INDIVIDUAL CANCER OR SPECIFIED DISEASE 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. Submit specific description of how each item can vary.		
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.	§15-201(d)	Size of Type		
A15.	COMAR 31.10.02	Simplified Language (Readability Certification)		
A16.	§15-201(h)	Ten-Day Right to Examine Policy		
A17.	§12-205(b)(5)	Form is Illegible		
A18.	§2-112(a)(10)	Filing Fee Insufficient		
A19.	COMAR 31.04.17.03F	Language other than English in Forms		

B. Mandated Benefits - (Refer to Title 15, Subtitle 8 of the Insurance Article for the applicable mandated benefits(s) that are not shown below for the coverage of the health insurance contract.)

	Citation	Description	"X" Means Applicable	Form/ Page
B1.	§15-803	Blood Products		
B2.		Health Care Cost Containment		
	§15-819(b)(1)	a. Outpatient Benefit		
	§15-819(b)(2)	b. Second Opinion		
B3.	§15-808	Home Health Care (expense incurred contracts)		
B4.	§15-809; COMAR 31.10.09	Hospice (Required Offering for expense incurred contracts)		
B5.	§15-814	Mammography (May not be subject to deductible) (expense incurred hospital, medical, or surgical benefits contracts)		

	Citation	Description	"X" Means Applicable	Form/ Page
	§15-814(b)	• Amended to "latest screening guidelines issued by American Cancer Society" for breast cancer screening		
	§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.		
B6.	§15-815	Reconstructive Breast Surgery (expense incurred medical or surgical benefits contracts)		
	§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		
B7.	§15-827	Coverage for Medical Clinical Trials (expense incurred hospital, medical, surgical or pharmaceutical benefits)		
B8.	§15-832	Coverage for Home Visits If Less than 48 hours of Inpatient Hospitalization is Provided for Surgical Removal of Testicle (expense incurred inpatient hospital, medical, or surgical benefits contracts)		
B9.	§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 (expense incurred inpatient hospital, medical, or surgical benefits contracts)		
	§15-832.1(a)	• Mastectomy Definition		
B10.	§15-834	Breast Prosthesis (expense incurred hospital, medical, or surgical benefits contracts)		
B11.	§15-836	Hair Prostheses for Hair Loss Resulting from Chemotherapy or Radiation Treatment for Cancer (expense incurred inpatient hospital, medical, surgical benefits contracts)		
B12.	§15-825	Prostate Cancer Screening (expense incurred inpatient hospital, medical, or surgical benefits contracts)		

	§15-825(c), Senate Bill 661, Chpt. 344, Acts of 2020 (effective 01/01/21)	• Deductible, Copayments or Coinsurance may not be applied		
B13.	§15-837; MIA Bulletin 08-33	Colorectal Cancer Screening (expense incurred hospital, medical, or surgical benefits contracts)		
B14.	§15-848	Ostomy Equipment and Supplies (expense incurred hospital, medical, or surgical benefits contracts)		
B15.	§15-139	Health Care Services Through Telehealth (expense incurred hospital, medical, or surgical benefits contracts)		
	§15-139(a), Senate Bill 534, Chpt, 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		
B16.	§15-853	Coverage for Lymphedema Diagnosis, Evaluation and Treatment (expense incurred hospital, medical, or surgical benefits contracts)		

	§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		
B17.	§15-859, House Bill 1217, Chpt. 323, Acts of 2023 (effective 01/01/24)	Biomarker Testing (contracts with expense incurred hospital, medical or surgical benefits)		
	§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”		
B18.	§15-860, House Bill 815, Chpt. 354, Acts of 2023 (effective 01/01/24)	Diagnostic Lung Cancer Screening (contracts with expense incurred hospital, medical or surgical benefits)		
	§15-860(b)(1), House Bill 1259, Chpt. 868, Acts of 2024 (effective 1/1/25)	a. 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)	b. Coverage for diagnostic ultrasound, magnetic resonance imaging, computed tomography, and image-guided biopsy		
	§15-860(c), House Bill 1259, Chpt. 868, Acts of 2024 (effective 1/1/25)	c. 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 of Coverage Requirements

