HEALTH MAINTENANCE ORGANIZATION – 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.** Unless otherwise specified, all section references are to the Insurance Article of the Annotated Code of Maryland.

A. Filing Submission Requirements

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

	Citation	Description	"X" Means Applicable	Form/ Page
A4.	§ 19-713, Health-General COMAR 31.12.02.08A	Premium Rates • Required to be Filed in Same SERFF Tracking # as Forms		
A5.	COMAR 31.12.02.03C(2)	Filing Fees Paid		

B. General Requirements for Forms

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

C. Eligibility, Enrollment, and Termination of Coverage

	Citation	Description	"X" Means Applicable	Form/ Page
C1.	42 USC § 300gg-1 45 CFR §147.104(a) §15-1410	Guaranteed availability of coverage		
		• 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.	42 USC § 300gg-7 45 CFR §147.116 §15-1A-12	May not impose a waiting period that exceeds 90 days		
C3.	§15-1406(a)	May not establish eligibility rules based on health status		

	Citation	Description	"X" Means Applicable	Form/ Page
C4.	45 CFR §146.121(e)	Deferred effective date provisions prohibited		
C5.	§15-403.2 COMAR 31.10.35	Domestic Partner Coverage, including Child Dependents of Domestic Partner		
C6.	§§15-401 15-403 15-403.1	Newborns/Adopted Children/Grandchildren/Guardianship		
C7.	42 USC § 300gg-14 45 CFR §147.120 MIA Bulletin 10-17 §15-1A-08	Child Dependent Coverage to Age 26		
	80 FR 72205 and 72275	• HMO may not deny coverage or terminate coverage if a child no longer lives, works, or resides in the HMO service area		
C8.	§15-418	Coverage of Grandchildren and Individuals Under Guardianship to Age 25		
C9.	§15-417	Part-Time Students with Disabilities		
C10.	§15-402(b)	Incapacitated Children		
C11.	§15-405	Court Ordered Coverage of Children		
	§15-405(c)	a. Coverage Requirements for Enrollment of Child (must appear in contract)		
	§15-405(d)	b. Prohibited Denials of Coverage for Child Enrollment		
	§15-405(e)	c. Child has coverage through the noncustodial parent, the carrier shall pay someone other than the insured for services received by the child under the contract (must appear in contract)		
	§15-405(h)	d. Special Enrollment Period for Employee and Child Required		
	§15-405(i)	e. Special Enrollment Period for Child Required		
C12.		Special Enrollment Period Provisions		
	§15-1406(d)	a. For employee/dependent who loses other coverage		
	§15-1406.1(c)(1)	b. For individuals who become dependents of employee		

	Citation	Description	"X" Means Applicable	Form/ Page
	§15-1406.1(c)(2)	c. Permit employee to enroll himself or herself when he or she acquires new dependents		
	§15-1406.1(c)(3)	d. For spouse of employee at birth or adoption of child		
C13.	COMAR 31.12.02.06J(6) §15-122	Renewal Provision		
C14.	COMAR 31.12.02.10	Termination Provision		
C15.	COMAR 31.12.02.10B §15-1408	Permissible Causes of Termination		
C16.	42 USC § 300gg-12 45 CFR §147.128 MIA Bulletin 10-23 §15-1A-21	May only rescind contract for fraud or intentional misrepresentation and requires 30-day advance notice		
C17.	§15-833	Extension of Benefits		
C18.		Continuation of Coverage		
	§15-407 COMAR 31.11.03	a. Surviving Spouses		
	§15-408 COMAR 31.11.02	b. Divorced Spouses		
	§15-409 COMAR 31.11.04	c. Termination of Employment		

D. Mandated Benefits

	Citation	Description	"X" Means Applicable	Form/ Page
D1.	§19-701(g)(2), Health-General	Unlimited Hospitalization		
D2.	§19-701(g)(2), Health-General	Physician Services		
D3.	§19-701(g)(2), Health-General	Laboratory		
D4.	§19-701(g)(2), Health-General	X-ray		

	Citation	Description	"X" Means Applicable	Form/ Page
D5.	§19-701(g)(2), Health-General 42 USC § 300gg-19a 45 CFR §147.138(b) MIA Bulletin 10-23 §15-1A-14	Emergency Services		
	45 CFR §149.30 45 CFR §149.110(c)(1) MIA Bulletin 21-24 §15-1A-14(a)(2)	a. Emergency medical condition definition		
	45 CFR §149.30 45 CFR §149.110(c)(2) 45 CFR §149.410(b) MIA Bulletin 21-24 §15-1A-14(a)(3)	b. Emergency services definition		
	45 CFR §149.420(b)(1) MIA Bulletin 21-24	c. Ancillary service definition		
	45 CFR §149.30 MIA Bulletin 21-24	d. Independent freestanding emergency department definition		
	45 CFR §149.30 MIA Bulletin 21-24	e. Nonparticipating emergency facility definition		
	45 CFR §149.30 MIA Bulletin 21-24	f. Nonparticipating provider definition		
	45 CFR §149.30 MIA Bulletin 21-24	g. Participating emergency facility definition		
	45 CFR §149.30 MIA Bulletin 21-24	h. Participating provider definition		
	45 CFR §149.30 MIA Bulletin 21-24	i. Treating provider definition		
	45 CFR §149.110(c)(3) MIA Bulletin 21-24	j. To stabilize definition		
	45 CFR §149.30 MIA Bulletin 21-24	k. Visit		

	Citation	Description	"X" Means Applicable	Form/ Page
	45 CFR §149.110(b)	l. 1) No prior authorization. 2) No limitations or exclusions for non-network providers. 3) No administrative requirements on non-network emergency services that are not imposed in-network. 4) No limitations on what constitutes an emergency solely on the basis of diagnosis codes. 5) No limitations regarding other terms or conditions of coverage.		
	§19-712.5, Health-General Article	m. Reimbursement to Hospital Emergency Facilities and Providers		
D6.	§19-712.5(f), Health-General	Emergency surgery follow-up care		
D7.	§§ 19-701(g)(2) 19-705.1(c)(4)(i), Health-General	Preventive Services		
	§15-1A-10(a) and (e), House Bill 974, Chpt. 745, Acts of 2025 (effective 6/1/2025)	a. Preventive services in effect on December 31, 2024 and any future recommendations and guidelines that enhance the scope of preventive services to the benefit of the consumer: • Evidence–based items or services that have a rating of A or B in the recommendations of the United States Preventive Services Task Force • Immunizations for routine use in children, adolescents, and adults that have a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention • With respect to infants, children, and adolescents, evidence–informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration • With respect to women, such additional preventive care and screenings, not described in bullet 1 above, as provided for in comprehensive guidelines supported by the Health Resources and Services Administration		

