HEALTH MAINTENANCE ORGANIZATION
SMALL EMPLOYER COVERAGE for NON-GRANDFATHERED HEALTH BENEFIT PLANS with POLICY YEARS THAT BEGIN ON OR AFTER JANUARY 1, 2026

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 25-1	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-25-1	Identification of the coverage level for each benefit design (i.e. bronze, silver, gold, platinum)		
A3.		The actuarial value of each plan design determined in accordance with 45 CFR §156.135		
	MIA Bulletin 25-1	• If using the AV calculator, carrier must provide the AV input charts. Review AV input charts against the schedules of benefits.		
A4.	45 CFR §156.122(a)(1) MIA Bulletin 25-1	Certification, signed by an individual with the authority to bind the carrier, that the plan's prescription drug benefit complies with 45 CFR §156.122(a)(1) based on the information provided in the 2017 – 2026 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		

A5.	45 CFR §146.136 MIA Bulletin 25-1 89 FR 77735-77747	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.		
A6.	MIA Bulletin 25-1	Separate schedule of benefits form for each plan design with specific combination of benefits and cost-sharing		
A7.	COMAR 31.12.02.04B(1)(b)	Statement of Variability.		
A8.	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.		
A9.	COMAR 31.12.02.03C(4)	Listing of Forms		
A10.	COMAR 31.12.02.06A	Form Number		
A11.	COMAR 31.12.02.06D	Corporate Name and Address		
A12.	COMAR 31.12.02.03E	Unacceptable Modifications		
A13.	COMAR 31.12.02.03G	Specimen Data		
A14.	COMAR 31.12.02.06F	Signature of Officer		
A15.	COMAR 31.12.02.06B	Size of Type		
A16.	§2-112(a)(10) COMAR 31.12.02.03C(2)	Filing Fees Insufficient		
A17.	§§15-1209(d) 15-1206(c)	Description of Participation Limits		
	45 CFR §155.706(b)(10) 45 CFR §156.286(d)	• For plans offered on the Exchange, minimum employee participation rate may only be applied to participation in the SHOP, not to the rate of participation in the particular health benefit plan.		
	45 CFR §147.104(b)(1)	• Minimum participation limit may NOT be applied if small employer applies for coverage during the period that begins November 15 and extends through December 15 of any year.		

A18.	§31-116(f)	Essential pediatric dental benefits not included in an off-Exchange plan. • Description of how the carrier will comply when plan is sold outside the Exchange		
A19.	COMAR 31.12.02.03H	Contracts with Insert Pages		
A20.	COMAR 3I.12.02.03I	Contracts Comprised of Sections		
A21.	45 CFR §147.102(a)(1)(iv) 78 FR 13414	If tobacco rating included, description of wellness program meeting the requirements of § 15-509 of the Insurance Article that offers tobacco users the opportunity to avoid paying the full amount of the tobacco rating factor		

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 §15-1A-14(a)(2), SB 217, Chpt. 118, Acts of 2024, effective 10/1/24	a. Emergency medical condition definition		
	45 CFR §149.30 45 CFR §149.110(c)(2) 45 CFR §149.410(b) MIA Bulletin 21-24 §15-1A-14(a)(3), SB 217, Chpt. 118, Acts of 2024, effective 10/1/24	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) 86 FR 36973	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: ○ There is no equivalent prescription drug or device in the formulary in a lower tier; ○ 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 ○ 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		

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) 89 FR 77737-77747	• 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) §31-115(b)(1) as amended by SB228, Chpt 116, Acts of 2024, effective 1/1/25	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. Pediatric dental benefits must be in every on-Exchange plan. Carriers can no longer omit these benefits from on-Exchange plans.		
	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.	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		

