INSURERS
STUDENT HEALTH BENEFIT PLANS FOR SCHOOL YEAR 2025-2026

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 31.04.17.03B	NAIC Company Number on Submission Letter		
A2.	COMAR 31.04.17.03-I(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 31.10.01.03A; 45 CFR §156.135; Title 11, Subtitle 6; MIA Bulletins 15-33, 25-2	Premium Rates and Actuarial Memorandum (Include in same SERFF tracking number filing for forms)		
		a. Disclosure of the actuarial value of the coverage and the metal level (or next lowest metal level) that would otherwise apply. The actuarial value must be at least 60% and must be determined in accordance with 45 CFR §156.135 using the AV calculator developed and made available by HHS.		
		b. The screen shots of each plan's AV calculator		
	45 CFR §156.135(b)	c. If plan design not compatible with the AV calculator, submit the actuarial certification from an actuary, who is a member of the American Academy of Actuaries, on the chosen methodology		
		d. All rating factors and a demonstration that there are no factors not allowed by PPACA and that family tier factors are reasonable and not a surrogate for rating by health status		
		e. Demonstration of the medical loss ratio calculation to show that the medical loss ratio is at least 80%		

	Citation	Description	"X" Means Applicable	Form/ Page
A4.	45 CFR §156.122(a)(1); MIA Bulletin 24-1	Certification, signed by an individual with the authority to bind the carrier, that the plan's prescription drug benefit complies with 45 CFR §156.122(a)(1) based on the information provided in the 2017-2024 EHB Benchmark Plan Information summary document provided by CMS and the version of the CMS Essential Health Benefits Rx Crosswalk Methodology that is current as of the date of the certification.		
A5.	45 CFR §146.136; MIA Bulletin 25-2	Actuarial documentation of compliance with Mental Health Parity and Addiction Equity Act demonstrating how each financial requirement applicable to a mental health or substance abuse benefit in the plan design is no more restrictive than the *predominant* financial requirement of that type that applies to *substantially all* of the medical/surgical benefits in the same classification. In performing the "substantially all" and "predominant" 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.		
A6.	COMAR 31.04.17.04A(2)	Statement of Variability		
		• Form contains text in brackets, denoting variability. Submit specific descriptions of how each bracketed item will vary.		

	Citation	Description	"X" Means Applicable	Form/ Page
	MIA Bulletin 25-2	• Student health benefit plan coverage must provide an actuarial value of at least 60%, and carriers must specify in any plan materials summarizing the terms of coverage the actuarial value and the level of coverage (or next lowest level of coverage) that the coverage would otherwise satisfy. If a variable schedule of benefits form is submitted, the form must include a variable section where the appropriate actuarial value and level of coverage will be specified, unless the carrier has established an alternative method to provide the required disclosure for each benefit design that is issued. If a carrier chooses to file a separate schedule of benefits form for each benefit design, then each schedule must disclose the appropriate actuarial value and level of coverage, unless an alternative method is used to provide the required disclosure.		
A7.	COMAR 31.04.17.03C	Listing of Forms		
A8.	COMAR 31.04.17.03D	Form Number (Form Number must be identical to form number in SERFF Form Schedule)		
A9.	COMAR 31.04.17.03G; COMAR 31.10.01.03B	Corporate Name and Address		
A10.	COMAR 31.04.17.03H	Unacceptable Modifications		
A11.	COMAR 31.04.17.03K	Specimen Data		
A12.	COMAR 31.04.17.03M	Signature of Officer		
A13.	COMAR 31.10.02.02A(4)	Size of Type		
A14.	COMAR 31.10.02; §15-201(d)	Simplified Language		
A15.	§2-112(a)(10)	Filing Fees Insufficient		
A16.	COMAR 31.04.17.03F	Language other than English in Forms		
A17.	COMAR 31.04.17.04B	Contracts with Insert Pages		
	COMAR 31.04.17.04B(1)(b)(i)	a. Description of How Pages will be Combined		

	Citation	Description	"X" Means Applicable	Form/ Page
	COMAR 31.04.17.04B(1)(b)(ii)	b. Listing of Substitute Pages		
	COMAR 31.04.17.04B(3)(a)	c. Form Number and Approval Date for Pages Replaced		
	COMAR 31.04.17.04B(3)(b)	d. Copy of Currently Approved Contract		
A18.	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		
A19.	§31-116(f)	Essential pediatric dental benefits not included. • Description of how the carrier will comply		

B. Essential Health Benefits (Benchmark Plan MIA Bulletins 13-01, 15-33, 22-17)

	Citation	Description	"X" Means Applicable	Form/ Page
B1.	COMAR 31.11.06.03A(1)	Care in medical offices for treatment of illness or injury		
B2.	COMAR 31.11.06.03A(2)	Inpatient hospital services		
B3.	COMAR 31.11.06.03A(3)	Outpatient hospital services		
B4.	COMAR 31.11.06.03A(6)	Emergency Services		
	45 CFR §149.30 45 CFR §149.110(c)(1) MIA Bulletin 21-24 §15-1A-14(a)(2), SB 217, Chpt. 118, Acts of 2024, effective 10/1/24)	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), SB 217, Chpt. 118, Acts of 2024, effective 10/1/24)	b. Emergency services definition		

