HEALTH MAINTENANCE ORGANIZATION
INDIVIDUAL COVERAGE for NON-GRANDFATHERED HEALTH BENEFIT PLANS with POLICY YEARS THAT BEGIN ON OR AFTER JANUARY 1, 2025

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

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

A. Filing Incomplete or in Unacceptable Format

	Citation	Description	"X" Means Applicable	Form/ Page
A1.	MIA Bulletin 24-4	Identification of where the plan(s) will be sold (i.e. in the Exchange, outside the Exchange, or both)		
A2.	45 CFR §156.140 MIA Bulletin-24-4	Identification of the coverage level for each benefit design that is not a catastrophic plan (i.e. bronze, silver, gold, platinum)		
A3.	45 CFR §147.150(c)	For each of the levels of coverage (bronze, silver, gold, platinum) identified in A2 above, coverage must be offered as a child-only plan		
A4.	45 CFR §156.420(a)	For each silver health plan that the carrier intends to offer on the Exchange, three variations of the standard silver plan must be submitted for individuals eligible for cost-sharing reductions		
A5.	45 CFR §156.420(b)	For each plan at any level of coverage that the carrier intends to offer on the Exchange, two variations of the plan must be submitted for the zero cost-sharing and limited cost-sharing plans for Indians		
	78 FR 15494	• The Exchange will allow the HMO to submit one zero cost sharing plan variation for only the standard plan within the set with the lowest premium, if the benefits, networks, and all other aspects of the standard plans are exactly the same		

	Citation	Description	"X" Means Applicable	Form/ Page
A6.	45 CFR §156.135	The actuarial value of each plan design determined in accordance with 45 CFR §156.135		
	MIA Bulletin 24-4	• If using the AV calculator carrier must provide the AV input charts. Follow SOP for review of AV input charts against the schedules of benefits.		
A7.	45 CFR §156.122(a)(1) MIA Bulletin 24-4	Certification, signed by an individual with the authority to bind the carrier, that the plan's prescription drug benefit complies 45 CFR §156.122(a)(1) based on the information provided in the 2017-2025 EHB Benchmark Plan Information summary document provided by CMS and the version of the CMS Essential Health Benefits Rx Crosswalk Methodology that is current as of the date of the certification		
A8.	45 CFR §146.136 MIA Bulletin 24-4	Actuarial documentation of compliance with Mental Health Parity and Addiction Equity Act demonstrating how each financial requirement applicable to a mental health or substance abuse benefit in the plan design is no more restrictive than the *predominant* financial requirement of that type that applies to *substantially all* of the medical/surgical benefits in the same classification. In performing the "substantially all" and "predominant" tests, carrier should use "plan" level claims data (as opposed to "product" level). If carrier does not have sufficient data at the "plan" level, "product" level data may be used provided the carrier can demonstrate the validity of the projection method.		
A9.	MIA Bulletin 24-4	Separate schedule of benefit form for each plan design with specific combination of benefits and cost-sharing		
A10.	COMAR 31.12.02.04A(2)	Form contains text in brackets, denoting variability. Only specific items allowed for variability. Submit specific description of how each bracketed item will vary. If other items are desired, include the item.		
A11.	COMAR 31.12.02.03F(2)	If the filing is not being made by the HMO, the filer must submit a signed third party authorization letter from the HMO.		
A12.	COMAR 31.12.02.03C(4)	Listing of Forms		
A13.	COMAR 31.12.02.06A	Form Number		
A14.	COMAR 31.12.02.06D	Corporate Name and Address		
A15.	COMAR 31.12.02.03E	Unacceptable Modifications		

	Citation	Description	"X" Means Applicable	Form/ Page
A16.	COMAR 31.12.02.03G	Specimen Data		
A17.	COMAR 31.12.02.06F	Signature of Officer		
A18.	COMAR 31.12.02.06B	Size of Type		
A19.	§2-112(a)(10) COMAR 31.12.02.03C(2)	Filing Fees Insufficient		
A20.	COMAR 31.12.02.03H	Contracts with Insert Pages		
A21.	COMAR 31.12.02.03I	Contracts Comprised of Sections		
A22.	§31-116(f)	Essential pediatric dental benefits not included. • Description of how the carrier will comply when plan is sold outside the Exchange.		

B. Essential Health Benefits (Benchmark Plan MIA Bulletins 13-01 and 15-33)

	Citation	Description	"X" Means Applicable	Form/ Page
B1.	COMAR 31.11.06.03A(1)	Care in medical offices for treatment of illness or injury		
B2.	COMAR 31.11.06.03A(2)	Inpatient hospital services		
B3.	COMAR 31.11.06.03A(3)	Outpatient hospital services		
B4.	COMAR 31.11.06.03A(6)	Emergency Services		
	45 CFR §149.30 45 CFR §149.110(c)(1) MIA Bulletin 21-24	a. Emergency medical condition definition		
	45 CFR §149.30 45 CFR §149.110(c)(2) 45 CFR §149.410(b) MIA Bulletin 21-24	b. Emergency services definition		
	45 CFR §149.420(b)(1) MIA Bulletin 21-24	c. Ancillary services definition		
	45 CFR §149.30 MIA Bulletin 21-24	d. Independent freestanding emergency department definition		
	45 CFR §149.30 MIA Bulletin 21-24	e. Nonparticipating emergency facility definition		
	45 CFR §149.30 MIA Bulletin 21-24	f. Nonparticipating provider definition		
	45 CFR §149.30 MIA Bulletin 21-24	g. Participating emergency facility definition		

	45 CFR §149.30 MIA Bulletin 21-24	h. Participating provider definition		
	45 CFR §149.30 MIA Bulletin 21-24	i. Treating provider definition		
	45 CFR §149.110(c)(3) MIA Bulletin 21-24	j. To stabilize definition		
	45 CFR §149.30 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.		
	COMAR 31.11.06.09A §19-712.5, Health-General Article	m. Reimbursement to Hospital Emergency Facilities and Providers		
	COMAR 31.11.06.09A §19-712.5(f), Health-General Article	n. Emergency surgery follow-up care		
B5.	COMAR 31.11.06.03A(8)	Ambulance services		
	45 CFR §149.30 MIA Bulletin 21-24	Air ambulance service definition		
B6.	COMAR 31.11.06.03A(11)	Home health care		
	COMAR 31.11.06.03A(11)(b)	• Coverage for Home Visits If Less than 48 hours of Inpatient Hospitalization is Provided for Mastectomy or Surgical Removal of Testicle or procedures are performed on an outpatient basis.		
B7.	COMAR 31.11.06.03A(12)	Hospice Care		
B8.	COMAR 31.11.06.03A(13)	Durable medical equipment, including nebulizers, peak flow meters, prosthetic devices such as leg, arm, back, or neck braces, artificial legs, arms, or eyes, and the training necessary to use these prostheses		
B9.	COMAR 31.11.06.03A(14)	Outpatient laboratory and diagnostic services		

B10.	COMAR 31.11.06.03A(15)	Outpatient rehabilitative services • 30 physical therapy visits per condition per year • 30 speech therapy visits per condition per year • 30 occupational therapy visits per condition per year		
B11.	COMAR 31.11.06.03A(16)	Chiropractic services • 20 visits per condition per year		
B12.	COMAR 31.11.06.03A(17)	Skilled nursing facility services • 100 days per year		
B13.	COMAR 31.11.06.03A(18)	Infertility services		
	§15-810(b)	• Benefits for infertility may not discriminate against married same-sex couples		
B14.	COMAR 31.11.06.03A(19)	Nutritional services		
	MIA Bulletins 13-01 and 15-33	• Benchmark plan expanded to include unlimited medically necessary nutritional counseling and medical nutrition therapy		
B15.	COMAR 31.11.06.03A(20)	Transplants		
	MIA Bulletins 13-01 and 15-33	• Benchmark plan expanded to include all medically necessary non-experimental/investigational solid organ transplants and non-solid organ transplant procedures, including the cost of hotel lodging and air transportation for the recipient and a companion (or two companions if recipient under age 18), to and from the site of the transplant		
B16.	COMAR 31.11.06.03A(21)	Medical food		
B17.	COMAR 31.11.06.03A(22)	Family planning services		
		• Includes prescription contraceptive drugs and devices, insertion and removal of contraceptive devices, medically necessary examinations associated with the use of contraceptive drugs and devices, and voluntary sterilization		
	§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)		
B18.	COMAR 31.11.06.03A(23)	Habilitative services for children 0-19 years old		

	45 CFR § 156.115(a)(5)(i)	• Habilitative services defined as health care services and devices that help a person keep, learn, or improve skills and functioning for daily living.		
		a. Visit limits may not be applied		
	COMAR 31.11.06.03A(23)	b. Services provided in early intervention and school services may be excluded.		
	COMAR 31.11.06.03B	c. Shall include cleft lip/cleft palate benefits, orthodontics, oral surgery, otologic, audiological, and speech therapy, physical therapy, and occupational therapy.		
B19.	MIA Bulletins 13-01 and 15-33	Habilitative services for adults age 19 and over		
	45 CFR §156.115(a)(5)(i)	• Habilitative services defined as health care services and devices that help a person keep, learn, or improve skills and functioning for daily living.		
	45 CFR §156.125	• Visit limits may not be applied.		
B20.	COMAR 31.11.06.03A(24)	Blood and blood products		
B21.	COMAR 31.11.06.03A(25) MIA Bulletins 13-01 and 15-33	Pregnancy and maternity services		
	§15-812	a. Minimum length of stay and coverage for home visits for mothers and newborns following childbirth		
	§19-703(f), Health General	b. Additional 4-day hospital stay of healthy newborn if mother requires hospitalization and requests that the newborn remain in the hospital		
B22.	COMAR 31.11.06.03A(26)	Prescription drugs		
	§15-831 COMAR 31.11.06.03E(1)	a. May use a closed formulary for brand-name drugs		
	45 CFR §156.122(c)	• If closed formulary is used, procedure for standard and expedited exception requests required		

