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STATE OF MARYLAND
MARYLAND INSURANCE ADMINISTRATION
525 ST. PAUL PLACE, BALTIMORE, MARYLAND 21202-2272

Maryland's Mandated Benefits

Benefits your health plan must provide in Maryland
As of Spring 2005 are included in this brochure.

What is the Maryland Insurance Administration (MIA)?

The Maryland Insurance Administration (MIA) is a State agency that regulates health insurers and HMOs in Maryland. The agency's job is to protect consumers by ensuring that insurance companies and HMOs obey state laws. The MIA is responsible for investigating consumer complaints and answering questions about insurance companies and HMOs operating in Maryland.

About this brochure

Health insurers, HMOs and nonprofit health service plans are different types of companies that all offer health benefit plans. The term "carrier" or "health carrier" will be used to refer to them collectively. In some cases, a law will apply to only one or two of these types of companies, but not all three. Most laws will apply to all three. Maryland law requires health carriers to include specific benefits in their health benefit plan contracts. These are called "mandated benefits" because the law mandates insurance carriers provide them. Maryland law also requires that certain other benefits be made available upon request. These are called "mandatory offerings." The requirements of the law depend on what type of plan you have. The law does not require an HMO to provide all of the mandatory benefits that are required from an insurance company. Your contract may have exclusions that are not described here or may include many benefits that are not required by law.

This brochure describes the mandatory benefits that are contained in your contract.

Who is protected by Maryland's mandated benefits?

Even though you are a resident of Maryland, you may have a health benefit plan that does not cover all of these benefits. There are several reasons why this might happen:

- You work for a small employer. Small employers have fewer than 50 eligible employees and are covered by the Comprehensive Standard Health Benefit Plan.

This Plan has benefits determined by the Maryland Health Care Commission. The details of those benefits are found in *A Guide to Purchasing Health Insurance for Small Employers*, which can be found at www.mhcc.state.md.us or by contacting the Maryland Health Care Commission at:

4160 Patterson Avenue
Baltimore, Maryland 21215
(410) 764-3460
(877) 245-1762

You may also obtain this information by contacting us at:

525 Saint Paul Place
Baltimore, Maryland 21202
(410) 468-2000
(800) 492-6116

- You are covered under the Maryland Health Insurance Plan. This is a State high risk pool for individuals with certain health conditions, those who are HIPAA eligible, and those who cannot obtain an individual policy due to health reasons as well as other circumstances. Under State law, MHIP is exempt from mandated benefits, and its benefits are set by its board of directors. MHIP covers many mandated benefits, and offers comprehensive health coverage, but does not cover all mandated benefits.

- You are covered under a group policy issued to the group's home office in another state. If you work for an employer based in another state, your health insurance policy may have been issued in that state. Maryland does not regulate policies issued in other states. This also applies if you are an individual insured by a group policy issued to an association in another state.

- You work for the federal government. States do not regulate federal government health programs.

- Your employer self-funds its health benefit plan. Many large employers do not purchase insurance for their employees' health benefit plan. Instead, they hire an insurance company to perform administrative services, such as processing claims for payment. The employer is still responsible for providing the money to pay the claims. There is no health insurance policy issued, so laws governing what must be covered in health insurance policies do not apply. Check with your employer to find out whether you are in a self-insured plan.

- You are covered under Medicare or Medicaid. These are federal programs that are not subject to state insurance law relating to benefits.

This section does not apply to Medicare Supplement contracts. For additional information, see the *Guide to Health Insurance for People with Medicare* developed jointly by the federal Centers for Medicare and Medicaid Services (CMS) and the National Association of Insurance Commissioners (NAIC).

The Mandated Benefit Chart

The chart contains a list of mandated benefits and identifies which plans must provide these benefits.

Mandatory Offerings

The following coverages must be offered in certain situations:

Alzheimer's Disease Treatment – This optional benefit covers treatment for Alzheimer's Disease. Only group insurers and nonprofit group plans must offer this coverage as referenced in §15-801 of the Insurance Article.

Disability Benefits for Disabilities Caused by Pregnancy or Childbirth – Insurers offering group policies that provide benefits for temporary disability shall offer the policyholder the option of providing benefits for temporary disability caused or contributed by pregnancy or childbirth as referenced in §15-813 of the Insurance Article.

Hospice Services – Inpatient and Outpatient – This optional benefit covers the services of hospice, a coordinated care program for people who are dying and their family members. This offering must be made by group and individual insurers and also by nonprofit health service plans as referenced in §15-809 of the Insurance Article. It is also applicable to HMOs pursuant to §19-703(c) of the Health – General Article.

