INSURERS—INDIVIDUAL STAND-ALONE DENTAL COVERAGE OFFERED THROUGH THE EXCHANGE OR CERTIFIED TO BE SOLD OUTSIDE THE EXCHANGE with POLICY YEARS THAT BEGIN ON OR AFTER JANUARY 1, 2025

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) 2025 Draft CMS Letter to Issuers dated November 15, 2023	2025 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) • $425 - one child • $850 - 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 24-4	Separate schedule of benefit form for each plan design with specific combination of benefits and cost-sharing		
A4.	COMAR 31.04.17.04A(1)	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 COMAR 31.10.01.03B	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.	§12-205(b)(5)	Illegible Form		
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 • 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		
	45 CFR§156.115(d)	• Non-medically necessary orthodontia may not be included as an essential pediatric dental benefit		
	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 §156.210(a)	Premium rates must be set for the entire benefit year		
C2.	45 CFR §155.20	Benefit year defined as a calendar year for which the carrier provides coverage for dental benefits		
C3.	45 CFR §156.265(d) §155.240(a)	Individual must be allowed to pay premium directly to the carrier		
C4.	45 CFR 156.265(b)	Individuals enrolled only if Exchange notifies the carrier that the individual is a qualified individual as determined by the Exchange in accordance with 45 CFR §155.305		
C5.	45 CFR §156.270(d) 81 FR 12350	Three (3)-month grace period for individuals receiving advance payments of the premium tax credit on the premium due date • Carrier may not condition eligibility for grace period on individual having paid at least one full month's premium during the benefit year		

D. Open Enrollment and Special Enrollment Periods 45 CFR §156.260. 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 §155.410(e)(4)(i) and (f)(3)(i)(A) and (B) §15-1316 Proposed NBPP pg 213 COMAR 14.35.07.11	Annual open enrollment period of November 1 through January 15 of the calendar year preceding the benefit year. An effective date of January 1 for applications received on or before December 31. An effective date of February 1 for applications received on or after December 31.		
D2.	45 CFR §147.104(b)(2) 45 CFR §155.420(d) §15-1316(c)(1) and (d)(1)	Upon experiencing a triggering event:		
	45 CFR §147.104(b)(2)(iii)	• For plans offered through the Exchange, except as otherwise specified below:		
	45 CFR §155.420(a)(3)	○ Individual not currently enrolled in a qualified dental plan must be allowed to enroll in any qualified dental plan		

	45 CFR §155.420(a)(4)(iii)(A)	○ Individual currently enrolled in a qualified dental plan must be allowed to enroll with his or her dependents in another qualified dental plan within the same level of coverage		
	45 CFR §155.420(a)(4)(iii)(B)	○ Non-covered dependent of an individual currently enrolled in a qualified dental plan must be allowed to be added to individual's current qualified dental plan; or must be allowed to enroll in any separate qualified dental plan		
	45 CFR §155.420(a)(4)(iii)(C)	○ Individual who is not an enrollee and has one or more dependents who are enrollees who do not also qualify for a special enrollment period must be allowed to enroll in the dependent's current qualified dental plan; or must be allowed to enroll in a separate qualified dental plan		
	45 CFR §147.104(b)(4)(ii), 45 CFR §155.420(b)(5) and (c)(5)	• Individual or dependent who did not receive timely notice of a triggering event must be provided access to the special enrollment period 60 days from the date they knew or reasonably should have known they experienced a triggering event to select a new plan.		
D3.	45 CFR §155.420(c)	Special enrollment period of 60 days for certain "triggering events"		
	45 CFR §155.420(d)(1)(i)	a. Loss of minimum essential coverage by the individual or dependent. The date of the loss of coverage is the last day the individual or dependent would have coverage under the previous plan or 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, except for circumstances in which an employer completely ceases its contributions to COBRA continuation coverage, or government subsidies of COBRA continuation coverage completely cease, or loss due to a rescission authorized under 45 CFR §147.128		
	45 CFR § 155.420(c)(2)	• May access the special enrollment period 60 days prior to the end of such coverage.		