	Citation	Description	"X" Means Applicable	Form/ Page
		• Required statement specifying that in accordance with § 15-1A-10 of the Insurance Article, the Maryland Insurance Commissioner shall determine which recommendations and guidelines are considered to be in effect and applicable, including whether and when any subsequent updates to the recommendations and guidelines will apply		
	§15-1A-10(c), House Bill 974, Chpt. 745, Acts of 2025 (effective 6/1/2025)	b. In-Network services required to be covered without cost-sharing. • For HDHP, may include the deductible for services, unless the Commissioner determines the coverage is identified in the "safe harbor" provision under 26 U.S.C. § 223(c)(2)(C).		
	§§ 19-701(g)(2) 19-705.1(c)(4)(i), Health-General	c. Hearing screening of newborns by hospital		
	§15-135	d. Covered annual preventive visits/screenings must be provided once at any time during the contract year		
D8.	§19-703(c), Health-General COMAR 31.10.09	Hospice Option		
D9.	§19-705.5, Health-General	Medical Foods		
D10.	§ 15-135.1	Dental Preventive Care, if benefit is provided		
		• 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		

	Citation	Description	"X" Means Applicable	Form/ Page
D11.	§15-139	Telehealth Services		
	§15-139(a), House Bill 869, Chpt. 482, Acts of 2025 (effective 6/1/2025)	a. Definition of "telehealth:" • Includes an 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 remove the time frame limitation for audio-only telephone conversations		
	§15-139(c)(1)	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)	c. Telehealth care services include counseling and treatment for substance use disorders and mental health conditions.		
	§15-139(e)	d. May not require that covered health care services delivered through telehealth be provided by a third-party vendor designated by the carrier		
D12.	§15-802	Mental Health/Substance Use Disorder		
	§15-802(c)	a. Required benefits for inpatient care, partial hospitalization, and outpatient care (including all office visits and psychological and neuropsychological testing for diagnostic purposes)		
	§15-840	b. Required benefits for residential crisis services		

	Citation	Description	"X" Means Applicable	Form/ Page
	§15-802(d)(2)(ii) 45 CFR §146.136(c)(2)(i)	c. 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) 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		
	§15-802(d)(2)(ii) 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		
	§15-802(d)(2)(iv) 45 CFR §146.136(c)(2)(i)	f. 60-day limit for partial hospitalization described in §15-802(d)(2)(iv), only permitted upon demonstration of compliance with 45 CFR §146.136(c)(2)(i)		
	§15-802(d)(2)-(4) 45 CFR §146.136(c)(4)	g. Prohibition on nonquantitative treatment limitations (including UR requirements) that are more restrictive than requirements for physical illnesses		
D13.	§15-803	Blood Products		
D14.	§15-810	In Vitro Fertilization		
	§15-810(b) and (d)(3)	• Includes 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)	• Time period and number of attempts to demonstrate a history of infertility		

	Citation	Description	"X" Means Applicable	Form/ Page
	§15-810(d)(4)	• Coverage for in vitro-fertilization benefit includes married and unmarried patients		
D15.	§15-810.1	Fertility Preservation Procedures for Iatrogenic Infertility		
	§15-810.1(a)	• Required definitions		
D16.	§15-812	Inpatient Hospitalization for Mothers and Newborns		
	§15-812	a. Mandated Coverage		
	§19-703(f), Health-General	b. Additional 4 days inpatient stay for newborn if mother requires inpatient care		
	§15-812(g)	c. Coverage of home visits for newborns may not be subject to deductible, copays or coinsurance		
	§15-812(g)(2)	d. For High Deductible Health Plans, home visits may not be subject to copays or coinsurance, but may be subject to deductible		
D17.	§15-814	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		
	§15-814.1(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. • For High Deductible Health Plans, may not be subject to copays or coinsurance, but may be subject to deductible		

	Citation	Description	"X" Means Applicable	Form/ Page
D18.	§15-815	Reconstructive Breast Surgery		
	§15-815(a)(2)	• Mastectomy Definition		
	§15-815(c)(2)	• Coverage for physical complications of all stages of mastectomy, including lymphedemas, in manner determined by physician		
D19.	§15-818	Coverage for Cleft Lip or Cleft Palate or Both		
D20.	§15-822	Diabetes Equipment, Supplies, & Self-Management Training		
	§15-822(b)	• Coverage for elevated or impaired blood glucose levels induced by pregnancy and elevated or impaired blood glucose levels induced by prediabetes, consistent with the American Diabetes Association's standards		
	§15-822(d)(3)	• Diabetes Test Strips- may not impose a deductible, copayment, or coinsurance		
	§15-822(d)(3)(ii)	• For High Deductible Health Plans, diabetes test strips may not impose a copayment or coinsurance, but may be subject to a deductible		
D21.	§15-823	Osteoporosis Prevention & Treatment Education		
D22.	§15-825	Prostate Cancer Screening		
	§15-825(c)	• Deductible, Copayments or Coinsurance may not be applied		
D23.	§15-826.2	Male Sterilization coverage		
	§15-826.2(b)(2)	• Deductible, Copayments or coinsurance may not be applied		
	§15-826.2(b)(3)	• High Deductible Health Plans may apply deductible, but may not apply copayments or coinsurance		
D24.	§15-826.3	Fertility Awareness-Based Methods		
	§15-826.3(d)	• May not be subject to deductible, copayment, or coinsurance in-network or out-of-network		

	Citation	Description	"X" Means Applicable	Form/ Page
D25.	§15-827	Coverage for Medical Clinical Trials		
	MIA Bulletin L&H #05-4	• May not apply Service Area Restrictions or Contracting Provider Requirements		
	42 USC § 300gg-8(d) §15-1A-02(a)(2)(xviii)	• Expanded definition of approved clinical trial		
D26.	§15-828	General Anesthesia for Dental Care		
D27.	§15-829	Annual Chlamydia Screening Test		
D28.	§15-829	Human Papillomavirus Screening Test		
D29.	§15-832	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		
D30.	§15-832.1	Coverage for Inpatient Hospitalization for a Minimum of 48 Hours Following Mastectomy and Coverage for Home Visits		
	§15-832.1(a)	• Mastectomy Definition		
D31.	§15-834	Breast Prosthesis		
D32.	§15-835	Habilitative Services for Children		
	§15-835(a)(2)	• Definition habilitative services		
	§15-835(c)	• Required to provide health benefits until end of month in which child turns age 19		
	COMAR 31.10.39	• If utilization review criteria for treatment of autism and autism spectrum disorders are included, criteria must comply		
	COMAR 31.10.39.03B and G	• Habilitative services benefit may not exclude applied behavior analysis for the treatment of autism and autism spectrum disorders		
D33.	§15-836	Hair Prostheses for Hair Loss Resulting from Chemotherapy or Radiation Treatment for Cancer		
D34.	§15-837	Colorectal Cancer Screening		

