GROUP DENTAL INSURANCE

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

This 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. The items listed below may paraphrase the law or regulation. Unless otherwise specified, all section references are to the Insurance Article of the Annotated Code of Maryland.

A. Filing Incomplete or in Unacceptable Format

	Citation	Description	"X" Means Applicable	Form/ Page
A1.	COMAR 31.10.01.03A	Premium Rates and Actuarial Memorandum (Include in same SERFF tracking number filing)		
A2.	COMAR 31.04.17.03I(2)	If the filing is not being made by the insurer, the filer must submit a signed third party authorization letter from the insurer.		
A3.	COMAR 31.04.17.03C	Listing of Forms		
A4.	COMAR 31.04.17.03J	Description of New Features		
A5.	COMAR 31.04.17.03D	Form Number (Form number must be identical to form number in SERFF Form Schedule)		
A6.	COMAR 31.04.17.03G, COMAR 31.10.01.03B	Corporate Name		
A7.	COMAR 31.04.17.03H	Unacceptable Modifications		
A8.	COMAR 31.04.17.03K	Specimen Data		
A9.	COMAR 31.04.17.03M	Signature of Officer		
A10.	COMAR 31.04.17.04A(2)	Form contains items in brackets, denoting variability. Submit specific description of how each item can vary. If other items are desired, include specific text		
A11.	COMAR 31.04.17.04	Contracts Comprised of Insert Pages		
	COMAR 31.04.17.04B(1)(b)(i)	a. Description of How Pages will be Combined		
	COMAR 31.04.17.04B(1)(b)(ii)	b. Listing of Substitute Pages		
	COMAR 31.04.17.04B(4)(a)	c. Form Number and Approval Date for Pages Replaced		

	Citation	Description	"X" Means Applicable	Form/ Page
	COMAR 31.04.17.04B(4)(b)	d. Copy of Currently Approved Contract		
A12.	COMAR 31.04.17.04C	Contracts Comprised of Sections		
	COMAR 31.04.17.04C(1)(b)(i)	a. Description of How Sections will be Combined		
	COMAR 31.04.17.04C(1)(b)(ii)	b. Listing of Substitute Sections		
	COMAR 31.04.17.04C(3)(a)	c. Form Number and Approval Date for Pages Replaced		
	COMAR 31.04.17.04C(3)(b)	d. Copy of Currently Approved Contract		
A13.	COMAR 31.10.01.03E	Signature of Policyholder for Reduction Rider		
A14.	§12-205(b)(5)	Illegible Form		
A15.	COMAR 31.10.02	Simplified Language (Readability Certification)		
A16.	COMAR 31.10.02.02A(4)	Size of Type		
A17.	§2-112(a)(10)	Filing Fees Insufficient		
A18.	COMAR 31.04.17.03F	Language other than English in Forms		

B. Required Provisions

	Citation	Description	"X" Means Applicable	Form/ Page
B1.	§15-833(j)	Extension of Benefits		
B2.	§15-110(d)	Required Exclusion for Prohibited Provider Referrals		
B3.	§12-209(1), §12-209(2), §12-209(4)	Contract Governed by Maryland Law and Maryland Courts		
B4.	COMAR 31.10.01.03C	Standard of Time		
B5.	COMAR 31.10.01.03R	Notice of Premium Increase		

C. Required Standard Provisions

	Citation	Description	"X" Means Applicable	Form/ Page
C1.	COMAR 31.11.10.03	Required Standard Provisions		
C2.	COMAR 31.11.10.04A	Entire Contract		
C3.	COMAR 31.11.10.04B	Contestability of Coverage		

	Citation	Description	"X" Means Applicable	Form/ Page
C4.	COMAR 31.11.10.04C	Notice of Claim		
C5.	COMAR 31.11.10.04D	Claim Forms		
C6.	COMAR 31.11.10.04E	Proofs of Loss		
	§15-1005(e)	For contracts that provide direct reimbursement to a provider, must include a statement that providers have 180 days from date of service to submit claim for payment		
C7.	COMAR 31.11.10.04F	Time of Payment of Claims		
C8.	COMAR 31.11.10.04G	Payment of Claims		
C9.	COMAR 31.11.10.04H	Legal Action		
C10.	COMAR 31.11.10.04I	Grace Period		
C11.	COMAR 31.11.10.04J	Certificates		
C12.	COMAR 31.11.10.04K	Addition of Employees/Members		
C13.	COMAR 31.11.10.04L	Misstatement of Age		
C14.	COMAR 31.11.10.04N	Premium Due Date		