	45 CFR § 155.420(d)(1)(iv)	b. Loss of medically needy coverage as described under section 1902(a)(10)(C) of the Social Security Act. The date of the loss of coverage is the last day the consumer would have medically needy coverage.		
	45 CFR § 155.420(c)(2)	• May access the special enrollment period 60 days prior to the end of such coverage.		
	45 CFR § 155.420(d)(1)(ii)	c. Individual or dependent is enrolled in any non-calendar year group health plan, individual health insurance coverage, or qualified small employer health reimbursement arrangement (QSEHRA), even if individual or dependent has the option to renew such coverage. The date of the loss of coverage is the last day of the plan or policy year.		
	45 CFR § 155.420(c)(2)	• May access the special enrollment period 60 days prior to the end of such coverage		
	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(a)(5) 45 CFR §155.420(d)(2)(i)(A)	• In the case of marriage, at least one spouse must demonstrate having minimum essential coverage for one or more days during the 60 days preceding the date of marriage, which can be satisfied by demonstrating that they: o Had minimum essential coverage; o Had medically needy coverage described in 45 CFR § 155.420(d)(7); o Are an Indian; o Lived in a foreign country or in a United States territory for one or more days during the 60 days preceding the marriage; or o For 1 or more days during the 60 days preceding the marriage or during their most recent preceding open enrolment period or special enrollment period, lived in a service area where no qualified dental plan was available through the Exchange		
	45 CFR §155.420(d)(2)(ii)	e. The individual 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)(3)	f. Individual or dependent who is reasonably expected to be a citizen, national, or lawfully present or is released from incarceration		
	45 CFR § 155.420(c)(2)	• Individual or dependent released from incarceration may access the special enrollment period 60 days prior to and after their release.		
	45 CFR §155.420(d)(4)	g. The individual's or dependent's enrollment or non-enrollment is unintentional, inadvertent or erroneous and is the result of the 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)	h. Individual or dependent adequately demonstrates to the Exchange that a qualified dental plan in which he or she is enrolled substantially violated a material provision of its contract with the individual		
	45 CFR §155.420(d)(6)(i) and (ii)	i. Individual or dependent enrolled in the same plan becomes newly eligible or newly ineligible for advance payments of premium tax credits or federal cost-sharing reductions		
	45 CFR §155.420(d)(7)	j. Individual 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)	• Individual/dependent can satisfy prior coverage requirement by demonstrating that they: o Had minimum essential coverage; o Had medically needy coverage described in 45 CFR § 155.420(d)(7); o Are an Indian; o Lived in a foreign country or in a United States territory for one or more days during the 60 days preceding the move; or o 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 qualified dental plan was available through the Exchange		
	45 CFR §155.420(c)(2)	• May access the special enrollment period 60 days in advance of or 60 days after the move		

