

HEALTH RELATED INSURANCE MANDATES
UPDATED SEPTEMBER 2008
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The following list of mandates is a summary of mandated benefits required for inclusion in insurance policies and certificates issued in New Hampshire. See the applicable RSA, N.H.ID bulletins and insurance regulations for specific details and guidance.

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BONE MARROW TESTING FOR DONATION

New Hampshire law requires insurance coverage for the cost of testing for bone marrow donation. The testing shall be performed in a facility that is accredited by the American Association of Blood Banks or the College of American Pathologists, or any other national accrediting body. The person tested shall complete and sign an informed consent form that also authorizes the results of the test to be used for participation in the National Marrow Donor Program.

Effective: July 25, 2006

RSA 415:6-m; 415:18-r; 420-A: 2; 420-B: 20 III

CHILDREN

CHILDREN – ADOPTION - Coverage of Children during Adoption Proceedings

All individual and group policies that provide coverage for family members shall provide health insurance benefits for any minor from the date the minor is placed in the custody of the insured pursuant to an adoption proceeding under the provisions of RSA 170-B. Such health insurance benefits shall terminate upon dismissal or withdrawal of the petition for adoption.

RSA 415:22-a, RSA 420-A: 15, RSA 420-B: 8-g

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CHILDREN - DENTAL

CHILDREN – DENTAL - Certain Dental Procedures Performed At Dental Office

Effective January 1, 2004:

Each dental insurer or other similar entity, including Delta Dental under RSA 420-F, that issues or renews any policy of group insurance providing benefits for oral surgical procedures, shall provide benefits for children who are residents of New Hampshire and under the age of 6 who have a dental condition of significant dental complexity, an exceptional medical circumstance or developmental disability, coverage for the administration of general anesthesia for procedures performed in a dentist's office.

RSA 415:18-h

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CHILDREN – DENTAL - Coverage for Dental Procedures: Medical or Hospital Group

Effective January 1, 2004:

Each insurer that issues or renews any group or blanket accident or health insurance policy or certificate providing benefits for medical or hospital expenses, shall provide benefits for children who are residents of N.H., under the age of 6 who have a dental condition of significant dental complexity, exceptional medical circumstances or a developmental disability, coverage for medically necessary hospital or surgical day care facility charges and administration of general anesthesia.

RSA 415:18-g, RSA 420-A: 17-b, RSA 420-B: 8-ee

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CHILDREN - Newborn Children Covered from Birth

All policies providing coverage on a provision of service or an expense shall provide health insurance benefits to newborn children of the insured from the moment of birth. Coverage for the newborn child shall consist of coverage for injury or sickness including the necessary care and treatment of medically diagnosed congenital defects and abnormalities.

If payment of a specific premium or subscription fee is required to provide coverage for a child, the policy may require that notification of the birth and payment of the required premium or fee must be furnished to the insurer within 31 days after the date of birth in order to have coverage continue after the 31-day period.

Unless the policy or contract specifically provides that grandchildren of the insured or subscriber are eligible for coverage, coverage for newly born children of a dependent child of the insured will not continue beyond the initial 31-day period following birth.

RSA 415:22, RSA 420-B: 8-j

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CHILDREN - Nonprescription Enteral Formulas

Any policy of accident or health insurance providing benefits for medical or hospital expenses, shall provide to insureds who are residents of this state, coverage for:

1. Nonprescription enteral formulas for the treatment of impaired absorption of nutrients caused by disorders affecting the absorptive surface, functional length, or motility of the gastrointestinal tract.
2. Nonprescription enteral formulas and food products required for persons with inherited diseases of amino acids and organic acids. Such coverage for inherited diseases of amino acids and organic acids shall, in addition to the enteral formula, include food products modified to be low protein, the amount shall not be less than \$1,800 annually for any insured individual.

RSA 415:6-c, RSA 415:18-e, RSA 420-A: 17, RSA 420-B: 8-ff

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CHILDREN - THERAPY - Early Intervention Therapy Services For Children

This law requires insurance coverage for the cost of early intervention services for children with a developmental disability or delay, from birth to 36 months of age. Coverage must be provided for expenses of licensed and credentialed occupational therapists, physical therapists, speech-language pathologists, and clinical social workers if referred by a primary physician. The benefits may be subject to deductibles, co-payments, coinsurance, or other terms and conditions of the policy, and may have a cap of \$3,200 per child per year with coverage maximums not less than \$9,600 by the child's third birthday.

