INSURERS
LARGE GROUP HEALTH BENEFIT PLAN

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

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

A. Filing Incomplete or in Unacceptable Format

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

	Citation	Description	"X" Means Applicable	Form/ Page
	COMAR 31.04.17.04B(3)(a)	c. Form Number and Approval Date for Pages Replaced		
	COMAR 31.04.17.04B(3)(b)	d. Copy of Currently Approved Contract		
A12.	COMAR 31.04.17.04C	Contracts Comprised of Sections		
	COMAR 31.04.17.04C(1)(b)(i)	a. Description of How Sections will be Combined		
	COMAR 31.04.17.04C(1)(b)(ii)	b. Listing of Substitute Sections		
	COMAR 31.04.17.04C(3)(a)	c. Form Number and Approval Date for Pages Replaced		
	COMAR 31.04.17.04C(3)(b)	d. Copy of Currently Approved Contract		
A13.	COMAR 31.10.01.03E	Signature of Policyholder for Reduction Rider		
A14.	COMAR 31.10.01.03B	Size of Type		
A15.	COMAR 31.10.02	Simplified Language (Readability Certification)		
A16.	§12-205(b)(5)	Illegible Form		
A17.	§2-112(a)(10)	Filing Fees Insufficient		
A18.	COMAR 31.04.17.03F	Language other than English in Forms		

B. Mandated Benefits

	Citation	Description	"X" Means Applicable	Form/ Page
B1.	§15-803	Blood Products		
B2.	§15-818	Cleft Lip/Cleft Palate		
B3.		Health Care Cost Containment		
	§15-819(b)(1)	a. Outpatient Benefit		
	§15-819(b)(2)	b. Second Opinion		
B4.	§15-808	Home Health Care		
B5.	§15-802	Mental Health/Substance Use Disorder		

	Citation	Description	"X" Means Applicable	Form/ Page
	§15-802(c)	a. Required benefits for inpatient care, (services in licensed or certified facility, including hospital inpatient and residential treatment center benefits) partial hospitalization, and outpatient care (including all office visits, diagnostic evaluation, opioid treatment services, medication evaluation and management and psychological and neuropsychological testing for diagnostic purposes) • Mental health services or tests must be covered if provided by licensed or certified practitioners when acting within the scope of their license if equivalent services are covered for physical illnesses.		
	§15-840	b. Required benefits for residential crisis services		
	§15-802(d)(2)(ii)2; 45 CFR §146.136(2)(i)	c. Each financial requirement applicable to a mental health or substance abuse benefit in the plan design may not be more restrictive than the *predominant* financial requirement of that type that applies to *substantially all* of the medical/surgical benefits in the same classification. In performing the "substantially all" and "predominated" tests, carrier should use "plan" level claims data (as opposed to "product" level). If carrier does not have sufficient data at the "plan" level, "product" level data may be used provided the carrier can demonstrate the validity of the projection method		
	§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, but separate sub-classifications for generalists and specialists are not permitted		

	Citation	Description	"X" Means Applicable	Form/ Page
	§27-913	• Multi-tiered prescription drug plan may not assign drug to more than 1 tier because such drug is based on the specific disease, diagnosis or indication being treated		
	§15-802(d)(2)(iv); 45 CFR §146.136(c)(2)(I)	f. 60-day limit for partial hospitalization 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 (include UR requirements) that are more restrictive than requirements for physical illnesses		
B6.	§15-809; COMAR 31.10.09	Hospice (Required Offering)		
B7.	§15-821	Coverage of Face, Neck or Head		
B8.	§15-814	Breast Cancer Screenings		
	§15-814(c)(1)	• Coverage for breast cancer screening in accordance with latest screening guidelines issued by American Cancer Society		
	§15-814(c)(2)	• Coverage for Digital Tomosynthesis that, under accepted standards in the practice of medicine, the treating physician determines is medically appropriate and necessary		
	§15-814(e)(1)	• May not be subject to deductible		
	§15-814.1(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		
B9.	§15-817, House Bill 1069, Chpt. 396, Acts of 2025 (effective 1/1/2026)	Child Wellness (May not be subject to deductible) Child Wellness Immunizations recommended by ACIP: • In effect on December 31, 2024; and		

	Citation	Description	"X" Means Applicable	Form/ Page
		• Any new vaccines recommended by the Centers for Disease Control and Prevention's Advisory Committee on Immunization Practices after December 31, 2024		
	§15-817(c)(2)(v)	a. Include all visits for obesity evaluation and management		
	§15-817(c)(2)(vi)	b. Include all visits for and costs of developmental screening as recommended by the American Academy of Pediatrics		
	§15-817(c)(2)(viii)	c. Coverage for laboratory tests considered necessary by physician for services in §15-817		
	§15-817(c)(2)(vii)	d. Physical examination, development assessment, and parental anticipatory guidance for the child to be covered as in §15-817		
B10.	§15-801; COMAR 31.11.05	Alzheimer's Disease (Required Offering)		
B11.	§15-807	Medical Food and Low Protein Food		
B12.	§15-815	Reconstructive Breast Surgery		
	§15-815(a)(2)	• Mastectomy definition does not include "breast cancer"		
	§15-815(c)(2)	• Coverage includes physical complications of all stages of mastectomy, including lymphedemas, in manner determined by physician		
B13.	§15-823	Osteoporosis Prevention and Treatment		
B14.	§15-825	Prostate Cancer Screening		
	§15-825(c)	• Deductible, Copayments or Coinsurance may not be applied		
B15.	§15-822	Diabetes Equipment, Supplies, Training		
	§15-822(d)(3)	• Diabetes Test Strips – Deductible, Copayment and Coinsurance May Not Be Applied. Exception: For high deductible plans, deductible may be applied to diabetes test strips		

	§15-822(b)(3)	• Includes benefits for both elevated or "impaired" blood glucose levels induced by pregnancy		
	§15-822(b)(4)	• Includes benefits for both elevated or impaired blood levels induced by prediabetes, consistent with American Diabetes Association standards		
B16.	§15-826.2	Male Sterilization coverage		
	§15-826.2(b)(2)	• Deductible, Copayments or Coinsurance may not be applied		
	§15-826.2(b)(3)	Exception: For high deductible plans, deductible may be applied to male sterilization		
B17.	§15-827	Coverage for Medical Clinical Trials		
	42 USC § 300gg-8(d); §15-1A-02(a)(2)(xviii)	• Expanded definition of approved clinical trial		
B18.	§15-828	General Anesthesia for Dental Care		
B19.	§15-829	Annual Chlamydia Screening Test		
	§15-829(c)(2)	• Human Papillomavirus Screening Test		
B20.	§15-832	Coverage for Home Visits If Less than 48 hours of Inpatient Hospitalization is Provided for Surgical Removal of Testicle		
B21.	§15-832.1	Coverage for Inpatient Hospitalization for a Minimum of 48 Hours Following Mastectomy or Coverage for Home Visits if less than 48 Hours of Inpatient Hospitalization		
	§15-832.1(a)	• Mastectomy Definition		
B22.	§15-834	Breast Prosthesis		
B23.	§15-835	Habilitative Services for Children • Revised Habilitative Services definition • Required to provide health benefits until end of month in which child turns age 19		
		Treatment of autism and autism spectrum disorders under services		
	COMAR 31.10.39	• Utilization review criteria must comply with COMAR 31.10.39		

