INDIVIDUAL LIMITED SHORT-TERM DURATION INSURANCE

COMPANY:	NAIC Code:
FORM(S):	
DATE:	
SERFF TRACKING NO.:	

The items listed below may paraphrase the law or regulation. The checklist is not required to be included with a form filing. It should be used as a guide in determining which laws and regulations apply to the contract. Unless otherwise specified, all section references are to the Insurance Article of the Annotated Code of Maryland.

A. Filing Incomplete or in Unacceptable Format

	Citation	Description	"X" Means Applicable	Form/ Page
A1.	COMAR 31.10.01.03A	Premium Rates and Actuarial Memorandum (Include in same SERFF tracking number filing)		
A2.	COMAR 31.04.17.03I(2)	If the filing is not being made by the insurer, the filer must submit a signed third party authorization letter from the insurer.		
A3.	COMAR 31.04.17.03C	Listing of Forms		
A4.	COMAR 31.04.17.03J	Description of New Features		
A5.	COMAR 31.04.17.03D	Form Number (Form number must be identical to form number in SERFF Form Schedule)		
A6.	COMAR 31.04.17.03G, COMAR 31.10.01.03B	Corporate Name		
A7.	COMAR 31.04.17.03H	Unacceptable Modifications		
A8.	COMAR 31.04.17.03K	Specimen Data		
A9.	COMAR 31.04.17.03M	Signature of Officer		
A10.	COMAR 31.04.17.04A(1)	Form contains items in brackets, denoting variability. Only specific Items allowed for variability. Submit specific description of how each item can vary. If other items are desired, include the item.		
A11.	COMAR 31.04.17.04B	Contracts Comprised of Insert Pages		
	COMAR 31.04.17.04B(1)(b)(i)	a. Description of How Pages will be Combined		
	COMAR 31.04.17.04B(1)(b)(ii)	b. Listing of Substitute Pages		
	COMAR 31.04.17.04B(3)(a)	c. Form Number and Approval Date for Pages Replaced		

	Citation	Description	"X" Means Applicable	Form/ Page
	COMAR 31.04.17.04B(3)(b)	d. Copy of Currently Approved Contract		
A12.	COMAR 31.04.17.04C	Contracts Comprised of Sections		
	COMAR 31.04.17.04C(1)(b)(i)	a. Description of How Sections will be Combined		
	COMAR 31.04.17.04C(1)(b)(ii)	b. Listing of Substitute Sections		
	COMAR 31.04.17.04C(3)(a)	c. Form Number and Approval Date for Pages Replaced		
	COMAR 31.04.17.04C(3)(b)	d. Copy of Currently Approved Contract		
A13.	COMAR 31.10.01.03E	Signature of Policyholder for Reduction Rider		
A14.	COMAR 31.10.01.03B	Size of Type		
A15.	COMAR 31.10.02	Simplified Language (Readability Certification)		
A16.	§12-205(b)(5)	Illegible Form		
A17.	§2-112(a)(10)	Filing Fees Insufficient		
A18.	COMAR 31.04.17.03F	Language other than English in Forms		
A19.	§15-201(h)	10 Day Right to Examine Policy		
A20.	§15-1301(s)	Requirements for Short-Term Limited Duration Insurance		
		a. Has a policy term that is less than 3 months after the original effective date of the policy or contract		
		b. May not be extended or renewed		
		c. Must apply the same underwriting standards to all applicants regardless of whether they have previously been covered by short-term limited duration insurance		
		d. Notice required by 45 CFR §144.103 in policy and application form for enrollment of coverage		
	88 FR 44596, revising 26 CFR 54.9801–2, 29 CFR 2590.701–2, and 45 CFR 144.103 effective 9/1/24	Revised Federal Definition for “short-term, limited- duration insurance” requires policies issued on or after 9/1/24 to include specific notice.		

B. Mandated Benefits

	Citation	Description	"X" Means Applicable	Form/ Page
B1.	§15-803	Blood Products		
B2.	§15-818	Cleft Lip/Cleft Palate		
B3.		Health Care Cost Containment		
	§15-819(b)(1)	a. Outpatient Benefit		
	§15-819(b)(2)	b. Second Opinion		
B4.	§15-808	Home Health Care		
B5.		Mental Illness and Substance Abuse		
	§15-802(c)	a. Required benefits for inpatient care, (services in licensed or certified facility, including hospital inpatient and residential treatment center benefits) partial hospitalization, and outpatient care (including all office visits, diagnostic evaluation, opioid treatment services, medication evaluation and management and psychological and neuropsychological testing for diagnostic purposes) • Mental health services or tests must be covered if provided by licensed or certified practitioners when acting within the scope of their license if equivalent services are covered for physical illnesses.		
	§15-840	b. Required benefits for residential crisis services		
	§15-802(d)(2)(ii)2; 45 CFR §146.136(2)(i)	c. Each financial requirement applicable to a mental health or substance abuse benefit in the plan design is no more restrictive than the *predominant* financial requirement of that type that applies to *substantially all* of the medical/surgical benefits in the same classification. In performing the "substantially all" and "predominated" tests, carrier should use "plan" level claims data (as opposed to "product" level). If carrier does not have sufficient data at the "plan" level, "product" level data may be used provided the carrier can demonstrate the validity of the projection method		

