# HEALTH MAINTENANCE ORGANIZATION – LARGE GROUP COVERAGE

| 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. **Refer to COMAR, The Insurance Article or Health-General Article, as amended to date, for the exact wording.** Unless otherwise specified, all section references are to the Insurance Article of the Annotated Code of Maryland.

## A. Filing Submission Requirements

| | Citation | Description | "X" Means Applicable | Form/ Page |
|---|---|---|---|---|
| A1. | COMAR 31.12.02.03C(4) | Listing of Forms with Brief Description | | |
| A2. | COMAR 31.12.02.03H | Contracts with Insert Pages | | |
| | COMAR 31.12.02.03H(1)(a) | a. Form Number | | |
| | COMAR 31.12.02.03H(1)(b)(i) | b. Description of How Pages will be Combined | | |
| | COMAR 31.12.02.03H(1)(b)(ii) | c. Listing of Substitute Pages | | |
| | COMAR 31.12.02.03H(3)(a) | d. Form Number and Approval Date for Pages Replaced | | |
| | COMAR 31.12.02.03H(3)(b) | e. Copy of Currently Approved Contract | | |
| A3. | COMAR 31.12.02.03I | Contracts Comprised of Sections | | |
| | COMAR 31.12.02.03I(1)(a) | a. Form Number | | |
| | COMAR 31.12.02.03I(1)(b)(i) | b. Description of How Sections will be Combined | | |
| | COMAR 31.12.02.03I(1)(b)(ii) | c. Listing of Substitute Sections | | |
| | COMAR 31.12.02.03I(3)(a) | d. Form Number and Approval Date for Sections Replaced | | |
| | COMAR 31.12.02.03I(3)(b) | e. Copy of Currently Approved Contract | | |

| | Citation | Description | "X" Means Applicable | Form/ Page |
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| A4. | § 19-713, Health-General, COMAR 31.12.02.08A | Premium Rates<br>• Required to be Filed in Same SERFF Tracking # as Forms | | |
| A5. | COMAR 31.12.02.03C(2) | Filing Fees Paid | | |

## B. General Requirements for Forms

| | Citation | Description | "X" Means Applicable | Form/ Page |
|---|---|---|---|---|
| B1. | COMAR 31.12.02.06B | Size of Type | | |
| B2. | COMAR 31.12.02.03E | Unacceptable Modifications | | |
| B3. | COMAR 31.12.02.03G | Specimen Data | | |
| B4. | COMAR 31.12.02.06A | Form Number | | |
| | | • For each Form Schedule Item submitted in SERFF, the number printed in the lower left hand corner of the first page of the form must match number entered in "Form Number" field | | |
| B5. | COMAR 31.12.02.06D | Corporate Name & Address | | |
| B6. | COMAR 31.12.02.06F | Signature of Officer | | |
| B7. | COMAR 31.12.02.07D | Signature of Applicant for Reduction Rider | | |
| B8. | COMAR 31.12.02.04B(1) | Form contains items in brackets, denoting variability. Submit specific description of how each item can vary. If other text is desired, include specific text. | | |

## C. Eligibility, Enrollment, and Termination of Coverage

| | Citation | Description | "X" Means Applicable | Form/ Page |
|---|---|---|---|---|
| C1. | 42 USC § 300gg-1, 45 CFR §147.104(a), §15-1410 | Guaranteed availability of coverage | | |
| | | • HMO must offer to any large employer in the state all large group products that are approved for sale, and must accept any employer that applies for any of those products | | |
| C2. | 42 USC § 300gg-7, 45 CFR §147.116, §15-1A-12 | May not impose a waiting period that exceeds 90 days | | |
| C3. | §15-1406(a) | May not establish eligibility rules based on health status | | |

| | Citation | Description | "X" Means Applicable | Form/ Page |
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| C4. | 45 CFR §146.121(e) | Deferred effective date provisions prohibited | | |
| C5. | §15-403.2, COMAR 31.10.35 | Domestic Partner Coverage, including Child Dependents of Domestic Partner | | |
| C6. | §§15-401, 15-403, 15-403.1 | Newborns/Adopted Children/Grandchildren/Guardianship | | |
| C7. | 42 USC § 300gg-14, 45 CFR §147.120, MIA Bulletin 10-17, §15-1A-08 | Child Dependent Coverage to Age 26 | | |
| | 80 FR 72205 and 72275 | • HMO may not deny coverage or terminate coverage if a child no longer lives, works, or resides in the HMO service area | | |
| C8. | §15-418 | Coverage of Grandchildren and Individuals Under Guardianship to Age 25 | | |
| C9. | §15-417 | Part-Time Students with Disabilities | | |
| C10. | §15-402(b) | Incapacitated Children | | |
| C11. | §15-405 | Court Ordered Coverage of Children | | |
| | §15-405(c) | a. Coverage Requirements for Enrollment of Child (must appear in contract) | | |
| | §15-405(d) | b. Prohibited Denials of Coverage for Child Enrollment | | |
| | §15-405(e) | c. 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 (must appear in contract) | | |
| | §15-405(h) | d. Special Enrollment Period for Employee and Child Required | | |
| | §15-405(i) | e. Special Enrollment Period for Child Required | | |
| C12. | | Special Enrollment Period Provisions | | |
| | §15-1406(d) | a. For employee/dependent who loses other coverage | | |
| | §15-1406.1(c)(1) | b. For individuals who become dependents of employee | | |

| | Citation | Description | "X" Means Applicable | Form/ Page |
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| | §15-1406.1(c)(2) | c. Permit employee to enroll himself or herself when he or she acquires new dependents | | |
| | §15-1406.1(c)(3) | d. For spouse of employee at birth or adoption of child | | |
| C13. | COMAR 31.12.02.06J(6), §15-122 | Renewal Provision | | |
| C14. | COMAR 31.12.02.10 | Termination Provision | | |
| C15. | COMAR 31.12.02.10B, §15-1408 | Permissible Causes of Termination | | |
| C16. | 42 USC § 300gg-12, 45 CFR §147.128, MIA Bulletin 10-23, §15-1A-21 | May only rescind contract for fraud or intentional misrepresentation and requires 30-day advance notice | | |
| C17. | §15-833 | Extension of Benefits | | |
| C18. | | Continuation of Coverage | | |
| | §15-407; COMAR 31.11.03 | a. Surviving Spouses | | |
| | §15-408; COMAR 31.11.02 | b. Divorced Spouses | | |
| | §15-409; COMAR 31.11.04 | c. Terminated of Employment | | |

