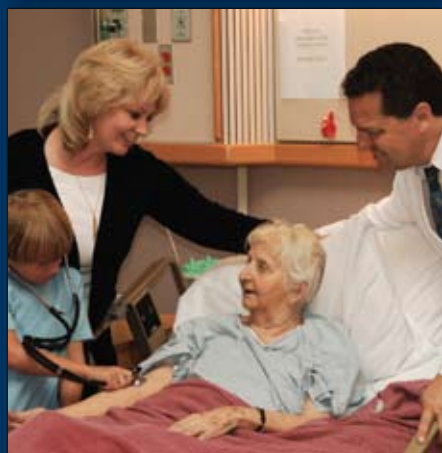


A CONSUMER GUIDE TO

HEALTH INSURANCE



A CONSUMER GUIDE TO
HEALTH
INSURANCE



INSURANCE
ADMINISTRATION

● ● ● ● ● Table of Contents ● ● ● ● ●

Who We Are And How We Help Consumers • • • • • 1

Why Is Health Insurance So Expensive? • • • • • 2

How To Select The Health Coverage That Is Right For You • • • • • 2

- **What Options Are Available To Maryland Consumers To Pay For Medical Care**
- **Questions To Ask When Shopping For Health Care Coverage**
- **Tips For Shopping For Health Care Coverage**
- **Frequently Asked Questions**
 - How Can I Find Individual Health Insurance?
 - Can My Health Plan Require That I Get A Referral Before I See A Specialist?
 - How Long May I Keep My Child On My Health Plan?
 - When Can A Child Be Added To My Health Plan?
 - What Can I Do If My Health Insurance Company Refused To Cover Services Because Of A "Preexisting Condition"?
 - I'm Leaving My Job. How Do I Keep My Health Insurance?
 - I Just Got Divorced. May I Stay On My Ex-Spouse's Insurance Policy?
 - My Spouse Recently Died. Can Our Children And I Keep The Health Insurance Coverage That My Spouse's Employer Provided?
 - My Cobra Coverage Is Ending. What Can I Do?

Maryland's Mandated Benefits • • • • • 19

- **About This Section of the Brochure**
- **Mandatory Offerings**
- **Are All Health Benefit Plans Required By Law To Include Mandatory Benefits?**
- **What Can You Do If Your Carrier Has Not Provided Or Offered These Benefits?**
- **Maryland Mandated Benefits Chart**

What Should I Do If My Health Claim Was Denied? • • • • • 31

Directory • • • • • 32

- **State Agencies And Programs**
- **Federal Agencies**

WHO WE ARE

The Maryland Insurance Administration (MIA) is the state agency that regulates the business of insurance in the State of Maryland. If you have a question about insurance or experience a problem, the MIA may be able to help.

How We Help Consumers

The MIA provides assistance to consumers, businesses, health care providers (including doctors and hospitals), and producers (agents or brokers) in all areas of insurance, including life, health, disability, automobile, homeowners, and property.

The MIA can:

- provide you with educational materials about the different types of insurance coverages that are available, and give you guides that may help you to compare rates among insurers writing automobile, homeowners, health coverage for small employers, and for Medicare supplement policies;
- suggest actions or procedures that you may take which may help resolve your insurance problem;
- forward a copy of your complaint to the insurance company, if appropriate;
- obtain information or explanations on your behalf from the insurance company or its representatives. This may involve written and verbal contact with such companies and persons;
- investigate a company's action(s) to determine compliance with state laws, regulations and policy contracts; and
- take corrective action against a company if it violated a state law, regulation or policy which the MIA enforces. A violation may have occurred if an insurance carrier, insurance producer (agent), or another entity engaged in the business of insurance:
 - did not pay or authorize the payment for medically necessary services;
 - improperly denied or delayed payment of all or some portion of your claim;
 - improperly terminated your insurance policy;
 - improperly raised your insurance premiums;
 - made false statements to you in connection with the sale of insurance or the processing of insurance claims; or
 - overcharged you for services, including premium finance charges.

Resources for Consumers

The MIA produces consumer guides, rate comparisons and frequently asked questions related to various types of insurance. The following is a partial list of available publications:

- *Consumer Guide to Homeowners Insurance*
- *Consumer Guide to Automobile Insurance*
- *Health Carriers for Small Employers (With Sample Premiums)*
- *Annual Premiums for Medicare Supplement Policies*
- *An Insurance Preparedness Guide to Natural Disasters*

You can get a copy of any of these publications and others by:

- downloading it from our web site, www.mdinsurance.state.md.us, on the Consumer Publications page;
- submitting a request by phone or in writing to the MIA;
- visiting our booth at any number of community events around the State; or
- finding these printed materials at various state and local agencies.

● ● ● ● ● WHY IS HEALTH INSURANCE SO EXPENSIVE? ● ● ●

Over the last few years, the costs of health care have risen sharply. There are many reasons for this. The average age in America is rising. As the baby boomers age, there are more older people with a greater need for health care. Technology has improved, but has also become more expensive. Doctors and hospitals are raising their fees as their costs increase. Advertising has helped stir demand for new prescription drugs, and the new drugs can be much more expensive than drugs already on the market. As health carriers pay more for these treatments, they raise premiums to cover their costs.

Health insurers and HMOs base their premiums, in part, on your age and geographic area. The areas around Baltimore and Washington have different cost factors associated with premiums than areas in Western Maryland or the Eastern Shore. If you have a small employer policy or an individual policy, you may find that your premiums go up sharply when your age or the group's age rises. Insurers and HMOs are not permitted to raise premiums for individuals or for small employers based on the claims of one person or based on the claims of the one employer group.

The role of the Insurance Administration is to make sure that the insurance companies and HMOs charge enough premium to pay claims and remain in business, while also protecting consumers from increases that are too high. Our actuaries carefully review premium increases to make certain that the company can justify the amount of the increase.

● ● ● ● HOW TO SELECT THE HEALTH COVERAGE THAT IS RIGHT FOR YOU ● ● ● ● ●

What Options Are Available To Maryland Consumers To Pay For Medical Care

Although many employers still offer some form of health benefits, many employees are finding that the type of care covered has decreased while the employee's required contribution has increased. As a result, some employees are purchasing additional coverage to fill in gaps and others must pay the full cost of health benefits. The purpose of this section is to give consumers an overview of what options are available and to help them know what questions to ask when they are making purchasing decisions.

What Is Available

Consumers have a wide array of options to choose from, depending upon their employment status, coverage needs and ability to pay. These options include:

- A. group health plans;
- B. small employer health plans;
- C. individual health plans;
- D. Maryland Health Insurance Plan;
- E. medical discount plans;
- F. health savings accounts;
- G. self-funded/self-insured plans;
- H. Government Assistance Programs (i.e. Medicaid/Medicare); and
- I. COBRA/Maryland Continuation Coverage.

Each of these options is described in general below. Questions to consider when making a choice, and tips for selecting and purchasing a health benefit policy appear after this section.

A. Group Health Plans – A group health plan is generally offered by employers, but can sometimes be obtained through a membership organization as well. If your employer offers health coverage to all of its employees, then it cannot refuse to offer this coverage to you because of your current medical status or medical history. (An employer may, however, refuse to provide you with coverage for another reason, such as you are a part-time employee and coverage is not given to any part-time employee.) Federal law also restricts group plans from denying coverage for “preexisting conditions.” Under this law, called “HIPAA”, the only preexisting conditions that may be excluded under a preexisting condition exclusion in a policy are those for which medical advice, diagnosis, care or treatment was recommended or received within the 6-month period before your enrollment date. If the condition is “preexisting,” then coverage can only be denied for a maximum of twelve (12) months. (If you join the health plan after you are hired and not during a regular or special enrollment period, the waiting period can be 18 months.) Even if your employer has a waiting period, if you previously had continuous insurance coverage, you may be eligible for an offset of some or all of the waiting period. This is referred to as “creditable coverage.” You will need to obtain a “Certificate of Coverage” from your former carrier as proof that you had health insurance coverage that was not interrupted by a break of 63 days in a row.

An individual who wishes to obtain group coverage through his employer must do so either 1) at the start of his employment (usually 30 to 60 days from the first day), 2) during the annual “open enrollment” period or 3) within 30 days of the date of a “qualifying event” such as marriage, divorce, death of a spouse, birth or adoption of a child, or if you or a dependent was covered under another employer group health plan and that coverage is terminated. Open enrollment is the term used to describe a period when you can join a health benefit plan without having to prove you are healthy. There is no state law regarding open enrollment periods. Most employers have an open enrollment period once a year. Typically, this is the only time when you may enroll in or make changes to your health benefit plan.