	Citation	Description	"X" Means Applicable	Form/ Page
	45 CFR §146.136(c)(2)(ii)	d. For purposes of determining mental health parity, benefit classifications limited to inpatient, in-network; inpatient, out-of-network; outpatient, in-network; outpatient, out-of- network; emergency care; and prescription drugs		
	45 CFR §146.136(c)(3)(iii)	e. Exceptions to six benefit classifications provided only for multi-tiered prescription drug benefits, multiple network tiers, and outpatient sub-classification of office visits, separate from other outpatient items and services, but separate sub-classifications for generalists and specialists are not permitted		
	§27-913	• Multi-tiered prescription drug plan may not assign drug to more than 1 tier because such drug is based on the specific disease, diagnosis or indication being treated		
	§15-802(d)(2)(iv); 45 CFR §146.136(c)(4)	f. 60-day limit for partial hospitalization only permitted upon demonstration of compliance with 45 CFR §146.136(c)(2)(i)		
	§15-802(d)(4); 45 CFR §146.136(c)(4);	g. Prohibition on nonquantitative treatment limitations (include UR requirements) that are more restrictive than requirements for physical illnesses		
B6.	§15-809; COMAR 31.10.09	Hospice (Required Offering)		
B7.	§15-821	Coverage of Face, Neck or Head		
B8.	§15-814	Mammography (May not be subject to deductible)		
	§15-814(c)(1)	• Coverage for breast cancer screening in accordance with latest screening guidelines issued by American Cancer Society		
	§15-814(c)(2)	• Coverage for Digital Tomosynthesis that, under accepted standards in the practice of medicine, the treating physician determines is medically appropriate and necessary		
	§15-814(e)(1)	• May not be subject to deductible		
	§15-814(e)(3)	• May not impose a copayment or coinsurance requirement for digital tomosynthesis that is greater than a copayment or coinsurance requirement for other breast cancer screenings		

	Citation	Description	"X" Means Applicable	Form/ Page
	§15-814.1(c), House Bill 1259,Chpt. 868, Acts of 2024 (effective 1/1/25)	Diagnostic and Supplemental Examinations and Biopsies, including image-guided breast biopsies, for Breast Cancer • May not be subject to copays, coinsurance, or deductible.		
B9.	§15-817	Child Wellness (May not be subject to deductible)		
	§15-817(c)(2)(v)	a. Include all visits for obesity evaluation and management		
	§15-817(c)(2)(vi)	b. Include all visits for and costs of developmental screening as recommended by the American Academy of Pediatrics		
	§15-817(c)(2)(viii)	c. Coverage for laboratory tests considered necessary by physician for services in §15-817		
	§15-817(c)(2)(vii)	d. Physical examination, development assessment, and parental anticipatory guidance for the child to be covered as in §15-817		
B10.	§15-807	Medical Food and Low Protein Food		
B11.	§15-815	Reconstructive Breast Surgery		
	§15-815(a)(2)	• Mastectomy definition does not include "breast cancer"		
	§15-815(c)(2)	• Coverage includes physical complications of all stages of mastectomy, including lymphedemas, in manner determined by physician		
B12.	§15-823	Osteoporosis Prevention and Treatment		
B13.	§15-825	Prostate Cancer Screening		
	§15-825(c)	• Deductible, Copayments or Coinsurance may not be applied		
B14.	§15-822	Diabetes Equipment, Supplies, Training		
	§15-822(d)(3)	• Diabetes Test Strips – Deductible, Copayment and Coinsurance May Not Be Applied		
	§15-822(b)(3)	• Include benefits for both elevated or "impaired" blood glucose levels induced by pregnancy		

	§15-822(b)(4)	• Include benefits for both elevated or impaired blood levels induced by prediabetes, consistent with American Diabetes Association standards		
B15.	§15-826.2	Male Sterilization coverage		
	§15-826.2(b)(2)	• Deductible, Copayments or Coinsurance may not be applied		
B16.	§15-827	Coverage for Medical Clinical Trials		
B17.	§15-828	General Anesthesia for Dental Care		
B18.	§15-829	Annual Chlamydia Screening Test		
	§15-829(c)(2)	• Human Papillomavirus Screening Test		
B19.	§15-832	Coverage for Home Visits If Less than 48 hours of Inpatient Hospitalization is Provided for Surgical Removal of Testicle		
B20.	§15-832.1	Coverage for Inpatient Hospitalization for a Minimum of 48 Hours Following Mastectomy or Coverage for Home Visits if less than 48 Hours of Inpatient Hospitalization.		
	§15-832.1(a)	• Mastectomy Definition		
B21.	§15-834	Breast Prosthesis		
B22.	§15-835	Habilitative Services for Children • Revised Habilitative Services definition • Required to provide health benefits until end of month in which child turns age 19		
		Treatment of autism and autism spectrum disorders under services		
	COMAR 31.10.39	• Utilization review criteria must comply with COMAR 31.10.39		
	COMAR 31.10.39.03G	• Applied behavior analysis (behavioral health treatment) cannot be excluded		
B23.	§15-855	Pediatric Autoimmune Neuropsychiatric Disorders associated with streptococcal infections and pediatric acute onset neuropsychiatric syndrome • Diagnosis, evaluation, and treatment, including the use of intravenous immunoglobulin therapy		

