HEALTH MAINTENANCE ORGANIZATIONS – LARGE GROUP COVERAGE

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. **Refer to COMAR, The Insurance Article or Health-General Article, as amended to date, for the exact wording.**

Brief Description & Law/Regulation Cite	**"X" Means Applicable**	**Form/Page**
A. Filing Submission Requirements		
A1. Listing of Forms with Brief Description – COMAR 31.12.02.03C(4)		
A2. Contracts with Insert Pages – COMAR 31.12.02.03H		
a. Form Number – COMAR 31.12.02.03H(1)(a)		
b. Description of How Pages will be Combined – COMAR 31.12.02.03H(1)(b)(i)		
c. Listing of Substitute Pages – COMAR 31.12.02.03H(1)(b)(ii)		
d. Form Number and Approval Date for Pages Replaced – COMAR 31.12.02.03H(3)(a)		
e. Copy of Currently Approved Contract – COMAR 31.12.02.03H(3)(b)		
A3. Contracts Comprised of Sections – COMAR 31.12.02.03I		
a. Form Number – COMAR 31.12.02.03I(1)(a)		
b. Description of How Sections will be Combined – COMAR 31.12.02.03I(1)(b)(i)		
c. Listing of Substitute Sections – COMAR 31.12.02.03I(1)(b)(ii)		
d. Form Number and Approval Date for Sections Replaced – COMAR 31.12.02.03I(3)(a)		

Brief Description & Law/Regulation Cite	"X" Means Applicable	Form/Page
e. Copy of Currently Approved Contract – COMAR 31.12.02.03I(3)(b)		
A4. Premium Rates – § 19-713, Health-General, COMAR 31.12.02.08A • Required to be Filed in Same SERFF Tracking # as Forms		
A5. Filing Fees Paid – COMAR 31.12.02.03C(2)		
A6. Transmittal Form – COMAR 31.12.02.03C(1) *Required for paper filings only*		
A7. Self-addressed Stamped Envelope – COMAR 31.12.02.03C(3) *Required for paper filings only*		
A8. Duplicate Forms – COMAR 31.12.02.03B *Required for paper filings only*		

B. General Requirements for Forms

B1. Size of Type – COMAR 31.12.02.06B		
B2. Unacceptable Modifications – COMAR 31.12.02.03E		
B3. Specimen Data – COMAR 31.12.02.03G		
B4. Form Number – COMAR 31.12.02.06A		
• For each Form Schedule Item submitted in SERFF, the number printed in lower lefthand corner of first page of form must match number entered in "Form Number" field		
B5. Corporate Name & Address – COMAR 31.12.02.06D		
B6. Signature of Officer – COMAR 31.12.02.06F		
B7. Signature of Applicant for Reduction Rider – COMAR 31.12.02.07D		
B8. Form contains items in brackets, denoting variability. Submit specific description of how each item can vary. If other text is desired, include specific text – COMAR 31.12.02.04B(1)(b)		

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C. Eligibility, Enrollment, and Termination of Coverage

C1.	Guaranteed Availability of Coverage – 42 USC § 300gg-1, 45 CFR §147.104(a), §15-1410, Insurance • HMO must offer to any large employer in the state all large group products that are approved for sale, and must accept any employer that applies for any of those products		
C2.	May not impose a waiting period that exceeds 90 days – 42 USC § 300gg-7, 45 CFR §147.116, §15-137.1, Insurance		
C3.	May Not Establish Eligibility Rules Based on Health Status – §15-1406(a), Insurance		
C4.	Deferred Effective Date Provisions Prohibited – 45 CFR §146.121(e)		
C5.	Domestic Partner Coverage, including Child Dependents of Domestic Partner – §15-403.2, Insurance, COMAR 31.10.35		
C6.	Newborns/Adopted Children/Grandchildren/Guardianship – §15-401, 15-403, 15-403.1, Insurance		
C7.	Child Dependent Coverage to Age 26 – 42 USC § 300gg-14, 45 CFR §147.120, MIA Bulletin 10-17, §15-137.1, Insurance • HMO may not deny coverage or terminate coverage if a child no longer lives, works, or resides in the HMO service area 80 FR 72205 and 72275		
C8.	Coverage of Grandchildren and Individuals Under Guardianship to Age 25 – §15-418 Insurance		
C9.	Part-Time Students with Disabilities – §15-417, Insurance		
C10.	Incapacitated Child Coverage – §15-402(b), Insurance		
C11.	Court Ordered Coverage of Children – §15-405, Insurance		
a.	Coverage Requirements for Enrollment of Child – §15-405(c)		
b.	Special Enrollment Period for Employee and Child Required – §15-405(h)		
c.	Special Enrollment Period for Child Required – §15-405(i)		
d.	Prohibited Denials of Coverage for Child Enrollment – §15-405(d)		

