MATERNITY AND NEWBORN CARE

Policy Number: BIP091.I
Effective Date: February 1, 2020

Covered benefits are listed in three (3) Sections - A, B and C. All services must be medically necessary. Each benefit plan contains its own specific provisions for coverage, limitations and exclusions as stated in the member's Evidence of Coverage (EOC)/Schedule of Benefits (SOB). If there is a discrepancy between this policy and the member's EOC/SOB, the member's EOC/SOB provision will govern.

Essential Health Benefits for Individual and Small Group
For plan years beginning on or after January 1, 2014, the Affordable Care Act of 2010 (ACA) requires fully insured non-grandfathered individual and small group plans (inside and outside of Exchanges) to provide coverage for ten categories of Essential Health Benefits (“EHBs”). Large group plans (both self-funded and fully insured), and small group ASO plans, are not subject to the requirement to offer coverage for EHBs. However, if such plans choose to provide coverage for benefits which are deemed EHBs (such as maternity benefits), the ACA requires all dollar limits on those benefits to be removed on all Grandfathered and Non-Grandfathered plans. The determination of which benefits constitute EHBs is made on a state by state basis. As such, when using this guideline, it is important to refer to the member’s specific plan document to determine benefit coverage.

For information related to those items covered on or after 08/01/12 under the Expanded Women’s Preventive Health Mandate, refer to the Medical Management Guideline titled Preventive Care Services.

A. FEDERAL/STATE MANDATED REGULATIONS

Newborns’ and Mothers’ Health Protection Act (NMHPA) of 1996, Title VI: Minimum Hospital Stay - UnitedHealthcare and its contracted providers may not restrict the benefits for any hospital length of stay for a mother and her newborn to less than 48 hours following a vaginal delivery and 96 hours following a Cesarean Section (C-Section). Protections for health plans include...
allowance of discharge before 48–96 hours if the attending physician, in consultation with the mother, makes the decision.  
https://www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/nmhpafactsheet.html

**Title VII of the Civil Rights Act, as amended by the Pregnancy Discrimination Act: 42 U.S. Code § 2000e**  
https://www.eeoc.gov/eeoc/publications/fs-preg.cfm

(k) The terms “because of sex” or “on the basis of sex” include, but are not limited to, because of or on the basis of pregnancy, childbirth, or related medical conditions; and women affected by pregnancy, childbirth, or related medical conditions shall be treated the same for all employment-related purposes, including receipt of benefits under fringe benefit programs, as other persons not so affected but similar in their ability or inability to work, and nothing in section 2000e–2 (h) of this title [section 703(h)] shall be interpreted to permit otherwise. This subsection shall not require an employer to pay for health insurance benefits for abortion, except where the life of the mother would be endangered if the fetus were carried to term, or except where medical complications have arisen from an abortion: Provided, That nothing herein shall preclude an employer from providing abortion benefits or otherwise affect bargaining agreements in regard to abortion.

**Note:** The Pregnancy Discrimination Act (PDA) amended the Title VII of the Civil Rights Act to prohibit employment discrimination based on pregnancy, childbirth, or related medical conditions. In summary, the PDA generally applies to all private and governmental (state and local) employers with 15 or more employees for each working day in at least 20 calendar weeks in the current or preceding calendar year. Any health insurance provided by such employers must cover expenses for pregnancy-related conditions on the same basis as costs for other medical conditions. Health insurance for expenses arising from abortion is not required, except where the life of the mother is endangered. Pregnancy-related expenses should be reimbursed exactly as those incurred for other medical conditions, whether payment is on a fixed basis or a percentage of reasonable-and-customary-charge basis. The amounts payable by the insurance provider can be limited only to the same extent as amounts payable for other conditions (i.e., no additional, increased, or larger deductible can be imposed).

**Direct Access to OB-GYN (California Health and Safety Code § 1367.695):**

b. Commencing January 1, 1999, every health care service plan contract issued, amended, renewed, or delivered in this state, except a specialized health care service plan, shall allow an enrollee the option to seek obstetrical and gynecological physician services directly from a participating obstetrician and gynecologist or directly from a participating family practice physician and surgeon designated by the plan as providing obstetrical and gynecological services.

c. In implementing this section, a health care service plan may establish reasonable provisions, governing utilization protocols and the use of obstetricians and gynecologists, or family practice physicians and surgeons, as provided for in subdivision (b), participating in the plan network, medical group, or independent practice association, provided that these provisions shall be consistent with the intent of this section and shall be those customarily applied to other physicians and surgeons, such as primary care physicians and surgeons, to whom the enrollee has direct access, and shall not be more restrictive for the provision of obstetrical and gynecological physician services. An enrollee shall not be required to obtain prior approval from another physician, another provider, or the health care service plan prior to obtaining direct access to obstetrical and gynecological physician services but the plan may establish reasonable requirements for the participating obstetrician and gynecologist or family practice physician and surgeon, as provided for in the subdivision (b), to communicate with the enrollee’s primary care physician and surgeon regarding the enrollee’s condition, treatment and any need for follow-up care.

