GROUP HEALTH INSURANCE

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

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

A. Filing Incomplete or in Unacceptable Format

	Citation	**Description**	**"X" Means Applicable**	**Form/ Page**
A1.	COMAR 31.10.01.03A	Premium Rates and Actuarial Memorandum (Include in same SERFF tracking number filing)		
A2.	COMAR 31.04.17.03I(2)	If the filing is not being made by the insurer, the filer must submit a signed third party authorization letter from the insurer.		
A3.	COMAR 31.04.17.03C	Listing of Forms		
A4.	COMAR 31.04.17.03J	Description of New Features		
A5.	COMAR 31.04.17.03D	Form Number (Form number must be identical to form number in SERFF Form Schedule)		
A6.	COMAR 31.04.17.03G, COMAR 31.10.01.03B	Corporate Name		
A7.	COMAR 31.04.17.03H	Unacceptable Modifications		
A8.	COMAR 31.04.17.03K	Specimen Data		
A9.	COMAR 31.04.17.03M	Signature of Officer		
A10.	COMAR 31.04.17.04A(2)	Form contains items in brackets, denoting variability. Submit specific description of how each item can vary. If other text is desired, include specific text.		
A11.	COMAR 31.04.17.04B	Contracts Comprised of Insert Pages		
	COMAR 31.04.17.04B(1)(b)(i)	a. Description of How Pages will be Combined		
	COMAR 31.04.17.04B(1)(b)(ii)	b. Listing of Substitute Pages		
	COMAR 31.04.17.04B(3)(a)	c. Form Number and Approval Date for Pages Replaced		

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

B. Mandated Benefits

	Citation	Description	"X" Means Applicable	Form/ Page
B1.	§15-803	Blood Products		
B2.	§15-818	Cleft Lip/Cleft Palate		
B3.		Health Care Cost Containment		
	§15-819(b)(1)	a. Outpatient Benefit		
	§15-819(b)(2)	b. Second Opinion		
B4.	§15-808	Home Health Care		
B5.	§15-809; COMAR 31.10.09	Hospice (Required Offering)		
B6.	§15-821	Coverage of Face, Neck or Head		
B7.	§15-814	Mammography (May not be subject to deductible)		

	Citation	Description	"X" Means Applicable	Form/ Page
	§15-814(c)(1)	• Coverage for breast cancer screening in accordance with latest screening guidelines issued by American Cancer Society		
	§15-814(c)(2)	• Coverage for Digital Tomosynthesis that, under accepted standards in the practice of medicine, the treating physician determines is medically appropriate and necessary		
	§15-814(e)(1)	• May not be subject to deductible		
	§15-814.1(c), House Bill 1259,Chpt. 868, Acts of 2024 (effective 1/1/25)	Diagnostic and Supplemental Examinations and Biopsies, including image-guided breast biopsies, for Breast Cancer • May not be subject to copays, coinsurance, or deductible. • For High Deductible Health Plans, may not be subject to copays or coinsurance, but may be subject to deductible		
B8.	§15-817, House Bill 1315, Chpt. 738, Acts of 2025 (effective 1/1/2026)	Child Wellness (May not be subject to deductible) Child Wellness Immunizations recommended by ACIP: • In effect on December 31, 2024; and • Any new vaccines recommended by the Centers for Disease Control and Prevention's Advisory Committee on Immunization Practices after December 31, 2024		
	§15-817(c)(2)(v)	a. Include all visits for obesity evaluation and management		
	§15-817(c)(2)(vi)	b. Include all visits for and costs of developmental screening as recommended by the American Academy of Pediatrics		
	§15-817(c)(2)(viii)	c. Coverage for laboratory tests considered necessary by physician for services in §15-817		
	§15-817(c)(2)(vii)	d. Physical examination, development assessment, and parental anticipatory guidance for the child to be covered as in §15-817		

B9.	§15-801; COMAR 31.11.05	Alzheimer's Disease (Required Offering)		
B10.	§15-807	Medical Food and Low Protein Food		
B11.	§15-815	Reconstructive Breast Surgery		
	§15-815(a)(2)	• Mastectomy definition does not include "breast cancer"		
	§15-815(c)(2)	• Coverage includes physical complications of all stages of mastectomy, including lymphedemas, in manner determined by physician		
B12.	§15-823	Osteoporosis Prevention and Treatment		
B13.	§15-825	Prostate Cancer Screening		
	§15-825(c), Senate Bill 661, Chpt. 344, Acts of 2020 (effective 01/01/21)	• Deductible, Copayments or Coinsurance may not be applied		
B14.	§15-822	Diabetes Equipment, Supplies, Training		
	§15-822(d)(3)	• Diabetes Test Strips – Deductible, Copayment and Coinsurance May Not Be Applied. Exception: For high deductible plans, deductible may be applied to diabetes test strips		
	§15-822(b)(3)	• Include benefits for both elevated or "impaired" blood glucose levels induced by pregnancy		
	§15-822(b)(4)	• Include benefits for both elevated or impaired blood levels induced by prediabetes, consistent with American Diabetes Association standards		
B15.	§15-826.2	Male Sterilization coverage		
	§15-826.2(b)(2)	• Deductible, Copayments or Coinsurance may not be applied		
	§15-826.2(b)(3)	Exception: For high deductible plans, deductible may be applied to male sterilization		
B16.	§15-827	Coverage for Medical Clinical Trials		
	42 USC § 300gg-8(d)	• Expanded definition of approved clinical trial		
B17.	§15-828	General Anesthesia for Dental Care		
B18.	§15-829	Annual Chlamydia Screening Test		