What you can do if your health plan has not provided these benefits

First, you should determine whether the benefit is covered by your health plan. You can look at your contract or call the customer service line to get that question answered. If the service is covered by your plan but the health plan is denying your coverage, you should file an appeal with the health plan. You should send a written appeal; a telephone call may not be enough. If your request for pre-authorization of services was denied, you have not yet received the services, and it is an emergency, you may request an expedited appeal. You may also receive an expedited appeal if your company says it is going to stop paying for services. You may also contact the Maryland Insurance Administration at (800) 492-6116 and we may be able to assist you. You should carefully review your certificate of coverage or policy and the denial notice that was sent to you to learn how to file an appeal. You should file your appeal as soon as possible. Your appeal may be denied by the health plan if it is past their deadline for appeals. The Health Education and Advocacy Unit in the Office of the Attorney General may assist you in preparing your appeal. Their toll-free telephone number is (877) 261-

8807, and their website is www.oag.state.md.us. (Complaint forms are available online.) If you are covered by a health insurance or HMO policy issued in Maryland, you only need to file one appeal with the company.

After you have received an appeal decision, if you remain dissatisfied, and your coverage is subject to Maryland law, you may file a complaint with the Maryland Insurance Administration. In some cases, you may be able to file a complaint regarding a denial based on medical necessity if you reside in Maryland, even if your policy was issued in another state. You may also file a complaint with the Insurance Administration if a claim is denied because your company states that the service is not covered by your policy. Our website, www.mdinsurance.state.md.us has both complaint forms and authorizations to release medical records that you may print out and send to us. You should include copies of the denial letters you received from the company and any other correspondence you have. For further assistance, our toll-free number is (800) 492-6116.

MANDATED BENEFITS

This chart includes a list and a brief description of all of the benefits mandated under Maryland law. As indicated in the introduction to this brochure, the requirements of the law depend on what type of plan you have. Therefore, you will need to look at your particular plan to see if your plan includes the mandate. The citation for the statute that provides the benefit is listed. If the box is blank, that indicates that the benefit is not mandated by law for your particular plan.

MANDATE	DESCRIPTION OF BENEFIT	INSURER	HMO	NONPROFIT HEALTH SERVICE PLAN
Anesthesia for Dental Care	Limited coverage for minors for anesthesia and associated hospital or ambulatory charges in conjunction with dental care.	Insurance Article §15-828	Health - General Article §19-706(i)	Insurance Article §15-828
Blood Products	Payment for blood products may not be excluded.	Insurance Article §15-803	Health - General Article §19-706(r)	Insurance Article §15-803
Breast Prosthesis	Requires carriers to provide coverage for a prosthesis prescribed by a physician where the member has had a mastectomy but has not had reconstructive surgery.	Insurance Article §15-834	Health - General Article §19-706(ii)	Insurance Article §15-834
Child Wellness	Covers certain preventative services including immunizations and screening tests for disease and problems.	Insurance Article §15-817	Health - General Article §19-705.1(d)(4) and (5)	Insurance Article §15-817
Chlamydia Screening	Covers screening for sexually active women under the age of 20 and for men and women who have multiple risk factors.	Insurance Article §15-829	Health - General Article §19-706(ff)	Insurance Article §15-829
Cleft Lip/Cleft Palate	Includes coverage for orthodontics, oral surgery, otologic, audiological and speech and language treatments.	Insurance Article §15-818	Health - General Article §19-706(bb)	Insurance Article §15-818
Clinical Trials	Provides for coverage of approved clinical trials for treatment provided for a life-threatening condition or prevention, early detection and treatment studies on cancer.	Insurance Article §15-827	Health - General Article §19-706(aa)	Insurance Article §15-827
Colorectal Cancer Screening	Covers colorectal screening in accordance with the latest screening guidelines issued by the American Cancer Society.	Insurance Article §15-837	Health - General Article §19-706(rr)	Insurance Article §15-837