	§15-831(c)	• For a closed formulary, must cover a prescription drug or device not in the formulary or allow a member to continue the same cost sharing requirements for a prescription drug or device that has been moved to a higher deductible, copayment, or coinsurance tier if in the judgement of the authorized prescriber: o There is no equivalent prescription drug or device in the formulary in a lower tier; o An equivalent drug or device in a lower tier has been ineffective in treating the disease or condition or has caused or is likely to cause an adverse reaction or other harm to the member; or o For a contraceptive drug or device, the prescription drug or device not on the formulary is medically necessary for the member to adhere to the appropriate use of the prescription drug or device.		
	COMAR 31.11.06.03E(3) COMAR 31.11.06.03E(4)	b. 90-day supply for maintenance drugs • Exception for first prescription or change in prescription		
	§15-826.1(d)	c. 12-month supply of prescription contraceptives		
	COMAR 31.11.06.03E(2)	d. Must cover insulin		
	Bulletin L/H 1/97	e. Coverage of maintenance drugs from local pharmacies same as mail order		
	§15-804	f. Off label use of drugs		
	§15-845	g. Coverage for Certain Prescription Eye Drop Refills		
	§15-142(c)	h. Step therapy or fail first protocols may not be imposed under certain circumstances		
	§15-849	i. 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		
B23.	COMAR 31.11.06.03A(27)	Controlled clinical trials		
	§15-1A-02(a)(2)(xviii)	• Benchmark plan benefit must be expanded to comply with §2709 of the Affordable Care Act		

	Bulletin L/H 05-4	• May not apply service area restrictions or contracting provider requirements		
B24.	COMAR 31.11.06.03A(28)	Other services approved by case management		
B25.	COMAR 31.11.06.03A(29)	Diabetes treatment, equipment and supplies		
	COMAR 31.11.06.03H	• Must include glucose monitoring equipment, insulin syringes, needles, and testing strips for glucose monitoring equipment		
	MIA Bulletins 13-01 and 15-33	• Benchmark plan expanded to cover insulin pumps		
	§15-139	• Self-management training may not be required to be in-person		
B26.	15-815 COMAR 31.11.06.03A(30)	Breast reconstructive surgery and breast prosthesis		
	COMAR 31.11.06.03-I	• Includes coverage on non-diseased breast to achieve symmetry		
B27.	COMAR 31.11.06.03A(32) COMAR 31.11.06.03J	General anesthesia and associated hospital or ambulatory facility charges for dental care benefit		
B28.	COMAR 31.11.06.03A(34)	Hearing Aids		
	45 CFR §147.126	• The $1400 limit may not be applied		
	MIA Bulletin 15-33 45 CFR §156.125(a) 45 CFR §156.200(e)	• Benefit may not be limited to children		
B29.	§15-839 COMAR 31.11.06.03A(35)A-1 COMAR 31.10.33.03	Surgical treatment of morbid obesity		
	§15-839(a)(3)	a. Morbid obesity definition		
	§15-839(a)(2)	b. Body mass index definition		

B30.	COMAR 31.11.06.03-1C COMAR 31.11.06.03-1D COMAR 31.11.06.03-1E	Preventive Care Services a. Services include: • Evidenced-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force, except that the current recommendations of the United States Preventive Service Task Force regarding breast cancer screening, mammography, and prevention of breast cancer shall be considered the most current other than those issued in or around November 2009; • Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved; • With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; and • 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		
	§15-135	b. Covered annual preventive visits/screenings must be provided once at any time during the contract year		
B31.	MIA Bulletins 13-01 and 15-33	Mental health and substance use services in accordance with the Government Employees Health Association, Inc. Benefit Plan		
	§31-115(b)(9)(iii) 45 CFR §156.115(a)(3) 45 CFR §146.136(c)(2) and (4)	• Any quantitative or nonquantitative treatment limitations must comply with the federal Mental Health Parity and Addiction Equity Act		
	MIA Bulletins 13-01 and 15-33	a. Professional services by licensed, registered, or certified professional mental health and substance use practitioners when acting within the scope of their license, registration, or certification, such as psychiatrists, psychologists, clinical social workers, licensed professional counselors, or marriage and family therapists.		

		1. Diagnosis and treatment of psychiatric conditions, mental illness, or mental disorders. Services include:		
		i. Diagnostic evaluation;		
		ii. Crisis intervention and stabilization for acute episodes;		
		iii. Medication evaluation and management (pharmacotherapy);		
		iv. Treatment and counseling (including individual or group therapy visits);		
		v. Diagnosis and treatment of alcoholism and drug abuse, including detoxification, treatment and counseling;		
		vi. Professional charges for intensive outpatient treatment in a provider's office or other professional setting.		
		2. Electroconvulsive therapy;		
		3. Inpatient professional fees;		
		4. Outpatient diagnostic tests provided and billed by a licensed, registered, or certified mental health and substance abuse practitioner;		
		5. Outpatient diagnostic tests provided and billed by a laboratory, hospital or other covered facility;		
		6. Psychological and neuropsychological testing necessary to determine the appropriate psychiatric treatment.		
		b. Inpatient hospital and inpatient residential treatment centers services, which includes		
		1. Room and board, such as:		
		i. Ward, semiprivate, or intensive care accommodations (Private room is covered only if medically necessary. If private room is not medically necessary, the contract may limit coverage only to the hospital's average charge for semiprivate accommodations.);		
		ii. General nursing care;		

		iii. Meals and special diets.		
		2. Other facility services and supplies--Services provided by a hospital or residential treatment center (RTC).		
		c. Outpatient services, such as partial hospitalization or intensive day treatment programs. • Services may not be limited to those performed in an outpatient hospital setting		
		d. Emergency room – Outpatient services and supplies billed by a hospital for emergency room treatment.		
B32.	MIA Bulletins 13-01 and 15-33 45 CFR §156.115(a)(6)	Pediatric vision benefits for children **until at least the end of the month in which the child turns 19 years of age** in accordance with the FEP Blue Vision high plan		
		a. One routine eye examination, including dilation if professionally indicated, each year;		
		b. One pair of prescription eyeglass lenses each year;		
		c. One frame each year;		
		d. In lieu of eyeglasses, either one pair of contact lenses each year, or multiple pairs of disposable contact lenses each year; and		
		e. Low vision services, including one comprehensive low vision evaluation every 5 years, 4 follow-up visits in any 5-year period, and prescribed optical devices, such as high-power spectacles, magnifiers and telescopes.		
B33.	MIA Bulletins 13-01 and 15-33 45 CFR §156.115(a)(6)	Pediatric dental benefits for children **until at least the end of the month in which the child turns 19 years of age** in accordance with the Maryland Children's Health Insurance Plan dental benefit or Pediatric Dental benefit in the benchmark plan.		
	CMS FAQ on Health Insurance Market Reforms and Marketplace Standards, May 26, 2016	• Waiting period may NOT be applied to orthodontia		
	MIA Bulletins 13-01 and 15-33	a. Periodic screening in accordance with the periodicity schedule developed by the American Academy of Pediatric Dentistry; and		

		b. Treatment of all dental services determined to be medically necessary for problems identified during screening or diagnostic evaluations. Benefits include diagnostic services, preventative services, restorative services, endodontic services, periodontic services, removable prosthodontics, maxillofacial prosthetics, fixed prosthodontics, oral and maxillofacial surgery, orthodontics for children with severe dysfunctional, handicapping malocclusion, and adjunctive general services.		
	§15-135.1	c. Preventive Care Frequency Intervals • Annual dental preventive care visit must be covered if provided at any time during the policy year – may not require visit to occur after a specified time period (e.g. 12 months) following prior visit • If the contract provides benefits for dental preventive care more frequently than once per policy year, the contract may not require that the visits be separated by more than 120 days		
B34.	MIA Bulletins 13-01 and 15-33	Wellness benefits, which include a health risk assessment that is completed by each individual on a voluntary basis; and written feedback to the individual who completes a health risk assessment, with recommendations for lowering risks identified in the completed health risk assessment		
B35.	MIA Bulletins 13-01 and 15-33	Cardiac rehabilitation benefits for individuals who have been diagnosed with significant cardiac disease, or who have suffered a myocardial infarction, or have undergone invasive cardiac treatment immediately preceding referral for cardiac rehabilitation. Cardiac rehabilitation is a comprehensive program involving medical evaluation, prescribed exercise, cardiac risk factor modification, education and counseling.		
		a. Continuous EKG telemetric monitoring during exercise, EKG rhythm strip with interpretation, physician's revision of exercise prescription, and follow up examination for physician to adjust medication or change regimen; and		
		b. Increased outpatient rehabilitation services (physical therapy, speech therapy and occupational therapy) for cardiac rehabilitation of 90 visits per therapy, per contract year		