	COMAR 31.10.39.03G	• Applied behavior analysis (behavioral health treatment) cannot be excluded		
B24.	§15-855	Pediatric Autoimmune Neuropsychiatric Disorders associated with streptococcal infections and pediatric acute onset neuropsychiatric syndrome • Diagnosis, evaluation, and treatment, including the use of intravenous immunoglobulin therapy		
	§15-855, House Bill 820, Chpt. 321, Acts of 2022 (effective 01/01/23)	• Modification of coverage requirement: Rituximab cannot be excluded for treatment of PANS/PANDAS solely on the basis that the FDA has not approved the drug for this indication.		
B25.	§15-139	Health Care Services Through Telehealth		
	§15-139(a), House Bill 869, Chapter 482, Acts of 2025 (effective June 1, 2025)	a. Revised to include a Definition of "telehealth:" • Audio-only telephone conversation between a health care provider and a patient that results in the delivery of a billable, covered health care service. • Amended to NOT include, except as provided above, audio-only telephone conversation between a health care provider and a patient.		
	§15-139(c)(1), Senate Bill 3, Chpt. 71, Acts of 2021 (effective 7/01/21)	b. Coverage shall: • Be provided regardless of the location of the patient at the time the telehealth services are provided. • Not be excluded or denied for a behavioral health care service that is a covered benefit under a health insurance policy or contract when provided in person solely because the behavioral Health Care Service may also be provided through a covered telehealth benefit.		
	§15-139(c)(2), Senate Bill 3, Chpt. 71, Acts of 2021 (effective 7/01/21)	c. Telehealth care services include counseling and treatment for substance use disorders and mental health conditions.		
	§15-139(e), Senate Bill 3, Chpt. 71, Acts of 2021 (effective 7/01/21)	d. Carrier may not require that telehealth services be provided by a third-party vendor designated by the carrier.		

B26.	§15-836	Hair Prostheses for Hair Loss Resulting from Chemotherapy or Radiation Treatment for Cancer		
B27.	§15-837	Colorectal Cancer Screening		
B28.	§15-839	Treatment of Morbid Obesity • If utilization review criteria are included, criteria must comply with COMAR 31.10.33		
B29.	§15-838	Hearing Aids Coverage for Children		
	45 CFR §147.126	• The $1,400 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. Review FAQ 10 from the February 17, 2012 CMS Plan Management FAQ Frequently Asked Questions on the Essential Health Benefits Bulletin)		
B30.	§15-838.1, Senate Bill 778, Chpt. 952, Acts of 2024 (effective 1/1/25)	Hearing Aids- Coverage for Adults		
	§ 15-838.1(c)(2), House Bill 1355, Chapter 742, Acts of 2025	• Expanded to include coverage for a hearing aid that is ordered, fitted and dispensed by a licensed hearing aid dispenser		
	§15-838.1(d)(1), Senate Bill 778, Chpt. 952, Acts of 2024 (effective 1/1/25) 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 1/1/25)	• Must permit member to select a hearing aid that costs more than the benefit listed in the contract and pay the additional cost of the hearing aid without financial or contractual penalty to the provider of the hearing aid		
B31.	§15-843	Amino Acid-Based Elemental Formula		
B32.	§15-844, Senate Bill 614, Chpt. 823, Acts of 2024 (effective 1/1/25)	Prosthetic Devices (including Components and Repairs)		
	§15-844(a), Senate Bill 614, Chpt. 823, Acts of 2024 (effective 1/1/25)	• Definition of “prostheses”		
	§15-844(c), Senate Bill 614, Chpt. 823, Acts of 2024 (effective 1/1/25)	• Benefits must be provided once annually		

	§15-844(d), Senate Bill 614, Chpt. 823, Acts of 2024 (effective 1/1/25)	• Coverage for prosthetic and component replacements		
	§15-844(e), Senate Bill 614, Chpt. 823, Acts of 2024 (effective 1/1/25)	• May not require copayment or coinsurance higher than other similar services		
	§15-844(g), Senate Bill 614, Chpt. 823, Acts of 2024 (effective 1/1/25)	• Medical necessity to be determined by the treating provider		
	§15-844(g)(1), Senate Bill 614, Chpt. 823, Acts of 2024 (effective 1/1/25)	• Any standard medical necessity exclusion in contract must indicate prostheses or components are considered medically necessary if satisfies medical necessity requirements established under the Medicare Coverage Database		
	§15-844(g)(2), Senate Bill 614, Chpt. 823, Acts of 2024 (effective 1/1/25)	• Benefits will be provided for prostheses health care provider determines are medically necessary when used for activities identified in statute		
B33.		Preventive Services		
	§15-135	• Benefits for annual preventive care must be available once per year at any time during the plan year established by the contract.		
	§15-135.1	• Dental Preventive Care, if benefit is provided, must cover annual benefit at any time during contract's plan year.		
	§15-1A-10(a) and (e), House Bill 974, Chpt. 745, Acts of 2025 (effective 6/1/2025)	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 • 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)	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).		
B34.	§15-848	Ostomy Equipment and Supplies		
B35.	§15-826.3	Coverage for Fertility Awareness-Based Methods		
	§15-826.3(c)	a. Coverage for instruction by a licensed health care provider on fertility awareness-based methods		
	§15-826.3(a)	b. Fertility Awareness-based Methods definition may not be more restrictive than provided by law		
	§15-826.3(d)	c. Deductible, Copayment or Coinsurance may not be applied (in-network and out-of-network)		
B36.	§15-853	Coverage for Lymphedema Diagnosis, Evaluation and Treatment		