	45 CFR §155.420(d)(9)	k. Individual or dependent demonstrates to the Exchange, in accordance with HHS guidelines, that the individual meets other exceptional circumstances		
	§155.420(d)(6)(iii)	l. Individual or dependent is enrolled in an employer-sponsored plan, is determined newly eligible for advance payments of premium tax credits ("APTC") based in part on the individual being ineligible for qualifying coverage in an eligible employer-sponsored plan, and is allowed to terminate existing coverage		
	45 CFR § 155.420(c)(2)	• May access the special enrollment period 60 days prior to or 60 days after the end of such coverage		
	45 CFR § 155.420(d)(6)(iv)	m. An individual who was previously ineligible for advance payments of the premium tax credit solely because of a household income below 100 percent of the FPL and who, during the same timeframe, was ineligible for Medicaid because he or she was living in a non-Medicaid expansion State, who either experiences a change in household income or moves to a different State resulting in the individual becoming newly eligible for advance payments of the premium tax credit		
	45 CFR § 155.420(c)(2)	• If becoming newly eligible as a result of move to a different State, may access the special enrollment period 60 days prior to or after the move.		
	45 CFR § 155.420(d)(6)(v)	n. At the option of the Exchange, an individual or dependent experiences a decrease in household income, is newly determined eligible by the Exchange for advance payments of premium tax credit, and had minimum essential coverage for one or more days during the 60 days preceding the date of the financial change.		
	45 CFR §155.420(d)(10)	o. Individual is a victim of domestic abuse or spousal abandonment, including a dependent or unmarried victim 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)	p. Individual or dependent 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		
	45 CFR § 155.420(d)(12)	q. The enrollment in a qualified dental plan through the Exchange was influenced by a material error related to plan benefits, service area, cost sharing or premium. A material error is one that is likely to have influenced the individual's, enrollee's, or their dependent's enrollment in a qualified dental plan.		
	45 CFR § 155.420(d)(13)	r. At the option of the Exchange, the individual provides satisfactory documentary evidence to verify his or her eligibility for an insurance affordability program or enrollment in a qualified dental plan through the Exchange following termination of Exchange enrollment due to a failure to verify such status within the time period specified in 45 CFR §155.315 or is under 100 percent of FPL and did not enroll in coverage while waiting for HHS to verify his or her citizenship, status as a national, or lawful presence		
	45 CFR §155.420(d)(14);	s. Individual or dependent who newly gains access to an individual coverage HRA or is newly provided a qualified small employer health reimbursement arrangement (QSEHRA)		
	45 CFR § 155.420(c)(3)	• May access the special enrollment period 60 days before the first day on which coverage under the HRA can take effect or the first day on which coverage under the QSEHRA takes effect, unless the HRA or QSEHRA was not required to provide the notice setting forth its terms at least 90 days before the beginning of the plan year, in which case the individual, enrollee, or dependent has 60 days before or after the triggering event to select a qualified dental plan		

	45 CFR §155.420(d)(15)	t. Individual or dependent is enrolled in COBRA continuation coverage for which an employer is paying all or part of the premiums or a government entity is subsidizing the premiums, and the employer or government entity completely ceases its contributions/subsidies, for COBRA continuation coverage.		
	45 CFR §155.420(c)(2)	• May access the special enrollment period 60 days prior to or after the cessation of employer contributions or government subsidies		
D4.	45 CFR §155.420(d)(8)(i)	Individuals who gain or maintain status as an Indian may enroll in or change to any qualified 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		
D5.	45 CFR 155.420(d)(16) 45 CFR 155.420(a)(4)(i)(D)	For individual or dependent who is eligible for advance payments of the premium tax ("APTC") credit, and whose household income, as defined by 26 CFR 1.36B-1(e), is expected to be no greater than 150 percent of the Federal poverty level. Individual or dependent may enroll in a qualified dental plan on the Exchange or change from one qualified dental plan on the Exchange to another, one time per month during periods of time when the applicable taxpayer's applicable percentage for purposes of calculating the premium assistance amount, as defined in section 36B(b)(3)(A) of the Internal Revenue Code, is set at zero If individual or dependent who is not currently enrolled qualifies for this special enrollment period, and has one or more household members who are currently enrolled, the currently enrolled household member currently must be allowed to add the newly enrolling household member to his or her current qualified dental plan. • May enroll 60 days following triggering event.		
D6.	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 medical needy coverage, loss of coverage under a non-calendar year group or individual plan, gaining access to new plans due to a permanent move, becoming newly eligible due to release from incarceration, or becoming newly eligible for advance payments of premium tax credit due to a move from a non-Medicaid expansion State 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 effective date rules in D6i apply based on the date of plan selection. For losses of minimum essential coverage [45 CFR §§155.420(d)(1) and (d)(6)(iii)], at the option of the Exchange, if plan selection is made on or before the last day of the month preceding the triggering event, the Exchange must ensure the coverage effective date is the first day 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 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 or dependent 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;		

		• The individual or dependent 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; • The individual's, or his or her dependent's enrollment in a qualified dental plan through the Exchange was influenced by a material error related to plan benefits, service area, cost sharing or premium; or • The individual provides satisfactory documentary evidence to verify his or her eligibility for an insurance affordability program or enrollment in a qualified dental plan through the Exchange following termination of Exchange enrollment due to a failure to verify such status within the time period specified in 45 CFR §155.315 or is under 100 percent of FPL and did not enroll in coverage while waiting for HHS to verify his or her citizenship, status as a national, or lawful presence The effective date is an appropriate date based on the specific circumstances and is determined by the Exchange		