D. Optional Standard Provisions

	Citation	Description	"X" Means Applicable	Form/ Page
D1.	COMAR 31.11.10.07A	Physical Examination		
D2.	COMAR 31.11.10.07B	Autopsy		
D3.	COMAR 31.11.10.07C	Arbitration		

E. Prohibited Provisions, Limitations and Exclusions

	Citation	Description	"X" Means Applicable	Form/ Page
E1.	§15-135.1	May not require Annual Dental Preventive Care visit or examination be in a required time period after prior visit or examination		
E2.	§15-104(c)	May not coordinate against guaranteed renewable individual intensive care or specified disease policies.		
E3.	§15-104(d)	May not provide benefits that are secondary to benefits under an automobile policy, including PIP		
E4.	COMAR 31.04.17.11B	Self-Destruction		

	Citation	Description	"X" Means Applicable	Form/ Page
E5.	COMAR 31.11.10.06A	May not limit or exclude loss due to insured's commission or attempt to commit a crime		
E6.	COMAR 31.11.10.06B	May not limit or exclude loss to which a contributing cause was the insured's being engaged in an illegal occupation		
E7.	COMAR 31.11.10.06C	May not limit or exclude loss due to use of intoxicants or narcotics		
	COMAR 31.11.10.06C(1)(a)	a. Sustain or contracted in consequence of the insured being intoxicated or under the influence of any drug		
	COMAR 31.11.10.06C(1)(b)	b. Due to the use of alcohol		
	COMAR 31.11.10.06C(1)(c)	c. Due to the use of drugs or narcotics		
	COMAR 31.11.10.06C(1)(d)	d. Due to alcoholism or drug addiction		
E8.	COMAR 31.04.17.18, COMAR 31.11.10.06D	Preexisting Conditions Limitation		
E9.	§15-401	Preexisting Condition exclusion may not apply to newly born or newly adopted dependent child/grandchild or minor for Guardianship		
E10.	§15-804	Off Label Use of Drugs		
E11.	§15-602	State Hospital, etc., Charitable or Otherwise		
E12.	§15-604	May not limit hospital payments to amounts other than those set by Health Services Cost Review Commission		
E13.	§15-502	No Reduction for Medical Assistance Program		
E14.	COMAR 31.10.01.03I	Frequency of Physician Visits		
E15.	§15-1009	Denial of Reimbursement for Pre-authorized Care Prohibited Except for Limited Reasons		
E16.	COMAR 31.10.01.03O	Chronic or Organic Disease		
E17.	COMAR 31.10.01.03P	Reimbursement Language		
E18.	COMAR 31.10.01.03Q	Strict Compliance Language		
E19.	COMAR 31.04.17.10B	Good Health Warranty Not Permitted		
E20.	§15-126	May Not Discourage or Prohibit access to the 911 emergency system		

	Citation	Description	"X" Means Applicable	Form/ Page
E21.	§27-504	Prohibited Discrimination for Domestic Violence Victims		
E22.	COMAR 31.11.10.07C	Arbitration Provision – May Not Require Insured or Policyholder to Use Arbitration to Settle Disputes with Insurer		
E23.	§15-503	May not deny, cancel, or refuse to renew coverage because insured has been exposed to diethylstilbestrol		
E24.	COMAR 31.04.17.07	Advertising Prohibited		
E25.	§12-211, House Bill 1069, Chapter 396, Acts of 2025 (effective October 1, 2025)	Discretionary Clauses Prohibited		
E26.	§27-209, Senate Bill 725, Chapter 38, Acts of 2023	Value Added Services/ Non Insurance Benefits		