	§15-829(c)(2)	• Human Papillomavirus Screening Test		
B19.	§15-832	Coverage for Home Visits If Less than 48 hours of Inpatient Hospitalization is Provided for Surgical Removal of Testicle		
B20.	§15-832.1	Coverage for Inpatient Hospitalization for a Minimum of 48 Hours Following Mastectomy or Coverage for Home Visits if less than 48 Hours of Inpatient Hospitalization.		
	§15-832.1(a)	• Mastectomy Definition		
B21.	§15-834	Breast Prosthesis		
B22.	§15-835	Habilitative Services for Children • Revised Habilitative Services definition • Required to provide health benefits until end of month in which child turns age 19		
		Treatment of autism and autism spectrum disorders under services		
	COMAR 31.10.39	• Utilization review criteria must comply with COMAR 31.10.39		
	COMAR 31.10.39.03G	• Applied behavior analysis (behavioral health treatment) cannot be excluded		
B23.	§15-855	Pediatric Autoimmune Neuropsychiatric Disorders associated with streptococcal infections and pediatric acute onset neuropsychiatric syndrome • Diagnosis, evaluation, and treatment, including the use of intravenous immunoglobulin therapy		
	§15-855, House Bill 820, Chpt. 321, Acts of 2022 (effective 01/01/23)	• Modification of coverage requirement: Rituximab cannot be excluded for treatment of PANS/PANDAS solely on the basis that the FDA has not approved the drug for this indication.		
B24.	§15-139	Health Care Services Through Telehealth		

	§15-139(a), House Bill 869, Chapter 482, Acts of 2025 (effective June 1, 2025)	a. Revised to include a Definition of "telehealth:" • Audio-only telephone conversation between a health care provider and a patient that results in the delivery of a billable, covered health care service. • Amended to NOT include, except as provided above, audio-only telephone conversation between a health care provider and a patient.		
	§15-139(c)(1), Senate Bill 3, Chpt. 71, Acts of 2021 (effective 7/01/21)	b. Coverage shall: • Be provided regardless of the location of the patient at the time the telehealth services are provided. • Not be excluded or denied for a behavioral health care service that is a covered benefit under a health insurance policy or contract when provided in person solely because the behavioral Health Care Service may also be provided through a covered telehealth benefit.		
	§15-139(c)(2), Senate Bill 3, Chpt. 71, Acts of 2021 (effective 7/01/21)	c. Telehealth care services include counseling and treatment for substance use disorders and mental health conditions.		
	§15-139(e), Senate Bill 3, Chpt. 71, Acts of 2021 (effective 7/01/21)	d. May not require that covered health care services delivered through telehealth be provided by a third-party vendor designated by the carrier.		
B25.	§15-836	Hair Prostheses for Hair Loss Resulting from Chemotherapy or Radiation Treatment for Cancer		
B26.	§15-837	Colorectal Cancer Screening		
B27.	§15-839	Treatment of Morbid Obesity • If utilization review criteria are included, criteria must comply with COMAR 31.10.33		
B28.	§15-838	Hearing Aids Coverage for Children		
B29.	§15-838.1, Senate Bill 778, Chpt. 952, Acts of 2024 (effective 1/1/25)	Hearing Aids- Coverage for Adults		
	§ 15-838.1(c)(2), House Bill 1355, Chapter 742, Acts of 2025	• Expanded to include coverage for a hearing aid that is ordered, fitted and dispensed by a licensed hearing aid dispenser		

	§15-838.1(d)(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.	§15-843	Amino Acid-Based Elemental Formula		
B31.	§15-844	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.		Preventive Services		
	§15-135	• Benefits for annual preventive care must be available once per year at any time during the plan year established by the contract.		
	§15-135.1	• Dental Preventive Care, if benefit is provided, must cover annual benefit at any time during contract’s plan year.		

B33.	§15-1A-10(a) and (e), House Bill 974, Chpt. 745, Acts of 2025 (effective 6/1/2025)	Preventive services in effect on December 31, 2024 and any future recommendations and guidelines that enhance the scope of preventive services to the benefit of the consumer: • Evidence–based items or services that have a rating of A or B in the recommendations of the United States Preventive Services Task Force • Immunizations for routine use in children, adolescents, and adults that have a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention • With respect to infants, children, and adolescents, evidence–informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration • With respect to women, such additional preventive care and screenings, not described in bullet 1 above, as provided for in comprehensive guidelines supported by the Health Resources and Services Administration Required statement specifying that in accordance with § 15-1A-10 of the Insurance Article, the Maryland Insurance Commissioner shall determine which recommendations and guidelines are considered to be in effect and applicable, including whether and when any subsequent updates to the recommendations		
	§15-1A-10(c), House Bill 974, Chpt. 745, Acts of 2025 (effective 6/1/2025)	In-Network services required to be covered without cost-sharing. • For HDHP, may include the deductible for services, unless the Commissioner determines the coverage is identified in the “safe harbor” provision under 26 U.S.C. § 223(c)(2)(C).		
B34.	§15-826.3	Coverage for Fertility Awareness-Based Methods		