Employers may offer different types of health plans. Insurers and non-profit health service plans can be divided into two categories; (1) Major Medical, and (2) Preferred Provider Organization Plans. Employers may also offer a third option of coverage through a health maintenance organization (HMO).

1. Major Medical Plans – This traditional type of policy is designed to cover and reimburse medical expenses such as hospitalization, doctor visits, surgery, diagnostic tests and prescription drugs. Traditional major medical policies usually require insureds to satisfy out-of-pocket deductibles and coinsurance provisions. These plans allow insureds to obtain medical treatment from the doctor or hospital of their choice. Benefits are typically based on Usual, Customary and Reasonable (UCR) charges. These plans generally limit the insured’s annual out-of-pocket expenses. Typically, a limit is also

placed on the amount of benefits payable over the insured's lifetime (e.g., \$1 million, \$5 million and \$10 million lifetime maximum).

2. Preferred Provider Organization (PPO) Plans – Insurers that offer PPO plans contract with physicians, hospitals and other health care providers who agree to provide health care services at a discounted rate. Generally, PPO plan members may obtain care from a doctor or a hospital that is not a preferred provider if they are willing to pay additional out-of-pocket expenses. However, some PPOs are much more restrictive and only allow members to receive treatment from a participating provider unless there is an emergency or unforeseen illness, injury or condition which requires immediate care. These exclusive provider plans are similar to HMOs in that the plan may deny coverage if you do not receive treatment from a preferred provider. Also, while some PPO plans permit members to visit specialists without any prior referral or authorization, others require members to obtain a referral before seeing a specialist. If you have specific questions about your plan, you should contact your human resources department or call the plan directly.

3. Health Maintenance Organizations (HMOs) – Your employer may also offer care through a health maintenance organization (HMO). HMOs sell “open panel” and “closed panel” type plans. Under a closed panel plan, the HMO generally requires members to use only certain providers under contract with the health plan. Exceptions are given for emergencies or while the member is outside the service area. Members select a primary care provider from the list of contracted providers and pay a co-payment for medical care. Members must also receive authorization from the primary care provider before they can see specialists who are also in the network. The HMO may deny coverage under the closed panel plan if care is delivered by an out-of-network provider.



HMO “open panel” plans are similar to PPO plans offered by insurers and nonprofit health service plans in that members have a choice of receiving care from both in-network providers and out-of-network providers. When the HMO member chooses an out-of-network provider, the member generally pays more out-of-pocket than if the member were to see an in-network provider. These higher out-of-pocket costs can come in the form of higher copayments, coinsurance and deductibles.

Regardless of the type of panel the Plan offers, HMOs are prohibited by law, from excluding coverage for preexisting conditions.

In addition to these plans, your employer may also offer coverage for specific illnesses (e.g. cancer), specific types of treatment (e.g. dental), treatment in a specific place (e.g. hospital), or treatment for a specific event (e.g. accident or disability).

If you have coverage under an employer's plan and you or the insured under whose policy you are enrolled becomes unemployed, you still may be able to continue your coverage for a limited time. Both federal and state law require group plans to offer continued coverage to employees, the spouse of an employee or an employee's dependent under certain conditions. While there are similarities between the federal and state laws, there are also important differences. Notably:

- Under federal law, when an employer has 20 or more employees, continued coverage under the group policy is available only if the coverage would otherwise terminate because of termination of employment, reduction in work hours, the death of the employee, divorce or legal separation, the employee qualifies for Medicare, or the dependent loses dependent status under the terms of the policy. (These conditions are referred to in the laws as “qualifying events.”) To continue coverage, the employee, spouse or dependent must elect to continue coverage within 60 days of the qualifying event.
- Maryland's Continuation Coverage law applies to all employers that purchase a Maryland contract, including those with less than 20 employees, and makes continued coverage available in the event of

involuntary termination of employment, death or divorce. To continue coverage, the employee, spouse or dependent must elect to continue coverage within 45 days of the qualifying event, except in the event of a divorce. In the event of a divorce, the insured employee or the divorced spouse of the insured employee shall notify the employer of the change in status within 60 days of the change in status.

Whether federal or state law applies, if an employee or a qualified dependent elects to continue coverage, the individual must pay the full premium and oftentimes, an administrative fee. The premium will likely be much higher than when subsidized by the employer. Also, the length of time the policy can be continued depends upon who is electing to continue coverage (e.g. the employee, the spouse of the dependent), the qualifying event, and whether premium payments are made on time. However, once the statutorily-required continuation period ends, you can elect to convert the group policy to an individual policy, usually at a higher premium than was available under the group or continuation coverage.

The Maryland Insurance Administration has taken the position that Maryland consumers who qualify for either state or federal protections are entitled to choose both, and that, if there are differences in qualifications or benefits, those differences are to be resolved in favor of the consumer.

B. Small Employer Health Plans – Under state law, certain small employers have the right to purchase the Comprehensive Standard Health Benefit Plan (CSHBP). The CSHBP, which was developed by the Maryland Health Care Commission, is a standardized health benefits plan that has the same benefits and program options from carrier to carrier. To be eligible to participate in the CSHBP, the small employer must show that a majority of eligible employees work in Maryland, and that there are at least 2 but no more than 50 eligible employees at the company who work at least 50 percent of its working days. A nonprofit with 501(c)(3) tax status also qualifies - even if it has only one employee. The Commission designs and monitors the plan so that, on average, the cost does not exceed 10 percent of Maryland’s average annual wage.

Employers who subscribe must offer it to any employee who works 30 or more hours, and may choose to purchase additional riders. Employers may also decide whether or not to offer benefits to employees who work less than 30 hours a week. Enrollment in a small employer’s health plan is similar to that discussed under the “Group Plan” section above. Although self-employed persons are not eligible to subscribe to CSHBP, by law, a carrier is required to offer a renewal policy to self-employed individuals who work and reside in Maryland, and are currently enrolled in the CSHBP. A small employer health plan may not refuse to insure an employee because of a preexisting condition.

The details of the plan’s benefits can be found in *A Guide to Purchasing Health Insurance for Small Employers*, which is available online at www.mhcc.md.gov or by contacting the Maryland Health Care Commission at:

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

You may also request this information from the Maryland Insurance Administration.

C. Individual Health Plans – This is health insurance sold to one person or all the members of one family under one policy. Individual coverage is usually purchased when a person’s employer does not offer health insurance or the person wishes to supplement an existing policy. Consumers can purchase individual health insurance directly from a health plan of their choice. Most of the plans that are available to groups are also available to individuals; however, an insurer that sells an individual policy is permitted to refuse to offer you a policy because of your health status. You and your family members must be in very good health to qualify. When you fill out the application, you must be as thorough as possible in answering the

questions. If the insurer finds out later that you had a medical condition that you did not tell them about on the application, they can take back the money that they have paid on your behalf, leaving you with unpaid claims.

If you buy your individual plan from an HMO, then your pre-existing condition **may not** be excluded. However, as discussed above, the HMO may refuse to offer you coverage based on your health status.

D. Maryland Health Insurance Plan (MHIP) – MHIP is Maryland’s high-risk insurance pool. Though operated by the state, it is administered by a contracted, third-party vendor. You may be eligible for the MHIP if you have lived in Maryland for six or more months and:

- are not eligible for group health coverage, COBRA, the Maryland Medical Assistance or Children’s Health Insurance Programs, Medicare or any other government-sponsored health insurance program;
- have exhausted all available group coverage;
- have, or have been offered, health insurance that provides limited or restricted coverage, or that excludes coverage for a specific medical condition or conditions;
- are receiving a federal Trade Readjustment Allowance or unemployment benefits under the Trade Adjustment Assistance program, or receiving pension payments from the Pension Benefit Guaranty Corporation; or
- have been refused individual health insurance for medical reasons or have a specified medical condition.

The six-month Maryland residency requirement is waived if you were enrolled in a high-risk pool in another state. Qualified enrollees may choose from four different plan options, including a PPO or a policy with a high deductible. The premium varies by the option selected and must be paid for by the enrollee. For more information or to enroll, visit MHIP’s web site, www.marylandhealthinsuranceplan.net, or call 888-444-9016.