## D. Mandated Benefits

| | Citation | Description | "X" Means Applicable | Form/ Page |
|---|---|---|---|---|
| D1. | §19-701(g)(2), Health-General | Unlimited Hospitalization | | |
| D2. | §19-701(g)(2), Health-General | Physician Services | | |
| D3. | §19-701(g)(2), Health-General | Laboratory | | |
| D4. | §19-701(g)(2), Health-General | X-ray | | |
| D5. | §19-701(g)(2), Health-General, 42 USC § 300gg-19a, 45 CFR §147.138(b), MIA Bulletin 10-23, §15-1A-14 | Emergency Services | | |

| | Citation | Description | "X" Means Applicable | Form/ Page |
|---|---|---|---|---|
| | 45 CFR §149.30<br>45 CFR §149.110(c)(1)<br>MIA Bulletin 21-24 | a. Emergency medical condition definition | | |
| | 45 CFR §149.30<br>45 CFR §149.110(c)(2)<br>45 CFR §149.410(b)<br>MIA Bulletin 21-24 | b. Emergency services definition | | |
| | 45 CFR §149.420(b)(1)<br>MIA Bulletin 21-24 | c. Ancillary service definition | | |
| | 45 CFR §149.30<br>MIA Bulletin 21-24 | d. Independent freestanding emergency department definition | | |
| | 45 CFR §149.30<br>MIA Bulletin 21-24 | e. Nonparticipating emergency facility definition | | |
| | 45 CFR §149.30<br>MIA Bulletin 21-24 | f. Nonparticipating provider definition | | |
| | 45 CFR §149.30<br>MIA Bulletin 21-24 | g. Participating emergency facility definition | | |
| | 45 CFR §149.30<br>MIA Bulletin 21-24 | h. Participating provider definition | | |
| | 45 CFR §149.30<br>MIA Bulletin 21-24 | i. Treating provider definition | | |
| | 45 CFR §149.110(c)(3)<br>MIA Bulletin 21-24 | j. To stabilize definition | | |
| | 45 CFR §149.30<br>MIA Bulletin 21-24 | k. Visit | | |
| | 45 CFR §149.110(b) | l. 1) No prior authorization. 2) No limitations or exclusions for non-network providers. 3) No administrative requirements on non-network emergency services that are not imposed in-network. 4) No limitations on what constitutes an emergency solely on the basis of diagnosis codes. 5) No limitations regarding other terms or conditions of coverage. | | |
| | §19-712.5, Health-General Article | m. Reimbursement to Hospital Emergency Facilities and Providers | | |
| D6. | §19-712.5(f), Health-General | Emergency surgery follow-up care | | |

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|---|---|---|---|---|
| D7. | §§ 19-701(g)(2), 19-705.1(c)(4)(i), Health-General | Preventive Services | | |
| | 42 USC § 300gg-13, 45 CFR §147.130, MIA Bulletin 10-23, §15-1A-10 | a. In-network preventive services as defined by ACA, including women's preventive services in accordance with HRSA guidelines, required to be covered without cost-sharing | | |
| | §§ 19-701(g)(2), 19-705.1(c)(4)(i), Health-General | b. Hearing screening of newborns by hospital | | |
| | §15-135 | c. Covered annual preventive visits/screenings must be provided once at any time during the contract year | | |
| D8. | §19-703(c), Health-General, COMAR 31.10.09 | Hospice Option | | |
| D9. | §19-705.5, Health-General | Medical Foods | | |
| D10. | § 15-135.1 | Dental Preventive Care, if benefit is provided | | |
| | | • Annual dental preventive care visit must be covered if provided at any time during the policy – may not require visit to occur after a specified time period (e.g. 12 months) following prior visit | | |
| | | • If the contract provides benefits for dental preventive care more frequently than once per policy year, the contract may not require that the visits be separated by more than 120 days | | |
| D11. | §15-139 | Telehealth Services | | |
| | §15-139(a), SB 534, Chpt 382, Acts of 2023 (effective 6/1/2023) | a. Definition of "telehealth:"<br>• revised to include, from July 1, 2021 to June 30, 2025, both inclusive, an audio-only telephone conversation between a health care provider and a patient that results in the delivery of a billable, covered health care service. | | |

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| | | • Amended to NOT include, except as provided above, audio-only telephone conversation between a health care provider and a patient | | |
| | §15-139(c)(1), SB 3, Chpt. 71, Acts of 2021 (effective 7/1/2021) | b. Coverage shall:<br>• be provided regardless of the location of the patient at the time the telehealth services are provided.<br>• 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), SB 3, Chpt. 71 Acts of 2021 (effective 7/1/2021) | c. Telehealth care services include counseling and treatment for substance use disorders and mental health conditions. | | |
| | §15-139(e), SB 3, Chpt. 71, Acts of 2021 (effective 7/1/2021) | d. May not require that covered health care services delivered through telehealth be provided by a third-party vendor designated by the carrier | | |
| D12. | §15-802 | Mental Health/Substance Use Disorder | | |
| | §15-802(c) | a. Required benefits for inpatient care, partial hospitalization, and outpatient care (including all office visits and psychological and neuropsychological testing for diagnostic purposes) | | |
| | §15-840 | b. Required benefits for residential crisis services | | |
| | §15-802(d)(2)(ii)<br>45 CFR §146.136(c)(2)(i) | c. May not apply any financial requirement or quantitative treatment limitation in any benefit classification that is more restrictive than the predominant financial requirement/treatment limitation of that type that applies to substantially all medical/surgical benefits in the same classification | | |

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| | §15-802(d)(2)(ii)<br>45 CFR<br>§146.136(c)(2)(ii) | d. For purposes of determining mental health parity, benefit classifications limited to inpatient, in-network; inpatient, out-of-network; outpatient, in-network; outpatient, out-of-network; emergency care; and prescription drugs | | |
| | §15-802(d)(2)(ii)<br>45 CFR<br>§146.136(c)(3)(iii) | e. Exceptions to six benefit classifications provided only for multi-tiered prescription drug benefits, multiple network tiers, and outpatient sub-classification of office visits, separate from other outpatient items and services | | |
| | §15-802(d)(2)(iv)<br>45 CFR §146.136(c)(2)(i) | f. 60-day limit for partial hospitalization described in §15-802(d)(2)(iv), only permitted upon demonstration of compliance with 45 CFR §146.136(c)(2)(i) | | |
| | §15-802(d)(2)-(4)<br>45 CFR §146.136(c)(4) | g. Prohibition on nonquantitative treatment limitations (including UR requirements) that are more restrictive than requirements for physical illnesses | | |
| D13. | §15-803 | Blood Products | | |
| D14. | §15-810 | In Vitro Fertilization | | |
| | §15-810(b) and (d)(3) | • Includes 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),<br>Senate Bill 988, Chpt. 325, Acts of 2020 (effective 01/01/21) | • Time period and number of attempts to demonstrate a history of infertility | | |
| | §15-810(d)(4),<br>Senate Bill 988, Chpt. 325, Acts of 2020 (effective 01/01/21) | • Coverage for in vitro-fertilization benefit includes married and unmarried patients | | |
| D15. | §15-810.1 | Fertility Preservation Procedures for Iatrogenic Infertility | | |
| | §15-810.1(a) | • Required definitions | | |

