Article - Insurance

§1–101.

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

(a–1) "Active duty" has the meaning stated in § 9–901 of the State Government Article.

(b) "Administration" means the Maryland Insurance Administration.

(b–1) "Affordable Care Act" means the federal Patient Protection and Affordable Care Act, as amended by the federal Health Care and Education Reconciliation Act of 2010, and any regulations adopted or guidance issued under the Acts.

(c) "Alien insurer" means an insurer that is formed under the laws of a jurisdiction other than the United States or a state.

(d) (1) "Annuity" means an agreement to make periodic payments for which the making or continuance of all or some of a series of the payments, or the amount of a payment, depends on the continuance of a human life.

(2) "Annuity" includes:

(i) an additional benefit that operates to safeguard the contract from lapse or to provide a special surrender value, special benefit, or annuity in the event of the total and permanent disability of the holder; and

(ii) benefits that provide payment or reimbursement for long–term home health care or long–term care in a nursing home or other related institution.

(3) "Annuity" does not include life insurance.

(e) "Annuity contract" means a contract that provides for an annuity.

(f) "Appointment" means an agreement between an insurance producer and insurer under which the insurance producer, for compensation, may sell, solicit, or negotiate policies issued by the insurer.

(g) "Authorized insurer" means an insurer that holds a valid certificate of authority.

(h) "Burial insurance" includes any kind of agreement, certificate, policy, contract, bond, assurance guarantee, or other arrangement, by bylaw, regulation, or otherwise, in or by which the party that issues the certificate, policy, contract, bond, assurance guarantee, or other arrangement agrees to:

(1) provide for the burial of a named or designated deceased individual;

(2) save harmless anyone for all or part of the costs of the burial of a named or designated deceased individual; or

(3) pay all or part of the incidents of the burial of a named or designated deceased individual.

(i) (1) "Casualty insurance" means:

(i) insurance against legal, contractual, or assumed liability for death, injury, or disability of a human being, or for damage to property;

(ii) if issued as an incidental coverage with or supplemental to liability insurance and regardless of legal liability of the insured, insurance that provides medical, hospital, or surgical disability benefits to injured individuals and funeral and death benefits to dependents, beneficiaries, or personal representatives of individuals killed; or

(iii) unless disapproved by the Commissioner as contrary to law or public policy, insurance against any other kind of loss, damage, or liability that is properly a subject of insurance and not within any other kind of insurance described in this subsection.

(2) "Casualty insurance" includes motor vehicle physical damage insurance, burglary and theft insurance, glass insurance, workers' compensation insurance, employer's liability insurance, and boiler and machinery insurance.

(j) "Certificate of authority" means a certificate issued by the Commissioner to engage in the insurance business.

(k) "Commissioner" means the Maryland Insurance Commissioner.

(l) "County" means a county of the State or Baltimore City.

(m) "Domestic insurer" means an insurer that is formed under the laws of the State.

(m–1) (1) "First–class mail tracking method" means a mail tracking method that provides evidence of the date that a piece of first–class mail was accepted for mailing by the United States Postal Service.

(2) "First–class mail tracking method" includes:

(i) a certificate of mail; and

(ii) an electronic mail tracking system used by the United States Postal Service.

(3) "First–class mail tracking method" does not include a certificate of bulk mailing.

(n) (1) "Foreign insurer" means an insurer that is formed under the laws of a jurisdiction other than this State.

(2) Unless the context requires otherwise, "foreign insurer" includes an alien insurer.

(o) "Fund producer" means a licensed insurance producer, including a licensed independent insurance producer, that has been assigned an authorization code by the Maryland Automobile Insurance Fund.

(p) (1) "Health insurance" means insurance of human beings against:

(i) bodily injury, disablement, or death by accident or accidental means, or the expenses of bodily injury, disablement, or death by accident or accidental means;

(ii) disablement or expenses resulting from sickness or childbirth; and

(iii) expenses incurred in prevention of sickness or dental care.

(2) "Health insurance" includes:

(i) accident insurance;

(ii) disability insurance; and

(iii) each insurance appertaining to health insurance.

(3) "Health insurance" does not include workers' compensation insurance.

(q) "Independent insurance producer" means an insurance producer:

(1) that is not owned or controlled by an insurer or group of insurers;

(2) the appointment of which does not prohibit the representation of more than one insurer or group of insurers; and

(3) the appointment of which provides that:

(i) at termination, the records of the insurance producer remain the property of the insurance producer; and

(ii) the insurance producer retains the use and control of all expirations incurred during the period when the appointment was in effect.

(r) "Industrial life insurance" means life insurance provided by an individual policy with the term "industrial" printed on the policy as part of the brief description required by § 16–213 of this article, and under which premiums are payable monthly or more frequently, if the face amount of the insurance provided by the policy does not exceed $1,000.

(s) Except as expressly provided otherwise in this article, "insurance" means a contract to indemnify or to pay or provide a specified or determinable amount or benefit on the occurrence of a determinable contingency.

(t) (1) "Insurance business" includes the transaction of:

(i) all matters pertaining to an insurance contract, either before or after it takes effect; and

(ii) all matters arising from an insurance contract or a claim under it.

(2) "Insurance business" does not include pooling by public entities for self–insurance of casualty, property, or health risks.

(u) (1) "Insurance producer" means a person that, for compensation, sells, solicits, or negotiates insurance contracts, including contracts for nonprofit health service plans, dental plan organizations, and health maintenance organizations, or the renewal or continuance of these insurance contracts for:

(i) persons issuing the insurance contracts; or

(ii) insureds or prospective insureds other than the insurance producer.

(2) "Insurance producer" does not include:

(i) an individual who performs clerical or similar office duties while employed by an insurance producer or insurer, including a clerical employee, other than a clerical employee of an insurer, who takes insurance information or receives premiums in the insurance producer's office, if the employee's compensation does not vary with the number of applications or amount of premiums;

(ii) a regular salaried officer or employee of an insurer who gives help to or for a licensed insurance producer, if the officer or employee is not paid a commission or other compensation that depends directly on the amount of business obtained; or

(iii) if not paid a commission, a person that obtains and forwards information for:

1. group insurance coverage;

2. enrolling individuals under group insurance coverage;

3. issuing certificates under group insurance coverage; or

4. otherwise assisting in administering group plans.