E. Medical Discount Plans – Discount plans offer savings on various goods and services, such as prescription drugs, doctors visits, eye glasses, vision care, dental services, and lab tests. For a monthly or annual fee, the “plan member” is entitled to receive services or goods from a specific doctor or pharmacy at a discounted price. Certain plans may be marketed in conjunction with some types of insurance coverage, such as accidental death or disability. Although discount plans may be structured to look like insurance, they are not insurance and therefore, are not regulated by the Maryland Insurance Administration. However, Maryland law requires that entities selling discount medical plans (except insurers, nonprofit health service plans, health maintenance organizations or dental plans licensed to do business in the state) register with the Insurance Commissioner. If you are unsure of whether a program is an insurance plan or a discount plan, or want to know if a particular discount plan is registered in Maryland, you may contact the Maryland Insurance Administration at 800-492-6116. For more information about discount medical plans, please refer to our brochure titled, “*What Consumers Need To Know About Discount Medical and Discount Drug Plans*,” which is available on our web site www.mdinsurance.state.md.us. Also, if you experience a problem with a medical discount plan, Maryland’s Office of the Attorney General Consumer Protection Division may be able to assist you. You may contact the Consumer Protection Division at 877-261-8807 toll-free, or online, www.oag.state.md.us and click the tab for “Consumer Protection.”



F. Health Savings Accounts (HSAs) – Authorized by federal law, Health Savings Accounts help individuals save for current and future qualified medical and retiree health expenses on a tax-free basis. Any individual who is covered by a high-deductible health plan may establish an HSA. Individuals currently eligible for Medicare may not open an HSA. Amounts contributed to an HSA belong to individuals and are completely portable. Every year the money not spent would stay in the account and gain interest tax-free, just like an IRA. Unused amounts remain available for later years.

Tax-advantaged contributions can be made in three ways: (1) the individual and family members can make tax deductible contributions to the HSA, whether or not the individual itemizes deductions; (2) the individual's employer can make tax-free contributions; and (3) employers with cafeteria plans can allow employees to contribute untaxed salary through a salary reduction plan. Funds distributed from the HSA are not taxed if they are used to pay for qualifying medical expenses. To encourage saving for health expenses after retirement, HSA owners between age 55 and 65 are allowed to make additional catch-up contributions to their HSAs. To learn more about HSAs, visit the federal government's web site, www.ustreas.gov/offices/public-affairs/hsa/, or contact:

United States Department of the Treasury
Office of the Executive Secretary
1500 Pennsylvania Avenue, N.W.
Washington, D.C. 20220
Telephone: 202-622-2000
Fax: 202-622-6415

G. Self-Funded / Self-Insured Plans – Some employers and labor unions provide group health benefits coverage for their employees or members through self-funded plan arrangements. Employers who self-insure employee health plan benefits are responsible for paying claims and performing certain administrative functions ordinarily handled by an insurance company under plans offered by private insurance companies. Frequently, self-insured plan sponsors contract with insurance companies or third party administrators (TPAs) to provide administrative services; however, the employer or plan sponsor is ultimately responsible for seeing that claims are paid in accordance with plan provisions and ensuring that the plan is properly administered.

Self-insured, single-employer plans are not subject to state insurance laws, and therefore, the Maryland Insurance Administration does not regulate such plans. Single-employer and union-sponsored self-funded health plans are regulated by the U.S. Department of Labor's Pension and Welfare Benefits Administration under the guidelines of the Employees' Retirement Income Security Act (ERISA) of 1974.

H. Out-of-State Association Contracts – Consumers may purchase health insurance through an association or group in which they are a member. (For example, certain clubs or fraternal organizations.) These association plans are frequently issued in another state and therefore, are not required to include Maryland's mandated benefits. Carriers offering out-of-state association plans must disclose:

1. that coverage is conditioned on association membership;
2. all costs related to joining and maintaining membership in the association;
3. that membership fees are due in addition to the premium for coverage;
4. that the terms and conditions of coverage under the contract are determined by the association
5. the health insurance benefits otherwise mandated in Maryland that are not included in the contract;
6. that the Maryland resident may purchase an individual health benefit plan that includes the mandated benefits that are not included in the contract;
7. that the contract is not regulated by the Insurance Commissioner; and
8. that the terms and conditions of coverage may be changed by the agreement of the association and the insurer without the consent of a member.

In addition, if the carrier collects membership fees or dues on behalf of an association, this must be disclosed on the enrollment application.

I. Government Assistance Programs – The federal government has established two major government assistance programs to ensure that targeted populations can obtain medical services. These programs -- Medicare and Medicaid -- are funded by the federal government. In Maryland, the programs are called: (i) Medicare; (ii) Maryland's Medical Assistance Program (Medicaid); and (iii) Maryland's Children's Health Insurance Program (MCHIP), which is a Medicaid program. Each of these programs is described briefly below.

1. Medicare – Medicare is the federal health insurance program for people age 65 or older, people under 65 with certain disabilities, and persons of any age who have End-Stage Renal Disease. Enrollees may choose between the “Original Medicare Plan” and “Medicare Advantage Plan.” For additional information about Medicare, including premium rates and specific services covered, view the federal government's consumer guide, “Medicare & You” on its website, www.medicare.gov or call 800-633-4227 to request a copy of the Guide.

2. Medicaid or Maryland's Medical Assistance Program – Maryland's Medical Assistance Program is a government-funded health insurance program for people with limited income and people with disabilities who meet income-sensitive eligibility guidelines and other criteria. If you receive benefits under Supplemental Security Income Program (SSI) or Temporary Cash Assistance (TCA), you are automatically enrolled in Medicaid. Otherwise, you must apply. You must show that you are income-eligible and:

- a. 65 years or older; or
- b. disabled; or
- c. blind; or
- d. under 21 years old; or
- e. caring for a related child in your home; or
- f. pregnant; or
- g. the parents of an unmarried child under 21.

Because countable income is not the same as your actual income, determining whether your income qualifies is a complicated process. Thus, the Maryland Department of Health and Mental Hygiene (DHMH) advises that if you think you may qualify for Medicaid, you should apply and a caseworker will determine whether you meet the eligibility requirements.

3. Maryland's Children's Health Insurance Program (MCHIP) – Under this state program, pregnant women of any age and their newborn children, and children up to age 19 may qualify for Medicaid.

For those who qualify, the state also offers a prescription plan, called, “Maryland Medicaid Pharmacy Plan.” For more information about this plan and Maryland's Medicaid program or the Maryland Children's Health Insurance Program, visit the DHMH's web site at www.dhmb.state.md.us. The contact information for your local department of social services is also available on this website. You may also contact the DHMH Recipient Relations Hotline at: 410-767-5800 or 800-492-5231.

12. Are there any limits on how much you must pay for health care services you receive (out-of-pocket maximums)?
13. Are there any limits on the number of times you may receive a service (lifetime maximums or annual benefit caps)?
14. Does the plan have a deductible amount for each insured person? That is, the amount each person must pay out-of-pocket before benefits will be paid.
15. Is there a separate deductible for some services, such as maternity?
16. Do some services require that you pay co-insurance?
 - for doctor office visits?
 - for an emergency room visit if not admitted to a hospital?
17. What are the renewal conditions? Under what circumstances can the carrier increase my premium?
18. Does the plan offer any incentive if I participate in a “bona fide” wellness program?

Coverage available under the plan

19. Does the plan have different benefit levels if I use an in-network/participating provider or an out-of-network/nonparticipating provider? How easy is it to get a list of participating providers? Are my doctors, medical facilities, or pharmacies included as participating providers? How easy is it to find a local participating/in-network provider? You may want to ask your doctor directly if he or she would accept this insurance for your care.
20. Does the plan require pre-authorization or pre-certification for some procedures and/or referrals from a primary care physician? Are there penalties if I don't pre-authorize or pre-certify treatment? Who do I contact to obtain pre-authorization or pre-certification?
21. What medical and hospital services does the health coverage include? If you have a medical condition that requires a particular type of care, medication, or assistive device, does the plan cover that need?
22. Are prescription medications covered in part or in full?
23. What services does the health coverage exclude?
24. Will the health coverage pay for preventative care, maternity care, well-baby care, substance abuse treatment, organ transplants, vision care, dental care, infertility treatment, durable medical equipment, or alternative therapies such as acupuncture or chiropractic care?
25. Does Maryland law require the carrier (the term ‘carrier’ includes insurers, HMOs and non-profit health plans) to cover certain benefits? To learn more about what benefits are required under Maryland law, see the Mandated Benefits Section of this brochure.
26. Are there waiting periods before certain illnesses are covered? Are there any other limitations on coverage of certain illnesses?

27. How easily can I change primary-care physicians if I want to?

28. Do I need to get permission before I see a specialist?

To learn more about the options available to cover your health care, see the previous section of this brochure.

● ● ● ● ● Tips For Shopping For Health Care Coverage ● ● ●

1. The most important point is to make sure that you have all of the documents related to the policy, and that you **read these documents carefully**. You should make certain that you understand all of the policy terms. Don't write a check, give out your bank account number or give any person money until you are completely sure that you understand exactly what coverage you are buying. Even if the person appears trustworthy, if you feel at all confused – wait. Give yourself as much time as you need to think about it and ask for the business card of the individual selling you the policy.