B41.	§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 - 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.		
B42.	§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-2023	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)	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 §15-1A-14(c)(3), SB217, Chpt. 118, Acts of 2024, effective 10/1/24	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 §15-1A-14(c)(3), SB217, Chpt. 118, Acts of 2024, effective 10/1/24	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 MIA Bulletin 21-24	• 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, HB1259, Chpt 868, Acts of 2024, effective 1/1/2025	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), HB1259, Chpt 868, Acts of 2024, effective 1/1/2025	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 lung cancer screening or 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) 89 FR 77737	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) 89 FR 77737-77738	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) 89 FR 77739	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 October 8, 2024— Premium Adjustment Percentage, Maximum Annual Limitation on Cost Sharing	a. Self-only coverage – $10,150		
		b. Other than self-only coverage – $20,300		
	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 §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	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 COMAR 31.11.06.03-1	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.	§15-139	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.		
D12.	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		
D13.	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.		
D14.	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		
D15.	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.		
D16.	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 §§155.706(b)(6) and 156.210(a)	Premium rates for the employer must be set for the entire plan year		
E2.	45 CFR §155.726(b)	The employer's plan year must consist of the 12-month period beginning with the qualified employer's effective date of coverage		

E3.	45 CFR §155.710(b) § 31-101(r)	Qualified employer definition		

F. Open Enrollment and Special Enrollment Periods

	Citation	Description	"X" Means Applicable	Form/ Page
F1.	§15-1208.2(b)	Annual open enrollment period of no less than 30 days for employees of small employer to enroll, discontinue enrollment, or change enrollment		
F2.	§15-1208.2(c)	Enrollment period of at least 30 days for new employees		
	42 USC §300gg-7 45 CFR §147.116 §15-1A-12	• Waiting period for an otherwise eligible employee to enroll may not exceed 90 days		
F3.	§15-1208.1(b)	Special enrollment period of 30 days for employee/dependent who loses other coverage		
F4.	§15-1208.1(c)(1)	Special enrollment period of 31 days for individuals who become dependents of employee through marriage, birth, adoption, placement for adoption, or placement for foster care		
	§15-1208.1(c)(2)	• Permit employee to enroll himself when he or she acquires new dependents		
	§15-1208.1(c)(3)	• For spouse of employee at birth or adoption of child, or placement of a child in foster care, or through a child support order or other court order		
F5.	§15-1208.1(c)(4)	At the option of the Exchange, special enrollment period of 31 days for an enrollee who is the eligible employee or spouse if the enrollee loses a dependent or is no longer considered a dependent through divorce or legal separation, or if the employee, or his or her dependent, dies • Applies only to plans offered in the SHOP Exchange		
F6.	§15-1208.2(d), SB 217, Chpt. 118, Acts of 2024, effective 10/1/2024 45 CFR §155.726(c) 45 CFR §156.286(b)	Special enrollment period of 30 days for certain "triggering events"		
	§15-1208.2(d)(4)(i) 45 CFR §155.420 (d)(1)(i)	a. Eligible employee or dependent loses minimum essential coverage. The date of the loss of coverage is the last day the consumer would have coverage under his or her previous plan or coverage.		

	Citation	Description	"X" Means Applicable	Form/ Page
	§15-1208.2(d)(5)	• 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, or loss due to a rescission authorized under 45 CFR §147.128		
	§15-1208.2(d)(4)(ii) 45 CFR §155.420(d)(1)(iii)	b. Eligible employee or dependent loses pregnancy related coverage under §1902(a)(10)(A)(i)(IV) and (a)(10)(A)(ii)(IX) of the Social Security Act (Medicaid) or loses 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 qualified individual would have pregnancy-related coverage or access to health care services through the unborn child coverage.		
	§15-1208.2(d)(4)(iii) 45 CFR §155.420(d)(1)(iv)	c. Eligible employee or dependent loses medically needy coverage as described under section 1902(a)(10)(C) of the Social Security Act. The date of the loss of coverage is the last day the consumer would have medically needy coverage.		
	§15-1208.2(d)(6)	• Permitted only once per year per individual		
	§15-1208.2(d)(4)(iv) 45 CFR §155.420(d)(5)	d. Eligible employee or a dependent enrolled in the SHOP Exchange adequately demonstrates to the Exchange that the qualified plan substantially violated a material provision of its contract in relation to the eligible employee or dependent		
	§15-1208.2(d)(4)(x) 45 CFR §155.420(d)(7) 45 CFR §155.420(a)(5)	e. Eligible employee or dependent gains access to new qualified health plans due to a permanent move and had minimum essential coverage for one or more days during the 60 days preceding the move • Employee/dependent may satisfy prior coverage requirement by demonstrating that they: o Had minimum essential coverage; o Had pregnancy related coverage or access to healthcare services through unborn child coverage described in 45 CFR § 155.420(d)(1)(iii) o Had medically needy coverage described in 45 CFR § 155.420(d)(1)(iv) o Are an Indian;		