Brief Description & Law/Regulation Cite	"X" Means Applicable	Form/Page
C12. Special Enrollment Period Provisions		
a. For employee/dependent who loses other coverage – §15-1406(d), Insurance		
b. For individuals who become dependents of employee – §15-1406.1(c)(1), Insurance		
c. Permit employee to enroll himself when he or she acquires new dependents – §15-1406.1(c)(2), Insurance		
d. For spouse of employee at birth or adoption of child – §15-1406.1(c)(3), Insurance		
C13. Renewal Provision – COMAR 31.12.02.06J(6), §15-122, Insurance		
C14. Termination Provision – COMAR 31.12.02.10		
C15. Permissible Causes of Termination – COMAR 31.12.02.10B, §15-1408, Insurance		
C16. May only rescind contract for fraud or intentional misrepresentation and requires 30-day advance notice – 42 USC § 300gg-12, 45 CFR §147.128, MIA Bulletin 10-23, §15-137.1, Insurance		
C17. Extension of Benefits – §15-833, Insurance		
C18. Continuation of Coverage		
a. Divorced Spouses – COMAR 31.11.02, §15-408, Insurance		
b. Terminated Employees – COMAR 31.11.04, §15-409, Insurance		
c. Surviving Spouses – COMAR 31.11.03 §15-407, Insurance		

D. Mandated Benefits

D1. Unlimited Hospitalization – §19-701(g)(2), Health-General		
D2. Physician Services – §19-701(g)(2), Health-General		
D3. Laboratory – §19-701(g)(2), Health-General		
D4. X-ray – §19-701(g)(2), Health-General		

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D5. Emergency – §19-701(g)(2), Health-General, 42 USC § 300gg-19a, 45 CFR §147.138(b), MIA Bulletin 10-23, §15-137.1, Insurance • "Emergency services" definition • "Emergency medical condition" definition • No prior authorization • No limitations or exclusions for non-network providers • No administrative requirements on non-network emergency services that are not imposed in-network • Copayments/coinsurance for services received from non-network providers may not exceed in-network copayments/coinsurance		
D6. Emergency Surgery, Follow-up Care – §19-712.5(f), Health-General		
D7. Preventive – §§ 19-701(g)(2), 19-705.1(c)(4)(i), Health-General		
a. In-network preventive services as defined by ACA, including women's preventive services in accordance with HRSA guidelines, required to be covered without cost-sharing – 42 USC § 300gg-13, 45 CFR §147.130, MIA Bulletin 10-23, §15-137.1, Insurance		
b. Hearing screening of newborns by hospital		
c. Covered annual preventive visits/screenings must be provided once at any time during the contract year – §15-135, Insurance		
D8. Dental Preventive Care, if benefit is provided § 15-135.1, Insurance • Annual dental preventive care visit must be covered if provided at any time during the policy – may not require visit to occur after a specified time period (e.g. 12 months) following prior visit • If the contract provides benefits for dental preventive care more frequently than once per policy year, the contract may not require that the visits be separated by more than 120 days		
D9. Breast Cancer Screening in accordance with latest screening guidelines issued by American Cancer Society (may not be subject to a deductible) – §15-814, Insurance • Coverage for Digital Tomosynthesis that, under accepted standards in the practice of medicine, the treating physician determines is medically appropriate and necessary SB 61, Chpt. 677, Acts of 2017 (effective		

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1/1/2018)		
D10. Colorectal Cancer Screening – §15-837, Insurance		
D11. Prostate Cancer Screening – §15-825, Insurance		
D12. Annual Chlamydia Screening Test – §15-829, Insurance		
D13. Human Pappillomavirus Screening Test – §15-829, Insurance		
D14. Male Sterilization coverage - § 15-826.2, Insurance, House Bill 1005, Chpt. 437, Acts of 2016, effective 1/1/18 • Deductible, Copayments or coinsurance may not be applied - § 15-826.2(b)(2), Insurance		
D15. Osteoporosis Prevention & Treatment Education – §15-823, Insurance		
D16. Mental Health/Substance Abuse – §15-802, Insurance		
a. Required benefits for inpatient care, partial hospitalization, and outpatient care (including all office visits and psychological and neuropsychological testing for diagnostic purposes) – §15-802(c), Insurance		
b. Required benefits for residential crisis services – §15-840, Insurance		
c. Methadone Maintenance Copayments – §15-802(d)(5), Insurance		
d. May not apply any financial requirement or quantitative treatment limitation in any benefit classification that is more restrictive than the predominant financial requirement/treatment limitation of that type that applies to substantially all medical/surgical benefits in the same classification – §15-802(d)(2)(ii), Insurance, 45 CFR §146.136(c)(2)(i)		
e. 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 – §15-802(d)(2)(ii), Insurance, 45 CFR §146.136(c)(2)(ii)		
f. Exceptions to six benefit classifications provided only for multi-tiered prescription drug benefits, multiple network tiers,		