	§15-855, House Bill 820, Chpt. 321, Acts of 2022 (effective 01/01/23)	Modification of coverage requirement: Rituximab cannot be excluded for treatment of PANS/PANDAS solely on the basis that the FDA has not approved the drug for this indication.		
B24.	§15-139	Health Care Services Through Telehealth		
	§15-139(a), Senate Bill 534, Chapter 382, Acts of 2023 (effective 6/01/23)	a. Revised to include, from July 1, 2021 to June 30, 2025, both inclusive, a Definition of "telehealth:" • Audio-only telephone conversation between a health care provider and a patient that results in the delivery of a billable, covered health care service. • Amended to NOT include, except as provided above, audio-only telephone conversation between a health care provider and a patient		
	§15-139(c)(1), Senate Bill 3, Chpt. 71, Acts of 2021 (effective 7/01/21)	b. Coverage shall: • Be provided regardless of the location of the patient at the time the telehealth services are provided. • Not be excluded or denied for a behavioral health care service that is a covered benefit under a health insurance policy or contract when provided in person solely because the behavioral Health Care Service may also be provided through a covered telehealth benefit.		
	§15-139(c)(2), Senate Bill 3, Chpt. 71, Acts of 2021 (effective 7/01/21)	c. Telehealth care services include counseling and treatment for substance use disorders and mental health conditions.		
	§15-139(e), Senate Bill 3, Chpt. 71, Acts of 2021 (effective 7/01/21)	d. May not require that covered health care services delivered through telehealth be provided by a third-party vendor designated by the carrier.		
B25.	§15-836	Hair Prostheses for Hair Loss Resulting from Chemotherapy or Radiation Treatment for Cancer		
B26.	§15-837	Colorectal Cancer Screening		
B27.	§15-839	Treatment of Morbid Obesity • If utilization review criteria are included, criteria must comply with COMAR 31.10.33		
B28.	§15-838	Hearing Aids Coverage for Children		
	§15-838.1, Senate Bill 778, Chpt. 952, Acts of 2024 (effective 1/1/25)	Hearing Aids- Coverage for Adults		

	§15-838.1(d)(2), Senate Bill 778, Chpt. 952, Acts of 2024 (effective 1/1/25)	• Must permit member to select a hearing aid that costs more than the benefit listed in the contract and pay the additional cost of the hearing aid without financial or contractual penalty to the provider of the hearing aid		
B29.	§15-843	Amino Acid-Based Elemental Formula		
B30.	§15-844, Senate Bill 614, Chpt. 823, Acts of 2024 (effective 1/1/25)	Prosthetic Devices (including Components and Repairs)		
	§15-844(a), Senate Bill 614, Chpt. 823, Acts of 2024 (effective 1/1/25)	• Definition of “prostheses”		
	§15-844(c), Senate Bill 614, Chpt. 823, Acts of 2024 (effective 1/1/25)	• Benefits must be provided once annually		
	§15-844(d), Senate Bill 614, Chpt. 823, Acts of 2024 (effective 1/1/25)	• Coverage for prosthetic and component replacements		
	§15-844(e), Senate Bill 614, Chpt. 823, Acts of 2024 (effective 1/1/25)	• May not require copayment or coinsurance higher than other similar services		
	§15-844(g), Senate Bill 614, Chpt. 823, Acts of 2024 (effective 1/1/25)	Medical necessity to be determined by the treating provider		
	§15-844(g)(1), Senate Bill 614, Chpt. 823, Acts of 2024 (effective 1/1/25)	• Any standard medical necessity exclusion in contract must indicate prostheses or components are considered medically necessary if satisfies medical necessity requirements established under the Medicare Coverage Database		
	§15-844(g)(2), Senate Bill 614, Chpt. 823, Acts of 2024 (effective 1/1/25)	• Benefits will be provided for prostheses health care provider determines are medically necessary when used for activities identified in statute		
B31.		Preventive Services		
	§15-135	• Benefits for annual preventive care must be available once per year at any time during the plan year established by the contract.		
	§15-135.1	• Dental Preventive Care, if benefit is provided, must cover annual benefit at any time during contract’s plan year.		

B32.	§15-826.3	Coverage for Fertility Awareness-Based Methods		
	§15-826.3(c)	a. Coverage for instruction by a licensed health care provider on fertility awareness-based methods		
	§15-826.3(a)	b. Fertility Awareness-based Methods definition may not be more restrictive than provided by law		
	§15-826.3(d)	c. Deductible, Copayment or Coinsurance may not be applied (in-network and out-of-network)		
B33.	§15-848	Ostomy Equipment and Supplies		
B34.	§15-853, House Bill 847, Chpt. 471, Acts of 2018 (effective 01/01/19)	Coverage for Lymphedema Diagnosis, Evaluation and Treatment		
	§15-853(c)	a. Coverage for medically necessary diagnosis, evaluation and treatment of lymphedema, including equipment, supplies, complex decongestive therapy, gradient compressing garments and self-management training and education		
	§15-853(a)	b. Gradient Compression Garment definition required		
	§15-853(d)	c. Annual Deductible, Copayment and Coinsurance cannot exceed the annual deductibles, coinsurance, copayments or coinsurance for similar coverages		
B35.	§15-857, House Bill 937, Chpt. 56, Acts of 2022 (effective 01/01/23)	Abortion care services (applicable to contracts that provide labor and delivery benefits to individuals or groups on an expense-incurred basis)		
	§15-857(a)(2)(ii), House Bill 937, Chpt. 56, Acts of 2022 (effective 01/01/23)	• Does not apply to high deductible health plans		
	§15-857(b)(1)(i), House Bill 812, Chpt. 249, Acts of 2023	• May not apply copayment, coinsurance, or deductible		
	§15-857(b)(1)(ii), House Bill 937, Chpt. 56, Acts of 2022 (effective 01/01/23)	• Prohibition on restrictions on the coverage that are inconsistent with the protected rights under Title 20, Subtitle 2 of the Health-General Article		
	§15-857(b)(2), House Bill 937, Chpt. 56, Acts of 2022 (effective 01/01/23)	• Term “abortion care” is required when describing coverage		