	Citation	Description	"X" Means Applicable	Form/ Page
		○ 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 SHOP Exchange		
	§15-1208.2(d)(4)(vi)4. 45 CFR §155.420(d)(9)	f. Eligible employee or dependent enrolled in the SHOP Exchange demonstrates to the Exchange, in accordance with HHS guidelines, that the eligible employee or dependent meets other exceptional circumstances • Applies only to plans offered in the SHOP Exchange		
	§15-1208.2(d)(4)(vi)1. 45 CFR §155.420(d)(4)	g. The eligible employee's or dependent's enrollment or non-enrollment is unintentional, inadvertent or erroneous and is the result of an error, misrepresentation, misconduct, or inaction of an officer, employee, or agent of the Exchange or HHS, its instrumentalities, or a non-Exchange entity providing enrollment assistance or conducting enrollment activities • Applies only to plans offered in the SHOP Exchange		
	§15-1208.2(d)(4)(vii) and (d)(10) 45 CFR § 155.420(d)(10)	h. Eligible employee is a victim of domestic abuse or spousal abandonment, including a dependent 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		

	§15-1208.2(d)(4)(viii) and (ix) 45 CFR § 155.420(d)(11)	i. Eligible employee or dependent applies for coverage on the Individual 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.		
	§15-1208.2(d)(4)(vi)3. and (d)(11), SB 217, Chpt.118, Acts of 2024, effective 10/1/2024 45 CFR § 155.420(d)(12)	j. The eligible employee's or 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. A material error is one that is likely to have influenced the eligible employee's or dependent's enrollment in a QHP. • Only applies to plans offered in the SHOP Exchange		
F7.	§15-1208.2(d)(9) 45 CFR §155.726(c)(3)(ii)	Special enrollment period of 60 days		
	§15-1208.2(d)(4)(v)1. 45 CFR §155.726(c)(2)(ii)	• Loss of eligibility for coverage under a Medicaid plan or CHIP plan		
	§15-1208.2(d)(4)(v)2. 45 CFR §155.726(c)(2)(iii)	• Becomes eligible for assistance, with respect to coverage under the SHOP Exchange, under such Medicaid or CHIP plan		
F8.	§ 15-1208.1(c)(5)	Special enrollment period of 90 days for eligible employee or dependent who becomes pregnant as confirmed by a health care practitioner		
	§ 15-1208.1(e)(2)	• Special enrollment period begins on the date the health care practitioner confirms the pregnancy		
F9.	§15-1208.2(d)(4)(vi)2. and (d)(8) 45 CFR §155.420(d)(8) 45 CFR §155.726(c)(2)(i);	Eligible employees who gain or maintain status as Indians 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 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 • Only applies to plans offered through the SHOP Exchange.		

F10.	§15-1208.1(f) §15-1208.2(e) 45 CFR §155.420(b)	Effective dates of coverage for individuals who enroll during a special enrollment period		
	45 CFR §155.420(b)(2)(iv) 88 FR 25827	a. In the case of: 1. Loss of minimum essential coverage; 2. Loss of pregnancy related coverage; 3. Loss of unborn child coverage; 4. Loss of medically needy coverage; or 5. Gaining access to new plans due to a permanent move 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, coverage is effective on the first day of the month following plan selection. • For losses of coverage [45 CFR §§155.420(d)(1)], 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 coverage effective date is the first day of the month after the individual selects a plan.		
	§15-1208.1(f)(1)(ii)-(iv) 45 CFR §155.420(b)(2)(i) §15-401(b)(2)	b. In the case of birth, adoption, placement for adoption, or placement for foster care, the date of birth, adoption, or placement for adoption or foster care		
	§15-1208.1(f)(1)(v) 45 CFR §155.420(b)(2)(i)	c. In the case of a child support order or other court order, the effective date of the court order • For SHOP Exchange plans, if permitted by the Exchange, the individual may instead elect a coverage effective date of the first day of the month following plan selection.		