	§15-853(c)	a. Coverage for medically necessary diagnosis, evaluation and treatment of lymphedema, including equipment, supplies, complex decongestive therapy, gradient compressing garments, and self-management training and education		
	§15-853(a)	b. Gradient Compression Garment definition required		
	§15-853(d)	c. Annual Deductible, Copayment and Coinsurance cannot exceed the annual deductibles, coinsurance, copayments or coinsurance for similar coverages		
		d. 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		
		e. 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		
		f. 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		
B37.	§15-857, House Bill 937, Chpt. 56, Acts of 2022 (effective 01/01/23)	Abortion Care Services (applicable to contracts that provide labor and delivery benefits to individuals or groups on an expense-incurred basis)		
	§15-857(b)(1)(ii)	• Does not apply to high deductible health plans		
	§15-857(d), House Bill 808, Chpt. 247, Acts of 2023, House Bill 812, Chpt. 249, Acts of 2023	• May not apply copayment, coinsurance, or deductible, except for high deductible health plans		
	§15-857(b)(1)(ii), House Bill 937, Chpt. 56, Acts of 2022 (effective 01/01/23)	• Prohibition on restrictions on the coverage that are inconsistent with the protected rights under Title 20, Subtitle 2 of the Health-General Article		
	§15-857(b)(2), House Bill 937, Chpt. 56, Acts of 2022 (effective 01/01/23)	• Term “abortion care” is required when describing coverage		

B38.	§15-859, House Bill 1217, Chpt. 323, Acts of 2023 (effective 01/01/24)	Biomarker Testing		
	§15-859(c), House Bill 1217, Chpt. 323, Acts of 2023 (effective 01/01/24)	a. Includes diagnosis, treatment, appropriate management and ongoing monitoring of a disease or condition that is supported by medical and scientific evidence		
	§15-859(a)(2), House Bill 1217, Chpt. 323, Acts of 2023 (effective 01/01/24)	b. Definition ”biomarker”		
	§15-859(a)(3), House Bill 1217, Chpt. 323, Acts of 2023 (effective 01/01/24)	c. Definition “Biomarker testing”		
B39.	§15-860, House Bill 815, Chpt. 354, Acts of 2023 (effective 01/01/24)	Diagnostic Lung Cancer Screening		
	§15-860(b)(1), House Bill 1259, Chpt. 868, Acts of 2024 (effective 1/1/25)	• Recommended screening or follow-up diagnostic imaging to assist in diagnosis of lung cancer when lung cancer screening or follow-up diagnostic imaging is recommended by USPSTF		
	§15-860(b)(2), House Bill 1259, Chpt. 868, Acts of 2024 (effective 1/1/25)	• Coverage for diagnostic ultrasound, magnetic resonance imaging, computed tomography, and image- guided biopsy may not require prior authorization		
	§15-860(c), House Bill 1259, Chpt. 868, Acts of 2024 (effective 1/1/25)	• 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		
B40.	§ 15-863(b),House Bill 666, Chapter 684, Acts of 2025, (effective January 1, 2026)	Required coverage for calcium score testing in accordance with the most recent guidelines issued by the American College of Cardiology that expand the scope of preventive care services for the benefit of consumers.		

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 • Insurer 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.	45 CFR §147.116; §15-1A-12	Waiting period may not exceed 90 days		
C3.	§15-1406	May not deny coverage to individual due to underwriting		
	§15-1406(a)	• May Not Establish Eligibility Rules Based on Health Status		
C4.	29 CFR §2590.702(e)(2)	Delete Deferred Effective Date Provisions (Actively-at-work Clauses)		
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	Newborn/Adopted Children/Grandchildren/Guardianship		
C7.	42 USC § 300gg-14; 45 CFR §147.120; MIA Bulletin 10-17; §15-1A-08	Dependent Children Coverage to Age 26		
C8.	§15-418	Grandchildren and Individuals under Guardianship Coverage to Age 25		
C9.	§15-417	Part-Time Students with Disabilities		
C10.	§15-402	Incapacitated Children Coverage		
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		
	§15-405(h)	d. Special Enrollment Period for Employee and Child Required		

	Citation	Description	"X" Means Applicable	Form/ Page
	§15-405(i)	e. Special Enrollment Period for Child Required		
C12.	§15-404	Open Enrollment		
	§15-411	Spouse Loses Job		
	§15-404	Dependent Children Death of Spouse		
C13.		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		
	§15-1406.1(c)(2)	c. Permit employee to enroll himself when he or she acquires new dependents and enrolls such dependents		
	§15-1406.1(c)(3)	d. For spouse of employee at birth or adoption of a Child		
C14.	§15-1408; 45 CFR §146.152	Permissible Causes of Termination		
C15.	45 USC § 300gg-12; 45 CFR §147.128; §15-1A-21; MIA Bulletin 10-23	Rescissions • May only rescind contract for fraud or intentional misrepresentation • Requires 30-day advance notice of rescission		
C16.	§15-833	Extension of Benefits		
C17.		Continuation		
	§15-409; COMAR 31.11.04	a. Termination of Employment		
	§15-408; COMAR 31.11.02	b. Divorced Spouses		
	§15-407; COMAR 31.11.03	c. Surviving Spouses		

D. Prescription Coverage Benefit

	Citation	Description	"X" Means Applicable	Form/ Page
D1.	§15-118.1, Senate Bill 773, Chpt. 692, Acts of 2025 (effective 1/1/2026)	Required statement about calculating the enrollee's contribution to coinsurance, copayments, deductibles*, or out-of-pocket maximums, and application of discount, financial assistance payment, product voucher, or other out-of-pocket expense made by or on behalf of the enrollee for a covered prescription drug if: • 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. *Exception for deductible in HDHP		
D2.	§15-805	Coverage of Drugs from Local Pharmacies Same as Mail Order		
D3.	§15-824	90 Day Supply for Maintenance Drugs • Exception for first prescription or change in prescription		
D4.	§15-826	Coverage for Contraceptive Drugs or Devices		
	§15-826.1	a. 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)	b. Copayments or coinsurance for FDA approved contraceptive drug dispensed without a prescription and available by prescription or over the counter may not exceed the copayment or coinsurance for the contraceptive drug when dispensed under a prescription		
	§15-826.1(d)	c. 12-month supply of prescription contraceptives		

	§15-826.1(c)(2)(ii)	d. 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)	e. 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		
D5.	§15-804	Off Label Use of Drugs		
	§15-804(a)(4)	• Include "Standard reference compendia" definition		
D6.	§15-831	May use a closed formulary for brand-name drugs in compliance		
	45 CFR §156.122(c)	• If closed formulary is used, procedure for standard and expedited exception requests required		
	§15-831	• For a closed formulary, must cover a prescription drug or device not in the formulary or allow a member to continue the same cost sharing requirements for a prescription drug or device that has been moved to a higher deductible, copayment, or coinsurance tier if in the judgement of the authorized prescriber: o There is no equivalent prescription drug or device in the formulary in a lower tier; o An equivalent drug or device in a lower tier has been ineffective in treating the disease or condition or has caused or is likely to cause an adverse reaction or other harm to the member; or o For a contraceptive drug or device, the prescription drug or device not on the formulary is medically necessary for the member to adhere to the appropriate use of the prescription drug or device.		
D7.	§15-841	Coverage for Smoking Cessation Treatment		
D8.	§15-842	Copayment or Coinsurance of prescription drug or device may not exceed the retail price of prescription drug or device		

