning the coverage of infertility services based on age.

[For purposes of [1][a] As used in [1][this] this section [1]:

"Infertility" means a disease [or] condition, or status characterized by [1][any of the following] [that results in the abnormal function of the reproductive system, as determined pursuant to American Society for Reproductive Medicine practice guidelines by a physician who is Board Certified or Board Eligible in Reproductive Endocrinology and Infertility or in Obstetrics and Gynecology or that the patient has met one of the following conditions:

1. A male is unable to impregnate a female;
2. A female with a male partner and under 35 years of age is unable to conceive after 12 months of unprotected sexual intercourse;
3. A female with a male partner and 35 years of age and over is unable to conceive after six months of unprotected sexual intercourse;
4. A female without a male partner and under 35 years of age who is unable to conceive after 12 failed attempts of intrauterine insemination under medical supervision;
5. A female without a male partner and over 35 years of age who is unable to conceive after six failed attempts of intrauterine insemination under medical supervision;
6. Partners are unable to conceive as a result of involuntary medical sterility;
7. A person is unable to carry a pregnancy to live birth; or
8. A previous determination of infertility pursuant to this section

1. the [1][failure to establish a pregnancy or carry a pregnancy to term] inability to achieve a successful pregnancy based on a patient’s medical, sexual, and reproductive history, age, physical findings, diagnostic testing, or any combination of those factors;
2. A person’s inability to reproduce as a single individual or with a partner of the individual without medical intervention the need for medical intervention, including, but not limited to, the use of donor gametes or donor embryos in order to achieve a successful pregnancy either as an individual or with a partner; or
3. A physician’s recommendation, diagnosis, treatment plan, or prescription based on a patient’s medical, sexual, and reproductive history, age, physical findings or diagnostic testing in patients having regular, unprotected intercourse and without any known etiology for either partner suggestive of impaired reproductive ability, evaluation should be initiated at 12 months when the female partner is under 35 years of age and at 6 months when the female partner is 35 years of age or older.

Nothing in this definition shall be used to deny or delay treatment to any individual, regardless of relationship status or sexual orientation.
“Treatment of infertility” means the recommended treatment plan or prescribed procedures, services, and medications directed by a licensed physician for infertility as defined in this section.

The benefits shall be provided to the same extent as for other pregnancy-related procedures medical conditions under the contract, except that the services provided for in this section shall be performed at facilities that conform to standards established by the American Society for Reproductive Medicine or the American College of Obstetricians and Gynecologists. The same copayments, deductibles and benefit limits shall apply to the diagnosis and treatment of infertility pursuant to this section as those applied to other medical or surgical benefits under the contract. Infertility resulting from voluntary sterilization procedures shall be excluded under the contract for the coverage required by this section. Infertility resulting from a voluntary unreversed sterilization procedure may be excluded if the voluntary unreversed sterilization is the sole cause of infertility, provided, however, that coverage for infertility services shall not be excluded if the voluntary sterilization is successfully reversed. A contract shall not impose any exclusions, limitations, or restrictions on coverage of any fertility services provided by or to a third party.

b. A religious employer may request, and a health maintenance organization shall grant, an exclusion under the contract for the coverage required by this section for in vitro fertilization, embryo transfer, artificial insemination, zygote intrafallopian transfer and intracytoplasmic sperm injection, if the required coverage is contrary to the religious employer’s bona fide religious tenets. The hospital service corporation that issues a contract containing such an exclusion shall provide written notice thereof to each prospective subscriber or subscriber, which shall appear in not less than 10 point type, in the contract, application and sales brochure. For the purposes of this subsection, "religious employer" means an employer that is a church, convention or association of churches or any group or entity that is operated, supervised or controlled by or in connection with a church or a convention or association of churches as defined in 26 U.S.C. s.3121(w)(3)(A), and that qualifies as a tax-exempt organization under 26 U.S.C. s.501(c)(3).

c. The provisions of this section shall apply to those contracts for health care services by health maintenance organizations under which the right to change the schedule of charges for enrollee coverage is reserved.

d. The provisions of this section shall not apply to a contract for health care services by a health maintenance organization which, pursuant to a contract between the health maintenance organization and the Department of Human Services, provides benefits to persons who are eligible for medical assistance under P.L.1968, c.413 (C.30:4D-1 et seq.), the NJ FamilyCare Program established pursuant to P.L.2005, c.156 (C.30:4J-8 et al.), or any other program
administered by the Division of Medical Assistance and Health Services in the Department of Human Services.