(v) "Insurer" includes each person engaged as indemnitor, surety, or contractor in the business of entering into insurance contracts.

(w) "Licensed insurance producer" means an insurance producer that has:

(1) obtained a license under Title 10, Subtitle 1 of this article; and

(2) in the case of an insurance producer that acts on behalf of an insurer other than the Maryland Automobile Insurance Fund, obtained an appointment under Title 10, Subtitle 1 of this article.

(x) (1) "Life insurance" means insurance for which the probabilities of the duration of human life or the rate of mortality are an element or condition of the insurance.

(2) "Life insurance" includes the granting of:

(i) endowment benefits;

(ii) additional benefits in the event of death by accident or accidental means;

(iii) additional disability benefits in the event of dismemberment or loss of sight;

(iv) additional disability benefits that operate to safeguard the contract from lapse or to provide a special surrender value, special benefit, or annuity in the event of total and permanent disability;

(v) benefits that provide payment or reimbursement for long–term home health care, or long–term care in a nursing home or other related institution;

(vi) burial insurance;

(vii) optional modes of settlement of proceeds of life insurance;

(viii) additional benefits for a second opinion for specified health conditions; and

(ix) additional benefits that provide a lump–sum benefit for a specified disease and that meet the requirements established by the Commissioner under § 15–109 of this article.

(3) "Life insurance" does not include workers' compensation insurance.

(y) "Life insurer" means an insurer in life insurance.

(z) (1) "Marine insurance" includes:

(i) insurance against loss or damage in connection with any risk of navigation, transit, or transportation, including war risks, marine builder's risks and personal property floater risks, to vessels, craft, aircraft, automobiles, trailers, or vehicles of any kind, as well as all goods, freight, cargoes, merchandise,

effects, disbursements, profits, money, bullion, precious stones, securities, choses in action, evidences of debt, valuable papers, bottomry and respondentia interests, and all other kinds of property and interests:

1. on or under water, on land, or in the air;

2. while being assembled, packed, crated, baled, compressed, or similarly prepared for shipment or while awaiting shipment; or

3. during any delay, storage, transshipment, or incidental reshipment;

(ii) except as provided in paragraph (2) of this subsection, insurance against:

1. loss or damage to a person or property in connection with or as part of marine, inland marine, transit, or transportation insurance arising out of or in connection with the construction, repair, operation, maintenance, or use of the subject matter of the insurance; and

2. legal liability of the insured for loss of or damage to the person or property;

(iii) insurance against loss or damage to precious stones, jewels, jewelry, gold, silver and other precious metals, whether used in business or trade or otherwise or whether in course of transportation or otherwise;

(iv) except as provided in paragraph (2) of this subsection, insurance against loss or damage to bridges, tunnels, other instrumentalities of transportation and communication, auxiliary facilities and related equipment, piers, wharves, docks, slips, other aids to navigation and transportation, dry docks, and marine railways; and

(v) travel insurance, as defined in § 10–101 of this article.

(2) "Marine insurance" does not include:

(i) life insurance, surety bonds, or insurance against loss because of bodily injury to a person arising out of ownership, maintenance, or use of an automobile, unless a part of travel insurance, as defined in § 10–101 of this article; or

(ii) insurance against loss or damage to buildings that are instrumentalities of transportation and communication, their furniture and furnishings, and fixed contents and supplies stored in the buildings.

(aa) "Marine protection and indemnity insurance" means insurance against, or against legal liability of the insured for, loss, damage, or expense arising out of or incident to the ownership, operation, chartering, maintenance, use, repair, or construction of a vessel, craft, or instrumentality used in ocean or inland waterways, including legal liability of the insured for personal injury, illness, or death or for loss or damage to the property of another person.

(bb) "Mutual insurer" means an insurer that is incorporated without capital stock and the governing body of which is elected in accordance with this article.

(cc) "Negotiate" means to confer directly with or offer advice directly to a purchaser or prospective purchaser of a particular contract of insurance concerning any of the substantive benefits, terms, or conditions of the contract, provided that the person engaged in that act either sells insurance or obtains insurance from insurers for purchasers.

(dd) "Person" means an individual, receiver, trustee, guardian, personal representative, fiduciary, representative of any kind, partnership, firm, association, corporation, or other entity.

(ee) (1) "Policy" means the written instrument in which an insurance contract is set forth.

(2) "Policy" includes all clauses, endorsements, riders, and other papers attached to or made part of the insurance contract.

(ff) (1) "Premium" means consideration for insurance.

(2) "Premium" includes:

(i) except as provided in paragraph (3) of this subsection, an assessment; and

(ii) a membership fee, policy fee, survey fee, inspection fee, service fee, driving record report fee, accident history report fee, or other similar fee in consideration for an insurance contract.

(3) "Premium" does not include:

(i) an assessment as described in § 9–225 of this article; or

(ii) an assessment made under any State law that provides for insolvency protection or insurance availability.

(gg) (1) "Property insurance" means insurance on real or personal property on land, in water, or in the air or an interest in real or personal property against loss or damage from any hazard or cause and against loss that is consequential to the loss or damage.

(2) "Property insurance" includes fire insurance, flood insurance, extended coverage insurance, homeowners insurance, farm owners insurance, allied lines insurance, earthquake insurance, growing crops insurance, aircraft physical damage insurance, automobile physical damage insurance, glass insurance, livestock insurance, and animal insurance.

(3) "Property insurance" does not include insurance against legal liability for loss or damage to real or personal property.

(hh) "Reciprocal insurance" means insurance that arises from an exchange among subscribers of mutual agreements of indemnity and that is effected through an attorney in fact common to the subscribers.

(ii) "Reciprocal insurer" means an unincorporated aggregation of subscribers that operate individually and collectively through an attorney in fact to provide reciprocal insurance.

(jj) "Reinsurance" means a contract under which an insurer obtains insurance for itself from another insurer for all or part of an insurance risk.