	§15-1208.1(f)(1)(i) 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 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. The individual applies for coverage on the Individual 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; or 5. The individual's enrollment in a QHP through the Exchange was influenced by a material error related to plan benefits, service area, cost sharing or premium. 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.		
	§15-1208.1(g)(1) 45 CFR §155.420(b)(2)(v)	f. In the case of an individual or dependent who dies, the first day of the month following the plan selection.		
	§15-1208.1(g)(2) 45 CFR §155.420(b)(1)	g. In the case of an eligible employee who loses a dependent or is no longer considered a dependent through divorce or legal separation, the first day of the month after the individual selects a plan.		

	§15-1208.1(f)(2)	h. In the case of an eligible employee or dependent who becomes pregnant as confirmed by a health care practitioner, the first day of the month in which the individual receives confirmation of the pregnancy.		
	§15-1208.2(e) 45 CFR §155.420(b)(1)	i. For all other triggering events the first day of the month after the individual selects a plan.		

G. Required Provisions

	Citation	Description	"X" Means Applicable	Form/ Page
G1.	§19-701(g)(2), Health-General	Out-of-Area urgent care		
G2.	§15-401	Newborn/Adopted Child/Grandchildren/Guardianship		
G3.	§15-402	Incapacitated Children		
G4.	§15-403.2 COMAR 31.10.35	Domestic Partner Coverage, including Child Dependents of Domestic Partner		
G5.	45 CFR §147.120 §15-1A-08	Child Dependent Coverage to age 26		
	80 FR 72205 and 72275	• HMO may not deny coverage or terminate coverage if a child no longer lives, works, or resides in the HMO service area		
G6.	§15-403 §15-403.1 §15-418	Grandchildren and Children under Guardianship		
G7.	§15-405	Court Ordered Coverage of Children		
G8.	§15-417	Part-Time Students with Disabilities (if student status required in order to be eligible beyond the age of 26)		
G9.	§15-833	Extension of Benefits		
G10.	§15-1212(e)(3)	60 Day Notice of Premium Increase Notice		
G11.	§15-1212 COMAR 31.12.02.10B	Permissible Causes of Termination		
G12.		Continuation		
	§15-407 COMAR 31.11.03	a. Surviving Spouse and Dependents		
	§15-408 COMAR 31.11.02	b. Divorced Spouse and Dependents		

	15-409 COMAR 31.11.04	c. Voluntary or Involuntary Termination of Employment		
G13.	COMAR 31.12.02.06P	Inability to Provide Services – Circumstances Beyond the Plan's Control		
G14.	§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)	b. Coverage shall: • Be provided regardless of the location of the patient at the time the telehealth services are provided. • Not be excluded or denied for a behavioral health care service that is a covered benefit under a health insurance policy or contract when provided in person solely because the behavioral Health Care Service may also be provided through a covered telehealth benefit.		
	§15-139(c)(2)	c. Telehealth care services include counseling and treatment for substance use disorders and mental health conditions.		
	§15-139(e)	d. May not require that covered health care services delivered through telehealth be provided by a third-party vendor designated by the carrier.		
G15.	COMAR 31.12.02.06J(12) COMAR 31.12.02.06M	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)(1)(ii)3. Senate Bill 791, Chpt 848, Acts of 2024, effective 1/1/2025	1. Name, address, telephone # of medical director or associate Medical director who made decision		

	§15-10A-02(f)(1)(ii)4. Senate Bill 791, Chpt 848, Acts of 2024, effective 1/1/2025	2. Details of internal grievance process		
	§15-10A-02(f)(1)(ii)5. Senate Bill 791, Chpt 848, Acts of 2024, effective 1/1/2025	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)1)(ii)5.B. Senate Bill 791, Chpt 848, Acts of 2024, effective 1/1/2025	4. Complaint may be filed without first filing grievance with HMO if compelling reason to do so is demonstrated		
	§15-10A-02(f)(1)(ii)5.C. Senate Bill 791, Chpt 848, Acts of 2024, effective 1/1/2025	5. Address, telephone #, facsimile # of Commissioner		
	§15-10A-02(f)(1)(ii)5.D. Senate Bill 791, Chpt 848, Acts of 2024, effective 1/1/2025	6. Health Advocacy Unit available to assist member with mediating and filing grievance		
	§15-10A-02(f)(1)(ii)5.E. Senate Bill 791, Chpt 848, Acts of 2024, effective 1/1/2025	7. Health Advocacy Unit's address, telephone #, facsimile #, and e-mail address		
	§15-10A-02(f)(2), Senate Bill 791, Chpt. 848, Acts of 2024, effective 1/1/2025	8. The business telephone number in the notice must be a dedicated number for adverse decisions		
	§15-10A-02(k)(2)	9. Statement that, when filing complaint with Commissioner, the member or member's representative will be required to authorize release of any medical records of member needed to reach decision on complaint		
		b. Details of internal grievance process		
	§15-10A-02(g), Senate Bill 791, Chpt. 848, Acts of 2024, effective 1/1/2025	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), Senate Bill 791, Chpt 848, Acts of 2024, effective 1/1/2025	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), Senate Bill 791, Chpt. 848, Acts of 2024, effective 1/1/2025	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), Senate Bill 791, Chpt 848, Acts of 2024, effective 1/1/2025	1. Adverse Decision		
	§15-10A-02(b)(3) Senate Bill 791, Chpt 848, Acts of 2024, effective 1/1/2025	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		
G16.	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		