	45 CFR § 155.420(b)(2)(iv)	f. In the case of an individual or dependent enrolled in an employer-sponsored plan, is determined newly eligible for advance payments of premium tax credits based on the individual being ineligible for qualifying coverage in an eligible employer-sponsored plan, and is allowed to terminate existing coverage, the effective date is based on date of plan selection—if plan selection is made on or before loss of coverage, new coverage becomes effective the first day of the month following the loss of coverage. If plan selection occurs after the date of loss the first day of the month after the individual selects a plan. At the option of the Exchange, if plan selection is made on or before the last day of the month preceding the triggering event, the Exchange must ensure the coverage effective date is the first day of the month in which the triggering event occurs		
	45 CFR §155.420(b)(2)(v)	g. In the case of an individual 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 after the individual selects a plan.		
	45 CFR § 155.420(b)(2)(vi)	h. In the case of an individual, enrollee, or dependent who newly gains access to an individual coverage HRA or is newly provided a QSEHRA, the effective date is based on date of plan selection. If the plan selection is made before the day of the triggering event, the coverage is effective on the first day of the month following the date of the triggering event or, if the triggering event is on the first day of a month, on the date of the triggering event. If the plan selection is made on or after the day of the triggering event, the coverage is effective on the first day of the month following plan selection.		
	45 CFR §155.420(b)(1) Proposed NBPP	i. For all other triggering events: the first day of the month after the individual selects a plan.		

	45 CFR §155.420(c)(6)	j. At the option of the MHBE, special enrollment period of 90 days after an individual loses Medicaid or CHIP. If the State Medicaid/CHIP agency has a reconsideration period of greater than 90 days, the MHBE may elect to extend the length of the enrollment period to match the length of the Medicaid/CHIP reconsideration period Coverage is effective the first day of the month after the individual selects a plan.		

E. Termination of Coverage Requirements 45 CFR §156.270. 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
E1.	45 CFR§155.430(b)(1)(i)	Covered person must be permitted to terminate coverage, including as a result of obtaining other minimum essential coverage		
E2.	45 CFR §155.430(d)(2)	Effective date of coverage when covered person terminates coverage		
		• When at least 14-day notice provided, date specified by covered person		
		• When less than 14-day notice provided, 14 days after the termination is requested by the covered person		
		• If the carrier is able to effectuate termination in fewer than 14 days and the covered person requests an earlier termination date, on the date determined by the carrier		
		• At the option of the Exchange, if the covered person is newly eligible for Medicaid or MCHIP, the day before the individual's date of eligibility for Medicaid or MCHIP		
		• If required by the Exchange, the date termination is requested by the member or another prospective date selected by the member, regardless of whether 14-day notice is provided		
E3.	45 CFR §155.430(b)(1)(iv)	Covered person must be permitted to retroactively terminate or cancel coverage in certain circumstances		

	Citation	Description	"X" Means Applicable	Form/ Page
	45 CFR §155.430(b)(1)(iv)(A)	a. Covered person demonstrates to the Exchange that he or she attempted to terminate coverage and experienced a technical error that did not allow the member to terminate coverage, and requests retroactive termination within 60 days after member discovered the technical error		
	45 CFR §155.430(b)(1)(iv)(B)	b. Covered person demonstrates to the Exchange that enrollment in a qualified dental plan was unintentional, inadvertent, or erroneous and was the result of the error or misconduct 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. Such enrollee must request cancellation within 60 days of discovering the unintentional, inadvertent, or erroneous enrollment		
	45 CFR §155.430(b)(1)(iv)(C)	c. Covered person demonstrates to the Exchange that he or she was enrolled in a qualified dental plan without his or her knowledge or consent by any third party, including third parties who have no connection with the Exchange, and requests cancellation within 60 days of discovering the enrollment		
E4.		Effective date of retroactive termination by member:		
	45 CFR §155.430(d)(9)	• For retroactive termination due to a technical error described in item E3.a. above, the termination date will be no sooner than the date that would have applied under E2. above, based on the date that the enrollee can demonstrate he or she contacted the Exchange to terminate his or her coverage or enrollment through the Exchange, had the technical error not occurred		
	45 CFR §155.430(d)(10)	• For retroactive cancellation or termination due to enrollment errors described in items E3.b. and c. above, the cancellation date or termination date will be the original coverage effective date or a later date, as determined appropriate by the Exchange, based on the circumstances of the cancellation or termination		

