

STATE OF RHODE ISLAND

IN GENERAL ASSEMBLY

JANUARY SESSION, A.D. 2023

A N A C T

RELATING TO INSURANCE -- ACCIDENT AND SICKNESS INSURANCE POLICIES

Introduced By: Senators Cano, Miller, Gallo, Euer, Quezada, Kallman, Lawson,  
DiMario, and Murray

Date Introduced: February 01, 2023

Referred To: Senate Health & Human Services

It is enacted by the General Assembly as follows:

1 SECTION 1. Sections 27-18-30 and 27-18-52 of the General Laws in Chapter 27-18  
2 entitled "Accident and Sickness Insurance Policies" are hereby amended to read as follows:

3 **27-18-30. Health insurance contracts — Infertility.**

4 (a) Any health insurance contract, plan, or policy delivered or issued for delivery or  
5 renewed in this state, except contracts providing supplemental coverage to Medicare or other  
6 governmental programs, that includes pregnancy-related benefits, shall provide coverage for  
7 medically necessary expenses of diagnosis and treatment of infertility for women between the ages  
8 of twenty-five (25) and forty-two (42) years, including preimplantation genetic diagnosis (PGD) in  
9 conjunction with in vitro fertilization (IVF), and for standard fertility-preservation services when a  
10 medically necessary medical treatment may directly or indirectly cause iatrogenic infertility to a  
11 covered person. To the extent that a health insurance contract provides reimbursement for a test or  
12 procedure used in the diagnosis or treatment of conditions other than infertility, the tests and  
13 procedures shall not be excluded from reimbursement when provided attendant to the diagnosis  
14 and treatment of infertility for women between the ages of twenty-five (25) and forty-two (42)  
15 years; provided, that a subscriber co-payment not to exceed twenty percent (20%) may be required  
16 for those programs and/or procedures the sole purpose of which is the treatment of infertility.

17 (b) For purposes of this section, "infertility" means the condition of an otherwise  
18 presumably healthy individual who is unable to conceive or sustain a pregnancy during a period of  
19 one year.

1 (c) For purposes of this section, “standard fertility-preservation services” means  
2 procedures consistent with established medical practices and professional guidelines published by  
3 the American Society for Reproductive Medicine, the American Society of Clinical Oncology, or  
4 other reputable professional medical organizations.

5 (d) For purposes of this section, “iatrogenic infertility” means an impairment of fertility by  
6 surgery, radiation, chemotherapy, or other medical treatment affecting reproductive organs or  
7 processes.

8 (e) For purposes of this section, “may directly or indirectly cause” means treatment with a  
9 likely side effect of infertility as established by the American Society for Reproductive Medicine,  
10 the American Society of Clinical Oncology, or other reputable professional organizations.

11 (f) Notwithstanding the provisions of § 27-18-19 or any other provision to the contrary,  
12 this section shall apply to blanket or group policies of insurance.

13 (g) The health insurance contract may limit coverage to a lifetime cap of one hundred  
14 thousand dollars (\$100,000).

15 (h) For purposes of this section, "preimplantation genetic diagnosis" or "PGD" means a  
16 technique used in conjunction with in vitro fertilization (IVF) to test embryos for specific genetic  
17 disorders prior to their transfer to the uterus.

18 **27-18-52. Genetic testing.**

19 (a) Except as provided in chapter 37.3 of title 5, insurance administrators, health plans and  
20 providers shall be prohibited from releasing genetic information without prior written authorization  
21 of the individual. Written authorization shall be required for each disclosure and include to whom  
22 the disclosure is being made. An exception shall exist for those participating in research settings  
23 governed by the Federal Policy for the Protection of Human Research Subjects (also known as  
24 “The Common Rule”). Tests conducted purely for research are excluded from the definition, as are  
25 tests for somatic (as opposed to heritable) mutations, and testing for forensic purposes.