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and outpatient sub-classification of office visits, separate from other outpatient items and services – §15-802(d)(2)(ii), Insurance, 45 CFR §146.136(c)(3)(iii)		
g. 60 day limit for partial hospitalization described in §15-802(d)(2)(iv), Insurance, only permitted upon demonstration of compliance with 45 CFR §146.136(c)(2)(i)		
h. Prohibition on nonquantitative treatment limitations (including UR requirements) that are more restrictive than requirements for physical illnesses – §15-802(d)(2)-(4), Insurance, 45 CFR §146.136(c)(4)		
D17. Inpatient Hospitalization for Mothers and Newborns – §15-812, Insurance		
a. Mandated Coverage – §15-812, Insurance		
b. Additional 4 days inpatient stay for newborn if mother requires inpatient care – §19-703(f), Health-General		
c. Coverage of home visits for newborns may not be subject to deductible, copays or coinsurance – §15-812(g), Insurance		
d. For High Deductible Health Plans, home visits may not be subject to copays or coinsurance, but may be subject to deductible – §15-812(g)(2), Insurance		
D18. In Vitro Fertilization – §15-810, Insurance • Expanded to include coverage for married same-sex couples – House Bill 838, Chpt. 483, Acts of 2015, (effective 7/1/15) • Amended to include exception to heterosexual couples § 15-810(d)(2), House Bill 11, Chpt. 326, Acts of 2016, (effective 7/1/16 for new and inforce policies)		
D19. Coverage for Home Visits for Surgical Removal of Testicle If Less than 48 hours of Inpatient Hospitalization is Provided or Surgery Done on Outpatient Basis – §15-832, Insurance		
D20. Coverage for Inpatient Hospitalization for a Minimum of 48 Hours Following Mastectomy and Coverage for Home Visits – §15-832.1, Insurance		
• Mastectomy Definition – §15-832.1(a)		
D21. Reconstructive Breast Surgery – §15-815, Insurance • Amended definition of mastectomy • Amended to include coverage for physical complications of all stages of mastectomy, including lymphedemas, in		

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manner determined by physician – Senate Bill 57, Chpt. 17, Acts of 2010, effective 4/13/10		
D22. Breast Prosthesis – §15-834, Insurance		
D23. Hair Prostheses for Hair Loss Resulting from Chemotherapy or Radiation Treatment for Cancer – §15-836, Insurance		
D24. Prosthetic Devices (including Components and Repairs) – §15-844, Insurance		
D25. Hearing Aids - Coverage for Children – §15-838, Insurance		
• The $1400 limit may not be applied – 45 CFR §147.126 (Benefits for hearing aids for children are considered essential health benefits in large group contracts because the Maryland-selected benchmark plan includes these benefits. See FAQ 10 from the February 17, 2012 CMS Plan Management FAQ *Frequently Asked Questions on the Essential Health Benefits Bulletin*)		
• Coverage for adults: if hearing aid coverage is provided with a dollar limit, must allow the choice of a higher price hearing aid with difference in cost paid by the covered person – §15-838(d), Insurance		
D26. Diabetes Equipment, Supplies, & Self-Management Training – §15-822, Insurance • Diabetes Test Strips- may not impose a deductible, copayment, or coinsurance, HB 730, Chpt. 277, Acts of 2017 (effective 1/1/2018) • For High Deductible Health Plans, diabetes test strips may not impose a copayment or coinsurance, but maybe subject to a deductible		
D27. Ostomy Equipment and Supplies – §15-848, Insurance, Senate Bill 241, Chapter 23, Acts of 2015, effective 10/1/15		
D28. Medical Foods – §19-705.5, Health-General		
D29. Amino Acid-Based Elemental Formula – §15-843, Insurance		
D30. Blood Products – §15-803, Insurance		
D31. General Anesthesia for Dental Care – §15-828, Insurance		
D32. Treatment of Morbid Obesity – §15-839, Insurance		