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| D16. | §15-812 | Inpatient Hospitalization for Mothers and Newborns | | |
| | §15-812 | a. Mandated Coverage | | |
| | §19-703(f), Health-General | b. Additional 4 days inpatient stay for newborn if mother requires inpatient care | | |
| | §15-812(g) | c. Coverage of home visits for newborns may not be subject to deductible, copays or coinsurance | | |
| | §15-812(g)(2) | d. For High Deductible Health Plans, home visits may not be subject to copays or coinsurance, but may be subject to deductible | | |
| D17. | §15-814 | 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 | | |
| D18. | §15-814.1(c), HB376, Chpt. 299, Acts of 2023 (effective 1/1/24) | Diagnostic and Supplemental Examinations and Biopsies for Breast Cancer<br>• May not be subject to copays, coinsurance, or deductible.<br>• For High Deductible Health Plans, may not be subject to copays or coinsurance, but may be subject to deductible | | |
| D19. | §15-815 | Reconstructive Breast Surgery | | |
| | §15-815(a)(2) | • Mastectomy Definition | | |
| | §15-815(c)(2) | • Coverage for physical complications of all stages of mastectomy, including lymphedemas, in manner determined by physician | | |
| D20. | §15-818 | Coverage for Cleft Lip or Cleft Palate or Both | | |
| D21. | §15-822 | Diabetes Equipment, Supplies, & Self-Management Training | | |

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| | §15-822(b) | • Coverage for elevated or impaired blood glucose levels induced by pregnancy and elevated or impaired blood glucose levels induced by prediabetes, consistent with the American Diabetes Association's standards | | |
| | §15-822(d)(3) | • Diabetes Test Strips- may not impose a deductible, copayment, or coinsurance | | |
| | §15-822(d)(3)(ii) | • For High Deductible Health Plans, diabetes test strips may not impose a copayment or coinsurance, but may be subject to a deductible | | |
| D22. | §15-823 | Osteoporosis Prevention & Treatment Education | | |
| D23. | §15-825 | Prostate Cancer Screening | | |
| | § 15-825(c), SB 661, Chpt. 344, Acts of 2020 (effective 1/1/21) | • Deductible, Copayments or Coinsurance may not be applied | | |
| D24. | § 15-826.2 | Male Sterilization coverage | | |
| | §15-826.2(b)(2) | • Deductible, Copayments or coinsurance may not be applied | | |
| | §15-826.2(b)(3) | • High Deductible Health Plans may apply deductible, but may not apply copayments or coinsurance | | |
| D25. | §15-826.3, SB 33, Chpt. 438, Acts of 2018 (effective 1/1/19) | Fertility Awareness-Based Methods | | |
| | §15-826.3(d) | • May not be subject to deductible, copayment, or coinsurance in-network or out-of-network | | |
| D26. | §15-827 | Coverage for Medical Clinical Trials | | |
| | MIA Bulletin L&H #05-4 | • May not apply Service Area Restrictions or Contracting Provider Requirements | | |
| | 42 USC § 300gg-8(d), §15-1A-02(a)(2)(xviii) | • Expanded definition of approved clinical trial | | |
| D27. | §15-828 | General Anesthesia for Dental Care | | |
| D28. | §15-829 | Annual Chlamydia Screening Test | | |
| D29. | §15-829 | Human Papillomavirus Screening Test | | |

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| D30. | §15-832 | Coverage for Home Visits for Surgical Removal of Testicle If Less than 48 hours of Inpatient Hospitalization is Provided or Surgery Done on Outpatient Basis | | |
| D31. | §15-832.1 | Coverage for Inpatient Hospitalization for a Minimum of 48 Hours Following Mastectomy and Coverage for Home Visits | | |
| | §15-832.1(a) | • Mastectomy Definition | | |
| D32. | §15-834 | Breast Prosthesis | | |
| D33. | §15-835 | Habilitative Services for Children | | |
| | §15-835(a)(2) | • Definition habilitative services | | |
| | §15-835(c) | • Required to provide health benefits until end of month in which child turns age 19 | | |
| | COMAR 31.10.39 | • If utilization review criteria for treatment of autism and autism spectrum disorders are included, criteria must comply | | |
| | COMAR 31.10.39.03B and G | • Habilitative services benefit may not exclude applied behavior analysis for the treatment of autism and autism spectrum disorders | | |
| D34. | §15-836 | Hair Prostheses for Hair Loss Resulting from Chemotherapy or Radiation Treatment for Cancer | | |
| D35. | §15-837 | Colorectal Cancer Screening | | |
| D36. | §15-838 | Hearing Aids - Coverage for Children | | |
| | §15-838(d) | • Coverage for adults: if hearing aid coverage is provided with a dollar limit, must allow the choice of a higher price hearing aid with difference in cost paid by the covered person | | |
| | 45 CFR §147.126 | • The $1400 limit may not be applied (Benefits for hearing aids for children are considered essential health benefits in large group contracts because the Maryland-selected benchmark plan includes these benefits. See FAQ 10 from the February 17, 2012 CMS Plan Management FAQ Frequently Asked Questions on the Essential Health Benefits Bulletin) | | |

| | Citation | Description | "X" Means Applicable | Form/ Page |
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| D37. | §15-839 | Treatment of Morbid Obesity | | |
| | COMAR 31.10.33 | • If utilization review criteria are included, criteria must comply | | |
| D38. | §15-843 | Amino Acid-Based Elemental Formula | | |
| D39. | §15-844 | Prosthetic Devices (including Components and Repairs) | | |
| D40. | §15-848 | Ostomy Equipment and Supplies | | |
| D41. | §15-853 | Lymphedema | | |
| | §15-853(a) | • Definition “gradient compression garment” | | |
| D42. | §15-855 | Pediatric Autoimmune Neuropsychiatric Disorders associated with streptococcal infections and pediatric acute onset neuropsychiatric syndrome | | |
| | §15-855(b)<br>HB 820, Chpt. 321, Acts of 2022 (effective 1/1/23) | • Diagnosis, evaluation, and treatment, including the use of intravenous immunoglobulin therapy | | |
| | | • No longer permitted to exclude Rituximab | | |
| D43. | §15-857, HB 937, Chpt. 56, Acts of 2022 (effective 1/1/23) | Abortion Care Services | | |
| | § 15-857(a)(2)(ii), HB 937, Chpt. 56, Acts of 2022 (effective 1/1/23) | • Does not apply to high deductible health plans | | |
| | §15-857(b)(1)(i), HB 812, Chpt 249, Acts of 2023 | • May not apply copayment, coinsurance, or deductible, except for high deductible health plans | | |
| | §15-857(b)(1)(ii), HB 937, Chpt. 56, Acts of 2022 (effective 1/1/23) | • 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), HB 937, Chpt. 56, Acts of 2022 (effective 1/1/23) | • Required use of term “abortion care” | | |
| D44. | §15-859, HB 1217, Chpt. 323, Acts of 2023 (effective 1/1/24) | Biomarker Testing | | |