	§15-826.3(c)	a. Coverage for instruction by a licensed health care provider on fertility awareness-based methods		
	§15-826.3(a)	b. Fertility Awareness-based Methods definition may not be more restrictive than provided by law		
	§15-826.3(d)	c. Deductible, Copayment or Coinsurance may not be applied (in-network and out-of-network)		
B35.	§15-848	Ostomy Equipment and Supplies		
B36.	§15-853	Coverage for Lymphedema Diagnosis, Evaluation and Treatment		
	§15-853(c)	a. Coverage for medically necessary diagnosis, evaluation and treatment of lymphedema, including equipment, supplies, complex decongestive therapy, gradient compressing garments, and self-management training and education		
	§15-853(a)	b. Gradient Compression Garment definition required		
	§15-853(d)	c. Annual Deductible, Copayment and Coinsurance cannot exceed the annual deductibles, coinsurance, copayments or coinsurance for similar coverages		
B37.	§15-857, House Bill 937, Chpt, 56, Acts of 2022 (effective 01/01/23)	Abortion Care Services (applicable to contracts that provide labor and delivery benefits to individuals or groups on an expense-incurred basis)		
		• Does not apply to high deductible health plans		
	§15-857(b)(i)	• May not apply copayment, coinsurance, or deductible		
	§15-857(b)(1)(ii), House Bill 937, Chpt. 56, Acts of 2022 (effective 01/01/23)	• Prohibition on restrictions on the coverage that are inconsistent with the protected rights under Title 20, Subtitle 2 of the Health-General Article		
	§15-857(b)(2), House Bill 937, Chpt. 56, Acts of 2022 (effective 01/01/23)	• Term “abortion care” is required when describing coverage		
B38.	§15-859, House Bill 1217, Chpt. 323, Acts of 2023 (effective 01/01/24)	Biomarker Testing		

	§15-859(c), House Bill 1217, Chpt. 323, Acts of 2023 (effective 01/01/24)	a. Includes diagnosis, treatment, appropriate management and ongoing monitoring of a disease or condition that is supported by medical and scientific evidence		
	§15-859(a)(2), House Bill 1217, Chpt. 323, Acts of 2023 (effective 01/01/24)	b. Definition ”biomarker”		
	§15-859(a)(3), House Bill 1217, Chpt. 323, Acts of 2023 (effective 01/01/24)	c. Definition ”biomarker testing”		
B39.	§15-860, House Bill 815, Chpt. 354, Acts of 2023 (effective 01/01/24)	Diagnostic Lung Cancer Screening		
	§15-860(b)(1), House Bill 1259, Chpt. 868, Acts of 2024 (effective 1/1/25)	• Recommended screening or follow-up diagnostic imaging to assist in diagnosis of lung cancer when lung cancer screening or follow-up diagnostic imaging is recommended by USPSTF		
	§15-860(b)(2), House Bill 815, Chpt. 354, Acts of 2023 (effective 01/01/24)	a. Coverage for diagnostic ultrasound, magnetic resonance imaging, computed tomography, and image-guided biopsy		
	§15-860(c), House Bill 815, Chpt. 354, Acts of 2023 (effective 01/01/24)	b. 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		
B40.	§15-863(b), House Bill 666, Chapter 684, Acts of 2025, (effective January 1, 2026)	Required coverage for calcium score testing in accordance with the most recent guidelines issued by the American College of Cardiology that expand the scope of preventive care services for the benefit of consumers.		

C. Eligibility, Enrollment and Termination of Coverage

	Citation	**Description**	**"X" Means Applicable**	**Form/ Page**
C1.	§15-403.2; COMAR 31.10.35	Domestic Partnership Coverage, Including Child Dependents of Domestic Partner		
C2.	§15-401, §15-403, §15-403.1	Newborn/Adopted Children/Grandchildren/Guardianship		

	Citation	Description	"X" Means Applicable	Form/ Page
C3.	§15-418	Grandchildren and Individuals under Guardianship Coverage to Age 25		
C4.	§15-417	Part-Time Students with Disabilities		
C5.	§15-402	Incapacitated Children Coverage		
C6.	§15-405	Court Ordered Coverage of Children		
	§15-405(c)	a. Coverage Requirements for Enrollment of Child		
		• Child has coverage through the noncustodial parent, the carrier shall pay someone other than the insured for services received by the child under the contract		
	§15-405(d)	b. Prohibited Denials of Coverage for Child Enrollment		
	§15-405(h)	c. Special Enrollment Period for Employee and Child Required		
	§15-405(i)	d. Special Enrollment Period for Child Required		
C7.		Open Enrollment		
	§15-411	Spouse Loses Job		
	§15-404	Dependent Children Death of Spouse		
C8.	§15-833	Extension of Benefits		
C9.		Continuation		
	§15-409; COMAR 31.11.04	a. Termination of Employment		
	§15-408; COMAR 31.11.02	b. Divorced Spouses		
	§15-407; COMAR 31.11.03	c. Surviving Spouses		

D. Prescription Coverage Benefit (applicable only if contract provides coverage for prescription drugs)

	Citation	Description	"X" Means Applicable	Form/ Page
D1.	§15-805	Coverage of Drugs from Local Pharmacies Same as Mail Order		
D2.	§15-824	90 Day Supply for Maintenance Drugs • Exception for first prescription or change in prescription		