	45 CFR §149.420(b)(1) MIA Bulletin 21-24	Ancillary services definition		
	45 CFR §149.30 MIA Bulletin 21-24	Independent freestanding emergency department definition		
	45 CFR §149.30 MIA Bulletin 21-24	Nonparticipating emergency facility definition		
	45 CFR §149.30 MIA Bulletin 21-24	Nonparticipating provider definition		
	45 CFR §149.30 MIA Bulletin 21-24	Participating emergency facility definition		
	45 CFR §149.30 MIA Bulletin 21-24	Participating provider definition		
	45 CFR §149.30 MIA Bulletin 21-24	Treating provider definition		
	45 CFR §149.110(c)(3) MIA Bulletin 21-24	To stabilize definition		
	45 CFR §149.30 MIA Bulletin 21-24	Visit		
	45 CFR §149.110(b) 86 FR 36973	c. 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.		
B5.	COMAR 31.11.06.03A(8)	Ambulance services		
	45 CFR §149.30 MIA Bulletin 21-24	Air ambulance service definition		
B6.	COMAR 31.11.06.03A(11)	Home health care		
	COMAR 31.11.06.03A(11)(b)	• Coverage for Home Visits If Less than 48 hours of Inpatient Hospitalization is Provided for Mastectomy or Surgical Removal of Testicle or procedures are performed on an outpatient basis.		
B7.	COMAR 31.11.06.03A(12)	Hospice Care		
B8.	COMAR 31.11.06.03A(13)	Durable medical equipment, including nebulizers, peak flow meters, prosthetic devices such as leg, arm, back, or neck braces, artificial legs, arms, or eyes, and the training necessary to use these prostheses		

B9.	COMAR 31.11.06.03A(14)	Outpatient laboratory and diagnostic services		
B10.	COMAR 31.11.06.03A(15)	Outpatient rehabilitative services • 30 physical therapy visits per condition per year • 30 speech therapy visits per condition per year • 30 occupational therapy visits per condition per year		
B11.	COMAR 31.11.06.03A(16)	Chiropractic services • 20 visits per condition per year		
B12.	COMAR 31.11.06.03A(17)	Skilled nursing facility services • 100 days per year		
B13.	COMAR 31.11.06.03A(18)	Infertility services		
	§15-810(b)	• Benefits for infertility may not discriminate against married same-sex couples		
B14.	COMAR 31.11.06.03A(19)	Nutritional services		
	MIA Bulletins 13-01, 15-33, 22-17	• Benchmark plan expanded to include unlimited medically necessary nutritional counseling and medical nutrition therapy		
B15.	COMAR 31.11.06.03A(20)	Transplants		
	MIA Bulletins 13-01, 15-33, 22-17	• Benchmark plan expanded to include all medically necessary non-experimental/investigational solid organ transplants and non-solid organ transplant procedures, including the cost of hotel lodging and air transportation for the recipient and a companion (or two companions if recipient under age 18), to and from the site of the transplant		
B16.	COMAR 31.11.06.03A(21)	Medical food		
B17.	COMAR 31.11.06.03A(22)	Family planning services		
		• Includes prescription contraceptive drugs and devices, insertion and removal of contraceptive devices, medically necessary examinations associated with the use of contraceptive drugs and devices, and voluntary sterilization		

	§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)		
B18.	COMAR 31.11.06.03A(23); MIA Bulletins 15-33, 22-17	Habilitative services for children 0-19 years old		
	45 CFR § 156.115(a)(5)(i)	• Habilitative services defined as health care services and devices that help a person keep, learn, or improve skills and functioning for daily living.		
		a. Visit limits may not be applied.		
	COMAR 31.11.06.03B	b. Services provided in early intervention and school services may be excluded.		
		c. Shall include cleft lip/cleft palate benefits, orthodontics, oral surgery, otologic, audiological, and speech therapy, physical therapy, and occupational therapy.		
B19.	MIA Bulletins 13-01 and 15-33	Habilitative services for adults age 19 and over		
	45 CFR §156.115(a)(5)(i)	• Habilitative services defined as health care services and devices that help a person keep, learn, or improve skills and functioning for daily living.		
	45 CFR §156.125 87 FR 27390	• Visit limits may not be applied.		
B20.	COMAR 31.11.06.03A(24)	Blood and blood products		
B21.	COMAR 31.11.06.03A(25); MIA Bulletins 13-01, 15-33, 22-17	Pregnancy and maternity services		
	§15-812	a. Minimum length of stay and coverage for home visits for mothers and newborns following childbirth		
	§15-811	b. Additional 4-day hospital stay of healthy newborn if mother requires hospitalization and requests that the newborn remain in the hospital		
B22.	COMAR 31.11.06.03A(26)	Prescription drugs		

	§15-831; COMAR 31.11.06.03E(1)	a. May use a closed formulary for brand-name drugs		
	45 CFR §156.122(c)	• If closed formulary is used, procedure for standard and expedited exception requests required		
	§15-831(c)	• 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: ○ There is no equivalent prescription drug or device in the formulary in a lower tier; ○ 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 ○ 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.		
	COMAR 31.11.06.03E(3) and COMAR 31.11.06.03E(4)	b. 90-day supply for maintenance drugs • Exception for first prescription or change in prescription		
	§15-826.1(d),	c. 12-month supply of prescription contraceptives		
	COMAR 31.11.06.03E(2)	d. Must cover insulin		
	§15-805	e. Coverage of drugs from local pharmacies same as mail order		
	§15-804	f. Off label use of drugs		
	§15-845	g. Coverage for Certain Prescription Eye Drop Refills		
	§15-142(c)	h. Step therapy or fail first protocols may not be imposed under certain circumstances.		