D9.	§15-845(b)(1) §15-845(b)(2)(i)	Coverage for Certain Prescription Eye Drop Refills (if contract provides coverage for prescription eye drops)		
D10.	§15-142(c)	A contract may not impose a step therapy or fail–first protocol on an insured or an enrollee if: 1) the step therapy drug has not been approved by the U.S. Food and Drug Administration for the medical condition being treated; or 2) a prescriber provides supporting medical information to the entity that a prescription drug covered by the entity: i. was ordered by a prescriber for the insured or enrollee within the past 180 days; and ii. based on the professional judgment of the prescriber, was effective in treating the insured's or enrollee's disease or medical condition.		
	§15-142(e), House Bill 970, Chpt 688, Acts of 2025 (effective January 1, 2026)	As of January 1, 2026, step therapy may also not be required when: The prescription drug is used to treat the insured's or enrollee's stage four advanced metastatic cancer; and a. The prescription drug is approved by the U.S. Food and Drug Administration and is insulin or an insulin analog used to treat Type 1, Type 2 or gestational diabetes. b. The prescription drug is approved by the U.S. Food and Drug Administration and is prescribed by a treating physician to treat a symptom or side effect from treatment of stage four advanced metastatic cancer if the use of the drug is: i. Consistent with best practices for the treatment of stage four advanced metastatic cancer, a condition associated with stage four advanced metastatic cancer, or a side effect associated with treatment of stage four advanced metastatic cancer; ii. Supported by peer-reviewed medical literature; and		

		iii. Covered under the terms of the contract.		
D11.	§15-850	Preauthorization cannot be required for certain drug products used to treat opioid use disorder		
D12.	§15-851	Preauthorization cannot be required for drugs used for treatment of opioid addiction		
D13.	§15-854	Limits on prior authorization requirements for certain drugs		
	§15-854(f), Senate Bill 791, Chpt. 848, Acts of 2024 (effective 1/1/25)	• More than one prior authorization prohibited if two or more tablets of different dosage strengths of the same prescription drug are prescribed at the same time and are made by the same manufacturer. This does not apply to opioids that are not opioid partial agonists.		
	§15-854(g), Senate Bill 791, Chpt. 848, Acts of 2024 (effective 1/1/25)	• Circumstances under which a carrier may not issue adverse decision on reauthorization		
D14.	§15-854.1, Senate Bill 791, Chpt. 848, Acts of 2024 (effective 1/1/25)	Prior Authorization for a Course of Treatment		
D15.	§15-849	Abuse-Deterrent Opioid Analgesic Drug Products – Tier Placement and Step Therapy		
	§15-849(c)(1)	• If contract lists specific drugs that are covered, must list at least two brand name and two generic abuse-deterrent opioid analgesic drugs on the lowest cost tier		
	§15-849(c)(2)	• No fail first protocol applied to opioid analgesic drugs before being allowed abuse-deterrent opioid analgesic drugs		
D16.	§15-847	Specialty drugs – Copayment/Coinsurance Limits • Definition excludes drugs for the treatment of diabetes, HIV, or AIDS		
D17.	§15-847.1	Prescription drugs for the treatment of diabetes, HIV, or AIDS -- Copayment/Coinsurance limits		

	§15-822.1, House Bill 1397, Chpt. 405, Acts of 2022, (effective 01/01/23)	• Copayment or coinsurance for insulin cannot be more than $30 for a 30-day supply, regardless of amount or type of insulin needed.		
D18.	§ 15-847.2, House Bill 1243, Chapter 729, Acts of 2025 (effective January 1, 2026)	For contracts that limit specialty drugs to a preferred pharmacy, the contract must indicate that benefits will be provided for an otherwise covered specialty drug administered or dispensed by an in-network provider of covered oncology services who complies with State regulations for the administering and dispensing of specialty drugs, if the covered specialty drug is: • auto-injected, or an oral targeted immune modulator; or • an oral medication that requires complex dosing based on clinical presentation or is used concomitantly with other infusion or radiation therapies.		
D19.	§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.		
D20.	§15-852	Prorated daily copayment/coinsurance for partial supply of prescription drug dispensed by in-network pharmacy		
D21.	§15-858, House Bill 970, Chpt. 684, Acts of 2022 (effective 01/01/23)	Prohibition on prior authorization for prescription drugs used as Postexposure Prophylaxis for the prevention of HIV if the drug is prescribed for use in accordance with Centers for Disease Control and Prevention guidelines		

E. Maternity

	Citation	**Description**	**"X" Means Applicable**	**Form/ Page**
E1.		Inpatient Hospitalization for Mothers and Newborns		
E2.	§15-812	a. Mandated Coverage		
	§15-811	b. Additional 4 days Inpatient Stay for Newborn if Mother Requires Inpatient Care		
	§15-812(g)(1)	c. Coverage of Home Visits for Mothers and Newborns May Not Be Subject to Deductibles, Copays or Coinsurance for health plans		

	Citation	Description	"X" Means Applicable	Form/ Page
	§15-812(g)(2)	d. High-Deductible Health Plan Coverage of Home Visits for Mothers and Newborns May Be Subject to Deductible		
E3.	§15-506	Maternity Care Regardless of Marital Status		
E4.	§15-811	Hospitalization Same as for Any Other Covered Sickness		
E5.	§15-810	In Vitro Fertilization		
	§15-810(b), §15-810(d)(3)	a. Expanded to include coverage for married same-sex couples		
	§15-810(d)(2)	b. 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)	• Period of time to demonstrate a history of infertility reduced from two years to one year.		
	§15-810(d)(4)	• Coverage for in vitro-fertilization benefit expanded to include unmarried patients		
E6.	§15-810.1	Coverage for fertility preservation procedures for iatrogenic infertility		
		Required Definitions:		
	§15-810.1(a)(2)	a. Iatrogenic Infertility		
	§15-810.1(a)(3)	b. Medical Treatment that May Directly or Indirectly Cause Iatrogenic Infertility		
	§15-810.1(a)(4)	c. Standard Fertility Preservation Procedures		

F. Practitioners

	Citation	Description	"X" Means Applicable	Form/ Page
F1.	§15-701	Health Care Providers		
	§15-701, Senate Bill 216, Chpt. 330, Acts of 2023 (effective 7/01/23)	• May not exclude medically necessary treatment services otherwise covered under the contract when those services are provided by a massage therapist		
F2.	§15-703	Certified Nurse Practitioner		
F3.	§15-708	Nurse Anesthetist		