	Citation	Description	"X" Means Applicable	Form/ Page
D35.	§15-838	Hearing Aids - Coverage for Children		
	45 CFR §147.126	• The $1400 limit may not be applied (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)		
D36.	§15-838.1, Senate Bill 778, Chpt. 952, Acts of 2024 (effective 1/1/2025)	Hearing Aids- Coverage for Adults		
	§15-838.1(c), House Bill 1355, Chpt. 742, Acts of 2025 (effective 1/1/2026)	• Prescribed, fitted, and dispensed by a licensed audiologist or ordered, fitted and dispensed by a licensed hearing aid dispenser		
	§15-838.1(d)(1), Senate Bill 778, Chpt. 952, Acts of 2024 (effective 1/1/2025) 45 CFR §147.126	• May not apply $1400 limit, unless plan does not define hearing aids as EHB		
	§15-838.1(d)(2), Senate Bill 778, Chpt. 952, Acts of 2024 (effective 1/1/2025)	• 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		
D37.	§15-839	Treatment of Morbid Obesity		
	COMAR 31.10.33	• If utilization review criteria are included, criteria must comply		
D38.	§15-843	Amino Acid-Based Elemental Formula		
D39.	§15-844, Senate Bill 614, Chpt. 823, Acts of 2024 (effective 1/1/2025)	Prosthetic Devices (including Components and Repairs)		
	§15-844(a), Senate Bill 614, Chpt. 823, Acts of 2024 (effective 1/1/2025)	• Definition of “prostheses”		
	§15-844(c), Senate Bill 614, Chpt. 823, Acts of 2024 (effective 1/1/2025)	• Benefits must be provided once annually		

	Citation	Description	"X" Means Applicable	Form/ Page
	§15-844(d), Senate Bill 614, Chpt. 823, Acts of 2024 (effective 1/1/2025)	• Coverage for prosthetic and component replacements		
	§15-844(e), Senate Bill 614, Chpt. 823, Acts of 2024 (effective 1/1/2025)	• May not require copayment or coinsurance higher than other similar services		
	§15-844(g), Senate Bill 614, Chpt. 823, Acts of 2024 (effective 1/1/2025)	• Medical necessity to be determined by the treating provider		
	§15-844(g)(1), Senate Bill 614, Chpt. 823, Acts of 2024 (effective 1/1/2025)	• 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 1/1/2025)	• Benefits will be provided for prostheses health care provider determines are medically necessary when used for activities identified in statute		
D40.	§15-848	Ostomy Equipment and Supplies		
D41.	§15-853	Lymphedema		
	§15-853(a)	• Definition “gradient compression garment”		
D42.	§15-855	Pediatric Autoimmune Neuropsychiatric Disorders associated with streptococcal infections and pediatric acute onset neuropsychiatric syndrome		
	§15-855(b)	• Diagnosis, evaluation, and treatment, including the use of intravenous immunoglobulin therapy		
		• No longer permitted to exclude Rituximab		
D43.	§15-857	Abortion Care Services		
	§15-857(a)(2)(ii)	• Does not apply to high deductible health plans		

	Citation	Description	"X" Means Applicable	Form/ Page
	§15-857(b)(1)(i)	• May not apply copayment, coinsurance, or deductible, except for high deductible health plans		
	§15-857(b)(1)(ii)	• 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)	• Required use of term “abortion care”		
D44.	§15-859	Biomarker Testing		
	§15-859(c)	• 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)	• Definition “biomarker”		
	§15-859(a)(3)	• Definition “biomarker testing”		
D45.	§15-860	Diagnostic Lung Cancer Screening		
	§15-860(b)(1), House Bill 1259, Chpt. 868, Acts of 2024 (effective 1/1/2025)	• 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 1/1/2025)	• Coverage for diagnostic ultrasound, magnetic resonance imaging, computed tomography, and image-guided biopsy • May not require prior authorization		
	§15-860(c), House Bill 1259, Chpt. 868, Acts of 2024 (effective 1/1/2025)	• 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). • For High Deductible Health Plans, follow-up diagnostic imaging may be subject to deductible		

	Citation	Description	"X" Means Applicable	Form/ Page
D46.	§15-863, House Bill 666, Chpt. 684, Acts of 2025 (effective 1/1/2026)	Calcium score testing in accordance with the most recent guidelines issued by the American College of Cardiology		

E. Prescription Drug Benefits

	Citation	Description	"X" Means Applicable	Form/ Page
E1.	§15-118.1, Senate Bill 773, Chpt. 692, Acts of 2025 (effective 1/1/2026)	Cost-sharing for prescription drugs must include any discounts, financial assistance payments, product vouchers or other out-of-pocket expenses made by or on behalf of the covered person for prescription drugs that either: • Does not have an AB-rated generic equivalent drug or an interchangeable biological product preferred under the plan's formulary; or • Has an AB-rated generic equivalent drug or an interchangeable biological product preferred under the plan's formulary, and for which the enrollee originally obtained coverage through prior authorization, a step therapy protocol, or an exception or appeal process.		
E2.	§15-142(c)	Step Therapy or Fail-First Protocols Prohibited under Certain Circumstances		
	§15-142(e), House Bills 970 and 1087, Chpts. 688 and 706, Acts of 2025, (effective 1/1/2026)	• Cannot be imposed on certain cancer drugs • Cannot be imposed on insulin or insulin analog used to treat diabetes		
E3.	§15-804	Off Label Use of Drugs		
	§15-804(a)(4)	• Definition Standard reference compendia		
E4.	§15-824	90 Day Supply for Maintenance Drugs		
E5.	Bulletin – L/H 1/97	Coverage of Maintenance Drugs from Local Pharmacies Same as Mail Order		