(kk) "Sell" means to exchange a contract of insurance by any means, for money or its equivalent, on behalf of an insurer.

(ll) "Solicit" means to attempt to sell insurance or to ask or urge a person to apply for a particular kind of insurance from a particular insurer.

(mm) Except as otherwise expressly provided in this article, "state" means:

(1) a state, possession, territory, or commonwealth of the United States; or

(2) the District of Columbia.

(nn) "Stock insurer" means an insurer that is incorporated with capital that is divided into shares and owned by its stockholders.

(oo) "Surety insurance" includes:

(1) fidelity insurance, which is insurance that guarantees the fidelity of persons that hold positions of public or private trust;

(2) insurance that guarantees the performance of contracts other than insurance contracts;

(3) insurance that guarantees the execution of bonds, undertakings, and contracts of suretyship; and

(4) insurance that indemnifies banks, bankers, brokers, or financial corporations or associations against loss from any cause of bills of exchange, notes, bonds, securities, evidences of debt, deeds, mortgages, warehouse receipts, other valuable papers, documents, money, precious metals, articles made from precious metals, jewelry, watches, necklaces, bracelets, gems, and precious and semi–precious stones, including loss during transportation by messenger or in armored motor vehicles, but not against other risks of transportation or navigation, and insurance against loss or damage to a bank's, banker's, broker's, or financial corporation's or association's premises or furniture, fixtures, equipment, safes, and vaults on the premises caused by burglary, robbery, theft, vandalism, or malicious mischief, or attempted burglary, robbery, theft, vandalism, or malicious mischief.

(pp) "Surplus lines insurance" means the full amount or kind of insurance needed to protect the interest of the insured that:

(1) cannot be obtained from an authorized insurer; or

(2) for the particular kind and class of insurance to provide coverage against liability of persons described in § 24–206(1) of this article, cannot be obtained from three or more authorized insurers that write that kind and class of insurance on a broad basis.

(qq) "Title insurance" means insurance of owners of property or other persons that have an interest in the property against loss by encumbrance, defective title, invalidity of title, or adverse claim to title.

(rr) "Unauthorized insurer" means an insurer that does not hold a certificate of authority.

(rr–1) "Uniformed services" has the meaning stated in § 9–901 of the State Government Article.

(ss) "Wet marine and transportation insurance" means the part of marine insurance that includes only:

(1) insurance of vessels, crafts, or hulls and interests in or related to them;

(2) insurance of marine builder's risks or marine war risks;

(3) marine protection and indemnity insurance;

(4) insurance of freights and disbursements pertaining to a subject of insurance under this subsection; and

(5) insurance of personal property and interests in personal property, in connection with any risk of navigation, transit, or transportation:

(i) in the course of exportation from or importation into a country and in the course of transportation along a coast or on inland waters, including transportation by land, water, or air from point of origin to final destination;

(ii) while being prepared for and while awaiting shipment; and

(iii) during any delay, storage, transshipment, or incidental reshipment.

(tt) (1) "Wholesale life insurance" means life insurance that is:

(i) distributed on a mass merchandising basis;

(ii) administered by group methods provided, with or without evidence of insurability, by individual policies; and

(iii) made available to employees or members under a program, which also may provide coverage of dependents of the employees or members, sponsored by:

1. an employer or association of employers;

2. a union or association of unions;

3. an association of individuals who have the same occupation or profession;

4. an association of civil service employees;

5. a religious, charitable, recreational, educational, civic, or fraternal organization or association;

6. a school;

7. a sports team;

8. a volunteer fire department; or

9. a group approved by the Commissioner that has a common administrative capacity, is not organized primarily for the sale of insurance, and has sufficient numbers to allow for lower rates.

(2) "Wholesale life insurance" does not include a policy solely because the premium for the policy is paid by salary deduction, salary savings, payroll allotment, or similar arrangement.

§1–201.

A person that engages in or transacts insurance business in the State, or performs an act relative to a subject of insurance resident, located, or to be performed in the State, shall comply with each applicable provision of this article.

§1–202.

(a) This article does not apply to:

(1) a fraternal benefit society, except as provided in Title 8, Subtitle 4 of this article;

(2) a nonprofit health service plan, except as otherwise provided in this article;

(3) an organization that:

(i) is organized and operated as a nonprofit organization exclusively for the purpose of helping nonprofit educational or scientific institutions by issuing annuity contracts only to or for the benefit of those institutions or individuals serving those institutions;

(ii) irrevocably appoints the Commissioner as attorney to receive service of process issued against it in the State so as to bind the organization

and its successors and to remain in effect as long as there is in force in the State a contract or obligation arising from it;

(iii) is legally organized and qualified to do business and has been actively doing business under the laws of its state of domicile for at least 10 years before July 1, 1977;

(iv) files with the Commissioner a copy of any contract form issued to residents of this State;

(v) files with the Commissioner on or before March 1 of each year:

1. a copy of its annual statement prepared under the laws of its state of domicile; and

2. any other financial material that the Commissioner requests;

(vi) agrees to submit to periodic examinations as the Commissioner considers necessary; and

(vii) pays the premium tax imposed by Title 6 of this article on all premiums allocable to this State for life insurance and health insurance in effect for residents of this State;

(4) a voluntary noncontractual religious publication arrangement that:

(i) is a nonprofit religious organization for which the State may not be held in any way liable or responsible for any of its debts, claims, obligations, or liabilities;

(ii) publishes a newsletter whose subscribers are limited to members of the same denomination or religion;

(iii) acts as an organizational clearinghouse for information between subscribers who have medical costs and subscribers who choose to assist with those costs;

(iv) matches subscribers with a willingness to pay and subscribers with present medical costs;

(v) coordinates payments directly from one subscriber to another;

(vi) suggests amounts to give that are voluntary among the subscribers, with no assumption of risk or promise to pay either among the subscribers or between the subscribers and the organization;

(vii) does not use a compensated insurance producer, representative, or other person to solicit or enroll subscribers;

(viii) does not make a direct or indirect representation that it is operating in a financially sound manner or that it has had a successful history of meeting subscribers' medical costs;