		c. Services may be limited to those provided at a place of service equipped and approved to provide cardiac rehabilitation		
B36.	MIA Bulletins 13-01 and 15-33	Pulmonary rehabilitation benefits (one (1) program per lifetime) for individuals who have been diagnosed with significant pulmonary disease • Services may be limited to those provided at a place of service equipped and approved to provide pulmonary rehabilitation		
B37.	MIA Bulletins 13-01 and 15-33	Delivery of benefits through patient centered medical homes for individuals with chronic conditions, serious illnesses or complex health care needs who agree to participate in a patient centered medical home program. This includes associated costs for coordination of care, such as		
		a. Liaison services between the individual and the health care provider, nurse coordinator, and the care coordination team;		
		b. Creation and supervision of a care plan;		
		c. Education of the individual and family regarding the individual's disease, treatment compliance and self-care techniques; and		
		d. Assistance with coordination of care, including arranging consultations with specialists and obtaining medically necessary supplies and services, including community resources.		
B38.	MIA Bulletin 15-33	Allergy serum		
B39.	MIA Bulletin 15-33	Birthing classes • May be limited to one (1) course per pregnancy		
B40.	§15-810	In-vitro fertilization		
	45 CFR §147.126	• $100,000 maximum lifetime benefit not permitted		
	§15-810(b) and (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 1/1/21	• Period of time to demonstrate a history of infertility reduced from two years to one year.		
	§15-810(d)(4) Senate Bill 988, Chpt 325, Acts of 2020, effective 1/1/21	• Coverage for in vitro-fertilization benefit expanded to include unmarried patients.		
B41.	§15-836	Hair prosthesis		
	45 CFR §147.126	• $350 limit not permitted		
	MIA Bulletin 23-5 45 CFR §156.125	• Hair prosthesis cannot be limited to hair loss only as a result of chemotherapy or radiation.		
B42.	45 CFR §156.115(d)	Routine non-pediatric dental services, routine non-pediatric eye exam services, long-term/custodial nursing home care benefits, or non-medically necessary orthodontia may not be included as essential health benefits		
B43.	§31-116(a) Maryland Benchmark Plan, Section 1.3.A.1., page B-3, form MD/CFBC/SHOP/ BCOA/DOCS (1/14)	Prostate cancer screenings a. Medically recognized diagnostic examinations including prostate-specific antigen (PSA) tests and digital rectal exams: • For men who are between forty (40) and seventy-five (75) years of age; • When used for the purpose of guiding patient management in monitoring the response to prostate cancer treatment; • When used for staging in determining the need for a bone scan for patients with prostate cancer; or • When used for male patients who are at high risk for prostate cancer.		
B44.	§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, except for HDHP)		
	§15-857(b)(1)(ii) House Bill 812, Chpt 249, Acts of 2023	• Zero cost sharing (applies to in-network and out-of-network benefits)		
	§15-857(b)(2)	• Term “abortion care” is required when describing coverage		

	Per Abortion Care Coverage Consumer Information Workgroup	The following language is allowed but not required: 1. "Abortion care services: ending a pregnancy. Your provider may prescribe medicine, do an in-office procedure, or refer you for a procedure." 2. For non-HSA plans, add the sentence "You do not need to pay for abortion care" or "Abortion care is covered at no charge." 3. For HSA plans, include the sentence "You may have to pay for abortion care because your plan is a Health Savings Account (HSA)-compatible high deductible health plan." And/or a sentence or bullet points with more specific information about cost-sharing if the carrier wishes to include it.		

C. Cost-sharing requirements

	Citation	Description	"X" Means Applicable	Form/ Page
C1.	45 CFR §147.130 COMAR 31.11.06.03-1F	Preventive services provided in-network without cost-sharing		
C2.	§15-825(c) Senate Bill 661, Chpt 344, Acts of 2020, effective 1/1/2021	May not apply a deductible, copayment or coinsurance for Prostate Cancer Screening		
C3.		Cost-sharing for emergency services		
	45 CFR §149.110(b)(3)(ii) 86 FR 36973	a. Copayments/coinsurance for emergency services received from non-network providers may not exceed in-network emergency services copayments/coinsurance		
	45 CFR §149.110(b)(3)(v) 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) 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		
C4.	45 CFR §149.130 86 FR 36974	Cost-sharing for air ambulance services.		

		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		
C5.		Cost-sharing for home visits for mothers and newborns following childbirth		
	§15-812(g)(1)	• For other than High Deductible Health Plans, visits may not be subject to deductibles, copayments or coinsurance		
	§15-812(g)(2)	• For High Deductible Health Plans, visits may not be subject to copays or coinsurance, but may be subject to deductible		
C6.	§15-842	Copayment for prescription drug or device may not exceed the retail price of drug/device		
C7.	§15-852	Prorated daily copayment/coinsurance for partial supply of prescription drug dispensed by network pharmacy		
C8.	§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		
C9.	§15-847	Specialty drugs – copayment/coinsurance limits		
	§15-847(a)(5)(ii)	• Definition excludes drugs prescribed to treat diabetes, HIV, or AIDS		
C10.	§15-847.1	Prescription drugs prescribed to treat diabetes, HIV, or AIDs – copayment/coinsurance limits		
C11.	§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		
C12.	§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		
C13.	§15-826.2(b)	Copayments, coinsurance, or deductibles may not be applied to male sterilization coverage		
	§15-826.2(b)(3)	• Exception – For High Deductible Health Plans, deductible may be applied to male sterilization		
C14.	§15-814.1, HB376, Chpt 299, Acts of 2023, effective 7/1/2023	Copayments, coinsurance, or deductibles may not be applied to diagnostic breast examinations or supplemental breast examinations. • Exception – For High Deductible Health Plans, deductible may be applied to diagnostic breast or supplemental breast examinations		
C15.	§15-860(c), HB815, Chpt 354, Acts of 2023, effective 7/1/2023	May not impose a copayment, coinsurance or deductible that is greater than the copay, coinsurance or deductible requirement for breast cancer screening and diagnosis for follow-up diagnostic lung cancer imaging for individuals for which lung cancer screening is recommended by the US Preventative Services Task Force • Exception – For High Deductible Health Plans, deductible may be applied to follow-up diagnostic lung cancer imaging		
C16.	§ 15-822(d)(3)	Copayments, coinsurance, or deductibles may not be applied to diabetes test strips		
	§ 15-822(d)(3)(ii)	• Exception—For High Deductible Health Plans, diabetes test strips may not be subject to copayments or coinsurance, but may be subject to the deductible		
C17.	§15-822.1 House Bill 1397, Chpt 405, Acts of 2022, effective 1/1/2023.	Copayment or coinsurance for insulin cannot be more than $30 for a 30-day supply, regardless of amount or type of insulin needed.		

C18.	§31-115(b)(9)(iii) 45 CFR §156.115(a)(3)	Cost sharing for mental health and substance use benefits must comply with the federal Mental Health Parity and Addiction Equity Act		
	45 CFR §146.136(c)(2)(i)	a. May not apply any financial requirement in any benefit classification that is more restrictive than the predominant financial requirement of that type that applies to substantially all medical/surgical benefits in the same classification		
	45 CFR §146.136(c)(2)(ii)	b. For purposes of determining mental health parity, classifications are (1) inpatient, in-network; (2) inpatient, out-of-network; (3) outpatient, in-network; (4) outpatient, out-of-network; (5) emergency care; and (6) prescription drugs		
	45 CFR §146.136(c)(3)(iii)	c. 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. Separate sub-classifications for generalists and specialists, are not permitted.		
C19.	45 CFR §156.130(a)	Annual limitation on cost-sharing (deductibles, coinsurance, copayments)		
	CMS Guidance Dated November 15, 2023—Premium Adjustment Percentage, Maximum Annual Limitation on Cost Sharing…	a. Self-only coverage – $9,200		
		b. Other than self-only coverage – $18,400		
	45 CFR § 156.130(c)	c. Out-of-network cost sharing is not required to count toward the limit		
	45 CFR § 156.230(e)	• Exception for QHPs – cost sharing for essential health benefits provided by out-of-network ancillary provider at in-network facility must count towards the limit if carrier fails to provide advance notice of potential additional costs associated with ancillary provider services		
	81 FR 94147	• For plans that do not cover out-of-network services (exclusive provider benefits), the cost-sharing for an out-of-network ancillary provider benefit is calculated as the carrier's in-network allowed amount for the service		

	80 FR 10825	d. 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		
C20.	45 CFR §147.126	No lifetime or annual limits for essential health benefits		
C21.	45 CFR §156.420	Cost-sharing and AV for silver plan variations offered through the Exchange		
	CMS Guidance Dated November 15, 2023—Premium Adjustment Percentage, Maximum Annual Limitation on Cost Sharing…	a. 100-150 percent of FPL • AV 94% -0/ +1% • Reduced annual limit on cost sharing o $3,050 self-only o $6,100 other than self-only		
		b. > 151 and ≤200 percent of FPL • AV 87% -0/ +1% • Reduced annual limit on cost sharing o $3,050 self-only o $6,100 other than self-only		
		c. >201 and ≤250 percent of FPL		
	45 CFR §156.420(f)	• AV 73% -0/ +1% subject to requirement that the AV of this variation and the standard silver plan to differ by at least 2%		
	CMS Guidance Dated November 15, 2023—Premium Adjustment Percentage, Maximum Annual Limitation on Cost Sharing…	• Reduced annual limit on cost-sharing o $7,350 self-only o $14,700 other than self-only		
	45 CFR §156.420(e)	d. The member cost-share for a benefit in any silver plan variation may not exceed the corresponding cost share in the standard silver plan or any silver plan variation thereof with a lower AV		
C22.	45 CFR §156.420(b)(1)	All cost-sharing eliminated in each health plan offered through the Exchange for Indians with incomes less than 300 percent of the FPL eligible under 45 CFR §155.350(a)		
	78 FR 15494	• The Exchange will allow the carrier to submit one zero cost sharing plan variation for only the standard plan within the set with the lowest premium, if the benefits, networks, and all other aspects of the standard plans are exactly the same		

C23.	45 CFR §156.420(b)(2)	For Indians regardless of income, cost-sharing eliminated in each health benefit offered through the Exchange for any essential health benefit furnished directly by the Indian Health Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization or through referral under contract health services		
C24.	45 CFR §156.420(c)	A standard silver plan and each silver plan variation thereof must cover the same benefits and providers		
C25.	45 CFR §156.420(d)	Each zero cost sharing plan variation of a QHP (C22. above) must cover the same benefits and providers and the out-of-pocket spending for a benefit that is not an essential health benefit may not exceed the corresponding out-of-pocket spending required in the limited cost-sharing variation (C.23.above) of the same QHP. In the case of a silver QHP, the out-of-pocket spending for a non-essential health benefit in the zero cost-sharing variation may not exceed the corresponding out-of-pocket spending in the silver 94 CSR variation		
C26.	45 CFR §156.420(d)	Each limited cost-sharing plan variation (C23. above) must cover the same benefits and providers and the out-of-pocket spending for a benefit that is not an essential health benefit may not exceed the corresponding out-of-pocket spending in the plan without the cost-sharing reduction. The out-of-pocket spending for essential health benefits that are not required to be reduced must be the same as the out-of-pocket spending in the plan without the cost-sharing reduction.		
C27.	45 CFR §149.120 86 FR 36973-36974 45 CFR §149.30 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.		
		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		

