Article - Insurance

§15–1301.

(a) In this subtitle the following words have the meanings indicated.

(b) "Affiliation period" means a period of time beginning on the date of enrollment and not to exceed 2 months, or 3 months in the case of a late enrollee, during which a health maintenance organization does not collect premium, and coverage issued does not become effective.

(c) "Association" or "bona fide association" means an association that:

(1) has been actively in existence for at least 5 years;

(2) has been formed and maintained in good faith for purposes other than obtaining insurance and does not condition membership on the purchase of association–sponsored insurance;

(3) does not condition membership in the association on any health status–related factor relating to an individual, and states so clearly in all membership and application materials;

(4) makes health insurance coverage offered through the association available to all members regardless of any health status–related factor relating to the members or individuals eligible for coverage and states so clearly in all membership and application materials;

(5) does not make health insurance coverage offered through the association available other than in connection with membership in the association, and states so clearly in all marketing and application materials; and

(6) provides and annually updates information necessary for the Commissioner to determine whether or not the association meets the definition of bona fide association before qualifying as an association under this subtitle.

(d) "Benefit year" means a calendar year in which a health benefit plan provides coverage for health benefits.

(e) "Carrier" means a person that is:

(1) an insurer that holds a certificate of authority in the State and provides health insurance in the State;

(2) a health maintenance organization that is licensed to operate in the State;

(3) a nonprofit health service plan that is licensed to operate in the State; or

(4) any other person or organization that provides health benefit plans subject to State insurance regulation.

(f) "Church plan" means a plan as defined under § 3(33) of the Employee Retirement Income Security Act of 1974.

(g) "Eligible individual" means an individual who applies for or is covered under an individual health benefit plan.

(h) "Employer sponsored plan" means an employee welfare benefit plan that provides medical care to employees or their dependents, and is not subject to State regulation in accordance with the federal Employee Retirement Income Security Act of 1974.

(i) "Enrollment date" means the date on which:

(1) an individual enrolls in a health benefit plan; or

(2) the first day of the waiting period before which the individual may enroll.

(j) "Governmental plan" means a plan as defined in § 3(32) of the Employee Retirement Income Security Act of 1974 and any federal governmental plan.

(k) "Grandfathered health plan coverage" has the meaning stated in 45 C.F.R. § 147.140.

(l) (1) "Health benefit plan" means a:

(i) hospital or medical policy or certificate, including those issued under multiple employer trusts or associations located in Maryland or any other state covering Maryland residents;

(ii) policy, contract, or certificate issued by a nonprofit health service plan that covers Maryland residents; or

(iii) health maintenance organization subscriber or group master contract.

(2) "Health benefit plan" does not include:

(i) one or more, or any combination of the following:

1. coverage only for accident or disability income insurance;

2. coverage issued as a supplement to liability insurance;

3. liability insurance, including general liability insurance and automobile liability insurance;

4. workers' compensation or similar insurance;

5. automobile medical payment insurance;

6. credit–only insurance; and

7. coverage for on–site medical clinics;

(ii) the following benefits if they are provided under a separate policy, certificate, or contract of insurance or are otherwise not an integral part of a plan:

1. limited scope dental or vision benefits; and

2. benefits for long–term care, nursing home care, home health care, community–based care, or any combination of these benefits;

(iii) coverage only for a specified disease or illness if offered as independent, noncoordinated benefits;

(iv) hospital indemnity or other fixed indemnity insurance if:

1. offered as independent, noncoordinated benefits;

2. except as provided in item 5 of this item, the benefits are provided only to individuals who attest in their hospital indemnity or fixed indemnity insurance application that they have other health coverage that is minimum essential coverage, or that they are treated as having minimum essential coverage due to their status as a bona fide resident of any possession of the United States under § 5000A(f)(4)(b) of the Internal Revenue Code, provided that if an application is not required as part of the renewal process, the continued payment of premiums by the individual after receipt of the notice described in item 5B of this item is deemed to satisfy the attestation requirement;

3. the benefits are paid in a fixed dollar amount per period of hospitalization, illness, or service, regardless of the amount of expenses incurred and of the amount of benefits provided with respect to the event or service under any other health coverage;

4. a notice is displayed prominently in the application materials, in at least 14 point type, that has the following language in capital letters: "This is a supplement to health insurance and is not a substitute for major medical coverage. Lack of major medical coverage (or other minimum essential coverage) may result in an additional payment with your taxes."; and

5. A. for hospital indemnity insurance or other fixed indemnity insurance contracts issued before May 1, 2015, that require an application as part of the renewal process, the individual provides, on or before October 1, 2016, a written attestation on the application that the individual has other health insurance

coverage that is minimum essential coverage, or that the individual is deemed to have minimum essential coverage due to the individual's status as a bona fide resident of any possession of the United States under § 5000A(f)(4)(b) of the Internal Revenue Code; or

B. for hospital indemnity or other fixed indemnity insurance contracts issued before May 1, 2015, that do not require an application as part of the renewal process, the issuer sends no later than the first renewal of the contract that occurs on or after October 1, 2016, a notice, in at least 14 point type, to the individual that includes the following language: "This is a supplement to health insurance and is not a substitute for major medical coverage. Lack of major medical coverage (or other minimum essential coverage) may result in an additional payment with your taxes. This insurance will remain in force as long as you continue to pay your premiums."; or

(v) the following benefits if offered as a separate insurance policy:

1. Medicare supplemental health insurance (as defined under § 1882(g)(1) of the Social Security Act);

2. coverage supplemental to the coverage provided under Chapter 55 of Title 10, United States Code; and

3. similar supplemental coverage provided to coverage under an employer sponsored plan.

(m) "Health status–related factor" means a factor related to:

(1) health status;

(2) medical condition;

(3) claims experience;

(4) receipt of health care;

(5) medical history;

(6) genetic information;

(7) evidence of insurability including conditions arising out of acts of domestic violence; or

(8) disability.

(n) "Individual Exchange" has the meaning stated in § 31–101 of this article.

(o) (1) "Individual health benefit plan" means:

(i) a health benefit plan other than a converted policy or a

professional association plan for eligible individuals and their dependents; and

(ii) a certificate issued to an eligible individual that evidences coverage under a policy or contract issued to a trust or association or other similar group of individuals, regardless of the situs of delivery of the policy or contract, if the eligible individual pays the premium and is not being covered under the policy or contract under either federal or State continuation of benefits provisions.

(2) "Individual health benefit plan" does not include short–term limited duration insurance.

(p) "Minimum essential coverage" has the meaning stated in 45 C.F.R. § 155.20.

(q) "Preexisting condition" means a condition that was present before the date of enrollment for coverage, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before that date.

(r) "Qualified health plan" has the meaning stated in § 31–101 of this article.

(s) "Waiting period" means the period of time that must pass before an individual is eligible to be covered for benefits under the terms of a group health benefit plan.