§ 15-844. Benefits for prosthetic devices.

(a) *"Prosthetic device" defined.*- In this section, "prosthetic device" means an artificial device to replace, in whole or in part, a leg, an arm, or an eye.

(b) *Scope.*- This section applies to:

(1) insurers and nonprofit health service plans that provide hospital, medical, or surgical benefits to individuals or groups on an expense-incurred basis under health insurance policies or contracts that are issued or delivered in the State; and

(2) health maintenance organizations that provide hospital, medical, or surgical benefits to individuals or groups under contracts that are issued or delivered in the State.

(c) *Coverage required.*- An entity subject to this section shall provide coverage for:

(1) prosthetic devices;

(2) components of prosthetic devices; and

(3) repairs to prosthetic devices.

(d) *Limitation of copayment.*- The covered benefits under this section may not be subject to a higher copayment or coinsurance requirement than the copayment or coinsurance for primary care benefits covered under the policy or contract of the insured or enrollee.

(e) *Annual or lifetime dollar maximum on coverage prohibited.*- An entity subject to this section may not impose an annual or lifetime dollar maximum on coverage required under this section separate from any annual or lifetime dollar maximum that applies in the aggregate to all covered benefits under the policy or contract of the insured or enrollee.

(f) *Requirements for medical necessity or appropriateness may not be more restrictive than those under Medicare.*- An entity subject to this section may not establish requirements for medical necessity or appropriateness for the coverage required under this section that are more restrictive than the indications and limitations of coverage and medical necessity established under the Medicare Coverage Database.

[2009, chs. 243, 244.]