26 (b) No individual or group health insurance contract, plan, or policy delivered, issued for  
27 delivery, or renewed in this state which provides health insurance medical coverage that includes  
28 coverage for physician services in a physician’s office, and every policy which provides major  
29 medical or similar comprehensive-type coverage excluding disability income, long term care and  
30 insurance supplemental policies which only provide coverage for specified diseases or other  
31 supplemental policies, shall:

32 (1) Use a genetic test or request for genetic tests or the results of a genetic test to reject,  
33 deny, limit, cancel, refuse to renew, increase the rates of, affect the terms or conditions of, or affect  
34 a group or an individual health insurance policy, contract, or plan;

1 (2) Request or require a genetic test for the purpose of determining whether or not to issue  
2 or renew an individual's health benefits coverage, to set reimbursement/co-pay levels or determine  
3 covered benefits and services;

4 (3) Release the results of a genetic test without the prior written authorization of the  
5 individual from whom the test was obtained, except in a format whereby individual identifiers are  
6 removed, encrypted, or encoded so that the identity of the individual is not disclosed. A recipient  
7 of information pursuant to this section may use or disclose this information solely to carry out the  
8 purpose for which the information was disclosed. Authorization shall be required for each  
9 redisclosure; an exception shall exist for participating in research settings governed by the Federal  
10 Policy for the Protection of Human Research Subjects (also known as "The Common Rule").

11 (4) Request or require information as to whether an individual has ever had a genetic test,  
12 or participated in genetic testing of any kind, whether for clinical or research purposes.

13 (c) For the purposes of this section, "genetic testing" is the analysis of an individual's DNA,  
14 RNA, chromosomes, proteins and certain metabolites in order to detect heritable disease-related  
15 genotypes, mutations, phenotypes or karyotypes for clinical purposes. Those purposes include  
16 predicting risk of disease, identifying carriers, establishing prenatal and clinical diagnosis or  
17 prognosis. Prenatal, newborn and carrier screening, as well as testing in high risk families may be  
18 included provided there is an approved release by a parent or guardian. Tests for metabolites are  
19 covered only when they are undertaken with high probability that an excess of deficiency of the  
20 metabolite indicates the presence of heritable mutations in single genes. "Genetic testing" does not  
21 mean routine physical measurement, a routine chemical, blood, or urine analysis or a test for drugs  
22 or for HIV infections.

23 (d) Any health insurance contract, plan, or policy delivered or issued for delivery or  
24 renewed in this state, except contracts providing supplemental coverage to Medicare or other  
25 governmental programs, that includes pregnancy-related benefits, shall provide coverage for the  
26 expenses of diagnosis and treatment of infertility for women between the ages of twenty-five (25)  
27 and forty-two (42) years, including preimplantation genetic diagnosis (PGD) in conjunction with  
28 in vitro fertilization (IVF). For purposes of this section:

29 (1) "Preimplantation genetic diagnosis" or "PGD" means a technique used in conjunction  
30 with in vitro fertilization (IVF) to test embryos for specific genetic disorders prior to their transfer  
31 to the uterus;

32 (2) "Infertility" means the condition of an otherwise presumably healthy individual who is  
33 unable to conceive or sustain a pregnancy during a period of one year.

34 SECTION 2. Sections 27-19-23 and 27-19-44 of the General Laws in Chapter 27-19

1 entitled "Nonprofit Hospital Service Corporations" are hereby amended to read as follows:

2 **27-19-23. Coverage for infertility.**

3 (a) Any nonprofit hospital service contract, plan, or insurance policies delivered, issued for  
4 delivery, or renewed in this state, except contracts providing supplemental coverage to Medicare  
5 or other governmental programs, that includes pregnancy-related benefits, shall provide coverage  
6 for medically necessary expenses of diagnosis and treatment of infertility for women between the  
7 ages of twenty-five (25) and forty-two (42) years, including preimplantation genetic diagnosis  
8 (PGD) in conjunction with in vitro fertilization (IVF), and for standard fertility-preservation  
9 services when a medically necessary medical treatment may directly or indirectly cause iatrogenic  
10 infertility to a covered person. To the extent that a nonprofit hospital service corporation provides  
11 reimbursement for a test or procedure used in the diagnosis or treatment of conditions other than  
12 infertility, those tests and procedures shall not be excluded from reimbursement when provided  
13 attendant to the diagnosis and treatment of infertility for women between the ages of twenty-five  
14 (25) and forty-two (42) years; provided, that a subscriber copayment, not to exceed twenty percent  
15 (20%), may be required for those programs and/or procedures the sole purpose of which is the  
16 treatment of infertility.

17 (b) For purposes of this section, "infertility" means the condition of an otherwise  
18 presumably healthy individual who is unable to conceive or sustain a pregnancy during a period of  
19 one year.