D. Permissible Exclusions (Benchmark Plan-MIA Bulletins 13-01 and 15-33)

	Citation	Description	"X" Means Applicable	Form/ Page
D1.	MIA Bulletins 13-01 and 15-33 COMAR 31.11.06.06B	Except as provided in this Section D, may not include exclusions not found in COMAR 31.11.06.06B		
D2.	MIA Bulletins 13-01 and 15-33	The exclusion for the purchase, examination and fitting of eyeglasses in COMAR 31.11.06.06B(6) is required to be revised to indicate that it does not apply to the pediatric vision benefit		
D3.	MIA Bulletins 13-01 and 15-33 COMAR 31.11.06.03-1	The exclusion for services for sterilization or reverse sterilization for a dependent minor in COMAR 31.11.06.06B(13)is required to be revised to indicate that it does not apply to FDA approved sterilization procedures for women with reproductive capacity as this is a required preventive benefit under the Affordable Care Act and COMAR 31.11.06.03-1		
D4.	§15-139 Senate Bill 3, Chpt 71, Acts of 2021, effective 7/1/2021	The exclusion for Charges for telephone consultations in COMAR 31.11.06.06B(21) must be followed by “except a covered telehealth consultation” in order to comply with §15-139 as amended.		
D5.	MIA Bulletins 13-01 and 15-33	The exclusion for travel found in COMAR 31.11.06.06B(24) is required to be modified to provide an exception for the cost of air transportation for the recipient and a companion (or two companions if recipient under age 18), to and from the site of a covered organ transplant		
D6.	MIA Bulletins 13-01 and 15-33	The exclusion for accidents occurring while and as a result of chewing in COMAR 31.11.06.06B(28) is required to be revised to indicate that it does not apply to the pediatric dental benefit.		
D7.	MIA Bulletins 13-01 and 15-33 45 CFR §156.200(e)	The exclusion for treatment leading to or in connection with transsexualism, or sex changes or modifications, including but not limited to surgery in COMAR 31.11.06.06B(32) is required to be deleted. Federal guidance has determined that this type of exclusion is a discriminatory benefit design and is prohibited.		
D8.	MIA Bulletins 13-01 and 15-33	The exclusion for organ transplants not otherwise listed in COMAR 31.11.06.03 in COMAR 31.11.06.06B(35) is required to be deleted. This exclusion contradicts the additional organ transplant benefit in the Benchmark plan.		

D9.	MIA Bulletins 13-01 and 15-33	The limitation found in COMAR 31.11.06.06B(50) requiring that all mental health and substance use services be provided through the carrier's managed care system is required to be deleted, as it violates the federal Mental Health Parity and Equity Addiction Act.		
D10.	MIA Bulletins 13-01 and 15-33	The exclusion for tobacco cessation in COMAR 31.11.06.06B(51) will not be permitted, as it contradicts the tobacco cessation preventive service benefits required by the Affordable Care Act and COMAR 31.11.06.03-1.		
D11.	MIA Bulletins 13-01 and 15-33	The exclusion for in vitro fertilization in COMAR 31.11.06.06B(11), will not be permitted as in vitro fertilization is an essential health benefit in the individual market.		
D12.	MIA Bulletins 13-01, 15-33 and 23-5 45 CFR §156.125	The exclusion for wigs or cranial prosthesis in COMAR 31.11.06.06B(39) is required to be revised to indicate that it does not apply to hair prostheses when prescribed by a provider.		
D13.	§15-139 Senate Bill 3, Chpt 71, Acts of 2021, effective 7/1/2021	The exclusion for telephone therapy for mental health and substance use benefits in the benchmark plan and MIA Bulletins 13-01 and 15-33 is prohibited.		
D14.	MIA Bulletins 13-01 and 15-33	Additional permissible exclusions for the mental health and substance use benefit		
		a. Services by pastoral or marital counselors		
		b. Therapy for sexual problems		
		c. Treatment for learning disabilities and intellectual disabilities		
		d. Travel time to the member's home to conduct therapy		
		e. Services rendered or billed by schools, or halfway houses or members of their staffs		
		f. Marriage counseling		
		g. Services that are not medically necessary		
D15.	MIA Bulletins 13-01 and 15-33	Additional permissible exclusion for cardiac and pulmonary rehabilitation benefits • Benefits will not be provided for maintenance programs. Maintenance programs consist of activities that preserve the individual's present level of function and prevent regression of that function. Maintenance begins when the therapeutic goals of a treatment plan have been achieved, or when no additional progress is apparent or expected to occur.		

D16.	MIA Bulletins 13-01 and 15-33 FEP Blue Vision plan	Additional permissible exclusions for pediatric vision services		
		a. Services and materials not meeting accepted standards of optometric practice		
		b. Services and materials resulting from the covered person's failure to comply with professionally prescribed treatment		
		c. Charges for office infection control		
		d. Charges associated with copies of records/charts		
		e. Visual therapy		
		f. Special lens designs or coatings other than those specified in the covered services		
		g. Replacement of lost/stolen eyewear		
		h. Non-prescription (Plano) lenses		
		i. Two pairs of eyeglasses in lieu of bifocals		
		j. Insurance of contact lenses		
D17.	MIA Bulletins 13-01 and 15-33 MCHIP dental benefit	Additional permissible exclusions for pediatric dental benefits		
		a. Charges for some or multiple radiographs of the same tooth or area if redundant, excessive, or not in keeping with federal guidelines relating to radiation exposure.		
		b. Individual radiographs taken on the same day limited to the allowed charge for a full mouth series.		
		c. Lower lingual holding arch placed where there is not premature loss of the primary molar.		
		d. Crowns placed within 30 days of the date of service of a root canal or restoration on the same tooth.		
		e. Restorations placed in a tooth within 36 months of the initial similar restoration on the same tooth.		
D18.	MIA Bulletins 13-01 and 15-33 §19-712.4(c), Health-General	Required Exclusion for Prohibited Health Care Practitioner Referrals		

E. Standards that Apply to Plans Offered through the Exchange

	Citation	Description	"X" Means Applicable	Form/ Page
E1.	45 CFR §156.265(d) 45 CFR §155.240(a)	Individual must be allowed to pay premium directly to the carrier		
E2.	45 CFR §156.1240 86 FR 6155	Carrier must accept premium payment via paper checks, cashier's checks, money orders, EFT, and all general-purpose pre-paid debit cards, including when these methods are used by or on behalf of an enrollee in connection with an individual coverage HRA or QSEHRA in which the enrollee is enrolled.		
E3.	45 CFR §156.265(b)	Individuals enrolled only if Exchange notifies the insurer that the individual is a qualified individual as determined by the Exchange in accordance with 45 CFR §155.305.		
E4.	45 CFR §156.270(d) §15-1315	Three (3)-month grace period for individuals receiving advance payments of the premium tax credit on the premium due date • For plans renewed in accordance with §15-1309, carrier may not condition eligibility for grace period on individual having paid the first month's premium following renewal		
E5.	45 CFR §156.210(a)	Premium rates must be set for an entire benefit year		
E6.	45 CFR §155.20	Benefit year defined as a calendar year for which the HMO provides coverage for benefits		

F. Open Enrollment and Special Enrollment Periods

	Citation	Description	"X" Means Applicable	Form/ Page
F1.	45 CFR §155.410(e)(4)(i) and (f)(3)(i)(A) and (B) §15-1316 Proposed NBPP pg 213 COMAR 14.35.07.11	Annual open enrollment period of November 1 through January 15 of the calendar year preceding the benefit year. An effective date of January 1 for applications received on or before December 31. An effective date of February 1 for applications received on or after December 31.		
F2.	45 CFR §147.104(b)(2) 45 CFR §155.420(d) §15-1316(c)(1) and (d)(1) 45 CFR §147.104(b)(2)(iii)	For plans offered outside the Exchange, individual/dependent may enroll in a health benefit plan or change from one health benefit plan to another		
F3.	45 CFR §147.104(b)(2) 45 CFR §155.420(d) §15-1316(c)(1) and (d)(1)	Special enrollment period of 60 days for certain "triggering events" Upon experiencing a triggering event:		

	Citation	Description	"X" Means Applicable	Form/ Page
		• For plans offered through the Exchange, except as otherwise specified below:		
	45 CFR §155.420(a)(3)	○ Individual not currently enrolled in a QHP must be allowed to enroll in any QHP		
	45 CFR §155.420(a)(4)(iii)(A)	○ Individual currently enrolled in a QHP must be allowed to enroll with his or her dependents in another QHP within the same level of coverage (or one metal level higher or lower, if no such QHP is available)		
	45 CFR §155.420(a)(4)(iii)(B)	○ Non-covered dependent of an individual currently enrolled in a QHP must be allowed to be added to individual's current QHP (if the QHP's business rules do not allow the dependent to enroll in the same QHP, must allow individual and dependents to enroll in different QHP within the same metal level, or, if no such QHP is available, one metal level higher or lower), or must be allowed to enroll in any separate QHP		
	45 CFR §155.420(a)(4)(iii)(C)	○ Individual who is not an enrollee and has one or more dependents who are enrollees who do not also qualify for a special enrollment period must be allowed to enroll in the dependent's current QHP (if the QHP's business rules do not allow the individual to enroll in the dependent's current QHP, must allow the individual to enroll with the dependent(s) in another QHP within the same level of coverage, or one metal level higher or lower, if no such QHP is available) or must be allowed to enroll in a separate QHP		
	45 CFR §147.104(b)(4)(ii) 45 CFR §155.420(b)(5) and (c)(5)	• Individual or dependent who did not receive timely notice of a triggering event must be provided access to the special enrollment period 60 days from the date they knew or reasonably should have known they experienced a triggering event to select a new plan.		
	45 CFR §155.420(d)(1)(i)	a. Loss of minimum essential coverage by the individual or dependent. The date of the loss of coverage is the last day the individual or dependent would have coverage under the previous plan or coverage.		