| | Citation | Description | "X" Means Applicable | Form/ Page |
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| | §15-859(c), HB 1217, Chpt. 323, Acts of 2023 (effective 1/1/24) | • 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), HB 1217, Chpt. 323, Acts of 2023 (effective 1/1/24) | • Definition "biomarker" | | |
| | §15-829(a)(3), HB 1217, Chpt. 323, Acts of 2023 (effective 1/1/24) | • Definition "biomarker testing" | | |
| D45. | §15-860, HB 815, Chpt. 354, Acts of 2023 (effective 1/1/24) | Diagnostic Lung Cancer Screening | | |
| | §15-860(b)(1), HB 815, Chpt. 354, Acts of 2023 (effective 1/1/24) | • Recommended follow-up diagnostic imaging to assist in diagnosis of lung cancer when lung cancer screening is recommended by USPSTF | | |
| | §15-860(b)(2), HB 815, Chpt. 354, Acts of 2023 (effective 1/1/24) | • Coverage for diagnostic ultrasound, magnetic resonance imaging, computed tomography, and image-guided biopsy | | |
| | §15-860(c), HB 815, Chpt. 354, Acts of 2023 (effective 1/1/24) | • May not be subject to copays, coinsurance, or deductible.<br>• For High Deductible Health Plans, may not be subject to copays or coinsurance, but may be subject to deductible | | |

## E. Prescription Drug Benefits

| | Citation | Description | "X" Means Applicable | Form/ Page |
|---|---|---|---|---|
| E1. | §15-142(c) | Step Therapy or Fail-First Protocols Prohibited under Certain Circumstances | | |
| | §15-142(e) | • Cannot be imposed on certain cancer drugs | | |
| E2. | §15-804 | Off Label Use of Drugs | | |
| | §15-804(a)(4) | • Definition Standard reference compendia | | |
| E3. | §15-824 | 90 Day Supply for Maintenance Drugs | | |
| E4. | Bulletin – L/H 1/97 | Coverage of Maintenance Drugs from Local Pharmacies Same as Mail Order | | |

| | Citation | Description | "X" Means Applicable | Form/ Page |
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| E5. | §15-826 | Coverage for Contraceptive Drugs or Devices | | |
| | §15-826.1(c)(2)(ii) | • Copayments or coinsurance may not be applied to FDA approved contraceptive drugs or devices prescribed by an authorized prescriber (applies to in-network and out-of-network benefits) | | |
| | §15-826.1(c)(3) | ○ Exception – Copayment or coinsurance may be applied to a contraceptive drug or device that is therapeutically equivalent to another contraceptive drug or device available under the contract without a copayment or coinsurance | | |
| | §15-826.1(d) | • 12-month supply of prescription contraceptives<br>○ Exceptions to the 12-month supply are not permitted | | |
| | §15-826.1(e) | • Coverage without a prescription for FDA approved contraceptive drugs that are available by prescription or over the counter (benefit may be limited to drugs received at in-network pharmacies and reasonable frequency limits may be applied) | | |
| | §15-826.1(e)(1)(ii) | • Copayment or coinsurance for FDA approved contraceptive drug dispensed without a prescription and available by prescription or over the counter may not exceed the copayment or coinsurance for the contraceptive drug when dispensed under a prescription | | |
| E6. | §15-831 | For Formulary Benefits – Right to Receive Non-Formulary Drugs | | |
| E7. | §15-841 | Coverage for Smoking Cessation Treatment | | |
| E8. | §15-842 | Copayment may not exceed the retail price of drug | | |
| E9. | §15-845 | Coverage for Certain Prescription Eye Drop Refills | | |
| E10. | §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 | | |
| E11. | §15-847 | Specialty Drugs – Copayment/Coinsurance Limits | | |

| | Citation | Description | "X" Means Applicable | Form/ Page |
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| | §15-847(a) | • Definition excludes drugs for the treatment of diabetes, HIV, or AIDS | | |
| E12. | §15-847.1 | Drugs for the treatment of diabetes, HIV, or AIDS -- Copayment/Coinsurance limits | | |
| | §15-822.1, House Bill 1397, Chpt 405, Acts of 2022, effective 1/1/2023 | • Except copayment or coinsurance for insulin cannot be more than $30 for a 30-day supply, regardless of amount or type of insulin needed. | | |
| E13. | §15-849 | Abuse-Deterrent Opioid Analgesic Drug Products – Tier Placement and Step Therapy | | |
| E14. | §15-852 | Prorated daily copayment or coinsurance amount for partial supply of prescription drug | | |
| E15. | §15-854 | Limits on Prior Authorization Requirements for certain prescription drugs | | |
| | §15-854(g), House Bill 785, Chpt 365, Acts of 2023 (effective 1/1/24) | • 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. | | |
| E16. | §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 | | |

## F. Provider Access and Reimbursement

| | Citation | Description | "X" Means Applicable | Form/ Page |
|---|---|---|---|---|
| F1. | §19-705.1(b)(1)(ii), Health-General | 24 Hour Access to Physician | | |
| F2. | §19-701(g)(2), Health-General | Out-of-Area Coverage (Urgent Care) | | |
| F3. | Title 15, Subtitle 17 | Requirements for Physician Rating Systems | | |
| | §15-1702(a) | a. Must provide documentation that physician rating system has been approved by ratings examiner | | |

| | Citation | Description | "X" Means Applicable | Form/ Page |
|---|---|---|---|---|
| | §15-1703(a)(1)<br>§15-1703(a)(2)<br>§15-1703(c) | b. Must provide certification that HMO has established:<br>• Appeals process for physicians<br>• System to notify physicians of changes to ratings<br>• Process to post required information on HMO's website | | |
| | §15-1704 | c. Must file annual report with Commissioner | | |
| F4. | 42 USC § 300gg-19a,<br>45 CFR §147.138(a),<br>MIA Bulletin 10-23,<br>§15-1A-13 | Right to choose any provider in the network as PCP and for children right to select allopathic or osteopathic pediatrician in the network | | |
| F5. | 45 CFR§ 147.138(a)(3),<br>§15-1A-13 | 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 | | |
| F6. | §15-830(b) | Right to Standing Referral to Network Specialist | | |
| F7. | §15-830(d) | Right to Request Referral to Specialist and Non-Physician Specialist Not on HMO's Provider Panel | | |
| | | • Referral must be granted if the HMO cannot provide reasonable access to a specialist without unreasonable travel or delay | | |
| | §15-830(a)(4), SB707, Chapter 272, Acts of 2022 (effective 7/1/22) | • Definition of "non-physician specialist" (if included in contract) revised to reference health care providers that are licensed as a behavioral health program | | |

