NONPROFIT HEALTH SERVICE PLAN—GROUP STAND-ALONE DENTAL COVERAGE OFFERED THROUGH THE SHOP EXCHANGE OR CERTIFIED TO BE SOLD OUTSIDE THE EXCHANGE with POLICY YEARS THAT BEGIN ON OR AFTER JANUARY 1, 2024

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.	45 CFR §156.150(b)	Certification of the actuarial value of coverage for the pediatric dental EHBs by a member of the American Academy of Actuaries using generally accepted actuarial principles		
A2.	45 CFR §156.150(a)(1) and (2) 2024 CMS Letter to Issuers dated May 1, 2023	2023 Annual limitation on cost-sharing for essential pediatric dental benefits (such annual limit is calculated without regard to EHBs provided by the QHP and without regard to out-of-network services) • $400 - one child • $800 - 2 or more children (in aggregate)		
	45 CFR§155.20	Cost-sharing defined as any expenditure required by or on behalf of an enrollee with respect to essential pediatric dental benefits; such term includes deductibles, coinsurance, copayments, or similar charges		
A3.	MIA Bulletin 23-2	Separate schedule of benefit form for each plan design with specific combination of benefits and cost-sharing		
A4.	COMAR 31.04.17.04A(2)	Form contains text in brackets, denoting variability. Only specific items allowed for variability. Submit specific description of how each bracketed item will vary. If other items are desired, include the item		
A5.	COMAR 31.10.01.03A	Premium Rates and Actuarial Memorandum		

	Citation	Description	"X" Means Applicable	Form/ Page
A6.	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.		
A7.	COMAR 31.04.17.03D	Form Number		
A8.	COMAR 31.04.17.03G	Corporate Name		
A9.	COMAR 31.04.17.03H	Unacceptable Modifications		
A10.	COMAR 31.04.17.03K	Specimen Data		
A11.	COMAR 31.04.17.03M	Signature of Officer		
A12.	COMAR 31.04.17.07	Advertising Prohibited		
A13.	COMAR 31.10.02.02A(4)	Size of Type		
A14.	COMAR 31.10.02	Simplified Language		
A15.	§14-103	Disclosure of Not-for-Profit Status		
A16.	§2-112(a)(10)	Filing Fees Insufficient		
A17.	COMAR 31.04.17.04B	Contracts Comprised of Insert Pages		
A18.	COMAR 31.04.17.04C	Contracts Comprised of Sections		

B. Essential Pediatric Dental Benefits (Benchmark Plan-MCHIP dental benefit)

	Citation	Description	"X" Means Applicable	Form/ Page
B1.	45 CFR § 156.115(a)(6)	Coverage **provided until at least the end of the month** in which the child turns 19 years of age		
B2.	MIA Bulletins 13-01 and 15-33	Periodic screening in accordance with the periodicity schedule developed by the American Academy of Pediatric Dentistry		
B3.	MIA Bulletins 13-01 and 15-33	Diagnostic services included in the Maryland Children's Health Insurance Plan (MCHIP) dental benefit		
B4.	MIA Bulletins 13-01 and 15-33	Preventive services included in the MCHIP dental benefit		
	§15-135.1	• Annual dental preventive care visit must be covered if provided at any time during the plan year – may not require visit to occur after a specified time period (e.g. 12 months) following prior visit		

	Citation	Description	"X" Means Applicable	Form/ Page
		• If the contract provides benefits for dental preventive care more often than once per plan year, the contract may not require that the visits be separated by more than 120 days		
B5.	MIA Bulletins 13-01 and 15-33	Restorative services included in the MCHIP dental benefit		
B6.	MIA Bulletins 13-01 and 15-33	Endodontic services included in the MCHIP dental benefit		
B7.	MIA Bulletins 13-01 and 15-33	Periodontic services included in the MCHIP dental benefit		
B8.	MIA Bulletins 13-01 and 15-33	Removable prosthodontics services included in the MCHIP dental benefit		
B9.	MIA Bulletins 13-01 and 15-33	Maxillofacial prosthetics included in the MCHIP dental benefit (codes D5992 and D 5993)		
B10.	MIA Bulletins 13-01 and 15-33	Fixed prosthodontic services included in the MCHIP dental benefit-(D6930-recement fixed partial denture)		
B11.	MIA Bulletins 13-01 and 15-33	Oral and Maxillofacial Surgery included in the MCHIP dental benefit		
B12.	MIA Bulletins 13-01 and 15-33	Orthodontics included in the MCHIP dental benefit - only for children with severe, dysfunctional, handicapping malocclusion		
	CMS FAQ on Health Insurance Market Reforms and Marketplace Standards, May 26, 2016	• Waiting period may NOT be applied		
B13.	MIA Bulletins 13-01 and 15-33	Adjunctive general dental services included in the MCHIP dental benefit		
B14.	45 CFR §155.1065(a)(2)	No lifetime or annual limits permitted for essential pediatric dental benefits		
B15.	Sec. 1311(d)(2)(B)(ii) of the ACA	Essential pediatric dental benefit must be included in all contracts sold on the Exchange, including contracts issued only to adults		

