**** Bill No. ****

Introduced By **********

By Request of the *********

A Bill for an Act entitled: "An Act providing for an individual limited health benefit plan; amending sections 33-22-111, 33-22-114, 33-22-131, 33-22-132, 33-22-134, 33-22-135, 33-22-242, 33-22-245, 33-22-301, 33-22-303, 33-22-304, 33-22-703, and 33-22-706, MCA; and providing a delayed effective date."

Be it enacted by the Legislature of the State of Montana:

Section 1. Section 33-22-111, MCA, is amended to read:

"33-22-111. Policies and certificates to provide for freedom of choice of practitioners -- professional practice not enlarged. (1) (a) ~~All~~ Except as provided in subsection (1)(b), all policies or certificates of disability insurance, including individual, group, and blanket policies or certificates, must provide that the insured has full freedom of choice in the selection of any licensed physician, physician assistant, dentist, osteopath, chiropractor, optometrist, podiatrist, psychologist, licensed social worker, licensed professional counselor, acupuncturist, naturopathic physician, physical therapist, or advanced practice registered nurse as specifically listed in 37-8-202 for treatment of any illness or injury within the scope and limitations of the person's practice. Whenever the policies or certificates insure against the expense of drugs, the

insured has full freedom of choice in the selection of any licensed and registered pharmacist.

(b) This section does not apply to an individual limited health benefit plan provided for in 33-22-245.

(2) This section may not be construed as enlarging the scope and limitations of practice of any of the licensed professions enumerated in subsection (1). This section may not be construed as amending, altering, or repealing any statutes relating to the licensing or use of hospitals."

{*Internal References to 33-22-111:*
33-22-101 *33-30-102*}

Section 2. Section 33-22-114, MCA, is amended to read:

"33-22-114. Coverage required for services provided by physician assistants. (1) ~~An~~ Except as provided in subsection (2), an insurer, a health service corporation, or any employee health and welfare fund that provides accident or health insurance benefits to residents of this state shall provide, in group and individual insurance contracts, coverage for health services provided by a physician assistant as normally covered by contracts for services supplied by a physician if health care services that the physician assistant is approved to perform are covered by the contract.

(2) The provisions of subsection (1) do not apply to an individual limited health benefit plan provided for in 33-22-245."

{*Internal References to 33-22-114:*
33-22-101}

Section 3. Section 33-22-131, MCA, is amended to read:

"33-22-131. Coverage for treatment of inborn errors of metabolism. (1) (a) ~~Each~~ Except as provided in subsection (5), each group or individual medical expense disability policy, certificate of insurance, and membership contract that is delivered, issued for delivery, renewed, extended, or modified in this state must provide coverage for the treatment of inborn errors of metabolism that involve amino acid, carbohydrate, and fat metabolism and for which medically standard methods of diagnosis, treatment, and monitoring exist.

(2) Coverage must include expenses of diagnosing, monitoring, and controlling the disorders by nutritional and medical assessment, including but not limited to clinical services, biochemical analysis, medical supplies, prescription drugs, corrective lenses for conditions related to the inborn error of metabolism, nutritional management, and medical foods used in treatment to compensate for the metabolic abnormality and to maintain adequate nutritional status.

(3) For purposes of this section:

(a) "medical foods" means nutritional substances in any form that are:

(i) formulated to be consumed or administered enterally under supervision of a physician;

(ii) specifically processed or formulated to be distinct in one or more nutrients present in natural food;

(iii) intended for the medical and nutritional management of

patients with limited capacity to metabolize ordinary foodstuffs or certain nutrients contained in ordinary foodstuffs or who have other specific nutrient requirements as established by medical evaluation; and

(iv) essential to optimize growth, health, and metabolic homeostasis;

(b) "treatment" means licensed professional medical services under the supervision of a physician.

(4) These services are subject to the terms of the applicable group or individual disability policy, certificate, or membership contract that establishes durational limits, dollar limits, deductibles, and copayment provisions as long as the terms are not less favorable than for physical illness generally.

(5) This section does not apply to an individual limited health benefit plan provided for in 33-22-245 or disability income, hospital indemnity, medicare supplement, accident-only, vision, dental, or specified disease policies."