	§15-859, House Bill 1217, Chpt. 323, Acts of 2023 (effective 01/01/24)	Biomarker Testing		
	§15-859(c), House Bill 1217, Chpt. 323, Acts of 2023 (effective 01/01/24)	a. Includes diagnosis, treatment, appropriate management and ongoing monitoring of a disease or condition that is supported by medical and scientific evidence		
	§15-859(a)(2), House Bill 1217, Chpt. 323, Acts of 2023 (effective 01/01/24)	b. Definition ”biomarker”		
	§15-859(a)(3), House Bill 1217, Chpt. 323, Acts of 2023 (effective 01/01/24)	c. Definition ”biomarker testing”		
	§15-860, House Bill 815, Chpt. 354, Acts of 2023 (effective 01/01/24)	Diagnostic Lung Cancer Screening		
	§15-860(b)(1), House Bill 1259, Chpt. 868, Acts of 2024 (effective 1/1/25)	• Recommended screening or follow-up diagnostic imaging to assist in diagnosis of lung cancer when lung cancer screening or follow-up diagnostic imaging is recommended by USPSTF		
	§15-860(b)(2), House Bill 1259, Chpt. 868, Acts of 2024 (effective 1/1/25)	• Coverage for diagnostic ultrasound, magnetic resonance imaging, computed tomography, and image-guided biopsy • May not require prior authorization		
	§15-860(c), House Bill 815, Chpt. 354, Acts of 2023 (effective 01/01/24)	• May not be subject to copays, coinsurance, or deductible that is greater than the copay, coinsurance or deductible applied to breast cancer screening and diagnosis under §§15-814(e) and 15-814.1(c).		

C. Eligibility and Enrollment

	Citation	**Description**	**"X" Means Applicable**	**Form/ Page**
C1.	§15-403.2; COMAR 31.10.35	Domestic Partner Coverage, including Child Dependents of Domestic Partner		
C2.	§15-401, §15-403, §15-403.1	Newborn/Adopted Children/Grandchildren/Guardianship		
C3.	§15-418	Grandchildren and children under Guardianship Coverage to Age 25		
C4.	§15-417	Part-Time Students with Disabilities		
C5.	§15-402	Incapacitated Children Coverage		

	Citation	Description	"X" Means Applicable	Form/ Page
C6.	§15-833	Extension of Benefits		

D. Prescription Coverage Benefit (applicable only if contract provides coverage for prescription drugs)

	Citation	Description	"X" Means Applicable	Form/ Page
D1.	§15-805	Coverage of Drugs from Local Pharmacies Same as Mail Order		
D2.	§15-824	90 Day Supply for Maintenance Drugs • Exception for first prescription or change in prescription		
D3.	§15-826, §15-826.1	Coverage for Contraceptive Drugs or Devices • Coverage without a prescription for FDA approved contraceptive drugs that are available by prescription or over the counter (benefit may be limited to drugs received at in-network pharmacies and reasonable frequency limits may be applied)		
	§15-826.1(e)(1)(ii)	a. Copayments or coinsurance for FDA approved contraceptive drug dispensed without a prescription and available by prescription or over the counter may not exceed the copayment or coinsurance for the contraceptive drug when dispensed under a prescription		
	§15-826.1(d)	b. 12-month supply of prescription contraceptives		
	§15-826.1(c)(2)(ii)	c. Copayments or coinsurance may not be applied to FDA approved contraceptive drugs or devices prescribed by an authorized prescriber (applies to in-network and out-of-network benefits)		
	§15-826.1(c)(3)	• Exception – Copayment or coinsurance may be applied to a contraceptive drug or device that is therapeutically equivalent to another contraceptive drug or device available under the contract without a copayment or coinsurance		
D4.	§15-804	Off Label Use of Drugs		
	§15-804(a)(4)	• Include “Standard reference compendia” definition		
D5.	§15-831	May use a formulary for brand-name drugs in compliance with §15-831		

	Citation	Description	"X" Means Applicable	Form/ Page
	§15-831	• Apply formulary exception process to drugs or devices that are removed from formulary or moved to a higher deductible, copayment or coinsurance tier		
	§15-831	• Must cover a contraceptive prescription drug or device that is not on the formulary if it is medically necessary for the member to adhere to the appropriate use of the prescription drug or device in the judgement of the authorized prescriber		
D6.	§15-841	Coverage for Smoking Cessation Treatment		
D7.	§15-842	Copayment or Coinsurance for prescription drug or device may not exceed the retail price of prescription drug or device		
D8.	§15-845(b)(1), §15-845(b)(2)(i)	Coverage for Certain Prescription Eye Drop Refills (if contract provides coverage for prescription eye drops)		
D9.	§15-142(c)	Step therapy or fail first protocol may not be imposed under certain circumstances		
	§15-142(e)	a. Preauthorization cannot be imposed on certain cancer drugs		
	§15-850	b. Preauthorization cannot be required for certain drug products used to treat opioid use disorder		
	§15-851	c. Preauthorization cannot be required for drugs used for treatment of opioid addiction		
D10.	§15-854	Limits on prior authorization requirements for certain drugs		
	§15-854(f), Senate Bill 791, Chpt. 848, Acts of 2024 (effective 1/1/25)	• More than one prior authorization prohibited if two or more tablets of different dosage strengths of the same prescription drug are prescribed at the same time and are made by the same manufacturer. This does not apply to opioids that are not opioid partial agonists.		
	§15-854(g), Senate Bill 791, Chpt. 848, Acts of 2024 (effective 1/1/25)	• Circumstances under which a carrier may not issue adverse decision on reauthorization		
D11.	§15-849	Abuse-Deterrent Opioid Analgesic Drug Products – Tier Placement and Step Therapy		

