(II) IS WRITTEN ON AN EXPENSE–INCURRED BASIS; AND

(3) EACH INDIVIDUAL OR GROUP MEDICAL OR MAJOR MEDICAL CONTRACT OR CERTIFICATE OF A NONPROFIT HEALTH SERVICE PLAN THAT:

(I) IS ISSUED OR DELIVERED IN THE STATE; OR

(II) COVERS INDIVIDUALS WHO RESIDE AND WORK IN THE STATE.

(B) EXCLUSION OF BENEFITS PROHIBITED.

(1) A POLICY, CONTRACT, OR CERTIFICATE 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 THE POLICYHOLDER, SUBSCRIBER, OR CERTIFICATE HOLDER; OR DEPENDENT SPOUSE OF THE POLICYHOLDER, SUBSCRIBER, OR CERTIFICATE HOLDER.

(2) THE BENEFITS UNDER THIS SUBSECTION SHALL BE PROVIDED TO THE SAME EXTENT AS THE BENEFITS PROVIDED FOR OTHER PREGNANCY-RELATED PROCEDURES.

(C) CONDITIONS FOR PROVISION OF BENEFITS.

SUBSECTION (B) OF THIS SECTION APPLIES IF:

(1) THE PATIENT IS THE POLICYHOLDER, SUBSCRIBER, OR CERTIFICATE HOLDER, OR A COVERED DEPENDENT OF THE POLICYHOLDER, SUBSCRIBER, OR CERTIFICATE HOLDER;

(2) THE PATIENT'S OOCYTES ARE FERTILIZED WITH THE PATIENT'S SPOUSE'S SPERM;

(3) (I) THE PATIENT AND THE PATIENT'S SPOUSE HAVE A HISTORY OF INFERTILITY OF AT LEAST 5 YEARS' DURATION; OR

(II) THE INFERTILITY IS ASSOCIATED WITH ANY OF THE FOLLOWING MEDICAL CONDITIONS:

1. ENDOMETRIOSIS;

2. EXPOSURE IN UTERO TO DIETHYLSTILBESTROL, COMMONLY KNOWN AS DES; OR

3. BLOCKAGE OF, OR SURGICAL REMOVAL OF, ONE OR BOTH FALLOPIAN TUBES (LATERAL OR BILATERAL SALPINGECTOMY);

(4) THE PATIENT HAS BEEN UNABLE TO ATTAIN A SUCCESSFUL PREGNANCY THROUGH A LESS COSTLY INFERTILITY TREATMENT FOR WHICH COVERAGE IS AVAILABLE UNDER THE POLICY, CONTRACT, OR CERTIFICATE; AND

(5) THE IN VITRO FERTILIZATION PROCEDURES ARE PERFORMED AT MEDICAL FACILITIES THAT CONFORM TO THE AMERICAN COLLEGE OF