{*Internal References to 33-22-131:*
2-18-704 *33-22-101** *33-22-262* *33-31-102*
33-31-111 *33-31-111* *33-35-306*}

Section 4. Section 33-22-132, MCA, is amended to read:

"33-22-132. Coverage for mammography examinations. (1) ~~Each~~ Except as provided in subsection (4), each group or individual medical expense, cancer, and blanket disability policy, certificate of insurance, and membership contract that is delivered, issued for delivery, renewed, extended, or modified in this state must provide minimum mammography examination coverage.

(2) For the purpose of this section, "minimum mammography examination" means:

(a) one baseline mammogram for a woman who is 35 years of age or older and under 40 years of age;

(b) a mammogram every 2 years for any woman who is 40 years of age or older and under 50 years of age or more frequently if recommended by the woman's physician; and

(c) a mammogram each year for a woman who is 50 years of age or older.

(3) A minimum $70 payment or the actual charge if the charge is less than $70 must be made for each mammography examination performed before the application of the terms of the applicable group or individual disability policy, certificate of insurance, or membership contract that establish durational limits, deductibles, and copayment provisions as long as the terms are not less favorable than for physical illness generally.

(4) This section does not apply to an individual limited health benefit plan provided for in 33-22-245 or disability income, hospital indemnity, medicare supplement, accident-only, vision, dental, or specified disease policies."

{*Internal References to 33-22-132:*
*33-22-101** *33-22-1827* *33-31-102* *53-6-101*}

Section 5. Section 33-22-134, MCA, is amended to read:

"33-22-134. Postmastectomy care. ~~Each~~ (1) Except as provided in subsection (2), each group and individual disability policy, certificate of insurance, or membership contract that is

delivered, issued for delivery, renewed, extended, or modified in this state must provide coverage for hospital inpatient care for a period of time as is determined by the attending physician and, in the case of a health maintenance organization, also the primary care physician, in consultation with the patient, to be medically necessary following a mastectomy, a lumpectomy, or a lymph node dissection for the treatment of breast cancer. This section also applies to the state employee group insurance program, the university system employee group insurance program, any employee group insurance program of a city, town, county, school district, or other political subdivision of the state, and any self-funded multiple employer welfare arrangement that is not regulated by the Employee Retirement Income Security Act of 1974.

(2) An individual limited health benefit plan provided for in 33-22-245 may exclude the coverage in subsection (1) that is not mandated by the Women's Health and Cancer Rights Act of 1998, 42 U.S.C. 300gg-6 through 300gg-52."

{*Internal References to 33-22-134:*
*33-22-101** *33-31-111* *33-31-111* *33-35-306*}

Section 6. Section 33-22-135, MCA, is amended to read:

"33-22-135. Coverage for reconstructive breast surgery after mastectomy. (1) ~~Each~~ Except as provided in subsection (2), each group and individual disability policy, certificate of insurance, or membership contract that is delivered, issued for delivery, renewed, extended, or modified in this state must provide coverage for:

(a) reconstructive breast surgery resulting from a mastectomy that resulted from breast cancer.

~~(2) Each group and individual disability policy, certificate of insurance, or membership contract that is delivered, issued for delivery, renewed, extended, or modified in this state must provide coverage for~~; and

(b) all stages of one reconstructive breast surgery on the nondiseased breast to establish symmetry with the diseased breast after definitive reconstructive breast surgery on the diseased breast has been performed.

(2) An individual limited health benefit plan provided for in 33-22-245 may exclude the coverage in subsection (1) that is not mandated by the Women's Health and Cancer Rights Act of 1998, 42 U.S.C. 300gg-6 through 300gg-52.

(3) For the purposes of this section:

(a) "mastectomy" means the surgical removal of all or part of a breast as a result of breast cancer;

(b) "reconstructive breast surgery" means surgery performed as a result of a mastectomy to reestablish symmetry between the breasts. The term includes augmentation mammoplasty, reduction mammoplasty, and mastopexy.

(4) Benefits for reconstructive breast surgery include but are not limited to the costs of prostheses and, under any contract providing outpatient x-ray or radiation therapy, benefits for outpatient chemotherapy following surgical procedures in connection with the treatment of breast cancer that must be included as a part of the outpatient x-ray or radiation

therapy benefit."

{*Internal References to 33-22-135:*
*33-22-101** *33-31-111* *33-31-111* *33-35-306*}

Section 7. Section 33-22-242, MCA, is amended to read:

"33-22-242. Waiver of preexisting condition exclusion -- exclusion prohibited. (1) (a) ~~A~~ Except as provided in subsection (1)(b), ahealth care insurer shall waive any time period applicable to a preexisting condition exclusion or limitation period with respect to particular services in an individual health benefit plan for the period of time that an individual was previously covered by qualifying previous coverage that provided benefits with respect to those services, if the qualifying previous coverage was continuous to a date not more than 30 days prior to the date of application for new coverage.