(ix) provides to each subscriber a written monthly statement listing both the total dollar amount of qualified medical costs submitted for publication and the amount actually published and assigned for payment;

(x) does not use funds paid by subscribers for medical costs to cover administrative costs;

(xi) submits a registration statement, including a copy of any application forms and guidelines, promotional, or informational material distributed by or on behalf of the arrangement, to the Secretary of State in accordance with the provisions of Title 6, Subtitle 4 of the Business Regulation Article; and

(xii) provides the following verbatim written disclaimer as a separate cover sheet for any and all documents distributed by or on behalf of the exempt arrangement, including applications, guidelines, promotional, or informational material and all periodic publications:

"Notice

This publication is not issued by an insurance company nor is it offered through an insurance company. It does not guarantee or promise that your medical bills will be published or assigned to others for payment. No other subscriber will be compelled to contribute toward the cost of your medical bills. Therefore, this publication should never be considered a substitute for an insurance policy. This activity is not regulated by the State Insurance Administration, and your liabilities are not covered by the Life and Health Guaranty Fund. Whether or not you receive any payments for medical expenses and whether or not this entity continues to operate, you are always liable for any unpaid bills."; or

(5) except as provided in subsection (b) of this section, a self–funded student health plan operated by an independent institution of higher education, as defined in § 10–101 of the Education Article, that provides health care services to its students and their dependents if the institution files on July 1 each year, for the student health plan that will be offered to students for the upcoming school year, a report with the Commissioner certifying under penalties of perjury that:

(i) the student health plan satisfies any applicable minimum essential coverage standards under federal law;

(ii) the institution pledges assets sufficient to support the liabilities of the student health plan;

(iii) the institution demonstrates an ability to operate the student health plan in a sound manner by having operated an employer–sponsored plan, as defined in § 15–1401 of this article, in the prior calendar year with at least 10,000 enrollees, including employees and their dependents;

(iv) the institution maintains at least an AA bond rating by one of the major credit rating agencies; and

(v) the institution operates the student health plan in compliance with Title 15, Subtitles 10A and 10D of this article.

(b) Title 15, Subtitles 10A and 10D of this article apply to a self–funded student health plan operated by an independent institution of higher education, as defined in § 10–101 of the Education Article, that provides health care services to its students and their dependents.

§1–203.

(a) (1) In this section the following words have the meanings indicated.

(2) "Certificate of guarantee" means an instrument that is issued:

(i) by a nonprofit association of contractors, or its wholly owned subsidiary that is approved to operate by a county; and

(ii) on behalf of a contractor for the purpose of satisfying:

1. county bond requirements for public improvements; or

2. other county bond requirements.

(3) "Contractor" means a person that, for a fixed price, commission, fee, or percentage, undertakes to bid on or accepts or offers to accept orders or contracts to perform or supervise the construction, improvement, or maintenance of a building, structure, or road.

(b) This article does not apply to a certificate of guarantee.

(c) A county:

(1) may honor certificates of guarantee; but

(2) is not required under this article to honor certificates of guarantee.

§1–203.1.

(a) (1) In this section the following words have the meanings indicated.

(2) (i) "Utility provider" means:

1. a public or private provider of electricity, gas, water, wastewater, solid waste collection, or similar service; or

2. a provider of communications services involving the transmission, conveyance, or routing of voice, data, audio, video, or any other information or signals, to a point, or between or among points, by or through an electronic, radio, satellite, cable, optical, microwave, or other medium or method in existence now or in the future, regardless of the protocol used for transmission.

(ii) "Utility provider" includes cable service, Internet access service, voice over Internet service, telephone or wireless telephone service, and other similar providers.

(3) "Waiver of customer liability" means an optional agreement:

(i) between a utility provider and a customer of the utility provider;

(ii) that is contained in:

1. the agreement under which the utility provider provides services to the customer; or

2. a separate agreement between the utility provider and the customer; and

(iii) under which the utility provider agrees, in return for a specified charge payable by the customer to the utility provider, to waive all or part of the customer's liability to the utility provider for incurred charges during a defined period in the event of any of the following qualifying events or conditions involving the customer:

1. call to active service in the uniformed services;

2. involuntary unemployment;

3. death;

4. disability;

5. hospitalization;

6. marriage;

7. divorce;

8. evacuation;

9. displacement due to natural disaster or other cause;

10. qualification for family leave; or

11. any other similar event or condition.

(b) Notwithstanding any provision of this article to the contrary, a waiver of customer liability is not considered insurance for purposes of this article.

§1–204.

Except for provisions governing the reporting and investigation of workers' compensation insurance fraud claims under § 2–201, Title 2, Subtitle 4, and Title 27, Subtitles 4 and 8 of this article, for the purpose of workers' compensation insurance, this article does not apply to an employer who:

(1) participates in a governmental self–insurance group under § 9–404 of the Labor and Employment Article; or

(2) self–insures under § 9–405 of the Labor and Employment Article.

§1–205.

(a) A county or municipal corporation of the State may not:

(1) require an insurer, insurance producer, adjuster, public adjuster, or advisor to obtain a local certificate of authority or certificate of qualification to transact insurance business in that county or municipal corporation; or

(2) impose a local occupational tax or fee for transacting insurance business.

(b) This section does not preempt or prevent the taxation and regulation of persons engaged in the bail bond business other than corporate sureties and their insurance producers that are required to be licensed under this article.

§1–206.

The provisions of this article supersede any inconsistent provisions of any other part of the Code.

§1–207.

A provision of this article that relates to a particular kind of insurance, particular type of insurer, or particular matter prevails over a provision that relates to insurance in general, insurers in general, or that matter in general.

§1–208.

A requirement in this article that a document be under oath means that the document shall be supported by:

(1) a written statement signed by the individual making it in which the individual solemnly affirms under the penalties of perjury that the contents of the document are true to the best of the individual's knowledge, information, and belief; or

(2) a certification of an officer authorized to administer an oath that a named individual made oath that the contents of the document are true to the best of the individual's knowledge, information, and belief.

§1–301.

