

Article - Insurance

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§12–205.

(a) (1) The Commissioner shall disapprove a form or withdraw the previous approval of a form filed under § 12–203 of this subtitle if the form does not meet the requirements of subsection (b) of this section.

(2) The order of disapproval or withdrawal of approval shall inform the insurer of:

(i) a statutory or regulatory basis for the disapproval or withdrawal of approval; and

(ii) an explanation of the application of the statutory or regulatory basis for the disapproval or withdrawal of approval.

(b) A form may not:

(1) in any respect violate or fail to comply with this article;

(2) contain or incorporate by reference, if the incorporation is otherwise permissible, any inconsistent, ambiguous, or misleading clauses, or exceptions and conditions that deceptively affect the risk purported to be assumed in the general coverage of the contract;

(3) have a title, heading, or other indication of its provisions that is likely to mislead the policyholder or certificate holder;

(4) contain an inequitable provision of insurance without substantial benefit to the policyholder;

(5) be printed or otherwise reproduced so as to make a provision of the form substantially illegible;

(6) provide benefits in a health insurance policy that are unreasonable in relation to the premium charged;

(7) contain, irrespective of the premium charged, a benefit that is not sufficient to be of real economic value to the insured;

(8) fail to provide minimum benefits or coverages that the Commissioner considers necessary to meet the minimum needs of the insured; or

(9) in a health insurance application form or a nonprofit health service plan application form, contain inquiries about:

(i) a preexisting condition, illness, or disease for which the applicant has not received medical care or advice from a licensed health care provider:

1. during the 7 years immediately before the date of application; or

2. for an application for an individual health benefit plan that is subject to § 15–508.1 of this article, during the 5 years immediately before the date of application; or

(ii) medical screening, testing, monitoring, or any other similar medical procedure that the Commissioner specifies and that the applicant received:

1. more than 7 years before the date of application; or

2. for an application for an individual health benefit plan that is subject to § 15–508.1 of this article, more than 5 years before the date of application.

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