	Citation	Description	"X" Means Applicable	Form/ Page
E6.	§15-826	Coverage for Contraceptive Drugs or Devices		
	§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		
	§15-826.1(d)	• 12-month supply of prescription contraceptives ○ Exceptions to the 12-month supply are not permitted		
	§15-826.1(e)	• 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)	• 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		
E7.	§15-831	For Formulary Benefits – Right to Receive Non-Formulary Drugs		
E8.	§15-841	Coverage for Smoking Cessation Treatment		
E9.	§15-842	Copayment may not exceed the retail price of drug		
E10.	§15-845	Coverage for Certain Prescription Eye Drop Refills		

	Citation	Description	"X" Means Applicable	Form/ Page
E11.	§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		
E12.	§15-847	Specialty Drugs – Copayment/Coinsurance Limits		
	§15-847(a)	• Definition excludes drugs for the treatment of diabetes, HIV, or AIDS		
E13.	§15-847.1	Drugs for the treatment of diabetes, HIV, or AIDS -- Copayment/Coinsurance limits		
	§15-822.1,	• Except copayment or coinsurance for insulin cannot be more than $30 for a 30-day supply, regardless of amount or type of insulin needed.		
E14.	§15-847.2, House Bill 1243, Chpt. 726, Acts of 2025 (effective 1/1/2026)	Oncology drugs under certain circumstances may not be limited to certain specialty pharmacies		
E15.	§15-849	Abuse-Deterrent Opioid Analgesic Drug Products – Tier Placement and Step Therapy		
E16.	§15-852	Prorated daily copayment or coinsurance amount for partial supply of prescription drug		
E17.	§15-854	Limits on Prior Authorization Requirements for certain prescription drugs		
	§15-854(f), Senate Bill 791, Chpt. 848, Acts of 2024 (effective 1/1/2025)	• 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 1/1/2025)	• Circumstances under which a carrier may not issue adverse decision on reauthorization		
E18.	§15-854.1, Senate Bill 791, Chpt. 848, Acts of 2024 (effective 1/1/2025)	Prior Authorization for a Course of Treatment		

	Citation	Description	"X" Means Applicable	Form/ Page
E19.	§15-858	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		

F. Provider Access and Reimbursement

	Citation	Description	"X" Means Applicable	Form/ Page
F1.	§19-705.1(b)(1)(ii), Health-General	24 Hour Access to Physician		
F2.	§19-701(g)(2), Health-General	Out-of-Area Coverage (Urgent Care)		
F3.	Title 15, Subtitle 17	Requirements for Physician Rating Systems		
	§15-1702(a)	a. Must provide documentation that physician rating system has been approved by ratings examiner		
	§15-1703(a)(1) §15-1703(a)(2) §15-1703(c)	b. Must provide certification that HMO has established: • Appeals process for physicians • System to notify physicians of changes to ratings • Process to post required information on HMO's website		
	§15-1704	c. Must file annual report with Commissioner		
F4.	42 USC § 300gg-19a 45 CFR §147.138(a) MIA Bulletin 10-23 §15-1A-13	Right to choose any provider in the network as PCP and for children right to select allopathic or osteopathic pediatrician in the network		
F5.	45 CFR § 147.138(a)(3) §15-1A-13	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		

	Citation	Description	"X" Means Applicable	Form/ Page
		• 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		
F6.	§15-830(b)	Right to Standing Referral to Network Specialist		
F7.	§15-830(d), House Bill 11, Chpt. 660, Acts of 2025 (effective 1/1/2026)	Right to Request Referral to Specialist and Non-Physician Specialist Not on HMO's Provider Panel		
	§15-830(d)(2), House Bill 11, Chpt. 660, Acts of 2025 (effective 1/1/2026)	• Referral must be granted if the HMO cannot provide reasonable access to a specialist without unreasonable travel or delay		
	§15-830(a)(4)	• Definition of "non-physician specialist" (if included in contract) revised to reference health care providers that are licensed as a behavioral health program		
	§15-830(e)	May not balance bill members for services received from out-of-network specialists and non-physician specialists as result of referral described in (d)		
F8.	§15-140(d)	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		
F9.	§15-118	Coinsurance Amounts for Contracting Providers Must Be Based on Negotiated Fees with HMO		

	Citation	Description	"X" Means Applicable	Form/ Page
F10.	§15-112(q)	Identify office and process for filing complaints		
F11.	§19-712.5, Health-General	Reimbursement to Hospital Emergency Facilities and Providers		
F12.	§19-710.1, Health-General	Reimbursement of non-contracting providers for covered services		
	45 CFR §149.410	Reimbursement for Emergency Services • The enrollee will not be liable for an amount that exceeds the enrollee's cost-sharing requirement for emergency services provided by a non-network provider.		
	§15-138 45 CFR §149.130	Reimbursement of Ambulance Service Providers • The enrollee will not be liable for any amount that exceeds the enrollee's cost-sharing requirement for air ambulance services provided by a non-network provider.		
	45 CFR §149.120	Non-emergency services provided by a non-network provider with respect to a covered visit at an in-network facility • The enrollee will not be liable for an amount that exceeds the enrollee's cost-sharing requirement.		
F13.		Cost-sharing for emergency services		
	45 CFR §149.110(b)(3)(ii)	a. Copayments/coinsurance for emergency services received from non-network providers may not exceed in-network emergency services copayments/coinsurance		
	45 CFR §149.110(b)(3)(v)	b. Deductibles/out of pocket maximums for emergency services received from non- network providers will be counted toward any applicable in-network emergency services deductible/out of pocket maximum.		

	Citation	Description	"X" Means Applicable	Form/ Page
	45 CFR §149.110(b)(3)(iii)	c. Any cost sharing requirement for emergency services provided by non-network providers will be calculated based on the recognized amount.		
	45 CFR §149.30	d. Recognized amount definition		
F14.	45 CFR §149.130	If plan covers air ambulance services, cost-sharing provisions for air ambulance services are required.		
		a. Cost-sharing for air ambulance services provided by a non-network provider may not exceed the same as if services were provided by an in-network provider.		
		b. Any cost-sharing requirement will be calculated based on the lesser of the qualifying payment amount (as determined in accordance with §149.140) or the billed amount for the services		
		c. Any cost-sharing payments made with respect to the air ambulance service will be counted toward any applicable in-network deductible and in-network out-of-pocket maximum		
	45 CFR §149.30 MIA Bulletin 21-24	d. Definition of air ambulance services (if definition is included)		
F15.	45 CFR §149.120	Cost-sharing for non-emergency services provided by a non-network provider with respect to a covered visit at an in-network facility, except when the non-network provider has satisfied the notice and consent criteria of 45 CFR §149.420(c) through (i).		
		a. Cost-sharing may not exceed the cost-sharing requirements listed for services provided by an in-network provider.		
		b. Any cost-sharing requirement for services will be calculated based on the recognized amount.		