2e. Nothing in this section shall preclude the health maintenance organization from performing utilization review, including periodic review of the medical necessity of a particular service, provided all utilization review decisions are consistent with American Society for Reproductive Medicine guidelines.²

(cf: P.L.2017, c.48, s.5)

6. (New section) a. Every individual health benefits plan that provides hospital or medical expense benefits and is delivered, issued, executed or renewed in this State pursuant to P.L.1992, c.161 (C.17B:27A-2 et seq.), or approved for issuance or renewal in this State on or after the effective date of this act, shall provide benefits to any person covered thereunder for medically necessary expenses incurred in the diagnosis and treatment of infertility as provided pursuant to this section. The individual health benefits plan shall provide for any services related to infertility that is recommended by a physician, which includes, but is not limited to: diagnosis and diagnostic tests; medications; surgery; intrauterine insemination; in vitro fertilization; genetic testing; embryo transfer; artificial insemination; intracytoplasmic sperm injection; four completed egg retrievals; and unlimited embryo transfers, in accordance with guidelines from the American Society for Reproductive Medicine, using single embryo transfer when recommended and deemed medically appropriate by a physician. The plan may provide that coverage for in vitro fertilization shall be limited to a covered person who has used all reasonable, less expensive and medically appropriate treatments, as determined by a licensed physician, and is still unable to become pregnant or carry a pregnancy to a live birth. Coverage for infertility services provided to partners of persons who have successfully reversed a voluntary sterilization shall not be excluded.

b. As used in this this section:

"Infertility" means a disease, condition, or status characterized by:

(1) the failure to establish a pregnancy or carry a pregnancy to term;
(2) a person’s inability to reproduce as a single individual or with a partner of the individual without medical intervention; or
(3) a physician’s recommendation, diagnosis, treatment plan, or prescription based on a patient’s medical, sexual, and reproductive history, age, physical findings or diagnostic testing.

“Treatment of infertility” means the recommended treatment plan or prescribed procedures, services, and medications directed by a licensed physician for infertility as defined in this section.

The benefits shall be provided to the same extent as for other medical conditions under the health benefits plan, except that the
services provided for in this section shall be performed at facilities that conform to standards established by the American Society for Reproductive Medicine or the American College of Obstetricians and Gynecologists. The same copayments, deductibles and benefit limits shall apply to the diagnosis and treatment of infertility pursuant to this section as those applied to other medical or surgical benefits under the plan. Infertility resulting from a voluntary unreversed sterilization procedure may be excluded if the voluntary unreversed sterilization is the sole cause of infertility, provided, however, that coverage for infertility services shall not be excluded if the voluntary sterilization is successfully reversed. A plan shall not impose any exclusions, limitations, or restrictions on coverage of any fertility services provided by or to a third party.

c. A religious employer may request, and a health maintenance organization shall grant, an exclusion under the contract for the coverage required by this section for in vitro fertilization, embryo transfer, artificial insemination, zygote intra fallopian transfer and intracytoplasmic sperm injection, if the required coverage is contrary to the religious employer's bona fide religious tenets. The hospital service corporation that issues a contract containing such an exclusion shall provide written notice thereof to each prospective subscriber or subscriber, which shall appear in not less than 10 point type, in the contract, application and sales brochure. For the purposes of this subsection, "religious employer" means an employer that is a church, convention or association of churches or any group or entity that is operated, supervised or controlled by or in connection with a church or a convention or association of churches as defined in 26 U.S.C. s.3121(w)(3)(A), and that qualifies as a tax-exempt organization under 26 U.S.C. s.501(c)(3).

d. This section shall apply to all individual health benefit plans in which the carrier has reserved the right to change the premium.

e. The provisions of this section shall not apply to an individual health benefit plan contract which, pursuant to a contract between the individual health benefit plan and the Department of Human Services, provides benefits to persons who are eligible for medical assistance under P.L.1968, c.413 (C.30:4D-1 et seq.), the NJ FamilyCare Program established pursuant to P.L.2005, c.156 (C.30:4J-8 et al.), or any other program administered by the Division of Medical Assistance and Health Services in the Department of Human Services.]