	Citation	Description	"X" Means Applicable	Form/ Page
	§15-849(c)(1)	• If contract lists specific drugs that are covered, must list at least two brand name and two generic abuse-deterrent opioid analgesic drugs on the lowest cost tier		
	§15-849(c)(2)	• No fail first protocol applied to opioid analgesic drugs before being allowed abuse-deterrent opioid analgesic drugs		
D12.	§15-847	Specialty drugs – Copayment/Coinsurance Limits • Definition excludes drugs for the treatment of diabetes, HIV, or AIDS		
D13.	§15-847.1	Prescription drugs for the treatment of diabetes, HIV, or AIDS -- Copayment/Coinsurance limits		
	§15-822.1, House Bill 1397, Chpt 405, Acts of 2022, (effective 01/01/23)	• Copayment or coinsurance for insulin cannot be more than $30 for a 30-day supply, regardless of amount or type of insulin needed.		
D14.	§15-846	Chemotherapy Parity – Coverage for benefits at same (or better) level for oral chemotherapy as benefits for cancer chemotherapy that is administered intravenously or by injection.		
D15.	§15-852	Prorated daily copayment/coinsurance for partial supply of prescription drug dispensed by in-network pharmacy		
D16.	§15-858, House Bill 970, Chpt. 684, Acts of 2022 (effective 01/01/23)	Prohibition on prior authorization for prescription drugs used as Postexposure Prophylaxis for the prevention of HIV if the drug is prescribed for use in accordance with Centers for Disease Control and Prevention guidelines.		

E. Maternity

	Citation	Description	"X" Means Applicable	Form/ Page
E1.		Inpatient Hospitalization for Mothers and Newborns		
E2.	§15-812	a. Mandated Coverage		
	§15-811	b. Additional 4 days Inpatient Stay for Newborn if Mother Requires Inpatient Care		

	§15-812(g)(1)	c. Coverage of Home Visits for Mothers and Newborns May Not Be Subject to Deductibles, Copays or Coinsurance for health plans		
E3.	§15-506	Maternity Care Regardless of Marital Status		
E4.	§15-811	Hospitalization Same as for Any Other Covered Sickness		
E5.	§15-810	In Vitro Fertilization		
	§15-810(b) and (d)(3)	• Expanded to include coverage for married same-sex couples		
	§15-810(d)(2)	• May not require that the patient's oocytes be fertilized by the patient's spouse's sperm if the spouse is unable to produce and deliver functional sperm not resulting from vasectomy or voluntary sterilization		
	§15-810(d)(3), Senate Bill 988, Chpt. 325, Acts of 2020 (effective 01/01/21)	• Period of time to demonstrate a history of infertility reduced from two years to one year.		
	§15-810(d)(4), Senate Bill 988, Chpt. 325, Acts of 2020 (effective 01/01/21)	• Coverage for in vitro-fertilization benefit expanded to include unmarried patients		
E6.	§15-810.1	Coverage for fertility preservation procedures for iatrogenic infertility		
		Required Definitions:		
	§15-810.1(a)(2)	a. Iatrogenic Infertility		
	§15-810.1(a)(3)	b. Medical Treatment that May Directly or Indirectly Cause Iatrogenic Infertility		
	§15-810.1(a)(4)	c. Standard Fertility Preservation Procedures		

F. Practitioners

	Citation	**Description**	**"X" Means Applicable**	**Form/ Page**
F1.	§15-701	Health Care Providers		
	§15-701, Senate Bill 216, Chpt. 330, Acts of 2023 (effective 7/01/23)	• May not exclude medically necessary treatment services otherwise covered under the contract when those services are provided by a massage therapist		
F2.	§15-703	Certified Nurse Practitioner		

	Citation	Description	"X" Means Applicable	Form/ Page
F3.	§15-708	Nurse Anesthetist		
F4.	§15-705	Chiropractor		
F5.	§15-709	Nurse Midwife		
F6.	§15-713	Podiatrists		
F7.	§15-704	Clinical Professional Counselors		
F8.	§15-707	Social Workers		
F9.	§15-710	Optometrists		
F10.	§15-714	Psychologists		
F11.	§15-715	Community Health Resource		

G. Other

	Citation	Description	"X" Means Applicable	Form/ Page
G1.	§15-604	Payment of Maryland Hospitals Based on Rate Set by Health Services Cost Review Commission		
G2.	§15-603	Reimbursement for Services Paid for or Provided by Department of Health		
G3.	§ 14-205	Preferred Provider		
	§14-205(b)(2)	a. Difference between coinsurance percentage for non- preferred and preferred providers may not exceed 20 percentage points		
	§14-205(b)(3)	b. PPO contract provisions for the insured to pay the balance bill may not apply to an on-call or hospital-based physician who has accepted an assignment of benefits in accordance with §14-205.2		
	§14-205(b)(4)	c. Insurer's allowed amount paid to non-preferred providers for a health care service covered by a PPO contract may not be less than the allowed amount paid to a similarly licensed provider who is a preferred provider for the same service in the same region		
	§15-118(c)	d. Coinsurance Amounts for Preferred Provider Must Be based on Negotiated Fees with Insurer		
	§15-830(a)	e. Referrals to Specialists – Definitions Are Unacceptable		