**California Health and Safety Code §1367.54**

Every group health care service plan contract that provides maternity benefits, except for a specialized health care service plan contract, that is issued, amended, renewed, or delivered on
or after January 1, 1999, and every individual health care service plan contract of a type and form first offered for sale on or after January 1, 1999, that provides maternity benefits, except a specialized health care service plan contract, shall provide coverage for participation in the California Prenatal Screening Program, which is a statewide prenatal testing program administered by the State Department of Public Health pursuant to Section 124977. Notwithstanding any other provision of law, a health care service plan that provides maternity benefits shall not require participation in the statewide prenatal testing program administered by the State Department of Public Health as a prerequisite to eligibility for, or receipt of, any other service.

(b) Coverage required by this section shall not be subject to copayment, coinsurance, deductible, or any other form of cost sharing.

(c) Reimbursement for services covered pursuant to this section shall be paid at the amount set pursuant to Section 124977 and regulations adopted thereunder.

California Expanded AFP Screening Program Update Prenatal Screening Program Expansion: Inclusion of First Trimester Specimens for Sequential Screening
The California Prenatal Screening Program (currently the Expanded AFP Screening Program) is pleased to announce a program expansion to include first trimester specimens and Nuchal Translucency (NT) results beginning in late March 2009. This will allow the California Program to provide Integrated Screening for Down syndrome and Trisomy 18.

A patient’s screening options for the chromosomal abnormalities will be:

- **Quad Marker Screening**
  - One blood specimen drawn at 15 weeks-20 weeks of pregnancy (current second trimester program).

- **Serum Integrated Screening**
  - Combines first trimester blood test results (10 weeks-13 weeks 6 days) with second trimester blood test results.

- **Sequential Screening**
  - Combines first and second trimester blood test results with Nuchal Translucency (NT) results. This type of ultrasound is done by clinicians with special training. It measures the back of the fetus’ neck to screen for Down syndrome (trisomy 21) and trisomy 18 (Note: the Screening Program does not pay for NT ultrasounds).
  - Patients with first trimester blood specimens and NT will get a preliminary risk assessment for chromosomal abnormalities in the first trimester. This preliminary risk will be revised when the second trimester blood specimen is received. The Prenatal Screening Program will offer follow-up services at State-approved Prenatal Diagnostic Centers for women with screen positive results in the first or second trimesters.

California Code of Regulations Title 28 § 1300.67: Scope of Basic Health Care Services
(g) 1 Emergency health care services which shall be available and accessible to enrollee’s on a twenty-four hour a day, seven days a week, basis within the health care service plan area. Emergency health care services shall include ambulance services for the area served by the plan to transport the enrollee to the nearest twenty-four hour emergency facility with physician coverage, designated by the Health Care Service Plan.

California Health And Safety Code - HSC
Division 2 Licensing Provisions [1200 - 1797.8] (Division 2 Enacted By Stats. 1939, Ch. 60.)
Chapter 2.2 Health Care Service Plans [1340 - 1399.864] (Chapter 2.2 Added By Stats. 1975, Ch. 941.)

(Article 3.16 added by Stats. 2012, Ch. 852, Sec. 3.)

California Health and Safety Code 1357.500
As used in this article, the following definitions shall apply:
(a) "Child" means a child described in Section 22775 of the Government Code and subdivisions (n) to (p), inclusive, of Section 599.500 of Title 2 of the California Code of Regulations.
(b) "Dependent" means the spouse or registered domestic partner, or child, of an eligible employee, subject to applicable terms of the health care service plan contract covering the
employee, and includes dependents of guaranteed association members if the association elects to include dependents under its health coverage at the same time it determines its membership composition pursuant to subdivision (m).

(v) “Family” means the subscriber and his or her dependent or dependents.

California Code of Regulations; § 599.500 Definitions
For the purposes of this subchapter:
(a) Terms used in this subchapter that are defined by the Public Employees’ Medical and Hospital Care Act (Title 2, Division 5, Part 5 (commencing with Section 22750) of the Government Code) shall have the meanings therein set forth.