(b) This subsection does not apply to an individual limited health benefit plan provided for in 33-22-245.

(2) A health care insurer that offers individual health insurance coverage to a federally defined eligible individual may not impose a preexisting condition exclusion with respect to that coverage."

{*Internal References to 33-22-242:*
33-22-241x}

Section 8. Section 33-22-245, MCA, is amended to read:

"33-22-245. Uniform individual health benefit plan -- individual limited health benefit plan. (1) Each insurer or health service corporation delivering or issuing for delivery in

this state a health benefit plan, as defined in 33-22-243, to an individual shall make available a uniform health benefit plan providing the benefits and services required in subsection (2) and an individual limited health benefit plan providing the benefits and services required in subsection (3).

(2) The uniform health benefit plan must:

(a) provide coverage for the services and articles required by 33-22-1521(2);

(b) pay 50% of the covered expenses in excess of an annual deductible that may not exceed $1,000 per person or $2,000 per family;

(c) include a limitation of $5,000 per person or $7,500 per family on the total annual out-of-pocket expenses for services covered; and

(d) be subject to a maximum lifetime benefit of $1 million.

(3) The individual limited health benefit plan must:

(a) provide medically necessary hospital services when prescribed by a physician or other licensed health care professional except as limited by the contract;

(b) pay 50% of the covered expenses in excess of an annual deductible that is specified in the contract in at least 10-point type and that allows separate triggering amounts for the individual and any family members that the individual policy holder may include under the policy;

(c) specify a limit in the contract in at least 10-point type that states total annual out-of-pocket expenses for services covered. The limit may be different for the individual and for

any family members that the individual policy holder may include under the policy.

(3) (a) Except as provided in ~~this section~~ subsection (2) or as provided in subsection (b) of this subsection, a health insurance issuer may exclude any category of licensed health care practitioner and any benefit or coverage for health care services otherwise required by law or rule from an individual uniform health benefit plan or an individual limited health benefit plan delivered or issued for delivery in this state.

(b) A uniform health benefit plan and an individual limited health benefit plan:

(i) may not discriminate as provided in 49-2-309;

(ii) must comply with federal individual insurance mandates; and

(iii) must meet network adequacy and quality assurance provisions in Title 33, chapter 36."

{*Internal References to 33-22-245:*
33-31-322x}

Section 9. Section 33-22-301, MCA, is amended to read:

"33-22-301. (Temporary) Coverage of newborn under disability policy. (1) (a) Except as provided in 33-22-262 and subsection (1)(b) of this section, each policy of disability insurance or certificate issued must contain a provision granting immediate accident and sickness coverage, from and after the moment of birth, to each newborn infant of any insured.

(b) Except as required by order under 40-5-208 or as

required under 42 U.S.C. 300gg-6 through 300gg-52, this section does not apply to an individual limited health benefit plan provided for in 33-22-245.

(2) The coverage for newborn infants must be the same as provided by the policy for the other covered persons. However, for newborn infants there may not be waiting or elimination periods. A deductible or reduction in benefits applicable to the coverage for newborn infants is not permissible unless it conforms and is consistent with the deductible or reduction in benefits applicable to all other covered persons.

(3) Except as provided in 33-22-262, a policy or certificate of insurance may not be issued or amended in this state if it contains any disclaimer, waiver, or other limitation of coverage relative to the accident and sickness coverage or insurability of newborn infants of an insured from and after the moment of birth.

(4) The policy or contract may require notification of the birth of a child and payment of a required premium or subscription fee to be furnished to the insurer or nonprofit or indemnity corporation within 31 days of the birth in order to have the coverage extend beyond 31 days. (Terminates June 30, 2009--sec. 14, Ch. 325, L. 2003.)

33-22-301. (Effective July 1, 2009) Coverage of newborn under disability policy. (1) (a) ~~Each~~ Except as provided in subsection (1)(b), a policy of disability insurance or certificate issued must contain a provision granting immediate accident and sickness coverage, from and after the moment of

birth, to each newborn infant of any insured.

(b) Except as required by order under 40-5-208 or as required under 42 U.S.C. 300gg-6 through 300gg-52, this section does not apply to an individual limited health benefit plan provided for in 33-22-245.