	Citation	Description	"X" Means Applicable	Form/ Page
	§15-830(b)	f. Procedure for Right to Standing Referral to Network Specialist		
	§15-830(d)	g. Procedure for Right to Request Referral to Specialist, Including Non-Physician Specialist Not on Carrier's Provider Panel		
	§15-830(d)(2)(ii)(2)	h. Referral must be granted if the carrier cannot provide reasonable access to a specialist without unreasonable travel or delay.		
	§15-830(e)(2), Senate Bill 707, Chpt 272, Acts of 2022 (effective 7/01/22)	i. Balance billing is prohibited for services received from a referral to a non-panel provider for mental health or substance use disorders.		
	§15-816	j. Direct Access to Obstetrical and Gynecological Care		
		• OB/GYN care may be received from in-network provider who specializes in obstetrics or gynecology without referral or authorization from carrier or primary care provider		
		• Includes any in-network provider authorized under State Law to provide OB/GYN care, including a person other than a physician (such as a certified nurse midwife)		
		• Includes all care received from OB/GYN (routine and non-routine) and the ordering of related obstetrical and gynecological items and services		
	§15-140	k. When member transitions from another carrier or managed care organization, receiving carrier must allow member to continue to receive health care services from a nonparticipating provider under certain circumstances		
	§14-205.2	l. Payment Rules for Assignment of Benefits for Physicians on Call and Hospital-Based Physicians		
	§14-205.3	m. Payment Rules for Assignment of Benefits for Physicians Not on Call or Hospital-Based Physicians		
	Title 15, Subtitle 17	n. Physician Rating System		
G4.		Exclusive Provider Benefit (EPO)		

	Citation	Description	"X" Means Applicable	Form/ Page
	§15-118(c)	a. Coinsurance Amounts for Preferred Provider must be based on Negotiated Fees with Insurer		
	§15-830(a)	b. Referrals to Specialists – Definitions Are Unacceptable		
	§15-830(b)	c. Procedure for Right to Standing Referral to Network Specialist		
	§15-830(d)	d. Procedure for Right to Request Referral to Specialist, Including Non-Physician Specialist Not on Carrier's Provider Panel		
	§15-830(d)(2)(ii)(2)	e. Referral must be granted if the carrier cannot provide reasonable access to a specialist without unreasonable travel or delay		
	§15-830(e)(2), Senate Bill 707, Chpt 272, Acts of 2022 (effective 07/01/22)	f. Balance billing is prohibited for services received from a referral to a non-panel provider for mental health or substance use disorders		
	§15-816	g. Direct Access to Obstetrical and Gynecological Care		
		• OB/GYN care may be received from in-network provider who specializes in obstetrics or gynecology without referral or authorization from carrier or primary care provider		
		• Includes any in-network provider authorized under State Law to provide OB/GYN care, including a person other than a physician (such as a certified nurse midwife)		
	§15-140	h. When member transitions from another carrier or managed care organization, receiving carrier must allow member to continue to receive health care services from a nonparticipating provider under certain circumstances		
	§14-205.2	i. Payment Rules for Assignment of Benefits for Physicians on Call and Hospital-Based Physicians		
	§14-205.3	j. Payment Rules for Assignment of Benefits for Physicians Not on Call or Hospital-Based Physicians		
	Title 15, Subtitle 17	k. Physician Rating System		

G5.	Title 15, Subtitle 10D; COMAR 31.10.29	Complaint process for coverage decisions		
	§15-10D-01(k)	• Revised member definition		
G6.	§15-112(q)	Identify office and process for filing complaints		
G7.	§15-919	Medicare Supplement Disclosure for Individuals eligible for Medicare Due to Age (non-employer and non-labor organization contracts only)		
G8.	COMAR 31.10.13	Return of Premium Benefits		
G9.	COMAR 31.10.01.03C	Standard of Time		
G10.	COMAR 31.10.01.03G	Right to Elect Alternative Benefits		
G11.	§12-209(1), §12-209(2), §12-209(4)	Contract Governed by Maryland Law and Maryland Courts		
G12.	§15-110(d)	Required Exclusion for Prohibited Practitioner Referral		
G13.	§15-1005(g)	Payment of Interest on Unpaid Claims		
G14.	COMAR 31.15.08	Payment of Claims, Unfair Trade Practices		
G15.	COMAR 31.10.28.05	Premium Due Date		
G16.	§15-138	Reimbursement of Ambulance Service Providers		
G17.	§27-216; MIA Bulletin 17-10	Requirements for Acceptance of Credit Cards for Premium Payment and Charging of Fees for Use of Credit Cards		

H. Prohibited Provisions

	Citation	**Description**	**"X" Means Applicable**	**Form/ Page**
H1.	COMAR 31.04.17.13B	Natural Death Benefit		
H2.	COMAR 31.10.01.03N	Damage to Conveyance		
H3.	COMAR 31.10.01.03O	Chronic or Organic Disease		
H4.	COMAR 31.10.01.03I	Frequency of Physician Visits		
H5.	COMAR 31.10.01.03P	Reimbursement Language		
H6.	COMAR 31.10.01.03Q	Strict Compliance Language		
H7.	COMAR 31.10.28.03A	May not limit or exclude loss due to insured's commission of or attempt to commit a crime.		

	Citation	Description	"X" Means Applicable	Form/ Page
H8.	COMAR 31.10.28.03B	May not limit or exclude loss to which a contributing cause was the insured's being engaged in an illegal occupation.		
H9.	COMAR 31.10.28.03C	May not limit or exclude loss due to use of intoxicants or narcotics		
	COMAR 31.10.28.03C(1)(a)	a. Sustained or contracted in consequence of the insured being intoxicated or under the influence of any drug.		
	COMAR 31.10.28.03C(1)(b)	b. Due to the use of alcohol		
	COMAR 31.10.28.03C(1)(c)	c. Due to the use of drugs or narcotics		
	COMAR 31.10.28.03C(1)(d)	d. Due to alcoholism or drug addiction		
H10.	COMAR 31.10.28.04	Arbitration Provision - May Not Require Insured To Use Arbitration To Settle Disputes With Insurer		
H11.	COMAR 31.04.17.18, COMAR 31.10.28.03D	Preexisting Conditions		
H12.	§15-401	Preexisting Condition may not apply to newly born or newly adopted dependent child/grandchild or minor for guardianship		
H13.	COMAR 31.04.17.10B	Good Health Warranty not permitted		
H14.	§15-711(b)	Physical Therapist Time Limitations		
H15.	§15-104(c)	May not coordinate against guaranteed renewable individual intensive care or specified disease policies.		
H16.	§15-104(d)	May not provide benefits that are secondary to benefits under an automobile policy, including PIP		
H17.	§15-126	May not discourage or prohibit access to the 911 emergency system		
H18.	§27-913	Benefits for Treatment of a Specified Disease or Diagnosis May Not Be Subject to Different Copays, Coinsurance, Deductibles, Annual or Lifetime Maximums		
H19.	§15-1009	Denial of Reimbursement for Pre-authorized care prohibited except for limited reasons.		
H20.	§27-303; MIA Bulletin L&H 99-25	Denial of Medically Necessary Inpatient Ancillary Charges Prohibited		

