§4234. Child coverage

1. Definitions. For the purposes of this section, unless the context otherwise indicates, the following terms have the following meanings.

A. "Dependent children" means children who are under 19 years of age and are children, stepchildren or adopted children of, or children placed for adoption with, the enrollee, member or spouse of the enrollee or member. [PL 1993, c. 666, Pt. A, §7 (NEW).]

B. "Placed for adoption" means the assumption and retention of a legal obligation by a person for the total or partial support of a child in anticipation of adoption of the child. If the legal obligation ceases to exist, the child is no longer considered placed for adoption. [PL 1993, c. 666, Pt. A, §7 (NEW).]

[PL 1993, c. 666, Pt. A, §7 (RPR).]

2. Coverage. All individual or group coverage subject to this chapter must provide unmarried enrollees with the same benefits or option of benefits for dependent children as is extended to dependent children of married enrollees, at appropriate rates and under the same terms and conditions.
[PL 1991, c. 200, Pt. B, §5 (NEW).]

3. Financial dependency. Financial dependency of dependent children on the enrollee or the spouse of the enrollee may not be required as a condition for eligibility for coverage.
[PL 1991, c. 200, Pt. B, §5 (NEW).]

4. Adopted children. All individual or group contracts issued in accordance with the requirements of this section must provide the same benefits to dependent children placed for adoption with the enrollee or spouse of the enrollee under the same terms and conditions as apply to natural dependent children or stepchildren of the enrollee or spouse of the enrollee, irrespective of whether the adoption has become final.
[PL 1993, c. 666, Pt. A, §8 (NEW).]

5. Medicaid. Health maintenance organizations may not consider the availability or eligibility for medical assistance under 42 United States Code, Section 13969, referred to as "Medicaid," when considering coverage eligibility or benefit calculations for enrollees and covered family members.

A. To the extent that payment for coverage expenses has been made under the Medicaid program for health care items or services furnished to an individual, the State is considered to have acquired the rights of the enrollee or family member to payment by the health maintenance organization for those health care items or services. Upon presentation of proof that the Medicaid program has paid for covered items or services, the health maintenance organization shall make payment to the Medicaid program according to the coverage provided in the contract or certificate. [PL 1993, c. 666, Pt. B, §3 (NEW).]

B. A health maintenance organization may not impose requirements on a state agency that has been assigned the rights of an individual eligible for Medicaid and covered by an enrollee contract that are different from requirements applicable to an agent or assignee of any other covered individual. [PL 1993, c. 666, Pt. B, §3 (NEW).]

[PL 1993, c. 666, Pt. B, §3 (NEW).]

SECTION HISTORY

PL 1991, c. 200, §B5 (NEW). PL 1993, c. 666, §§A7,8,B3 (AMD).