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MARYLAND'S MANDATED BENEFITS FOR LARGE GROUP PLANS AND GRANDFATHERED PLANS[1]

As of February 5, 2024

Who should use this chart?

This handout describes the Mandatory Benefits that may be contained in your contract if you have coverage through a large group (groups of more than 50 employees[2]) health benefit plan or are in a grandfathered plan. (Your plan is a grandfathered plan if you were in a plan on or prior to March 23, 2010 and the plan has not substantially changed[3].)For discussion purposes, the terms "carrier" or "health carrier" will be used to refer to all of the different types of health insurer providers, including insurers, HMOs and nonprofit health service plans. This handout also describes Mandatory Offerings.

If you have a small group plan or a non-grandfathered individual plan, this chart does not apply to you. Please refer to the Essential Health Benefits Chart that may be found at www.insurance.maryland.gov or by contacting us at (800) 492-6116.

Background

Maryland law requires certain health carriers to include specific benefits in their large group and grandfathered health benefit plan contracts. These are called "Mandated Benefits" because the law mandates insurance carriers provide them. Maryland law also requires that health carriers offer certain benefits, though it is up to the policyholder whether to purchase such benefits. These are called "Mandatory Offerings." The requirements of the law with respect to Mandatory Benefits and Mandatory Offerings depend on what type of plan you have. For example, HMOs are not required to provide

[1] This advisory does not include grandfathered small group plans.
[2] The number of employees is determined by adding the full-time employees (those working 30 hours per week) plus the number of full time equivalent employees. The number of full-time equivalent employees for a particular month is calculated by dividing the aggregate number of hours worked in that month by all employees who are not full-time employees and dividing the sum by 120.
[3] Substantive changes can include, for example, certain increases in copayments, coinsurance or deductibles. To determine whether your plan is a grandfathered plan, contact your insurance company or review your insurance documents (plans are required to inform you whether your plan is a grandfathered plan).

all of the Mandatory Benefits that insurance companies are required to provide. Your contract may also include exclusions that are not described here or may include benefits that are not required by law. If a health carrier fails to provide Mandatory Benefits, or does not offer benefits which it is required by law to offer, the carrier may be subject to fines or sanctions, including the payment of restitution, if appropriate. If you believe a carrier has violated the insurance law, you may file a complaint with the Maryland Insurance Administration (MIA).

Below, please find a list of benefits that must be offered by certain carriers under certain circumstances ("Mandatory Offerings"), followed by a discussion regarding Mandatory Benefits. Attached is a chart containing a list of Mandated Benefits and the types of plans that must provide coverage for these Mandated Benefits along with a description of when a carrier may impose a deductible or copayment.

Mandatory Offerings

The following coverages must be offered by certain carriers in certain situations:

Alzheimer's Disease Treatment – This optional benefit covers expenses arising from the care of individuals with Alzheimer's Disease and includes nursing home care and intermediate or custodial nursing care. Only group insurers and nonprofit health service group plans must offer this coverage. (Insurance Article §15-801)

Disability Benefits for Disabilities Caused by Pregnancy or Childbirth – Insurers offering group policies that provide benefits for temporary disability must offer the policyholder the option to purchase coverage for temporary disability caused or contributed by pregnancy or childbirth. (Insurance Article §15-813)

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. By law, all health carriers are required to offer this benefit. (Health General Article § 19-703(c) for HMOs; Insurance Article § 15-809 for all other carriers)

Are All Health Benefit Plans Required By Law To Include Mandatory Benefits?

The law exempts certain carriers and health benefit plans from the requirement to provide Mandatory Benefits and the requirement to make Mandatory Offerings. These include:

- Group policies issued to the group's home office which is not located in Maryland. If you work for an employer whose home office is located in another state, your health insurance policy may have been issued in that other state. The MIA regulates only those policies issued or delivered in Maryland. This also applies if you are an individual insured under a group policy issued to an association that is not located in Maryland.

- The federal government's health benefit plans. States do not regulate federal government health benefit plans.