	Citation	Description	"X" Means Applicable	Form/ Page
H21.	§27-504; 26 CFR §54.98021(b)(2)(iii)	Prohibited Discrimination on Domestic Violence Victims		
H22.	COMAR 31.04.17.11B	Self-Destruction		
H23.	§15-602	State Hospitals, etc., Charitable or Otherwise		
H24.	§15-505	House Confinement, Medical Treatment Permitted Elsewhere		
H25.	§15-502	No Reduction for Medical Assistance Program		
H26.	§15-503	May not deny, cancel, or refuse to renew coverage because insured has been exposed to diethylstilbestrol.		
H27.	§15-810(b)	Benefits for Infertility may not discriminate against same-sex married couples who might require such services		
H28.	COMAR 31.04.17.07	Advertising Prohibited		
H29.	§15-510	May not deny behavioral counseling services provided by participating provider solely on the basis that it is school based		
H30.	§15-704	Art Therapy May Not Be Excluded		
H31.	§27-221	May Not Reunderwrite An Individual For Health Coverage Under Individual Contract After Individual Contract Has Been Issued		
H32.	§27-915	Prohibits denying organ transplantation solely on basis if an insured's or enrollee's disability (if contract provides organ transplantation)		
H33.	COMAR 31.04.17.12	Military Service Exclusion		
H34.	§15-716, House Bill 1151,Chpt. 301, Acts of 2023 (amended effective 01/01/24); §15-701	May not exclude coverage for licensed pharmacists providing patient assessment regarding and in administering self-administered medications or maintenance injectable medications when acting within lawful scope of practice.		
	§15-716, House Bill 1151,Chpt. 301, Acts of 2023 (amended effective 01/01/24)	• May not condition on whether pharmacist is employed by a physician, pharmacy, or facility or acting under physician's order		

I. Required Standard Provisions

	Citation	Description	"X" Means Applicable	Form/ Page
I1.	§15-202	Required Standard Provisions		

	Citation	Description	"X" Means Applicable	Form/ Page
I2.	§15-207	Entire Contract		
I3.	§15-208	Time Limit on Certain Defenses		
I4.	§15-209	Grace Period		
I5.	§15-210	Reinstatement		
I6.	§15-211	Notice of Claim		
I7.	§15-212	Claim Form		
I8.	§15-213	Proofs of Loss		
	§12-102, §12-102(c)(2)	a. Extends proof of loss period to one year for claim • If not reasonably possible to submit claim within one year, time period extended to two years after date of service • Enrollee's legal incapacity shall suspend the time to submit a claim		
	§15-1011	b. Methods for Claim Submission		
	§15-1005(e)	• Provider must be permitted minimum of 180 days to file claim		
I9.	§15-214	Time of Payment of Claims		
I10.	§15-215	Payment of Claims		
I11.	§15-216	Physical Examination and Autopsy		
I12.	§15-217	Legal Actions		
I13.	§15-218	Change of Beneficiary		

J. Optional Standard Provisions

	Citation	Description	"X" Means Applicable	Form/ Page
J1.	§15-202	Optional Provisions		
J2.	§15-219	Change of Occupation		
J3.	§15-220, §15-204	Misstatement of Age		
J4.	§15-221	Other Insurance with Insurer		
J5.	§15-222, §15-223	Insurance with Other Insurers		
J6.	§15-225	Unpaid Premiums		
J7.	§15-226	Conformity with State Statutes		

K. Utilization Review

	Citation	Description	"X" Means Applicable	Form/ Page
K1.	§15-10A-02(k)	Grievance Procedure Not Included. Please Advise Where Grievance Information Is Provided		
	§15-1001; Title 15, Subtitle 10B; COMAR 31.10.18	• Company not certified as Private Review Agent (PRA) in Maryland		
	§15-1001; Title 15, Subtitle 10B; COMAR 31.10.18; §15-10A-02	• Identify Company's PRA for making utilization review determinations of what health care service is medically necessary, experimental or investigative, or cosmetic		
K2.	§15-142(e)	May not require prior authorization on certain cancer drugs		
K3.	§15-850	May not require prior authorization for a covered opioid antagonist unless at least one formulation of the opioid antagonist is covered without a prior authorization requirement		
K4.	§15-851	May not require prior authorization for a prescription drug containing methadone, buprenorphine, or naltrexone when the drug is used for treatment of an opioid use disorder		
K5.	§15-802(d)(4)	The processes, strategies, evidentiary standards, or other factors used to manage the mental health and substance use benefits must be comparable as written and in operation to, and applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used to manage the benefits for physical illnesses covered under the contract.		
K6.	§15-10B-05(a)(4)	Utilization review agent must be reasonably available 7 days a week, 24 hours a day		
K7.	§12-205(b)	May not require preauthorization for emergency care		
K8.	§15-826.1(c)(2)(i)	May not require prior authorization for an IUD or implantable rod if the IUD or implantable rod is approved by the FDA and obtained under a prescription written by an authorized prescriber		
K9.	§15-10B-06(a)	Initial authorization of course of treatment made:		
	§15-10B-06(a)(1)(i), Senate Bill 791, Chpt. 848, Acts of 2024 (effective 1/1/25)	a. For non-emergencies, within 2 working days of receipt of information necessary to make determination		