	Citation	Description	"X" Means Applicable	Form/ Page
D3.	§15-826, §15-826.1	Coverage for Contraceptive Drugs or Devices • Coverage without a prescription for FDA approved contraceptive drugs that are available by prescription or over the counter (benefit may be limited to drugs received at in-network pharmacies and reasonable frequency limits may be applied)		
	§15-826.1(e)(1)(ii)	a. Copayments or coinsurance for FDA approved contraceptive drug dispensed without a prescription and available by prescription or over the counter may not exceed the copayment or coinsurance for the contraceptive drug when dispensed under a prescription		
	§15-826.1(d)	b. 12-month supply of prescription contraceptives		
	§15-826.1(c)(2)(ii)	c. 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		
D4.	§15-804	Off Label Use of Drugs		
	§15-804(a)(4)	• Include “Standard reference compendia” definition		
D5.	§15-831	May use a formulary for brand-name drugs in compliance with §15-831		
	§15-831	• Apply formulary exception process to drugs or devices that are removed from formulary or moved to a higher deductible, copayment or coinsurance tier		
	§15-831	• Must cover a contraceptive prescription drug or device that is not on the formulary if it is medically necessary for the member to adhere to the appropriate use of the prescription drug or device in the judgement of the authorized prescriber		
D6.	§15-841	Coverage for Smoking Cessation Treatment		

	Citation	Description	"X" Means Applicable	Form/ Page
D7.	§15-842	Copayment or Coinsurance for prescription drug or device may not exceed the retail price of prescription drug or device		
D8.	§15-845(b)(1), §15-845(b)(2)(i)	Coverage for Certain Prescription Eye Drop Refills (if contract provides coverage for prescription eye drops)		
D9.	§15-142(c)	A contract may not impose a step therapy or fail–first protocol on an insured or an enrollee if: 1) the step therapy drug has not been approved by the U.S. Food and Drug Administration for the medical condition being treated; or 2) a prescriber provides supporting medical information to the entity that a prescription drug covered by the entity: i. was ordered by a prescriber for the insured or enrollee within the past 180 days; and ii. based on the professional judgment of the prescriber, was effective in treating the insured's or enrollee's disease or medical condition.		
	§15-142(e), House Bill 970, Chpt 688, Acts of 2025 (effective January 1, 2026)	As of January 1, 2026, step therapy may also not be required when: The prescription drug is used to treat the insured's or enrollee's stage four advanced metastatic cancer; and a. The prescription drug is approved by the U.S. Food and Drug Administration and is insulin or an insulin analog used to treat Type 1, Type 2 or gestational diabetes**.** b. The prescription drug is approved by the U.S. Food and Drug Administration and is prescribed by a treating physician to treat a symptom or side effect from treatment of stage four advanced metastatic cancer if the use of the drug is:		

	Citation	Description	"X" Means Applicable	Form/ Page
		i. Consistent with best practices for the treatment of stage four advanced metastatic cancer, a condition associated with stage four advanced metastatic cancer, or a side effect associated with treatment of stage four advanced metastatic cancer; ii. Supported by peer-reviewed medical literature; and iii. Covered under the terms of the contract.		
	§15-850	a. Preauthorization cannot be required for certain drug products used to treat opioid use disorder		
	§15-851	b. Preauthorization cannot be required for drugs used for treatment of opioid addiction		
D10.	§15-854	Limits on prior authorization requirements for certain drugs		
	§15-854(g), House Bill 785, Chpt 365, Acts of 2023 (effective 01/01/24)	• 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.		
D11.	§15-849	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		
	§15-849(c)(2)	• May not apply fail first protocol to opioid analgesic drugs before being allowed abuse-deterrent opioid analgesic drugs		
D12.	§15-847	Specialty drugs – Copayment/Coinsurance Limits • Definition excludes drugs for the treatment of diabetes, HIV, or AIDS		

D13.	§15-847.1	Prescription drugs for the treatment of diabetes, HIV, or AIDS -- Copayment/Coinsurance limits		
D14.	§15-822.1, House Bill 1397, Chpt. 405, Acts of 2022, (effective 01/01/23)	Copayment or coinsurance for insulin cannot be more than $30 for a 30-day supply, regardless of amount or type of insulin needed.		
D15.	§ 15-847.2, House Bill 1243, Chapter 729, Acts of 2025 (effective January 1, 2026)	For contracts that limit specialty drugs to a preferred pharmacy, the contract must indicate that benefits will be provided for an otherwise covered specialty drug administered or dispensed by an in-network provider of covered oncology services who complies with State regulations for the administering and dispensing of specialty drugs, if the covered specialty drug is: • auto-injected, or an oral targeted immune modulator; or an oral medication that requires complex dosing based on clinical presentation or is used concomitantly with other infusion or radiation therapies		
D16.	§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.		
D17.	§15-852	Prorated daily copayment/coinsurance for partial supply of prescription drug dispensed by in-network pharmacy		
D18.	§15-858, House Bill 970, Chpt. 684, Acts of 2022 (effective 01/01/23)	Prohibition on prior authorization for prescription drugs used as Postexposure Prophylaxis for the prevention of HIV if the drug is prescribed for use in accordance with Centers for Disease Control and Prevention guidelines		
D19.	§15-118.1, Senate Bill 773, Chpt. 692, Acts of 2025 (effective 1/1/2026)	Required statement about calculating the enrollee's contribution to coinsurance, copayments, deductibles*, or out-of-pocket maximums, and application of discount, financial assistance payment, product voucher, or other out-of-pocket expense made by or on behalf of the enrollee for a covered prescription drug if: • Does not have an AB-rated generic equivalent drug or an interchangeable biological product preferred under the plan's formulary; or		