- Self-funded plans/self-insured plans. A self-funded/self-insured plan is a type of health insurance in which a company determines what health benefits will be offered to its employees and directly pays for the costs of the health care for its employees. 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/self-funded plan.

- Medicare or Medicaid (Maryland Medical Assistance Program and Maryland's Children's Health Insurance Program). These federally-regulated programs and policies are not subject to state insurance law relating to benefits.

What Can You Do If Your Carrier Has Not Provided Or Offered These Benefits?

You should look at your policy or contract, or call the carrier's customer service department to determine which benefits are covered under the terms of your policy. Your carrier is required to provide you with a Summary of Benefits and Coverage. If the service is covered by your plan but the health plan is denying your coverage, you may file an appeal with the health plan.

If you believe that the carrier has improperly denied your claim for health care services or is not in compliance with Maryland's mandatory benefits and offerings laws, you may file a complaint with the MIA. The MIA regulates only those policies that are issued or delivered in Maryland. You can obtain complaint forms and authorizations to release medical records from the MIA's website, www.insurance.maryland.gov. These completed forms, along with copies of any related documents, such as the policy, should be mailed to the MIA. For further assistance, you may call the MIA at (800) 492- 6116.

Maryland's Mandated Benefits Chart

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 plan to see if your plan is required to include the Mandated Benefit. 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 plan. Generally, a carrier may require an insured to pay a deductible or copayment for Mandatory Benefits; however, the law may prohibit these fees for certain benefits. The chart also indicates when such fees are prohibited.

MANDATE	DESCRIPTION OF BENEFIT	INSURER	HMO	NONPROFIT HEALTH SERVICE PLAN
Amino Acid–Based Elemental Formula (also see Medical Foods)	Coverage for amino acid-based elemental formula, regardless of delivery method, for the diagnosis and treatment of: (I) Immunoglobulin E and non-immunoglobulin E mediated allergies to multiple food proteins; (II) Severe food protein induced Enterocolitis Syndrome; (III) Eosinophilic disorders, as evidenced by the results of a biopsy; and (IV) Impaired absorption of nutrients caused by disorders affecting the absorptive surface, functional length, and motility of the gastrointestinal tract. Provided that the ordering physician issues a written order that states the amino acid-based elemental formula is medically necessary for treatment of one of the above listed diseases or disorders.	Insurance Article §15-843	Insurance Article §15-843	Insurance Article §15-843
Anesthesia for Dental Care	Limited coverage for individuals age 7 or younger or individuals with developmental disabilities for general anesthesia and associated hospital or ambulatory charges in conjunction with dental care when a successful result cannot be expected without anesthesia.	Insurance Article §15-828	Insurance Article §15-828	Insurance Article §15-828
Biomarker Testing	Requires coverage for biomarker testing for the purpose of diagnosis, treatment, appropriate management, or ongoing monitoring of a disease or condition that is supported by medical and scientific evidence, including testing:(1) cleared or approved by the U.S. Food and Drug Administration;(2) required or recommended for a drug approved by the U.S. Food and Drug Administration to ensure an insured or enrollee is a good candidate for the drug treatment;(3) required or recommended through a warning or precaution for a drug approved by the U.S. Food and Drug Administration to identify whether an insured or enrollee will have an adverse reaction to the drug treatment or dosage;(4) covered under a Centers for Medicare and Medicaid Services National Coverage Determination or Medicare Administrative Contractor Local Coverage Determination; or (5) supported by nationally recognized clinical practice guidelines.	Insurance Article §15-859	Insurance Article §15-859	Insurance Article §15-859
MANDATE	**DESCRIPTION OF BENEFIT**	**INSURER**	**HMO**	**NONPROFIT HEALTH SERVICE PLAN**