In addition to any administrative penalty otherwise applicable, a person that willfully violates any provision of this article, with respect to which a greater penalty is not provided by other applicable State law, is guilty of a misdemeanor and on conviction is subject to a fine not exceeding $100,000.

§2–101.

(a) (1) There is a Maryland Insurance Administration.

(2) The Administration is an independent unit of the State government.

(b) The head of the Administration is the Maryland Insurance Commissioner.

(c) The Commissioner shall control and supervise the Administration.

§2–102.

(a) (1) The Commissioner shall establish divisions or sections in the Administration, along the following lines of responsibility:

(i) life insurance and health insurance;

(ii) property insurance and casualty insurance;

(iii) audit and examination;

(iv) insurance professions;

(v) consumer affairs; and

(vi) insurance fraud.

(2) The Commissioner may:

(i) establish other areas of responsibility in the Administration; and

(ii) reorganize or abolish areas of responsibility as necessary to fulfill effectively the duties of the Commissioner.

(b) The Commissioner shall report to the General Assembly about:

(1) the initial organizational structure of the Administration; and

(2) any substantial changes in organizational structure.

(c) The organization of each division shall be according to functional area and shall be designed for efficiency, service to the public, and effective regulation.

§2–103.

(a) (1) The Governor shall appoint the Commissioner with the advice and consent of the Senate.

(2) The Commissioner shall serve for a term of 4 years.

(3) The Commissioner is directly responsible to the Governor.

(4) The Commissioner shall counsel and advise the Governor on all matters assigned to the Administration.

(5) The Commissioner may be removed by the Governor for:

(i) malfeasance;

(ii) incompetence; or

(iii) failure to carry out the duties of office in a manner consistent with the regulatory purpose and requirements of this article.

(b) (1) The Commissioner is responsible for the operation of the Administration.

(2) The Commissioner shall:

(i) exercise the powers and perform the duties of the Administration under this article;

(ii) organize the Administration to function efficiently and to serve the public; and

(iii) establish, in the Administration, the units necessary for the exercise of the powers and performance of the duties of the Administration.

(c) The Commissioner shall devote full time to the duties of office.

(d) The Commissioner is in the executive service of the State Personnel Management System and is entitled to compensation under the Executive Pay Plan in accordance with the State budget.

(e) The Commissioner shall be covered by a surety bond or an insurance policy of the type and in the amount of coverage determined by the State Treasurer under § 5–108 of the State Government Article.

(f) (1) The Commissioner shall have a seal of office in the form approved by the Governor.

(2) The impression and description of the seal shall be filed with the Secretary of State.

§2–104.

(a) (1) Subject to the approval of the Governor, the Commissioner shall appoint a Deputy Commissioner.

(2) The Deputy Commissioner is in the executive service of the State Personnel Management System and is entitled to compensation in accordance with the State budget.

(3) The Deputy Commissioner shall be covered by a surety bond or an insurance policy of the type and in the amount of coverage determined by the State Treasurer under § 5–108 of the State Government Article.

(4) The Deputy Commissioner shall exercise the powers and perform the duties vested by law in the Commissioner:

(i) if the office of the Commissioner is vacant; or

(ii) if for any reason the Commissioner is absent or unable to exercise the powers and perform the duties of office.

(b) The Commissioner may appoint employees to head divisions or sections established under § 2-102 of this subtitle or for any special purpose that the Commissioner designates.

(c) (1) The Commissioner shall appoint an actuary.

(2) The Commissioner may appoint assistant actuaries.

(3) The actuary and assistant actuaries shall:

(i) perform the actuarial duties of the Administration;

(ii) examine or help to examine insurers; and

(iii) perform any other duties that the Commissioner assigns.

(d) (1) The Commissioner shall appoint a chief examiner.

(2) The Commissioner may appoint assistant examiners.

(3) The chief examiner and assistant examiners shall examine or help to examine insurers and other persons subject to examination under this article.

(e) (1) The Commissioner shall appoint an auditor and examiner for the Administration.

(2) The auditor and examiner shall:

(i) examine and audit the annual statements of all authorized insurers;

(ii) examine and audit the books, accounts, and affairs of the Administration; and

(iii) perform any other auditing that the Commissioner directs.

(f) (1) The Commissioner may appoint investigators, accountants, and statisticians.

(2) As directed by the Commissioner, the investigators shall investigate, in the State, violations or alleged violations of this article, including insurance fraud as defined in § 27-801 of this article.

(g) (1) The Administration shall be represented by the Office of the Attorney General.

(2) The Administration shall have:

(i) a principal counsel who is an assistant Attorney General; and

(ii) other assistant Attorneys General, including assistant Attorneys General specifically assigned to the Fraud Division, as provided by the State budget.

(3) The Commissioner may employ on a full-time basis other attorneys at law as the Commissioner considers necessary.

(h) The Commissioner may appoint any other assistants and clerks that are necessary to help the Commissioner in performing the duties of the Commissioner under this article.

(i) The Commissioner may procure, on a fee or part-time basis or both, actuarial, legal, technical, or other professional services, including the services of independent review organizations and medical experts.

(j) (1) Subject to approval by the Board of Public Works under the State Finance and Procurement Article, the Commissioner may enter into contracts for performance of licensing services under this article with persons that are not governmental entities.

(2) A contract authorized under this subsection:

(i) shall specify the amount of any administrative charge required under this subsection and the manner in which the charge will be collected;

(ii) shall limit the administrative charge to the cost to the contractor of providing the service specified by the contract; and

(iii) may require the contractor to collect any fees required under this article and remit them to the General Fund of the State.

(3) The Commissioner may require an amount equivalent to the administrative cost of providing licensing services to be paid directly to a contractor by any person who is an applicant for a certificate of authority or certificate of qualification issued by the Commissioner or any insurer, health maintenance organization, nonprofit health service plan, fraternal benefit society, the Maryland Automobile Insurance Fund, or other entity operating in this State under a certificate of authority issued by the Commissioner.

(k) The Commissioner shall appoint or contract with a physician and may appoint or contract with other health care providers for the purpose of assisting the Commissioner in performing those duties of the Commissioner that relate to the regulation of health insurance and health maintenance organizations.