		• Has an AB-rated generic equivalent drug or an interchangeable biological product preferred under the plan's formulary, and for which the enrollee originally obtained coverage through prior authorization, a step therapy protocol, or an exception or appeal process. *Exception for deductible in HDHP		

E. Maternity

	Citation	Description	"X" Means Applicable	Form/ Page
E1.		Inpatient Hospitalization for Mothers and Newborns		
E2.	§15-812	a. Mandated Coverage		
	§15-811	b. Additional 4 days Inpatient Stay for Newborn if Mother Requires Inpatient Care		
	§15-812(g)(1)	c. Coverage of Home Visits for Mothers and Newborns May Not Be Subject to Deductibles, Copays or Coinsurance for health plans		
	§15-812(g)(2)	d. High-Deductible Health Plan Coverage of Home Visits for Mothers and Newborns May Be Subject to Deductible		
E3.	§15-506	Maternity Care Regardless of Marital Status		
E4.	§15-811	Hospitalization Same as for Any Other Covered Sickness		
E5.	§15-810	In Vitro Fertilization (applicable for expense incurred hospital, medical or surgical benefits)		
	§15-810(b), §15-810(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), Senate Bill 988, Chpt. 325, Acts of 2020 (effective 01/01/21)	• Period of time to demonstrate a history of infertility reduced from two years to one year.		

	Citation	Description	"X" Means Applicable	Form/ Page
	§15-810(d)(4), Senate Bill 988, Chpt. 325, Acts of 2020 (effective 01/01/21)	• Coverage for in vitro-fertilization benefit expanded to include unmarried patients		
E6.	§15-810.1	Coverage for fertility preservation procedures for iatrogenic infertility		
		Required Definitions:		
	§15-810.1(a)(2)	a. Iatrogenic Infertility		
	§15-810.1(a)(3)	b. Medical Treatment that May Directly or Indirectly Cause Iatrogenic Infertility		
	§15-810.1(a)(4)	c. Standard Fertility Preservation Procedures		

F. Practitioners

	Citation	Description	"X" Means Applicable	Form/ Page
F1.	§15-701	Health Care Providers		
	§15-701, Senate Bill 216, Chpt. 330, Acts of 2023 (effective 7/01/23)	• May not exclude medically necessary treatment services otherwise covered under the contract when those services are provided by a massage therapist		
F2.	§15-703	Certified Nurse Practitioner		
F3.	§15-708	Nurse Anesthetist		
F4.	§15-705	Chiropractor		
F5.	§15-709	Nurse Midwife		
F6.	§15-713	Podiatrists		
F7.	§15-704	Clinical Professional Counselors		
F8.	§15-707	Social Workers		
F9.	§15-710	Optometrists		
F10.	§15-714	Psychologists		
F11.	§15-715	Community Health Resource		

G. Disability

	Citation	Description	"X" Means Applicable	Form/ Page
G1.	§15-813	Disability Benefits for Pregnancy or Childbirth		

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

H. Other

	Citation	Description	"X" Means Applicable	Form/ Page
H1.	§15-604	Payment of Maryland Hospitals Based on Rate Set by Health Services Cost Review Commission		
H2.	§15-603	Reimbursement for Services Paid for or Provided by Department of Health		
H3.		Preferred Provider		
	§14-205(b)(2)	a. Difference between coinsurance percentage for non-preferred and preferred providers may not exceed 20 percentage points		
	§14-205(b)(3)	b. PPO contract provisions for the insured to pay the balance bill may not apply to an on-call or hospital-based physician who has accepted an assignment of benefits in accordance with §14-205.2		

	Citation	Description	"X" Means Applicable	Form/ Page
	§14-205(b)(4)	c. Insurer's allowed amount paid to non-preferred providers for a health care service covered by a PPO contract may not be less than the allowed amount paid to a similarly licensed provider who is a preferred provider for the same service in the same region		
	§15-118(c)	d. Coinsurance Amounts for Preferred Provider Must Be based on Negotiated Fees with Insurer		
	§15-830(a)	e. Referrals to Specialists – Definitions Are Unacceptable		
	§15-830(b)	f. Procedure for Right to Standing Referral to Network Specialist		
	§15-830(d)(2)(ii)(2)	g. Procedure for Right to Request Referral to Specialist, Including Non-Physician Specialist Not on Carrier's Provider Panel • Referral must be granted if the carrier cannot provide reasonable access to a specialist without unreasonable travel or delay.		
	§15-816	h. 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(c)	• Written treatment plan may not be required		
	§15-140	i. When member transitions from another carrier or managed care organization, receiving carrier must allow member to continue to receive health care services from a nonparticipating provider under certain circumstances		