(n) A “child,” as described in Government Code section 22775, means an adopted, step, or recognized natural child until attainment of age 26, unless the child is disabled as described in section 599.500, subdivision (p).

(o) In addition to a “child” as described in Government Code section 22775, “family member” also includes any child for whom the employee or annuitant has assumed a parent-child relationship (PCR), in lieu of the relationship described in subdivision (n), as indicated by intentional assumption of parental status, or assumption of parental duties by the employee or annuitant, as certified by the employee or annuitant at the time of enrollment of the child, and annually thereafter up to the age of 26, unless the child is disabled as described in section 599.500, subdivision (p). This section should not be construed to include foster children.

(p) “Disabled child,” means a child, as described in Government Code section 22775 and section 599.500, subdivision (n) or (o), who at the time of attaining age 26, is incapable of self-support because of a physical or mental disability which existed continuously from a date prior to attainment of age 26 and who is enrolled pursuant to section 599.501, subdivisions (f) and (g), until termination of such incapacity.

California Health & Safety Code 1373(c) (specific to the coverage of grandchildren) which in part states:
(c) “Every plan contract that provides coverage to the spouse or dependents of the subscriber or spouse shall grant immediate accident and sickness coverage, from and after the moment of birth, to each newborn infant of any subscriber or spouse covered”

B. STATE MARKET PLAN ENHANCEMENTS

None

C. COVERED BENEFITS

IMPORTANT NOTE: Covered benefits are listed in Sections A, B and C. Always refer to Sections A and B for additional covered benefits not listed in this Section.

Note: The term child includes other dependents, including grandchildren for whom the Subscriber has assumed a parent-child relationship and assumption of parental duties by the Subscriber, as certified by the Subscriber at the time of enrollment of the child, and annually thereafter up to the age of 26 as determined eligible by the Employer Group. The child may continue coverage beyond age 26 if determined to be permanently disabled by UnitedHealthcare. The term child does not include foster children which is an optional benefit that may be purchased by the employer.

Note: UnitedHealthcare may seek recovery of actual costs incurred by UnitedHealthcare from a member who is receiving reimbursement for medical expenses for maternity services while acting as a surrogate.

Note: Certain prenatal services are covered as preventive care. Refer to the Medical Management Guideline titled Preventive Care Services.
1. **Prenatal and Postnatal Care** must be provided by a Plan Provider, including a network/participating Licensed/Certified Nurse-Midwife only when available within and authorized by, the member’s network/participating medical group.
   a. Examples include, but are not limited to:
      1) Prenatal office visits
      2) Postnatal (after delivery) office visits up to 6 weeks post-delivery
      3) Outpatient (office visit) physician services
      4) Screening and diagnostic laboratory (including the California Prenatal Screening Program) and radiological procedures, including but not limited to:
         a) Alpha fetoprotein blood testing (Refer to section A for more information regarding Prenatal screening)
         b) Fetal fibronectin enzyme immunoassay for women symptomatic for pre-term birth
            i. Symptomatic pregnancy between 24 and 34 weeks, especially when tocolytic therapy is initiated
            ii. Minimal cervical dilation (< 3 cm)
      5) Prenatal diagnosis of fetal genetic disorders including tests for specific genetic disorders for which genetic counseling is available.
      6) Educational materials for individual needs provided in physician's office

2. **Inpatient Maternity Care:** Inpatient maternity care, including but not limited to:
   a. Inpatient hospital care (A minimum 48 hour inpatient stay for normal vaginal delivery and a minimum 96-hour inpatient stay following delivery by cesarean section are covered. Coverage for inpatient hospital care may be for a time period less than the minimum hours if the decision for an earlier discharge of the mother and newborn is made by the treating Physician in consultation with the mother. In addition, if the mother and newborn are discharged prior to the 48 or 96 hour minimum time periods, a post-discharge follow-up visit for the mother and newborn will be provided within 48 hours of discharge, when prescribed by the treating Physician.)
   b. Labor and delivery room care, treatment and services
   c. Alternative birthing center services when provided or arranged by a Network Hospital affiliated with the Member’s Network Medical Group.
   d. Delivery by either normal/vaginal or Cesarean-section (C-Section)
   e. Treatment of a miscarriage and complications of pregnancy or childbirth
   f. Physician services (visits) related to all medically necessary inpatient maternity care, treatment and services
   g. All medically necessary ancillary services related to inpatient maternity care, treatment and services, including but not limited to:
      1) Diagnostic laboratory and/or radiologic procedures
   h. Services of a Licensed/Certified Nurse-Midwife only when available within the member’s Network/Participating Medical Group.
   i. Circumcision
      1) For male newborns performed at the hospital prior to hospital discharge
      2) For male newborns performed after hospital discharge when:
         a) Circumcision was delayed by the network provider during first hospitalization. Unless the delay was for medical reasons, the circumcision is covered after discharge only through the twenty-eight (28) day neonatal period, or
         b) Circumcision was determined to be medically inappropriate during first hospitalization due to medical reasons (for example, prematurity, congenital deformity, etc.) The circumcision is covered when the network provider determines it is medically safe and the circumcision is performed within 90 days from that determination.
      Note: All other requests for circumcision must be reviewed for medical necessity by the network medical group or UnitedHealthcare Medical Director or designee.