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

G. Disability

	Citation	Description	"X" Means Applicable	Form/ Page
G1.	§15-813	Disability Benefits for Pregnancy or Childbirth		
G2.	COMAR 31.10.01.03L	Definition of Total Disability		
G3.	COMAR 31.10.01.03M	Definition of Partial Disability		
G4.	§15-501	Social Security “Freeze”		
G5.	§15-413	Conversion Privilege (non-employer contracts only)		
G6.	§15-701(b)	Permit Licensed Health Care Provider to Attest to Rendition Of Service Within the Lawful Scope of His/Her Practice		
G7.	§ 27-909.1, House Bill 1007, Chapter 394, Acts of 2025 (effective October 1, 2025)	Discrimination based on genetic information in life and disability coverage		
	§ 27-909.1(c), House Bill 1007, Chapter 394, Acts of 2025 (effective October 1, 2025)	An insurance carrier offering life insurance or disability insurance policies or contracts in Maryland may not: a. access sensitive medical information, including the genetic data of an individual, without first obtaining the individual’s signed, written consent b. mandate existing or new genetic testing or full genome sequencing as a prerequisite for life insurance or disability insurance eligibility or coverage		

H. Other

	Citation	Description	"X" Means Applicable	Form/ Page
H1.	§15-604	May not limit hospital payments to amounts other than those set by Health Services Cost Review Commission		
H2.	§15-603	Reimbursement for Services Paid for or Provided by Department of Health		
H3.	Title 15, Subtitle 17	Requirements for Physician Rating Systems		
	§15-1703(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 carrier has established: • Appeals process for physicians • System to notify physicians of changes to ratings • Process to post required information on carrier's website		
	§15-1704	c. Must file annual report with Commissioner		
H4.		Preferred Provider		
	§14-205(b)(2)	a. Difference between coinsurance percentage for non- preferred and preferred providers may not exceed 20 percentage points		
	§14-205(b)(3)	b. PPO contract provisions for the insured to pay the balance bill may not apply to an on-call or hospital-based physician who has accepted an assignment of benefits in accordance with §14-205.2		
	§14-205(b)(4)	c. Insurer's allowed amount paid to non-preferred providers for a health care service covered by a PPO contract may not be less than the allowed amount paid to a similarly licensed provider who is a preferred provider for the same service in the same region		
	§15-118(c)	d. Coinsurance Amounts for Preferred Provider Must Be based on Negotiated Fees with Insurer		
	§15-830(a)	e. Referrals to Specialists – Definitions Are Unacceptable		
	§15-830(b)	f. Procedure for Right to Standing Referral to Network Specialist		

	Citation	Description	"X" Means Applicable	Form/ Page
	§15-830(d), House Bill 11, Chapter 660, Acts of 2025 (effective January 1, 2026)	g. Procedure for Right to Request Referral to Specialist, Including Non-Physician Specialist Not on Carrier's Provider Panel • Referral must be granted if the carrier cannot provide reasonable access to a specialist without unreasonable travel or delay. • Reasonable access for mental health or substance use disorder care is determined by the reasonable appointment waiting time and travel distance standards established in regulation for mental health and substance use disorder care.		
	§15-830(e)(2) House Bill 11, Chapter 660, Acts of 2025 (effective January 1, 2026)	h. Balance billing is prohibited for services received from a referral to a non-panel provider for mental health or substance use disorders. i. Carrier must ensure that services for mental health or substance use disorders are provided *for the duration of the treatment plan* at no greater cost to the covered individual than if the covered benefit were provided by a provider on the carrier's provider panel.		
	45 CFR §147.138(a)(3); §15-1A-13	j. Direct Access to Obstetrical and Gynecological Care		
		• OB/GYN care may be received from in-network provider who specializes in obstetrics or gynecology without referral or authorization from carrier or primary care provider		
		• Includes any in-network provider authorized under State Law to provide OB/GYN care, including a person other than a physician (such as a certified nurse midwife)		
		• Includes all care received from OB/GYN (routine and non-routine) and the ordering of related obstetrical and gynecological items and services		
	§15-140	k. When member transitions from another carrier or managed care organization, receiving carrier must allow member to continue to receive health care services from a nonparticipating provider under certain circumstances		

	Citation	Description	"X" Means Applicable	Form/ Page
	§14-205.2	l. Payment Rules for Assignment of Benefits for Physicians on Call and Hospital-Based Physicians		
	§14-205.3	m. Payment Rules for Assignment of Benefits for Physicians Not on Call or Hospital-Based Physicians		
	42 USC § 300gg-19a; 45 CFR §147.138(a); MIA Bulletin 10-23; §15-1A-13	n. Right to choose any provider as PCP		
		• For children, the right to select allopathic or osteopathic pediatrician in the network		
H5.	§14-205.1	Exclusive Provider Benefit Contract		
	§14-205.1(a)	a. Plan may not restrict payment for certain covered services provided by non-preferred providers		
	§14-205.1(a)(1)	• Emergency Services – As defined in §19-701 of the Health-General Article		
	§14-205.1(a)(2)	• An unforeseen illness, injury or condition requiring immediate care		
	§14-205.1(a)(3)	• Referrals to Specialists as required by §15-830		
	§15-118(c)	b. Coinsurance Amounts for Preferred Provider must be based on Negotiated Fees with Insurer		
	§15-830(a)	c. Referrals to Specialists – Definitions Are Unacceptable		
	§15-830(b)	d. Procedure for Right to Standing Referral to Network Specialist		
	§15-830(d)	e. Procedure for Right to Request Referral to Specialist, Including Non-Physician Specialist Not on Carrier's Provider Panel		
	§15-830(d)(2)(ii)(2)	f. Referral must be granted if the carrier cannot provide reasonable access to a specialist without unreasonable travel or delay		
	§15-830(e)(2), Senate Bill 707, Chpt. 272, Acts of 2022, (effective 7/01/22)	g. Balance billing is prohibited for services received from a referral to a non-panel provider for mental health or substance use disorders.		
	45 CFR §147.138(a)(3); §15-1A-13	h. Direct Access to Obstetrical and Gynecological Care		

	Citation	Description	"X" Means Applicable	Form/ Page
		• OB/GYN care may be received from in-network provider who specializes in obstetrics or gynecology without referral or authorization from carrier or primary care provider		
		• Includes any in-network provider authorized under State Law to provide OB/GYN care, including a person other than a physician (such as a certified nurse midwife) without prior visit to PCP		
		• Includes all care received from OB/GYN (routine and non-routine) and the ordering of related obstetrical and gynecological items and services		
	42 USC § 300gg-19a; 45 CFR §147.138(a); MIA Bulletin 10-23; §15-1A-13	i. Right to choose any provider as PCP		
		• For children, the right to select allopathic or osteopathic pediatrician in the network		
		j. 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		
		k. Payment Rules for Assignment of Benefits for Physicians on Call and Hospital-Based Physicians		
		l. Payment Rules for Assignment of Benefits for Physicians Not on Call or Hospital-Based Physicians		
	§14-205.1(b)(1)	m. Required Point-of-Service (POS) benefit rider option if only offering a closed network plan (EPO plan) to Group Policyholder's employees or members		
		1. POS benefit must include all services under the contract, but would permit the covered individual to receive the services from a Non-Preferred Provider		