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• If utilization review criteria are included, criteria must comply with COMAR 31.10.33		
D33. Coverage for Medical Clinical Trials – §15-827, Insurance		
• May not apply Service Area Restrictions or Contracting Provider Requirements – MIA Bulletin L&H #05-4		
• Expanded definition of approved clinical trial - 42 USC § 300gg-8(d), §15-137.1, Insurance		
D34. Coverage for Cleft Lip or Cleft Palate or Both – §15-818, Insurance		
D35. Habilitative Services for Children – §15-835, Insurance, (amended definition, effective 10/1/16, Senate Bill 297, Chpt. 371, Acts of 2016) • Revised Habilitative Services definition • Required to provide health benefits until end of month in which child turns age 19		
• If utilization review criteria for treatment of autism and autism spectrum disorders are included, criteria must comply with COMAR 31.10.39.		
• Habilitative services benefit may not exclude applied behavior analysis for the treatment of autism and autism spectrum disorders – COMAR 31.10.39.03B and G		
D36. Telemedicine Services – §15-139, Insurance		
D37. Hospice Option – §19-703(c), Health-General, COMAR 31.10.09		

E. Prescription Drug Benefits

E1. Coverage for Contraceptive Drugs or Devices – §15-826, Insurance • 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), House Bill 1005, Chpt. 437, Acts of 2016 (effective 1/1/18) • 6month supply of prescription contraceptives § 15-826.1(d), House Bill 1005, Chpt. 437, Acts of 2016 (effective 1/1/18) o Exception if 6-month supply would extend beyond the		

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plan year (subject to maintenance drug requirements in § 15-824) o Exception for the first 2-month supply of a new prescription or change in prescription • 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)(2)(ii), House Bill 1005, Chpt. 437, Acts of 2016 (effective 1/1/18) o 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 §15-826.1(c)(3), House Bill 1005, Chpt. 437, Acts of 2016 (effective 1/1/18) • Copayment 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(e)(1)(ii), House Bill 1005, Chpt. 437, Acts of 2016 (effective 1/1/18)		
E2. Coverage for Smoking Cessation Treatment – §15-841, Insurance		
E3. Coverage for Certain Prescription Eye Drop Refills – §15-845, Insurance		
E4. 90 Day Supply for Maintenance Drugs – §15-824, Insurance		
E5. For Formulary Benefits – Right to Receive Non- Formulary Drugs – §15-831, Insurance • As amended by HB 1005, Chpt. 437, Acts of 2016 (effective 1/1/18)		
E6. Off Label Use of Drugs – §15-804, Insurance • Amended "Standard reference compendia" definition		
E7. Step Therapy or Fail-First Protocols Prohibited under Certain Circumstances – §15-142, Insurance (as amended by HB740/SB919, Chpt. 678/679, Acts of 2017 (effective 10/1/17)		
E8. Copayment may not exceed the retail price of drug – §15-842, Insurance		
E9. Coverage of Maintenance Drugs From Local Pharmacies Same as Mail Order – Bulletin – L/H 1/97		

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E10. 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 – §15-846, Insurance		
E11. Specialty Drugs – Copayment/Coinsurance Limits – §15-847, Insurance, effective 10/1/14 (applicability effective 1/1/16)		
E12. Abuse-Deterrent Opioid Analgesic Drug Products – Tier Placement and Step Therapy – §15-849, Insurance, Senate Bill 606, Chpt. 372, Acts of 2015, effective 1/1/16		

F. Provider Access and Reimbursement

F1. 24 Hour Access to Physician – §19-705.1(b)(1)(ii), Health-General		
F2. Out-of-Area Coverage – §19-701(g)(2), Health-General		
F3. Requirements for Physician Rating Systems – Title 15, Subtitle 17, Insurance		
a. Must provide documentation that physician rating system has been approved by ratings examiner – §15-1702(a), Insurance		
b. Must provide certification that HMO has established: • Appeals process for physicians – §15-1703(a)(1), Insurance • System to notify physicians of changes to ratings – §15-1703(a)(2), Insurance • Process to post required information on HMO's website – §15-1703(c), Insurance		
c. Must file annual report with Commissioner – §15-1704, Insurance		
F4. Right to choose any provider in the network as PCP and for children right to select allopathic or osteopathic pediatrician in the network, 42 USC § 300gg-19a, 45 CFR §147.138(a), MIA Bulletin 10-23, §15-137.1, Insurance		
F5. Direct Access to Obstetrical and Gynecological Care 45 CFR § 147.138(a)(3); § 15-137.1 • 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		