20 (c) For purposes of this section, "standard fertility-preservation services" means  
21 procedures consistent with established medical practices and professional guidelines published by  
22 the American Society for Reproductive Medicine, the American Society of Clinical Oncology, or  
23 other reputable professional medical organizations.

24 (d) For purposes of this section, "iatrogenic infertility" means an impairment of fertility by  
25 surgery, radiation, chemotherapy, or other medical treatment affecting reproductive organs or  
26 processes.

27 (e) For purposes of this section, "may directly or indirectly cause" means treatment with a  
28 likely side effect of infertility as established by the American Society for Reproductive Medicine,  
29 the American Society of Clinical Oncology, or other reputable professional organizations.

30 (f) The health insurance contract may limit coverage to a lifetime cap of one hundred  
31 thousand dollars (\$100,000).

32 (g) For purposes of this section, "preimplantation genetic diagnosis" or "PGD" means a  
33 technique used in conjunction with in vitro fertilization (IVF) to test embryos for specific genetic  
34 disorders prior to their transfer to the uterus.

1           **27-19-44. Genetic testing.**

2           (a) Except as provided in chapter 37.3 of title 5, insurance administrators, health plans and  
3 providers shall be prohibited from releasing genetic information without prior written authorization  
4 of the individual. Written authorization shall be required for each disclosure and include to whom  
5 the disclosure is being made. An exception shall exist for those participating in research settings  
6 governed by the federal policy for the protection of human research subjects (also known as “The  
7 Common Rule”). Tests conducted purely for research are excluded from the definition, as are tests  
8 for somatic (as opposed to heritable) mutations, and testing for forensic purposes.

9           (b) No nonprofit health service corporation subject to the provisions of this chapter shall:

10           (1) Use a genetic test or request for a genetic test or the results of a genetic test or other  
11 genetic information to reject, deny, limit, cancel, refuse to renew, increase the rates of, affect the  
12 terms or conditions of, or affect a group or an individual’s health insurance policy, contract, or  
13 plan;

14           (2) Request or require a genetic test for the purpose of determining whether or not to issue  
15 or renew a group, individual health benefits coverage to set reimbursement/co-pay levels or  
16 determine covered benefits and services;

17           (3) Release the results of a genetic test without the prior written authorization of the  
18 individual from whom the test was obtained, except in a format by which individual identifiers are  
19 removed, encrypted, or encoded so that the identity of the individual is not disclosed. A recipient  
20 of information pursuant to this section may use or disclose the information solely to carry out the  
21 purpose for which the information was disclosed. Authorization shall be required for each  
22 redisclosure. An exception shall exist for participation in research settings governed by the federal  
23 policy for the protection of human research subjects (also known as “The Common Rule”);

24           (4) Request or require information as to whether an individual has ever had a genetic test,  
25 or participated in genetic testing of any kind, whether for clinical or research purposes.

26           (c) For the purposes of this section, “genetic testing” is the analysis of an individual’s DNA,  
27 RNA, chromosomes, proteins and certain metabolites in order to detect heritable disease-related  
28 genotypes, mutations, phenotypes or karyotypes for clinical purposes. These purposes include  
29 predicating risk of disease, identifying carriers, establishing prenatal and clinical diagnosis or  
30 prognosis. Prenatal, newborn and carrier screening, as well as testing in high risk families may be  
31 included provided there is an approved release by a parent or guardian. Tests for metabolites are  
32 covered only when they are undertaken with high probability that an excess or deficiency of the  
33 metabolite indicates the presence of heritable mutations in single genes. “Genetic testing” does not  
34 mean routine physical measurement, a routine chemical, blood, or urine analysis, or a test for drugs

1 or for HIV infection.

2 (d) Any health insurance contract, plan, or policy delivered or issued for delivery or  
3 renewed in this state, except contracts providing supplemental coverage to Medicare or other  
4 governmental programs, that includes pregnancy-related benefits, shall provide coverage for the  
5 expenses of diagnosis and treatment of infertility for women between the ages of twenty-five (25)  
6 and forty-two (42) years, including preimplantation genetic diagnosis (PGD) in conjunction with  
7 in vitro fertilization (IVF). For purposes of this section:

8 (1) "Preimplantation genetic diagnosis" or "PGD" means a technique used in conjunction  
9 with in vitro fertilization (IVF) to test embryos for specific genetic disorders prior to their transfer  
10 to the uterus;

11 (2) "Infertility" means the condition of an otherwise presumably healthy individual who is  
12 unable to conceive or sustain a pregnancy during a period of one year.