F. Eligibility and Enrollment of Coverage Requirements

	Citation	Description	"X" Means Applicable	Form/ Page
F1.	§15-411	Open Enrollment for Spouse		
F2.	§15-404	Open Enrollment for Children		
F3.	§15-405	Court Ordered Coverage of Children		
	§15-405(c)	a. Coverage Requirements for Enrollment of Child		
	§15-405(h)	b. Special Enrollment Period for Employee and Child Required		
	§15-405(i)	c. Special Enrollment Period for Child Required		
	§15-405(d)	d. Prohibited Denials of Coverage for Child Enrollment		
F4.	§15-402	Incapacitated Child		
F5.	§15-401, §15-403, §15-403.1	Newborn/Adopted Child/Grandchild/Guardianship		

G. Other

	Citation	Description	"X" Means Applicable	Form/ Page
G1.	§15-701	Health Care Providers		

	Citation	Description	"X" Means Applicable	Form/ Page
	§15-701, Senate Bill 216, Chpt. 330, Acts of 2023 (effective 7/01/23)	• May not exclude medically necessary treatment services otherwise covered under the contract when those services are provided by a massage therapist		
G2.	§15-715	Community Health Resource		
G3.	§15-603	Reimbursement for Services Paid for or Provided by Department of Health		
G4.		Preferred Provider Contract		
	§14-205(b)(2)	a. Difference between coinsurance percentage for non- preferred and preferred providers may not exceed 20 percentage points.		
	§14-205(b)(4)	b. Insurer's allowed amount paid to non-preferred providers for a health care service covered by a PPO contract may not be less than the allowed amount paid to a similarly licensed provider who is a preferred provider for the same service in the same region.		
	§15-118(c)	c. Coinsurance Amounts for Preferred Provider Must Be Based on Negotiated Fees With Insurer		
	§15-830(a)	d. Referrals to Specialists – Definitions Are Unacceptable		
	§15-830(b)	e. Procedure for Right to Standing Referral to Network Specialist		
	§15-830(d)	f. Procedure for Right to Request Referral to Specialist, Including Non-Physician Specialist Not on Carrier's Provider Panel • Referral must be granted if the carrier cannot provide reasonable access to a specialist without unreasonable travel or delay.		
	§15-140	g. When member transitions from another carrier or managed care organization, receiving carrier must allow member to continue to receive dental care services from a nonparticipating provider under certain circumstances		
G5.	§14-205.3	Payment Rules for Assignment of Benefits for Physicians Not On Call or Hospital-Based Physicians		

	Citation	Description	"X" Means Applicable	Form/ Page
G6.	§14-205.1	Exclusive Provider Benefit Contract		
	§14-205.1(a)	a. Does not restrict payment for certain covered services provided by Non-preferred providers		
	§14-205.1(a)(1)	• For Emergency Services – As defined in §19-701 of the Health-General Article		
	§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 of Insurance Article		
	§15-830(a)	b. Referrals to Specialists – Definitions Are Unacceptable		
	§15-830(b)	c. Procedure for Right to Standing Referral to Network Specialist		
	§15-830(d)	d. Procedure for Right to Request Referral to Specialist, Including Non-Physician Specialist Not on Carrier's Provider Panel • Referral must be granted if the carrier cannot provide reasonable access to a specialist without unreasonable travel or delay		
	§15-140	e. When member transitions from another carrier or managed care organization, receiving carrier must allow member to continue to receive dental care services from a nonparticipating provider under certain circumstances		
	§15-118(c)	f. Coinsurance Amounts for Preferred Provider Must Be Based on Negotiated Fees With Insurer		
G7.	Title 15, Subtitle 10D; COMAR 31.10.29	Complaint process for coverage decisions		
	§15-10D-01(k)	• Revised member definition		
G8.	§15-112(q)	Identify office and process for filing complaints		
G9.	§15-1005(g)	Payment of Interest on Unpaid Claims		
G10.	COMAR 31.15.08	Payment of Claims, Unfair Trade Practices		

G11.	§15-919	Medicare Supplement Disclaimers for Individuals Eligible for Medicare Due to Age (non-employer and non-labor organization contracts only)		
G12.	§27-216; MIA Bulletin 17-10	Requirements for Acceptance of Credit Cards for Premium Payment and Charging of Fees for Use of Credit Cards		
G13.	COMAR 31.10.01.03G	Right to Elect Alternative Benefits		