MANDATE	DESCRIPTION OF BENEFIT	INSURER	HMO	NONPROFIT HEALTH SERVICE PLAN
Contraceptive Drugs or Devices	This mandate only applies to individuals that have prescription coverage. It applies to FDA approved drugs or devices that are prescribed for use as a contraceptive. Also covers insertion or removal of contraceptive devices as well as any medically necessary examination associated with the use of a contraceptive drug or device. [Subject to the requirements of §15-826, health coverage provided through a religious organization may exclude this mandated health benefit.]	Insurance Article §15-826	Health - General Article §19-706(i)	Insurance Article §15-826
Diabetic Equipment and Supplies	Covers all medically appropriate and necessary diabetes equipment, diabetic supplies, and diabetes outpatient self-management training and educational services, including medical nutrition therapy. Covers insulin pumps, but does not cover insulin.	Insurance Article §15-822	Health - General Article §19-706(x)	Insurance Article §15-822
Emergency Room Services	This benefit covers the cost of emergency room visits.		Health – General Article §19-701(g)(2)	
Extension of Benefits	Requires carriers to extend certain benefits under specific circumstances except when coverage is terminated because of specified conditions. Charging of premiums is prohibited when benefits are extended.	Insurance Article §15-833	Health - General Article §19-706(hh)	Insurance Article §15-833
Gynecological Care	In the instances where the patient belongs to a health plan that requires the member to receive a referral prior to receiving treatment from a specialist, the law provides that women must have direct access to gynecological care from an in-network obstetrician/gynecologist or other non-physician, including a certified nurse midwife, who is not her primary care physician; requires an obstetrician/gynecologist to confer with a primary care physician.	Insurance Article §15-816	Health - General Article §19-706(l)	Insurance Article §15-816
Habilitative Services	Covers services, including occupational therapy, physical therapy, and speech therapy, for the treatment of a child with a congenital or genetic birth defect to enhance the child's ability to function. Coverage is not required for services delivered through early intervention or school services.	Insurance Article §15-835	Health - General Article §19-706(nn)	Insurance Article §15-835

MANDATE	DESCRIPTION OF BENEFIT	INSURER	HMO	NONPROFIT HEALTH SERVICE PLAN
Hair Prosthesis (Wigs)	Covers a hair prosthesis prescribed by the oncologist in attendance where the hair loss results from chemotherapy or radiation treatment for cancer. The coverage is for one prosthesis and the benefit may be limited to $350.	Insurance Article §15-836	Health - General Article §19-706(i)	Insurance Article §15-836
Hearing Aids for Minor Children	Covers hearing aids that are prescribed, fitted and dispensed by a licensed audiologist. The benefit may be limited to $1,400 per hearing aid for each impaired ear every 36 months.	Insurance Article §15-838	Health - General Article §19-706(tt)	Insurance Article §15-838
Home Health Service	Health insurance policies that provide coverage for inpatient hospital care on an expense-incurred basis must provide coverage for home health care. The carrier may limit visits to 40 visits in any calendar year.	Insurance Article §15-808		Insurance Article §15-808
Human Papillomavirus Screening Test	New plans shall provide coverage for a FDA approved Human Papillomavirus screening at the testing intervals outlined in the recommendations for cervical cytology screening developed by the American College of Obstetricians and Gynecologists for women who are under the age of 20 years if they are sexually active; and at least 20 years old if they have multiple risk factors; and men who have multiple risk factors. This is applicable to policies that are issued, delivered, or renewed in Maryland on or after October 1, 2005.	Insurance Article §15-829	Insurance Article §15-829	Insurance Article §15-829
Infertility Benefits	*In Vitro Fertilization* – Carriers that provide pregnancy-related benefits may not exclude benefits for all outpatient expenses arising from IVF procedures. The benefits shall be provided the same as for other pregnancy-related procedures. The patient or the patient's spouse must have a history of infertility of at least 2 years or have become infertile from endometriosis, exposure to DES, blockage or removal of fallopian tubes, or abnormal male factors. Carriers may limit the benefit to $100,000 per lifetime and three attempts per live birth.	Insurance Article §15-810	Health - General Article §19-706(oo)	Insurance Article §15-810
Inpatient Hospital Services	This benefit covers the cost of a hospital stay.		Health – General Article §19-701(g)(2)	

MANDATE	DESCRIPTION OF BENEFIT	INSURER	HMO	NONPROFIT HEALTH SERVICE PLAN
Laboratory Services	This benefit covers tests, ordered by a doctor or other health care provider, that are conducted at a lab.		Health – General Article §19-701(g)(2)	
Mammograms		Insurance Article §15-814 [includes coverage for a baseline mammogram for women who are 35 to 39, a biannual mammogram for women who are 40 to 49, and an annual mammogram for women who are at least 50]	Covered as a preventative service pursuant to Health – General §19-701 (g)(2)	Insurance Article §15-814 [includes coverage for a baseline mammogram for women who are 35 to 39, a biannual mammogram for women who are 40 to 49, and an annual mammogram for women who are at least 50]
Mastectomies/ Surgical Removal of Testicles	Requires carriers to cover at least 1 home health visit within 24 hours after discharge for a patient who had less than 48 hours of inpatient hospitalization after a mastectomy or surgical removal of a testicle, or who undergoes either procedure on an outpatient basis. Additionally, visits will be covered if ordered by the physician.	Insurance Article §15-832	Health - General Article §19-706(gg)	Insurance Article §15-832
Medical Foods	Covers medical foods and low protein modified food products for the treatment of inherited metabolic diseases if the medical foods or low protein modified food products are: (1) prescribed as medically necessary for therapeutic treatment of inherited metabolic diseases; and, (2) administered under the direction of a physician.	Insurance Article §15-807	Health - General Article §19-705.5	Insurance Article §15-807