	Citation	Description	"X" Means Applicable	Form/ Page
	45 CFR §155.420(e)	• Does not include loss of coverage due to voluntary termination, failure to pay premiums on a timely basis, including COBRA premiums prior to the expiration of COBRA, except for circumstances in which an employer completely ceases its contributions to COBRA continuation coverage, or government subsidies of COBRA continuation coverage completely cease, or loss due to a rescission authorized under 45 CFR §147.128		
	45 CFR §155.420(c)(2)	• May access the special enrollment period 60 days prior to the end of such coverage.		
	45 CFR §155.420(d)(1)(iii)	b. Loss of pregnancy related coverage under section 1902(a)(10)(A)(i)(IV) and (a)(10)(A)(ii)(IX) of the Social Security Act (Medicaid) or loss of access to health care services through coverage provided to a pregnant woman's unborn child. The date of the loss of coverage is the last day the individual or dependent would have pregnancy-related coverage or access to health care services through the unborn child coverage.		
	45 CFR §155.420(c)(2)	• May access the special enrollment period 60 days prior to the end of such coverage.		
	45 CFR §155.420(d)(1)(iv)	c. Loss of medically needy coverage, as described under section 1902(a)(10)(C) of the Social Security Act, by individual or dependent only once per calendar year. The date of the loss of coverage is the last day the consumer would have medically needy coverage.		
	45 CFR §155.420(c)(2)	• May access the special enrollment period 60 days prior to the end of such coverage		
	45 CFR §155.420(d)(1)(ii)	d. Individual or dependent is enrolled in any non-calendar year group health plan, individual health insurance coverage, or qualified small employer health reimbursement arrangement (QSEHRA), even if individual or dependent has the option to renew such coverage. The date of the loss of coverage is the last day of the plan or policy year.		

	Citation	Description	"X" Means Applicable	Form/ Page
	45 CFR §155.420(c)(2)	• May access the special enrollment period 60 days prior to the end of such coverage		
	45 CFR §155.420(d)(2)(i)	e. Individual gains a dependent or becomes a dependent through marriage, birth, adoption, placement for adoption, or placement in foster care or through a child support order or other court order		
		• For plans offered through the Exchange:		
	45 CFR §155.420(a)(3)	○ Individual not currently enrolled in a QHP may enroll in any QHP		
	45 CFR §155.420(a)(4)(i)	○ Individual currently enrolled in a QHP may add dependent to same QHP or enroll dependent in any separate QHP (if the carrier's business rules for the current QHP do not allow the dependent to enroll in the same QHP, must allow individual and dependents to enroll in different QHP within the same metal level, or, if no such QHP is available, one metal level higher or lower)		
	45 CFR §§155.420(a)(5) and (d)(2)(i)(A)	• For on and off the Exchange, in the case of marriage, at least one spouse must demonstrate having minimum essential coverage for one or more days during the 60 days preceding the date of marriage, which can be satisfied by demonstrating that they: ○ Had minimum essential coverage; ○ Had pregnancy related coverage or access to healthcare services through unborn child coverage described in 45 CFR § 155.420(d)(1)(iii)**;** ○ Had medically needy coverage described in 45 CFR § 155.420(d)(1)(iv) ○ Are an Indian; ○ Lived in a foreign country or in a United States territory for one or more days during the 60 days preceding the marriage; or ○ For 1 or more days during the 60 days preceding the marriage or during their most recent preceding open enrolment period or special enrollment period, lived in a service area where no QHP was available through the Exchange		

	45 CFR §155.420(d)(2)(ii)	f. The individual loses a dependent or is no longer considered a dependent through divorce or legal separation as defined by State law in the State in which the divorce or legal separation occurs, or if the enrollee, or his or her dependent, dies.		
	45 CFR § 155.420(c)(2) 45 CFR §155.420(d)(3)	g. Individual or dependent who is reasonably expected to be a citizen, national, or lawfully present or is released from incarceration • Only applies to plans offered through the Exchange • Individual or dependent released from incarceration may access the special enrollment period 60 days prior to and after their release.		
	45 CFR §155.420(d)(4)	h. The individual's or dependent's enrollment or non-enrollment is unintentional, inadvertent or erroneous and is the result of the error, misrepresentation, misconduct, or inaction of an officer, employee, or agent of the Exchange or HHS, its instrumentalities, or a non-Exchange entity providing enrollment assistance or conducting enrollment activities		
	45 CFR §155.420(a)(3) and (4)(iii)	• For plans offered through the Exchange, individual or dependent must be allowed to enroll in or change to any QHP, regardless of whether the individual or dependent is currently enrolled in a QHP		
	45 CFR §155.420(d)(5)	i. Individual or dependent adequately demonstrates to the Exchange that a QHP in which he or she is enrolled substantially violated a material provision of its contract in relation to the enrollee		
	45 CFR §155.420(d)(6)(i) and (ii)	j. Individual or dependent enrolled in the same plan becomes newly eligible or newly ineligible for advance payments of premium tax credits or federal cost-sharing reductions		
		• For plans offered through the Exchange:		
	45 CFR §155.420(d)(6)(i) and (ii)	○ Individual is determined newly eligible or newly ineligible for advance payments of the premium ta credit ("APTC") or has a change in eligibility for cost-sharing reductions. ○ Dependent enrolled in the same QHP becomes newly eligible or newly ineligible for APTC or has a change in eligibility for cost-sharing reductions.		

	45 CFR §155.420(a)(4)(ii)(A)	○ Individual or dependent newly "eligible" for cost-sharing reductions and not enrolled in a silver-level QHP must be allowed to enroll in a silver-level QHP		
	45 CFR §155.420(a)(4)(ii)(B)	○ Beginning January 2022, Individual or dependent newly "ineligible" for cost-sharing reductions and enrolled in a silver-level QHP must be allowed to enroll in a QHP one level higher or lower		
	45 CFR §155.420(a)(4)(iii)	○ Individual or dependent newly "eligible" for APTC is subject to general enrollment restrictions described in item F3 above.		
	45 CFR §155.420(a)(4)(ii)(C) 86 FR 24216	○ Enrollee or dependent newly "ineligible" for APTC must be allowed to change to a new plan at any metal level.		
	45 CFR § 147.104(b)(2)(i)(B) 45 CFR § 147.104(b)(2)(iii)	• For plans offered outside the Exchange		
		○ Applies only to individual or dependent who becomes newly "ineligible" for APTC or cost-sharing reductions.		
		○ Individual or dependent experiencing this triggering event must be allowed to enroll in a health benefit plan or change from one health benefit plan to another		
	45 CFR §155.420(d)(7)	k. Individual or dependent gains access to new QHP's due to a permanent move and had minimum essential coverage for one or more days during the 60 days preceding the move		
	45 CFR §155.420(a)(5)	• Individual or dependent can satisfy prior coverage requirement by demonstrating that they: ○ Had minimum essential coverage; ○ Had pregnancy related coverage or access to healthcare services through unborn child coverage described in 45 CFR § 155.420(d)(1)(iii); ○ Had medically needy coverage described in 45 CFR § 155.420(d)(1)(iv) ○ Are an Indian; ○ Lived in a foreign country or in a United States territory for one or more days during the 60 days preceding the move; or		

		○ For 1 or more days during the 60 days preceding the move or during their most recent preceding open enrollment period or special enrollment period, lived in a service area where no QHP was available through the Exchange		
	45 CFR §155.420(c)(2)	• May access the special enrollment period 60 days in advance of or 60 days after the move		
	45 CFR §155.420(d)(9)	l. Individual or dependent demonstrates to the Exchange, in accordance with HHS guidelines, that the individual meets other exceptional circumstances • Only applies to plans offered through the Exchange		
	45 CFR §155.420(a)(3) and (4)(iii)	• Individual or dependent must be allowed to enroll in or change to any QHP, regardless of whether the individual or dependent is currently enrolled in a QHP		
	45 CFR §155.420(d)(6)(iii)	m. Individual or dependent is enrolled in an employer-sponsored plan, is determined newly eligible for advance payments of premium tax credits ("APTC") based in part on the individual being ineligible for qualifying coverage in an eligible employer-sponsored plan, and is allowed to terminate existing coverage. • Only applies to plans offered through the Exchange		
	45 CFR §155.420(c)(2)	• May access the special enrollment period 60 days prior to the end of the such coverage		
	45 CFR § 155.420(d)(6)(iv)	n. An individual who was previously ineligible for advance payments of the premium tax credit solely because of a household income below 100 percent of the FPL and who, during the same timeframe, was ineligible for Medicaid because he or she was living in a non-Medicaid expansion State, who either experiences a change in household income or moves to a different State resulting in the individual becoming newly eligible for advance payments of the premium tax credit • Only applies to plans offered through the Exchange		
	45 CFR § 155.420(c)(2)	• If becoming newly eligible as a result of move to a different State, may access the special enrollment period 60 days prior to or after the move.		