Blood Products	Payment for blood products, other than whole blood or concentrated red blood cells, may not be excluded.	Insurance Article §15-803	Insurance Article §15-803	Insurance Article §15-803
Breast Cancer Screening (including mammograms)	Coverage for breast cancer screening in accordance with the latest screening guidelines issued by the American Cancer Society. Coverage shall include digital tomosynthesis that, under accepted standards in the practice of medicine, the treating physician determines is medically appropriate and necessary for an enrollee or insured. This may include screening mammograms. A copayment or coinsurance requirement for digital tomosynthesis may not be greater than a copayment or coinsurance requirement for other breast cancer screenings for which coverage is required.	Insurance Article §15-814	Insurance Article §15-814	Insurance Article §15-814
Breast Prosthesis	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	Insurance Article §15-834	Insurance Article §15-834
Child Wellness	Requires coverage of certain preventative services, including well child visits, immunizations and screening tests for hearing, vision, tuberculosis, anemia and lead toxicity. For newborns, coverage of hereditary and metabolic screening also included.	Insurance Article §15-817	Health – General Article §19-701 (g)(2) and §19-705.1(c)(4)	Insurance Article §15-817
Chlamydia Screening	Coverage for annual screening Chlamydia for sexually active women under the age of 20, and for men and women 20 years and older who have multiple risk factors.	Insurance Article §15-829	Insurance Article §15-829	Insurance Article §15-829
Cleft Lip/Cleft Palate	Coverage for inpatient or outpatient expenses arising from orthodontics, oral surgery, and otologic, audiological, and speech/language treatment involved in the management of cleft lip and/or cleft palate.	Insurance Article §15-818	Insurance Article §15-818	Insurance Article §15-818
Clinical Trials	Coverage for patient cost for participation in a clinical trial approved by specified institutions including National Institutes of Health, U.S. Food and Drug Administration or the U.S. Department of Veteran's Affairs, for treatment provided for a life-threatening condition, or prevention, early detection and treatment studies on cancer.	Insurance Article §15-827	Insurance Article §15-827	Insurance Article §15-827
Colorectal Cancer Screening	Coverage for colorectal screening.	Insurance Article §15-837	Insurance Article §15-837	Insurance Article §15-837
Contraceptive Drugs or Devices	This mandate only applies to individuals that have prescription coverage. Coverage of FDA-approved drugs or devices that are prescribed for use as a contraceptive. Coverage for the insertion or removal of contraceptive devices as well as any medically necessary examination associated with the use of a contraceptive drug or device. Health coverage provided through a religious organization may exclude this mandated health benefit if it conflicts with the organizations *bona fide* religious beliefs and practices.	Insurance Article §15-826	Insurance Article §15-826	Insurance Article §15-826

MANDATE	DESCRIPTION OF BENEFIT	INSURER	HMO	NONPROFIT HEALTH SERVICE PLAN
Diabetic Equipment and Supplies	Coverage for all medically appropriate and necessary diabetes equipment, diabetic supplies, and diabetes outpatient self-management training and educational services, including medical nutrition therapy necessary for the treatment of insulin-using diabetes; noninsulin-using diabetes; elevated or impaired blood glucose levels induced by pregnancy; or consistent with the American Diabetes Association's standards, elevated or impaired blood glucose levels induced by prediabetes. A deductible, copayment, or coinsurance requirement on diabetes test strips may not be imposed; however, if an insured or enrollee is covered under a high-deductible health plan, may subject diabetes test strips to the deductible requirement of the high-deductible health plan.	Insurance Article §15-822	Insurance Article §15-822	Insurance Article §15-822
Emergency Room Services	This benefit covers the cost of emergency room visits. Requires that an HMO have a system for providing a member with 24-hour access to a physician in cases where there is an immediate need for medical services. Requires HMO to provide coverage for emergency services rendered by a physician other than one preauthorized by the plan when the 24-hour telephone system is not operational or the member's primary care provider or specialist cannot be accessed within a reasonable time as determined by the treating emergency physician.		Health – General Article §19-701(g); §19-705.1(b); §19-705.6	
Extension of Benefits	Unless coverage is terminated due to non-payment or fraud or misrepresentation, requires carriers that provide benefits on an expense incurred basis to extend certain benefits according to the terms of the policy. Charging of premiums is prohibited when benefits are extended.	Insurance Article §15-833	Insurance Article §15-833	Insurance Article §15-833
Fertility Awareness-Based Methods	Coverage for instruction by a licensed health care provider on fertility awareness-based methods which can be used to identify times of fertility and infertility by an individual to avoid pregnancy.	Insurance Article §15-826.3	Insurance Article §15-826.3	Insurance Article §15-826.3
Fertility Preservation Procedures	Coverage for "standard fertility preservation procedures" that are medically necessary to preserve fertility due to a need for medical treatment that may directly or indirectly cause iatrogenic infertility. Standard fertility preservation procedures are those that are consistent with established medical practices and professional guidelines published by the American Society for Reproductive Medicine, the American College of Gynecologists, or the American Society of Clinical Oncology. Coverage includes sperm/oocyte cryopreservation and associated laboratory assessments, medications, and treatments, but does not include the storage of sperm or oocytes. Health coverage provided through a religious organization may exclude this mandated health benefit if it conflicts with the organizations *bona fide* religious beliefs and practices.	Insurance Article §15-810.1	Insurance Article §15-810.1	Insurance Article §15-810.1