	Citation	Description	"X" Means Applicable	Form/ Page
		2. POS benefit must indicate that benefits required under§14-205.1(a)(2) (i.e., those for emergency, unforeseen illness, injury, or condition requiring immediate care, or required under §15-830) will not be paid under the POS benefit, even if provided by a Non-Preferred Provider, but will pay as if received from a Preferred Provider under the contract		
	§14-205.1(b)(2)	n. Applications for Exclusive Provider Benefit Contract		
		1. Group Policyholder Application • Required Disclosure Statement or Actual Option of POS benefit in application		
		• If only Disclosure Statement appears in application, a separate application is needed for employer/group application to select POS benefit option		
		2. Employee/Member Application • If group policyholder applicant accepts POS benefit option, then primary employee/member application/ enrollment form must include this POS benefit option		
H6.	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	a. Emergency medical condition definition		
	45 CFR §149.30, 45 CFR §149.110(c)(2); MIA Bulletin 21-24	b. Emergency services definition		
	45 CFR §149.420(b)(1); MIA Bulletin 21-24	c. Ancillary services 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 §149.30; MIA Bulletin 21-24	j. To stabilize definition		
	45 CFR §149.30; MIA Bulletin 21-24	k. Visit		
	45 CFR §149.110(b); 86 FR 36973	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.		
H7.		Reimbursement of non-contracting providers for covered services		
	45 CFR §149.410; 86 FR 36981	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.		
	45 CFR §149.410; 86 FR 36981; §15-138	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; 86 FR 36973-36974	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.		
H8.		Cost sharing for emergency services		
	45 CFR §149.110(b)(3)(ii); 86 FR 36973	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); 86 FR 36973	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		
	45 CFR §149.110(b)(3)(iii); 86 FR 36973	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; MIA Bulletin 21-24	▪ Recognized amount definition		
H9.		Ambulance services		
	45 CFR §149.30; MIA Bulletin 21-24	Air Ambulance service definition (if definition is included)		
	45 CFR §149.130; 86 FR 36974	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		
H10.	45 CFR §149.120; 86 FR 36973-36974; 45 CFR §149.30; MIA Bulletin 21-24	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.		
		c. Any cost-sharing payments will be counted toward any applicable in-network deductible and in-network out of pocket maximum.		
		d. Authorized representative definition		
		e. Health care facility definition		

		f. Participating health care facility definition		
H11.		Items in above H10 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 an on-call physician or a hospital based physician who has obtained an assignment of benefits from the enrollee • 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.		
H12.	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.		
H13.	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		
H14.	Title 15, Subtitle 10D; COMAR 31.10.29	Complaint process for coverage decisions		
	§15-10D-01(k)	• Revised member definition		
H15.	§15-112(q)	Identify office and process for filing complaints		
H16.	§15-919	Medicare Supplement Disclaimers for Individuals eligible for Medicare Due To Age (non-employer and non-labor organization contracts only)		
H17.	COMAR 31.10.01.03C	Standard of Time		
H18.	COMAR 31.10.01.03G	Right to Elect Alternative Benefits		
H19.	§12-209(1), §12-209(2), §12-209(4)	Contract Governed by Maryland Law and Maryland Courts		
H20.	§15-110(d)	Required Exclusion for Prohibited Practitioner Referral		
H21.	§15-304	Direct Payment of Hospital or Medical Services		
H22.	§15-1005(g)	Payment of Interest on Unpaid Claims		
H23.	COMAR 31.15.08	Payment of Claims, Unfair Trade Practices		
H24.	§15-122	Must be Given at Least a 45-Day Notice of Premium Increase at Renewal		
H25.	COMAR 31.11.10.04N	Premium Due Date		
H26.	§15-1410	Plan Year Defined		
H27.	45 CFR §146.121(f); §15-1A-02(a)(2)(iv), §15-509(b); COMAR 31.10.38	Wellness Programs – Reasonable Incentives		

	§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), §15-509(g)(1)(ii)	1. Full reward must be available to all similarly situated individuals		
	§15-509(d)(1), §15-509(g)(1)(i)	2. Must provide chance to qualify for reward at least once per year		
	§15-509(d)(2), §15-509(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		
		i. Activity-only Wellness Program:		
	45 CFR §146.121(f)(3)(iv)(A)	• Alternative standard required in unreasonably difficult to satisfy (or inadvisable to attempt to satisfy) standard due to medical condition		
	45 CFR §146.121(f)(3)(iv)(E)	• Carrier may require individual's physician to verify that alternative standard is needed due to medical condition		
	45 CFR §146.121(f)(3)(iv)(C)(4)	• Alternative standard must accommodate recommendations of individual's physician		
		ii. Outcome-based Wellness Program:		
	45 CFR §146.121(f)(4)(iv)(A)	• Alternative standard required if initial standard is not met for any reason		
	45 CFR §146.121(f)(4)(iv)(E)	• 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)(C)(4)	• Alternative standard must accommodate recommendations of individual's physician		

	45 CFR §146.121(f)(3)(v), 45 CFR §146.121(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		
H28.	§27-216; MIA Bulletin 17-10	Requirements for Acceptance of Credit Cards for Premium Payment and Charging of Fees for Use of Credit Cards		
H29.	§ 27-209, Senate Bill 725, Chapter 38, Acts of 2023	Value Added Services/ Non Insurance Benefits		

I. Prohibited Provisions, Limitations and Exclusions

	Citation	Description	"X" Means Applicable	Form/ Page
I1.	COMAR 31.10.01.03N	Damage to Conveyance		
I2.	COMAR 31.10.01.03O	Chronic or Organic Disease		
I3.	COMAR 31.10.01.03I	Frequency of Physician Visits		
I4.	COMAR 31.10.01.03P	Reimbursement Language		
I5.	COMAR 31.10.01.03Q	Strict Compliance Language		
I6.	§15-503	May not deny, cancel, or refuse to renew coverage because insured has been exposed to diethylstilbestrol		
I7.	COMAR 31.11.10.06A(1)	May not limit or exclude loss due to insured's commission of or attempt to commit a crime.		
I8.	COMAR 31.11.10.06B(1)	May not limit or exclude loss to which a contributing cause was the insured's being engaged in an illegal occupation.		
I9.	COMAR 31.11.10.06C	May not limit or exclude loss due to use of intoxicants or narcotics		
	COMAR 31.11.10.06C(1)(a)	a. Sustained or contracted in consequence of the insured being intoxicated or under the influence of any drug.		
	COMAR 31.11.10.06C(1)(b)	b. Due to the use of alcohol		
	COMAR 31.11.10.06C(1)(c)	c. Due to the use of drugs or narcotics		
	COMAR 31.11.10.06C(1)(d)	d. Due to alcoholism or drug addiction		