2. If you allow the insurance company to deduct payments directly from your bank account and you decide to end your insurance, it could take several months to stop the deductions and longer still to get back the money they continue to collect.

3. **Comparison shop.** Policies differ widely in coverage and cost. Request and read copies of the brochures describing the benefits and how to use them. For a list of companies selling individual health policies, HMO policies and small employer policies, visit our web site at www.mdinsurance.state.md.us.

4. If your employer offers different health benefit options, or if you are purchasing a policy on your own, you should carefully consider how you use health care to select the best value for you. If you rarely go to the doctor, and have savings to cover a deductible, you may want to select a policy that will have a lower monthly premium, but high deductibles. If you have a high-deductible policy, you may be able to use a health savings account to gain tax advantages. You should discuss this option with a trusted financial adviser or broker.

5. **Take the necessary time to learn all you can about the insurance you want to buy.** Ask people you trust for their opinion and enlist their help in your search. Is your doctor familiar with this health insurer, HMO or PPO plan provider? Also, make sure to find out if the product you are purchasing is an insurance policy, health maintenance organization (HMO) contract, a self-funded plan, or a medical discount plan. It is important that you understand what you are purchasing and the benefits being provided.

6. **Do not be misled by advertising.** Do not buy a policy simply because it is endorsed on television or radio, in newspapers or other advertisements by famous people. Only you can decide if a policy is the right one for you.

7. Find out at the time you are applying for coverage if, and under what circumstances, a company can refuse to renew your policy.

8. **Fill out your application completely and accurately.** If you do not give correct and complete answers to all questions, your claims may be denied or your policy cancelled. If someone else fills out the application for you, read it carefully before signing it. When you sign an application, you are agreeing that it is correct and complete even if someone else has filled it in for you.



9. Be careful how you pay for the policies. It is best to pay by check, money order, or bank draft made out to the insurance carrier or by credit card. If you pay cash, make sure you get a receipt.

10. Once you receive your policy, read it to make sure it provides the kind of coverage that's right for you. Make sure to read the section on "Exclusions and Limitations." If a benefit or service is limited or excluded, you will not be covered even though treatment may be considered medically necessary.

11. Check to see that the policy states the date that the policy will begin providing coverage, what benefits are provided or excluded and what deductibles, copayments, coinsurance or out-of-pocket maximums apply. If the policy's coverage is not what you thought you had purchased, return it. Under Maryland law, companies are required to give you at least ten (10) days to look over your policy after you receive it and to decide whether to keep it. Carriers are, however, allowed to charge you for the period of time the policy was in effect.

12. If you are considering buying a supplemental policy, make sure the health plan you currently have does not already cover the same services. If it does, the insurer of the supplemental policy may require you to file all claims with the primary insurer before submitting claims to it, and may limit the amount of money you will be reimbursed from the supplemental policy.

13. Before an insurance company will accept you as a potential policyholder, the company may want to place an exclusionary rider on your policy for a specified condition. If the policy is issued with an exclusionary rider, you will be responsible for the cost of any medical care, including doctor visits, prescription drugs and emergency care services received for the treatment of the excluded condition. Under Maryland law, carriers are not permitted to exclude mandated benefits. For a list of mandated benefits, go to the Mandated Benefits Section of this brochure, or visit our web site at www.mdinsurance.state.md.us.

● ● ● ● ● ● Frequently Asked Questions ● ● ● ● ●

Coverage Issues

How Can I Find Individual Health Insurance?

If you are between jobs, leaving school, or starting your own business, you may find that you need an individual health insurance policy. You should consider your needs and budget carefully before applying for a policy. Policies offer different levels of coverage for different levels of premium. For some policies, you may have to prove that you are in good health. When a company reviews your health to determine if you can be insured, it is called medical underwriting.

The least expensive option for individual health insurance will be a medically underwritten policy. This option is the least expensive because insurance companies and HMOs are very selective about issuing these policies. You and your family members must be in very good health to qualify. When you fill out the application, you must be as thorough as possible in answering the questions. If the insurer finds out later that you had a medical condition that you did not tell them about on the application, they can take back the money that they have paid on your behalf, leaving you with unpaid claims. A list of carriers offering individual policies is available on the Insurance Administration's web site, www.mdinsurance.state.md.us or by calling us at 800-492-6116.

If you are leaving a group policy, you may be eligible for continuation coverage under that policy. This means that you would still be a member of the group, but you would pay your entire premium yourself. You may also be able to convert your coverage to an individual policy that does not require medical underwriting. You should read your certificate of coverage or call the insurance company to learn the details of how to take advantage of one of these options.

If you are denied an individual policy for health reasons, you can enroll in the Maryland Health Insurance Plan (MHIP). For more information about MHIP, visit MHIP's website, www.marylandhealthinsuranceplan.net or call 888-444-9016.

Can My Health Plan Require That I Get A Referral Before I See A Specialist?

Not all health plans allow you direct access to specialists. Under some health plans, you must first receive a referral to a specialist from your primary care physician. However, Maryland law states that you may receive a standing referral to a specialist if:

- a) the primary care physician, in consultation with the specialist, determines that you need continuing care from a specialist; **AND**
- b) you have a condition or disease that:
 - 1) is life threatening, degenerative, chronic or disabling; **AND**
 - 2) requires specialized medical care.

The specialist must have expertise in treating your disease or condition; and except in special circumstances, must be part of the health plan's provider panel.

The law prohibits a carrier from requiring you to see a physician **in addition** to your primary care physician before you receive the standing referral.

Unless you are pregnant and receiving a standing referral to an obstetrician, you, your primary care physician and the specialist must develop a treatment plan that may:

- a) limit the number of visits to the specialist;
- b) limit the period of time in which visits to the specialist are authorized; and
- c) require the specialist to communicate regularly with the primary care physician regarding your treatment and health status.

If you are pregnant, by law, you must receive a standing referral to an obstetrician without the need for a treatment plan. The obstetrician will have primary responsibility for the management of your pregnancy, including the issuance of referrals, in accordance with the company's policies and procedures, through the postpartum period.

If your health plan does not have a specialist in its provider panel with the professional training and expertise to treat your condition or disease, or cannot provide reasonable access to such a specialist without unreasonable delay or travel, then the carrier is required to give you a referral to a specialist outside of the provider panel. Your deductible, copayment and coinsurance will be the same as if the specialist were a member of the health plan's provider panel. The specialist may be a health care provider that is not a physician if the specialist is licensed or certified under the Maryland Health Occupation Article and is certified or trained to treat or provide health services for a specified condition or disease in a manner that is within the scope of their license or certification.

How Long May I Keep My Child On My Health Plan?

Maryland law requires carriers to allow a dependent child to remain on a parent's health insurance policy up to the age of 25 under certain circumstances.

Prior to July 1, 2009, this law only applied to fully insured health plans issued in the State of Maryland. Due to a change in state law though, insured health benefit plans issued to small employers (an employer with at least two but no more than 50 employees) issued or renewed on or after July 1, 2009 are also required to comply with this law. Your employer may elect to provide more beneficial coverage for dependents. Check with your employer or health plan to verify your coverage for dependents.

The law does not apply to individuals whose health coverage is provided through: (1) federal plans or programs (Federal Employee Benefit Plan, Medicare, Medicaid); (2) self-funded groups or union plans; (3) group or individual coverage issued and delivered outside the state; and (4) small employer whose contract was not issued or renewed on or after July 1, 2009. Your employer or insurer can tell you if this law applies to your coverage.

If your child is a full time student, unmarried and is a “qualifying child” as defined by the Internal Revenue Service (IRS), then your child may remain on a parent’s policy until the end of the year in which your child reaches age 23. While the IRS criteria may change, as of September 2008, a qualifying child is one who:

- does not provide over one-half of his or her own support; and
- meets the following residency test:
 - the child lives with you for more than one-half of the year; or
 - meets the following alternative residence test:
 - the child receives over half of the child’s support during the calendar year from the child’s parents;
 - the child is in the custody of one or both parents for more than half of the year; and
 - the child’s parents:
 - are divorced or legally separated under a decree of divorce or separation order signed by a judge;
 - are living separately under a written separation agreement; or
 - live apart at all times for the last six months of the calendar year.

If your child is not a full-time student but is a “qualifying relative” as defined by the Internal Revenue Service, the child may stay on a parent’s policy until he or she reaches age 25. For your child to be a qualifying relative, you must supply over half of the child’s support and the child must not be a qualifying child of any person, including you.

Be sure to check with your tax adviser or the IRS to be sure your child meets the definition of a qualifying child or qualifying relative.