7. (New section) a. Every small employer health benefits plan that provides hospital or medical expense benefits and is delivered, issued, executed or renewed in this State pursuant to P.L.1992, c.162 (C.17B:27A-17 et seq.), or approved for issuance or renewal in this State on or after the effective date of this act, shall provide to any person covered thereunder for medically necessary expenses incurred in the diagnosis and treatment of infertility as provided
pursuant to this section. The health benefits plan shall provide for any services related to infertility that is recommended by a physician, which includes, but is not limited to: diagnosis and diagnostic tests; medications; surgery; intrauterine insemination; in vitro fertilization; genetic testing; embryo transfer; artificial insemination; intracytoplasmic sperm injection; four completed egg retrievals; and unlimited embryo transfers, in accordance with guidelines from the American Society for Reproductive Medicine, using single embryo transfer when recommended and deemed medically appropriate by a physician. The health benefits plan may provide that coverage for in vitro fertilization shall be limited to a covered person who has used all reasonable, less expensive and medically appropriate treatments, as determined by a licensed physician, and is still unable to become pregnant or carry a pregnancy to a live birth. Coverage for infertility services provided to partners of persons who have successfully reversed a voluntary sterilization shall not be excluded.

b. As used in this section:

"Infertility" means a disease, condition, or status characterized by:

1. the failure to establish a pregnancy or carry a pregnancy to term;
2. a person’s inability to reproduce as a single individual or with a partner of the individual without medical intervention; or
3. a physician’s recommendation, diagnosis, treatment plan, or prescription based on a patient’s medical, sexual, and reproductive history, age, physical findings or diagnostic testing.

“Treatment of infertility” means the recommended treatment plan or prescribed procedures, services, and medications directed by a licensed physician for infertility as defined in this section.

The benefits shall be provided to the same extent as for other medical conditions under the health benefits plan, except that the services provided for in this section shall be performed at facilities that conform to standards established by the American Society for Reproductive Medicine or the American College of Obstetricians and Gynecologists. The same copayments, deductibles and benefit limits shall apply to the diagnosis and treatment of infertility pursuant to this section as those applied to other medical or surgical benefits under the plan. Infertility resulting from a voluntary unreversed sterilization procedure may be excluded if the voluntary unreversed sterilization is the sole cause of infertility, provided, however, that coverage for infertility services shall not be excluded if the voluntary sterilization is successfully reversed. A plan shall not impose any exclusions, limitations, or restrictions on coverage of any fertility services provided by or to a third party.

c. A religious employer may request, and a health maintenance organization shall grant, an exclusion under the contract for the coverage required by this section for in vitro fertilization, embryo
transfer, artificial insemination, zygote intra fallopian transfer and intracytoplasmic sperm injection, if the required coverage is contrary to the religious employer's bona fide religious tenets. The hospital service corporation that issues a contract containing such an exclusion shall provide written notice thereof to each prospective subscriber or subscriber, which shall appear in not less than 10 point type, in the contract, application and sales brochure. For the purposes of this subsection, "religious employer" means an employer that is a church, convention or association of churches or any group or entity that is operated, supervised or controlled by or in connection with a church or a convention or association of churches as defined in 26 U.S.C. s.3121(w)(3)(A), and that qualifies as a tax-exempt organization under 26 U.S.C. s.501(c)(3).

d. The provisions of this section shall apply to all health benefit plans in which the carrier has reserved the right to change the premium.

e. The provisions of this section shall not apply to a small employer health benefits plan contract which, pursuant to a contract between the small employer health benefits plan and the Department of Human Services, provides benefits to persons who are eligible for medical assistance under P.L.1968, c.413 (C.30:4D-1 et seq.), the NJ FamilyCare Program established pursuant to P.L.2005, c.156 (C.30:4J-8 et al.), or any other program administered by the Division of Medical Assistance and Health Services in the Department of Human Services.

[6] 18 6. Section 6 of P.L.2017, c.48 (C.52:14-17.29y) is amended to read as follows:

   6. The State Health Benefits Commission shall ensure that every contract under the State Health Benefits Program shall provide coverage for medically necessary expenses, as determined by a physician, incurred in the diagnosis and treatment of infertility as provided pursuant to this section. The State Health Benefits Program shall provide coverage for any services related to infertility that is recommended in accordance with American Society for Reproductive Medicine guidelines and as determined by a physician, which includes, but is not limited to, the following services related to infertility: diagnosis and diagnostic tests; medications; surgery; intraterine insemination; in vitro fertilization, including in vitro fertilization using donor eggs and in vitro fertilization where the embryo is transferred to a gestational carrier or surrogate; genetic testing; embryo transfer; artificial insemination; gamete intra fallopian transfer; zygote intra fallopian transfer; intracytoplasmic sperm injection; and four completed egg retrievals per lifetime of the covered person; unlimited embryo transfers, in accordance with guidelines from the American Society for Reproductive Medicine, using single embryo transfer when
recommended and deemed medically appropriate by a physician; and medical costs of egg or sperm donors, including office visits, medications, laboratory and radiological procedures and retrieval, shall be covered until the donor is released from treatment by the reproductive endocrinologist. The State Health Benefits Commission may provide that coverage for in vitro fertilization, gamete intrafallopian transfer and zygote intrafallopian transfer shall be limited to a covered person who has used all reasonable, less expensive and medically appropriate treatments, as determined by a licensed physician, and is still unable to become pregnant or carry a pregnancy to a live birth. b. has not reached the limit of four completed egg retrievals; and c. is 45 years of age or younger. Coverage for infertility services provided to partners of persons who have successfully reversed a voluntary sterilization shall not be excluded.