I10.	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		
I11.	COMAR 31.04.17.10B	Good Health Warranty not permitted		
I12.	§15-711(b)	Physical Therapist Time Limitations		
I13.	§15-104(c)	May not coordinate against guaranteed renewable individual intensive care or specified disease policies.		
I14.	§15-104(d)	May not provide benefits that are secondary to benefits under an automobile policy, including PIP		
I15.	§15-126	May not discourage or prohibit access to the 911 emergency system		
I16.	§27-913	Benefits for Treatment of a Specified Disease or Diagnosis May Not Be Subject to Different Copays, Coinsurance, Deductibles, Annual or Lifetime Maximums		
I17.	§15-1009	Denial of Reimbursement for Pre-authorized care prohibited except for limited reasons.		
I18.	§27-303; MIA Bulletin L&H 99-25	Denial of Medically Necessary Inpatient Ancillary Charges Prohibited		
I19.	§27-504; 26 CFR §54.98021(b)(2)(iii)	Prohibited Discrimination on Domestic Violence Victims		
I20.	COMAR 31.04.17.11B	Self-Destruction		
I21.	§15-602	State Hospitals, etc., Charitable or Otherwise		
I22.	§15-505	House Confinement, Medical Treatment Permitted Elsewhere		
I23.	§15-502	No Reduction for Medical Assistance Program		
I24.	§15-503	May not deny, cancel, or refuse to renew coverage because insured has been exposed to diethylstilbestrol.		
I25.	§15-1407	Premium - May Not Charge Extra Premium Based on Health Status		
I26.	42 USC § 300gg-11; 45 CFR §147.126; MIA Bulletin 10-23; §15-1A-02(a)(2)(vi)	Annual dollar limits for “essential benefits” prohibited		
I27.	42 USC § 300gg-11; 45 CFR §147.126; MIA Bulletin 10-23; §15-1A-02(a)(2)(v)	Lifetime maximum limits for “essential benefits” prohibited		

I28.	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 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 2024 – may not exceed $9,450 for self-only coverage and $18,900 for other than self-only coverage. • For Plan Year 2023 – may not exceed $9,100 for self-only coverage and $18,200 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		
I29.	42 USC § 300gg-13; 45 CFR §147.130; MIA Bulletin 10-23; §15-1A-02(a)(2)(xiv)	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.		
I30.	45 CFR §147.128; §15-1A-02(a)(2)(xvii)	Prohibits a carrier from charging a different premium for a young adult child who is over age 19 and has not reached the limiting age from the premium charged for a child who is under age 19		
I31.	45 CFR §146.121(b)(2)(iii)	Prohibited Suicide or Self-Inflicted Injury Exclusion		
I32.	§15-810(b)	Benefits for Infertility may not discriminate against same-sex married couples who might require such services		
I33.	COMAR 31.04.17.07	Advertising Prohibited		
I34.	§15-510	May not deny behavioral counseling services provided by participating provider solely on the basis that it is school based		
I35.	§15-704	Art Therapy May Not Be Excluded		
I36.	§27-915	Prohibits denying organ transplantation solely on basis of an insured's or enrollee's disability (if contract provides organ transplantation)		

I37.		Prohibition on discrimination:		
	45 CFR §156.125(a)	• 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)		
	45 CFR §156.200(e); §15-1A-22	• 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)		
I38.	§15-716, House Bill 1151, Chpt. 301, Acts of 2023 (amended effective 01/01/24); §15-701	May not exclude coverage for licensed pharmacists providing patient assessment regarding and in administering self-administered medications or maintenance injectable medications when acting within lawful scope of practice		
	§15-716, House Bill 1151,Chpt. 301, Acts of 2023 (amended effective 01/01/24)	• May not condition on whether pharmacist is employed by a physician, pharmacy, or facility or acting under physician's order		
I39.	§ 15-862, House Bill 1086, Chapter 683, Acts of 2025 (effective January 1, 2026)	Time Limitations on Anesthesia Prohibited		
I40.	§ 12-201	Insurable Interest Required		
I41.	§ 12-211, House Bill 1069, Chapter 396, Acts of 2025 (effective October 1, 2025)	Discretionary Clauses Prohibited		

J. Required Standard Provisions

	Citation	Description	"X" Means Applicable	Form/ Page
J1.	COMAR 31.11.10.03	Required Standard Provisions		
J2.	COMAR 31.11.10.04A	Entire Contract		
J3.	COMAR 31.11.10.04B	Contestability of Coverage		
J4.	COMAR 31.11.10.04C	Notice of Claim		
J5.	COMAR 31.11.10.04D	Claim Forms		

	Citation	Description	"X" Means Applicable	Form/ Page
J6.	COMAR 31.11.10.04E	Proofs of Loss		
	§12-102, §12-102(c)(2)	a. Extends proof of loss period to one year for claim • If not reasonably possible to submit claim within one year, time period extended to two years after date of service • Enrollee's legal incapacity shall suspend the time to submit a claim		
	§15-1011	b. Methods for Claim Submission		
	§15-1005(e)	• Provider must be permitted minimum of 180 days to file claim		
J7.	COMAR 31.11.10.04F	Time of Payment of Claims		
J8.	COMAR 31.11.10.04G	Payment of Claims		
J9.	COMAR 31.11.10.04H	Legal Action		
J10.	COMAR 31.11.10.04I	Grace Period		
J11.	COMAR 31.11.10.04J	Certificates		
J12.	COMAR 31.11.10.04K	Addition of Employees/Members		
J13.	COMAR 31.11.10.04L	Misstatement of Age		

K. Optional Standard Provisions

	Citation	Description	"X" Means Applicable	Form/ Page
K1.	COMAR 31.11.10.07A	Physical Examination		
K2.	COMAR 31.11.10.07B	Autopsy		
K3.	COMAR 31.11.10.07C	Arbitration		

L. Utilization Review

	Citation	Description	"X" Means Applicable	Form/ Page
L1.	§15-10A-02(k)	Grievance Procedure Not Included. Please Advise Where Grievance Information Is Provided		
	§15-1001; Title 15, Subtitle 10B; COMAR 31.10.18	• Company not certified as Private Review Agent (PRA) in Maryland		