Also, if your child is permanently and totally disabled and is incapable of self support due to mental or physical incapacity, your child may remain covered under a parent’s policy. For additional information about coverage options for a disabled child, please contact your insurer or employer.

Once your child is no longer eligible for coverage under a parent’s policy, the child does have other options. He or she may qualify for COBRA coverage. Not all group policies have COBRA provisions. Check with your insurer or employer to see if COBRA coverage is an option for your child. Be sure you understand the requirements for obtaining COBRA coverage, the cost and the covered benefits.

Your child may purchase coverage directly through an insurer in the non-group market. There are many insurers that offer coverage in the individual market and some have policies specifically designed to meet the

needs of younger adults. In Maryland, these policies are subject to medical underwriting. When your child applies for individual coverage, he or she will be asked to fill out a health risk assessment form.

If an insurer refuses to issue a policy because your child has a particular health condition and your child is not eligible for COBRA coverage, your child may qualify for coverage through the Maryland Health Insurance Plan (MHIP). Contact MHIP at 888-444-9016 to determine if this option is available.

If your child is covered under your HMO or PPO plan but is a student and does not live in the service area, you should ask your carrier how and where the child can seek services. For example, a student insured through an HMO may be outside the HMO service area of physicians and hospitals while away at school. If this occurs, the student likely will have coverage for emergency care, but may have to travel to a physician and hospital within the HMO service area for other care. Similarly, a health plan may pay benefits at out-of-network levels for students who are outside a PPO network. Check your plan provisions or speak with your health plan to know the level of benefits provided when a student is at a school outside the service area.

Be sure the college student has a copy of the relevant insurance cards and knows how to obtain any required approvals before seeking treatment.

When Can A Child Be Added To My Health Plan?

Maryland law allows you to add certain dependent children automatically to your group health plan when you initially enroll, and during open enrollment. For group policies and individual policies, a dependent child is defined as:

- 1) the natural child, stepchild, adopted child, or grandchild of the insured; or
- 2) a child placed with the insured for legal adoption.

The child must also be unmarried and meet the definition of a “qualifying child” or “qualifying relative” as defined by the Internal Revenue Service. For policies issued, delivered or renewed after January 1, 2008, certain dependent children of the domestic partner of an insured may also be eligible for coverage by operation of state law. Qualified dependents of domestic partners include:

- 1) the natural child, stepchild, adopted child, or grandchild of the domestic partner of an insured;
- 2) a child placed with the domestic partner of an insured for legal adoption; or
- 3) a child who is under testamentary or court appointed guardianship, other than temporary guardianship of less than 12 months’ duration, of the domestic partner of an insured.

The dependent child of a domestic partner must also reside with the insured, be unmarried and meet the same requirements as applied to other dependent children. If you already have a group health plan with family coverage, you may add, during the plan year, a child who becomes your dependent through marriage, birth, adoption, placement for adoption, legal guardianship, or, if you are the grandparent, a grandchild who becomes your dependent. In most cases, you must first notify the health plan and pay any extra premium due within 31 days. If you already have family coverage, and no additional premium is required for the added child, you should still notify the plan within 31 days to avoid denied claims.

If you do not already have a group health plan with family coverage, but are eligible to enroll, you can still get coverage for a child who becomes your dependent through marriage, birth, adoption, or placement for adoption. To do so, you must enroll yourself at the same time you seek to enroll your new dependents. However, grandparents of dependent children, and legal guardians may not have this right. Consumers with individual policies should consult with their health plan prior to the birth, adoption, guardianship, or custody of a child to determine the necessary steps to obtain coverage for the child.

If you are unable to afford healthcare for your child, you should consider the Maryland Children's Health Insurance Program or Maryland's Medical Assistance Program. For additional information about these programs, refer to the earlier section of this brochure, "What Options are Available to Maryland Consumers To Pay For Medical Care"

What Can I Do If My Health Insurance Company Refused To Cover Services Because Of A "Preexisting Condition"?

If you have a history of a health problem, or if you have a health problem at the time you apply for health insurance, in certain circumstances, an insurance company could either refuse to give you a policy or apply an exclusionary rider that excludes your health problem from coverage for a period of time. In some cases, the company may only issue a policy with a rider that permanently excludes the "preexisting condition."

If you are applying for an individual health benefit plan, you should be aware that Maryland law prohibits a health insurance application form or a non-profit health service plan application form from asking questions about:

1. a preexisting condition, illness, or disease for which the applicant has not received medical care or advice from a licensed health care provider during the five years immediately before the date of the application; or
2. medical screening, testing, monitoring or any other similar medical procedure that the applicant has not received during the five years immediately before the date of the application.

When you fill out the application, you must be as thorough as possible in answering the questions. If the insurer finds out later that you had a medical condition for which you sought treatment or if you have been diagnosed as having a medical condition that you did not tell them about on the application, they can take back the money that they have paid on your behalf, leaving you with unpaid claims.

As discussed in the earlier section, "*What Options Are Available...*" whether coverage for a preexisting condition can be denied depends upon the type of policy. If you believe your health plan has improperly excluded coverage on the grounds that it is an excluded "preexisting condition," you can appeal the decision to the health plan.

To appeal the decision, make sure to follow the appeal procedure explained in your certificate of coverage or policy and any instructions in the denial notice that was sent to you. You should file your appeal as soon as possible because your appeal may be denied by the health plan if it is past their deadline for appeals. Also, it is a good idea to put your appeal in writing so that you can document what happened, when and what relief you are seeking. The Health Education and Advocacy Unit (HEAU) in the Office of the Attorney General may assist you in preparing your appeal. You can contact HEAU toll-free at 877-261-8807, or via their web site, 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 are still dissatisfied, and your coverage is subject to Maryland law, you may file a complaint with the Maryland Insurance Administration. Our web site, 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.

Continuation of Benefits

I'm Leaving My Job. How Do I Keep My Health Insurance?

Option 1:

If you are married, and your spouse has health coverage available at work, you and your family may be able to enroll in your spouse's plan. You must enroll within 30 days of voluntary termination of your employment. You may be able to do this even if it is not open enrollment. In the event of involuntary termination, you have six months to enroll. Check with your spouse's human resources department for the specific rules.

Option 2:

If you are enrolled in your employer's group plan, you may be able to continue your existing coverage under COBRA, which is a federal law. COBRA only applies to employers with 20 or more employees. Additional information about COBRA is available at www.dol.gov.

Option 3:

You may be able to continue your group coverage under Maryland Continuation Coverage laws. These laws apply to employers of any size, including those with 20 or fewer employees, if the group policy is a Maryland contract and is not self-funded. Check with your human resources department to find out if your policy was issued and delivered in another state or is self-funded.

Under Maryland law, you are eligible for continuation coverage if:

- You quit your job voluntarily, or you are involuntarily terminated, but not for cause.
- You were covered under the group health plan for at least 3 months before termination.
- You are a resident of Maryland.

You must notify your employer as soon as possible if you want to continue coverage. Your employer is required by law to supply you with an election notification form within 14 days of your request. You must complete, sign, and return this form to your employer within 45 days of your termination.

Option 4:

You may also be able to obtain an individual conversion policy without regard to your health status. This policy may not include all of the benefits you had under your group policy, and may be more expensive than group coverage.

You should carefully read your certificate of coverage to learn more about continuation options. There are some important differences between Maryland law and COBRA.

I Just Got Divorced. May I Stay On My Ex-Spouse's Insurance Policy?

If you were covered as a spouse under an employer group health benefit plan, you may be able to remain in the employer's group health plan. Most people have heard of the federal law called COBRA, which allows people who get divorced to continue their health insurance coverage under their ex-spouse's employer group plan. COBRA only applies to employers with 20 or more employees. Maryland also has laws that require continuation of group coverage. These laws apply to employers of any size, including those with 20 or fewer employees, provided that the group policy is issued in Maryland and is not self-funded by the employer. Your employer's human resources department can tell you if the group policy is self-funded or was issued and delivered in another state. You should carefully read your certificate of coverage to learn more about continuation options. There are some important differences between Maryland law and COBRA.

To be eligible to continue coverage under Maryland law, you must meet the following requirements:

- Your spouse must be a resident of Maryland.
- Your spouse must be covered under a policy issued to an employer in Maryland.
- For the thirty days immediately preceding the divorce, you were covered as a spouse under the employer's group policy.

A dependent child of the insured is also eligible to continue coverage.

Your continuation coverage will be the same coverage available to other spouses covered under the group policy. You will need to pay the premium, including the portion usually paid by the employer for spouses. You and your spouse may agree on how to divide the premium payment between you, or it may be specified in a court order. There is no administrative fee under Maryland law, although there may be if you continue coverage under COBRA. You should carefully review your certificate of coverage for a detailed explanation of the continuation coverage available.