§2–105.

(a) In this section, "Secretary" means the Secretary of Budget and Management.

(b) All employees of the Administration that serve in a management, professional, or technical capacity are in the executive service, management service, or are special appointments in the State Personnel Management System and serve at the pleasure of the Commissioner.

(c) In accordance with the State budget, the Commissioner may set the compensation of an employee under subsection (b) of this section in a position that:

(1) is unique to the Administration;

(2) requires specific skills or experience to perform the duties of the position; and

(3) does not require the employee to perform functions that are comparable to functions performed in other units of the Executive Branch of State government.

(d) The Secretary, in consultation with the Commissioner, shall determine the positions for which the Commissioner may set compensation under subsection (c) of this section.

(e) (1) At least 45 days before the effective date of the change, the Commissioner shall submit to the Secretary each change to salary plans that involves increases or decreases in salary ranges other than those associated with routine reclassifications and promotions or general salary increases approved by the General Assembly.

(2) Reportable changes include creation or abolition of classes, regrading the classes from one established range to another, or creation of new pay schedules or ranges.

(3) The Secretary shall:

(i) review the proposed changes; and

(ii) at least 15 days before the effective date of the proposed changes, advise the Commissioner whether the changes would have an adverse effect on comparable State jobs.

(4) Failure of the Secretary to respond in a timely manner is not considered a statement of adverse effect.

§2–106.

Except as otherwise provided by law, all skilled service employees of the Administration shall be appointed and removed by the Commissioner in accordance with the provisions of Division I of the State Personnel and Pensions Article that govern skilled service employees.

§2–107.

(a) Except as provided in subsection (b) of this section, the Commissioner or a deputy, examiner, assistant, or employee of the Commissioner may not be financially interested in an insurer, insurance agency, or insurance transaction, other than as a policyholder or claimant under a policy.

(b) The Commissioner may employ or retain an actuary, attorney, or other technician who is similarly employed or retained by insurers or other persons if the individual:

(1) is independently practicing the profession of the individual; and

(2) does not have a conflict of interest in the matter for which the individual is employed or retained.

§2–108. IN EFFECT

In addition to any powers and duties set forth elsewhere by the laws of the State, the Commissioner:

(1) has the powers and authority expressly conferred on the Commissioner by or reasonably implied from this article;

(2) shall enforce this article;

(3) shall perform the duties imposed on the Commissioner by this article; and

(4) in addition to examinations and investigations expressly authorized, may conduct examinations and investigations of insurance matters as necessary to fulfill the purposes of this article.

§2–108. ** TAKES EFFECT OCTOBER 1, 2026 PER CHAPTERS 198 AND 199 OF 2025 **

In addition to any powers and duties set forth elsewhere by the laws of the State, the Commissioner:

(1) has the powers and authority expressly conferred on the Commissioner by or reasonably implied from this article;

(2) shall enforce this article;

(3) shall perform the duties imposed on the Commissioner by this article;

(4) in addition to examinations and investigations expressly authorized, may conduct examinations and investigations of insurance matters as necessary to fulfill the purposes of this article; and

(5) shall enforce § 4A–12A–11 of the Corporations and Associations Article.

§2–108. // EFFECTIVE MAY 18, 2025 PER CHAPTER 224 OF 2023 //

In addition to any powers and duties set forth elsewhere by the laws of the State, the Commissioner:

(1) has the powers and authority expressly conferred on the Commissioner by or reasonably implied from this article;

(2) shall enforce this article;

(3) shall perform the duties imposed on the Commissioner by this article; and

(4) in addition to examinations and investigations expressly authorized, may conduct examinations and investigations of insurance matters as necessary to fulfill the purposes of this article.

§2–109.

(a) The Commissioner may adopt regulations to:

(1) carry out this article;

(2) establish, maintain, and administer reserves under Title 3, Subtitle 2A of the Courts Article; and

(3) regulate the solicitation by a domestic stock insurer or other person of proxies, consents, and authorizations with respect to equity securities of the domestic stock insurer.

(b) (1) The Commissioner shall:

(i) compile and keep in the office of the Commissioner a set of current regulations adopted under this article; and

(ii) make a copy of the regulations for anyone who asks for one.

(2) The Commissioner may set a fee to cover the cost of making and mailing a copy of the current regulations.

(c) (1) By regulation, the Commissioner shall establish or direct the establishment of a toll-free telephone number to help consumers with and educate consumers about the purchase of private passenger automobile insurance.

(2) The Commissioner:

(i) may not recommend specific insurers or insurance producers; but

(ii) may provide to callers educational material, including a rate guide and a list of insurers and insurance producers.

(d) (1) By regulation, the Commissioner shall establish standards governing the privacy of consumer financial and health information pursuant to Title V of the Federal Financial Services Modernization Act of 1999 (Public Law 106-102).

(2) The regulations shall be consistent with the provisions of the model regulation adopted by the National Association of Insurance Commissioners entitled "Privacy of Consumer Financial and Health Information Regulation".

(e) By regulation, the Commissioner shall establish criteria and a process to allow an individual who is otherwise prohibited from engaging in or participating in the business of insurance under the Federal Violent Crime Control and Law Enforcement Act of 1994 (Public Law 103-322) to obtain written consent from the Commissioner to engage in or participate in the business of insurance under the federal Act.

(f) In addition to any other penalty provided, a person that willfully violates a regulation adopted under this article is subject to any applicable penalty under this article for violation of the provision to which the regulation relates.

§2–110.