E5.	45 CR §155.430(b)(2)	Carrier may only terminate coverage: • When covered person is no longer eligible for coverage through the Exchange. • For non-payment of premiums; • When coverage is rescinded in accordance with 45 CFR §147.128 (if required by the Exchange, the qualified dental plan must demonstrate to the reasonable satisfaction of the Exchange that the rescission is appropriate); • When the qualified dental plan terminates or is decertified. • When the covered person changes from one qualified dental plan to another during an annual open enrollment period or special enrollment period; • When member was enrolled in a qualified plan without his or her knowledge or consent by a third party, including by a third party with no connection with the Exchange		
E6.	45 CFR §156.270(b)(1);	For any termination events described in 45 CFR § 155.430(b), carrier must promptly and without undue delay provide the member notice of termination of coverage that includes the termination date and the reason for termination		
E7.		Effective dates of termination of coverage		
	45 CFR §155.430(d)(3)	• When covered person no longer eligible, the last day of eligibility as described in 45 CFR § 155.330(f), unless the member requests an earlier termination date		
	45 CFR §155.430(d)(4)	• For nonpayment of premium by covered person receiving advance payments of the premium tax credit, the last day of the first month of the 3-month grace period		
	45 CFR §155.430(d)(5)	• For nonpayment of premium for covered person NOT receiving advance payments of the premium tax credit, the last day of the 31-day grace period		
	45 CFR §155.430(d)(6)	• When covered person changes from one qualified dental plan to another, the day before the effective date of coverage in the new qualified dental plan		
	45 CFR § 155.430(d)(7)	• In the case of termination due to death, the last day of coverage is the date of death		

	45 CFR §155.430(d)(11)	• In the case of cancellation when the member was enrolled in a qualified by a third party without the member's knowledge or consent, the original coverage effective date, following reasonable notice to the enrollee (where possible)		

F. Required Standard Provisions

	Citation	Description	"X" Means Applicable	Form/ Page
F1.	§15-207	Entire Contract; Changes		
F2.	§15-208(a)(1)	Time Limit on Certain Defenses		
F3	§15-209	Grace Period for covered persons not receiving advance payments of premium tax credits		
F4.	§15-210	Reinstatement		
F5.	§15-211	Notice of Claim		
F6.	§15-212	Claims Forms		
F7.	§15-213	Proofs of Loss		
	§15-1005(e)	• Provider must be permitted minimum of 180 days to file claim		
F8.	§15-214	Time Payment of Claims		
F9.	§15-215	Payment of Claims		
F10.	§15-217	Legal Action		
F11.	§15-201(h)	10-Day Right to Examine Contract		
F12.	§15-216	Physical Examination and Autopsy		
F13.	COMAR 31.10.28.05	Premium Due Date		

G. Optional Standard Provisions

	Citation	Description	"X" Means Applicable	Form/ Page
G1.	§15-220 §15-204	Misstatement of Age		
G2.	§15-221	Other Insurance With Insurer		
G3.	§15-222 §15-223	Insurance With Other Insurers		
G4.	§15-225	Unpaid Premiums		

	Citation	Description	"X" Means Applicable	Form/ Page
G5.	§15-226	Conformity With State Statutes		

H. Other

	Citation	Description	"X" Means Applicable	Form/ Page
H1.	§15-402	Incapacitated Child		
H2.	§15-401, §15-403 §15-403.1	Newborn/Adopted Children/ Grandchildren/ Guardianship (*expense-incurred contracts only*)		
H3.	§15-833(j)	Extension of Benefits		
H4.	§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		
H5.		Preferred Provider Contracts with Expense-Incurred Benefits		
	§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		