	§15-849	i. Abuse-Deterrent Opioid Analgesic Drug Products – Tier Placement and Step Therapy • If contract lists specific drugs that are covered, must list at least two brand name and two generic abuse-deterrent opioid analgesic drugs on the lowest cost tier		
B23.	COMAR 31.11.06.03A(27)	Controlled clinical trials		
	§15-1A-02(a)(2)(xviii)	• Benchmark plan benefit must be expanded to comply with §2709 of the Affordable Care Act		
B24.	COMAR 31.11.06.03A(28)	Other services approved by case management		
B25.	COMAR 31.11.06.03A(29)	Diabetes treatment, equipment and supplies		
	COMAR 31.11.06.03H	• Must include glucose monitoring equipment, insulin syringes, needles, and testing strips for glucose monitoring equipment		
	MIA Bulletins 13-01, 15-33, 22-17	• Benchmark plan expanded to cover insulin pumps		
	§15-139	• Self-management training may not be required to be in-person		
B26.	15-815; COMAR 31.11.06.03A(30)	Breast reconstructive surgery and breast prosthesis		
	COMAR 31.11.06.03-I	• Includes coverage on non-diseased breast to achieve symmetry		
B27.	COMAR 31.11.06.03A(32) COMAR 31.11.06.03J	General anesthesia and associated hospital or ambulatory facility charges for dental care benefit		
B28.	§15-838 COMAR 31.11.06.03A(34)	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)		

B29.	§15-838.1, Senate Bill 778, Chpt. 952, Acts of 2024 (effective 1/1/25)	Hearing Aids- Coverage for Adults		
	§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		
B30.	§15-839 COMAR 31.11.06.03A(35)A-1 COMAR 31.10.33.03	Surgical treatment of morbid obesity		
	§15-839(a)(3)	a. Morbid obesity definition		
	§15-839(a)(2)	b. Body mass index definition		
B31.	§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		
B32.	COMAR 31.11.06.03-1C COMAR 31.11.06.03-1D COMAR 31.11.06.03-1E	Preventive Care Services a. Services include: • Evidenced-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force, except that the current recommendations of the United States Preventive Service Task Force regarding breast cancer screening, mammography, and prevention of breast cancer shall be considered the most current other than those issued in or around November 2009; • Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved; • With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; and • 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		
	§15-135	b. Covered annual preventive visits/screenings must be provided once at any time during the contract year		
B33.	MIA Bulletins 13-01 15-33 and 22-17	Mental health and substance use services in accordance with the Government Employees Health Association, Inc. Benefit Plan		
	§31-115(b)(9)(iii) 45 CFR §156.115(a)(3) 45 CFR §146.136(c)(2) and (4) 89 FR 77737-77747	• Any quantitative or nonquantitative treatment limitations must comply with the federal Mental Health Parity and Addiction Equity Act.		

	MIA Bulletins 13-01 and 15-33	a. Professional services by licensed, registered, or certified professional mental health and substance use practitioners when acting within the scope of their license, registration, or certification, such as psychiatrists, psychologists, clinical social workers, licensed professional counselors, or marriage and family therapists.		
		1. Diagnosis and treatment of psychiatric conditions, mental illness, or mental disorders. Services include:		
		i. Diagnostic evaluation;		
		ii. Crisis intervention and stabilization for acute episodes;		
		iii. Medication evaluation and management (pharmacotherapy);		
		iv. Treatment and counseling (including individual or group therapy visits);		
		v. Diagnosis and treatment of alcoholism and drug abuse, including detoxification, treatment and counseling;		
		vi. Professional charges for intensive outpatient treatment in a provider's office or other professional setting.		
		2. Electroconvulsive therapy;		
		3. Inpatient professional fees;		
		4. Outpatient diagnostic tests provided and billed by a licensed, registered, or certified mental health and substance abuse practitioner;		
		5. Outpatient diagnostic tests provided and billed by a laboratory, hospital or other covered facility;		
		6. Psychological and neuropsychological testing necessary to determine the appropriate psychiatric treatment.		
		b. Inpatient hospital and inpatient residential treatment centers services, which includes		
		1. Room and board, such as:		

		i. Ward, semiprivate, or intensive care accommodations (Private room is covered only if medically necessary. If private room is not medically necessary, the contract may limit coverage only to the hospital's average charge for semiprivate accommodations.);		
		ii. General nursing care;		
		iii. Meals and special diets.		
		2. Other facility services and supplies-- Services provided by a hospital or residential treatment center (RTC).		
		c. Outpatient services, such as partial hospitalization or intensive day treatment programs. • Services may not be limited to those performed in an outpatient hospital setting		
		d. Emergency room – Outpatient services and supplies billed by a hospital for emergency room treatment.		
B34.	MIA Bulletins 13-01 and 15-33; 45 CFR §156.115(a)(6)	Pediatric vision benefits for children **until at least the end of the month in which the child turns 19 years of age** in accordance with the FEP Blue Vision high plan		
		a. One routine eye examination, including dilation if professionally indicated, each year;		
		b. One pair of prescription eyeglass lenses each year		
		c. One frame each year;		
		d. In lieu of eyeglasses, either one pair of contact lenses each year, or multiple pairs of disposable contact lenses each year; and		
		e. Low vision services, including one comprehensive low vision evaluation every 5 years, 4 follow-up visits in any 5-year period, and prescribed optical devices, such as high-power spectacles, magnifiers and telescopes.		

B35.	MIA Bulletins 13-01 15-33, and 22-17 45 CFR §156.115(a)(6)	Pediatric dental benefits for children **until at least the end of the month in which the child turns 19 years of age** in accordance with the Maryland Children's Health Insurance Plan dental benefit		
	CMS FAQ on Health Insurance Market Reforms and Marketplace Standards, May 26, 2016	• Waiting period may NOT be applied to orthodontia		
	MIA Bulletins 13-01 and 15-33	a. Periodic screening in accordance with the periodicity schedule developed by the American Academy of Pediatric Dentistry; and		
		b. Treatment of all dental services determined to be medically necessary for problems identified during screening or diagnostic evaluations. Benefits include diagnostic services, preventative services, restorative services, endodontic services, periodontic services, removable prosthodontics, maxillofacial prosthetics, fixed prosthodontics, oral and maxillofacial surgery, orthodontics for children with severe dysfunctional, handicapping malocclusion, and adjunctive general services.		
	§15-135.1	c. Preventive Care Frequency Intervals • Annual dental preventive care visit must be covered if provided at any time during the policy year – 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		
B36.	MIA Bulletins 13-01,15-33 and 22-17	Wellness benefits, which include a health risk assessment that is completed by each individual on a voluntary basis; and written feedback to the individual who completes a health risk assessment, with recommendations for lowering risks identified in the completed health risk assessment		