| | Citation | Description | "X" Means Applicable | Form/ Page |
|---|---|---|---|---|
| | §15-830(e), SB707, Chapter 272, Acts of 2022 (effective 7/1/22)<br>§19-710(p), Health-General | • May not balance bill members for services received from out-of-network specialists and non-physician specialists as result of referral described in (d) | | |
| F8. | §15-140(d) | 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 | | |
| F9. | §15-118 | Coinsurance Amounts for Contracting Providers Must Be Based on Negotiated Fees with HMO | | |
| F10. | §15-112(q) | Identify office and process for filing complaints | | |
| F11. | §19-712.5, Health-General | Reimbursement to Hospital Emergency Facilities and Providers | | |
| F12. | §19-710.1, Health-General | Reimbursement of non-contracting providers for covered services | | |
| | 45 CFR §149.410<br>86 FR 36981 | Reimbursement for Emergency Services<br>• The enrollee will not be liable for an amount that exceeds the enrollee's cost-sharing requirement for emergency services provided by a non-network provider. | | |
| | §15-138<br>45 CFR §149.130<br>86 FR 36974 | Reimbursement of Ambulance Service Providers<br>• The enrollee will not be liable for any amount that exceeds the enrollee's cost-sharing requirement for air ambulance services provided by a non-network provider. | | |
| | 45 CFR §149.120<br>86 FR 36973-36974 | Non-emergency services provided by a non-network provider with respect to a covered visit at an in-network facility,<br>• The enrollee will not be liable for an amount that exceeds the enrollee's cost-sharing requirement. | | |
| F13. | | Cost-sharing for emergency services | | |
| | 45 CFR §149.110(b)(3)(ii)<br>86 FR 36973 | a. Copayments/coinsurance for emergency services received from non-network providers may not exceed in-network emergency services copayments/coinsurance | | |

| | Citation | Description | "X" Means Applicable | Form/ Page |
|---|---|---|---|---|
| | 45 CFR §149.110(b)(3)(v)<br>86 FR 36973 | b. Deductibles/out of pocket maximums for emergency services received from non-network providers will be counted toward any applicable in-network emergency services deductible/out of pocket maximum. | | |
| | 45 CFR §149.110(b)(3)(iii)<br>86 FR 36973 | c. Any cost sharing requirement for emergency services provided by non-network providers will be calculated based on the recognized amount. | | |
| | 45 CFR §149.30 | Recognized amount definition | | |
| F14. | 45 CFR §149.130<br>86 FR 36974 | If plan covers air ambulance services, cost-sharing provisions for air ambulance services are required. | | |
| | | a. Cost-sharing for air ambulance services provided by a non-network provider may not exceed the same as if services were provided by an in-network provider. | | |
| | | b. Any cost-sharing requirement will be calculated based on the lesser of the qualifying payment amount (as determined in accordance with §149.140) or the billed amount for the services | | |
| | | c. Any cost-sharing payments made with respect to the air ambulance service will be counted toward any applicable in-network deductible and in-network out-of-pocket maximum | | |
| | 45 CFR §149.30<br>MIA Bulletin 21-24 | Definition of air ambulance services (if definition is included) | | |
| F15. | 45 CFR §149.120<br>86 FR 36973-36974<br>45 CFR §149.30<br>MIA Bulletin 21-24 | Cost-sharing for non-emergency services provided by a non-network provider with respect to a covered visit at an in-network facility, except when the non-network provider has satisfied the notice and consent criteria of 45 CFR §149.420(c) through (i). | | |
| | | a. Cost-sharing may not exceed the cost-sharing requirements listed for services provided by an in-network provider. | | |
| | | b. Any cost-sharing requirement for services will be calculated based on the recognized amount. | | |

| | Citation | Description | "X" Means Applicable | Form/ Page |
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| | | c. Any cost-sharing payments will be counted toward any applicable in-network deductible and in-network out of pocket maximum. | | |
| | | d. Authorized representative definition | | |
| | | e. Health care facility definition | | |
| | | f. Participating health care facility definition | | |
| F16. | 45 CFR §149.420(b)<br>86 FR 36982 | Items in F15. are not applicable when the non-network provider has satisfied the notice and consent criteria of 45 CR §149.420 (c) through (i). The notice and consent criteria do not apply to non-network providers with respect to:<br>• Covered services rendered by a health care provider for which payment is required under §19-710.1 of the Health General Article<br>• Ancillary Services<br>• Items or services furnished as a result of unforeseen, urgent medical needs that arise at the time an item or service is furnished, regardless of whether the non-network provider satisfied the notice and consent criteria. | | |
| F17. | §42 USC 300gg-115(b)<br>§42 USC 300gg-139(b) | Provider Directories | | |
| | | If, through a telephone call or from a provider directory whether electronic, web-based, or internet-based means, a provider is incorrectly listed as an in-network provider and an enrollee receives services based on the incorrect information:<br>• The copayment amount, coinsurance percentage, and/or other cost-sharing requirement for such item or services furnished by the non-network provider is the same as if services were provided by an in-network provider.<br>• Any cost-sharing payments made with respect to the item or service will be counted toward any applicable in-network deductible and in-network out-of-pocket maximum. | | |
| F18. | 42 USC §300gg-138<br>42 USC §300gg-113(a) | Continuity of care | | |

| | Citation | Description | "X" Means Applicable | Form/ Page |
|---|---|---|---|---|
| | | a. A continuing care patient receiving care from an in-network provider may elect to continue to receive transitional care from such provider if the provider's participating provider contract is terminated or non-renewed for reasons other than for failure to meet applicable quality standards or for fraud. | | |
| | | b. Carrier is to notify each enrollee who is a continuing care patient with respect to a provider or facility at the time of a provider contract termination or non-renewal for reasons other than failure to meet quality standards or fraud. | | |
| | | c. Benefits for a continuing care patient will be the same as if termination had not occurred. | | |
| | | d. Benefits will be provided for 90 days from the date the carrier notifies the continuing care patient of the termination. Benefits will end either after the 90 days or on the date the enrollee is no longer a continuing care patient with respect to such provider or facility. | | |
| | | e. The enrollee will not be liable for an amount that exceeds the cost-sharing that would have applied had the termination not occurred. | | |
| | | f. Continuing care patient definition | | |
| | | g. Serious and complex condition definition | | |