Maryland's continuation coverage for divorced spouses does not end after a specific time period. It does end when you become eligible for a group health benefit plan or Medicare, or become covered under an individual health policy. It will also end when you decide to remarry or decide to drop the coverage. If you have questions, ask your human resources department, or call the Maryland Insurance Administration at 800-492-6116.

My Spouse Recently Died. Can Our Children And I Keep The Health Insurance Coverage That My Spouse's Employer Provided?

Maryland law requires that coverage be offered to the surviving spouse and dependant children of a deceased employee if the deceased employee was a Maryland resident insured under a group contract for at least three months prior to the employee's death. To learn the cost of this coverage and how to obtain the coverage, contact the employer's human resources department.

My Cobra Coverage Is Ending. What Can I Do?

If you have been continuing coverage under a group plan, and your continuation coverage is ending, you have several options to consider:

Option 1:

If you or your spouse has group coverage available at work, you may be eligible for a special enrollment period in that group policy. This means that you can enroll even if you did not during open enrollment. You should enroll as soon as possible. You may be unable to enroll if you wait too long after your continuation coverage ends. Your new employer, or your spouse's employer, should be able to tell you if you qualify.

Option 2:

If you are in very good health, you may consider applying for an individual, medically underwritten health policy. "Medically underwritten" means that the insurance company or health maintenance organization (HMO) may deny your application if you do not meet their standards of good health. It is important to answer all of the questions on the application honestly and thoroughly. Your policy may be cancelled later if your application had errors. A medically underwritten policy will be less expensive than an individual policy that does not require evidence of good health. A list of companies selling individual policies is available on our web site, www.mdinsurance.state.md.us.

Option 3:

You may be able to convert your current group coverage to an individual policy with the same company. Conversion policies do not require you to prove you are in good health. The benefits may not be the same as with your group policy, and the premiums may be higher.

Option 4:

The federal law, known as HIPAA, requires that your current insurance company issue you a certificate of creditable coverage when your coverage ends. This creditable coverage will offset any waiting period for coverage of a pre-existing condition under a new policy. HIPAA also gives you the right to coverage at the end of continuation coverage. In Maryland, you can obtain this coverage through the Maryland Health Insurance Plan (MHIP). MHIP is a State-administered plan for people with certain medical conditions, HIPAA eligible individuals, and people who are denied a medically underwritten policy, as well as certain other categories. There are several delivery options, all of which require a premium payment. Their web site is www.marylandhealthinsuranceplan.net. Their telephone number is 888-444-9016.

● ● ● ● ● MARYLAND'S MANDATED BENEFITS ● ● ● ●

About This Section of the Brochure

Maryland law requires certain 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 health carriers offer certain benefits, though it is up to the consumer whether to purchase such benefits. These are called “mandatory offerings.” The requirements of the law depend on what type of plan you have. For example, HMOs are not required to provide all of the mandatory benefits that an insurance company is required to offer. Your contract may also have exclusions that are not described here or may include many 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. If you believe a carrier has violated the law, you should file a complaint with the Maryland Insurance Administration. For information on how to do this, see the upcoming section, “*What Can You Do If Your Health Plan Has Not Provided Or Offered These Benefits?*”

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

The Mandated Benefit Chart

The upcoming chart contains a list of mandated benefits and identifies which plans must provide these benefits. Generally, a carrier may require payment of a deductible or copay for mandatory benefits. However, the law does prohibit such fees for certain benefits; the chart indicates when such fees are prohibited.

Mandatory Offerings

The following coverages must be offered 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 of providing benefits 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 mandatory benefits and offerings requirements. These include:

- health benefit plans issued to small employers in Maryland (See explanation of small groups in previous section.)
- the Maryland Health Insurance Plan (MHIP). Under State law, MHIP is exempt from mandated benefits. However, MHIP's Board of Directors, which determines which services are covered, has elected to cover many (though not all) of the benefits mandated by law for other carriers.
- group policies 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.
- the federal government's health benefit plans. States do not regulate federal government health programs.
- self-funded and self-insured plans. 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.
- 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.

For additional information about various government programs, refer to the earlier section of this brochure, *"What Options are Available to Maryland Consumers To Pay for Medical Care."*

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 actually covered under the terms of your policy. 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. See the upcoming section "*My Health Claim Was Denied. What Should I Do?*" for information about how to file a complaint when you believe a health claim is improperly denied.

If you believe that the carrier is not in compliance with Maryland's mandatory benefits and offerings laws, you may file a complaint with the Maryland Insurance Administration. Remember, though, that the Maryland Insurance Administration only regulates 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.mdinsurance.state.md.us. 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 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
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 made applicable by Health – General Article §19-706(ppp)	Insurance Article §15-843
Anesthesia for Dental Care	Limited coverage for minors for general anesthesia and associated hospital or ambulatory charges in conjunction with dental care.	Insurance Article §15-828	Insurance Article §15-828, made applicable by Health – General Article §19-706(i)	Insurance Article §15-828
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, made applicable by Health – General Article §19-706(r)	Insurance Article §15-803
Breast Cancer Screening	Coverage for breast cancer screening in accordance with the latest screening guidelines issued by the American Cancer Society.	Insurance Article §15-814	Insurance Article §15-814, made applicable by Health – General §19-706 (ttt)	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, made applicable by Health – General Article §19-706(ii)	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 §19-705.1(d)(4) and (5)	Insurance Article §15-817

MANDATE	DESCRIPTION OF BENEFIT	INSURER	HMO	NONPROFIT HEALTH SERVICE PLAN
Chlamydia Screening	Coverage for Chlamydia screening 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, made applicable by Health – General Article §19-706(ff)	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, made applicable by Health – General Article §19-706(bb)	Insurance Article §15-818
Clinical Trials	Coverage of clinical trials approved by specified institutions including National Institutes of Health, federal Food and Drug Administration or the federal 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, made applicable by Health – General Article §19-706(aa)	Insurance Article §15-827
Colorectal Cancer Screening	Coverage for colorectal screening	Insurance Article §15-837	Insurance Article §15-837, made applicable by Health – General Article §19-706(rr)	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. [Subject to the requirements of §15-826, 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	Health – General Article §19-706(i)	Insurance Article §15-826
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.	Insurance Article §15-822	Insurance Article §15-822, made applicable by Health – General Article §19-706(x)	Insurance Article §15-822

MANDATE	DESCRIPTION OF BENEFIT	INSURER	HMO	NONPROFIT HEALTH SERVICE PLAN
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)(2); §19-705.6	
Extension of Benefits	Requires carriers to extend certain benefits according to the terms of the policy except when coverage is terminated under specific circumstances. Charging of premiums is prohibited when benefits are extended.	Insurance Article §15-833	Insurance Article §15-833, made applicable by 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	Coverage for services including occupational therapy, physical therapy, and speech therapy, for the treatment of a child under the age of 19 years of age 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	Insurance Article §15-835, made applicable by Health – General Article §19-706(nn)	Insurance Article §15-835
Hair Prosthesis (Wigs)	Coverage for a hair prosthesis prescribed by the treating 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	Insurance Article §15-836, made applicable by Health – General Article §19-706(i)	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, made applicable by Health – General Article §19-706(tt)	Insurance Article §15-838

MANDATE	DESCRIPTION OF BENEFIT	INSURER	HMO	NONPROFIT HEALTH SERVICE PLAN
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; 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 Human Papillomavirus screening 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, made applicable by Health – General Article §19-706(ff)	Insurance Article §15-829
Infertility Benefits	<p><i>In Vitro Fertilization</i> – Carriers that provide pregnancy-related benefits may not exclude benefits for all outpatient expenses arising from IVF procedures.</p> <ul style="list-style-type: none"> 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 carriers, 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, and has been unable to attain a successful pregnancy through a less costly infertility treatment for which coverage is available under the policy. The procedure must be performed at medical facilities that meet the minimum guidelines for invitro fertilization established by the American College of Obstetrics and Gynecology or the American Fertility Society. Carriers may limit the benefit to \$100,000 per lifetime and three attempts per live birth. 	Insurance Article §15-810	Insurance Article §15-810, made applicable by Health – General Article §19-706(oo)	Insurance Article §15-810
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)	
Mammograms	Coverage for breast cancer screening in accordance with the latest screening guidelines issued by the American Cancer Society.	Insurance Article §15-814	Insurance Article §15-814, made applicable by Health – General §19-706 (ttt)	Insurance Article §15-814