	Citation	Description	"X" Means Applicable	Form/ Page
	§14-205.2	j. Payment Rules for Assignment of Benefits for Physicians on Call and Hospital-Based Physicians		
	§14-205.3	k. Payment Rules for Assignment of Benefits for Physicians Not on Call or Hospital-Based Physicians		
	Title 15, Subtitle 17	l. Physician Rating System		
H4.	§14-205.1	Exclusive Provider Benefit (EPO)		
	§14-205.1(a)	a. Plan must not restrict payment for certain covered services provided by non-preferred providers		
	§14-205.1(a)(1)	• Emergency Services – As defined in §19-701 of the Health-General Article		
	§14-205.1(a)(2)	• An unforeseen illness, injury or condition requiring immediate care		
	§14-205.1(a)(3)	• Referrals to Specialists as required by §15-830		
	§15-118(c)	b. Coinsurance Amounts for Preferred Provider must be based on Negotiated Fees with Insurer		
	§15-830(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		
	§15-830(d), House Bill 11, Chapter 660, Acts of 2025 (effective January 1, 2026)	e. Referral must be granted if the carrier cannot provide reasonable access to a specialist without unreasonable travel or delay f. Reasonable access for mental health or substance use disorder care is determined by the reasonable appointment waiting time and travel distance standards established in regulation for mental health and substance use disorder care.		
	§15-830(e)(2) House Bill 11, Chapter 660, Acts of 2025 (effective January 1, 2026)	g. Balance billing is prohibited for services received from a referral to a non-panel provider for mental health or substance use disorders.		

	Citation	Description	"X" Means Applicable	Form/ Page
		h. Carrier must ensure that services for mental health or substance use disorders are provided *for the duration of the treatment plan* at no greater cost to the covered individual than if the covered benefit were provided by a provider on the carrier's provider panel.		
	§15-816	i. 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		
	§14-205.1(b)(1)	j. Required Point-of-Service (POS) benefit rider option if only offering a closed network plan (EPO plan) to Group Policyholder's employees or members		
		1. POS benefit must include all services under the contract, but would permit the covered individual to receive the services from a Non-Preferred Provider		
		2. POS benefit must indicate that benefits required under§14-205.1(a)(2) (i.e., those for emergency, unforeseen illness, injury, or condition requiring immediate care, or required under §15-830) will not be paid under the POS benefit, even if provided by a Non-Preferred Provider, but will pay as if received from a Preferred Provider under the contract		
	§14-205.1(b)(2)	k. Applications for EPO Contract		
		1. Group Policyholder Application • Required Disclosure Statement or Actual Option of POS benefit in application		

	Citation	Description	"X" Means Applicable	Form/ Page
		• If only Disclosure Statement appears in application, a separate application is needed for employer/group application to select POS benefit option		
		2. Employee/Member Application • If group policyholder applicant accepts POS benefit option, then primary employee/member application/ enrollment form must include this POS benefit option		
	§15-140	l. When member transitions from another carrier or managed care organization, receiving carrier must allow member to continue to receive health care services from a nonparticipating provider under certain circumstances		
	§14-205.2	m. Payment Rules for Assignment of Benefits for Physicians on Call and Hospital-Based Physicians		
	§14-205.3	n. Payment Rules for Assignment of Benefits for Physicians Not on Call or Hospital-Based Physicians		
	Title 15, Subtitle 17	o. Physician Rating System		
H5.	Title 15, Subtitle 10D; COMAR 31.10.29	Complaint process for coverage decisions		
	§15-10D-01(k)	• Revised member definition		
H6.	§15-112(q)	Identify office and process for filing complaints		
H7.	§15-919	Medicare Supplement Disclaimers for Individuals eligible for Medicare Due To Age (non-employer and non-labor organization contracts only)		
H8.	COMAR 31.10.01.03C	Standard of Time		
H9.	COMAR 31.10.01.03G	Right to Elect Alternative Benefits		
H10.	§12-209(1), §12-209(2), §12-209(4)	Contract Governed by Maryland Law and Maryland Courts		
H11.	§15-110(d)	Required Exclusion for Prohibited Practitioner Referral		
H12.	§15-304	Direct Payment of Hospital or Medical Services		
H13.	§15-1005(g)	Payment of Interest on Unpaid Claims		

	Citation	Description	"X" Means Applicable	Form/ Page
H14.	COMAR 31.15.08	Payment of Claims, Unfair Trade Practices		
H15.	§15-122	Must be Given at Least a 45-Day Notice of Premium Increase at Renewal		
H16.	COMAR 31.11.10.04	Premium Due Date		
H17.	§15-138	Reimbursement of Ambulance Service Providers		
H18.	§27-216; MIA Bulletin 17-10	Requirements for Acceptance of Credit Cards for Premium Payment and Charging of Fees for Use of Credit Cards		
H19.	§ 27-209, Senate Bill 725, Chapter 38, Acts of 2023	Value Added Services/ Non Insurance Benefits		

I. Prohibited Provisions, Limitations and Exclusions

	Citation	Description	"X" Means Applicable	Form/ Page
I1.	COMAR 31.10.01.03N	Damage to Conveyance		
I2.	COMAR 31.10.01.03O	Chronic or Organic Disease		
I3.	COMAR 31.10.01.03I	Frequency of Physician Visits		
I4.	COMAR 31.10.01.03P	Reimbursement Language		
I5.	COMAR 31.10.01.03Q	Strict Compliance Language		
I6.	COMAR 31.11.10.06A(1)	May not limit or exclude loss due to insured's commission of or attempt to commit a crime.		
I7.	COMAR 31.11.10.06B(1)	May not limit or exclude loss to which a contributing cause was the insured's being engaged in an illegal occupation.		
I8.	COMAR 31.11.10.06C	May not limit or exclude loss due to use of intoxicants or narcotics		
	COMAR 31.11.10.06C(1)(a)	a. Sustained or contracted in consequence of the insured being intoxicated or under the influence of any drug.		
	COMAR 31.11.10.06C(1)(b)	b. Due to the use of alcohol		
	COMAR 31.11.10.06C(1)(c)	c. Due to the use of drugs or narcotics		
	COMAR 31.11.10.06C(1)(d)	d. Due to alcoholism or drug addiction		
	COMAR 31.04.17.18, COMAR 31.11.10.06D	e. Preexisting Conditions		