MANDATE	DESCRIPTION OF BENEFIT	INSURER	HMO	NONPROFIT HEALTH SERVICE PLAN
Gynecological Care	Requires that an obstetrician/gynecologist may be classified as a primary care provider or that a woman may receive services from an in-network obstetrician/gynecologist without first requiring a visit to a primary care provider for routine 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	Insurance Article §15-816	Insurance Article §15-816
Habilitative Services	Coverage for services and devices, including occupational therapy, physical therapy, and speech therapy, that help a child keep, learn, or improve skills and functioning for daily living. Coverage must be kept in effect until the end of the month in which the child turns 19 years old. Coverage is not required for services delivered through early intervention or school services.	Insurance Article §15-835	Insurance Article §15-835	Insurance Article §15-835
Hair Prosthesis (Wigs)	Coverage for a hair prosthesis where the hair loss results from chemotherapy or radiation treatment for cancer and when prescribed by the treating oncologist. The coverage is for one prosthesis and the benefit may be limited to $350.	Insurance Article §15-836	Insurance Article §15-836	Insurance Article §15-836
Hearing Aids for Minor Children	Coverage for hearing aids for a child under the age of 19 years 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; an insured or enrollee can choose a more expensive unit and pay the difference between the actual cost and benefit maximum if she or he so elects.	Insurance Article §15-838	Insurance Article §15-838	Insurance Article §15-838
Home Health Care	Health insurance policies that provide coverage for inpatient hospital care on an expense-incurred basis must provide coverage for home health care if institutionalization has been required without the use of home health care. The carrier may limit visits to 40 visits in any calendar year; up to 4 hours of home health care services is considered one home health care visit. The service provider must be licensed under the Health Occupations Article.	Insurance Article §15-808		Insurance Article §15-808
Human Papillomavirus Screening Test	Coverage for annual screening for Human Papillomavirus for sexually active women under the age of 20, and for men and women 20 years and older who have multiple risk factors.	Insurance Article §15-829	Insurance Article §15-829	Insurance Article §15-829