C. Stand-alone Dental Plan Standards 45 CFR §155.1065(a)(3). Applicable to Qualified Dental Plans sold on the Exchange (§31-101(q)), but not to Exchange Certified Stand-Alone Dental Plans sold outside the Exchange (§31-116(f)(1)(ii))

	Citation	Description	"X" Means Applicable	Form/ Page
C1.	45 CFR §155.706(b)(6) 45 CFR §156.210(a)	Premium rates for the employer must be set for the entire plan year		
C2.	45 CFR §155.20	Plan year defined as a consecutive 12 month period during which the carrier provides coverage for dental benefits		
C3.	45 CFR §155.706(b)(10) §156.286(d);	Minimum employee participation rate may not be applied to the rate of participation in the particular qualified dental plan		
C4.	45 CFR 155.710(b) §31-101(r)	Qualified employer definition		
C5.	§31-101(aa)	Small employer definition		

D. Open Enrollment and Special Enrollment Periods 45 CFR §156.286(b). Applicable to Qualified Dental Plans sold on the Exchange (§31-101(q)), but not to Exchange Certified Stand-Alone Dental Plans sold outside the Exchange (§31-116(f)(1)(ii))

	Citation	Description	"X" Means Applicable	Form/ Page
D1.	45 CFR §156.286(b) 45 CFR §155.726(c)(2)(i)	Special enrollment period of 30 days for certain "triggering events"		
	45 CFR §155.420 (d)(1)(i)	a. Eligible employee or dependent loses minimum essential coverage		
	45 CFR §155.420(e)	• Does not include loss of coverage due to voluntary termination, failure to pay premiums on a timely basis, including COBRA premiums or loss due to a rescission authorized under 45 CFR §147.128		
	45 CFR §155.420(d)(1)(iii)	b. Loss of pregnancy related coverage under section 1902(a)(10)(A)(i)(IV) and (a)(10)(A)(ii)(IX) of the Social Security Act (Medicaid) or loses access to health care services through coverage provided to a pregnant woman's unborn child		
	45 CFR §155.420(d)(1)(iv)	c. Loss of medically needy coverage as described under section 1902(a)(10)(C) of the Social Security Act		

	45 CFR §155.420(d)(2)(i)	d. Individual gains a dependent or becomes a dependent through marriage, birth, adoption, placement for adoption, or placement in foster care or through a child support order or other court order		
	45 CFR §155.420(d)(2)(ii)	e. The enrollee loses a dependent or is no longer considered a dependent through divorce or legal separation as defined by State law in the State in which the divorce or legal separation occurs, or if the enrollee, or his or her dependent, dies		
	45 CFR §155.420(d)(4)	f. The eligible employee's or dependent's enrollment or non-enrollment is unintentional, inadvertent or erroneous and is the result of an error, misrepresentation, misconduct, or inaction of an officer, employee, or agent of the Exchange or HHS, its instrumentalities, or a non-Exchange entity providing enrollment assistance or conducting enrollment activities.		
	45 CFR §155.420(d)(5)	g. Eligible employee or dependent enrolled in the SHOP exchange demonstrates to the Exchange that the qualified plan substantially violated a material provision of its contract in relation to the eligible employee or dependent		
	45 CFR §155.420(d)(7)	h. Eligible employee or dependent gains access to new plans due to a permanent move and had minimum essential coverage for one or more days during the 60 days preceding the move		
	45 CFR §155.420(a)(5)	• Employee/dependent may satisfy prior coverage requirement by demonstrating that they: ○ Had minimum essential coverage; ○ Had pregnancy related coverage or access to healthcare services through unborn child coverage described in 45 CFR § 155.420(d)(1)(iii) ○ Had medically needy coverage described in 45 CFR § 155.420(d)(7) ○ Are an Indian; ○ Lived in a foreign country or in a United States territory for one or more days during the 60 days preceding the move; or		