	Citation	Description	"X" Means Applicable	Form/ Page
	§15-401	f. Preexisting Condition exclusion may not apply to newly born or newly adopted dependent child/grandchild or minor for guardianship		
I9.	COMAR 31.04.17.10B	Good Health Warranty not permitted		
I10.	§15-711(b)	Physical Therapist Time Limitations		
I11.	§15-104(c)	May not coordinate against guaranteed renewable individual intensive care or specified disease policies.		
I12.	§15-104(d)	May not provide benefits that are secondary to benefits under an automobile policy, including PIP		
I13.	§15-126	May not discourage or prohibit access to the 911 emergency system		
I14.	§27-913	Benefits for Treatment of a Specified Disease or Diagnosis May Not Be Subject to Different Copays, Coinsurance, Deductibles, Annual or Lifetime Maximums		
I15.	§15-1009	Denial of Reimbursement for Pre-authorized care prohibited except for limited reasons.		
I16.	§27-303; MIA Bulletin L&H 99-25	Denial of Medically Necessary Inpatient Ancillary Charges Prohibited		
I17.	§27-504; 26 CFR §54.98021(b)(2)(iii)	Prohibited Discrimination on Domestic Violence Victims		
I18.	COMAR 31.04.17.11B	Self-Destruction		
I19.	§15-602	State Hospitals, etc., Charitable or Otherwise		
I20.	§15-505	House Confinement, Medical Treatment Permitted Elsewhere		
I21.	§15-502	No Reduction for Medical Assistance Program		
I22.	§15-503	May not deny, cancel, or refuse to renew coverage because insured has been exposed to diethylstilbestrol.		
I23.	45 CFR §146.121(b)(2)(iii)	Prohibited Suicide or Self-Inflicted Injury Exclusion		
I24.	§15-810(b)	Benefits for Infertility may not discriminate against same-sex married couples who might require such services		
I25.	COMAR 31.04.17.07	Advertising Prohibited		

	Citation	Description	"X" Means Applicable	Form/ Page
I26.	§15-510	May not deny behavioral counseling services provided by participating provider solely on the basis that it is school based		
I27.	§15-704	Art Therapy May Not Be Excluded		
I28.	§27-915	Prohibits denying organ transplantation solely on basis if an insured's or enrollee's disability (if contract provides organ transplantation)		
I29.	§15-716, House Bill 1151, Chpt. 301, Acts of 2023 (amended effective 01/01/24); §15-701	May not exclude coverage for licensed pharmacists providing patient assessment regarding and in administering self-administered medications or maintenance injectable medications when acting within lawful scope of practice.		
	§15-716, House Bill 1151,Chpt. 301, Acts of 2023 (amended effective 01/01/24)	• May not condition on whether pharmacist is employed by a physician, pharmacy, or facility or acting under physician's order		
I30.	§ 12-201	Insurable Interest Required		
I31.	§ 12-211, House Bill 1069, Chapter 396, Acts of 2025 (effective October 1, 2025)	Discretionary Clauses Prohibited		
I32.	§ 15-862, House Bill 1086, Chapter 683, Acts of 2025 (effective January 1, 2026)	Time Limitations on Anesthesia Prohibited		

J. Required Standard Provisions

	Citation	Description	"X" Means Applicable	Form/ Page
J1.	COMAR 31.11.10.03	Required Standard Provisions		
J2.	COMAR 31.11.10.04A	Entire Contract		
J3.	COMAR 31.11.10.04B	Contestability of Coverage		
J4.	COMAR 31.11.10.04C	Notice of Claim		
J5.	COMAR 31.11.10.04D	Claim Forms		
J6.	COMAR 31.11.10.04E	Proofs of Loss		

	Citation	Description	"X" Means Applicable	Form/ Page
	§12-102, §12-102(c)(2)	a. Extends proof of loss period to one year for claim • If not reasonably possible to submit claim within one year, time period extended to two years after date of service • Enrollee's legal incapacity shall suspend the time to submit a claim		
	§15-1011	b. Methods for Claim Submission		
	§15-1005(e)	• Provider must be permitted minimum of 180 days to file claim		
J7.	COMAR 31.11.10.04F	Time of Payment of Claims		
J8.	COMAR 31.11.10.04G	Payment of Claims		
J9.	COMAR 31.11.10.04H	Legal Action		
J10.	COMAR 31.11.10.04I	Grace Period		
J11.	COMAR 31.11.10.04J	Certificates		
J12.	COMAR 31.11.10.04K	Addition of Employees/Members		
J13.	COMAR 31.11.10.04L	Misstatement of Age		
J14	COMAR 31.11.10.04N	Premium Due Date		