	Citation	Description	"X" Means Applicable	Form/ Page
		c. Any cost-sharing payments will be counted toward any applicable in-network deductible and in-network out of pocket maximum.		
	45 CFR §149.30 MIA Bulletin 21-24	d. Authorized representative definition		
	45 CFR §149.30 MIA Bulletin 21-24	e. Health care facility definition		
	45 CFR §149.30 MIA Bulletin 21-24	f. Participating health care facility definition		
F16.	45 CFR §149.420(b)	Items in F15. are not applicable when the non-network provider has satisfied the notice and consent criteria of 45 CR §149.420 (c) through (i). The notice and consent criteria do not apply to non-network providers with respect to: • Covered services rendered by a health care provider for which payment is required under §19-710.1 of the Health General Article • Ancillary Services • Items or services furnished as a result of unforeseen, urgent medical needs that arise at the time an item or service is furnished, regardless of whether the non-network provider satisfied the notice and consent criteria.		
F17.	§42 USC 300gg-115(b) §42 USC 300gg-139(b)	Provider Directories		
		If, through a telephone call or from a provider directory whether electronic, web-based, or internet-based means, a provider is incorrectly listed as an in-network provider and an enrollee receives services based on the incorrect information: • The copayment amount, coinsurance percentage, and/or other cost-sharing requirement for such item or services furnished by the non-network provider is the same as if services were provided by an in-network provider. • Any cost-sharing payments made with respect to the item or service will be counted toward any applicable in-network deductible and in-network out-of-pocket maximum.		

	Citation	Description	"X" Means Applicable	Form/ Page
F18.	42 USC §300gg-138 42 USC §300gg-113(a)	Continuity of care		
		a. A continuing care patient receiving care from an in-network provider may elect to continue to receive transitional care from such provider if the provider's participating provider contract is terminated or non-renewed for reasons other than for failure to meet applicable quality standards or for fraud.		
		b. Carrier is to notify each enrollee who is a continuing care patient with respect to a provider or facility at the time of a provider contract termination or non-renewal for reasons other than failure to meet quality standards or fraud.		
		c. Benefits for a continuing care patient will be the same as if termination had not occurred.		
		d. Benefits will be provided for 90 days from the date the carrier notifies the continuing care patient of the termination. Benefits will end either after the 90 days or on the date the enrollee is no longer a continuing care patient with respect to such provider or facility.		
		e. The enrollee will not be liable for an amount that exceeds the cost-sharing that would have applied had the termination not occurred.		
		f. Continuing care patient definition		
		g. Serious and complex condition definition		

G. Required Standard Provisions

	Citation	Description	"X" Means Applicable	Form/ Page
G1.	COMAR 31.12.07.04A	Entire Contract; Changes		
G2.	COMAR 31.12.07.04B	Contestability of the Contract		
G3.	COMAR 31.12.07.04C	Notice of Claim		

	Citation	Description	"X" Means Applicable	Form/ Page
G4.	COMAR 31.12.07.04D	Claims Forms		
G5.	COMAR 31.12.07.04E	Proofs of Loss		
	§15-1011	• Methods for Claim Submission		
	§15-1005(d)	• Provider must be permitted minimum of 180 days to file claim		
	§12-102	• Proof of loss period one year for claim		
	§12-102(c)(2)	• If not reasonably possible to submit claim within one year, time period extended to two years after date of service		
G6.	COMAR 31.12.07.04F	Time Payment of Claims		
G7.	COMAR 31.12.07.04G	Payment of Claims		
G8.	COMAR 31.12.07.04H	Legal Action		
G9.	COMAR 31.12.07.04I	Grace Period		
G10.	COMAR 31.12.07.04J	Certificates		
G11.	COMAR 31.12.07.04K	Addition of Employees/Members		
G12.	COMAR 31.12.07.04L	Misstatement of Age		
G13.	COMAR 31.12.07.04M	Premium Due Date		

H. Optional Provisions

	Citation	Description	"X" Means Applicable	Form/ Page
H1.	COMAR 31.12.07.07C	Physical Examination		
H2.	COMAR 31.12.07.07D	Arbitration		

I. Prohibited Provisions, Limitations, and Exclusions

	Citation	Description	"X" Means Applicable	Form/ Page
I1.	§15-1407	Premium – May Not Charge Extra Premium Based on Health Status		
I2.	COMAR 31.12.02.12A(1)	Excessive Copayments, Deductibles		

	Citation	Description	"X" Means Applicable	Form/ Page
I3.	42 USC § 300gg-11 45 CFR §147.126 MIA Bulletin 10-23 §15-1A-02(a)(2)(vi)	Annual dollar limits for essential health benefits are prohibited		
I4.	42 USC § 300gg-11 45 CFR §147.126 MIA Bulletin 10-23 §15-1A-02(a)(2)(v)	Lifetime dollar limits for essential health benefits are prohibited		
I5.	§27-913	Benefits for treatment of a specified disease or diagnosis may not be subject to different copays, coinsurance, deductibles, annual or lifetime maximums		
I6.	§15-810(b)	Benefits for infertility may not discriminate against married same-sex couples		
I7.	§15-1009	Denial of Reimbursement for Pre-authorized Care Prohibited Except for Limited Reasons		
I8.	§19-713.1(b), Health-General	May not coordinate against guaranteed renewable intensive care or specified disease policies		
I9.	§19-713.1(e), Health-General	May not recover any payment made to Subscriber under PIP		
I10.	COMAR 31.12.02.06H(2)(a) §19-713.1(e), Health-General	May not provide benefits that are secondary to benefits payable under an automobile policy, including PIP		
I11.	COMAR 31.12.02.06H(2)(b) §19-713.1(e), Health-General	May not include an exclusion for losses covered by an automobile policy, including PIP		
I12.	§19-713.1(f), Health-General	May not recover medical expenses under subrogation unless the Subscriber recovers for medical expenses in a cause of action		
I13.	§19-705.4, Health-General	Physical Therapist Time Limitations		
I14.	COMAR 31.12.07.06D 42 USC § 300gg-3 45 CFR §147.108(b) MIA Bulletin 10-23 §15-1A-02(a)(2)(ii)	May not include a limitation or exclusion for a pre-existing condition		
I15.	45 CFR §146.121(b)(2)(iii)	Prohibited Suicide or Self-Inflicted Injury Exclusion		
I16.	§27-303, MIA Bulletin L&H 99-25	Denial of Medically Necessary Inpatient Ancillary Charges Prohibited		