MANDATE	DESCRIPTION OF BENEFIT	INSURER	HMO	NONPROFIT HEALTH SERVICE PLAN
Infertility Benefits (For Iatrogenic Infertility, see also "Fertility Preservation Procedures")	In Vitro Fertilization – Carriers that provide pregnancy-related benefits may not exclude benefits for all outpatient expenses arising from IVF procedures. • For insurers and nonprofit health service plans, benefits provided must be the same as for other pregnancy-related procedures. • For HMOs, the benefits provided must be the same as provided for other infertility services. • For all insurers, nonprofit health service plans and HMOs that provide infertility benefits, the coverage must be provided: (a) for a patient whose spouse is of the opposite sex, the patient's oocytes are fertilized with the patient's spouse's sperm; unless: ▪ the patient's spouse is unable to produce and deliver functional sperm; and ▪ the inability to produce and deliver functional sperm does not result from: - a vasectomy; or - another method of voluntary sterilization; (b) the patient and the patient's spouse have a history of involuntary infertility, which may be demonstrated by a history of: ▪ If the patient and the patient's spouse are of opposite sexes, intercourse of at least 2 years' duration failing to result in pregnancy; or ▪ If the patient and the patient's spouse are of the same sex, six attempts of artificial insemination over the course of 2 years failing to result in pregnancy. (c) the infertility is associated with any of the following medical conditions: ▪ Endometriosis; ▪ Exposure in utero to diethylstilbestrol, commonly known as DES; ▪ Blockage of, or surgical removal of, one or both fallopian tubes (lateral or bilateral salpingectomy); or ▪ Abnormal male factors, including oligospermia, contributing to the infertility. (d) the patient has been unable to attain a successful pregnancy through a less costly infertility treatment for which coverage is available under the policy or contract; and (e) the procedure must be performed at medical facilities that meet the minimum guidelines for in vitro fertilization established by the American College of Obstetricians and Gynecologists or the American Society for Reproductive Medicine. • Carriers may limit the benefit to $100,000 per lifetime and three attempts per live birth. • Carriers are not responsible for any cost incurred by the patient or the patient's spouse in obtaining donor sperm.	Insurance Article §15-810	Insurance Article §15-810	Insurance Article §15-810

MANDATE	DESCRIPTION OF BENEFIT	INSURER	HMO	NONPROFIT HEALTH SERVICE PLAN
Inpatient Hospital Services	This benefit covers the cost of a hospital stay. For hospitalization due to childbirth or maternal care, see "Pregnancy and Maternity Benefits."		Health – General Article §19-701(g)(2)	
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)	
Lung Cancer Screening	Requires coverage for recommended follow-up diagnostic Imaging to assist in the diagnosis of lung cancer for individuals when the screening is recommended by the U.S Preventive Services Task Force, including diagnostic, ultrasound, magnetic resonance imaging; computed tomography; and image-guided biopsy. The copayment; co insurance and deductible shall not be greater than the copayment; co insurance and deductible for breast cancer screening and diagnosis.	Insurance Article §15-860	Insurance Article §15-860	Insurance Article §15-860
Lymphedema Diagnosis, Evaluation and Treatment	Coverage for the medically necessary diagnosis, evaluation, and treatment of lymphedema, including equipment, supplies, complex decongestive therapy, gradient compression garments, and self-management training and education. The annual deductible, copayment or coinsurance requirements imposed may not be more than those imposed for similar coverages.	Insurance Article §15-853	Insurance Article §15-853	Insurance Article §15-853
Male Sterilization	Coverage for male sterilization. No deductible, copayment, or coinsurance requirement may be imposed unless it is a grandfathered plan. If it is a high-deductible health plan, the benefit may be subject to the deductible requirement of the high-deductible health plan. Health coverage provided through a religious organization may exclude this mandated health benefit if it conflicts with the organizations *bona fide* religious beliefs and practices.	Insurance Article §15-826.2	Insurance Article §15-826.2	Insurance Article §15-826.2
Mastectomies	Coverage for a minimum 48-hour inpatient hospital stay following a mastectomy. The patient may request a shorter length of stay. A carrier must provide a patient that receives less than a 48 hour stay, or who undergoes a mastectomy on an outpatient basis, one home visit scheduled to occur within 24 hours after discharge and an additional home visit if prescribed.	Insurance Article §15-832.1	Insurance Article §15-832.1	Insurance Article §15-832.1
Medical Foods (Also see Amino Acid-Based Elemental Formula)	Coverage for 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 Misuse Treatment	*Coverage* – Coverage shall be provided for at least the following benefits for the diagnosis and treatment of a mental illness, emotional disorder, drug use disorder or alcohol use disorder: (1) Inpatient benefits for services provided in a licensed or certified facility, including hospital inpatient and residential treatment center benefits; (2) Partial hospitalization benefits; and (3) Outpatient and intensive outpatient benefits, including all office visits, diagnostic evaluation, opioid treatment services, medication evaluation and management, and psychological and neuropsychological testing for diagnostic purposes. Although federal law does not require a plan to provide coverage for mental health benefits, when such coverage is provided, the Mental Health Parity Act generally requires that the mental health benefits not be more restrictive than medical and surgical benefits provided under the plan.	Insurance Article §15-802	Insurance Article §15-802	Insurance Article §15-802
	Methadone Maintenance Treatment – As of January 1, 2020, an insurer, nonprofit health service plan, or health maintenance organization shall use the ASAM criteria for all medical necessity and utilization management determinations for substance use disorder benefits.	Insurance Article §15-802(d)(5)	Insurance Article §15-802(d)(5)	Insurance Article §15-802(d)(5)
	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 who is experiencing or is 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 out of the individual's residence in a community-based residential setting; and (4) Provided by DHMH-licensed entities.	Insurance Article §15-840	Insurance Article §15-840	Insurance Article §15-840

