

Article - Insurance

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§15–817.

(a) In this section, “child wellness services” means preventive activities designed to protect children from morbidity and mortality and promote child development.

(b) This section applies to each individual hospital or major medical insurance policy, group or blanket health insurance policy, and nonprofit health service plan that:

- (1) is delivered or issued for delivery in the State;
- (2) is written on an expense-incurred basis; and
- (3) provides coverage for a family member of the insured.

(c) (1) A policy or plan subject to this section shall include under the family member coverage a minimum package of child wellness services that are consistent with:

- (i) public health policy;
- (ii) professional standards; and
- (iii) scientific evidence of effectiveness.

(2) The minimum package of child wellness services shall cover at least:

(i) all visits for and costs of childhood and adolescent immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;

(ii) visits for the collection of adequate samples, the first of which is to be collected before 2 weeks of age, for hereditary and metabolic newborn screening and follow-up between birth and 4 weeks of age;

(iii) universal hearing screening of newborns provided by a hospital before discharge;

(iv) all visits for and costs of age-appropriate screening tests for tuberculosis, anemia, lead toxicity, hearing, and vision as determined by the American Academy of Pediatrics;

(v) all visits for obesity evaluation and management;

(vi) all visits for and costs of developmental screening as

recommended by the American Academy of Pediatrics;

(vii) a physical examination, developmental assessment, and parental anticipatory guidance services at each of the visits required under items (i), (ii), (iv), (v), and (vi) of this paragraph; and

(viii) any laboratory tests considered necessary by the physician as indicated by the services provided under items (i), (ii), (iv), (v), (vi), or (vii) of this paragraph.

(d) Except as provided in subsection (e) of this section, an insurer or nonprofit health service plan that issues a policy or plan subject to this section, on notification of the pregnancy of the insured and before the delivery date, shall:

(1) encourage and help the insured to choose and contact a primary care provider for the expected newborn before delivery; and

(2) provide the insured with information on postpartum home visits for the mother and the expected newborn, including the names of health care providers that are available for postpartum home visits.

(e) An insurer or nonprofit health service plan that does not require or encourage the insured to use a particular health care provider or group of health care providers that has contracted with the insurer or nonprofit health service plan to provide services to the insurer's or nonprofit health service plan's insureds need not comply with subsection (d) of this section.

(f) (1) A policy or plan subject to this section may not impose a deductible on the coverage required under this section.

(2) Each health insurance policy and certificate shall contain a notice of the prohibition established by paragraph (1) of this subsection in a form approved by the Commissioner.

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