## G. Required Standard Provisions

| | Citation | Description | "X" Means Applicable | Form/ Page |
|---|---|---|---|---|
| G1. | COMAR 31.12.07.04A | Entire Contract; Changes | | |
| G2. | COMAR 31.12.07.04B | Contestability of the Contract | | |
| G3. | COMAR 31.12.07.04C | Notice of Claim | | |
| G4. | COMAR 31.12.07.04D | Claims Forms | | |
| G5. | COMAR 31.12.07.04E | Proofs of Loss | | |
| | §15-1011 | • Methods for Claim Submission | | |

| | Citation | Description | "X" Means Applicable | Form/ Page |
|---|---|---|---|---|
| | §15-1005(d) | • Provider must be permitted minimum of 180 days to file claim | | |
| | §12-102 | • Proof of loss period one year for claim | | |
| | §12-102(c)(2) | • If not reasonably possible to submit claim within one year, time period extended to two years after date of service | | |
| G6. | COMAR 31.12.07.04F | Time Payment of Claims | | |
| G7. | COMAR 31.12.07.04G | Payment of Claims | | |
| G8. | COMAR 31.12.07.04H | Legal Action | | |
| G9. | COMAR 31.12.07.04I | Grace Period | | |
| G10. | COMAR 31.12.07.04J | Certificates | | |
| G11. | COMAR 31.12.07.04K | Addition of Employees/Members | | |
| G12. | COMAR 31.12.07.04L | Misstatement of Age | | |
| G13. | COMAR 31.12.07.04M | Premium Due Date | | |

## H. Optional Provisions

| | Citation | Description | "X" Means Applicable | Form/ Page |
|---|---|---|---|---|
| H1. | COMAR 31.12.07.07C | Physical Examination | | |
| H2. | COMAR 31.12.07.07D | Arbitration | | |

## I. Prohibited Provisions, Limitations, and Exclusions

| | Citation | Description | "X" Means Applicable | Form/ Page |
|---|---|---|---|---|
| I1. | §15-1407 | Premium – May Not Charge Extra Premium Based on Health Status | | |
| I2. | COMAR 31.12.02.12A(1) | Excessive Copayments, Deductibles | | |
| I3. | 42 USC § 300gg-11,<br>45 CFR §147.126,<br>MIA Bulletin 10-23,<br>§15-1A-02(a)(2)(vi) | Annual dollar limits for essential health benefits are prohibited | | |
| I4. | 42 USC § 300gg-11,<br>45 CFR §147.126,<br>MIA Bulletin 10-23,<br>§15-1A-02(a)(2)(v) | Lifetime dollar limits for essential health benefits are prohibited | | |

| | Citation | Description | "X" Means Applicable | Form/ Page |
|---|---|---|---|---|
| I5. | §27-913 | Benefits for treatment of a specified disease or diagnosis may not be subject to different copays, coinsurance, deductibles, annual or lifetime maximums | | |
| I6. | §15-810(b) | Benefits for infertility may not discriminate against married same-sex couples | | |
| I7. | §15-1009 | Denial of Reimbursement for Pre-authorized Care Prohibited Except for Limited Reasons | | |
| I8. | §19-713.1(b), Health-General | May not coordinate against guaranteed renewable intensive care or specified disease policies | | |
| I9. | §19-713.1(e), Health-General | May not recover any payment made to Subscriber under PIP | | |
| I10. | COMAR 31.12.02.06H(2)(a) §19-713.1(e), Health-General | May not provide benefits that are secondary to benefits payable under an automobile policy, including PIP | | |
| I11. | COMAR 31.12.02.06H(2)(b), §19-713.1(e), Health-General | May not include an exclusion for losses covered by an automobile policy, including PIP | | |
| I12. | §19-713.1(f), Health-General | May not recover medical expenses under subrogation unless the Subscriber recovers for medical expenses in a cause of action | | |
| I13. | §19-705.4, Health-General | Physical Therapist Time Limitations | | |
| I14. | COMAR 31.12.07.06D, 42 USC § 300gg-3, 45 CFR §147.108(b), MIA Bulletin 10-23, §15-1A-02(a)(2)(ii) | May not include a limitation or exclusion for a pre-existing condition | | |
| I15. | 45 CFR §146.121(b)(2)(iii) | Prohibited Suicide or Self-Inflicted Injury Exclusion | | |
| I16. | §27-303, MIA Bulletin L&H 99-25 | Denial of Medically Necessary Inpatient Ancillary Charges Prohibited | | |
| I17. | COMAR 31.12.07.06A(1) | May not limit or exclude loss due to member's commission of or attempt to commit a crime | | |
| I18. | COMAR 31.12.07.06A(2) | May not limit or exclude loss due to commission of or the attempt to commit a crime by an individual other than the member | | |
| I19. | COMAR 31.12.07.06B | May not limit or exclude loss due to member being engaged in an illegal occupation | | |

| | Citation | Description | "X" Means Applicable | Form/ Page |
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| I20. | COMAR 31.12.07.06C(1), COMAR 31.12.07.06C(2)(a), COMAR 31.12.07.06C(2)(b), COMAR 31.12.07.06C(2)(c) | May not limit or exclude loss:<br>• Sustained or contracted in consequence of the member being intoxicated or under the influence of any drug<br>• Due to the use of alcohol<br>• Due to the use of drugs or narcotics<br>• Due to alcoholism or drug addiction | | |
| I21. | §15-126 | May Not Discourage or Prohibit Access to the 911 Emergency System | | |
| I22. | COMAR 31.12.02.06G | Advertising Prohibited in Forms | | |
| I23. | §15-510 | May not deny behavioral counseling services provided by participating provider solely on the basis that it is school based | | |
| I24. | 45 CFR §156.125(a), 45 CFR §156.200(e), §15-1A-22 | Prohibition on discrimination:<br>• based on individual's age, expected length of life, present or predicted disability, degree of medical dependency, quality of life, or other health conditions (applies only to benefit design, or the implementation of a benefit design)<br>• on the basis of race, creed, color, national origin, disability, age, marital status, sex, gender identity or sexual orientation (limitations/restrictions based on marital status still permissible if otherwise provided under state law) | | |
| I25. | §15-716, HB 1151, Chpt. 301, Acts of 2023 (effective 1/1/24) | 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(c), HB 1151, Chpt. 301, Acts of 2023 (effective 1/1/24) | • May not condition on whether pharmacist is employed by a physician, pharmacy, or facility or acting under physician's orders | | |
| I26. | §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 | | |

| | Citation | Description | "X" Means Applicable | Form/ Page |
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| I27. | §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 | | |

## J. Other

| | Citation | Description | "X" Means Applicable | Form/ Page |
|---|---|---|---|---|
| J1. | COMAR 31.12.02.06I, §15-122 | 45-Day Premium Increase Notice; At renewal | | |
| J2. | 45 CFR §146.121(f), §§15-1A-02(a)(2)(iv), 15-509 | Requirements for Wellness Programs | | |
| | §15-509(c)(2) | a. Participatory Wellness Programs:<br>• Program must be available to all similarly situated individuals | | |
| | | b. Health-Contingent Wellness Programs: | | |
| | §15-509(d)(4) and (g)(1)(ii) | 1. Full reward must be available to all similarly situated individuals | | |
| | §15-509(d)(1) and (g)(1)(i) | 2. Must provide chance to qualify for reward at least once per year | | |
| | §15-509(d)(2) and (g)(1)(i) | 3. Combined reward for all health-contingent wellness programs may not exceed 30% of premium, increased additional 20 percentage points (to 50%) for tobacco cessation | | |
| | | 4. Must allow reasonable alternative standard (or waiver of standard) for obtaining reward | | |
| | 45 CFR §146.121(f)(3)(iv)(A), 45 CFR §146.121(f)(3)(iv)(E), 45 CFR §146.121(f)(3)(iv)(C)(4) | i) Activity-only Wellness Program:<br>• Alternative standard required if unreasonably difficult to satisfy (or inadvisable to attempt to satisfy) standard due to medical condition<br>• Carrier may require individual's physician to verify that alternative standard is needed due to medical condition<br>• Alternative standard must accommodate recommendations of individual's physician | | |