MANDATE	DESCRIPTION OF BENEFIT	INSURER	HMO	NONPROFIT HEALTH SERVICE PLAN
Morbid Obesity	Coverage for surgical treatment 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. Coverage must be to the same extent as for other medically necessary surgical procedures under the policy.	Insurance Article §15-839	Insurance Article §15-839	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	Insurance Article §15-823	Insurance Article §15-823
Ostomy Equipment and Supplies	Coverage for all medically appropriate and necessary equipment and supplies used for the treatment of ostomies, including flanges, collection bags, clamps, irrigation devices, sanitizing products, ostomy rings, ostomy belts, and catheters used for drainage of urostomies. The annual deductibles or coinsurance requirements may not be greater than the annual deductibles or coinsurance requirements for similar coverages.	Insurance Article §15-848	Insurance Article §15-848	Insurance Article §15-848
Physician Services	This benefit covers the services of a physician.		Health – General Article §19-701(g)(2)	
Pregnancy and Maternity Benefits	*Hospitalization Benefits for Child Birth* – 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 must pay the cost of additional hospitalization for the newborn for up to 4 days.	Insurance Article §15-811	Health – General Article §19-703(f)	Insurance Article §15-811
	Inpatient Hospital Coverage for Mothers and Newborns – Requires carriers that provide inpatient hospitalization coverage on an expense-incurred basis 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; if the mother requests a shorter hospital stay, the carrier must provide coverage for one home visit by a registered nurse within 24 hours after discharge from the hospital, and if prescribed by the attending provider, an additional home visit.	Insurance Article §15-812	Insurance Article §15-812	Insurance Article §15-812

MANDATE	DESCRIPTION OF BENEFIT	INSURER	HMO	NONPROFIT HEALTH SERVICE PLAN
Prescription Benefits *{Note: Carriers are not required to include prescription drug benefits. When benefits are provided under a policy or contract, these laws apply.}*	*Off-Label Use of Drugs* – A policy or contract that provides coverage for drugs may not exclude coverage of 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	Insurance Article §15-804	Insurance Article §15-804
	Reimbursement for Pharmaceutical Products – If a policy provides reimbursement for a pharmaceutical product (i.e. a drug or medicine prescribed by an authorized prescriber), it cannot establish varied reimbursement based on the type of prescriber and cannot request different copayments, deductibles, or any other condition when a community pharmacy is utilized rather than a mail order program. A policy issued to an employer under a collective bargaining agreement is not required to include this benefit.	Insurance Article §15-805		Insurance Article §15-805
	Choice of Pharmacy. A nonprofit health service plan is required to allow the member to fill prescriptions at the pharmacy of choice.			Insurance Article §15-806
	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. An insured or enrollee who is a resident of a nursing home is not entitled to this mandatory benefit.	Insurance Article §15-824	Insurance Article §15-824	Insurance Article §15-824
	Copayment/Coinsurance – Carriers may not impose a copayment or coinsurance that exceeds the retail price.	Insurance Article §15-842	Insurance Article §15-842	Insurance Article §15-842
	Use of Formulary – Each entity limiting its coverage of Rx drugs or devices to those in a formulary shall establish & implement a procedure by which a member can receive a Rx drug or device that is not in the entity's formulary or have been removed from the formulary or continue the same cost sharing requirements if the prescription drug or device has been moved to a higher deductible, copayment, or coinsurance tier.	Insurance Article §15-831	Insurance Article §15-831	Insurance Article §15-831
	Coverage or Abuse-Deterrent Opioid Analgesic Drug Products – A policy or contract that provides coverage for prescription drugs shall provide coverage for: • At least two brand name abuse-deterrent opioid analgesic drug products, each containing different analgesic ingredients, on the lowest cost tier for brand name prescription drugs on the entity's formulary for prescription drug coverage; and • If available, at least two generic abuse-deterrent opioid analgesic drug products, each containing different analgesic ingredients, on the lowest cost tier for generic drugs on the entity's formulary for prescription drug coverage. Carriers may not require an insured or an enrollee to first use an opioid analgesic drug product without abuse-deterrent labeling before providing coverage for an abuse-deterrent opioid analgesic drug product covered on the entity's formulary for prescription drug coverage. Carriers may undertake utilization review, including preauthorization, for an abuse-deterrent opioid analgesic drug product covered by the carrier, if the same utilization review requirements are applied to non-abuse-deterrent opioid analgesic drug products covered by the carrier in the same formulary tier as the abuse-deterrent opioid analgesic product.	Insurance Article §15-849	Insurance Article §15-849	Insurance Article §15-849