13 SECTION 3. Section 27-20-20 and 27-20-39 of the General Laws in Chapter 27-20 entitled  
14 "Nonprofit Medical Service Corporations" are hereby amended to read as follows:

15 **27-20-20. Coverage for infertility.**

16 (a) Any nonprofit medical service contract, plan, or insurance policies delivered, issued for  
17 delivery, or renewed in this state, except contracts providing supplemental coverage to Medicare  
18 or other governmental programs, that includes pregnancy-related benefits, shall provide coverage  
19 for the medically necessary expenses of diagnosis and treatment of infertility for women between  
20 the ages of twenty-five (25) and forty-two (42) years, including preimplantation genetic diagnosis  
21 (PGD) in conjunction with in vitro fertilization (IVF), and for standard fertility-preservation  
22 services when a medically necessary medical treatment may directly or indirectly cause iatrogenic  
23 infertility to a covered person. To the extent that a nonprofit medical service corporation provides  
24 reimbursement for a test or procedure used in the diagnosis or treatment of conditions other than  
25 infertility, those tests and procedures shall not be excluded from reimbursement when provided  
26 attendant to the diagnosis and treatment of infertility for women between the ages of twenty-five  
27 (25) and forty-two (42) years; provided, that subscriber copayment, not to exceed twenty percent  
28 (20%), may be required for those programs and/or procedures the sole purpose of which is the  
29 treatment of infertility.

30 (b) For purposes of this section, "infertility" means the condition of an otherwise  
31 presumably healthy individual who is unable to conceive or sustain a pregnancy during a period of  
32 one year.

33 (c) For purposes of this section, "standard fertility-preservation services" means  
34 procedures consistent with established medical practices and professional guidelines published by

1 the American Society for Reproductive Medicine, the American Society of Clinical Oncology, or  
2 other reputable professional medical organizations.

3 (d) For purposes of this section, “iatrogenic infertility” means an impairment of fertility by  
4 surgery, radiation, chemotherapy, or other medical treatment affecting reproductive organs or  
5 processes.

6 (e) For purposes of this section, “may directly or indirectly cause” means treatment with a  
7 likely side effect of infertility as established by the American Society for Reproductive Medicine,  
8 the American Society of Clinical Oncology, or other reputable professional organizations.

9 (f) The health insurance contract may limit coverage to a lifetime cap of one hundred  
10 thousand dollars (\$100,000).

11 (g) For purposes of this section, "preimplantation genetic diagnosis" or "PGD" means a  
12 technique used in conjunction with in vitro fertilization (IVF) to test embryos for specific genetic  
13 disorders prior to their transfer to the uterus.

14 **27-20-39. Genetic testing.**

15 (a) Except as provided in chapter 37.3 of title 5, insurance administrators, health plans and  
16 providers shall be prohibited from releasing genetic information without prior written authorization  
17 of the individual. Written authorization shall be required for each disclosure and include to whom  
18 the disclosure is being made. An exception shall exist for those participating in research settings  
19 governed by the federal policy for the protection of human research subjects (also known as “The  
20 Common Rule”). Tests conducted purely for research are excluded from the definition, as are tests  
21 for somatic (as opposed to heritable) mutations, and testing for forensic purposes.

22 (b) No nonprofit health insurer subject to the provisions of this chapter shall:

23 (1) Use a genetic test or request for a genetic test or the results of a genetic test to reject,  
24 deny, limit, cancel, refuse to renew, increase the rates of, affect the terms or conditions of, or affect  
25 a group or individual’s health insurance policy, contract, or plan;

26 (2) Request or require a genetic test for the purpose of determining whether or not to issue  
27 or renew health benefits coverage, to set reimbursement/co-pay levels or determine covered  
28 benefits and services;

29 (3) Release the results of a genetic test without the prior written authorization of the  
30 individual from whom the test was obtained, except in a format by which individual identifiers are  
31 removed, encrypted, or encoded so that the identity of the individual is not disclosed. A recipient  
32 of information pursuant to this section may use or disclose the information solely to carry out the  
33 purpose for which the information was disclosed. Authorization shall be required for each  
34 redisclosure. An exception shall exist for participation in research settings governed by the federal

1 policy for the protection of human research subjects (also known as “The Common Rule”); or

2 (4) Request or require information as to whether an individual has ever had a genetic test,  
3 or participated in genetic testing of any kind, whether for clinical or research purposes.