(2) The coverage for newborn infants must be the same as provided by the policy for the other covered persons. However, that for newborn infants there may not be waiting or elimination periods. A deductible or reduction in benefits applicable to the coverage for newborn infants is not permissible unless it conforms and is consistent with the deductible or reduction in benefits applicable to all other covered persons.

(3) A policy or certificate of insurance may not be issued or amended in this state if it contains any disclaimer, waiver, or other limitation of coverage relative to the accident and sickness coverage or insurability of newborn infants of an insured from and after the moment of birth.

(4) The policy or contract may require notification of the birth of a child and payment of a required premium or subscription fee to be furnished to the insurer or nonprofit or indemnity corporation within 31 days of the birth in order to have the coverage extend beyond 31 days."

{*Internal References to 33-22-301:*
33-22-101 *33-22-262* *33-22-1521* *40-5-816*}

Section 10. Section 33-22-303, MCA, is amended to read:

"33-22-303. Coverage for well-child care. (1) (a) ~~Each~~

Except as provided in subsection (4), each medical expense policy of disability insurance or certificate issued under the policy that is delivered, issued for delivery, renewed, extended, or modified in this state by a disability insurer and that provides coverage for a family member of the insured or subscriber must provide coverage for well-child care for children from the moment of birth through 7 years of age. Benefits provided under this coverage are exempt from any deductible provision that may be in force in the policy or certificate issued under the policy.

(2) Coverage for well-child care under subsection (1)(a) must include:

(a) a history, physical examination, developmental assessment, anticipatory guidance, and laboratory tests, according to the schedule of visits adopted under the early and periodic screening, diagnosis, and treatment services program provided for in 53-6-101; and

(b) routine immunizations according to the schedule for immunizations recommended by the immunization practices advisory committee of the U.S. department of health and human services.

(3) Minimum benefits may be limited to one visit payable to one provider for all of the services provided at each visit cited in this section.

(4) This section does not apply to individual limited health benefit plans, or disability income, specified disease, accident-only, medicare supplement, or hospital indemnity policies.

(5) For purposes of this section:

(a) "well-child care" means the services described in subsection (2) and delivered by a physician or a health care professional supervised by a physician; and

(b) "developmental assessment" and "anticipatory guidance" mean the services described in the Guidelines for Health Supervision II, published by the American academy of pediatrics.

(6) When a policy of disability insurance or a certificate issued under the policy provides coverage or benefits to a resident of this state, it is considered to be delivered in this state within the meaning of this section, whether the insurer that issued or delivered the policy or certificate is located inside or outside of this state."

{*Internal References to 33-22-303:*
33-31-301 *33-31-301*}

Section 11. Section 33-22-304, MCA, is amended to read:

"33-22-304. Continuation of coverage for individuals with disabilities -- individual contracts. (1) ~~An~~ Except as provided in subsection (3), an individual hospital or medical expense insurance policy or hospital or medical service plan contract delivered or issued for delivery in this state that provides that coverage of a dependent child terminates upon attainment of the limiting age for dependent children specified in the policy or contract must also provide in substance that attainment of the limiting age may not operate to terminate the coverage of the child while the child is and continues to be both incapable of self-sustaining employment by reason of mental retardation or

physical disability and chiefly dependent upon the policyholder or subscriber for support and maintenance. Proof of retardation or the disability and dependency must be furnished to the insurer or hospital or medical service plan corporation by the policyholder or subscriber within 31 days of the child's attainment of the limiting age and subsequently as may be required by the insurer or corporation. Proof may not be required more frequently than annually after the 2-year period following the child's attainment of the limiting age.

(2) Notwithstanding any other exemption or contrary law, the provisions of this section have equal application to hospital or medical expense insurance policies and hospital and medical service plan contracts.

(3) This section does not apply to an individual limited health benefit plan provided for in 33-22-245."