K. Optional Standard Provisions

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

L. Utilization Review

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

	Citation	Description	"X" Means Applicable	Form/ Page
	§15-1001; Title 15, Subtitle 10B; COMAR 31.10.18; §15-10A-02	• Identify Company's PRA for making utilization review determinations of what health care service is medically necessary, experimental or investigative, or cosmetic		
L2.	§15-142(e)	May not require prior authorization on certain cancer drugs		
L3.	§15-850	May not require prior authorization for a covered opioid antagonist unless at least one formulation of the opioid antagonist is covered without a prior authorization requirement		
L4.	§15-851	May not require prior authorization for a prescription drug containing methadone, buprenorphine, or naltrexone when the drug is used for treatment of an opioid use disorder		
L5.	§15-10B-05(a)(4)	Utilization review agent must be reasonably available 7 days a week, 24 hours a day		
L6.	§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		
L7.	§ 15-861, House Bill 1301, Chapter 612, Acts of 2025 (effective January 1, 2026)	Transfers to Special Pediatric Hospitals - Prior Authorizations		
	§ 15-861 (c), House Bill 1301, Chapter 612, Acts of 2025 (effective January 1, 2026)	For contracts that require prior authorization for hospital admissions, must include an exception for the transfer of a patient to a special pediatric hospital.		
	§ 15-861 (a), House Bill 1301, Chapter 612, Acts of 2025 (effective January 1, 2026)	Definition for "special pediatric hospital" required if prior authorization is required		
L8.	§15-10B-06(a)	Initial authorization of course of treatment made:		
	§ 15-10B-06(a)(1)(i), Senate Bill 791, Chpt. 848, Acts of 2024 (effective 1/1/25)	a. For non-emergencies, within 2 working days of receipt of information necessary to make determination		
	§15-10B-06(a)(1)(ii)	b. For extended stays or additional health care services, within 1 working day of receipt of necessary information		

	Citation	Description	"X" Means Applicable	Form/ Page
	§ 15-10B-06(a)(1)(iii), Senate Bill 791, Chpt. 848, Acts of 2024 (effective 1/1/25)	c. For additional visits or days of care as part of existing treatment, within 1 working day of receipt of necessary information		
	§ 15-10B-06(a)(2), Senate Bill 791, Chpt. 848, Acts of 2024 (effective 1/1/25)	d. After receipt of initial request, if more information is necessary to make decision, inform provider no more than 3 calendar days following initial request of the need for more information		
	§ 15-10B-06(b), Senate Bill 791, Chpt. 848, Acts of 2024 (effective 1/1/25)	e. For emergency inpatient or residential crisis services admissions for the treatment of a mental, emotional, or substance abuse disorder, within 2 hours of receipt of the necessary information		
	§ 15-10B-06(c), Senate Bill 791, Chpt. 848, Acts of 2024 (effective 1/1/25)	f. For step therapy exception request submitted electronically, make determination in real time if no additional information is needed and request meets the PRA's criteria for approval		
L9.	§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.		
L10.	§15-10B-07(c)	May not retroactively deny approval of preauthorized services		
L11.	§ 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		
L12.	§ 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		
L13.	§15-10B-06(h), Senate Bill 791, Chpt. 848, Acts of 2024 (effective 1/1/25)	Involuntary or voluntary psychiatric admission of patient in danger – may not deny care during the first 24 hours after voluntary inpatient admission or 72 hours after involuntary admission		

	Citation	Description	"X" Means Applicable	Form/ Page
L14.	§15-140(c)(1), §15-140(c)(2)	When health plan is the receiving carrier, the health plan must, upon request, accept a preauthorization from the relinquishing carrier for the lesser of the course of treatment or 90 days; and for pregnancy the duration of the 3 trimesters of pregnancy and the initial postpartum visit.		

M. Applications

	Citation	Description	"X" Means Applicable	Form/ Page
M1.	COMAR 31.04.17.06I(2)	Check-off boxes required for carrier name if application is to be used by more than one carrier.		
M2.	COMAR 31.04.17.06I(3)	Application must clearly identify coverages underwritten by each carrier, when more than one carrier uses the same application with the same group applicant		
M3.	COMAR 31.04.17.06A	Application shall stipulate the plan and amount of insurance and any added optional benefits applied for.		
M4.	§27-805; MIA Bulletin 12-07	Insurance Fraud-required Disclosure Statement		
M5.	§12-205(b)(9)	Seven Year Limit for Health Questions		
M6.	§27-504(b)	Domestic Violence		
M7.	§27-909(c)	May Not Inquire About Genetic Tests or Genetic Information		
M8.	COMAR 31.04.17.06E; §12-207	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		
M9.	COMAR 31.04.17.06C	Questions about "hazardous activities" must list activities considered to be "hazardous"		
M10.	COMAR 31.04.17.06D	Questions about the use of "habit-forming drugs" must list specific drugs considered to be "habit-forming"		
M11.	COMAR 31.04.17.06F, COMAR 31.04.17.06G	Questions about symptoms or indications of physical/mental conditions must ask about "known symptoms" and "known indications"		
M12.	§12-202(c)	Application Changes		
M13.	COMAR 31.04.17.08	Proxy Not Permitted		

	Citation	Description	"X" Means Applicable	Form/ Page
M14.	COMAR 31.04.17.10B	Good health warranty not permitted		
M15.	COMAR 31.04.17.06B	Certain States		
M16.	§12-205(b)(2)	Description of the preexisting conditions limitation is not the same as in the policy		
M17.	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 that must be attached to insurance contract to exclude person from coverage.		