MANDATE	DESCRIPTION OF BENEFIT	INSURER	HMO	NONPROFIT HEALTH SERVICE PLAN
Mental Health/ Substance Abuse Treatment *{Mental Health Parity – All policies providing coverage For health care may not discriminate against any person with a mental illness, emotional disorder, or drug abuse or alcohol abuse disorder by failing to provide benefits for treatment and diagnosis of these illnesses under the same terms and conditions that apply under the contract or policy for treatment of physical illness}*	*Inpatient Services* – covered the same as inpatient services for physical illness.	Insurance Article §15-802	Health - General Article §19-703.1	
	Partial Hospitalization – a minimum of at least 60 days of partial hospitalization.	Insurance Article §15-802	Health - General Article §19-703.1	
	Outpatient Services – 80% coverage for first 5 visits in any calendar year or benefit period; 65% coverage for 6-30 visits; 50% coverage for 31st visit and any visits after the 31st. For all new contracts that are issued, delivered or renewed in Maryland on or after October 1, 2005, this shall include psychological and neuropsychological testing for diagnostic purposes.	Insurance Article §15-802	Health - General Article §19-703.1	
	Medication Management – visits are covered the same as medication management for physical illness.	Insurance Article §15-802	Health - General Article §19-703.1	
	New Methadone Maintenance Treatment – a copayment that is greater than 50% of the daily cost for methadone maintenance treatment may not be charged.	Insurance Article §15-802	Health – General Article §19-703.1	Insurance Article §15-802
	Residential Crisis Services – Coverage for medically necessary residential crisis services defined as intensive mental health and support services: (1) provided to a child or an adult with a mental illness at risk of a psychiatric crisis; (2) designed to prevent or provide an alternative to a psychiatric inpatient admission, or shorten the length of inpatient stay; (3) provided at the residence on a short-term basis; and (4) provided by DHMH-licensed entities.	Insurance Article §15-840	Health - General Article §19-706(yy)	Insurance Article §15-840

MANDATE	DESCRIPTION OF BENEFIT	INSURER	HMO	NONPROFIT HEALTH SERVICE PLAN
Morbid Obesity	Coverage for the surgical treatment of morbid obesity that is: (1) recognized by the National Institutes of Health as effective for the long-term reversal of morbid obesity; and (2) consistent with guidelines approved by the National Institutes of Health.	Insurance Article §15-839	Health - General Article §19-706(uu)	Insurance Article §15-839
Osteoporosis Prevention and Treatment	Coverage for qualified individuals for reimbursement for bone mass measurement for the prevention, diagnosis, and treatment of osteoporosis when the bone mass measurement is requested by a health care provider for the qualified individual.	Insurance Article §15-823	Health - General Article §19-706(p)	Insurance Article §15-823
Physician Services	This benefit covers the services of a physician.		Health – General Article §19-701(g)(2)	
Pregnancy and Maternity Benefits	*Child Birth Benefits* – Every insurance policy that provides hospitalization benefits for normal pregnancy must provide hospitalization benefits to the same extent as that for any covered illness. In addition, whenever a mother is required to remain hospitalized after childbirth for medical reasons and the mother requests that the newborn remain in the hospital, the insurer or nonprofit health service plan shall pay the cost of additional hospitalization for the newborn for up to 4 days.	Insurance Article §15-811	Health - General Article §19-703(g)	Insurance Article §15-811
	Inpatient Hospital Coverage for Mothers and Newborns – Requires carriers to provide inpatient hospitalization coverage for a mother and newborn child for a minimum of 48 hours after an uncomplicated vaginal delivery and 96 hours after an uncomplicated caesarean section; authorizes a home visit by an experienced registered nurse if the mother requests a shorter hospital stay and an additional home visit if prescribed by the provider; and prohibits sanctions against a provider who advocates a longer stay.	Insurance Article §15-812	Health - General Article §19-706(i)	Insurance Article §15-812