A contract shall not impose any restriction concerning the coverage of infertility services based on age.

For purposes of this section, "Infertility" means a disease, condition, or status characterized by any of the following: (1) A male is unable to impregnate a female; (2) A female with a male partner and under 35 years of age is unable to conceive after 12 months of unprotected sexual intercourse; (3) A female with a male partner and 35 years of age and over is unable to conceive after six months of unprotected sexual intercourse; (4) A female without a male partner and under 35 years of age who is unable to conceive after 12 failed attempts of intrauterine insemination under medical supervision; (5) A female without a male partner and over 35 years of age who is unable to conceive after six failed attempts of intrauterine insemination under medical supervision; (6) Partners are unable to conceive as a result of involuntary medical sterility; (7) A person is unable to carry a pregnancy to live birth; or (8) A previous determination of infertility pursuant to this section.

(1) the failure to establish a pregnancy or carry a pregnancy to term inability to achieve a successful pregnancy based on a patient’s medical, sexual, and reproductive history, age, physical findings, diagnostic testing, or any combination of those factors; (2) a person’s inability to reproduce as a single individual or with a partner of the individual without medical intervention the need for medical intervention, including, but not limited to, the use of donor
gametes or donor embryos in order to achieve a successful pregnancy
either as an individual or with a partner; or
(3) A physician’s recommendation, diagnosis, treatment plan, or
prescription based on a patient’s medical, sexual, and reproductive
history, age, physical findings or diagnostic testing in patients having
regular, unprotected intercourse and without any known etiology for
either partner suggestive of impaired reproductive ability, evaluation
should be initiated at 12 months when the female partner is under 35
years of age and at 6 months when the female partner is 35 years of
age or older.
Nothing in this definition shall be used to deny or delay treatment
to any individual, regardless of relationship status or sexual
orientation.
“Treatment of infertility” means the recommended treatment plan
or prescribed procedures, services, and medications directed by a
licensed physician for infertility as defined in this section.
The benefits shall be provided to the same extent as for other
[pregnancy-related procedures] medical conditions under the contract,
except that the services provided for in this section shall be performed
at facilities that conform to standards established by the American
Society for Reproductive Medicine or the American College of
Obstetricians and Gynecologists. The same copayments, deductibles
and benefit limits shall apply to the diagnosis and treatment of
infertility pursuant to this section as those applied to other medical or
surgical benefits under the contract. [Infertility resulting from
voluntary sterilization procedures shall be excluded under the contract
for the coverage required by this section] Infertility resulting from a
voluntary unreversed sterilization procedure may be excluded if the
voluntary unreversed sterilization is the sole cause of infertility,
provided, however, that coverage for infertility services shall not be
excluded if the voluntary sterilization is successfully reversed. [A
contract shall not impose any exclusions, limitations, or restrictions on
coverage of any fertility services provided by or to a third party]
Nothing in this section shall preclude the carrier from performing
utilization review, including periodic review of the medical necessity
of a particular service, provided all utilization review decisions are
consistent with American Society for Reproductive Medicine
guidelines.
(cf: P.L.2017, c.48, s.6)