	Citation	Description	"X" Means Applicable	Form/ Page
C1.	§15-402	Incapacitated Children		
C2.	§15-401, §15-403, §15-403.1	Newborn/Adopted Children/Grandchildren/Guardianship (expense incurred hospital, medical or surgical benefits contracts)		
C3.	§15-417	Part-Time Students with Disabilities (expense incurred hospital, medical or surgical benefits contracts)		
C4.	§15-403.2; COMAR 31.10.35	Domestic Partner Coverage, including Child Dependent of Domestic Partner		
C5.	§15-833	Extension of Benefits		

D. Practitioners

	Citation	Description	"X" Means Applicable	Form/ Page
D1.	§15-703, §15-708, §15-709	Certified Nurse Practitioner, Nurse Anesthetist, Nurse Midwife		
D2.	§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		
D3.	§15-715	Community Health Resource		
D4.	§15-704	Clinical Professional Counselors		

E. Required Standard Provisions - §15-202

	Citation	Description	"X" Means Applicable	Form/ Page
E1.	§15-207	Entire Contract		
E2.	§15-208	Time Limit on Certain Defenses		
E3.	§15-209	Grace Period		
E4.	§15-210	Reinstatement		
E5.	§15-211	Notice of Claim		
E6.	§15-212	Claim Forms		
E7.	§15-213	Proofs of Loss		

	Citation	Description	"X" Means Applicable	Form/ Page
	§12-102	a. Extends proof of loss period to one year for claim		
	§15-1011	b. Methods for Claim Submission		
	§15-1005(e)	• Provider must be permitted minimum of 180 days to file claim		
E8.	§15-214	Time of Payment of Claims		
E9.	§15-215	Payment of Claims		
E10.	§15-216	Physical Examination and Autopsy		
E11.	§15-217	Legal Actions		
E12.	§15-218	Change of Beneficiary		

F. Optional Provisions - §15-202

	Citation	Description	"X" Means Applicable	Form/ Page
F1.	§15-219	Change of Occupation		
F2.	§15-220, §15-204	Misstatement of Age		
F3.	§15-221	Other Insurance with Insurer		
F4.	§15-222, §15-223	Insurance with Other Insurers		
F5.	§15-225	Unpaid Premiums		
F6.	§15-226	Conformity with State Statutes		
F7.	§15-203	Optional Renewal by Insurer		

G. Other

	Citation	Description	"X" Means Applicable	Form/ Page
G1.	§15-602	State Hospitals, etc., Charitable or Otherwise		
G2.	§15-505	House Confinement, Medical Treatment Permitted Elsewhere		
G3.	§15-502	No Reduction for Medical Assistance Program		
G4.	§15-503	May not deny, cancel, or refuse to renew coverage because insured has been exposed to diethylstilbestrol		
G5.	§15-603	Reimbursement for Services paid for or provided by Department of Health		

	Citation	Description	"X" Means Applicable	Form/ Page
G6.	COMAR 31.10.01.03D	Policy may not be issued at an age which does not provide full coverage for a reasonable period of time		
G7.	§14-205(b)(2)	Preferred Provider 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		
	§15-830(b)	f. Procedure for Right to Standing Referral to Network Specialist		
	§15-830, §15-830(d)(2)(ii)(2)	g. Procedure for Right to Request Referral to Specialist, Including Non-Physician Specialist Not on Carrier's Provider Panel • Referral must be granted if the carrier cannot provide reasonable access to a specialist without unreasonable travel or delay		
	§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		
G8.	§14-205.2	Payment Rules for Assignment of Benefits for Physicians On Call and Hospital-Based Physicians		
G9.	§14-205.3	Payment Rules for Assignment of Benefits for Physicians Not On Call or Hospital-Based Physicians		