	Citation	Description	"X" Means Applicable	Form/ Page
	§15-10B-06(a)(1)(ii)	b. For extended stays or additional health care services, within 1 working day of receipt of necessary information		
	§15-10B-06(a)(1)(iii), Senate Bill 791, Chpt. 848, Acts of 2024 (effective 1/1/25)	c. For additional visits or days of care as part of existing treatment, within 1 working day of receipt of necessary information		
	§15-10B-06(a)(2), Senate Bill 791, Chpt. 848, Acts of 2024 (effective 1/1/25)	d. After receipt of initial request, if more information is necessary to make decision, inform provider no more than 3 calendar days following initial request of the need for more information		
	§15-10B-06(b), Senate Bill 791, Chpt. 848, Acts of 2024 (effective 1/1/25)	e. For emergency inpatient or residential crisis services admissions for the treatment of a mental, emotional, or substance abuse disorder, within 2 hours of receipt of the necessary information		
	§15-10B-06(c), Senate Bill 791, Chpt. 848, Acts of 2024 (effective 1/1/25)	f. For step therapy exception request submitted electronically, make determination in real time if no additional information is needed and request meets the PRA's criteria for approval		
K10.	§15-10A-02(f)(1), Senate Bill 791, Chpt. 848, Acts of 2024 (effective 1/1/25)	For non-emergency cases, notice of adverse decision must be provided within 5 working days after adverse decision is made to member, member's representative and a health care provider acting on behalf of the member		
	§15-10A-02(f)(1)(i), Senate Bill 791, Chpt. 848, Acts of 2024 (effective 1/1/25)	• A carrier may, but is not required, to use an alternative method of communication, with the consent of the member, member's representative, or provider.		
K11.	§15-10B-07(c)	May not retroactively deny approval of preauthorized services		
K12.	§ 15-10B-06(f)(1), Senate Bill 791, Chpt. 848, Acts of 2024 (effective 1/1/25)	If provider requests immediate reconsideration of denial, must give decision by telephone within 24 hours of request		
	§ 15-10B-06(f)(2), Senate Bill 791, Chpt. 848, Acts of 2024 (effective 1/1/25)	• Must provide additional contact information if physician is unable to immediately speak with provider		
K13.	§ 15-10B-06(g), Senate Bill 791, Chpt. 848, Acts of 2024 (effective 1/1/25)	May not deny authorization for inpatient emergency care on basis of late notification from the hospital, if patient's condition prevented the hospital from knowing insurance status or emergency notice process		

	Citation	Description	"X" Means Applicable	Form/ Page
K14.	§ 15-10B-06(h), Senate Bill 791, Chpt. 848, Acts of 2024 (effective 1/1/25)	Involuntary or voluntary psychiatric admission of patient in danger – may not deny care during the first 24 hours after voluntary inpatient admission or 72 hours after involuntary admission		
K15.	§15-140(c)(1) §15-140(c)(2)	When health plan is the receiving carrier, the health plan must, upon request, accept a preauthorization from the relinquishing carrier for the lesser of the course of treatment or 90 days; and for pregnancy the duration of the 3 trimesters of pregnancy and the initial postpartum visit.		

L. Applications

	Citation	Description	"X" Means Applicable	Form/ Page
L1.	88 FR 44596, revising 26 CFR 54.9801–2, 29 CFR 2590.701–2, and 45 CFR 144.103 effective 9/1/24	Short-Term Limited Duration Insurance Required Notice		
L2.	COMAR 31.04.17.06I(2)	Check-off boxes required for carrier name if application is to be used by more than one carrier.		
L3.	COMAR 31.04.17.06I(3)	Application must clearly identify coverages underwritten by each carrier, when more than one carrier uses the same application with the same applicant		
L4.	COMAR 31.04.17.06A	Application shall stipulate the plan and amount of insurance and any added optional benefits applied for.		
L5.	§27-805; MIA Bulletin 12-07	Insurance Fraud-required Disclosure Statement		
		Questions on Applications		
L6.	§12-205(b)(9)	Seven-Year Limit for Health Questions		
L7.	§27-909(c)	May Not Inquire About Genetic Tests or Genetic Information		
L8.	§27-504(b)	Domestic Violence		
L9.	COMAR 31.04.17.06E; §12-207	Health questions must be asked to the best of the applicant's knowledge and belief or application must include statement that all answers provided are representations and are not warranties		
L10.	COMAR 31.04.17.06C	Questions about "hazardous activities" must list activities considered to be "hazardous"		

	Citation	Description	"X" Means Applicable	Form/ Page
L11.	COMAR 31.04.17.06D	Questions about the use of “habit-forming drugs” must list specific drugs considered to be “habit-forming”		
L12.	COMAR 31.04.17.06F, COMAR 31.04.17.06G	Questions about symptoms or indications of physical/mental conditions must ask about “known symptoms” and “known indications”		
L13.	§12-202(c)	Application Changes		
L14.	COMAR 31.04.17.08	Proxy		
L15.	COMAR 31.04.17.10B	Good health warranty not permitted		
L16.	COMAR 31.04.17.06B	Certain States		
L17.	COMAR 31.10.28.03D	There is a statement that if the applicant answers the questions in a particular manner, coverage will not be provided to the affected person. To use this statement, provide written assurance that carrier uses a signed waiver/exclusion rider that must be attached to insurance contract to exclude person from coverage.		