	Citation	Description	"X" Means Applicable	Form/ Page
I17.	COMAR 31.12.07.06A(1)	May not limit or exclude loss due to member's commission of or attempt to commit a crime		
I18.	COMAR 31.12.07.06A(2)	May not limit or exclude loss due to commission of or the attempt to commit a crime by an individual other than the member		
I19.	COMAR 31.12.07.06B	May not limit or exclude loss due to member being engaged in an illegal occupation		
I20.	COMAR 31.12.07.06C(1) COMAR 31.12.07.06C(2)(a) COMAR 31.12.07.06C(2)(b) COMAR 31.12.07.06C(2)(c)	May not limit or exclude loss: • Sustained or contracted in consequence of the member being intoxicated or under the influence of any drug • Due to the use of alcohol • Due to the use of drugs or narcotics • Due to alcoholism or drug addiction		
I21.	§15-126	May Not Discourage or Prohibit Access to the 911 Emergency System		
I22.	COMAR 31.12.02.06G	Advertising Prohibited in Forms		
I23.	§15-510	May not deny behavioral counseling services provided by participating provider solely on the basis that it is school based		
I24.	45 CFR §156.125(a) 45 CFR §156.200(e) §15-1A-22	Prohibition on discrimination: • based on individual's age, expected length of life, present or predicted disability, degree of medical dependency, quality of life, or other health conditions (applies only to benefit design, or the implementation of a benefit design) • on the basis of race, creed, color, national origin, disability, age, marital status, sex, gender identity or sexual orientation (limitations/restrictions based on marital status still permissible if otherwise provided under state law)		

	Citation	Description	"X" Means Applicable	Form/ Page
I25.	§15-716	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(c)	• May not condition on whether pharmacist is employed by a physician, pharmacy, or facility or acting under physician's orders		
I26.	§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		
I27.	§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		
I28.	§§19-701(d) 19-710(p), Health-General	May not permit balance billing for any covered service		
I29.	§19-706(q), Health-General Article §12-211, House Bill 1069, Chpt. 396, Acts of 2025 (effective 10/1/2025)	Prohibition of Discretionary Clauses		
I30.	§15-861, House Bill 1301, Chpt. 612, Acts of 2025 (effective 1/1/2026)	May not require prior authorization for the transfer of a patient to a special pediatric hospital.		
I31.	§15-862, House Bill 1086, Chpt. 683, Acts of 2025 (effective 1/1/2026)	Anesthesia – Prohibiting Time Limitations		

J. Other

	Citation	Description	"X" Means Applicable	Form/ Page
J1.	COMAR 31.12.02.06I §15-122	45-Day Premium Increase Notice; At renewal		
J2.	45 CFR §146.121(f) §§15-1A-02(a)(2)(iv) 15-509	Requirements for Wellness Programs		

	Citation	Description	"X" Means Applicable	Form/ Page
	§15-509(c)(2)	a. Participatory Wellness Programs: • Program must be available to all similarly situated individuals		
		b. Health-Contingent Wellness Programs:		
	§15-509(d)(4) and (g)(1)(ii)	1. Full reward must be available to all similarly situated individuals		
	§15-509(d)(1) and (g)(1)(i)	2. Must provide chance to qualify for reward at least once per year		
	§15-509(d)(2) and (g)(1)(i)	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		
		4. Must allow reasonable alternative standard (or waiver of standard) for obtaining reward		
	45 CFR §146.121(f)(3)(iv)(A) 45 CFR §146.121(f)(3)(iv)(E) 45 CFR §146.121(f)(3)(iv)(C)(4)	i) Activity-only Wellness Program: • Alternative standard required if unreasonably difficult to satisfy (or inadvisable to attempt to satisfy) standard due to medical condition • Carrier may require individual's physician to verify that alternative standard is needed due to medical condition • Alternative standard must accommodate recommendations of individual's physician		
	45 CFR §146.121(f)(4)(iv)(A) 45 CFR §146.121(f)(4)(iv)(E) 45 CFR §146.121(f)(4)(iv)(C)(4)	ii) Outcome-based Wellness Program • Alternative standard required if initial standard is not met for any reason • Carrier may NOT require individual's physician to verify that alternative standard is needed due to medical condition • Alternative standard must accommodate recommendations of individual's physician		

	Citation	Description	"X" Means Applicable	Form/ Page
	45 CFR §146.121(f)(3)(v) and (f)(4)(v)	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		
J3.	42 USC § 300gg-6, 45 CFR §156.130(a) §15-1A-02(a)(2)(xiv)	Annual limitation on cost-sharing (including copays, coinsurance, and deductibles) for essential health benefits		
	CMS Guidance Dated November 15, 2023—Premium Adjustment Percentage, Maximum Annual Limitation on Cost Sharing 2025 Marketplace Integrity Final Rule June 24, 2025 (effective 8/25/2025), 90 FR 27168	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 2025 – may not exceed $9,200 for self-only coverage and $18,400 for other than self-only coverage. • For Plan Year 2026 – may not exceed $10,600 for self-only coverage and $21,200 for other than self-only coverage		
	45 CFR §156.130(c)	b. Out-of-network cost sharing is not required to count toward the limit		
	80 FR 10825	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		
J4.	COMAR 31.12.02.06E	Time References		
J5.	§19-713(b)(2), Health-General	HMO may include subrogation provision in contract if rating methodology includes an adjustment that reflects the subrogation		
J6.	§19-713.1(d)(1), Health-General	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		

	Citation	Description	"X" Means Applicable	Form/ Page
J7.	COMAR 31.12.02.06P	Required Provision for Inability to Provide Services - Circumstances Beyond the Plan's Control		
J8.	§19-712.4(c), Health-General	Required Exclusion for Prohibited Practitioner Referral		