	Citation	Description	"X" Means Applicable	Form/ Page
G10.	Title 15, Subtitle 17	Physician Rating System		
G11.	§15-1005(g)	Payment of Interest on Unpaid Claims		
G12.	COMAR 31.15.08	Payment of Claims, Unfair Trade Practices		
G13.	Title 15, Subtitle 10D; COMAR 31.10.29	Complaint process for coverage decisions		
	§15-10D-01(f)(3)	• Coverage decision definition excludes Pharmacy Inquiries		
G14.	§15-112(q)	Identify office and process for filing complaints		
G15.	§12-209(1), §12-209(2), §12-209(3)	Contract Governed by Maryland Law and Maryland Courts		
G16.	§15-110(d)	Required Exclusion for Prohibited Practitioner Referral		
G17.	COMAR 31.10.01.03R	Notice of Premium Increase		
G18.	COMAR 31.10.28.05	Premium Due Date		
G19.		Prescription Drug Benefit (applicable only if contract provides prescription drugs)		
	§15-805	a. Coverage of Drugs from Local Pharmacies Same As Mail Order		
	§15-824	b. 90-Day Supply for Maintenance Drugs • Exception for first prescription or change in prescription		
	§15-804	c. Off-Label Use of Drugs		
	§15-804(a)(4)	• Include “Standard reference compendia” definition		
	§15-826 §15-826.1(e)	d. 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)	• 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)	• 12-month supply of prescription contraceptives		
	§15-826.1(c)(2)(ii)	• 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		
	§15-831	e. May use a formulary for brand-name drugs in compliance with §15-831		
	§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	• For a closed formulary, 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		
	§15-841	f. Coverage for Smoking Cessation Treatment		
	§15-842	g. Copayment or coinsurance for prescription or drug may not exceed the retail price of prescription drug or device		
	§15-845(b)(1), §15-845 (b)(2)(i)	h. Coverage for Certain Prescription Eye Drop Refills (if contract provides coverage for prescription eye drops)		
	§15-846	i. 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		

	§15-847	j. Specialty Drugs-Copayment/Coinsurance Limits		
	§15-847(a)	• Definition excludes drugs for the treatment of diabetes, HIV, or AIDS		
	§15-847.1	k. 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.		
	§15-142(c)	l. Step therapy or fail first protocol may not be imposed under certain circumstances		
	§15-142(e)	• Preauthorization cannot be imposed on certain cancer drugs		
	§15-850	• Preauthorization cannot be required for certain drug products used to treat opioid use disorder		
	§15-851	• Preauthorization cannot be required for drug used for treatment of opioid addiction		
	§15-854	m. 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		

	§15-849	n. Abuse-Deterrent Opioid Analgesic Drug Products – Tier Placement and Step Therapy • 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		
	§15-852	o. Prorated daily copayment/coinsurance for partial supply of prescription drug dispensed by in-network pharmacy		
	§15-858, House Bill 970, Chpt. 684, Acts of 2022 (effective 01/01/23)	p. 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		
G20.	COMAR 31.10.13	Return of Premium Benefits		
G21.	COMAR 31.10.01.03C	Standard of Time		
G22.	COMAR 31.10.01.03G	Right to Elect Alternative Benefits		
G23.	COMAR 31.10.01.03F	If contract indicates that one of several benefits will be payable for one accident or sickness, it must state the largest of the benefits will be payable		
G24.	§15-919	Medicare Supplement Disclaimer for Individuals Eligible For Medicare Due to Age		
G25.	COMAR 31.04.17.12	Military Service Exclusion		
G26.	§15-138	Reimbursement of Ambulance Service Providers		
G27.	§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, Limitations and Exclusions

	Citation	**Description**	**"X" Means Applicable**	**Form/ Page**
H1.	COMAR 31.04.17.13B	Natural Death Benefit		
H2.	COMAR 31.04.17.11B	Self-Destruction		
H3.	COMAR 31.10.01.03N	Damage to Conveyance		

H4.	COMAR 31.10.01.03-O	Chronic or Organic Disease		
H5.	COMAR 31.10.01.03-I	Frequency of Physician Visits		
H6.	COMAR 31.10.01.03P	Reimbursement Language		
H7.	COMAR 31.10.01.03Q	Strict Compliance Language		
H8.	COMAR 31.10.28.03A	May not limit or exclude loss due to insured's commission of or attempt to commit a crime		
H9.	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.		
H10.	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		
H11.	COMAR 31.04.17.18, COMAR 31.10.28.03D	Preexisting Conditions Limitation		
H12.	§15-401	Preexisting Condition exclusion 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.	§15-126	May Not Discourage or Prohibit Access to the 911 Emergency System		
H16.	§15-104(c)	May not coordinate against guaranteed renewable individual intensive care or specified disease policies.		
H17.	§15-104(d)	May not provide benefits that are secondary to benefits under an automobile policy, including PIP		
H18.	§15-1009	Denial of Reimbursement for Pre-Authorized Care Prohibited Except for Limited Reasons		
H19.	§27-913	Benefits for Treatment of a Specified Disease or Diagnosis May Not Be Subject to Different Copays, Coinsurance, Deductibles, Annual or Lifetime Maximums		