| | Citation | Description | "X" Means Applicable | Form/ Page |
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| | 45 CFR §146.121(f)(4)(iv)(A)<br>45 CFR §146.121(f)(4)(iv)(E)<br>45 CFR §146.121(f)(4)(iv)(C)(4) | ii) Outcome-based Wellness Program<br>• Alternative standard required if initial standard is not met for any reason<br>• Carrier may NOT require individual's physician to verify that alternative standard is needed due to medical condition<br>• Alternative standard must accommodate recommendations of individual's physician | | |
| | 45 CFR §146.121(f)(3)(v) and (f)(4)(v) | 5. Certificate must disclose availability of reasonable alternative standard (including contact information for obtaining reasonable alternative standard) and that recommendations of individual's personal physician will be accommodated | | |
| J3. | 42 USC § 300gg-6, 45 CFR §156.130(a), §15-1A-02(a)(2)(xiv) | Annual limitation on cost-sharing (including copays, coinsurance, and deductibles) for essential health benefits | | |
| | CMS Guidance Dated December 12, 2022—Premium Adjustment Percentage, Maximum Annual Limitation on Cost Sharing… | a. For each plan year, cost sharing may not exceed the dollar limit for calendar year 2014, increased by the premium adjustment percentage (if any) applicable to the current plan year<br>• For Plan Year 2023 – may not exceed $9,100 for self-only coverage and $18,200 for other than self-only coverage.<br>• For Plan Year 2024 – may not exceed $9,450 for self-only coverage and $18,900 for other than self-only coverage. | | |
| | 45 CFR§ 156.130(c) | b. Out-of-network cost sharing is not required to count toward the limit | | |
| | 80 FR 10825 | c. The annual limitation on cost sharing for self-only coverage applies to all individuals regardless of whether the individual is covered by a self-only plan or is covered by a plan that is other than self-only | | |
| J4. | COMAR 31.12.02.06E | Time References | | |
| J5. | §19-713(b)(2), Health-General | HMO may include subrogation provision in contract if rating methodology includes an adjustment that reflects the subrogation | | |
| J6. | §19-713.1(d)(1), Health-General | HMO may only subrogate to the extent that any actual payments made by the HMO result from the occurrence that gave rise to the cause of action | | |

| | Citation | Description | "X" Means Applicable | Form/ Page |
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| J7. | COMAR 31.12.02.06P | Required Provision for Inability to Provide Services - Circumstances Beyond the Plan's Control | | |
| J8. | §19-712.4(c), Health-General | Required Exclusion for Prohibited Practitioner Referral | | |

## K. Utilization Review

| | Citation | Description | "X" Means Applicable | Form/ Page |
|---|---|---|---|---|
| K1. | §19-712.5(d), Health-General | May not require preauthorization for emergency care | | |
| | 42 USC § 300gg-19a, 45 CFR §147.138(b), MIA Bulletin 10-23, §15-1A-14(c)(1) | • No administrative requirements on non-network emergency services that are not imposed in-network | | |
| K2. | § 15-826.1(c)(2)(i) | May not require prior authorization for an IUD or implantable rod if the IUD or implantable rod is approved by the FDA and obtained under a prescription written by an authorized prescriber | | |
| K3. | | Initial authorization of course of treatment made: | | |
| | §§ 19-706(f), Health-General 15-10B-06(a)(1)(i) | a. For non-emergencies, within 2 working days of receipt of information necessary to make determination | | |
| | §§ 19-706(f), Health-General, 15-10B-06(a)(1)(ii) | b. For extended stays or additional health care services within 1 working day of receipt of necessary information | | |
| | §§ 19-706(f), Health-General, 15-10B-06(a)(3) | c. 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 | | |
| | §§ 19-706(f), Health-General, 15-10B-06(a)(4), HB 785, Chpt. 365, Acts of 2023 (effective 1/1/24) | d. 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 | | |
| K4. | §§ 19-706(f), Health-General, 15-10B-06(a)(2) | PRA must inform health care provider that additional information is needed to make determination within 3 calendar days after initial request | | |
| K5. | §15-10A-02(f) | For non-emergency cases, notice of adverse decision must be provided within 5 working days after adverse decision is made | | |

| | Citation | Description | "X" Means Applicable | Form/ Page |
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| | §15-10A-02(f)(1), SB 724, Chpt. 37, Acts of 2023 (effective 10/1/23) | • 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 to inform the member of an adverse decision | | |
| K6. | §§ 19-706(f), Health-General, 15-10B-07(c) | May not retroactively deny approval of preauthorized services | | |
| K7. | §§ 19-706(f), Health-General, 15-10B-06(b) | If provider requests immediate reconsideration of denial, must give decision by telephone within 24 hours of request | | |
| K8. | §§ 19-706(f), Health-General, 15-10B-06(c) | 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 | | |
| K9. | §§ 19-706(f), Health-General, 15-10B-06(d) | Involuntary or voluntary psychiatric admission of patient in danger - may not issue adverse decision as to admission during first 24 hours after voluntary inpatient admission or 72 hours after involuntary admission | | |
| K10. | §15-140(c) | When member transitions from another carrier or managed care organization, receiving carrier 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 | | |

## L. Internal Appeal and Grievance Process

| | Citation | Description | "X" Means Applicable | Form/ Page |
|---|---|---|---|---|
| L1. | COMAR 31.12.02.06J(12) | HMO contract must include formal procedure to be followed in filing complaints or grievances. | | |
| L2. | Title 15, Subtitle 10A | Internal Appeal and Grievance Process for Adverse Decisions | | |
| | §15-10A-02(k) | a. Information required to be included in policy | | |
| | §15-10A-02(f)(2)(iii)1 | 1. Name, address, telephone # of medical director or associate Medical director who made decision | | |
| | §15-10A-02(f)(2)(iv) | 2. Details of internal grievance process | | |