4 (c) For the purposes of this section, “genetic testing” is the analysis of an individual’s DNA,  
5 RNA, chromosomes, proteins and certain metabolites in order to detect heritable disease-related  
6 genotypes, mutations, phenotypes or karyotypes for clinical purposes. Those purposes include  
7 predicting risk of disease, identifying carriers, establishing prenatal and clinical diagnosis or  
8 prognosis. Prenatal, newborn and carrier screening, as well as testing in high risk families may be  
9 included provided there is an approved release by a parent or guardian. Tests for metabolites are  
10 covered only when they are undertaken with high probability that an excess of deficiency of the  
11 metabolite indicates the presence of heritable mutations in single genes. “Genetic testing” does not  
12 mean routine physical measurement, a routine chemical, blood, or urine analysis or a test for drugs  
13 or for HIV infections.

14 (d) Any health insurance contract, plan, or policy delivered or issued for delivery or  
15 renewed in this state, except contracts providing supplemental coverage to Medicare or other  
16 governmental programs, that includes pregnancy-related benefits, shall provide coverage for the  
17 expenses of diagnosis and treatment of infertility for women between the ages of twenty-five (25)  
18 and forty-two (42) years, including preimplantation genetic diagnosis (PGD) in conjunction with  
19 in vitro fertilization (IVF). For purposes of this section:

20 (1) "Preimplantation genetic diagnosis" or "PGD" means a technique used in conjunction  
21 with in vitro fertilization (IVF) to test embryos for specific genetic disorders prior to their transfer  
22 to the uterus;

23 (2) "Infertility" means the condition of an otherwise presumably healthy individual who is  
24 unable to conceive or sustain a pregnancy during a period of one year.

25 SECTION 4. Sections 27-41-33 and 27-41-53 of the General Laws in Chapter 27-41  
26 entitled "Health Maintenance Organizations" are hereby amended to read as follows:

27 **27-41-33. Coverage for infertility.**

28 (a) Any health maintenance organization service contract plan or policy delivered, issued  
29 for delivery, or renewed in this state, except a contract providing supplemental coverage to  
30 Medicare or other governmental programs, that includes pregnancy-related benefits, shall provide  
31 coverage for medically necessary expenses of diagnosis and treatment of infertility for women  
32 between the ages of twenty-five (25) and forty-two (42), including preimplantation genetic  
33 diagnosis (PGD) in conjunction with in vitro fertilization (IVF), years and for standard fertility-  
34 preservation services when a medically necessary medical treatment may directly or indirectly



1 cause iatrogenic infertility to a covered person. To the extent that a health maintenance organization  
2 provides reimbursement for a test or procedure used in the diagnosis or treatment of conditions  
3 other than infertility, those tests and procedures shall not be excluded from reimbursement when  
4 provided attendant to the diagnosis and treatment of infertility for women between the ages of  
5 twenty-five (25) and forty-two (42) years; provided, that subscriber copayment, not to exceed  
6 twenty percent (20%), may be required for those programs and/or procedures the sole purpose of  
7 which is the treatment of infertility.

8 (b) For purposes of this section, “infertility” means the condition of an otherwise healthy  
9 individual who is unable to conceive or sustain a pregnancy during a period of one year.

10 (c) For purposes of this section, “standard fertility-preservation services” means  
11 procedures consistent with established medical practices and professional guidelines published by  
12 the American Society for Reproductive Medicine, the American Society of Clinical Oncology, or  
13 other reputable professional medical organizations.

14 (d) For purposes of this section, “iatrogenic infertility” means an impairment of fertility by  
15 surgery, radiation, chemotherapy, or other medical treatment affecting reproductive organs or  
16 processes.

17 (e) For purposes of this section, “may directly or indirectly cause” means treatment with a  
18 likely side effect of infertility as established by the American Society for Reproductive Medicine,  
19 the American Society of Clinical Oncology, or other reputable professional organizations.

20 (f) The health insurance contract may limit coverage to a lifetime cap of one hundred  
21 thousand dollars (\$100,000).