{*Internal References to 33-22-304:*
33-6-101x *33-22-101x*}

Section 12. Section 33-22-703, MCA, is amended to read:

"33-22-703. Coverage for mental illness, alcoholism, and drug addiction. A group health plan or a health insurance issuer ~~that provides~~ in its offerings of group health insurance coverage shall provide for Montana residents covered by the plan at least the following level of benefits for the necessary care and treatment of mental illness, alcoholism, and drug addiction:

(1) under basic inpatient expense policies or contracts, inpatient hospital benefits and outpatient benefits consisting of

durational limits, dollar limits, deductibles, and coinsurance factors that are not less favorable than for physical illness generally, except that:

(a) inpatient treatment for mental illness is subject to a maximum yearly benefit of 21 days;

(b) inpatient treatment for mental illness may be traded on a 2-for-1 basis for a benefit for partial hospitalization through a program that complies with the standards for a partial hospitalization program that are published by the American association for partial hospitalization if the program is operated by a hospital;

(c) inpatient and outpatient treatment for alcoholism and drug addiction, excluding costs for medical detoxification, is subject to a maximum benefit of $6,000 for a 12-month period until a lifetime maximum inpatient benefit of $12,000 is met, after which the annual benefit may be reduced to $2,000; and

(d) costs for medical detoxification treatment must be paid the same as any other illness under the terms of the contract and are not subject to the annual and lifetime limits in subsection (1)(c);

(2) under major medical policies or contracts, inpatient benefits and outpatient benefits consisting of durational limits, dollar limits, deductibles, and coinsurance factors that are not less favorable than for physical illness generally, except that:

(a) inpatient treatment for mental illness is subject to a maximum yearly benefit of 21 days;

(b) inpatient treatment for mental illness may be traded on

a 2-for-1 basis for a benefit for partial hospitalization through a program that complies with the standards for a partial hospitalization program that are published by the American association for partial hospitalization if the program is operated by a hospital;

(c) inpatient and outpatient treatment for alcoholism and drug addiction, excluding costs for medical detoxification, may be subject to a maximum benefit of $6,000 for a 12-month period until a lifetime maximum inpatient benefit of $12,000 is met, after which the annual benefit may be reduced to $2,000;

(d) costs for medical detoxification treatment must be paid the same as any other illness under the terms of the contract and are not subject to the annual and lifetime benefits in subsection (2)(c); and

(e) outpatient treatment for mental illness may be subject to a maximum yearly benefit of no less than $2,000, but this subsection (2)(e) does not apply to benefits for services furnished before September 30, 2001."

{*Internal References to 33-22-703: 33-22-1521**}

Section 13. Section 33-22-706, MCA, is amended to read:

"33-22-706. (Temporary) Coverage for severe mental illness -- definition. (1) Except as provided in 33-22-262(3) and subject to 33-22-262(4), a policy or certificate of health insurance or disability insurance that is delivered, issued for delivery, renewed, extended, or modified in this state must provide a level

of benefits for the necessary care and treatment of severe mental illness, as defined in subsection (6), that is no less favorable than that level provided for other physical illness generally. Benefits for treatment of severe mental illness may be subject to managed care provisions contained in the policy or certificate.

(2) Benefits provided pursuant to subsection (1) include but are not limited to:

(a) inpatient hospital services;

(b) outpatient services;

(c) rehabilitative services;

(d) medication;

(e) services rendered by a licensed physician, licensed advanced practice registered nurse with a specialty in mental health, licensed social worker, licensed psychologist, or licensed professional counselor when those services are part of a treatment plan recommended and authorized by a licensed physician; and

(f) services rendered by a licensed advanced practice registered nurse with prescriptive authority and specializing in mental health.

(3) Benefits provided pursuant to this section must be included when determining maximum lifetime benefits, copayments, and deductibles.

(4) (a) This section applies to health service benefits provided by:

(i) individual and group health and disability insurance;

(ii) individual and group hospital or medical expense

insurance;

(iii) medical subscriber contracts;

(iv) membership contracts of a health service corporation;

(v) health maintenance organizations; and

(vi) the comprehensive health association created by 33-22-1503.

(b) This section does not apply to the following coverages:

(i) blanket;

(ii) short-term travel;

(iii) ~~accident only~~ accident-only;

(iv) limited or specific disease;

(v) Title XVIII of the Social Security Act (medicare);

(vi) an individual limited health benefit plan provided for in 33-22-245; or

~~(vi)~~ (vii) any other similar coverage under state or federal government plans.

(5) This section does not limit benefits for an illness or condition that does not constitute a severe mental illness, as defined in subsection (6), but that does constitute a mental illness, as defined in 33-22-702.

(6) As used in this section, "severe mental illness" means the following disorders as defined by the American psychiatric association:

(a) schizophrenia;

(b) schizoaffective disorder;

(c) bipolar disorder;

(d) major depression;

(e) panic disorder;

(f) obsessive-compulsive disorder; and

(g) autism. (Terminates June 30, 2009--sec. 14, Ch. 325, L. 2003.)