B37.	MIA Bulletins 13-01,15-33, and 22-17	Cardiac rehabilitation benefits for individuals who have been diagnosed with significant cardiac disease, or who have suffered a myocardial infarction, or have undergone invasive cardiac treatment immediately preceding referral for cardiac rehabilitation. Cardiac rehabilitation is a comprehensive program involving medical evaluation, prescribed exercise, cardiac risk factor modification, education and counseling.		
		a. Continuous EKG telemetric monitoring during exercise, EKG rhythm strip with interpretation, physician's revision of exercise prescription, and follow up examination for physician to adjust medication or change regimen; and		
		b. Increased outpatient rehabilitation services (physical therapy, speech therapy and occupational therapy) for cardiac rehabilitation of 90 visits per therapy, per contract year		
		c. Services may be limited to those provided at a place of service equipped and approved to provide cardiac rehabilitation		
B38.	MIA Bulletins 13-01,15-33, and 22-17	Pulmonary rehabilitation benefits (one (1) program per lifetime) for individuals who have been diagnosed with significant pulmonary disease • Services may be limited to those provided at a place of service equipped and approved to provide pulmonary rehabilitation		
B39.	MIA Bulletins 13-01 and 15-33	Delivery of benefits through patient centered medical homes for individuals with chronic conditions, serious illnesses or complex health care needs who agree to participate in a patient centered medical home program. This includes associated costs for coordination of care, such as		
		a. Liaison services between the individual and the health care provider, nurse coordinator, and the care coordination team;		
		b. Creation and supervision of a care plan;		
		c. Education of the individual and family regarding the individual's disease, treatment compliance and self-care techniques; and		

		d. Assistance with coordination of care, including arranging consultations with specialists and obtaining medically necessary supplies and services, including community resources.		
B40.	MIA Bulletin 15-33	Allergy serum		
B41.	MIA Bulletin 15-33	Birthing classes • May be limited to one (1) course per pregnancy		
B42.	§15-810	In-vitro fertilization		
	45 CFR §147.126	• $100,000 maximum lifetime benefit not permitted		
	§15-810(b) and (d)(3)	• Expanded to include coverage for married same-sex couples		
	§15-810(d)(2)	• May not require that the patient's oocytes be fertilized by the patient's spouse's sperm if the spouse is unable to produce and deliver functional sperm not resulting from vasectomy or voluntary sterilization		
	§15-810(d)(3)	• 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.		
B43.	§15-836	Hair prosthesis		
	45 CFR §147.126	• $350 limit not permitted		
B44.	45 CFR §156.115(d)	Routine non-pediatric dental services, routine non-pediatric eye exam services, long-term/custodial nursing home care benefits, or non-medically necessary orthodontia may not be included as essential health benefits.		

B45.	§31-116(a) Maryland Benchmark Plan, Section 1.3.A.1., page B-3, form MD/CFBC/SHOP/ BCOA/DOCS (1/14)	Prostate cancer screenings Medically recognized diagnostic examinations including prostate-specific antigen (PSA) tests and digital rectal exams: • For men who are between forty (40) and seventy-five (75) years of age; • When used for the purpose of guiding patient management in monitoring the response to prostate cancer treatment; • When used for staging in determining the need for a bone scan for patients with prostate cancer; or • When used for male patients who are at high risk for prostate cancer.		
B46.	§15-857, House Bill 937, Chpt, 56, Acts of 2022 (effective 01/01/2023)	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) House Bill 812, Chpt 249, Acts of 2023	Zero cost sharing (applies to in-network and out-of-network benefits)		
	§15-857(b)(2)	Term “abortion care” is required when describing coverage		
B47.	§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		

C. Cost-sharing requirements

	Citation	Description	"X" Means Applicable	Form/ Page
C1.	45 CFR §147.130, COMAR 31.11.06.03-1F	Preventive services provided in-network without cost-sharing		
C2.	§15-825(c)	May not apply a deductible, copayment or coinsurance to Prostate Cancer Screening.		
C3.		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 §15-1A-14(c)(3), SB217, Chpt. 118, Acts of 2024, effective 10/1/24	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 §15-1A-14(c)(3), SB217, Chpt. 118, Acts of 2024, effective 10/1/24	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		
C4.	45 CFR §149.130 86 FR 36974	Cost-sharing for air ambulance services.		
		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.		
C5.		Cost-sharing for home visits for mothers and newborns following childbirth		

	§15-812(g)(1)	• For other than High Deductible Health Plans, visits may not be subject to deductibles, copayments or coinsurance.		
	§15-812(g)(2)	• For High Deductible Health Plans, visits may not be subject to copays or coinsurance, but may be subject to deductible.		
C6.	§15-842	Copayment for prescription drug or device may not exceed the retail price of drug/device		
C7.	§15-852	Prorated daily copayment/coinsurance for partial supply of prescription drug dispensed by network pharmacy		
C8.	§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		
C9.	§15-847	Specialty drugs – copayment/coinsurance limits		
	§15-847(a)(5)(ii)	• Definition excludes drugs prescribed to treat diabetes, HIV, or AIDS		
C10.	§15-847.1	Prescription drugs prescribed to treat diabetes, HIV, or AIDs – copayment/coinsurance limits		
C11.	§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.		
C12.	§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		
C13.	§15-826.2(b)	Copayments, coinsurance, or deductibles may not be applied to male sterilization coverage.		
	§15-826.2(b)(3)	• Exception – For High Deductible Health Plans, deductible may be applied to male sterilization		