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	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		
F6.	Right to Standing Referral to Network Specialist – §15-830(b), Insurance		
F7.	Right to Request Referral to Specialist Not on HMO's Provider Panel – §15-830(d), Insurance • Amended to include nonphysician specialist • Referral must be granted if the HMO cannot provide reasonable access to a specialist without unreasonable travel or delay • Deleted the provision that the out-of-network provider agree to accept the same reimbursement as a network specialist		
F8.	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 – §15-140(d), Insurance		
F9.	Coinsurance Amounts for Contracting Providers Must Be Based on Negotiated Fees with HMO – §15-118, Insurance		
F10.	Reimbursement of Non-Contracting Providers for Covered Services – §19-710.1, Health-General		
	• Reimbursement of Ambulance Service Providers – §15-138, Insurance		
F11.	Reimbursement to Hospital Emergency Facilities and Providers – §19-712.5, Health-General		
F12.	Identify office and process for filing complaints – §15-112(q), Insurance		

G. Required Standard Provisions

G1.	Entire Contract; Changes – COMAR 31.12.07.04A		
G2.	Contestability of the Contract – COMAR 31.12.07.04B		
G3.	Notice of Claim – COMAR 31.12.07.04C		

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G4. Claims Forms – COMAR 31.12.07.04D		
G5. Proofs of Loss – COMAR 31.12.07.04E		
• Methods for Claim Submission – §15-1011, Insurance, Senate Bill 450, Chpt. 35, Acts of 2015, effective 10/1/15 (applicability effective 10/1/17)		
• Provider must be permitted minimum of 180 days to file claim – §15-1005(d), Insurance		
• Extends proof of loss period to one year for claim - § 12-102, Insurance Senate Bill 887, Chpt. 445, Acts of 2016 (effective 1/1/17) • If not reasonably possible to submit claim within one year, time period extended to two years after date of service § 12-102(c)(2), Insurance		
G6. Time Payment of Claims – COMAR 31.12.07.04F		
G7. Payment of Claims – COMAR 31.12.07.04G		
G8. Legal Action – COMAR 31.12.07.04H		
G9. Grace Period – COMAR 31.12.07.04I		
G10. Certificates – COMAR 31.12.07.04J		
G11. Addition of Employees/Members – COMAR 31.12.07.04K		
G12. Misstatement of Age – COMAR 31.12.07.04L		
G14. Premium Due Date – COMAR 31.12.07.04M		

H. Optional Provisions

H1.	Physical Examination – COMAR 31.12.07.07C		
H2.	Arbitration – COMAR 31.12.07.07D		

I. Prohibited Provisions, Limitations, and Exclusions

I1.	Premium – May Not Charge Extra Premium Based on Health Status – §15-1407, Insurance		
I2.	Excessive Copayments, Deductibles – COMAR 31.12.02.12A(1)		

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I3.	Annual dollar limits for essential health benefits are prohibited – 42 USC § 300gg-11, 45 CFR §147.126, MIA Bulletin 10-23, §15-137.1, Insurance		
I4.	Lifetime dollar limits for essential health benefits are prohibited – 42 USC § 300gg-11, 45 CFR §147.126, MIA Bulletin 10-23, §15-137.1, Insurance		
I5.	Benefits for Treatment of a Specified Disease or Diagnosis May Not be Subject to Different Copays, Coinsurance, Deductibles, Annual or Lifetime Maximums – §27-913, Insurance		
I6.	Benefits for infertility may not discriminate against married same-sex couples – §15-810(b), Insurance, House Bill 838, Chpt. 483, Acts of 2015, effective 7/1/15		
I7.	Denial of Reimbursement for Pre-authorized Care Prohibited Except for Limited Reasons – §15-1009, Insurance		
I8.	May not coordinate against guaranteed renewable intensive care or specified disease policies – §19-713.1(b), Health-General		
I9.	May not recover any payment made to Subscriber under PIP – §19-713.1(e), Health-General		
I10.	May not provide benefits that are secondary to benefits payable under an automobile policy, including PIP – COMAR 31.12.02.06H(2)(a), §19-713.1(e), Health-General		
I11.	May not include an exclusion for losses covered by an automobile policy, including PIP – COMAR 31.12.02.06H(2)(b), §19-713.1(e), Health-General		
I12.	May not recover medical expenses under subrogation unless the Subscriber recovers for medical expenses in a cause of action – §19-713.1(f), Health-General		
I13.	Physical Therapist Time Limitations – §19-705.4, Health-General		
I14.	May not include a limitation or exclusion for a pre-existing condition – COMAR 31.12.07.06D, 42 USC § 300gg-3, 45 CFR §147.108(b), MIA Bulletin 10-23, §15-137.1, Insurance		
I15.	Prohibited Suicide or Self-Inflicted Injury Exclusion – 45 CFR §146.121(b)(2)(iii)		