3. **Newborn Care**
   a. Postnatal hospital services are covered, including special care nursery.
D. NOT COVERED

1. Non-medically indicated diagnostic testing such as:
   a. Any procedure intended solely for sex determination (e.g., ultrasound)
   b. Blood testing to determine paternity

2. Take home medications and/or supplies, unless member has a supplemental pharmacy benefit

3. Childbirth classes (e.g., Lamaze)

4. Elective Home delivery unless covered under Section A

5. Maternity services for non-UnitedHealthcare member acting as surrogate to UnitedHealthcare member

6. Educational Courses on childcare

7. Newborn coverage of a grandchild unless the employer provides the coverage or the Subscriber, Subscriber’s Spouse or Domestic Partner has guardianship as filed in a court or provides proof of placement for adoption

E. DEFINITIONS

Certified Nurse-Midwife: A registered nurse (RN) who has successfully completed a program of study and clinical experience in nurse-midwifery, meeting prescribed guidelines or who has been certified by a recognized organization such as the American College of Nurse-Midwives.

Newborns' and Mothers' Health Protection Act (NMHPA) of 1996: This act established new requirements for plans and insurers with respect to hospital length of stay for childbirth. The NMHPA applies to all group health plans, including self-insured plans, and health insurance coverage. Plans and issuers that do not provide maternity benefits are not required to offer them, and thus are not subject to the provisions of the Act. The Act does not apply to Medicaid or the handful of births covered each year under Medicare. The NMHPA states that the Act is applicable when a beneficiary is receiving the coverage through a group health plan. Group health plan is defined as an employee welfare benefit plan to the extent that the plan provides medical care to employees or their dependents directly or through insurance. The NMHPA does not apply to individuals who are Medicare independent of a group health plan. The Act is not applicable to Medicaid beneficiaries.

Postnatal: The period of time occurring or being after birth, generally considered to be 6 weeks.

Prenatal: Occurring, existing, or performed before birth.

F. REFERENCES


Newborns’ and Mothers’ Health Protection Act (NMHPA) of 1996, Title VI
### G. POLICY HISTORY/REVISION INFORMATION

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<tr>
<td><strong>02/01/20</strong></td>
<td><strong>Related Policies</strong></td>
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<tr>
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<td>• Added reference link to the Benefit Interpretation Policy titled Abortion</td>
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<td><strong>Covered Benefits</strong></td>
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<td>• Revised language to indicate Prenatal and Postnatal Care must be provided by a plan provider, including a network/participating Licensed/Certified Nurse-Midwife only when available within and authorized by the member’s network/participating medical group</td>
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<td>• Updated list of examples of covered services; replaced:</td>
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<td>○ Screening and diagnostic laboratory and radiological procedures” with “screening and diagnostic laboratory (including the California Prenatal Screening Program) and radiological procedures”</td>
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<td>○ “Related genetic testing and counseling for prenatal diagnosis of congenital disorders of the unborn child when authorized by the Member’s Network/Participating Medical Group” with “prenatal diagnosis of fetal genetic disorders including tests for specific genetic disorders for which genetic counseling is available”</td>
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<td><strong>Inpatient Maternity Care</strong></td>
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<td>○ “Contracted birthing center/alternate birthing centers when available through the member’s participating Medical Group” with “alternative birthing center services when provided or arranged by a Network Hospital affiliated with the Member’s Network Medical Group”</td>
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<td>○ “Services of a Certified Nurse-Midwife only when available within the member’s network group” with “services of a Licensed/Certified Nurse-Midwife only when available within the member’s Network/Participating Medical Group”</td>
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<td><strong>Supporting Information</strong></td>
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