C14.	§15-814.1, HB1259, Chpt 868, Acts of 2024, effective 1/1/2025	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.		
C15.	§15-860(c), HB1259, Chpt 868, Acts of 2024, effective 1/1/2025	May not impose a copayment, coinsurance or deductible that is greater than the copay, coinsurance or deductible requirement for breast cancer screening and diagnosis for follow-up diagnostic lung cancer imaging for individuals for which lung cancer screening is recommended by the US Preventative Services Task Force • Exception – For High Deductible Health Plans, deductible may be applied to follow-up diagnostic lung cancer imaging		
C16.	§ 15-822(d)(3)	Copayments, coinsurance, or deductibles may not be applied to diabetes test strips.		
	§ 15-822(d)(3)(ii)	• Exception—For High Deductible Health Plans, diabetes test strips may not be subject to copayments or coinsurance, but may be subject to the deductible.		
C17.	§15-822.1, House Bill 1397, Chpt 405, Acts of 2022, effective 1/1/2023.	Copayment or coinsurance for insulin cannot be more than $30 for a 30-day supply, regardless of amount or type of insulin needed.		
C18.	§31-115(b)(9)(iii) 45 CFR §156.115(a)(3)	Cost sharing for mental health and substance use benefits must comply with the federal Mental Health Parity and Addiction Equity Act.		
	45 CFR §146.136(c)(2)(i) 89 FR 77737	a. May not apply any financial requirement in any benefit classification that is more restrictive than the predominant financial requirement of that type that applies to substantially all medical/surgical benefits in the same classification		
	45 CFR §146.136(c)(2)(ii) 89 FR 77737-44438	b. For purposes of determining mental health parity, classifications are (1) inpatient, in-network; (2) inpatient, out-of-network; (3) outpatient, in-network; (4) outpatient, out-of-network; (5) emergency care; and (6) prescription drugs		

	45 CFR §146.136(c)(3)(iii)	c. 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. Separate sub-classifications for generalists and specialists, are not permitted.		
	§27-913	• Multi-tiered prescription drug plan may not assign drug to more than 1 tier because such drug is based on the specific disease, diagnosis or indication being treated		
C19.	45 CFR §156.130(a)	Annual limitation on cost-sharing (deductibles, coinsurance, copayments)		
	CMS Guidance Dated October 8, 2024—Premium Adjustment Percentage, Maximum Annual Limitation on Cost Sharing	a. Self-only coverage – $10,150		
		b. Other than self-only coverage – $20,300		
	45 CFR § 156.130(c)	c. Out-of-network cost sharing is not required to count toward the limit.		
	80 FR 10825	d. 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.		
	45 CFR § 156.130(h);	e. Cost-sharing assistance provided by drug manufacturers for specific prescription drugs is permitted, but not required, to be counted toward the annual limitation on cost sharing.		
C20.	45 CFR §147.126	No lifetime or annual limits for essential health benefits		
C21.	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		

D. Permissible Exclusions (Benchmark Plan-MIA Bulletins 13-01, 15-33, 22-17)

	Citation	Description	"X" Means Applicable	Form/ Page
D1.	MIA Bulletins 13-01, 15-33 and 22-17 COMAR 31.11.06.06B	Except as provided in this Section D, may not include exclusions not found in COMAR 31.11.06.06B		
D2.	MIA Bulletins 13-01, 15-33 and 22-17	The exclusion for the purchase, examination and fitting of eyeglasses in COMAR 31.11.06.06B(6) is required to be revised to indicate that it does not apply to the pediatric vision benefit.		
D3.	MIA Bulletins 13-01, 15-33 and 22-17 COMAR 31.11.06.03-1	The exclusion for services for sterilization or reverse sterilization for a dependent minor in COMAR 31.11.06.06B(13) is required to be revised to indicate that it does not apply to FDA approved sterilization procedures for women with reproductive capacity as this is a required preventive benefit under the Affordable Care Act and COMAR 31.11.06.03-1.		
D4.	§15-139	The exclusion for Charges for telephone consultations in COMAR 31.11.06.06B(21) must be followed by “except a covered telehealth consultation” in order to comply with §15-139 as amended.		
D5.	MIA Bulletins 13-01, 15-33 and 22-17	The exclusion for travel found in COMAR 31.11.06.06B(24) is required to be modified to provide an exception for the cost of air transportation for the recipient and a companion (or two companions if recipient under age 18), to and from the site of a covered organ transplant.		
D6.	MIA Bulletins 13-01, 15-33 and 22-17	The exclusion for accidents occurring while and as a result of chewing in COMAR 31.11.06.06B(28) is required to be revised to indicate that it does not apply to the pediatric dental benefit.		

D7.	MIA Bulletins 13-01, 15-33 and 22-17	The exclusion for treatment leading to or in connection with transsexualism, or sex changes or modifications, including but not limited to surgery in COMAR 31.11.06.06B(32) is required to be deleted. Federal guidance has determined that this type of exclusion is a discriminatory benefit design and is prohibited.		
D8.	MIA Bulletins 13-01, 15-33 and 22-17	The exclusion for organ transplants not otherwise listed in COMAR 31.11.06.03 in COMAR 31.11.06.06B(35) is required to be deleted. This exclusion contradicts the additional organ transplant benefit in the Benchmark plan.		
D9.	MIA Bulletins 13-01, 15-33 and 22-17	The limitation found in COMAR 31.11.06.06B(50) requiring that all mental health and substance use services be provided through the carrier's managed care system is required to be deleted, as it violates the federal Mental Health Parity and Equity Addiction Act.		
D10.	MIA Bulletins 13-01, 15-33 and 22-17 COMAR 31.11.06.03-1	The exclusion for tobacco cessation in COMAR 31.11.06.06B(51) will not be permitted, as it contradicts the tobacco cessation preventive service benefits required by the Affordable Care Act and COMAR 31.11.06.03-1.		
D11.	MIA Bulletins 13-01, 15-33 and 22-17	The exclusion for in vitro fertilization in COMAR 31.11.06.06B(11), will not be permitted as in vitro fertilization is an essential health benefit in the individual market.		
D12.	MIA Bulletins 13-01, 15-33 and 22-17	The exclusion for wigs or cranial prosthesis in COMAR 31.11.06.06B(39) is required to be revised to indicate that it does not apply to hair prostheses for covered persons whose hair loss results from chemotherapy or radiation treatment for cancer as this is an essential health benefit in the individual market.		
D13.	§15-139	The exclusion for telephone therapy for mental health and substance use benefits in the benchmark plan and MIA Bulletins 13-01 and 15-33 is prohibited.		
D14.	MIA Bulletins 13-01, 15-33 and 22-17	Additional permissible exclusions for the mental health and substance use benefit		
		a. Services by pastoral or marital counselors		
		b. Therapy for sexual problems		
		c. Treatment for learning disabilities and intellectual disabilities		
		d. Travel time to the member's home to conduct therapy		