22 (g) For purposes of this section, "preimplantation genetic diagnosis" or "PGD" means a  
23 technique used in conjunction with in vitro fertilization (IVF) to test embryos for specific genetic  
24 disorders prior to their transfer to the uterus.

25 **27-41-53. Genetic testing.**

26 (a) Except as provided in chapter 37.3 of title 5, insurance administrators, health plans and  
27 providers shall be prohibited from releasing genetic information without prior written authorization  
28 of the individual. Written authorization shall be required for each disclosure and include to whom  
29 the disclosure is being made. An exception shall exist for those participating in research settings  
30 governed by the federal policy for the protection of human research subjects (also known as “The  
31 Common Rule”). Tests conducted purely for research are excluded from the definition, as are tests  
32 for somatic (as opposed to heritable) mutations, and testing for forensic purposes.

33 (b) No health maintenance organization subject to the provisions of this chapter shall:

34 (1) Use a genetic test or request for genetic test the results of a genetic test to reject, deny,

1 limit, cancel, refuse to renew, increase the rates of, affect the terms or conditions of, or affect a  
2 group or an individual's health insurance policy contract, or plan;

3 (2) Request or require a genetic test for the purpose of determining whether or not to issue  
4 or renew an individual's health benefits coverage, to set reimbursement/co-pay levels or determine  
5 covered benefits and services;

6 (3) Release the results of a genetic test without the prior written authorization of the  
7 individual from whom the test was obtained, except in a format where individual identifiers are  
8 removed, encrypted, or encoded so that the identity of the individual is not disclosed. A recipient  
9 of information pursuant to this section may use or disclose the information solely to carry out the  
10 purpose for which the information was disclosed. Authorization shall be required for each re-  
11 disclosure. An exception shall exist for participation in research settings governed by the federal  
12 policy for the protection of human research subjects (also known as "The Common Rule"); or

13 (4) Request or require information as to whether an individual has ever had a genetic test,  
14 or participated in genetic testing of any kind, whether for clinical or research purposes.

15 (c) For the purposes of this section, "genetic testing" is the analysis of an individual's DNA,  
16 RNA, chromosomes, protein and certain metabolites in order to detect heritable inheritable disease-  
17 related genotypes, mutations, phenotypes or karyotypes for clinical purposes. Those purposes  
18 include predicting risk of disease, identifying carriers, establishing prenatal and clinical diagnosis  
19 or prognosis. Prenatal, newborn and carrier screening, and testing in high risk families may be  
20 included provided there is an approved release by a parent or guardian. Tests for metabolites are  
21 covered only when they are undertaken with high probability that an excess or deficiency of the  
22 metabolite indicates the presence of heritable mutations in single genes. "Genetic testing" does not  
23 mean routine physical measurement, a routine chemical, blood, or urine analysis or a test for drugs  
24 or for HIV infections.

25 (d) Any health insurance contract, plan, or policy delivered or issued for delivery or  
26 renewed in this state, except contracts providing supplemental coverage to Medicare or other  
27 governmental programs, that includes pregnancy-related benefits, shall provide coverage for the  
28 expenses of diagnosis and treatment of infertility for women between the ages of twenty-five (25)  
29 and forty-two (42) years, including preimplantation genetic diagnosis (PGD) in conjunction with  
30 in vitro fertilization (IVF). For purposes of this section:

31 (1) "Preimplantation genetic diagnosis" or "PGD" means a technique used in conjunction  
32 with in vitro fertilization (IVF) to test embryos for specific genetic disorders prior to their transfer  
33 to the uterus;

34 (2) "Infertility" means the condition of an otherwise presumably healthy individual who is

1 [unable to conceive or sustain a pregnancy during a period of one year.](#)

2 SECTION 5. This act shall take effect on January 1, 2024.

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EXPLANATION  
BY THE LEGISLATIVE COUNCIL  
OF  
A N A C T  
RELATING TO INSURANCE -- ACCIDENT AND SICKNESS INSURANCE POLICIES

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1           This act would mandate all insurance contracts, plans or policies provide insurance  
2 coverage for the expense of diagnosing and treating infertility for women between the ages of  
3 twenty-five and forty-two years including preimplantation genetic diagnosis (PGD) in conjunction  
4 with in vitro fertilization (IVF).

5           This act would take effect on January 1, 2024.

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