(a) No later than December 31 of each year, the Commissioner shall prepare an annual report about the previous fiscal year that includes:

(1) a list of the authorized insurers transacting insurance business in the State, with any summary of their financial statements that the Commissioner considers appropriate;

(2) the name of each insurer whose business was closed during the year, the cause of the closure, and the amount of assets and liabilities of the insurer that is ascertainable;

(3) the name of each insurer against whom delinquency or similar proceedings were initiated, a concise statement of facts about each delinquency or similar proceeding, and the status of each proceeding;

(4) a list of the rulings and decisions made in cases before the Administration during the year;

(5) a statement of all fees, taxes, and administrative fines and penalties received by the Commissioner and deposited into the General Fund of the State;

(6) the ratio of complaints filed during the calendar year against each insurer for each major line of insurance written by the insurer and a summary of the resolution of the complaints;

(7) recommendations of the Commissioner about changes in the laws affecting insurance and about matters affecting the Administration;

(8) information about the operation of the Fraud Division, including:

(i) the number of complaints received that relate to insurance fraud, the nature of the complaints, and the resolution of the complaints;

(ii) the number of complaints and cases referred to a State's Attorney and the resolution of the complaints or cases;

(iii) the number of complaints and cases referred to the Office of the Attorney General and the resolution of the complaints or cases;

(iv) the number of calls made to the insurance fraud hot line;

(v) the number of complaints received from persons regulated by the Commissioner;

(vi) the number of cases received from the Workers' Compensation Commission under § 9-310.2 of the Labor and Employment Article and the resolution of the cases;

(vii) the total number of cases, by type of insurance fraud; and

(viii) the number and percentage of cases that result in the imposition of civil or criminal penalties;

(9) a list of all staff positions, classifications, and salaries in the Administration as of the end of the preceding calendar year; and

(10) any other relevant information that the Commissioner considers proper.

(b) (1) At least once every 5 years after December 1, 1995, the Commissioner shall prepare a report recommending any changes that the Commissioner considers appropriate under §§ 4-104 and 4-105 of this article.

(2) When required, the report described in paragraph (1) of this subsection may be prepared with the annual report required by subsection (a) of this section.

(c) Reports required under subsection (a) or (b) of this section shall be submitted to the Governor and, subject to § 2-1257 of the State Government Article, the General Assembly.

§2–111.

(a) The Commissioner shall keep records of official transactions, examinations, investigations, and proceedings of the Commissioner.

(b) Except as otherwise provided in this article for particular records or insurance filings, the records of the Commissioner and insurance filings in the office of the Commissioner are open to public inspection.

(c) (1) On request, the Commissioner shall provide a certificate under seal as to the authority of any person to transact insurance business.

(2) The certificate of the Commissioner under seal is evidence of the facts contained in it.

§2–112.

(a) Fees for the following certificates, licenses, permits, and services shall be collected in advance by the Commissioner, and shall be paid by the appropriate persons, including health maintenance organizations, to the Commissioner:

(1) fees for certificates of authority:

(i) application fee for initial certificate of authority, including filing the application, articles of incorporation and other charter documents, except as provided in item (2) of this subsection, bylaws, financial statement, examination report, power of attorney to the Commissioner, and all other documents and filings in connection with the application $1,000

(ii) fee for initial certificate of authority $200

(iii) fee for annual renewal of certificate of authority for all foreign insurers and for domestic insurers with their home or executive office in the State.....$500

(iv) fee for annual renewal of certificate of authority for domestic insurers with their home or executive office outside the State, except those domestic insurers that had their home or executive office outside the State before January 1, 1929:

1. with premiums written in the most recent calendar year not exceeding $500,000..... $2,500

2. with premiums written in the most recent calendar year not exceeding $1,000,000..... $5,000

3. with premiums written in the most recent calendar year not exceeding $2,000,000..... $7,000

4. with premiums written in the most recent calendar year not exceeding $5,000,000..... $9,000

5. with premiums written in the most recent calendar year of more than $5,000,000..... $11,000

(v) reinstatement of certificate of authority..... $500

(2) fees for articles of incorporation of a domestic insurer or foreign insurer, exclusive of fees required to be paid to the Department of Assessments and Taxation:

(i) fee for filing the articles of incorporation with the Commissioner for approval $25

(ii) fee for amendment of the articles of incorporation..... $10

(3) fees for filing bylaws or amendments to bylaws with the Commissioner.....$10

(4) fees for certificates of qualification:

(i) application fee $25

(ii) managing general agent certificate of qualification:

1. fee for initial certificate..... $30

2. annual renewal fee..... $30

(iii) surplus lines broker certificate of qualification:

1. fee for initial certificate within 1 year of renewal.....$100

2. fee for initial certificate over 1 year from renewal.....$100

3. biennial renewal fee $200

(5) fee for temporary insurance producer licenses and appointments.....$27

(6) fees for licenses and permits:

(i) public adjuster license:

1. fee for initial license within 1 year of renewal.... $25

2. fee for initial license over 1 year from renewal... $50

3. biennial renewal fee $50

(ii) adviser license:

1. fee for initial license within 1 year of renewal.. $100

2. fee for initial license over 1 year from renewal. $200

3. biennial renewal fee $200

(iii) insurance producer license:

1. fee for initial license $54

2. biennial renewal fee $54

(iv) SHOP Exchange navigator license:

1. fee for initial license $54

2. biennial renewal fee $54

3. fee for reinstatement of license..... $100

(v) SHOP Exchange enrollment permit:

1. fee for initial permit $54

2. biennial renewal fee $54

3. fee for reinstatement of permit..... $100

(vi) application fee $25

(7) fee for each insurance vending machine license, for each machine, every second year $50

(8) fees for approval as a surplus lines insurer:

(i) fee for initial approval $1,000

(ii) annual renewal fee..... $1,000

(9) fees for eligibility as an accredited or certified reinsurer:

(i) fee for initial eligibility $1,000

(ii) annual fee for continued eligibility $1,000

(10) fees for required filings, including form and rate filings, under Title 11, Subtitles 2 through 4, Title 26, §§ 12–203, 13–110, 14–126, and 27–613 of this article, and § 15–311.2 of the Transportation Article $125

(11) service of legal process fee under §§ 3–318(e), 3–319(d), and 4–107 of this article and § 19–708(b)(12) of the Health – General Article $15

(12) annual fee for registration of an obligor under § 15–311.2 of the Transportation Article $25

(13) fees for required filings under § 15–143 of this article..... $125

(b) A court may award reimbursement of a service of process fee imposed under subsection (a)(10) of this section to a prevailing plaintiff in any proceeding against an insurer, surplus lines broker, or health maintenance organization.