		e. Services rendered or billed by schools, or halfway houses or members of their staffs		
		f. Marriage counseling		
		g. Services that are not medically necessary		
D15.	MIA Bulletins 13-01, 15-33 and 22-17	Additional permissible exclusion for cardiac and pulmonary rehabilitation benefits • Benefits will not be provided for maintenance programs. Maintenance programs consist of activities that preserve the individual's present level of function and prevent regression of that function. Maintenance begins when the therapeutic goals of a treatment plan have been achieved, or when no additional progress is apparent or expected to occur.		
D16.	MIA Bulletins 13-01, 15-33 and 22-17 FEP Blue Vision plan	Additional permissible exclusions for pediatric vision services		
		a. Services and materials not meeting accepted standards of optometric practice		
		b. Services and materials resulting from the covered person's failure to comply with professionally prescribed treatment		
		c. Charges for office infection control		
		d. Charges associated with copies of records/charts		
		e. Visual therapy		
		f. Special lens designs or coatings other than those specified in the covered services		
		g. Replacement of lost/stolen eyewear		
		h. Non-prescription (Plano) lenses		
		i. Two pairs of eyeglasses in lieu of bifocals		
		j. Insurance of contact lenses		
D17.	MIA Bulletins 13-01, 15-33 and 22-17 MCHIP dental benefit	Additional permissible exclusions for pediatric dental benefits		
		a. Charges for some or multiple radiographs of the same tooth or area if redundant, excessive, or not in keeping with federal guidelines relating to radiation exposure.		
		b. Individual radiographs taken on the same day limited to the allowed charge for a full mouth series.		

		c. Lower lingual holding arch placed where there is not premature loss of the primary molar.		
		d. Crowns placed within 30 days of the date of service of a root canal or restoration on the same tooth.		
		e. Restorations placed in a tooth within 36 months of the initial similar restoration on the same tooth.		
D18.	MIA Bulletins 13-01, 15-33 and 22-17 §15-110(d)	Required Exclusion for Prohibited Health Care Practitioner Referrals		

E. Required Provisions

	Citation	Description	"X" Means Applicable	Form/ Page
E1.	§15-401	Newborn/Adopted Child/Grandchildren/Guardianship		
E2.	§15-402	Incapacitated Children		
E3.	§15-403.2 COMAR 31.10.35	Domestic Partner Coverage, including Child Dependents of Domestic Partner		
E4.	45 CFR §147.120 §15-1A-08	Child Dependent Coverage to age 26		
E5.	§15-403 §15-403.1 §15-418	Grandchildren and Children under Guardianship		
E6.	§15-417	Part-Time Students with Disabilities (if student status required in order to be eligible beyond the age of 26)		
E7.	§15-833	Extension of Benefits		
E8.	§15-122	45 Day Notice of Premium Increase		
E9.	§15-139	Coverage for Services Delivered through Telehealth		
	§15-139(a)(2) Senate Bill 534, Chpt 382, Acts of 2023, effective 6/1/2023	a. Definition of "telehealth:" • Revised to include, from July 1, 2021 to June 30, 2025, both inclusive, 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 NOT include, except as provided above, audio-only telephone conversation between a health care provider and a patient.		

	Citation	Description	"X" Means Applicable	Form/ Page
	§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 b be provided by a third-party vendor designated by the carrier.		

F. Required Standard Provisions

	Citation	Description	"X" Means Applicable	Form/ Page
F1.	COMAR 31.11.10.04A	Required Standard Provisions		
F2.	COMAR 31.11.10.04A	Entire Contract		
F3.	COMAR 31.11.10.04B	Contestability of Coverage		
F4.	COMAR 31.11.10.04C	Notice of Claim		
F5.	COMAR 31.11.10.04D	Claims Forms		
F6.	COMAR 31.11.10.04E	Proofs of Loss		
	§12-102(c)(2)	• Enrollee must be permitted a minimum of 1 year after the date of service to submit a claim • Enrollee's legal incapacity shall suspend the time to submit a claim • If not reasonably possible to submit claim within one year, time period extended to two years after date of service		
	§15-1011	a. Methods for Claim Submission		
	§15-1005(e)	b. Provider must be permitted minimum of 180 days to file claim		
F7.	COMAR 31.11.10.04F	Time Payment of Claims		

	Citation	Description	"X" Means Applicable	Form/ Page
F8.	COMAR 31.11.10.04G	Payment of Claims		
F9.	COMAR 31.11.10.04H	Legal Action		
F10.	COMAR 31.11.10.04-I	Grace Period		
F11.	COMAR 31.11.10.04J	Certificates		
F12.	COMAR 31.11.10.04K	Addition of Students		
F13.	COMAR 31.11.10.04L	Misstatement of Age		
F14.	COMAR 31.11.10.04N	Premium Due Date		