H. Required Standard Provisions

	Citation	Description	"X" Means Applicable	Form/ Page
H1.	COMAR 31.12.07.04A	Entire Contract; Changes		
H2.	COMAR 31.12.07.04B	Contestability of the Contract		
H3.	COMAR 31.12.07.04C	Notice of Claim		
H4.	COMAR 31.12.07.04D	Claim Forms		
H5.	§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		
H6.	COMAR 31.12.07.04F	Time Payment of Claims		
H7.	COMAR 31.12.07.04G	Payment of Claims		
H8.	COMAR 31.12.07.04H	Legal Action		
H9.	COMAR 31.12.07.04I	Grace Period		
H10.	COMAR 31.12.07.04J	Certificates		
H11.	COMAR 31.12.07.04K	Addition of Employees/Members		
H12.	COMAR 31.12.07.04L	Misstatement of Age		
H13.	COMAR 31.12.07.04M	Premium Due Date		

I. Optional Standard Provisions

	Citation	Description	"X" Means Applicable	Form/ Page
I1.	COMAR 31.12.07.07C	Physical Examination		
I2.	COMAR 31.12.07.07D	Arbitration		

J. Prohibited Provisions

	Citation	Description	"X" Means Applicable	Form/ Page
J1.	COMAR 31.12.02.06G	Advertising in forms		
J2.	§19-705.4, Health-General	Physical Therapist Time Limitations		
J3.	§19-713.1(b), Health-General	May not coordinate against guaranteed renewable individual intensive care or specified disease policies		
J4.	§15-126	Access to the 911 Emergency System		
J5.	§27-913	Benefits for Treatment of a Specified Disease or Diagnosis May Not be Subject to Different Copays, Coinsurance, Deductibles, Annual or Lifetime Maximums		
J6.	§15-1009	Denial of Reimbursement for Pre-authorized Care Prohibited Except for Limited Reasons		
J7.	§27-303 MIA Bulletin L&H 99-25	Denial of Medically Necessary Inpatient Ancillary Charges		
J8.	§19-713.1(e), Health-General	HMO may not recover any payment made to Subscriber under PIP		
J9.	§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		
J10.	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		
J11.	COMAR 31.11.06.03F	May not exclude benefits for covered services provided by licensed health care practitioners		
J12.	§15-510	May not deny behavioral counseling services provided by participating provider solely on the basis that service is school-based		
J13.	§31-108(d)	Penalties for enrollment in other coverage is prohibited.		
J14.	§§19-701(d), 19-710(p), Health-General	May not allow balance billing of any covered service		