Effective September 14, 2007

RSA 415:6- n, 415:18-s, 420-A:17-g, 420-B:8-r

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DEPENDENTS

DEPENDENT - Michelle's Law - Extends health insurance coverage to full-time students on medical leaves of absence

Health coverage for dependent children who are full-time students, as defined by the educational institution and beyond the age of 18, will be allowed to continue their health insurance for a medically necessary leave of absence from school for a period not to exceed 12 months or the date on which coverage would otherwise end pursuant to the terms and conditions of the policy, whichever comes first. Any breaks in the school semester shall not disqualify the dependent child from coverage.

Documentation and certification of the medical necessity leave of absence shall be submitted to the insurer by the student's attending physician and shall be considered adequate evidence of entitlement to coverage. The date of the documentation shall be the date the insurance coverage begins.

Effective June 22, 2006
RSA 415:5, RSA 415:18

Effective January 1, 2008, this law was expanded to include RSA 420-A:15-b, 420-B: 8-q, 420-C:4-a, 420-F:5, 420-J:6-d

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DEPENDENT - Coverage for a Dependent who is Mentally or Physically Incapable of earning their Own Living

Every policy that includes coverage for family members shall continue coverage for an insured family member who is mentally or physically incapable of earning his own living on the date such dependent's status as a covered family member would otherwise expire because of age. While the policy remains in force, or is replaced by another policy, it shall continue to cover the dependent as long as the incapacity continues and as long as said dependent remains chiefly financially dependent on the policyholder for support.

RSA 415:5 (3-a); RSA 415:18 V

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CHIROPRACTIC CARE - 12 Self-Referred Visits

Managed care health care plans offering chiropractic benefits shall provide benefits to a covered person who utilizes services of a chiropractic provider (doctor of chiropractic) by self-referral for 12 visits. After 12 self-referral visits, a covered person who is continuing chiropractic care may be subject to utilization review from the health plan for the purpose continued care.

RSA 420-J: 6-b

BULLETIN: 00-010-AB - THE IMPLEMENTATION OF SB 147 (C 14, LAWS OF 2000) RELATIVE TO SELF-REFERRALS FOR CHIROPRACTIC CARE UNDER MANAGED CARE ORGANIZATIONS

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ALTERNATIVE SERVICES - Services Performed By Chiropractic, Osteopathy, Podiatry, Optometry, or Advanced Registered Nurse Practitioner

Any policy that provides for reimbursement for any service which may be alternatively performed by a N.H. licensed chiropractor, osteopath, podiatrist, optometrist, or advanced registered nurse practitioner, reimbursement shall not be denied coverage when such service is rendered by a person so licensed.

RSA 415:5 (8); RSA 415:18 VI

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CIVIL UNIONS

New Hampshire law provides that partners in a "civil union" shall have the same benefit protections and responsibilities under the law as are granted to spouses in a marriage. All plans that include dependent coverage are to be amended to provide coverage to a partner in a civil union. The department has issued a bulletin (dated 12/18/07) that provides further guidance on the application of this law.

Effective January 1, 2008

RSA 457-A

Bulletin: 07-088-AB **IMPLEMENTATION OF N.H.'S CIVIL UNION LAW, RSA 457-A:6**

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CLINICAL TRIALS - Coverage for Qualified Clinical Trials

All group hospital and medical expense policies, shall provide coverage for medically necessary routine patient care costs incurred as a result of a treatment being provided in accordance with a clinical trial [to the extent such costs would be covered by non-investigative treatments if the treatment is being provided or the studies are being conducted in a phase I, phase II, phase III or phase IV clinical trial for cancer or the treatment is being provided for any other life-threatening condition]. Coverage for phase I or phase II clinical trials shall be decided on a case by case basis.

Coverage shall be required if:

1. Treatment is being provided by an approved clinical trial
2. Standard treatment has been or would be ineffective, does not exist, or there is no superior non-investigational treatment alternative
3. Facility and personnel providing the treatment are capable of doing so by virtue of their experience
4. Available clinical data provide a reasonable expectation that the treatment will be at least as effective as the non-investigational alternative

The provisions of this section shall not apply to policies paid under the federal Medicare program nor the state children's health insurance program.

RSA 415:18-I

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DIABETES

Diabetes Services and Supplies

Any individual, group, blanket policy or HMO contract that provides benefits for medical or hospital expenses shall provide to insureds who are residents of this state, coverage for medically appropriate and necessary outpatient self-management training and educational services, pursuant to a written order of a primary care physician or practitioner. Required coverage includes, but is not limited to medical nutrition therapy for the treatment of diabetes provided by a certified, registered or licensed health care professional with expertise in diabetes.