MANDATE	DESCRIPTION OF BENEFIT	INSURER	HMO	NONPROFIT HEALTH SERVICE PLAN
Prescription Benefits *{Note: Carriers are not required to provide prescription drug benefits. When benefits are provided, these laws apply.}*	*Off-Label Use of Drugs* – A policy or contract that provides coverage for drugs may not exclude coverage for a drug for an off-label use of the drug if the drug is recognized for treatment in any of the standard reference compendia or in the medical literature. Coverage of a drug required by this subsection also includes medically necessary services associated with the administration of the drug.	Insurance Article §15-804	Health - General Article §19-706(i)	
	Reimbursement for Pharmaceutical Products – subject policies cannot establish varied reimbursement based on the type of prescribor and cannot vary copayments, deductibles, or any other condition based on community pharmacy vs. mail order.	Insurance Article §15-805		Insurance Article §15-805
	Choice of Pharmacy			Insurance Article §15-806 [the nonprofit health service plan shall allow the member to fill prescriptions at the pharmacy of choice]
	Maintenance Drug Coverage – Carrier shall allow the insured to receive up to a 90-day supply of a prescribed maintenance drug in a single dispensing, except for new prescriptions or changes in prescriptions. If carrier increases copayment, they shall proportionally increase the dispensing fee.	Insurance Article §15-824	Health - General Article §19-706(q)	Insurance Article §15-824
	Use of Formulary – Each entity limiting its coverage of Rx drugs or devices to those in a formulary shall establish & implement a procedure for a member to receive a Rx drug or device that is not in the entity's formulary when there is no equivalent Rx drug or device in the entity's formulary, or an equivalent Rx drug is ineffective or has caused an adverse reaction.	Insurance Article §15-831	Health - General Article §19-706(gg)	Insurance Article §15-831

MANDATE	DESCRIPTION OF BENEFIT	INSURER	HMO	NONPROFIT HEALTH SERVICE PLAN
Preventative Services	This benefit covers all preventative services that are meant to help prevent disease and injury.		Health – General Article §19-701(g)(2)	
Prosthetic Devices	Coverage for prosthetic and orthopedic devices.			Insurance Article §15-820
Prostate Cancer Screening	Coverage shall be provided for a medically recognized diagnostic examination including a digital rectal exam and prostate-specific antigen (PSA) test for: 1) men between 40 and 75; 2) when used for the purpose of guiding patient management in monitoring the response to prostate cancer treatment; 3) when used for staging in determining the need for a bone scan in patients with prostate cancer; or 4) when used for male patients who are at high risk for prostate cancer.	Insurance Article §15-825	Health - General Article §19-706(u)	Insurance Article §15-825
Reconstructive Breast Surgery	Requires carriers to provide coverage for reconstructive breast surgery resulting from a mastectomy to reestablish symmetry between the two breasts. Treatment may include surgery on the nondiseased breast to establish symmetry.	Insurance Article §15-815	Health - General Article §19-706(d)(2)	Insurance Article §15-815
Referrals to Specialist	Requires carriers that do not allow direct access to specialists to establish and implement a procedure by which a member may receive, under certain circumstances, a standing referral to a participating specialist and under certain circumstances to a non-participating specialist; provides pregnant members with a standing referral to an obstetrician.	Insurance Article §15-830	Health - General Article §19-706(gg)	Insurance Article §15-830
Second Opinions and Coverage of Outpatient Services	Requires carriers to provide reimbursement for a second opinion when denied hospital admission by a utilization review program and when required by a utilization review program and outpatient coverage for a service for which an admission is denied.	Insurance Article §15-819		Insurance Article §15-819

MANDATE	DESCRIPTION OF BENEFIT	INSURER	HMO	NONPROFIT HEALTH SERVICE PLAN
Smoking Cessation	New plans that provide prescription coverage must provide coverage for any drug that is not an over-the-counter product that is approved by the FDA as an aid for the cessation of the use of tobacco products; and is obtained under a prescription written by an authorized prescriber. The plan also shall provide two 90-day courses of nicotine replacement therapy during each policy year. Copayments or coinsurance amounts for drugs provided must be the same as that for comparable prescriptions. This mandate is effective for policies issued, delivered or renewed in Maryland on or after October 1, 2005.	Insurance Article §15-841	Health – General Article §19-706(ddd)	Insurance Article §15-841
Temporo-Mandibular Joint Syndrome (TMJ) Treatment	Health insurers that provide coverage for a diagnostic or surgical procedure involving a bone or joint of the skeletal structure may not exclude or deny coverage for the same diagnostic or surgical procedure involving a bone or joint of the face, neck, or head if the procedure is medically necessary to treat a condition caused by a congenital deformity, disease, or injury.	Insurance Article §15-821		Insurance Article §15-821
X-Ray	This benefit covers x-rays ordered by a doctor or other health professional.		Health – General Article §19-701(g)(2)	