H. Applications

	Citation	**Description**	**"X" Means Applicable**	**Form/ Page**
H1.		Questions on Applications		
	§12-205(b)(9)	a. Seven-Year Limit for Health Questions		
	§27-909(c)	b. May Not Inquire About Genetic Tests or Genetic Information		
	§27-504(b)	c. Domestic Violence		
	COMAR 31.04.17.06E; §12-207	d. Health questions 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		
	COMAR 31.04.17.06C	e. Questions about "hazardous activities" must list activities considered to be "hazardous"		
	COMAR 31.04.17.06D	f. Questions about the use of "habit-forming drugs" must list specific drugs considered to be "habit-forming"		
	COMAR 31.04.17.06F, COMAR 31.04.17.06G	g. Questions about symptoms or indications of physical/mental conditions must ask about "known symptoms" and "known indications"		
H2.	§12-202(c)	Application Changes		
H3.	COMAR 31.04.17.08	Proxy Not Permitted		
H4.	COMAR 31.04.17.10B	Good Health Warranty Not Permitted		
H5.	COMAR 31.04.17.06B	Certain States		
H6.	§12-205(b)(2)	Description of the preexisting conditions limitation is not the same as in the contract		

	Citation	Description	"X" Means Applicable	Form/ Page
H7.	COMAR 31.11.10.06D(4)	There is a statement that if the applicant answers the questions in a particular manner, coverage will not be provided to the affected person. To use this statement, provide written assurance that carrier uses a signed waiver/exclusion rider that must be attached to contract to exclude person from coverage		
H8.	COMAR 31.04.17.06I(2)	Check-off boxes required for carrier name if application is to be used by more than one carrier		
H9.	COMAR 31.04.17.06I(3)	Application must clearly identify coverages underwritten by each carrier, when more than one carrier uses the same application with the same group applicant		
H10.	COMAR 31.04.17.06J	If application (enrollment form) 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		
H11.	COMAR 31.04.17.06A	Application shall stipulate the plan and amount of insurance and any added optional benefits applied for		
H12.	§27-805; MIA Bulletin 12-07	Insurance Fraud-Required Disclosure Statement		

I. Utilization Review

	Citation	Description	"X" Means Applicable	Form/ Page
I1.	§15-10A-02(k)	Grievance Procedure Not Included. Please Advise Where Grievance Information Is Provided		
	§15-1001; Subtitle 10B; COMAR 31.10.18	• Company not certified as Private Review Agent (PRA) 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		
I2.	§15-10B-05(a)(4)	Utilization review agent must be reasonably available 7 days a week, 24 hours a day		
I3.	§12-205(b)	May not require preauthorization for emergency care		

I4.	§15-10B-06(a)(1)(i), Senate Bill 791, Chpt. 848, Acts of 2024 (effective 1/1/25)	Initial authorization of course of treatment made: a. For non-emergencies, within 2 working days of receipt of information necessary to make determination		
	§15-10B-06(a)(1)(ii)	b. For extended stays or additional health care services, within 1 working day of receipt of necessary information		
	§ 15-10B-06(a)(1)(iii), Senate Bill 791, Chpt. 848, Acts of 2024 (effective 1/1/25)	c. For additional visits or days of care as part of existing treatment, within 1 working day of receipt of necessary information		
	§ 15-10B-06(a)(2), Senate Bill 791, Chpt. 848, Acts of 2024 (effective 1/1/25)	d. After receipt of initial request, if more information is necessary to make decision, inform provider no more than 3 calendar days following initial request of the need for more information		
I5.	§15-10B-06(a)(2)	PRA must inform healthcare provider that additional information is needed to make determination within 3 calendar days after initial request		
I6.	§15-10A-02(f)(1 Senate Bill 791, Chpt. 848, Acts of 2024 (effective 1/1/25)	For non-emergency, 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.		
I7.	§15-10B-07(c)	May not retroactively deny approval of preauthorized services		
I8	§ 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		