MANDATE	DESCRIPTION OF BENEFIT	INSURER	HMO	NONPROFIT HEALTH SERVICE PLAN
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, made applicable by Health General Article § 19-706(ttt)	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
Mental Health/ Substance Abuse Treatment	<i>Inpatient Services</i> – coverage is at least equal to the coverage for inpatient services for physical illness under the contract or policy.	Insurance Article §15-802	Health – General Article §19-703.1	Insurance Article §15-802
<i>[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, or require payment of a deductible separate from the deductible payable for services related to physical illnesses.]</i>	<i>Partial Hospitalization</i> – a minimum of at least 60 days of partial hospitalization under the same terms and conditions that apply to the benefits available under the policy or contract for physical illness.	Insurance Article §15-802	Health – General Article §19-703.1	Insurance Article §15-802
	<i>Outpatient Services</i> – coverage for expenses arising from services to treat mental illness, emotional disorders, or drug or alcohol abuse, including psychological or neuropsychological testing for diagnostic purposes, at a rate, after the applicable deductible is not less than 80% for the first 5 visits in any calendar year or benefit period of not more than 12 months; 65% coverage for 6-30 visits; 50% coverage for 31st visit and any visits after the 31st.	Insurance Article §15-802	Health – General Article §19-703.1	Insurance Article §15-802
	<i>Medication Management</i> – Coverage for office visits to a physician or health care provider for medication management are covered under the same terms and conditions under the policy for physical illness.	Insurance Article §15-802	Health – General Article §19-703.1	Insurance Article §15-802
	<i>New Methadone Maintenance Treatment</i> – 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
	<i>Residential Crisis Services</i> – 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, made applicable by Health – General Article §19-706(yy)	Insurance Article §15-840

MANDATE	DESCRIPTION OF BENEFIT	INSURER	HMO	NONPROFIT HEALTH SERVICE PLAN
Morbid Obesity	<p>Coverage for surgical treatment which is:</p> <p>(1) recognized by the National Institutes of Health as effective for the long-term reversal of morbid obesity; and</p> <p>(2) consistent with guidelines approved by the National Institutes of Health.</p> <p>Coverage must be to the same extent as for other medically necessary surgical procedures under the policy.</p>	Insurance Article §15-839	Insurance Article §15-839, made applicable by 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	Insurance Article §15-823, made applicable by 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	<p><i>Child Birth Benefits</i> – 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.</p> <p><i>Inpatient Hospital Coverage for Mothers and Newborns</i> – 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.</p>	Insurance Article §15-811	Health – General Article §19-703(g)	Insurance Article §15-811
		Insurance Article §15-812	Insurance Article §15-812, made applicable by Health – General Article §19-706(i)	Insurance Article §15-812

MANDATE	DESCRIPTION OF BENEFIT	INSURER	HMO	NONPROFIT HEALTH SERVICE PLAN
<p>Prescription Benefits {Note: Carriers are not required to provide prescription drug benefits. When benefits are provided, these laws apply.}</p>	<p><i>Off-Label Use of Drugs</i> – 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.</p>	<p>Insurance Article §15-804</p>	<p>Insurance Article §15-804, made applicable by Health – General Article §19-706(i)</p>	<p>Insurance Article §15-804</p>
	<p><i>Reimbursement for Pharmaceutical Products</i> – 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.</p>	<p>Insurance Article §15-805</p>		<p>Insurance Article §15-805</p>
	<p><i>Choice of Pharmacy</i> - A nonprofit health service plan is required to allow the member to fill prescriptions at the pharmacy of choice.</p>			<p>Insurance Article §15-806</p>
	<p><i>Maintenance Drug Coverage</i> – 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.</p>	<p>Insurance Article §15-824</p>	<p>Insurance Article §15-824, made applicable by Health – General Article §19-706(q)</p>	<p>Insurance Article §15-824</p>
	<p><i>Copayment/Coinsurance</i> – Carriers may not impose a copayment or coinsurance that exceeds the retail price</p>	<p>Insurance Article §15-842</p>	<p>Insurance Article §15-842, made applicable by Health – General Article §19-706 (jjj)</p>	<p>Insurance Article §15-842</p>
	<p><i>Use of Formulary</i> – 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 when there is no equivalent Rx drug or device in the entity's formulary, or an equivalent Rx drug listed on the entity's formulary is ineffective or has caused an adverse reaction.</p>	<p>Insurance Article §15-831</p>	<p>Insurance Article §15-831, made applicable by Health – General Article §19-706(gg)</p>	<p>Insurance Article §15-831</p>
<p>Preventative Services</p>	<p>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."</p>		<p>Health – General Article §19-701(g)(2)</p>	

MANDATE	DESCRIPTION OF BENEFIT	INSURER	HMO	NONPROFIT HEALTH SERVICE PLAN
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, made applicable by Health – General Article §19-706 (ttt)	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, made applicable by 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	Insurance Article §15-815, made applicable by 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 (including a physician or nonphysician 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	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, made applicable by Health – General Article §19-706(ddd)	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. An additional visit must be covered if ordered by the treating physician.	Insurance Article §15-832	Insurance Article §15-832, made applicable by Health – General Article §19-706(gg)	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)	

DISCLAIMER: The information in this chart is provided for informational purposes only and is not intended as legal advice or legal analysis. If you have a question as to whether a specific service or healthcare product is required to be covered, you should seek the advice of independent legal counsel.

● ● ● ● WHAT SHOULD I DO IF MY HEALTH CLAIM IS DENIED? ● ● ● ● ● ● ● ●

Health insurance and HMO claims may be denied for many reasons. Under Maryland law, the company is required to give you notice of the claim denial, including the reason the claim was denied. The notice should also explain how to appeal the decision.

In general, an appeal is first filed with the health plan. This is called an internal grievance. 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. It is also a good idea to make your appeal in writing because a telephone call may not be enough. Remember your appeal may be denied by the health plan if it is past their deadline for appeals.

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.

If you need help in filing an appeal, you may contact the Maryland Insurance Administration at 800-492-6116. The Health Education and Advocacy Unit (HEAU) in the Office of the Attorney General may also assist you in preparing your internal grievance. HEAU may be reached at 877-261-8807, or you can submit a complaint form online at www.oag.state.md.us. If you are covered by a health insurance or HMO policy issued in Maryland, you only need to file one appeal with the company.

If you are unsuccessful in your appeal, you may file a complaint with the Maryland Insurance Administration. The MIA can only investigate complaints concerning policies issued in Maryland or to a Maryland resident. You may find complaint forms and authorizations to release medical records on the MIA's website, www.mdinsurance.state.md.us. Once completed, these should be mailed to the MIA along with copies of the denial letters you received from the company and any other correspondence or documentation you have related to the claim. For further assistance, call the MIA at 800-492-6116.



DIRECTORY

State Agencies and Programs

Health Education and Advocacy Unit of the Attorney General's Office

The Health Education and Advocacy Unit (“HEAU”) helps consumers resolve billing disputes with hospitals, doctors, insurance companies and other health care providers. The HEAU also helps consumers negotiate refunds for medical equipment that is defective or was never delivered, and seeks repairs for medical equipment and other health care products. You may also contact HEAU if your insurance company refuses to pay or authorize services because it claims they are not medically necessary. HEAU may also help you prepare an appeal of that decision. For more information and assistance, contact HEAU at:

200 St. Paul Street
Baltimore, Maryland 21202
410-528-1840
877-261-8807
www.oag.state.md.us

Maryland Department of Aging

The Department of Aging provides information and assistance to seniors about various services including insurance, long-term care, housing, health, nutrition, legal assistance and a variety of other topics that are of concern for seniors. Available assistance includes:

- Senior Health Insurance Assistance Program (“SHIP”) – Provides assistance to individuals that have questions about their Medicare benefits. This program has trained individuals that can answer questions about benefits, billing and rights under the terms of the policy. Contact the SHIP office in your locality for assistance.
- Long Term Care Ombudsman – Provides help to people that live in long-term care facilities. Contact the Office of Aging in your locality to receive assistance.

You can contact the Department of Aging at:

301 West Preston Street, Suite 1007
Baltimore Maryland 21201
410-767-1100
800-243-3425
410-333-7943 (fax)
www.mdoa.state.md.us

Each county also has an Office of Aging which has information about local programs for seniors. The phone number for your local Office of Aging can be found in the blue pages of the telephone directory, or on your county's webpage.