33-22-706. (Effective July 1, 2009) Coverage for severe mental illness -- definition. (1) A policy or certificate of health insurance or disability insurance that is delivered, issued for delivery, renewed, extended, or modified in this state must provide a level of benefits for the necessary care and treatment of severe mental illness, as defined in subsection (6), that is no less favorable than that level provided for other physical illness generally. Benefits for treatment of severe mental illness may be subject to managed care provisions contained in the policy or certificate.

(2) Benefits provided pursuant to subsection (1) include but are not limited to:

(a) inpatient hospital services;

(b) outpatient services;

(c) rehabilitative services;

(d) medication;

(e) services rendered by a licensed physician, licensed advanced practice registered nurse with a specialty in mental health, licensed social worker, licensed psychologist, or licensed professional counselor when those services are part of a treatment plan recommended and authorized by a licensed physician; and

(f) services rendered by a licensed advanced practice

registered nurse with prescriptive authority and specializing in mental health.

(3) Benefits provided pursuant to this section must be included when determining maximum lifetime benefits, copayments, and deductibles.

(4) (a) This section applies to health service benefits provided by:

(i) individual and group health and disability insurance;

(ii) individual and group hospital or medical expense insurance;

(iii) medical subscriber contracts;

(iv) membership contracts of a health service corporation;

(v) health maintenance organizations; and

(vi) the comprehensive health association created by 33-22-1503.

(b) This section does not apply to the following coverages:

(i) blanket;

(ii) short-term travel;

(iii) ~~accident only~~ accident-only;

(iv) limited or specific disease;

(v) Title XVIII of the Social Security Act (medicare);

(vi) an individual limited health benefit plan provided for in 33-22-245; or

~~(vi)~~ (vii) any other similar coverage under state or federal government plans.

(5) This section does not limit benefits for an illness or condition that does not constitute a severe mental illness, as

defined in subsection (6), but that does constitute a mental illness, as defined in 33-22-702.

(6) As used in this section, "severe mental illness" means the following disorders as defined by the American psychiatric association:

(a) schizophrenia;

(b) schizoaffective disorder;

(c) bipolar disorder;

(d) major depression;

(e) panic disorder;

(f) obsessive-compulsive disorder; and

(g) autism."

{*Internal References to 33-22-706:*
33-22-262 *33-22-701* *33-22-702* *33-22-704*
33-22-1521 *33-31-111* *33-31-111*}

Section 14. Section 33-30-1001, MCA, is amended to read:

"33-30-1001. (Temporary) Newborn infants covered by insurance by health service corporation. (1) Except as provided in 33-22-262 and subsection (2), a disability insurance plan or group disability insurance plan issued by a health service corporation may not be issued or amended in this state if it contains any disclaimer, waiver, preexisting condition exclusion, or other limitation of coverage relative to the accident and sickness coverage or insurability of newborn infants of the persons insured from and after the moment of birth. Each policy must contain a provision granting immediate accident and sickness coverage, from and after the moment of birth, to each newborn

infant of any insured person. The policy or contract may require notification of the birth of a child and payment of a required premium or subscription fee to be furnished to the insurer or nonprofit or indemnity corporation within 31 days of the birth in order to have the coverage extend beyond 31 days.

(2) This section does not apply to an individual limited health benefit plan as provided in 33-22-245. (Terminates June 30, 2009--sec. 14, Ch. 325, L. 2003.)

33-30-1001. (Effective July 1, 2009) Newborn infants covered by insurance by health service corporation. ~~A~~ (1) Except as provided in subsection (2), a disability insurance plan or group disability insurance plan issued by a health service corporation may not be issued or amended in this state if it contains any disclaimer, waiver, preexisting condition exclusion, or other limitation of coverage relative to the accident and sickness coverage or insurability of newborn infants of the persons insured from and after the moment of birth. Each policy must contain a provision granting immediate accident and sickness coverage, from and after the moment of birth, to each newborn infant of any insured person. The policy or contract may require notification of the birth of a child and payment of a required premium or subscription fee to be furnished to the insurer or nonprofit or indemnity corporation within 31 days of the birth in order to have the coverage extend beyond 31 days.

(2) This section does not apply to an individual limited health benefit plan provided for in 33-22-245."

{*Internal References to 33-30-1001:*

33-22-262}

NEW SECTION. **Section 15. {standard} Effective date.** [This act] is effective January 1, 2010.

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