		○ For 1 or more days during the 60 days preceding the move or during their most recent preceding open enrollment period or special enrollment period, lived in a service area where no QHP was available through the Exchange		
	45 CFR §155.420(d)(9)	i. Eligible employee or dependent enrolled in the SHOP Exchange demonstrates to the Exchange, in accordance with HHS guidelines, that the eligible employee or dependent meets other exceptional circumstances		
	45 CFR § 155.420(d)(10)	j. Eligible employee is a victim of domestic abuse or spousal abandonment, including a dependent within a household, is enrolled in minimum essential coverage and seeks to enroll in coverage separate from the perpetrator of the abuse or abandonment; or is a dependent of a victim of domestic abuse or spousal abandonment, on the same application as the victim, and seeks to enroll in coverage at the same time as the victim		
	45 CFR § 155.420(d)(11)	k. Eligible employee or dependent applies for coverage on the Individual Exchange during the annual open enrollment period or due to a qualifying event, is assessed by the Exchange as potentially eligible for Medicaid or the Children's Health Insurance Program (CHIP), and is determined ineligible for Medicaid or CHIP by the State Medicaid or CHIP agency either after open enrollment has ended or more than 60 days after the qualifying event OR applies for coverage at the State Medicaid or CHIP agency during the annual open enrollment period, and is determined ineligible for Medicaid or CHIP after open enrollment has ended		
	45 CFR § 155.420(d)(12)	l. The eligible employee, or his or her dependent, adequately demonstrates to the Exchange that a material error related to plan benefits, service area, or premium influenced the eligible employee's decision to purchase a QHP through the Exchange		
D2.	45 CFR §155.420(d)(8)	Eligible employees who gain or maintain status as Indians may enroll in or change to any dental plan on the Exchange once per month		

	45 CFR §155.420(d)(8)(ii)	• Individual who is or becomes a dependent of an Indian, and is enrolled or is in enrolling in a plan on the same application as the Indian, may change plans one time per month at the same time as the Indian		
D3.	45 CFR §155.726(c)(3)(ii)	Special enrollment period of 60 days		
	45 CFR §155.726(c)(2)(ii)	• Loss of eligibility for coverage under a Medicaid plan or CHIP plan		
	45 CFR §155.726(c)(2)(iii)	• Becomes eligible for assistance, with respect to coverage under the SHOP Exchange, under such Medicaid or CHIP plan		
D4.	45 CFR §155.420(b)	Effective dates of coverage for individuals who enroll during a special enrollment period		
	45 CFR §155.420(b)(2)(iv)	a. In the case of loss of minimum essential coverage, loss of pregnancy related coverage, loss of unborn child coverage, loss of medical needy coverage, or gaining access to new plans due to a permanent move, the effective date is based on date of plan selection—if plan selection is made on or before the date of the triggering event, new coverage becomes effective the first day of the month following the triggering event. If plan selection occurs after the date of the triggering event, the first day of the following month when a selection is made between the 1st and 15th* day of any month; and the first day of the second following month when a selection is made between the 16th and the last day of any month. If plan selection is made on or before the last day of the month preceding the triggering event, coverage becomes effective the first of the month in which the triggering event occurs.		
	45 CFR §155.420(b)(2)(i) §15-401(b)(2)	b. In the case of birth, adoption, or placement for adoption, the date of birth, adoption, or placement for adoption		
	45 CFR § 155.420(b)(2)(i)	c. In the case of placement in foster care or a court order, the date of placement in foster care or the effective date of the court order or if permitted by the Exchange the individual may elect a coverage effective date of the first day of the month following plan selection or in accordance with 45 CFR §155.420(b)(1)		
	45 CFR § 155.420(b)(2)(ii)	d. In the case of marriage, the first day of the month following plan selection		