Maryland Department of Disabilities

The Department of Disabilities (DOD) evaluates programs and services for Maryland citizens with disabilities. The DOD also helps Marylanders with disabilities find public and private agencies that provide particular services. You can contact DOD at:

217 East Redwood Street, Suite 1300
Baltimore, Maryland 21202
410-767-3660 voice/TTY
800-637-4113 voice/TTY
www.mdod.maryland.gov

Maryland Department of Health and Mental Hygiene

The Department of Health and Mental Hygiene (“DHMH”) oversees numerous boards, commissions and advisory groups relating to both private and public health issues. This includes Maryland’s Medical Assistance Program and the Maryland Children’s Health Insurance Program, as well as the professional licensing boards for physicians, nurses and other medical personnel. A full listing of the boards and commissions that DHMH oversees is available by contacting DHMH at:

201 West Preston Street
Baltimore, Maryland 21201
410-767-6860
877-463-3464
www.dhmb.state.md.us

The following is a limited listing of the offices within DHMH:

Office of Health Care Quality – Responsible for licensing and regulating hospitals and health-related institutions in Maryland. Investigates quality of care complaints filed against health maintenance organizations. You can contact them at:

Spring Grove Hospital Center
Bland Bryant Building
55 Wade Avenue
Catonsville, Maryland 21228
410-402-8000 or 877-402-8218

Health Professional Boards and Commissions – The DHMH encompasses various boards that oversee the licensing of health care providers including dentists and physicians. For a list of specific boards, and contact information, visit DHMH’s website. Consumers may also file complaints about providers, and obtain information about the licensing status of a particular provider by contacting the appropriate licensing board. You can contact them at:

4201 Patterson Avenue
Baltimore, Maryland 21215
410-764-4700
www.dhmb.state.md.us/html/proflcm.htm

Health Care Financing (HCF) – HCF administers Maryland’s medical assistance programs, including Maryland Medical Assistance and Maryland Children’s Health Program. You can contact HCF at:

201 West Preston Street
Baltimore, Maryland 21201
410-767-1463 (Maryland Medical Assistance)
800-456-8900 (Maryland Children’s Health Program)

Maryland Health Care Commission (MHCC) – Responsible for establishing quality and performance standards for HMOs, nursing homes, ambulatory surgery centers and hospitals. They are also responsible for developing a comprehensive standard health benefit plan and limited benefit plan for the small group market. You can contact MHCC at:

4160 Patterson Avenue
Baltimore, Maryland 21215
410-764-3460
877-245-1762
www.mhcc.maryland.gov

Health Services Cost Review Commission (HSCRC) – Responsible for setting the rates that Maryland hospitals may charge. They also publish the “Consumer’s Guide to Maryland Hospitals.” You can contact them at:

4160 Patterson Avenue
Baltimore Maryland 21215
410-764-2605
888-287-3229
www.hscrc.state.md.us

Mental Hygiene Administration – Responsible for assisting people on Medicaid and people with limited incomes that are not on Medicaid obtain quality mental health care. You can contact them at:

Spring Grove Hospital Center
Dix Building
55 Wade Avenue
Catonsville, Maryland 21228
410-402-8300
800-735-2258 (TTY/MD Relay)

Maryland Medical Assistance Program – This program is responsible for providing access to health care services to low income residents of the State of Maryland. Services are provided through three programs – Maryland Medicaid Program, Maryland Children’s Health Insurance Program (MCHIP) and Maryland Pharmacy Assistance Program. To find out more information, contact your local Department of Social Services or your local Health Department. You may also contact the DHMH Recipient Relations Hotline at:

410-767-5800
800-492-5231
www.dhmb.state.md.us

The Maryland AIDS Administration – Dedicated to working with public and private partners to reduce the transmission of HIV, and help Marylanders already infected live longer and healthier lives. This is accomplished by promoting and developing comprehensive, compassionate and quality services, for both prevention and care. Programs supported by the AIDS Administration include education, prevention and social services. You can contact them at:

500 North Calvert Street, 5th Floor
Baltimore, Maryland 21202
410-767-5227
800-358-9001
www.dhmb.state.md.us/AIDS/

Maryland Pharmacy Program – Maryland residents have several programs available to assist them to obtain prescription medication and supplies. To learn more about these programs, contact the Maryland Pharmacy Plan at:

201 W. Preston Street, Room 408/409
Baltimore, Maryland 21201
800-492-5231
www.dhmb.state.md.us/mma/mpap/

Maryland Kidney Disease Program (“KDP”) – Provides reimbursement for approved services required as a direct result of end-stage renal disease (“ESRD”). Applications may be obtained from the affiliated dialysis or transplant facility, or by calling the Kidney Disease Program. Completed applications and all required documentation should be submitted to the following address:

Kidney Disease Program of Maryland
201 West Preston Street, Room SS-3
Baltimore, Maryland 21201
410-764-5000

www.dhmb.state.md.us/mdckd/kdp.html

Maryland Worker’s Compensation Commission

The Worker’s Compensation Commission (WCC) may be able to assist you if you are injured on the job or as a result of a job-related activity. If you have questions regarding your claim or benefits, you should contact the WCC at:

10 East Baltimore Street, 4th Floor
Baltimore Maryland 21202
410-864-5100
800-492-0479

www.wcc.state.md.us

Maryland Department of Budget & Management – Office of Personnel Services and Benefits

State of Maryland employees that have questions about their health benefits and their rights should contact the Employee Benefits Division at:

301 West Preston Street, Room 510
Baltimore, MD 21201
410-767-4775
800-30-STATE

410-767-4006 (TTY/TDD)

www.dbm.maryland.gov

Maryland Life & Health Insurance Guaranty Corporation

The Life & Health Guaranty Corporation (LHGC) provides limited protection, as set forth in the Maryland Guaranty Corporation Act, to consumers who have policies or contracts with companies that are members of the LHGC. To learn more about the LHGC, contact them at:

P.O. Box 671
Owings Mills, MD 21117
410-998-3907
410-998-3909 (fax)

Maryland Health Insurance Plan

Maryland Health Insurance Plan (“MHIP”) is the state’s health insurance program for people who cannot get insurance in the private sector because of their health history. (See discussion in previous section of this brochure) Although MHIP is a state program, MHIP is administered by CareFirst Blue Cross Blue Shield. To learn more about MHIP or to enroll, contact:

MHIP
10455 Mill Run Circle
Mail Stop RR-291
Owings Mills, MD 21117-9185
443-738-0667
1-888-444-9016

www.marylandhealthinsuranceplan.net

Federal Agencies

Centers for Medicare & Medicaid Services

The Centers for Medicare & Medicaid Services (“CMS”) is responsible for administering the Medicare program and working with the State to administer Medicaid, the State Children’s Health Insurance Program, and the health insurance portability standards. You can contact them at:

7500 Security Boulevard
Baltimore MD 21244-1850
410-786-3000
877-267-2323
866-226-1819 (TTY)
www.cms.hhs.gov
Medicare hotline: 800-MEDICARE

United States Department of Labor

If your employer provides health coverage through a self-insured plan, you should contact your employer to learn how to appeal any decision with which you disagree. If you still are not satisfied with the decision, you may contact the United States Department at:

200 Constitution Avenue, NW
Washington D.C. 20210
866-444-3272
www.dol.gov/ebsa

Federal Employees Health Benefits Program

Federal employees must submit claims to the designated health benefits office for the region and plan. When a claim is denied, the employee may appeal the decision; contact your agency’s human resources department for information about this appeal process and where to file appeals. If a federal employee is not satisfied with the result, the decision may then be reviewed by the Office of Personnel Management. Requests for review should be sent to:

Office of Personnel Management
Attn.: Insurance Programs
1900 E Street, NW
Washington, DC 20415-1000
202-606-1800
www.opm.gov/insure/health/consumers/disputes.asp

A horizontal row of 15 dots, the first 10 are light gray and the last 5 are black, positioned above the word 'Notes'.

Notes

This consumer guide should be used for educational purposes only. It is not intended to provide legal advice or opinions regarding coverage under a specific insurance policy or contract; nor should it be construed as an endorsement of any product, service, person, or organization mentioned in this guide.

This publication has been produced by the Maryland Insurance Administration (MIA) to provide consumers with general information about insurance-related issues and/or state programs and services. This publication may contain copyrighted material which was used with permission of the copyright owner. Publication herein does not authorize any use or appropriation of such copyrighted material without consent of the owner.

All publications issued by the MIA are available free of charge on the MIA's website or by request. The publication may be reproduced in its entirety without further permission of the MIA provided the text and format are not altered or amended in any way, and no fee is assessed for the publication or duplication thereof. The MIA's name and contact information must remain clearly visible, and no other name, including that of the company or agent reproducing the publication, may appear anywhere in the reproduction. Partial reproductions are not permitted without the prior written consent of the MIA.

Persons with disabilities may request this document in an alternative format. Requests should be submitted in writing to the Director of Public Affairs at the address listed below.



200 St. Paul Place, Suite 2700
Baltimore, MD 21202
410-468-2000
800-492-6116
800-735-2258 TTY

www.mdinsurance.state.md.us

Martin O'Malley
Governor

Anthony G. Brown
Lt. Governor