	45 CFR § 155.420(d)(6)(v)	o. At the option of the Exchange, an individual or dependent experiences a decrease in household income, is newly determined eligible by the Exchange for advance payments of premium tax credit, and had minimum essential coverage for one or more days during the 60 days preceding the date of the financial change • Only applies to plans offered through the Exchange		
	45 CFR § 155.420(d)(10)	p. Individual is a victim of domestic abuse or spousal abandonment, including a dependent or unmarried victim within a household, is enrolled in minimum essential coverage and seeks to enroll in coverage separate from the perpetrator of the abuse or abandonment; or is a dependent of a victim of domestic abuse or spousal abandonment, on the same application as the victim, and seeks to enroll in coverage at the same time as the victim.		
	45 CFR §155.420(a)(3) and (4)(iii)	• For plans offered through the Exchange, individual or dependent must be allowed to enroll in or change to any QHP, regardless of whether the individual or dependent is currently enrolled in a QHP		
	45 CFR § 155.420(d)(11)	q. Individual or dependent applies for coverage on the Exchange during the annual open enrollment period or due to a qualifying event, is assessed by the Exchange as potentially eligible for Medicaid or the Children's Health Insurance Program (CHIP), and is determined ineligible for Medicaid or CHIP by the State Medicaid or CHIP agency either after open enrollment has ended or more than 60 days after the qualifying event OR applies for coverage at the State Medicaid or CHIP agency during the annual open enrollment period, and is determined ineligible for Medicaid or CHIP after open enrollment has ended.		
	45 CFR § 155.420(d)(12)	r. The enrollment in a QHP through the Exchange was influenced by a material error related to plan benefits, service area, cost sharing or premium. A material error is one that is likely to have influenced the individual's, enrollee's, or their dependent's enrollment in a QHP. • Only applies to plans offered through the Exchange		
	45 CFR §155.420(a)(3) and (4)(iii)	• Individual must be allowed to enroll in or change to any QHP, regardless of whether the individual is currently enrolled in a QHP		

	45 CFR § 155.420(d)(13)	s. At the option of the Exchange, the individual provides satisfactory documentary evidence to verify his or her eligibility for an insurance affordability program or enrollment in a QHP through the Exchange following termination of Exchange enrollment due to a failure to verify such status within the time period specified in 45 CFR §155.315 or is under 100 percent of FPL and did not enroll in coverage while waiting for HHS to verify his or her citizenship, status as a national, or lawful presence • Only applies to plans offered through the Exchange		
	45 CFR §155.420(d)(14)	t. Individual or dependent who newly gains access to an individual coverage HRA or is newly provided a qualified small employer health reimbursement arrangement (QSEHRA)		
	45 CFR § 155.420(c)(3)	• May access the special enrollment period 60 days before the first day on which coverage under the HRA can take effect or the first day on which coverage under the QSEHRA takes effect, unless the HRA or QSEHRA was not required to provide the notice setting forth its terms at least 90 days before the beginning of the plan year, in which case the individual, enrollee, or dependent has 60 days before or after the triggering event to select a QHP		
	45 CFR §155.420(a)(3) and (4)(iii)	• For plans offered through the Exchange, individual or dependent must be allowed to enroll in or change to any QHP, regardless of whether the individual or dependent is currently enrolled in a QHP		
	45 CFR §155.420(d)(15)	u. COBRA continuation coverage for which an employer is paying all or part of the premiums or a government entity is subsidizing the premiums, and the employer or government entity completely ceases its contributions/subsidies, for COBRA continuation coverage.		
	45 CFR §155.420(c)(2)	• May access the special enrollment period 60 days prior to or after the cessation of employer contributions or government subsidies		
F4.	45 CFR §155.420(b) §15-1316(f)	Effective dates of coverage for individuals who enroll during a special enrollment period		

	45 CFR §155.420(b)(2)(iv)	a. In the case of loss of minimum essential coverage, loss of pregnancy related coverage, loss of unborn child coverage, loss of medical needy coverage, loss of coverage under a non-calendar year group or individual plan, gaining access to new plans due to a permanent move, becoming newly eligible due to release from incarceration, becoming newly eligible for advance payments of premium tax credit due to a move from a non-Medicaid expansion State, or is enrolled in COBRA continuation coverage and employer contributions to or government subsidies of this coverage completely cease, the effective date is as follows: **On-Exchange:** • If plan selection is made on or before the date of the triggering event, the Exchange must ensure coverage is effective on the first day of the month following the date of the triggering event. • If plan selection is made after the date of the triggering event, the first day of the month after the individual selects a plan or, at the option of the Exchange, coverage is effective on the first day of the following month • For losses of minimum essential coverage [45 CFR §§155.420(d)(1) and (d)(6)(iii)], at the option of the Exchange, if plan selection is made on or before the last day of the month preceding the triggering event, the Exchange must ensure the coverage effective date is the first day of the month in which the triggering event occurs **Off-Exchange:** If plan selection is made on or before the date of the triggering event, the coverage effective date is the first day of the month following the date of the triggering event; if plan selection is made after the date of the triggering event, the first day of the month after the individual selects a plan.		
	45 CFR §155.420(b)(2)(i) §15-401(b)(2)	b. In the case of birth, adoption, or placement for adoption, the date of birth, adoption, or placement for adoption		
	45 CFR §155.420(b)(2)(i)	c. In the case of placement in foster care or a court order, the date of placement in foster care or the effective date of the court order, or in accordance with 45 CFR §155.420(b)(1).		

	45 CFR §155.420(b)(2)(ii)	d. In the case of marriage, the first day of the month following plan selection		
	45 CFR §155.420 (b)(2)(iii)	e. In the case of an individual or dependent eligible for special enrollment when: 1. Enrollment or non-enrollment was unintentional, inadvertent or erroneous and the result of an error misrepresentation, misconduct, or inaction of an officer, employee, or agent of by the Exchange or HHS, its instrumentalities, or a non-Exchange entity providing enrollment assistance or conducting enrollment activities; 2. The qualified plan substantially violated a material provision of its contract with the individual; 3. The individual meets other exceptional circumstances; 4. Individual or dependent applies for coverage on the Exchange during the annual open enrollment period or due to a qualifying event, is assessed by the Exchange as potentially eligible for Medicaid or the Children's Health Insurance Program (CHIP), and is determined ineligible for Medicaid or CHIP by the State Medicaid or CHIP agency either after open enrollment has ended or more than 60 days after the qualifying event OR applies for coverage at the State Medicaid or CHIP agency during the annual open enrollment period, and is determined ineligible for Medicaid or CHIP after open enrollment has ended; 5. The individual's, or his or her dependent's enrollment in a QHP through the Exchange was influenced by a material error related to plan benefits, service area, cost sharing or premium; or 6. The individual provides satisfactory documentary evidence to verify his or her eligibility for an insurance affordability program or enrollment in a QHP through the Exchange following termination of Exchange enrollment due to a failure to verify such status within the time period specified in 45 CFR §155.315 or is under 100 percent of FPL and did not enroll in coverage while waiting for HHS to verify his or her citizenship, status as a national, or lawful presence.		

			For Exchange plans, the effective date is an appropriate date based on the specific circumstances and is determined by the Exchange. For non-exchange plans, the first day of the month after the individual selects a plan.		
	45 CFR §155.420(b)(2)(iv)	f.	In the case of an individual or dependent enrolled in an employer-sponsored plan, is determined newly eligible for advance payments of premium tax credits based on the individual being ineligible for qualifying coverage in an eligible employer-sponsored plan, and is allowed to terminate existing coverage, the effective date is based on date of plan selection. If plan selection is made on or before loss of coverage, the Exchange must ensure new coverage becomes effective the first day of the month following the loss of coverage. If plan selection occurs after the date of loss the first day of the month after the individual selects a plan. At the option of the Exchange, if plan selection is made on or before the last day of the month preceding the triggering event, the Exchange must ensure the coverage effective date is the first day of the month in which the triggering event occurs.		
	45 CFR § 155.420(b)(2)(v)	g.	In the case of an individual or dependent who dies, the first day of the month following the plan selection, or if permitted by the Exchange the individual may elect a coverage effective date of the first day of the month after the individual selects a plan..		
	45 CFR § 155.420 (b)(2)(vi)	h.	In the case of an individual, enrollee, or dependent who newly gains access to an individual coverage HRA or is newly provided a QSEHRA, the effective date is based on date of plan selection. If the plan selection is made before the day of the triggering event, the coverage is effective on the first day of the month following the date of the triggering event or, if the triggering event is on the first day of a month, on the date of the triggering event. If the plan selection is made on or after the day of the triggering event, the coverage is effective on the first day of the month following plan selection.		
	45 CFR §155.420(b)(5)	i.	In the case of an individual or dependent who did not receive timely notice of a triggering event, at the option of the individual or dependent, the effective date will be the earliest effective date that would have been available based on the applicable special triggering event.		

	45 CFR §155.420(b)(1) Proposed NBPP	j. For all other triggering events the first day of the month after the individual selects a plan		
F5.	45 CFR §155.420(c)(6)	At the option of the MHBE, special enrollment period of 90 days after an individual loses Medicaid or CHIP. If the State Medicaid/CHIP agency has a reconsideration period of greater than 90 days, the MHBE may elect to extend the length of the enrollment period to match the length of the Medicaid/CHIP reconsideration period. Coverage is effective the first day of the month after the individual selects a plan		
F6.	§ 15-1316(c)(2) and (d)(2)	Special enrollment period of 90 days for individual or dependent who becomes pregnant as confirmed by a health care practitioner		
	§ 15-1316(e)(2)	• Special enrollment period begins on the date the health care practitioner confirms the pregnancy		
	§ 15-1316(f)(2)	• Coverage effective date is the first day of the month in which the individual receives confirmation of the pregnancy		
F7.	45 CFR §155.420(d)(8)(i)	Individuals who gain or maintain status as an Indian may enroll in or change to any QHP on the Exchange once per month		
	45 CFR §155.420(d)(8)(ii)	• Individual who is or becomes a dependent of an Indian, and is enrolled or is in enrolling in a plan on the same application as the Indian, may change plans one time per month at the same time as the Indian		
F8.	45 CFR 155.420(d)(16) 45 CFR 155.420(a)(4)(i)(D)	For individual or dependent who is eligible for advance payments of the premium tax ("APTC") credit, and whose household income, as defined by 26 CFR 1.36B-1(e), is expected to be no greater than 150 percent of the Federal poverty level. Individual or dependent may enroll in a QHP or change from one QHP to another one time per month during periods of time when the applicable taxpayer's applicable percentage for purposes of calculating the premium assistance amount, as defined in section 36B(b)(3)(A) of the Internal Revenue Code, is set at zero. If individual or dependent qualifies for this special enrollment period, the individual and dependent must be allowed to change to any available silver-level QHP if they elect to change their QHP enrollment.		