RSA 415:6-e, RSA 415:18-f, RSA 420-A: 17-a, RSA 420-B: 8-k

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Diabetes Treatments

Any individual or group policy or contract that provides benefits for medical or hospital expenses and coverage for durable medical equipment coverage shall provide for medically appropriate or necessary equipment used to treat diabetes, coverage is subject to the terms and conditions of the policy.

RSA 415:6-e, RSA 415:18-f, RSA 420-A: 17-a, RSA 420-B: 8-k (also listed under Prescription Drugs)

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DIVORCE/LEGAL SEPARATION - Continuation of Group Health and Dental Insurance Coverage In The Event Of Divorce or Legal Separation

This law expands continuation of group health and dental insurance in the event of divorce or legal separation. The law allows a former spouse or eligible dependent to stay on the ex-spouse's group policy for a period of 3 years and then obtain New Hampshire continuation coverage at the end of the 3 year period. The law applies to any group policy that covers a resident of New Hampshire regardless of where the policy was issued or delivered. The department has issued a bulletin (dated 7/7/07) that provides further guidance on the application of this law.

Effective January 1, 2008

RSA 415:18, 458:18

BULLETIN - 07-064-AB- IMPLEMENTATION OF SB 197 - DIVORCED SPOUSE BILL

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MENTAL HEALTH

MENTAL HEALTH - Health Maintenance Organization Benefits for Mental and Nervous Conditions and Treatment for Chemical Dependency

Benefits for mental or nervous conditions shall conform to the requirements of (RSA 415:18-a) or alternatively with the basic health services requirements of the Health Maintenance Organization Act of 1973. If the HMO provides these alternative benefits, such benefits will not be subject to any deductible and any coinsurance cannot exceed 20%.

A HMO must allow its subscribers 2 visits to a psychiatrist or other mental health care providers, within the organization's network, for diagnosis followed by up to 3 visits in each contract year without utilization review. Subsequent visits within the contract year may be subject to utilization review.

RSA 420-B: 8-b I

Coverage shall be provided for expenses arising from the treatment for chemical dependency, including alcoholism, up to a specified limit which may be defined in terms of a dollar amount or a maximum number of days or visits. Coverage shall include both an inpatient and outpatient benefit for detoxification and rehabilitation. (Effective 1/1/03)

RSA 420-B: 8-b III

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MENTAL HEALTH - Coverage For Certain Biologically Based Mental Illnesses

Each insurer that issues or renews any policy of group, blanket accident or health insurance under RSA 415:18 and each nonprofit health service corporation under RSA 420-A and health maintenance organization under RSA 420-B providing benefits for disease or sickness in the State of New Hampshire shall provide benefits for treatment and diagnosis of certain mental illnesses as defined in most current Diagnostic and Statistical Manual (DSM):

Schizophrenia and other psychotic disorders

1. *Schizophrenia and other psychotic disorders*
2. *Schizoaffective disorder*
3. *Major depressive disorder*
4. *Bipolar disorder*
5. *Paranoia and other psychotic disorders*
6. *Anorexia nervosa and bulimia nervosa*
7. *Obsessive-compulsive disorder*

8. Panic disorder
9. Pervasive developmental disorder or autism
10. *Chronic post-traumatic stress disorder*

Coverage shall be under the same terms and conditions and which as coverage provided for any other type of health care for physical illness. The benefits required under this section begin when benefits provided under RSA 415:18-a and RSA 420-B: 8-b, as applicable, are exhausted.

RSA 417-E: 1 III

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MENTAL HEALTH - Services Rendered at a Community Mental Health Center or Psychiatric Residential Program

Each insurer of group, blanket accident or health insurance policy providing benefits for medical or hospital expenses shall provide to insureds who are residents of New Hampshire and whose principal place of employment is in this state, benefits for services rendered at a community mental health center or psychiatric residential program approved by the department of health and human services. Those benefits shall be subject to the terms and conditions at least as favorable as those which apply to the treatment of other illnesses.

RSA 415:18-a III (b)

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MENTAL HEALTH - Court Ordered Psychiatric and Psychological Services

No policy or certificate issued shall contain a provision denying insurance benefits for psychiatric and psychological services solely because they have been ordered by the court. Benefits for services shall be subject to the same dollar limits, deductibles and co-pays, policy conditions and managed care provisions as for other services.

