MATERNITY AND NEWBORN CARE

Policy Number: BIP095.F
Effective Date: December 1, 2018

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, please refer to the Medical Management Guideline: 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.

Title VII of the Civil Rights Act, as amended by the Pregnancy Discrimination Act: 42 U.S. Code § 2000e

(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 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).

ORS 743B.222 Designation of women's health care provider as primary care provider; direct access to women's health care provider.

(1) As used in this section, “women’s health care provider” means an obstetrician or gynecologist, physician assistant specializing in women’s health, advanced registered nurse practitioner specialist in women’s health or certified nurse midwife, practicing within the applicable lawful scope of practice.

(2) Every health insurance policy that covers hospital, medical or surgical expenses and requires an enrollee to designate a participating primary care provider shall permit a female enrollee to designate a women’s health care provider as the enrollee’s primary care provider if:

(a) The women’s health care provider meets the standards established by the insurer in collaboration with interested parties, including but not limited to the Oregon section of the American College of Obstetricians and Gynecologists; and

(b) The women’s health care provider requests that the insurer make the provider available for designation as a primary care provider.

(3) If a female enrollee has designated a primary care provider who is not a women’s health care provider, an insurance policy as described in subsection (2) of this section shall permit the enrollee to have direct access to a women’s health care provider, without a referral or prior authorization, for obstetrical or gynecological care by a participating health care professional who specializes in obstetrics or gynecology.

(4) The standards established by the insurer under subsection (2) of this section shall not prohibit an insurer from establishing the maximum number of participating primary care providers and participating women’s health care providers necessary to serve a defined population or geographic service area.

ORS: 743A.090

(1) All individual and group health benefit plans, as defined in ORS 743B.005 (Definitions), that include coverage for a family member of the insured shall also provide that the health insurance benefits applicable for children in the family shall be payable with respect to:

(a) A child of the insured from the moment of birth; and

(b) An adopted child effective upon placement for adoption.
(2) The coverage of natural and adopted children required by subsection (1) of this section shall consist of coverage of preventive health services and treatment of injury or sickness, including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities.

(3) If payment of an additional premium is required to provide coverage for a child, the policy may require that notification of the birth of the child or of the placement for adoption of the child and payment of the premium be furnished to the insurer within 31 days after the date of birth or date of placement in order to effectuate the coverage required by this section and to have the coverage extended beyond the 31-day period.

(4) In any case in which a policy provides coverage for dependent children of participants or beneficiaries, the policy shall provide benefits to dependent children placed with participants or beneficiaries for adoption under the same terms and conditions as apply to the natural, dependent children of the participants and beneficiaries, regardless of whether the adoption has become final.

(5) As used in this section:
   (a) "Child" means an individual who is under 26 years of age.
   (b) "Placement for adoption" means the assumption and retention by a person of a legal obligation for total or partial support of a child in anticipation of the adoption of the child. The child’s placement with a person terminates upon the termination of such legal obligations.

(6) The provisions of ORS 743A.001 (Automatic repeal of certain statutes on individual and group health insurance) do not apply to this section. [Formerly 743.707; 2011 c.500 §40; 2013 c.681 §33]

ORS 743A.080 Pregnancy and childbirth expense.
   (1) As used in this section, "pregnancy care" means the care necessary to support a healthy pregnancy and care related to labor and delivery.
   (2) All health benefit plans as defined in ORS 743B.005 (Definitions) must provide payment or reimbursement for expenses associated with pregnancy care and childbirth. Benefits provided under this section shall be extended to all members, enrolled spouses and enrolled dependents.

ORS 743B.225 Continuity of care
   (8) An enrollee who is undergoing care for a pregnancy and who becomes entitled to continuity of care after commencement of the second trimester of the pregnancy shall receive the care until the later of the following dates:
       (A) The 45th date after the birth; or
       (B) As long as the enrollee continues under an active course of treatment, but not later than the 120th day after the date of notification by the insurer to the enrollee of the termination of the contractual relationship with the individual provider.