	45 CFR § 155.420(b)(2)(iii)	e. In the case of an individual eligible for special enrollment when: • enrollment or non-enrollment was unintentional, inadvertent or erroneous and the result of an error misrepresentation, misconduct, or inaction of an officer, employee, or agent of the Exchange or HHS, its instrumentalities, or a non-Exchange entity providing enrollment assistance or conducting enrollment activities; • the qualified plan substantially violated a material provision of its contract with the individual; • the individual meets other exceptional circumstances; • individual applies for coverage on the Exchange during the annual open enrollment period or due to a qualifying event, is assessed by the Exchange as potentially eligible for Medicaid or the Children's Health Insurance Program (CHIP), and is determined ineligible for Medicaid or CHIP by the State Medicaid or CHIP agency either after open enrollment has ended or more than 60 days after the qualifying event OR applies for coverage at the State Medicaid or CHIP agency during the annual open enrollment period, and is determined ineligible for Medicaid or CHIP after open enrollment has ended; or • the individual adequately demonstrates to the Exchange that a material error related to plan benefits, service area, or premium influenced the individual's decision to purchase a QHP through the Exchange The effective date is an appropriate date based on the specific circumstances and is determined by the Exchange.		
	45 CFR § 155.420(b)(2)(v)	f. In the case of an enrollee or dependent who dies, the first day of the month following the plan selection, or if permitted by the Exchange the individual may elect a coverage effective date of the first day of the following month when a selection is received between the 1st and 15th day of any month; and the first day of the second following month when a selection is received between the 16th and the last day of any month.		

	45 CFR §155.420(b)(1)	g. For all other triggering events: the first day of the following month when a selection is received by the Exchange between the 1st and 15th day of any month; and the first day of the second following month when a selection is received by the Exchange between the 16th and the last day of any month		

E. Required Standard Provisions

	Citation	Description	"X" Means Applicable	Form/ Page
E1.	COMAR 31.11.10.04A	Entire Contract; Changes		
E2.	COMAR 31.11.10.04B	Contestability of the Contract		
E3.	COMAR 31.11.10.04C	Notice of Claim		
E4.	COMAR 31.11.10.04D	Claims Forms		
E5.	COMAR 31.11.10.04E	Proofs of Loss		
	§15-1005(e)	• Provider must be permitted minimum of 180 days to file claim		
E6.	COMAR 31.11.10.04F	Time Payment of Claims		
E7.	COMAR 31.11.10.04G	Payment of Claims		
E8.	COMAR 31.11.10.04H	Legal Action		
E9.	COMAR 31.11.10.04I	Grace Period		
E10.	COMAR 31.11.10.04J	Certificates		
E11.	COMAR 31.11.10.04K	Addition of Employees/Members		
E12.	COMAR 31.11.10.04L	Misstatement of Age		
E13.	COMAR 31.11.10.04N	Premium Due Date		

F. Optional Standard Provisions

	Citation	Description	"X" Means Applicable	Form/ Page
F1.	COMAR 31.11.10.07A	Physical Examination		
F2.	COMAR 31.11.10.07B	Autopsy		
F3.	COMAR 31.11.10.07C	Arbitration		

G. Other

	Citation	Description	"X" Means Applicable	Form/ Page
G1.	§15-402	Incapacitated Child		
G2.	§15-401 §15-403 §15-403.1	Newborn/Adopted Children/ Grandchildren/ Guardianship (*expense-incurred contracts only*)		
G3.	§15-405	Court Ordered Coverage of Children		
G4.	§15-833(j)	Extension of Benefits		
G5.	§15-135.1	Benefits for Adult Dental Preventive Care • Annual dental preventive care visit must be covered if provided at any time during the plan 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 often than once per plan year, the contract may not require that the visits be separated by more than 120 days		
G6.		Preferred Provider Contracts		
	§14-205(b)(2)	a. Coinsurance Differential – Difference between coinsurance percentage for non-preferred and preferred providers may not exceed 20 percentage points		
	§15-118(c)	b. Coinsurance amounts for preferred provider must be based on negotiated fees with insurer		
	§14-205(b)(4)	c. 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		
	§15-830(b)	d. Right to Standing Referral to Network Specialist (*gatekeeper plans only*)		
	§15-830(d)	e. Right to Request Referral to Specialist Not on Carrier's Provider Panel • Referral must be granted if the carrier cannot provide reasonable access to a specialist without unreasonable travel or delay		
	§15-112(q)	f. Office to file complaints		