K. Other

	Citation	Description	"X" Means Applicable	Form/ Page
K1.	45 CFR §147.138(a)(3) §15-1A-13, Senate Bill 217, Chpt. 118, Acts of 2024, effective 10/1/2024	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		
K2.	§15-830(b)	Right to Standing Referral to Network Specialist		
K3.	§15-830(d)	Right to request referral to specialist, including nonphysician specialist, not on HMO's Provider Panel		
K4.	§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).		
K5.	§15-112(q)	Identify office and process for filing complaints		
K6.	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.		
K7.	§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.		
K8.	§15-118	Coinsurance Amounts Must Be Based on Negotiated Fees with HMO		
K9.	§19-713(b)(2), Health-General	HMO may include subrogation provision in contract if rating methodology includes an adjustment that reflects the subrogation		
K10.	§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		
K11.	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		
K12.	45 CFR §147.138(a) MIA Bulletin 10-23 §15-1A-13, Senate Bill 217, Chpt. 118, Acts of 2024, effective 10/1/2024	Right to choose any provider in the network as PCP and for children right to select allopathic or osteopathic pediatrician in the network		
K13.		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	• 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)		
K14.	COMAR 31.12.02.06E	Time References		
K15.	§15-1201(h)	Full-time employee definition		
K16.	§15-1201(n)	Part-time employee definition		
K17.	§§15-1201(x) §31-101(aa)	Small employer definition		
K18.	§15-140(d)	Receiving carrier requirements for members transitioning to HMO		

K19.	45 CFR §147.104(b)(1)(i)(C)	Uniform Plan Effective Dates for Small Employer Group Enrollments • Unless the small employer opts for a later date, effective date must be no later than the first day of the following month if the group enrollment is received by the carrier on the 1st through the 15th day of any month, and no later than the first day of the second following month if the group enrollment is received by the carrier on the 16th through the last day of any month.		
K20.	45 CFR §147.106(e)	HMO may only uniformly modify the contract at renewal		
	45 CFR §147.106(f)(2)	• Must provide notice of the uniform modification 60 calendar days before the date of the coverage will be renewed		
K21.	45 CFR §146.121(f) §15-1A-02(a)(2)(iv) §15-509	Requirements for Wellness Programs		
K22.	Title 15, Subtitle 17	Physician Rating System		
K23.	45 CFR §149.420(b) 86 FR 36982	Items in C21 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.		

K24.	§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.		
K25.	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		

K26.	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.		

L. Utilization Review

	Citation	Description	"X" Means Applicable	Form/ Page
L1.	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.		
L2.	§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		
L3.	§15-850	May not require prior authorization for a covered opioid antagonist unless at least one formulation of the opioid antagonist is covered without a prior authorization requirement		
L4.	§15-851	May not require prior authorization for a prescription drug containing methadone, buprenorphine, or naltrexone when the drug is used for treatment of an opioid use disorder		
L5.	§15-854	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.		
	§15-854(f), Senate Bill 791, Chpt 848, Acts of 2024, effective 1/1/2025	• 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.		

	§15-854(g), Senate Bill 791, Chpt 848, Acts of 2024, effective 1/1/2025	• Adverse decision on a reauthorization for the same prescription drug for the treatment of a mental disorder is prohibited.		
L6.	§15-854.1(c)(1) Senate Bill 791, Chpt 848, Acts of 2024, effective 1/1/2025	Must approve prior authorization for a course of treatment: • For a period of time that is as long as necessary to avoid disruptions in care; and • Determined in accordance with applicable coverage criteria, the insured's medical history and the provider's recommendations.		
	§15-854.1(c)(2) Senate Bill 791, Chpt 848, Acts of 2024, effective 1/1/2025	For new enrollees, may not disrupt or require reauthorization for an active course of treatment for at least 90 days after the date of enrollment.		
L7.	§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), Senate Bill 217, Chpt. 118, Acts of 2024, effective 10/1/2024	• No administrative requirements on non-network emergency services that are not imposed in-network		
L8.		Initial authorization of course of treatment made:		
	§19-706, Health-General §15-10B-06(a)(1)(i), Senate Bill 791, Chpt 848, Acts of 2024, effective 1/1/2025	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)(1)(iii) Senate Bill 791, Chpt 848, Acts of 2024, effective 1/1/2025	c. For additional visits or days of care submitted as part of an existing course of treatment, within 1 working day after receipt of the necessary information		
	§19-706, Health-General §15-10B-06(a)(2) Senate Bill 791, Chpt 848, Acts of 2024, effective 1/1/2025	d. After receipt of initial request, if more information is necessary to make decision, inform provider no more than 3 calendar days following initial request of the need for more information		