G. Optional Standard Provisions

	Citation	Description	"X" Means Applicable	Form/ Page
G1.	COMAR 31.11.10.07A	Misstatement of Age Physical Examination		
G2.	COMAR 31.11.10.07B	Unpaid Premiums Autopsy		
G3.	COMAR 31.11.10.07C	Arbitration		

H. Prohibited Provisions

	Citation	Description	"X" Means Applicable	Form/ Page
H1.	COMAR 31.04.17.07	Advertising in forms		
H2.	§15-126	May Not Discourage or Prohibit Access to the 911 Emergency System		
H3.	§15-711(b)	Physical Therapist Time Limitations		
H4.	COMAR 31.04.17.13B	Natural Death Benefit		
H5.	COMAR 31.10.01.03-I	Frequency of Physician Visits		
H6.	COMAR 31.10.01.03P	Reimbursement Language		
H7.	COMAR 31.10.01.03Q	Strict Compliance Language		
H8.	§27-913	Benefits for Treatment of a Specified Disease or Diagnosis May Not be Subject to Different Copays, Coinsurance, Deductibles, Annual or Lifetime Maximums		
H9.	§15-1009	Denial of Reimbursement for Pre-authorized Care Prohibited Except for Limited Reasons		
H10.	§27-303; MIA Bulletin L&H 99-25	Denial of Medically Necessary Inpatient Ancillary Charges		

H11.	§15-104	Coordination of Benefits • May not coordinate against guaranteed renewable individual intensive care or specified disease policies • May not provide benefits that are secondary to benefits payable under Personal Injury Protection (PIP)		
H12.	§15-701 COMAR 31.11.06.03F; COMAR 31.11.06.09A	May not exclude benefits for covered services provided by licensed health care practitioners		
H13.	§15-510	May not deny behavioral counseling services provided by participating provider solely on the basis that service is school-based		

I. Other

	Citation	Description	"X" Means Applicable	Form/ Page
I1.	§15-602	State Hospitals, etc., Charitable or Otherwise		
I2.	§15-604	Payment of Hospitals Based on Rate Set by Health Services Cost Review Commission		
I3.	§15-505	House Confinement, Medical Treatment Permitted Elsewhere		
I4.	§15-502	No Reduction for Medical Assistance Program		
I5.	§15-603	Reimbursement for Services Paid for or Provided by Maryland Department of Health		
I6.	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.		
I7.	§15-138	Reimbursement of Ambulance Service Providers		
	45 CFR §149.130 86 FR 36974	• 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.		
I8.	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.		

I9.	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		
I10.		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)		
	§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)		
I11.	COMAR 31.10.01.03C	Standard of Time		
I12.	COMAR 31.10.01.03G	Right to Elect Alternative Benefits		
I13.	§12-209(1) §12-209(2) §12-209(4)	Contract Governed by Maryland Law and Maryland Courts		
I14.	§15-919	Medicare Supplement Disclaimers for Individuals eligible for Medicare Due to Age		
I15.	§15-304	Direct Payment of Hospital or Medical Services		
I16.	§15-1005(g)	Payment of Interest on Unpaid Claims		
I17.	COMAR 31.15.08	Payment of Claims, Unfair Trade Practices		
I18.	§15-1309	Carrier may only terminate coverage: • When individual is no longer eligible for coverage • For non-payment of required premiums • Where the individual has made an intentional misrepresentation of material fact under terms of the coverage • Where the individual is no longer a student, provided that the coverage is terminated under this provision uniformly without regard to any health status-related factor of covered individuals.		
I19.	§27-216 MIA Bulletin 17-10	Requirements of Acceptance of Credit Cards for Premium Payment and Charging of Fees for Use of Credit Cards.		
I20.	45 CFR §146.121(f) §15-1A-02(a)(2)(iv) §15-509	Requirements for Wellness Programs		

I21.	Title 15, Subtitle 10D	Complaint process for coverage decisions		
I22.	Title 15, Subtitle 17	Physician Rating System		
I23	45 CFR §149.420(b) 86 FR 36982	Items in C21 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.		
I24.	§42 USC 300gg-115(b) §42 USC 300gg-139(b)	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: 1. 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.		
		2. 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.		
		3. The enrollee will not be liable for an amount that exceeds the cost-sharing that would have applied to the enrollee if the provider was an in-network provider.		
I25.	42 USC 300gg-113(a) 42 USC 300gg-138	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		

J. Preferred Provider Benefits

	Citation	Description	"X" Means Applicable	Form/ Page
J1.	§15-118(c)	Coinsurance amounts for preferred provider must be based on negotiated fees with insurer		
J2.	§14-205(b)(2)	Coinsurance Differential – Difference between coinsurance percentage for non-preferred and preferred providers may not exceed 20 percentage points		
J3.	§14-205(b)(4)	Allowed Amounts – The allowed amount paid to non-preferred providers for a health care service covered under 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.		
J4.	§14-205(b)(3)	Balance Billing – Any contract provisions requiring 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.		
J5.	§15-830(d)	Right to Request Referral to Specialist Not on Carrier's Provider Panel		

J6.	§15-830(e)(2) Senate Bill 707, Chpt 272, Acts of 2022, effective 7/1/2022	Balance billing is prohibited for services received from a referral to a non-panel specialists and non-physician specialists as result of referral described in (d) for mental health or substance use disorders.		
J7.		Gatekeeper-Type PPO		
	45 CFR §147.138(a)(3); §15-1A-13	a. 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		
	§15-830(b)	b. Right to Standing Referral to Network Specialist		
	42 USC § 300gg-19a; 45 CFR §147.138(a); MIA Bulletin 10-23; §15-1A-13	c. Right to choose any provider in network as PCP and for children, right to select allopathic or osteopathic pediatrician in network		
J8.	§14-205.2	Assignment of benefits for on-call and hospital-based physicians payment rules		
J9.	§14-205.3	Assignment of benefits for physicians other than on-call and hospital based physicians payment rules		
J10.	§15-112(q)	Identify office and process for filing complaints		
J11.	§15-140	Receiving carrier requirements for members transitioning to carrier's plan		
J12.	§14-205.1	Exclusive Provider Benefit		
	§14-205.1(a)	1. 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)	• Unforeseen illness, injury, or condition requiring immediate care		