K. Utilization Review

	Citation	Description	"X" Means Applicable	Form/ Page
K1.	§19-712.5(d), Health-General	May not require preauthorization for emergency care		
	42 USC § 300gg-19a 45 CFR §147.138(b) MIA Bulletin 10-23 §15-1A-14(c)(1)	• No administrative requirements on non-network emergency services that are not imposed in-network		
K2.	§ 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		
K3.		Initial authorization of course of treatment made:		
	§§ 19-706(f), Health-General 15-10B-06(a)(1)(i), Senate Bill 791, Chpt. 848, Acts of 2024 (effective 1/1/2025)	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)(ii)	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)(iii), Senate Bill 791, Chpt. 848, Acts of 2024 (effective 1/1/2025)	c. For additional visits or days of care as part of existing treatment, within 1 working day of receipt of necessary information		
	§§ 19-706(f), Health-General 15-10B-06(a)(2), Senate Bill 791, Chpt. 848, Acts of 2024 (effective 1/1/2025)	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		

	Citation	Description	"X" Means Applicable	Form/ Page
	§§ 19-706(f), Health-General 15-10B-06(b), Senate Bill 791, Chpt. 848, Acts of 2024 (effective 1/1/2025)	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		
	§§ 19-706(f), Health-General 15-10B-06(c), Senate Bill 791, Chpt. 848, Acts of 2024 (effective 1/1/2025)	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		
K4.		For emergency course of treatment or healthcare service:		
	§§ 19-706(f), Health-General 15-10B-06(d)(1)(i), Senate Bill 791, Chpt. 848, Acts of 2024 (effective 1/1/2025)	a. Make initial determination within 24 hours after initial request for necessary information		
	§§ 19-706(f), Health-General 15-10B-06(d)(1)(ii), Senate Bill 791, Chpt. 848, Acts of 2024 (effective 1/1/2025)	b. If additional information is needed, PRA must promptly request information and no later than 2 hours after receipt of information notify provider of determination		
	§§ 19-706(f), Health-General 15-10B-06(d)(2), Senate Bill 791, Chpt. 848, Acts of 2024 (effective 1/1/2025)	c. Circumstances PRA shall initiate expedited procedure for emergency case		
K5.	§§ 19-706(f), Health-General 15-10B-06(e), Senate Bill 791, Chpt. 848, Acts of 2024 (effective 1/1/2025)	PRA fails to make determination, course of treatment is deemed approved		
K6.	§15-10A-02(f)(1), Senate Bill 791, Chpt. 848, Acts of 2024 (effective 1/1/2025)	For non-emergency cases, notice of adverse decision must be provided within 5 working days after adverse decision is made		

	Citation	Description	"X" Means Applicable	Form/ Page
	§15-10A-02(f)(1)(i), Senate Bill 791, Chpt. 848, Acts of 2024 (effective 1/1/2025)	• 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 to inform the member of an adverse decision		
K7.	§§ 19-706(f), Health-General 15-10B-07(c)	May not retroactively deny approval of preauthorized services		
K8.	§§ 19-706(f), Health-General 15-10B-06(f)(1), Senate Bill 791, Chpt. 848, Acts of 2024 (effective 1/1/2025)	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(f)(2), Senate Bill 791, Chpt. 848, Acts of 2024 (effective 1/1/2025)	• Must provide additional contact information if physician is unable to immediately speak with provider		
K9.	§§ 19-706(f), Health-General 15-10B-06(g), Senate Bill 791, Chpt. 848, Acts of 2024 (effective 1/1/2025)	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		
K10.	§§ 19-706(f), Health-General 15-10B-06(h), Senate Bill 791, Chpt. 848, Acts of 2024 (effective 1/1/2025)	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		
K11.	§15-140(c)	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		

L. Internal Appeal and Grievance Process

	Citation	Description	"X" Means Applicable	Form/ Page
L1.	COMAR 31.12.02.06J(12)	HMO contract must include formal procedure to be followed in filing complaints or grievances.		

	Citation	Description	"X" Means Applicable	Form/Page
L2.	Title 15, Subtitle 10A	Internal Appeal and Grievance Process for Adverse Decisions		
	15-10A-02(k), House Bill 848, Chpt 669, Acts of 2025 (effective 10/1/2025)	a. Information required to be included in policy (Note that citation references within §15-10A-02(k) to (f)(1)(ii)3, 4 and 5 were not updated with HB848. Correct reference should be to (f)(1)(ii)4, 5 and 6)		
	§15-10A-02(f)(1)(ii)4., House Bill 848, Chpt 669, Acts of 2025 (effective 6/1/2025)	1. Unique identifier, address, telephone # of medical director or associate Medical director who made decision		
	§15-10A-02(f)(1)(ii)5., House Bill 848, Chpt 669, Acts of 2025 (effective 6/1/2025)	2. Details of internal grievance process		
	§15-10A-02(f)(1)(ii)6.A., House Bill 848, Chpt 669, Acts of 2025 (effective 6/1/2025)	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)(1)(ii)6.B., House Bill 848, Chpt 669, Acts of 2025 (effective 6/1/2025)	4. Complaint may be filed without first filing grievance with HMO if compelling reason to do so is demonstrated		
	§15-10A-02(f)(1)(ii)6.C., House Bill 848, Chpt 669, Acts of 2025 (effective 6/1/2025)	5. Address, telephone #, facsimile # of Commissioner		
	§15-10A-02(f)(1)(ii)6.D., House Bill 848, Chpt 669, Acts of 2025 (effective 6/1/2025)	6. Health Advocacy Unit available to assist member with mediating and filing grievance		
	§15-10A-02(f)(1)(ii)6.E., House Bill 848, Chpt 669, Acts of 2025 (effective 6/1/2025)	7. Health Advocacy Unit's address, telephone #, facsimile #, and e- mail address		
	§15-10A-02(f)(2), Senate Bill 791, Chpt. 848, Acts of 2024 (effective 1/1/2025)	8. The business telephone number in the notice must be a dedicated number for adverse decisions		

	Citation	Description	"X" Means Applicable	Form/ Page
	§15-10A-02(k)(2)	9. 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		
		b. Details of internal grievance process		
	§15-10A-02(g), Senate Bill 791, Chpt. 848, Acts of 2024 (effective 1/1/25)	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(b)(2)(v)	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		
		3. Non-emergency case grievance review (prospective denial)		
	§15-10A-02(b)(2)(ii)	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 working days with the member's written approval		
	§15-10A-02(i)(1)(ii), House Bill 848, Chpt 669, Acts of 2025 (effective 10/1/2025)	ii. Written notice is required within 5 working days after decision is rendered		
		4. Non-emergency case grievance review (retrospective denial)		