	§19-706, Health-General §15-10B-06(b) Senate Bill 791, Chpt 848, Acts of 2024, effective 1/1/2025	e. For emergency inpatient or residential crisis services admissions for the treatment of a mental, emotional, or substance abuse disorder, within 2 hours of receipt of the necessary information		
	§15-10B-06(c)(1) Senate Bill 791, Chpt 848, Acts of 2024, effective 1/1/2025	f. 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 working day after all information necessary to make a decision is received.		
L9.	§19-706, Health-General §15-10B-06(a)(2) §15-10B-06(c)(2) Senate Bill 791, Chpt 848, Acts of 2024, effective 1/1/2025	PRA must inform health care provider that additional information is needed to make determination within 3 calendar days after initial request		
L10.	§19-706, Health-General §15-10A-02(f)(1), Senate Bill 791, Chpt. 848, Acts of 2024, effective 1/1/2025	Notice of adverse decision must be provided within 5 working days after adverse decision is made		
L11.	§19-706, Health-General §15-10B-07(c)	May not retroactively deny approval of preauthorized services		
L12.	§19-706, Health-General §15-10B-06(f)(1) Senate Bill 791, Chpt 848, Acts of 2024, effective 1/1/2025	If provider requests immediate reconsideration of denial, must give decision by telephone within 24 hours of request		
	§19-706, Health-General §15-10B-06(f)(2) Senate Bill 791, Chpt 848, Acts of 2024, effective 1/1/2025	• If physician is unable to immediately speak with the provider, the physician must provide a direct telephone number that is not the general customer call number or a monitored email address that is dedicated to UR.		
L13.		For emergency course of treatment or healthcare service:		
	§§ 19-706(f), Health-General, 15-10B-06(d)(1)(i), Senate Bill 791, Chpt 848, Acts of 2024, effective 1/1/2025	a. Make initial determination within 24 hours after initial request for necessary information		

	§§ 19-706(f), Health-General, 15-10B-06(d)(1)(ii), Senate Bill 791, Chpt 848, Acts of 2024, effective 1/1/2025	b. If additional information is needed, PRA must promptly request information and no later than 2 hours after receipt of information notify provider of determination		
	§§ 19-706(f), Health-General 15-10B-06(d)(2), Senate Bill 791, Chpt 848, Acts of 2024, effective 1/1/2025	c. Circumstances PRA shall initiate expedited procedure for emergency case		
L14.	§§ 19-706(f), Health-General 15-10B-06(e), Senate Bill 791, Chpt 848, Acts of 2024, effective 1/1/2025	PRA fails to make determination, course of treatment is deemed approved		
L15.	§19-706, Health-General §15-10B-06(g), Senate Bill 791, Chpt 848, Acts of 2024, effective 1/1/2025	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		
L16.	§19-706, Health-General §15-10B-06(h), Senate Bill 791, Chpt 848, Acts of 2024, effective 1/1/2025	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		
L17.	§15-140(c)	When HMO is the receiving carrier, the health plan must, upon request, accept a preauthorization from the relinquishing carrier for the lesser of the course of treatment or 90 days; and for pregnancy the duration of the 3 trimesters of pregnancy and the initial postpartum visit.		
L18.	§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.		

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

	Citation	Description	"X" Means Applicable	Form/ Page
M1.	§19-705.1(d)(4)(ii), Health-General	Required Notice		
M2.	§19-706(e), Health-General §27-805	Insurance Fraud-Required Disclosure Statement		
M3.	§15-1210(a)(2)	Employer application must allow employer to elect to cover part-time employees		

	Citation	Description	"X" Means Applicable	Form/ Page
M4.	§15-1206(c)(3)	Employee application should contain a question regarding other insurance for purposes of applying the minimum participation requirement		
M5.	COMAR 31.12.02.07A	Application shall stipulate the plan and amount of insurance and any added optional benefits applied for		
M6.	COMAR 31.12.02.07E	Proxy not permitted		
M7.	COMAR 31.12.02.07K(3)	Application must clearly identify coverages underwritten by each carrier, when more than one carrier uses the same application with the same group applicant.		
M8.	45 CFR §147.102(a)(iv)	Employee application 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		
M9.	COMAR 31.12.02.07K(2)	Check-off boxes required for carrier name if application is to be used by more than one carrier		
M10.	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		
M11.	§31-116(f)(3)	Required question when plan sold outside the Exchange does not provide the pediatric dental essential health benefits		
M12.	§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		
M13.	§27-216 MIA Bulletin 17-10	Requirements for Acceptance of Credit Cards for Premium Payment and Charging of Fees for Use of Credit Cards		