	Citation	Description	"X" Means Applicable	Form/ Page
	§15-1001; Title 15, Subtitle 10B; COMAR 31.10.18; §15-10A-02	• Identify Company's PRA for making utilization review determinations of what health care service is medically necessary, experimental or investigative, or cosmetic		
L2.	§15-142(e)	May not require prior authorization on certain cancer drugs		
L3.	§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		
L4.	§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		
L5.	§ 15-861, House Bill 1301, Chapter 612, Acts of 2025 (effective January 1, 2026)	Transfers to Special Pediatric Hospitals - Prior Authorizations		
	§ 15-861 (c), House Bill 1301, Chapter 612, Acts of 2025 (effective January 1, 2026)	• For contracts that require prior authorization for hospital admissions, must include an exception for the transfer of a patient to a special pediatric hospital.		
	§ 15-861 (a), House Bill 1301, Chapter 612, Acts of 2025 (effective January 1, 2026)	• Definition for "special pediatric hospital" required if prior authorization is required.		
L6.	Federal Mental Health Parity and Addiction Equity Act; 45 CFR §156.115(a)(3)	The processes, strategies, evidentiary standards, or other factors used to manage the mental health and substance use benefits must be comparable as written and in operation to, and applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used to manage the benefits for physical illnesses covered under the contract.		
L7.	§15-10B-05(a)(4)	Utilization review agent must be reasonably available 7 days a week, 24 hours a day		
L8.	42 USC § 300gg-19a, 45 CFR §147.138(b); MIA Bulletin 10-23; §15-1A-14(c)(1)	Emergency Care • May not require preauthorization for emergency care • No administrative requirements on non-network emergency services that are not imposed in-network.		

	Citation	Description	"X" Means Applicable	Form/ Page
L9.	§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		
L10.	§15-10B-06(a)	Initial authorization of course of treatment made:		
	§ 15-10B-06(a)(1)(i), Senate Bill 791, Chpt. 848, Acts of 2024 (effective 1/1/25)	a. For non-emergencies, within 2 working days of receipt of information necessary to make determination		
	§15-10B-06(a)(1)(ii)	b. For extended stays or additional health care services, within 1 working day of receipt of necessary information		
	§ 15-10B-06(a)(1)(iii), Senate Bill 791, Chpt. 848, Acts of 2024 (effective 1/1/25)	c. For additional visits or days of care as part of existing treatment, within 1 working day of receipt of necessary information		
	§ 15-10B-06(a)(2), Senate Bill 791, Chpt. 848, Acts of 2024 (effective 1/1/25)	d. After receipt of initial request, if more information is necessary to make decision, inform provider no more than 3 calendar days following initial request of the need for more information		
	§ 15-10B-06(b), Senate Bill 791, Chpt. 848, Acts of 2024 (effective 1/1/25)	e. For emergency inpatient or residential crisis services admissions for the treatment of a mental, emotional, or substance abuse disorder, within 2 hours of receipt of the necessary information		
	§ 15-10B-06(c), Senate Bill 791, Chpt. 848, Acts of 2024 (effective 1/1/25)	f. For step therapy exception request submitted electronically, make determination in real time if no additional information is needed and request meets the PRA's criteria for approval		
L11.	§15-10B-06(a)(2)	PRA must inform healthcare provider that additional information is needed to make determination within 3 calendar days after initial request		
L12.	§15-10A-02(f)(1), Senate Bill 791, Chpt. 848, Acts of 2024 (effective 1/1/25)	For non-emergency cases, notice of adverse decision must be provided within 5 working days after adverse decision is made to member, member's representative and a health care provider acting on behalf of the member		
	§15-10A-02(f)(1)(i), Senate Bill 791, Chpt. 848, Acts of 2024 (effective 1/1/25)	• A carrier may, but is not required, to use an alternative method of communication, with the consent of the member, member's representative, or provider.		

	Citation	Description	"X" Means Applicable	Form/ Page
	§15-10A-02(f)(1)(ii)1. and §15-10A-02(i)(1)(ii), House Bill 848, Chpt 669, Acts of 2025 (effective 10/1/2025)	Required disclosure to be added to the adverse decision and grievance decision letters. At top of letter in prominent bold print: • The notice is a denial of a requested health care service • The member may file an appeal • The phone number and email address as required under §15-10B-05(e) • Additional information on how to file and receive assistance for filing a complaint		
L13.	§15-10B-07(c)	May not retroactively deny approval of preauthorized services		
L14.	§ 15-10B-06(f)(1), Senate Bill 791, Chpt. 848, Acts of 2024 (effective 1/1/25)	If provider requests immediate reconsideration of denial, must give decision by telephone within 24 hours of request		
	15-10B-06(f)(2), Senate Bill 791, Chpt. 848, Acts of 2024 (effective 1/1/25)	• Must provide additional contact information if physician is unable to immediately speak with provider		
L15.	§ 15-10B-06(g), Senate Bill 791, Chpt. 848, Acts of 2024 (effective 1/1/25)	May not deny authorization for inpatient emergency care on basis of late notification from the hospital, if patient's condition prevented the hospital from knowing insurance status or emergency notice process		
L16.	§ 15-10B-06(h), Senate Bill 791, Chpt. 848, Acts of 2024 (effective 1/1/25)	Involuntary or voluntary psychiatric admission of patient in danger – may not deny care during the first 24 hours after voluntary inpatient admission or 72 hours after involuntary admission		
L17.	§15-140(c)(1) §15-140(c)(2)	When health plan is the receiving carrier, the health plan must, upon request, accept a preauthorization from the relinquishing carrier for the lesser of the course of treatment or 90 days; and for pregnancy the duration of the 3 trimesters of pregnancy and the initial postpartum visit.		

M. Applications

	Citation	Description	"X" Means Applicable	Form/ Page
M1.	COMAR 31.04.17.06I(2)	Check-off boxes required for carrier name if application is to be used by more than one carrier.		

	Citation	Description	"X" Means Applicable	Form/ Page
M2.	COMAR 31.04.17.06I(3)	Application must clearly identify coverages underwritten by each carrier, when more than one carrier uses the same application with the same group applicant		
M3.	COMAR 31.04.17.06A	Application shall stipulate the plan and amount of insurance and any added optional benefits applied for.		
M4.	§27-805; MIA Bulletin 12-07	Insurance Fraud-required Disclosure Statement		
M5.	45 CFR §147.104(a); §15-1410	May not reject entire group due to underwriting		
M6.	45 CFR §147.116; §15-1A-12	Waiting period may not exceed 90 days		
M7.	§27-909(c)	May Not Inquire About Genetic Tests or Genetic Information		
M8.	COMAR 31.04.17.06E; §12-207	Health questions (if permitted) 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		
M9.	COMAR 31.04.17.06C	Questions about "hazardous activities" must list activities considered to be "hazardous"		
M10.	COMAR 31.04.17.06D	Questions about the use of "habit-forming drugs" must list specific drugs considered to be "habit-forming"		
M11.	COMAR 31.04.17.06F COMAR 31.04.17.06G	Questions about symptoms or indications of physical/mental conditions must ask about "known symptoms" and "known indications"		
M12.	§12-202(c)	Application Changes		
M13.	COMAR 31.04.17.08	Proxy		
M14.	COMAR 31.04.17.10B	Good health warranty not permitted		
M15.	COMAR 31.04.17.06B	Certain States		