	Citation	Description	"X" Means Applicable	Form/ Page
	§15-140(d)	g. Receiving carrier requirements for members transitioning to carrier's plan		
		h. Exclusive Provider Benefit – May not restrict payment for certain covered services provided by non-preferred providers:		
	§14-205.1(a)(2)	• For an unforeseen illness, injury or condition requiring immediate care		
	§14-205.1(a)(3)	• As required under §15-830		
G7.	COMAR 31.10.01.03C	Standard of Time		
G8.	§15-122	Must give at least 45 days notice of premium increase at renewal		
G9.	§15-701	Health Care Providers		
G10.	§15-1005(g)	Payment of Interest on Unpaid Claims		
G11.	§15-603	Reimbursement for Services Paid for or Provided by Maryland Department of Health		
G12.	Title 15, Subtitle 10D	Complaint process for coverage decisions		
G13.	§15-110(d)	Required Exclusion for Prohibited Health Care Practitioner Referrals		

H. Prohibited Provisions, Limitations and Exclusions

	Citation	Description	"X" Means Applicable	Form/ Page
H1.	COMAR 31.10.01.03P	Reimbursement Language		
H2.	COMAR 31.10.01.03Q	Strict Compliance Language		
H3.	§15-1009	Denial of Reimbursement for Pre-authorized Care Prohibited Except for Limited Reasons		
H4.	§15-502	Reduction for Medical Assistance Program		
H5.	COMAR 31.11.10.06A	Exclusion for loss due to insured's commission or attempt to commit a crime		
H6.	COMAR 31.11.10.06B	Exclusion for loss to which a contributing cause was the insured's being engaged in an illegal occupation		
H7.	COMAR 31.11.10.06C	Exclusion for loss due to use of alcohol or drugs		
H8.		Coordination of Benefits		

	Citation	Description	"X" Means Applicable	Form/ Page
	§15-104(c)	• May not coordinate against guaranteed renewable individual intensive care or specified disease policies		
	§15-104(d)	• May not provide benefits that are secondary to benefits payable under Personal Injury Protection (PIP)		
	§14-126(b)(3)(i)2	• Excess of other insurance clause prohibited		

I. Utilization Review

	Citation	Description	"X" Means Applicable	Form/ Page
I1.		Initial authorization of course of treatment made:		
	§15-10B-06(a)(1)(i)	a. For non-emergencies, within 2 working days of receipt of information necessary to make determination		
	§15-10B-06(a)(1)(ii)	b. For additional health care services, within 1 working day of receipt of necessary information		
I2.	§15-10A-02(f)(2)	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		
I3.	§15-10B-07(c)	May not retroactively deny approval of preauthorized services		
I4.	§15-1001 Title 15, Subtitle 10B COMAR 31.10.18	Company not certified as Private Review Agent in Maryland		
I5.	§15-10A-02(k) Title 15, Subtitle 10A	Grievance Procedure Not Included. Please Advise Where Grievance Information Is Provided		
I6.	§15-140(c)	When carrier is the receiving carrier, the carrier must, upon request, accept a preauthorization from the relinquishing carrier for the lesser of the course of treatment or 90 days		

J. Applications for Use with Plans Offered Outside of the Exchange

	Citation	Description	"X" Means Applicable	Form/ Page
J1.	§27-805	Insurance Fraud-Required Disclosure Statement		
J2.	§15-1210(a)(2)	Employer application must allow employer to elect to cover part-time employees		
J3.	§15-1206(c)(3)	Employee application should contain a question regarding other insurance for purposes of applying the minimum participation requirement		
J4.	45 CFR §147.102(a)(iv)	Employee application may ask question about the use of any tobacco product, except religious or ceremonial use, on average four orJmore times per week within the period no longer than the past 6 months. • If yes, then must ask when tobacco product was last used		
J5.	COMAR 31.04.17.06I(2)	Check-off boxes required for carrier name if application is to be used by more than one carrier		
J6.	COMAR 31.04.17.06I(3)	Applications for use by multiple carriers for same group applicant must clearly identify the coverage underwritten by each carrier		
J7.	§14-205.1(b)(2)	EPO option disclosure statement for out-of-network option offered if EPO is sole delivery system		
J8.	§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		
J9.	§27-216 MIA Bulletin 17-10	Requirements for Acceptance of Credit Cards for Premium Payment and Charging of Fees for Use of Credit Cards		
J10.	COMAR 31.12.02.07A	Application shall stipulate the plan and amount of insurance and any added optional benefits applied for		