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I16. Denial of Medically Necessary Inpatient Ancillary Charges Prohibited – §27-303, MIA Bulletin L&H 99-25		
I17. May not limit or exclude loss due to member's commission of or attempt to commit a crime – COMAR 31.12.07.06A(1)		
I19. May not limit or exclude loss due to commission of or the attempt to commit a crime by an individual other than the member – COMAR 31.12.07.06A(2)		
I20. May not limit or exclude loss due to member being engaged in an illegal occupation – COMAR 31.12.07.06B		
I21. May not limit or exclude loss: • Sustained or contracted in consequence of the member being intoxicated or under the influence of any drug – COMAR 31.12.07.06C(1) • Due to the use of alcohol – COMAR 31.12.07.06C(2)(a) • Due to the use of drugs or narcotics – COMAR 31.12.07.06C(2)(b) • Due to alcoholism or drug addiction – COMAR 31.12.07.06C(2)(c)		
I22. May Not Discourage or Prohibit Access to the 911 Emergency System – §15-126, Insurance		
I23. Advertising Prohibited in Forms – COMAR 31.12.02.06G		
I24. May not deny behavioral counseling services provided by participating provider solely on the basis that it is school based - § 15-510, Insurance HB 786, Chpt. 583, Acts of 2017 (effective 7/1/17)		

J. Other

J1. 45-Day Premium Increase Notice – COMAR 31.12.02.06I; At Renewal – §15-122, Insurance		
J2. Requirements for Wellness Programs – 45 CFR §146.121(f), §§ 15-137.1, 15-509, Insurance		
a. Participatory Wellness Programs: • Program must be available to all similarly situated individuals - §15-509(c)(2), Insurance		
b. Health-Contingent Wellness Programs: 1. Full reward must be available to all similarly situated individuals - §15-509(d)(4) and (g)(1)(ii), Insurance		

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2. Must provide chance to qualify for reward at least once per year – §15-509(d)(1) and (g)(1)(i), Insurance		
3. Combined reward for all health-contingent wellness programs may not exceed 30% of premium, increased additional 20 percentage points (to 50%) for tobacco cessation – §15-509(d)(2) and (g)(1)(i), Insurance		
4. Must allow reasonable alternative standard (or waiver of standard) for obtaining reward		
i) Activity-only Wellness Program: • Alternative standard required if unreasonably difficult to satisfy (or inadvisable to attempt to satisfy) standard due to medical condition – 45 CFR §146.121(f)(3)(iv)(A) • Carrier may require individual's physician to verify that alternative standard is needed due to medical condition – 45 CFR §146.121(f)(3)(iv)(E) • Alternative standard must accommodate recommendations of individual's physician – 45 CFR §146.121(f)(3)(iv)(C)(4)		
ii) Outcome-based Wellness Program: • Alternative standard required if initial standard is not met for any reason – 45 CFR §146.121(f)(4)(iv)(A) • Carrier may *NOT* require individual's physician to verify that alternative standard is needed due to medical condition – 45 CFR §146.121(f)(4)(iv)(E) • Alternative standard must accommodate recommendations of individual's physician – 45 CFR §146.121(f)(4)(iv)(C)(4)		
5. Certificate must disclose availability of reasonable alternative standard (including contact information for obtaining reasonable alternative standard) and that recommendations of individual's personal physician will be accommodated – 45 CFR §146.121(f)(3)(v) and (f)(4)(v)		
J3. Annual limitation on cost-sharing (including copays, coinsurance, and deductibles) for essential health benefits – 42 USC § 300gg-6, 45 CFR §156.130(a), §15-137.1, Insurance		

Brief Description & Law/Regulation Cite	"X" Means Applicable	Form/Page
a. For each plan year, cost sharing may not exceed the dollar limit for calendar year 2014, increased by the premium adjustment percentage (if any) applicable to the current plan year • For Plan Year 2017 – may not exceed $7,150 for self-only coverage and $14,300 for other than self-only coverage. • For Plan Year 2018 – may not exceed $7,350 for self-only coverage and $14,700 for other than self-only coverage.		
b. Out-of-network cost sharing is not required to count toward the limit – 45 CFR§ 156.130(c)		
c. The annual limitation on cost sharing for self-only coverage applies to all individuals regardless of whether the individual is covered by a self-only plan or is covered by a plan that is other than self-only – 80 FR 10825		
J4. Time References – COMAR 31.12.02.06E		
J5. HMO may include subrogation provision in contract if rating methodology includes an adjustment that reflects the subrogation – §19-713(b)(2), Health-General		
J6. HMO may only subrogate to the extent that any actual payments made by the HMO result from the occurrence that gave rise to the cause of action – §19-713.1(d)(1), Health-General		
J7. Required Provision for Inability to Provide Services - Circumstances Beyond the Plan's Control – COMAR 31.12.02.06P		
J8. Required Exclusion for Prohibited Practitioner Referral – §19-712.4(c), Health-General		