[7] 7'. Section 7 of P.L.2017, c.48 (C.52:14-17.46.6g) is
amended to read as follows:
7. The School Employees Health Benefits Commission shall
ensure that every contract under the School Employees Health
Benefits Program shall provide coverage for medically necessary
costs, as determined by a physician, incurred in the diagnosis and
treatment of infertility as provided pursuant to this section. The
School Employees Health Benefits Program contract shall provide coverage for any services related to infertility (that is recommended) in accordance with American Society for Reproductive Medicine guidelines and as determined by a physician, which includes, but is not limited to, the following services related to infertility: diagnosis and diagnostic tests; medications; surgery; intrauterine insemination; in vitro fertilization, including in vitro fertilization using donor eggs and in vitro fertilization where the embryo is transferred to a gestational carrier or surrogate; genetic testing; artificial insemination; gamete intrafallopian transfer; zygote intrafallopian transfer; intracytoplasmic sperm injection; embryo transfer; gamete intrafallopian transfer; and four completed egg retrievals per lifetime of the covered person; unlimited embryo transfers, in accordance with guidelines from the American Society for Reproductive Medicine, using single embryo transfer when recommended and deemed medically appropriate by a physician; and medical costs of egg or sperm donors, including office visits, medications, laboratory and radiological procedures and retrieval, shall be covered until the donor is released from treatment by the reproductive endocrinologist. The School Employees Health Benefits Commission may provide that coverage for in vitro fertilization, gamete intrafallopian transfer and zygote intrafallopian transfer shall be limited to a covered person who: a. has used all reasonable, less expensive and medically appropriate treatments, as determined by a licensed physician, and is still unable to become pregnant or carry a pregnancy to a live birth; b. has not reached the limit of four completed egg retrievals; and c. is 45 years of age or younger. Coverage for infertility services provided to partners of persons who have successfully reversed a voluntary sterilization shall not be excluded. A contract shall not impose any restriction concerning the coverage of infertility services based on age. For purposes of this section: "Infertility" means a disease or condition, or status characterized by any of the following: that results in the abnormal function of the reproductive system, as determined pursuant to American Society for Reproductive Medicine practice guidelines by a physician who is Board Certified or Board Eligible in Reproductive Endocrinology and Infertility or in Obstetrics and Gynecology or that the patient has met one of the following conditions:

1. A male is unable to impregnate a female;
2. A female with a male partner and under 35 years of age is unable to conceive after 12 months of unprotected sexual intercourse;
3. A female with a male partner and 35 years of age and over is unable to conceive after six months of unprotected sexual intercourse;
4. A female without a male partner and under 35 years of age who is unable to conceive after 12 failed attempts of intrauterine insemination under medical supervision;
(5) A female without a male partner and over 35 years of age who is unable to conceive after six failed attempts of intrauterine insemination under medical supervision;

(6) Partners are unable to conceive as a result of involuntary medical sterility;

(7) A person is unable to carry a pregnancy to live birth; or

(8) A previous determination of infertility pursuant to this section

(1) the [failure to establish a pregnancy or carry a pregnancy to term] inability to achieve a successful pregnancy based on a patient’s medical, sexual, and reproductive history, age, physical findings, diagnostic testing, or any combination of those factors;

(2) [A person’s inability to reproduce as a single individual or with a partner of the individual without medical intervention] the need for medical intervention, including, but not limited to, the use of donor gametes or donor embryos in order to achieve a successful pregnancy either as an individual or with a partner; or

(3) [A physician’s recommendation, diagnosis, treatment plan, or prescription based on a patient’s medical, sexual, and reproductive history, age, physical findings or diagnostic testing] in patients having regular, unprotected intercourse and without any known etiology for either partner suggestive of impaired reproductive ability, evaluation should be initiated at 12 months when the female partner is under 35 years of age and at 6 months when the female partner is 35 years of age or older.

Nothing in this definition shall be used to deny or delay treatment to any individual, regardless of relationship status or sexual orientation.

“Treatment of infertility” means the recommended treatment plan or prescribed procedures, services, and medications directed by a licensed physician for infertility as defined in this section.

The benefits shall be provided to the same extent as for other pregnancy-related procedures. medical conditions under the contract, except that the services provided for in this section shall be performed at facilities that conform to standards established by the American Society for Reproductive Medicine or the American College of Obstetricians and Gynecologists. The same copayments, deductibles and benefit limits shall apply to the diagnosis and treatment of infertility pursuant to this section as those applied to other medical or surgical benefits under the contract. Infertility resulting from voluntary sterilization procedures shall be excluded under the contract for the coverage required by this section. Infertility resulting from a voluntary unreversed sterilization procedure may be excluded under the contract if the voluntary unreversed sterilization is the sole cause of infertility, provided, however, that coverage for infertility services shall not be excluded if the voluntary sterilization is successfully reversed. [A contract shall not impose any exclusions, limitations, or
restrictions on coverage of any fertility services provided by or to a third party.

Nothing in this section shall preclude the carrier from performing utilization review, including periodic review of the medical necessity of a particular service, provided all utilization review decisions are consistent with American Society for Reproductive Medicine guidelines.

(cf: P.L.2017, c.48, s.7)

This act shall take effect immediately on the first day of the seventh month next following the date of enactment and shall apply to contracts issued or renewed on or after the effective date.