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Preventative Services	This benefit covers all preventative services that are meant to help prevent disease and injury. For preventative services related to the care of a minor child, see "Child Wellness."	*See Specific Service	Health – General Article §19-701(g)(2)	See Specific Service
Prosthetic Devices	Coverage for prosthetic devices, components of prosthetic devices and repairs to prosthetic devices. Copayment and coinsurance requirements for these devices may not be higher than those required for any primary care benefit. No annual or lifetime dollar maximum on coverage for the device can be applied that is separate from the aggregate maximum applicable total benefit.	Insurance Article §15-844	Insurance Article §15-844	Insurance Article §15-820 and §15-844
Prostate Cancer Screening	Coverage for the expenses incurred in conducting 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	Insurance Article §15-825	Insurance Article §15-825
Reconstructive Breast Surgery	Coverage for reconstructive breast surgery resulting from a mastectomy to reestablish symmetry between the two breasts. Coverage includes surgery on the nondiseased breast to establish symmetry when reconstructive breast surgery is performed on the diseased breast. Coverage of physical complications of all stages of mastectomy, including lymphedemas, is also mandatory.	Insurance Article §15-815	Insurance Article §15-815	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 (including a physician or nonphysician specialist); provides pregnant members with a standing referral to an obstetrician.	Insurance Article §15-830	Insurance Article §15-830	Insurance Article §15-830
Second Opinions and Coverage of Outpatient Services	If the policy provides coverage for an inpatient service in an acute general hospital, and coverage for an inpatient admission is denied, the carrier must cover the expenses of: (1) Corresponding outpatient service that is provided to the insured instead of the inpatient service; and (2) An objective second opinion, given to the insured when requested by a utilization review program under § 19-319 of the Health-General Article.	Insurance Article §15-819		Insurance Article §15-819

MANDATE	DESCRIPTION OF BENEFIT	INSURER	HMO	NONPROFIT HEALTH SERVICE PLAN
Smoking Cessation	Plans that provide prescription coverage must provide coverage for any drug that is not an over-the-counter product which 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 must also provide coverage for 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.	Insurance Article §15-841	Insurance Article §15-841	Insurance Article §15-841
Surgical Removal of Testicles	Coverage for at least 1 home health visit within 24 hours after discharge for a patient who had less than 48 hours of inpatient hospitalization after surgical removal of a testicle, or who undergoes the procedure on an outpatient basis and an additional visit must be covered if ordered by the treating physician.	Insurance Article §15-832	Insurance Article §15-832	Insurance Article §15-832
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. Coverage for intraoral prosthetic devices is not mandatory.	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)	