		If individual or dependent who is not currently enrolled qualifies for this special enrollment period, and has one or more household members who are currently enrolled, the currently enrolled household member currently must be allowed to add the newly enrolling household member to his or her current QHP, (or change to a silver-level QHP and add the newly enrolling household member, or change to a silver-level QHP and enroll the newly enrolling individual or dependent in a separate QHP) • May enroll 60 days following triggering event.		
	45 CFR 155.420(b)(2)(vii)	• Coverage is effective the first day of the month after the individual selects a plan.		

G. Termination of Coverage Requirements for Plans offered through the Exchange 45 CFR §156.270

	Citation	Description	"X" Means Applicable	Form/ Page
G1.	45 CFR §155.430(b)(1)(i)	Member must be permitted to terminate coverage, including as a result of obtaining other minimum essential coverage		
G2.	45 CFR §155.430(d)(2)	Effective date of termination when member terminates coverage		
		• When at least 14-day notice provided, date specified by the member		
		• When less than 14-day notice provided, 14 days after the termination is requested by the member		
		• If the HMO is able to effectuate termination in fewer than 14 days and the member requests an earlier termination date, on the date determined by the carrier		
		• At the option of the Exchange, if member is newly eligible for Medicaid or MCHIP, the day before the individual's date of eligibility for Medicaid or MCHIP		
		• If required by the Exchange, the date termination is requested by the member or another prospective date selected by the member, regardless of whether 14-day notice is provided		

G3.	45 CFR §155.430(b)(1)(iv)	Member must be permitted to retroactively terminate or cancel coverage in certain circumstances		
	45 CFR §155.430(b)(1)(iv)(A)	a. Member demonstrates to the Exchange that he or she attempted to terminate coverage and experienced a technical error that did not allow the member to terminate coverage, and requests retroactive termination within 60 days after member discovered the technical error		
	45 CFR §155.430(b)(1)(iv)(B)	b. Member demonstrates to the Exchange that enrollment in a QHP was unintentional, inadvertent, or erroneous and was the result of the error or misconduct of an officer, employee, or agent of the Exchange or HHS, its instrumentalities, or a non-Exchange entity providing enrollment assistance or conducting enrollment activities. Such enrollee must request cancellation within 60 days of discovering the unintentional, inadvertent, or erroneous enrollment		
	45 CFR §155.430(b)(1)(iv)(C)	c. Member demonstrates to the Exchange that he or she was enrolled in a QHP without his or her knowledge or consent by any third party, including third parties who have no connection with the Exchange, and requests cancellation within 60 days of discovering the enrollment		
G4.	45 CFR §155.430(d)(9) 85 FR 29261	Effective date of retroactive termination by member:		
		• For retroactive termination due to a technical error described in item G3.a. above, the termination date will be no sooner than the date that would have applied under G2. above, based on the date that the enrollee can demonstrate he or she contacted the Exchange to terminate his or her coverage or enrollment through the Exchange, had the technical error not occurred		
	45 CFR §155.430(d)(10)	• For retroactive cancellation or termination due to enrollment errors described in items G3.b. and c. above, the cancellation date or termination date will be the original coverage effective date or a later date, as determined appropriate by the Exchange, based on the circumstances of the cancellation or termination		

G5.	45 CFR §155.430(b)(2)	HMO may only terminate enrollment through the Exchange: • When member no longer eligible for coverage through the Exchange. Member may not be terminated from coverage with the carrier for this reason. Coverage must be continued outside of the Exchange; • For non-payment of premiums; • When coverage is rescinded in accordance with 45 CFR §147.128 (if required by the Exchange, HMO must demonstrate to the reasonable satisfaction of the Exchange that the rescission is appropriate); • When the qualified health plan is decertified. Member may not be terminated from coverage with the HMO for this reason. Coverage must be continued outside of the Exchange. • When the member changes from one qualified health plan to another during an annual open enrollment period or special enrollment period; • When member was enrolled in a QHP without his or her knowledge or consent by a third party, including by a third party with no connection with the Exchange; • For any reason for termination of coverage described in §15-1309		
G6.	45 CFR §155.430(b)(3)	Carriers may not terminate coverage for a dependent child before the end of the plan year in which the child attains age 26.		
G7.	45 CFR §156.270(b)(1); 85 FR 29262	For any termination events described in 45 CFR § 155.430(b), carrier must promptly and without undue delay provide the member notice of termination of coverage that includes the termination date and the reason for termination		
G8		Effective dates of termination of coverage or enrollment in a QHP:		

	45 CFR §155.430(d)(3)	• When member no longer eligible, the last day of enrollment in a QHP is the last day of eligibility as described in 45 CFR §155.330(f), unless the member requests an earlier termination date		
	45 CFR §155.430(d)(4)	• For nonpayment of premium by the member receiving advance payments of the premium tax credit, the last day of the first month of the 3-month grace period		
	45 CFR §155.430(d)(5)	• For nonpayment of premium for member NOT receiving advance payments of the premium tax credit, the last day of the 31-day grace period		
	45 CFR §155.430(d)(6)	• When member changes from one qualified health plan to another, the day before the effective date of coverage in the new qualified health plan		
	45 CFR §155.430(d)(7)	• In the case of termination due to death, the last day of coverage is the date of death		
	45 CFR §155.430(d)(11)	• In the case of cancellation when the member was enrolled in a QHP by a third party without the member's knowledge or consent, the original coverage effective date, following reasonable notice to the enrollee (where possible)		
G9.	§31-108(d)	Penalties for enrollment in other coverage is prohibited.		

H. Required Provisions

	Citation	Description	"X" Means Applicable	Form/ Page
H1.	§19-701(g)(2), Health-General	Out-of-Area urgent care		
H2.	§15-401	Newborn/Adopted Child/Grandchildren/Guardianship		
H3.	§15-402	Incapacitated Children		
H4.	§15-403.2 COMAR 31.10.35	Domestic Partner Coverage, including Child Dependents of Domestic Partner		
H5.	45 CFR §147.120 §15-1A-08	Child Dependent Coverage to age 26		

	80 FR 72205	• HMO may not deny coverage or terminate coverage if a child no longer lives, works, or resides in the HMO service area		
H6.	§15-403 §15-403.1 §15-418	Grandchildren and Children under Guardianship		
H7.	§15-417	Part-Time Students with Disabilities (if student status required in order to be eligible beyond the age of 26)		
H8.	§15-833	Extension of Benefits		
H9.	COMAR 31.12.02.06I	Premium Increase Notice		
H10.	COMAR 31.12.02.06J(6)	Renewal Provision		
	45 CFR §147.106(f)(1)	• Written notice of renewal or uniform modification of coverage must be provided before the first day of the next open enrollment period		
H11.	COMAR 31.12.02.10	Termination Provision		
	COMAR 31.12.07.05D(5)	• HMO may not require subscriber to provide advance notice of intent to terminate (not applicable to the notice required for plans offered through the Exchange)		
H12.	§15-1309 COMAR 31.12.02.10B	• Permissible Causes of Termination		
H13.	COMAR 31.12.02.06J(7)	Addition of New Family Member		
H14.	COMAR 31.12.02.06K	Successor Subscriber • For plans offered through the Exchange, successor subscriber must be eligible for coverage through the Exchange		
H15.	COMAR 31.12.02.06L	10 Day Free Look		
H16.	COMAR 31.12.02.06P	Inability to Provide Services - Circumstances Beyond the Plan's Control		
H17.	§15-139	Coverage for Services Delivered through Telehealth		

	§15-139(a)(2) Senate Bill 534, Chpt 382, Acts of 2023, effective 6/1/2023	a. Definition of "telehealth:" • 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. • 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 7/1/2021	b. Coverage shall: • Be provided regardless of the location of the patient at the time the telehealth services are provided. • 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 7/1/2021	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 7/1/2021	d. May not require that covered health care services delivered through telehealth be provided by a third-party vendor designated by the carrier		
H18.	COMAR 31.12.02.06J(12)	HMO contract must include formal procedure to be followed in filing complaints or grievances.		
	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		
	§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		
	§15-10A-02(g)	b. Details of internal grievance process 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		
	§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		
		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		
H19.	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)	i. Urgent Medical Condition		
	§15-10D-02(e)	ii. Notice of Coverage Decision		
	§15-10D-02(f)	iii. Notice of Appeal Decision		

I. Required Standard Provisions

	Citation	Description	"X" Means Applicable	Form/ Page
I1.	COMAR 31.12.07.05B	Entire Contract; Changes		
I2.	COMAR 31.12.07.05C	Contestability of the Contract		
I3.	COMAR 31.12.07.05D	Grace Period		
I4.	COMAR 31.12.07.05E	Reinstatement • Modified to remove statement regarding accidental injury sustained after the date of reinstatement or loss due to sickness beginning more than ten days after		
I5.	COMAR 31.12.07.05A and .04C	Notice of Claim		
I6.	COMAR 31.12.07.05F	Claims Forms		
I7.	COMAR 31.12.07.05G	Age Limit; Misstatement of Age		

	Citation	Description	"X" Means Applicable	Form/ Page
I8.	§12-102(c)(2)	Proofs of Loss • Enrollee must be permitted a minimum of 1 year after the date of service to submit a claim • Enrollee's legal incapacity shall suspend the time to submit a claim • If not reasonably possible to submit claim within one year, time period extended to two years after date of service		
	§15-1011	a. Methods for Claim Submission		
	§15-1005(e)	b. Provider must be permitted minimum of 180 days to file claim		
I9.	COMAR 31.12.07.05A and .04F	Time Payment of Claims		
I10.	COMAR 31.12.07.05A and .04G	Payment of Claims		
I11.	COMAR 31.12.07.05A and .04H	Legal Action		
I12.	COMAR 31.12.07.05A and .04L	Misstatement of Age		
I13.	COMAR 31.12.07.05H	Premium Due Date		

J. Optional Standard Provisions

	Citation	Description	"X" Means Applicable	Form/ Page
J1.	COMAR 31.12.07.08A and .07C	Physical Examination		
J2.	COMAR 31.12.07.08C	Unpaid Premiums		
J3.	COMAR 31.12.07.08A and .07D	Arbitration		