RSA 415:6-b; RSA 415:18-a VII; RSA 420-B: 8 II

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MENTAL HEALTH - Coverage for Dependents who are Mentally or Physically Incapable of earning their own living

Every policy that includes coverage for family members shall continue coverage for an insured family member who is mentally or physically incapable of earning his own living on the date such dependent's status as a covered family member would otherwise expire because of age. While the policy remains in force, or is replaced by another policy, it shall continue to cover the dependent as long as

the incapacity continues and as long as said dependent remains chiefly financially dependent on the policyholder.

RSA 415:5 (3-a); RSA 415:18 V

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MENTAL HEALTH - Coverage for Mental or Nervous Conditions and Treatment for Chemical Dependency Required

Any group, blanket accident or health insurance policy providing benefits for medical or hospital expenses, shall provide to insureds who are residents of New Hampshire, and whose principle place of employment is in this state, coverage for expenses arising from the treatment of mental illness and emotional disorders which are subject to significant improvement through short-term therapy, and benefits for expenses arising from diagnosis and evaluation of all other mental illnesses and emotion disorders.

In the case of policies providing benefits for hospital and medical expenses on a major medical basis, benefits arising from the treatment, diagnosis and evaluation of mental illnesses and disorders shall be subject to deductibles and coinsurance at least as favorable as those which apply to the benefits for any other illness. Benefits payable for expenses incurred in any consecutive 12-month period may be limited to an amount not less than \$3,000 per covered individual, and to a lifetime maximum of not less than \$10,000 per covered individual.

RSA 415:18-a IV (a)

Any group, blanket accident or health insurance policy providing benefits for medical or hospital expenses, shall include coverage for expenses arising from the treatment for chemical dependency including alcoholism and shall include both an inpatient and outpatient benefit for detoxification and rehabilitation.

RSA 415:18-a I(c)

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OBESITY - OBESITY & MORBID OBESITY / BARIATRIC SURGERY

This law provides N.H. residents coverage for the diseases and ailments caused by obesity and morbid obesity, including bariatric surgery, when the prescribing physician has issued a written order stating that bariatric surgery is medically necessary and is in accordance with the patient qualifications and treatment standards set forth by the American Society for Metabolic and Bariatric Surgery or the American College of Surgeons. The covered insured shall be at least 18 years of age. The benefits included in this section shall be subject to the terms and conditions of the policy and shall be no less extensive than coverage provided for similar conditions or illnesses.

Insurers are required to include bariatric surgery on policies and certificates issued or renewed on or after September 14, 2008.

Effective: September 14, 2008
RSA 415:6-o, 415:18-t, 420-A:2, 420-B:20

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PRE-CERTIFICATION

In the event that a person is covered by more than one plan that requires pre-certification, the member shall obtain pre-certification from the primary plan. Although the member shall not be required to obtain pre-certification from the secondary plan, the secondary plan shall not be required to treat such services as covered services if the services do not meet its certification criteria. The secondary plan shall not refuse payment for such services solely on the basis that the services were not pre-certified by the secondary plan.

Effective January 1, 2008

RSA 415:18, 415:6, 420-J:3-b

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PRESCRIPTION

PRESCRIPTION - 90-Day Supply of Prescription Drugs

This law requires insurance companies to allow for the purchase of up to a 90-day supply of covered prescription drugs on the health plan formulary under certain circumstances.

Effective August 10, 2007
RSA 415:6-aa, 420-J:7-b

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PRESCRIPTION - Off Label Prescription Drugs

Policies that include coverage for prescription drugs shall not exclude coverage for any drug for a particular indication on the ground that the drug has not been approved by the Food and Drug Administration (FDA) for that indication, if such drug is recognized for treatment in one of the standard reference compendia or in the medical literature as recommended by the current American Medical Association (AMA) policies. Any coverage of a drug required by this section shall also include medically necessary services associated with the administration of the drug.

RSA 415:6-g, RSA 415:18-j

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PROSTHESES

PROSTHESES - Artificial Limb Coverage

Each insurer that issues or renews an individual, group, blanket accident, or health insurance policy or certificate providing benefits for medical or hospital expenses, shall provide to certificate holders who are residents of N.H., coverage for the provision of benefits for prosthetic devices under the same terms and conditions that apply to other durable medical equipment covered under the policy, except as otherwise provided in this section.

"Prosthetic device" means an artificial limb device to replace, in whole or in part, an arm or leg.