K. Utilization Review

K1. May not require preauthorization for emergency care – §19-712.5(d), Health-General		
• No administrative requirements on non-network emergency services that are not imposed in-network – 42 USC § 300gg-19a, 45 CFR §147.138(b), MIA Bulletin 10-23, §15-137.1, Insurance		

Brief Description & Law/Regulation Cite	"X" Means Applicable	Form/Page
K2. 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 § 15-826.1(c)(2)(i), House Bill 1005, chpt. 437, Acts of 2016, effective 1/1/18		
K3. Initial authorization of course of treatment made: a. For non-emergencies, within 2 working days of receipt of information necessary to make determination – §§ 19-706(f), Health-General, 15-10B-06(a)(1)(i), Insurance		
b. For extended stays or additional health care services within 1 working day of receipt of necessary information – §§ 19-706(f), Health-General, 15-10B-06(a)(1)(ii), Insurance		
c. 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 – §§ 19-706(f), Health-General, 15-10B-06(a)(3), Insurance		
K4. PRA must inform health care provider that additional information is needed to make determination within 3 calendar days after initial request – §§ 19-706(f), Health-General, 15-10B-06(a)(2), Insurance		
K5. Notice of adverse decision must be provided within 5 days after adverse decision is made – §15-10A-02(f), Insurance		
K6. May not retroactively deny approval of preauthorized services – §§ 19-706(f), Health-General, 15-10B-07(c), Insurance		
K7. If provider requests immediate reconsideration of denial, must give decision by telephone within 24 hours of request – §§ 19-706(f), Health-General, 15-10B-06(b), Insurance		
K8. 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 – §§ 19-706(f), Health-General, 15-10B-06(c), Insurance		
K9. Involuntary or voluntary psychiatric admission of patient in danger - may not issue adverse decision as to admission during first 24 hours after voluntary inpatient admission or 72 hours after involuntary admission – §§ 19-706(f), Health-General, 15-10B-06(d), Insurance		

Brief Description & Law/Regulation Cite	"X" Means Applicable	Form/Page
K10. When member transitions from another carrier or managed care organization, receiving carrier 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 – §15-140(c), Insurance		

L. Internal Appeal and Grievance Process

L1. HMO contract must include formal procedure to be followed in filing complaints or grievances – COMAR 31.12.02.06J(12)		
L2. Internal Grievance Process for Adverse Decisions – Title 15, Subtitle 10A, Insurance		
a. Information required to be included in certificate – §15-10A-02(k), Insurance 1. Name, address, telephone # of medical director or associate medical director who made decision – §15-10A-02(f)(2)(iii)1, Insurance		
2. Details of internal grievance process – §15-10A-02(f)(2)(iv), Insurance		
3. Member, member's representative, or provider has right to file a complaint with Commissioner within 4 months after receipt of HMO's decision – §15-10A-02(f)(2)(v)1, Insurance		
4. Complaint may be filed without first filing grievance with HMO if compelling reason to do so is demonstrated – §15-10A-02(f)(2)(v)2, Insurance		
5. Address, telephone #, facsimile # of Commissioner – §15-10A-02(f)(2)(v)3, Insurance		
6. Health Advocacy Unit available to assist member with mediating and filing grievance – §15-10A-02(f)(2)(v)4, Insurance		
7. Health Advocacy Unit's address, telephone #, facsimile #, and e-mail address – §15-10A-02(f)(2)(v)5, Insurance		
8. Statement that, when filing complaint with Commissioner, the member or member's representative will be required to authorize release of any medical records of member needed to reach decision on complaint – §15-10A-02(k)(2), Insurance		

Brief Description & Law/Regulation Cite	"X" Means Applicable	Form/Page
b. Details of internal grievance process 1. Insufficient Information - The HMO is required to notify the member, member's representative, or a health care provider filing a grievance on behalf of a member within 5 working days of the filing date if more information is required – §15-10A-02(g), Insurance		
2. For retrospective denials, must permit the member, the member's representative, or health care provider a minimum of 180 days to file a grievance – §15-10A-02(b)(2)(v), Insurance		
3. Nonemergency case grievance review (prospective denial)		
i) Carrier must render a written final decision within 30 working days after the filing date. The carrier may have an extension not to exceed 30 days with the member's written approval – §15-10A-02(b)(2)(ii), Insurance		
ii) Written notice is required within 5 working days after decision is rendered – §15-10A-02(i)(1)(ii), Insurance		
4. Nonemergency case grievance review (retrospective denial)		
i) Carrier must render a written final decision within 45 working days after the filing date. The carrier may have an extension not to exceed 30 working days with the member's written approval – §15-10A-02(b)(2)(iv), Insurance		
ii) Written notice is required within 5 working days after decision is rendered – §15-10A-02(i)(1)(ii), Insurance		
5. Emergency case grievance		
i) The carrier must render a decision within 24 hours after the receipt of a grievance – §15-10A-02(b)(2)(i), Insurance		
ii) Written notice of the decision must be sent within one day after the oral decision has been communicated – §15-10A-02(j), Insurance		
6. Complaints may be filed with the Commissioner:		