K. Prohibited Provisions

	Citation	Description	"X" Means Applicable	Form/ Page
K1.	COMAR 31.12.02.06G	Advertising in forms		
K2.	§19-705.4, Health-General	Physical Therapist Time Limitations		

K3.	§19-713.1(b), Health-General	May not coordinate against guaranteed renewable intensive care or specified disease policies		
K4.	§15-126	Access to the 911 Emergency System		
K5.	§27-913	Benefits for Treatment of a Specified Disease or Diagnosis May Not be Subject to Different Copays, Coinsurance, Deductibles, Annual or Lifetime Maximums		
K6.	§15-1009	Denial of Reimbursement for Pre-authorized Care Prohibited Except for Limited Reasons		
K7.	§27-303 MIA Bulletin L&H 99-25	Denial of Medically Necessary Inpatient Ancillary Charges		
K8.	§19-713.1(e), Health-General	HMO may not recover any payment made to Subscriber under PIP		
K9.	§19-713.1(f), Health-General	HMO may not recover medical expenses under subrogation unless the Subscriber recovers for medical expenses in a cause of action		
K10.	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		
K11.	COMAR 31.11.06.03F	May not exclude benefits for covered services provided by licensed health care practitioners		
K12.	§15-510	May not deny behavioral counseling services provided by participating provider solely on the basis that service is school-based		

L. Other

	Citation	Description	"X" Means Applicable	Form/ Page
L1.	45 CFR §147.138(a)(3) §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		

L2.	§15-830(b)	Right to Standing Referral to Network Specialist		
L3.	§15-830(d)	Right to request referral to specialist, including non-physician specialist, not on HMO's Provider Panel		
L4.	§15-830(e)(2) Senate Bill 707, Chpt 272, Acts of 2022, effective 7/1/2022 §19-710(p), Health-General	Balance billing is prohibited for services received from a referral to a non-panel specialist and non-physician specialist as result of referral described in (d).		
L5.	§15-112(q)	Identify office and process for filing complaints		
L6.	45 CFR §149.410 86 FR 36981	Reimbursement for Emergency Services • 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.		
L7.	§19-710.1, Health-General	Reimbursement of non-contracting providers for covered services		
	§15-138 45 CFR §149.130 86 FR 36974	• Reimbursement of Ambulance Service Providers • 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 86 FR 36973-36974	• Non-emergency services provided by a non-network provider with respect to a covered visit at an in-network facility, • The enrollee will not be liable for an amount that exceeds the enrollee's cost-sharing requirement.		
L8.	§15-118	Coinsurance Amounts Must Be Based on Negotiated Fees with HMO		
L9.	§19-713(b)(2), Health-General	HMO may include subrogation provision in contract if rating methodology includes an adjustment that reflects the subrogation		
L10.	§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		
L11.	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		

L12.	45 CFR §147.138(a) MIA Bulletin 10-23 §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		
L13.		Prohibition on discrimination:		
	45 CFR §156.125(a)	• 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)		
	45 CFR §156.200(e) §15-1A-22 Senate Bill 872, Chapter 621, Acts of 2020, effective 5/7/20	• 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)		
L14.	COMAR 31.12.02.06E	Time References		
L15.	45 CFR §147.104(f)	Coverage must be offered on a calendar year basis with the policy year ending on December 31 of each calendar year		
L16.	§ 15-1309(i)	HMO may not cancel or refuse to renew coverage due to Medicare enrollment or entitlement if individual is renewing coverage under the same policy or contract		
L17.	§15-140	Receiving carrier requirements for members transitioning to HMO		
L18.	45 CFR §147.106(e)	HMO may only uniformly modify the contract at renewal		
	45 CFR § 147.106(f)(1)	• Must provide notice of the uniform modification before the first day of the next open enrollment period		
L19.	45 CFR §146.121(f) §15-1A-02(a)(2)(iv) §15-509	Requirements for Wellness Programs		
L20.	Title 15, Subtitle 17	Physician Rating System		
L21.	45 CFR §149.420(b) 86 FR 36982	Items in C27 are not applicable when the non-network provider has satisfied the notice and consent criteria of 45 CFR §149.420 (c) through (i). The notice and consent criteria do not apply to non-network providers with respect to: • Covered services rendered by a health care provider for which payment is required under §19-710.1 of the Health General Article		

		• Ancillary Services • 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.		
L22.	§42 USC 300gg-115(b) §42 USC 300gg-139(b)	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: • 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. • 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.		
L23.	42 USC 300gg-113(a) 42 USC 300gg-138	Continuity of care		
		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		
L24.	45 CFR §156.225(c)	If plan names are shown on the forms, they must include correct information, without omission of material fact and may not include content that is misleading.		

M. Utilization Review

	Citation	Description	"X" Means Applicable	Form/ Page
M1.	Federal Mental Health Parity and Addiction Equity Act §31-115(b)(9)(iii) 45 CFR §156.115(a)(3)	The processes, strategies, evidentiary standards, or other factors used to manage the mental health and substance use benefits must be comparable as written and in operation to, and applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used to manage the benefits for physical illnesses covered under the contract.		
M2.	§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		
M3.	§19-712.5(d), Health-General	May not require preauthorization for emergency care		
	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		
M4.	§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		
M5.	§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		
M6.	§15-854	Limits on Prior Authorization Requirements for certain prescription drugs- • A prior authorization issued by the carrier under the member's prior health plan coverage must be honored for a covered prescription drug when the member changes to a new health plan issued by the same carrier • A prior authorization for a covered prescription drug (except for an opioid) must be honored when the dosage changes if the change is consistent with FDA labeled dosages.		

	Citation	Description	"X" Means Applicable	Form/ Page
	§15-854(g), House Bill 785, Chpt 365, Acts of 2023	• 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.		
M7.		Initial authorization of course of treatment made:		
	§19-706, 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, 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, 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		
	§15-10B-06(a)(4) HB785, Chpt 365, Acts of 2023	d. For a step-therapy exception request submitted electronically, in real time if no additional information is needed and the request meets the criteria for approval. If a request is not approved as noted above, then within 1 business day after all information necessary to make a decision is received.		
M8.	§19-706, 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		
M9.	§19-706, Health-General §15-10A-02(f)	Notice of adverse decision must be provided within 5 working days after adverse decision is made		
M10.	§19-706, Health-General §15-10B-07(c)	May not retroactively deny approval of preauthorized services		
M11.	§19-706, Health-General §15-10B-06(b)	If provider requests immediate reconsideration of denial, must give decision by telephone within 24 hours of request		
M12.	§19-706, 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		

	Citation	Description	"X" Means Applicable	Form/ Page
M13.	§19-706, 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		
M14.	§15-140	When HMO is the receiving carrier, the HMO 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.		
M15.	§15-857 House Bill 970, Chpt 684, Acts of 2022, effective 1/1/2023	Prior authorization for post exposure prophylaxis for the prevention of HIV is prohibited.		

N. Catastrophic Plans

	Citation	Description	"X" Means Applicable	Form/ Page
N1.	45 CFR §156.155(a)(5)	Covers only individuals who meet either of the following conditions: • Have not attained the age of 30 prior to the first day of the policy year; or • Have received a certificate of exemption under either (i) section 5000A(e)(1) of the IRS Code (relating to individuals without affordable coverage); or (ii) section 5000A(e)(5) of the IRS Code (relating to individuals with hardships)		
N2.	45 CFR §156.155(c)	For other than self-only coverage, each individual enrolled must meet the eligibility requirements in N1. Above		
N3.	45 CFR §156.155(a)(3)	Deductible equal to the annual limitation on cost-sharing • Self-only coverage – $9,200 for **2025** • Other than self-only coverage – $18,400 for **2025**		
N4.	45 CFR §156.155(b)	No cost-sharing for preventive services		

N5.	45 CFR §156.155(a)(4) COMAR 31.11.06.02B(55)	Provides coverage for at least three primary care visits per year before the deductible is met. • The 3 visits are in addition to visits for preventive services • Primary care includes services rendered by health care practitioners in the following disciplines: general internal medicine; family practice medicine; pediatrics; or obstetrics/gynecology		
N6.	78 FR 13419	Individual covered under the plan is no longer eligible if at the beginning of the new policy year the individual fails to meet eligibility requirements in N1. Above		

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

	Citation	Description	"X" Means Applicable	Form/ Page
O1.	§19-705.1(d)(4)(ii), Health-General	Required Notice		
O2.	§19-706(e), Health-General §27-805	Insurance Fraud-Required Disclosure Statement		
O3.	45 CFR §147.104(a)	May not ask questions related to health status or health history		
O4.	§27-909	May Not Inquire About Genetic Tests or Genetic Information		
O5.	Maryland Health Connection Carrier Reference Manual 2020 § 31-115(b)(5)(v)	May NOT ask questions about the use of any tobacco product for Exchange plans, when offered on or off the Exchange		
O6.	45 CFR §147.102(a)(iv)	For plans sold exclusively outside of the Exchange, may ask question about the use of any tobacco product, except religious or ceremonial use, on average four or more times per week within the period no longer than the past 6 months. • If yes, then must ask when tobacco product was last used		
O7.	COMAR 31.12.02.07J(1)	Check-off boxes required for carrier name if application is to be used by more than one carrier		
O8.	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		
O9.	§27-504	Domestic Violence		

	Citation	Description	"X" Means Applicable	Form/ Page
O10.	§31-116(f)(3)	Required question when plan sold outside the Exchange does not provide the pediatric dental essential health benefits		
O11.	§15-403.2 COMAR 31.10.35	Expand application to include a selection of Domestic Partner, including Child Dependents of Domestic Partner for applying for coverage		
O12.	§27-216 MIA Bulletin 17-10	Requirements for Acceptance of Credit Cards for Premium Payment and Charging of Fees for Use of Credit Cards		
O13.	COMAR 31.12.02.07A	Application shall stipulate the plan and amount of insurance and any added optional benefits applied for		
O14.	COMAR 31.12.02.07E	Proxy not permitted		