An insurer shall not apply amounts paid for prosthetic devices to any annual or lifetime dollar maximum applicable to other durable medical equipment covered under the policy other than an annual or lifetime dollar maximum that applies in the aggregate to all items and services covered under the policy.

Effective January 1, 2004

RSA 415:6-j, RSA 415:18-n

BULLETIN: 04-004-AB Prosthetic Device Interpretation RSA 415:18-n (Group) and RSA 415:6-j (Individual)

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PROSTHESES - Scalp Hair Prostheses

Each insurer that issues or renews any group, blanket accident, health service corporation or health insurance policy or certificate providing benefits for medical or hospital expenses, which provides coverage for outpatient services shall provide coverage for other prostheses, to insureds who are residents of this state and whose principal place of employment is in this state, coverage for expenses for scalp hair prostheses. Coverage applies to hair prostheses worn for hair loss suffered as a result of alopecia areata, alopecia totalis, alopecia medicamentosa resulting from the treatment of any form of cancer or leukemia, or permanent loss of scalp hair due to injury. This coverage is subject to a written recommendation by the treating physician stating that the hair prosthesis is a medical necessity. Such coverage shall be subject to the same limitations and guidelines as other prostheses, provided, that such coverage for alopecia medicamentosa shall not exceed \$350 per year.

RSA 415:18-d, RSA 420-A: 14, RSA 420-B: 8-f

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WOMEN – GENERAL

WOMEN - GENERAL - Mammography & for testing for Occult Breast Cancer

All policies of accident and health insurance providing benefits for hospital expense, medical-surgical expense, or major medical expense shall provide coverage for screening by low-dose mammography for all women 35 years or older for the presence of occult breast cancer within the provisions of the policy, contract or certificate. The coverage shall be as follows:

1. A baseline mammogram for women 35-39 years of age.
2. A mammogram every 1 to 2 years, even if symptoms are not present, for women 40 to 49 years of age.
3. An annual mammogram for women 50 years of age or older.

RSA 417-D: 2

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WOMEN - GENERAL - Obstetrical-Gynecological Coverage

Managed care health plans shall not require prior authorization by a person's primary care provider for coverage of the following services by participating providers who specialize in obstetrics and gynecology:

1. Maternity care;
2. An annual gynecological visit and;
3. Follow-up care for obstetrical or gynecological conditions identified during such maternity care or annual gynecological visit.

RSA 420-J: 6-a

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WOMEN - CANCER

WOMEN - CANCER - Reconstruction Surgery as a result of Mastectomy

Every insurer that provides coverage for mastectomy surgery shall provide coverage for reconstruction of the breast on which surgery has been performed and surgery and reconstruction of the other breast to produce a symmetrical appearance if the patient elects reconstruction and in the manner chosen by the patient and the physician.

RSA 417-D: 2-b

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WOMEN - CANCER - Scalp Hair Protheses

Each insurer that issues or renews any group, blanket accident, health service corporation or health insurance policy or certificate providing benefits for medical or hospital expenses and which provides coverage for outpatient services shall provide coverage for other prostheses, shall provide to insureds who are residents of this state and whose principal place of employment is in N.H., coverage for expenses for scalp hair prostheses. Coverage applies to hair prostheses worn for hair loss suffered as a result of alopecia areata, alopecia totalis, alopecia medicamentosa resulting from the treatment of any form of cancer or leukemia, or permanent loss of scalp hair due to injury. This coverage is subject to a written recommendation by the treating physician stating that the hair prosthesis is a medical necessity. Such coverage shall be subject to the same limitations and guidelines as other prostheses, provided, that such coverage for alopecia medicamentosa shall not be less than \$350 per year.

RSA 415:18-d, RSA 420-A: 14, RSA 420-B: 8-f

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WOMEN - CANCER - Treatment of Breast Cancer by Autologous Bone Marrow Transplants

All policies that provide benefits for medical and hospital expenses to residents and employees of N.H. shall cover expenses for the treatment of breast cancer by autologous bone marrow transplants according to protocols reviewed and approved by the National Cancer Institute.

RSA 415:18-c, RSA 420-A: 13, RSA 420-B: 8-e (also listed under Women's Health Care)

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WOMEN – CONTRACEPTIVES

WOMEN - CONTRACEPTIVES - Contraceptive Services

Each insurer that issues or renews any group, blanket accident or health insurance policy or certificate providing benefits for medical or hospital expenses, which provides coverage for outpatient services, shall provide coverage for outpatient contraceptive services under the same terms and conditions as for other outpatient services. "Outpatient contraceptive services" means consultations, examinations, and medical services provided on an outpatient basis and related to the use of contraceptive methods to prevent pregnancy that has been approved by the U.S. Food and Drug Administration.