Brief Description & Law/Regulation Cite	"X" Means Applicable	Form/Page
i) Within 4 months after receipt of the HMO's grievance decision – §15-10A-03(a), Insurance		
ii) For prospective denials, if grievance decision from carrier is not received on or before the 30th working day after the filing date – §15-10A-02(d)(2), Insurance		
iii) For retrospective denials, if grievance decision from carrier is not received on or before the 45th working day after the filing date – §15-10A-02(d)(2), Insurance		
iv) Without exhausting the internal grievance process if HMO waives the requirement, if HMO fails to comply with any requirements of internal grievance process, or for compelling reason – §15-10A-02(d)(1), Insurance		
c. Definitions 1. Adverse Decision – §15-10A-01(b), Insurance		
2. Emergency Case – COMAR 31.10.18.05A		
3. Filing Date – COMAR 31.10.18.02B(5)		
4. Grievance – §15-10A-01(f), Insurance		
5. Grievance Decision – §15-10A-01(g), Insurance		
6. Health Care Provider – §15-10A-01(j), Insurance		
7. Member's representative – §15-10A-01(m), Insurance		
L3. Complaint Process for Coverage Decisions – Title 15, Subtitle 10D, Insurance		
a. HMO must render final appeal decision in writing within 60 working days – §15-10D-02(b), Insurance		
b. HMO's internal appeal process must be exhausted prior to filing a complaint with Commissioner except for urgent medical conditions for which care has not been rendered – §15-10D-02(c) and (d), Insurance		
c. Member, member's representative, or provider may file a complaint with Commissioner within 4 months after receipt of HMO's appeal decision – §15-10D-02(f)(2)(ii)1, Insurance		
d. Definitions 1. Appeal – §15-10D-01(b), Insurance		

Brief Description & Law/Regulation Cite	"X" Means Applicable	Form/Page
2. Appeal Decision – §15-10D-01(c), Insurance		
3. Coverage Decision – §15-10D-01(f), Insurance		
4. Urgent Medical Condition – COMAR 31.10.29.02B(12)		
5. Notice of Coverage Decision – §15-10D-02(e), Insurance		
6. Notice of Appeal Decision – §15-10D-02(f), Insurance		

M. Applications

M1.	Check-off boxes required for carrier name if application is to be used by more than one carrier – COMAR 31.12.02.07K(2)		
M2.	Application must clearly identify coverages underwritten by each carrier, when more than one carrier uses the same application with the same group applicant – COMAR 31.12.02.07K(3)		
M3.	Application shall stipulate the plan and amount of insurance and any added optional benefits applied for – COMAR 31.12.02.07A		
M4.	Waiting period may not exceed 90 days – 42 USC § 300gg-7, 45 CFR §147.116, §15-137.1, Insurance		
M5.	May not reject entire group due to underwriting – 42 USC § 300gg-1, 45 CFR §147.104(a), §15-1410, Insurance		
M6.	May not deny coverage to individual due to underwriting – §15-1406, Insurance		
M7.	May Not Inquire About Genetic Tests or Genetic Information – §27-909, Insurance		
M8.	7-year look back limitation for health questions – COMAR 31.12.02.07B(1)(a)		
M9.	Health questions (if included) 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 31.12.02.07C		
M10.	Questions about "hazardous activities" must list activities considered to be "hazardous" – COMAR 31.12.02.07F		

Brief Description & Law/Regulation Cite		"X" Means Applicable	Form/Page
M11.	Questions about the use of "habit-forming drugs" must list specific drugs considered to be "habit-forming" – COMAR 31.12.02.07G		
M12.	Questions about symptoms or indications of physical/mental conditions must ask about "known symptoms" and "known indications" – COMAR 31.12.02.07H and I		
M13.	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 – COMAR 31.12.02.07L		
M14.	Required Notice – §19-705.1(d)(4)(ii), Health-General		
M15.	Insurance Fraud-Required Disclosure Statement – §§ 19-706(e), Health-General, 27-805, Insurance (amended effective 1/1/13, House Bill 301, Chpt. 120, Acts of 2012), MIA Bulletin 12-07		