	§14-205.1(a)(3)	• Referrals to Specialists as required by §15-830		
		2. EPO is sole delivery system offered to individual student		
	§14-205.1(b)(1)	• Policyholder must be offered mandatory out-of-network option for students to accept or reject		

K. Utilization Review

	Citation	Description	"X" Means Applicable	Form/ Page
K1.	Federal Mental Health Parity and Addiction Equity Act §31-115(b)(9)(iii) 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.		
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.	§15-850	May not require prior authorization for a covered opioid antagonist unless at least one formulation of the opioid antagonist is covered without a prior authorization requirement		
K4.	§15-851	May not require prior authorization for a prescription drug containing methadone, buprenorphine, or naltrexone when the drug is used for treatment of an opioid use disorder		
K5.	§15-854	Limits on Prior Authorization Requirements for certain prescription drugs- • A prior authorization issued by the carrier under the member's prior health plan coverage must be honored for a covered prescription drug when the member changes to a new health plan issued by the same carrier. • A prior authorization for a covered prescription drug (except for an opioid) must be honored when the dosage changes if the change is consistent with FDA labeled dosages.		

	§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.		
K6.	§15-854.1, Senate Bill 791, Chpt. 848, Acts of 2024 (effective 1/1/25)	Prior Authorization for a Course of Treatment		
K7.		Initial authorization of course of treatment made:		
	§ 15-10B-06(a)(1)(i), Senate Bill 791, Chpt. 848, Acts of 2024 (effective 1/1/25)	a. For non-emergencies, within 2 working days of receipt of information necessary to make determination		
	§15-10B-06(a)(1)(ii)	b. For extended stays or additional health care services, within 1 working day of receipt of necessary information		
	§ 15-10B-06(a)(1)(iii), Senate Bill 791, Chpt. 848, Acts of 2024 (effective 1/1/25)	c. For additional visits or days of care as part of existing treatment, within 1 working day of receipt of necessary information		
	§15-10B-06(b) Senate Bill 791, Chpt. 848, Acts of 2024 (effective 1/1/25)	d. For emergency inpatient or residential crisis services admissions for the treatment of a mental, emotional, or substance abuse disorder, within 2 hours of receipt of the necessary information		
	§15-10B-06(c) Senate Bill 791, Chpt. 848, Acts of 2024 (effective 1/1/25)	e. For a step-therapy exception request submitted electronically, in real time if no additional information is needed and the request meets the criteria for approval. If a request is not approved as noted above, then within 1 business day after all information necessary to make a decision is received.		
K8.	§15-10B-06(a)(2) Senate Bill 791, Chpt. 848, Acts of 2024 (effective 1/1/25)	PRA must inform health care provider that additional information is needed to make determination within 3 calendar days after initial request		

K9.	§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.		
K10.	§15-10B-07(c)	May not retroactively deny approval of preauthorized services		
K11.	§ 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		
K12.	§ 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		
K13.	§ 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 issue adverse decision as to admission during first 24 hours after voluntary inpatient admission or 72 hours after involuntary admission		
K14.	§15-10B-05(a)(4)	Utilization review agent must be reasonably available 7 days a week, 24 hours a day		
K15.	§15-10A-02(k)	Grievance Procedure Not Included. Please advise where grievance information is provided		
K16.	§15-1001 Title 15, Subtitle 10B COMAR 31.10.18	Company not certified as Private Review Agent in Maryland		
	§15-1001 Title 15, Subtitle 10B COMAR 31.10.18 §15-10A-02	Identify Company's PRA for making utilization review determinations of what health care service is medically necessary, experimental or investigative, or cosmetic.		
K17.	§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.		

K18.	§15-857 House Bill 970, Chpt 684, Acts of 2022, effective 1/1/2023	Prior authorization for post exposure prophylaxis for the prevention of HIV is prohibited.		

L. Applications

	Citation	Description	"X" Means Applicable	Form/ Page
L1.	§27-805 MIA Bulletin 12-07	Insurance Fraud-Required Disclosure Statement		
L2.	45 CFR §147.104(a)	May not ask questions related to health status or health history		
L3.	§27-909(c)	May Not Inquire About Genetic Tests or Genetic Information		
L4.	COMAR 31.04.17.06I(1)	Check-off boxes required for carrier name if application is to be used by more than one carrier		
L5.	COMAR 31.04.17.06J	If application is to be completed by more than one individual, application signature box must clearly indicate that signature applies only to portion of application completed by that individual		
L6.	COMAR 31.04.17.06A	Application shall stipulate the plan and amount of insurance and any added optional benefits applied for		
L7.	COMAR 31.04.17.06B	Certain States		
L8.	COMAR 31.04.17.08	Proxy not permitted		
L9.	§14-205.1(b)(2)	EPO option disclosure statement for out-of-network option offered if EPO is sole delivery system		
L10.	§27-504	Domestic Violence		
L11.	§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		
L12.	§27-216 MIA Bulletin 17-10	Requirements for Acceptance of Credit Cards for Premium Payment and Charging of Fees for Use of Credit Cards		
L13.	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		

	Citation	Description	"X" Means Applicable	Form/ Page
L14.	COMAR 31.04.17.06C	Questions about “hazardous activities” must list activities considered to be “hazardous”		
L15.	COMAR 31.04.17.06D	Questions about the use of “habit-forming drugs” must list specific drugs considered to be “habit-forming”		
L16.	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”		
L17.	COMAR 31.04.17.10B	Good health warranty not permitted		