ORS 743A.082 Diabetes management for pregnant women
   (1) Except as provided in subsections (2) and (3) of this section, a health benefit plan, as defined in ORS 743B.005, (Definitions) may not require a copayment or impose a coinsurance requirement or a deductible on the covered health services, medications and supplies that are medically necessary for a woman to manage her diabetes during the period of each pregnancy, beginning with conception and ending six weeks postpartum.
   (2) Subsection (1) of this section does not apply to a high deductible health plan described in 26 U.S.C. 223.
   (3) The coverage required by subsection (1) of this section may be limited by network and formulary restrictions that apply to other benefits under the plan. Subsection (1) of this section does not apply to services, medications, test strips and syringes that are not covered due to the network or formulary restrictions.
   (4) An insurer may require an enrollee or the enrollee’s health care provider to notify the insurer orally, in a timely manner, that the enrollee is diabetic and is pregnant or has given birth and is within six weeks postpartum.
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:** Depending on the member’s benefit plan, some members may have coverage for dependents, including grandchildren for medical coverage which includes maternity care. Refer to the member's Evidence of Coverage (EOC)/Schedule of Benefit (SOB) to determine coverage eligibility.

**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. Please refer to the Medical Management Guideline titled Preventive Care Services.

1. Prenatal and Postnatal care must be provided by a Plan Provider, including a participating Licensed/Nurse-Midwife.
   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 and radiological procedures, including but not limited to:  
         a) Alpha fetoprotein blood testing (Please see above 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) Genetic testing and counseling for Prenatal diagnosis of congenital disorders of the unborn child when authorized by the Member’s Participating Medical Group  
      6) Educational materials for individual needs provided in physician’s office

2. Complete inpatient maternity care, including but not limited to:
   1) Complete inpatient hospital care
   2) Labor and delivery room care, treatment and services
   3) Contracted birthing center/alternate birthing centers when provided by or arranged by a Participating Hospital affiliated with the Member’s Participating Medical Group
   4) Delivery by either normal/vaginal or Cesarean-section (C-Section)
   5) Treatment of a miscarriage and complications of pregnancy or childbirth
   6) Physician services (visits) related to all medically necessary inpatient maternity care, treatment and services
   7) All medically necessary ancillary services related to inpatient maternity care, treatment and services, including but not limited to:  
      a) Diagnostic laboratory and/or radiologic procedures  
      b) Services of a Certified Registered Nurse-Midwife within the contracting network
   8) Circumcision  
      a) For male newborns performed at the hospital prior to hospital discharge  
      b) For male newborns performed after hospital discharge when:  
         i. Circumcision is delayed by the physician at the time of hospitalization. Unless the delay is for a medical reason, the circumcision will be covered after discharge only through the twenty-eight (28) day neonatal period.
ii. It is medically inappropriate to circumcise at birth due to medical reasons (e.g., prematurity, congenital deformity, etc.). The circumcision must be postponed and offered to the parent(s) when the infant's physician determines it is medically safe and the circumcision is performed within 90 days of that determination.

**Note:** All other requests for circumcision must be reviewed for medical necessity by a UnitedHealthcare Medical Director or designee

3. **Newborn Care:**
   Postnatal hospital services including special nursery care

### 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 *(See Note Above)*

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

6. Education courses on childcare unless part of an authorized Prenatal birthing program

### E. DEFINITIONS

**Certified Registered 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

<table>
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<tr>
<th>Date</th>
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| 12/01/2018 | • Updated list of related policies; added reference link to the Benefit Interpretation Policy titled:  
  o **Fetal Aneuploidy Testing using Cell-Free Fetal Nucleic Acids in Maternal Blood**  
  o **Intrauterine Fetal Surgery**  
  **Federal/State Mandated Regulations**  
  • Replaced references to “member” with “enrollee”  
  • Updated code title for ORS: 743A.080 Pregnancy and Childbirth Expense; previously titled ORS: 743A.080 Reimbursement for Pregnancy and Childbirth Expense  
  • Updated language pertaining to ORS 743A.082 Diabetes Management for Pregnant Women  
  **Covered Benefits**  
  • Added notation to indicate:  
    o 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  
    o Certain prenatal services are covered as preventive care; refer to the Medical Management Guideline titled **Preventive Care Services**  
  **References**  
  • Updated references  
  • Archived previous policy version BIP095.E |