	Citation	Description	"X" Means Applicable	Form/ Page
	§15-10A-02(b)(2)(iv)	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(i)(1)(ii), House Bill 848, Chpt 669, Acts of 2025 (effective 10/1/2025) Senate Bill 791, Chpt. 848, Acts of 2024 (effective 1/1/2025)	ii. Written notice is required within 5 working days after decision is rendered		
		5. Emergency case grievance		
	§15-10A-02(b)(2)(i)	i. The carrier must render a decision within 24 hours after the receipt of a grievance		
	§15-10A-02(j)	ii. Written notice of the decision must be sent within one day after the oral decision has been communicated		
		6. Complaints may be filed with the Commissioner:		
	§15-10A-03(a)	i. Within 4 months after receipt of the HMO's grievance decision		
	§15-10A-02(d)(2)	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)	iii. For retrospective denials, if grievance decision from carrier is not received on or before the 45th working day after the filing date		

	Citation	Description	"X" Means Applicable	Form/ Page
	§15-10A-02(d)(1)	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		
		c. Definitions		
	§15-10A-01(b), Senate Bill 791, Chpt. 848, Acts of 2024 (effective 1/1/2025)	1. Adverse Decision		
	§15-10A-02(b)(3), Senate Bill 791, Chpt. 848, Acts of 2024 (effective 1/1/2025)	2. Emergency Case		
	COMAR 31.10.18.02B(5)	3. Filing Date		
	§15-10A-01(f)	4. Grievance		
	§15-10A-01(g)	5. Grievance Decision		
	§15-10A-01(j)	6. Health Care Provider		
	§15-10A-01(m)	7. Member's representative		
	COMAR 31.10.18.11	8. Compelling Reason		
L3.	Title 15, Subtitle 10D	Complaint Process for Coverage Decisions		
	§15-10D-02(b)	a. HMO must render final appeal decision in writing within 60 working days		
	§15-10D-02(c) and (d)	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(f)(2)(ii)1.	c. Member, member's representative, or provider may file a complaint with Commissioner within 4 months after receipt of HMO's appeal decision		
		d. Definitions		

	Citation	Description	"X" Means Applicable	Form/ Page
	§15-10D-01(b)	1. Appeal		
	§15-10D-01(c)	2. Appeal Decision		
	§15-10D-01(f)	3. Coverage Decision		
	COMAR 31.10.29.02B(12)	4. Urgent Medical Condition		
	§15-10D-02(e)	5. Notice of Coverage Decision		
	§15-10D-02(f)	6. Notice of Appeal Decision		

M. Grandfathered Plans

	Citation	Description	"X" Means Applicable	Form/Page
M1.	45 CFR §147.140	Grandfathered Plans		
	COMAR 31.12.07.06D 42 USC § 300gg-3 45 CFR §147.108(b) MIA Bulletin 10-23 §15-1A-02(a)(2)(ii)	a. Prohibition on pre-existing conditions exclusion		
	42 USC § 300gg-7 45 CFR §147.116 §15-1A-12	b. Waiting period may not exceed 90 days		
	42 USC § 300gg-11 45 CFR §147.126 MIA Bulletin 10-23	c. Prohibition on lifetime and annual dollar limits on essential health benefits		
	45 CFR §147.128 MIA Bulletin 10-23	d. Rules for rescission		
	42 USC § 300gg-14 45 CFR §147.120 MIA Bulletin 10-17 §15-1A-08	e. Dependent coverage to age 26		
M2.	45 CFR §§147.130 147.140 §§ 19-701(g)(2) 19-705.1(c)(4)(i), Health-General §15-135	Not required to cover preventive care services defined by the ACA, but must cover preventive care services required under Health-General Article		
	45 CFR §147.140	• ACA Preventive care services may be subject to cost-share, if included		

	Citation	Description	"X" Means Applicable	Form/ Page
M3.	45 CFR §147.140	Not subject to ACA deductible and out-of-pocket maximum cost-sharing limits		
M4.	§15-816	Benefits for Routine Gynecological Care		
M5.	§15-826.1(c)	Not subject to prior authorization and cost-share prohibition for contraceptive drugs and devices		
M6.	§15-826.2(b)(2)	Not subject to cost-share prohibition for male sterilization		
M7.	§15-826.3(d)	Not subject to cost-share prohibition for fertility awareness-based methods		
M8.	45 CFR §147.140 42 USC § 300gg-8(d) §15-1A-02(a)(2)(xviii)	Not subject to expansion of clinical trial definition		

N. Applications

	Citation	Description	"X" Means Applicable	Form/ Page
N1.	COMAR 31.12.02.07K(1)	Separate filing required for each company		
N2.	COMAR 31.12.02.07K(2)	Check-off boxes required for carrier name if application is to be used by more than one carrier		
N3.	COMAR 31.12.02.07K(3)	Application must clearly identify coverages underwritten by each carrier, when more than one carrier uses the same application with the same group applicant		
N4.	COMAR 31.12.02.07A	Application shall stipulate the plan and amount of insurance and any added optional benefits applied for		
N5.	42 USC § 300gg-7 45 CFR §147.116 §15-1A-12	Waiting period may not exceed 90 days		
N6.	42 USC § 300gg-1 45 CFR §147.104(a) §15-1410	May not reject entire group due to underwriting		
N7.	§15-1406	May not deny coverage to individual due to underwriting		
N8.	§27-909	May Not Inquire About Genetic Tests or Genetic Information		
N9.	§27-504	May not ask about Domestic Violence		

	Citation	Description	"X" Means Applicable	Form/ Page
N10.	COMAR 31.12.02.07B(1)(a)	7-year look back limitation for health questions		
N11.	COMAR 31.12.02.07C	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		
N12.	COMAR 31.12.02.07D	If a rider or endorsement modifies the coverage applied for, signed acceptance is required by applicant before delivery of contract		
N13.	COMAR 31.12.02.07E	Proxy statement prohibited		
N14.	COMAR 31.12.02.07F	Questions about "hazardous activities" must list activities considered to be "hazardous"		
N15.	COMAR 31.12.02.07G	Questions about the use of "habit-forming drugs" must list specific drugs considered to be "habit-forming"		
N16.	COMAR 31.12.02.07H and I	Questions about symptoms or indications of physical/mental conditions must ask about "known symptoms" and "known indications"		
N17.	COMAR 31.12.02.07L	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		
N18.	§19-705.1(d)(4)(ii), Health-General	Required Notice		
N19.	§§ 19-706(e), Health-General 27-805 MIA Bulletin 12-07	Insurance Fraud-Required Disclosure Statement		
N20.	§15-403.2 COMAR 31.10.35	Expand application to include a selection of Domestic Partner, including Child Dependents of Domestic Partner for applying for coverage		