	Citation	Description	"X" Means Applicable	Form/ Page
	§15-112(q)	f. Office to file complaints		
	§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		
H6.	COMAR 31.10.01.03C	Standard of Time		
H7.	COMAR 31.10.01.03R	Notice of Premium Increase By Mail		
H8.	§15-701	Health Care Providers		
H9.	§15-1005(g)	Payment of Interest on Unpaid Claims		
H10.	§15-603	Reimbursement for Services Paid for or Provided by Maryland Department of Health		
H11.	Title 15, Subtitle 10D	Complaint process for coverage decisions		
H12.	§15-110(d)	Required Exclusion for Prohibited Health Care Practitioner Referrals		
H13.	§12-209(1), (2), and (4)	Contract Governed by Maryland Law and Maryland Courts		

I. Prohibited Provisions, Limitations and Exclusions

	Citation	Description	"X" Means Applicable	Form/ Page
I1.	COMAR 31.10.01.03P	Reimbursement Language		
I2.	COMAR 31.10.01.03Q	Strict Compliance Language		
I3.	§15-1009	Denial of Reimbursement for Pre-authorized Care Prohibited Except for Limited Reasons		
I4.	§15-502	Reduction for Medical Assistance Program		
I5.	COMAR 31.10.25.05A(1)	Exclusion for loss due to insured's commission or attempt to commit a crime		
I6.	COMAR 31.10.25.05A(2)	Exclusion for loss to which a contributing cause was the insured's being engaged in an illegal occupation		
I7.	COMAR 31.10.25.05C	Exclusion for loss due to use of alcohol or drugs		

	Citation	Description	"X" Means Applicable	Form/ Page
I8.		Coordination of Benefits		
	§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)		
	§12-205(b)(4)	• Excess of other insurance clause prohibited		
I9.	COMAR 31.10.28.04	Arbitration Provision - May Not Require Insured To Use Arbitration To Settle Disputes With Insurer		

J. Utilization Review

	Citation	Description	"X" Means Applicable	Form/ Page
J1.		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		
J2.	§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		
J3.	§15-10B-07(c)	May not retroactively deny approval of preauthorized services		
J4.	§15-1001 Title 15, Subtitle 10B COMAR 31.10.18	Company not certified as Private Review Agent in Maryland		
J5.	§15-10A-02(k), Title 15, Subtitle 10A	Grievance Procedure Not Included. Please Advise Where Grievance Information Is Provided		
J6.	§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		

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

	Citation	Description	"X" Means Applicable	Form/ Page
K1.	§27-805	Insurance Fraud-Required Disclosure Statement		
K2.	45 CFR §147.104(a)	May not ask questions related to health status or health history		
K3.	§27-909	May Not Inquire About Genetic Tests or Genetic Information		
K4.	Maryland Health Connection Carrier Reference Manual 2020 § 31-115(b)(5)(v)	May NOT ask questions about the use of any tobacco product for Exchange plans, when offered on or off the Exchange		
K5	45 CFR §147.102(a)(iv)	For plans sold exclusively outside of the Exchange, may ask question about the use of any tobacco product, except religious or ceremonial use, on average four or more times per week within the period no longer than the past 6 months. • If yes, then must ask when tobacco product was last used		
K6.	COMAR 31.04.17.06H(1)	Check-off boxes required for carrier name if application is to be used by more than one carrier		
K7.	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		
K8.	§12-202	Application Changes		
K9.	COMAR 31.04.17.06B	Certain States		
K10.	COMAR 31.04.17.08	Proxy not permitted		
K11.	§27-504	Domestic Violence		
K12.	§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		
K13.	§27-216 MIA Bulletin 17-10	Requirements for Acceptance of Credit Cards for Premium Payment and Charging of Fees for Use of Credit Cards		
K14.	COMAR 31.04.18.06A	Application shall stipulate the plan and amount of insurance and any added optional benefits applied for		