| | Citation | Description | "X" Means Applicable | Form/ Page |
|---|---|---|---|---|
| | §15-10A-02(f)(2)(v)1 | 3. Member, member's representative, or provider has right to file a complaint with Commissioner within 4 months after receipt of HMO's decision | | |
| | §15-10A-02(f)(2)(v)2 | 4. Complaint may be filed without first filing grievance with HMO if compelling reason to do so is demonstrated | | |
| | §15-10A-02(f)(2)(v)3 | 5. Address, telephone #, facsimile # of Commissioner | | |
| | §15-10A-02(f)(2)(v)4 | 6. Health Advocacy Unit available to assist member with mediating and filing grievance | | |
| | §15-10A-02(f)(2)(v)5 | 7. Health Advocacy Unit's address, telephone #, facsimile #, and e-mail address | | |
| | §15-10A-02(k)(2) | 8. Statement that, when filing complaint with Commissioner, the member or member's representative will be required to authorize release of any medical records of member needed to reach decision on complaint | | |
| | | b. Details of internal grievance process | | |
| | §15-10A-02(g) | 1. Insufficient Information - The HMO is required to notify the member, member's representative, or a health care provider filing a grievance on behalf of a member within 5 working days of the filing date if more information is required | | |
| | §15-10A-02(b)(2)(v) | 2. For retrospective denials, must permit the member, the member's representative or health care provider a minimum of 180 days to file a grievance | | |
| | | 3. Non-emergency case grievance review (prospective denial) | | |
| | §15-10A-02(b)(2)(ii) | i. Carrier must render a written final decision within 30 working days after the filing date. The carrier may have an extension not to exceed 30 working days with the member's written approval | | |

| | Citation | Description | "X" Means Applicable | Form/ Page |
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| | §15-10A-02(i)(1)(ii) | ii. Written notice is required within 5 working days after decision is rendered | | |
| | | 4. Non-emergency case grievance review (retrospective denial) | | |
| | §15-10A-02(b)(2)(iv) | i. Carrier must render a written final decision within 45 working days after the filing date. The carrier may have an extension not to exceed 30 working days with the member's written approval | | |
| | §15-10A-02(i)(1)(ii) | ii. Written notice is required within 5 working days after decision is rendered | | |
| | | 5. Emergency case grievance | | |
| | §15-10A-02(b)(2)(i) | i. The carrier must render a decision within 24 hours after the receipt of a grievance | | |
| | §15-10A-02(j) | ii. Written notice of the decision must be sent within one day after the oral decision has been communicated | | |
| | | 6. Complaints may be filed with the Commissioner: | | |
| | §15-10A-03(a) | i. Within 4 months after receipt of the HMO's grievance decision | | |
| | §15-10A-02(d)(2) | ii. For prospective denials, if grievance decision from carrier is not received on or before the 30th working day after the filing date | | |
| | §15-10A-02(d)(2) | iii. For retrospective denials, if grievance decision from carrier is not received on or before the 45th working day after the filing date | | |
| | §15-10A-02(d)(1) | iv. Without exhausting the internal grievance process if HMO waives the requirement, if HMO fails to comply with any requirements of internal grievance process, or for compelling reason | | |

| | Citation | Description | "X" Means Applicable | Form/ Page |
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| | | c. Definitions | | |
| | §15-10A-01(b) | 1. Adverse Decision | | |
| | COMAR 31.10.18.05A | 2. Emergency Case | | |
| | COMAR 31.10.18.02B(5) | 3. Filing Date | | |
| | §15-10A-01(f) | 4. Grievance | | |
| | §15-10A-01(g) | 5. Grievance Decision | | |
| | §15-10A-01(j) | 6. Health Care Provider | | |
| | §15-10A-01(m) | 7. Member's representative | | |
| | COMAR 31.10.18.11 | 8. Compelling Reason | | |
| L3. | Title 15, Subtitle 10D | Complaint Process for Coverage Decisions | | |
| | §15-10D-02(b) | a. HMO must render final appeal decision in writing within 60 working days | | |
| | §15-10D-02(c) and (d) | b. HMO's internal appeal process must be exhausted prior to filing a complaint with Commissioner except for urgent medical conditions for which care has not been rendered | | |
| | §15-10D-02(f)(2)(ii)1 | c. Member, member's representative, or provider may file a complaint with Commissioner within 4 months after receipt of HMO's appeal decision | | |
| | | d. Definitions | | |
| | §15-10D-01(b) | 1. Appeal | | |
| | §15-10D-01(c) | 2. Appeal Decision | | |
| | §15-10D-01(f) | 3. Coverage Decision | | |
| | COMAR 31.10.29.02B(12) | 4. Urgent Medical Condition | | |
| | §15-10D-02(e) | 5. Notice of Coverage Decision | | |
| | §15-10D-02(f) | 6. Notice of Appeal Decision | | |

## M. Applications

| | Citation | Description | "X" Means Applicable | Form/ Page |
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| M1. | COMAR 31.12.02.07K(1) | Separate filing required for each company | | |

| | Citation | Description | "X" Means Applicable | Form/ Page |
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| M2. | COMAR 31.12.02.07K(2) | Check-off boxes required for carrier name if application is to be used by more than one carrier | | |
| M3. | COMAR 31.12.02.07K(3) | Application must clearly identify coverages underwritten by each carrier, when more than one carrier uses the same application with the same group applicant | | |
| M4. | COMAR 31.12.02.07A | Application shall stipulate the plan and amount of insurance and any added optional benefits applied for | | |
| M5. | 42 USC § 300gg-7, 45 CFR §147.116, §15-1A-12 | Waiting period may not exceed 90 days | | |
| M6. | 42 USC § 300gg-1, 45 CFR §147.104(a), §15-1410 | May not reject entire group due to underwriting | | |
| M7. | §15-1406 | May not deny coverage to individual due to underwriting | | |
| M8. | §27-909 | May Not Inquire About Genetic Tests or Genetic Information | | |
| M9. | §27-504 | May not ask about Domestic Violence | | |
| M10. | COMAR 31.12.02.07B(1)(a) | 7-year look back limitation for health questions | | |
| M11. | COMAR 31.12.02.07C | Health questions (if included) 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 | | |
| M12. | COMAR 31.12.02.07D | If a rider or endorsement modifies the coverage applied for, signed acceptance is required by applicant before delivery of contract | | |
| M13. | COMAR 31.12.02.07E | Proxy statement prohibited | | |
| M14. | COMAR 31.12.02.07F | Questions about "hazardous activities" must list activities considered to be "hazardous" | | |
| M15. | COMAR 31.12.02.07G | Questions about the use of "habit-forming drugs" must list specific drugs considered to be "habit-forming" | | |
| M16. | COMAR 31.12.02.07H and I | Questions about symptoms or indications of physical/mental conditions must ask about "known symptoms" and "known indications" | | |

| | Citation | Description | "X" Means Applicable | Form/ Page |
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| M17. | COMAR 31.12.02.07L | 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 | | |
| M18. | §19-705.1(d)(4)(ii), Health-General | Required Notice | | |
| M19. | §§ 19-706(e), Health-General,<br>27-805,<br>MIA Bulletin 12-07 | Insurance Fraud-Required Disclosure Statement | | |
| M20. | §15-403.2,<br>COMAR 31.10.35 | Expand application to include a selection of Domestic Partner, including Child Dependents of Domestic Partner for applying for coverage | | |