RSA 415:18-i, RSA 420-A: 17-c, RSA 420-B: 8-gg

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WOMEN - CONTRACEPTIVES - Prescription Contraceptives

Each insurer that issues or renews any group, blanket accident or health insurance policies or certificate that provide prescription coverage shall cover all prescription contraceptive drugs and prescription contraceptive devices approved by the U.S. Food and Drug Administration under the same terms and conditions as other prescription drugs.

RSA 415:18-i, RSA 420-A: 17-c, RSA 420-B: 8-gg (also listed under Prescription Drugs)

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WOMEN – PREGNANCY

WOMEN - PREGNANCY - Coverage for delivery by a midwife

This law states N.H. residents are entitled to coverage for midwives who are certified under RSA 326-D, meet an insurer's standards and mechanisms for credentialing and contracting and contingent upon the services being provided in a licensed health care facility and being within the scope of practice of a certified midwife.

Effective: April 14, 2006,

Effective: August 27, 2008, this law was expanded to include at home services.

RSA 415:6-l; 415:18-q, 420-A: 17-f; 420-B: 8-p, 420-C

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WOMEN - PREGNANCY - Obstetrical-Gynecological Coverage

Managed care health plans shall not require prior authorization by a person's primary care provider for coverage of the following services by participating providers who specialize in obstetrics and gynecology:

1. Maternity care;
2. An annual gynecological visit and;
3. Follow-up care for obstetrical or gynecological conditions identified during such maternity care or annual gynecological visit.

RSA 420-J: 6-a

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WOMEN - PREGNANCY - Pregnancy, Delivery and Postpartum Coverage

Each health insurance policy that provides maternity benefits for hospital expense, medical surgical expense, or major medical expense shall provide:

1. The length of hospital stay and number of postpartum visits shall be determined by the attending health care provider based on clinical information that demonstrates that the mother and infant are clinically stable based on nationally accepted guidelines. Any length of stay shorter than the current minimum nationally accepted guidelines for perinatal care, shall be at the recommendation of the attending health care provider in consultation with the mother. If the hospital stay is shorter than the current minimum, then the insurer shall pay for at least 2 postpartum visits. During one such visit, the collection of an

adequate sample from the newborn for screening for genetic and metabolic diseases shall take place in accordance with RSA 132 and applicable rules.

2. Upon notification of the pregnancy to the insurer, the insured shall inform the pregnant woman in writing regarding the insurer's prenatal, maternity and postpartum benefits, including but not limited to prenatal visits, diagnostic tests, prenatal education, hospital length of stay, postpartum care, homemaker services and contraceptive counseling and referrals.
3. The insurer shall pay for medically necessary prenatal homemaker services when a woman is confined to bed rest or her activities of daily living are otherwise restricted on the recommendation of her attending health care provider who shall consult with the applicable case manager.
4. Postpartum visits shall include the physical assessment of the mother and infant, including but not limited to: infant nutrition and feeding, infant behavior, family interactions, safety and injury prevention, infant and maternal health promotion, and community resources. Providers of postpartum visits shall be licensed health care providers experienced in perinatal care.
5. The insurer shall pay for appropriate medically necessary postpartum homemaker services as determined by the attending health care provider who shall consult with the applicable case manager.

RSA 417-D: 2-a

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WOMEN - PREGNANCY - Newborn Children Covered from Birth

All policies providing coverage on a provision of service or an expense incurred basis shall also provide that the health insurance benefits applicable for children are payable with respect to newborn children of the insured or subscriber or a newborn child of a dependent child of the insured or subscriber from the moment of birth. Coverage for the newborn child shall consist of coverage for injury or sickness including the necessary care and treatment of medically diagnosed congenital defects and abnormalities.

If payment of a specific premium or subscription fee is required to provide coverage for a child, the policy may require that notification of the birth and payment of the required premium or fee must be furnished to the insurer within

31 days after the date of birth in order to have coverage continue after the 31-day period.

Unless the policy or contract specifically provides that grandchildren of the insured or subscriber are eligible for coverage, coverage for newly born children of a dependent child of the insured will not continue beyond the initial 31-day period following birth.

RSA 415:22, RSA 420-B: 8-j

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