H20.	§27-303; MIA Bulletin L&H 99-25	Denial of Medically Necessary Inpatient Ancillary Charges Prohibited		
H21.	§27-504	Prohibited Discrimination on Domestic Violence Victims		
H22.	COMAR 31.10.28.04	Arbitration Provision – May Not Require Insured to Use Arbitration to Settle Disputes With Insurer		
H23.	§27-221	May Not Re-underwrite an Individual for Coverage Under Individual Contract After Individual Contract Has Been Issued		
H24.	COMAR 31.04.17.07	Advertising Prohibited		
H25.	§15-604	May not limit hospital payments to amounts other than those set by Health Services Cost Review Commission		
H26.	§27-915	Prohibits denying organ transplantation solely on basis of an insured's or enrollee's disability (if contract provides organ transplantation)		
H27.	§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 (also applies to prescription only coverage)		
	§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. Applications

	Citation	**Description**	**"X" Means Applicable**	**Form/ Page**
I1.		Questions on Applications		
	§12-205(b)(9)	a. Seven-Year Limit for Health Questions		
	§27-909(c)	b. May Not Inquire About Genetic Tests or Genetic Information		
	§27-504	c. Domestic Violence		
	COMAR 31.04.17.06E; §12-207	d. 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		
	COMAR 31.04.17.06C	e. Questions about "hazardous activities" must list activities considered to be "hazardous"		

	Citation	Description	"X" Means Applicable	Form/ Page
	COMAR 31.04.17.06D	f. Questions about the use of "habit-forming drugs" must list specific drugs considered to be "habit-forming"		
	COMAR 31.04.17.06F, COMAR 31.04.17.06G	g. Questions about symptoms or indications of physical/mental conditions must ask about "known symptoms" and "known indications"		
I2.	§12-202(c)	Application Changes		
I3.	COMAR 31.04.17.08	Proxy		
I4.	COMAR 31.04.17.10B	Good Health Warranty Not Permitted		
I5.	COMAR 31.04.17.06B	Certain States		
I6.	§12-205(b)(2)	The description of the preexisting conditions limitation is not the same as in the policy		
I7.	COMAR 31.04.17.06J	If application is to be completed by more than one individual, application signature box must clearly indicate that signature applies only to portion of application completed by that individual		
I8.	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 policy to exclude person from coverage		
I9.	COMAR 31.04.17.06H(1)	Check-off boxes required for carrier name if application is to be used by more than one carrier		
I10.	COMAR 31.04.17.06A	Application shall stipulate the plan and amount of Insurance and any added optional benefits applied for		
I11.	§27-805; MIA Bulletin 12-07	Insurance Fraud-Required Disclosure Statement		

J. Utilization Review

	Citation	Description	"X" Means Applicable	Form/ Page
J1.	§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		

	Citation	Description	"X" Means Applicable	Form/ Page
	§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		
J2.	§15-10B-05(a)(4)	Utilization review agent must be reasonably available 7 days a week, 24 hours a day		
J3.	§12-205(b)	May not require preauthorization for emergency care		
J4.	§ 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		
	§ 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(b), Senate Bill 791, Chpt. 848, Acts of 2024 (effective 1/1/25)	d. 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)	e. 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		
J5.	§15-10B-06(a)(2)	PRA must inform healthcare provider that additional information is needed to make determination within 3 calendar days after initial request		
J6.	§ 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.		

	Citation	Description	"X" Means Applicable	Form/ Page
J7.	§15-10B-07(c)	May not retroactively deny approval of preauthorized services		
J8.	§ 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		
J9.	§ 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		
J10.	§ 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		