§2–112.2.

(a) (1) In this section the following words have the meanings indicated.

(2) "Carrier" means a person that offers a health benefit plan and is:

(i) an authorized insurer that provides health insurance in the State;

(ii) a nonprofit health service plan;

(iii) a health maintenance organization;

(iv) a dental plan organization; or

(v) except for a managed care organization as defined in Title 15, Subtitle 1 of the Health - General Article, any other person that provides health benefit plans subject to regulation by the State.

(3) (i) "Health benefit plan" means:

1. a hospital or medical policy, contract, or certificate, including those issued under multiple employer trusts or associations;

2. a hospital or medical policy, contract, or certificate issued by a nonprofit health service plan;

3. a health maintenance organization contract; or

4. a dental plan.

(ii) "Health benefit plan" does not include one or more, or any combination of the following:

1. long-term care insurance;

2. disability insurance;

3. accidental travel and accidental death and dismemberment insurance;

4. credit health insurance;

5. any insurance, medical policy, or certificate for which payment of benefits is conditioned on a determination of medical necessity made solely by the treating health care provider not acting on behalf of the carrier;

6. any other insurance, medical policy, or certificate for which payment of benefits is not conditioned on a determination of medical necessity; or

7. a health benefit plan issued by a managed care organization, as defined in Title 15, Subtitle 1 of the Health - General Article.

(4) (i) "Premium" has the meaning stated in § 1-101 of this article to the extent it is allocable to health insurance policies or contracts issued or delivered in this State.

(ii) "Premium" includes any amounts paid to a health maintenance organization as compensation for providing to members and subscribers the services specified in Title 19, Subtitle 7 of the Health - General Article to the extent the amounts are allocable to this State.

(b) The Commissioner shall:

(1) collect a health care regulatory assessment from each carrier for the costs attributable to the implementation of § 2-303.1 of this title and Title 15, Subtitles 10A, 10B, and 10C of this article; and

(2) deposit the amounts collected under paragraph (1) of this subsection into the Health Care Regulatory Fund established in § 2-112.3 of this subtitle.

(c) The health care regulatory assessment that is payable by each carrier shall be calculated by taking the total costs under subsection (b)(1) of this section multiplied by the percentage of gross direct health insurance premiums written in the State attributable to that carrier in the prior calendar year.

§2–112.3.

(a) In this section, "Fund" means the Health Care Regulatory Fund.

(b) There is a Health Care Regulatory Fund.

(c) The purpose of the Fund is to pay all costs and expenses incurred by the Administration related to the implementation of § 2-303.1 of this title and Title 15, Subtitles 10A, 10B, and 10C of this article.

(d) The Fund shall consist of:

(1) all revenue deposited into the Fund that is received through the imposition and collection of the health care regulatory assessment under § 2-112.2 of this subtitle; and

(2) income from investments that the State Treasurer makes for the Fund.

(e) (1) Expenditures from the Fund to cover the costs and expenses for the implementation of § 2-303.1 of this title and Title 15, Subtitles 10A, 10B, and 10C of this article may only be made:

(i) with an appropriation from the Fund approved by the General Assembly in the annual State budget; or

(ii) by the budget amendment procedure provided for in § 7-209 of the State Finance and Procurement Article.

(2) (i) If, in any given fiscal year, the amount of the health care regulatory assessment revenue collected by the Commissioner and deposited into the Fund exceeds the actual expenditures incurred by the Administration for the implementation of § 2-303.1 of this title and Title 15, Subtitles 10A, 10B, and 10C of this article, the excess amount shall be carried forward within the Fund for the purpose of reducing the assessment imposed by the Administration for the following fiscal year.

(ii) If, in any given fiscal year, the amount of the health care regulatory assessment revenue collected by the Commissioner and deposited into the Fund is insufficient to cover the actual expenditures incurred by the Administration to implement § 2-303.1 of this title and Title 15, Subtitles 10A, 10B, and 10C of this article because of an unforeseen emergency and expenditures are made in accordance with the budget amendment procedure provided for in § 7-209 of the State Finance and Procurement Article, an additional health care regulatory assessment may be made.

(f) (1) The State Treasurer is the custodian of the Fund.

(2) The Fund shall be invested and reinvested in the same manner as State funds.

(3) The State Treasurer shall deposit payments received from the Commissioner into the Fund.

(g) (1) The Fund is a continuing, nonlapsing fund and is not subject to § 7-302 of the State Finance and Procurement Article, and may not be deemed a part of the General Fund of the State.

(2) No part of the Fund may revert or be credited to:

(i) the General Fund of the State; or

(ii) a special fund of the State, unless otherwise provided by law.

§2–113.

(a) Subject to the approval of the Treasurer, the Commissioner may provide by regulation for the payment of unpaid premium taxes or fees owed by an insurer in funds that are immediately available to the State on the date that the payment is due if the total of the unpaid premium taxes or fees is at least $20,000.

(b) Any regulations adopted under this section shall establish a suitable means for payment in immediately available funds to ensure the availability of those funds to the State on the date that payment is due.

§2–114.

(a) The following money shall be considered general funds of the State:

(1) except as provided under § 6–107 of this article, revenue received under Title 6, Subtitle 1 of this article;

(2) all revenue received under §§ 3–324, 4–209, 6–303, and 6–304 of this article; and

(3) all penalties imposed by the Commissioner, including the following penalties imposed under:

(i) §§ 4–113(d), 4–212, 10–126(c), 11–232, 14–140, 23–208, 23–506, 26–502, 27–305, and 27–408 of this article; and

(ii) § 19–730 of the Health – General Article.

(b) The following money may not be considered general funds of the State and shall be deposited into the Insurance Regulation Fund established under Subtitle 5 of this title:

(1) all revenue received through the imposition and collection of the assessment fee under Subtitle 5 of this title;

(2) all revenue received through the imposition and collection of the fees set forth in § 2–112 of this subtitle;

(3) all revenue received through the imposition and collection of the fraud prevention fee under Title 6, Subtitle 2 of this article;

(4) all revenue received through the collection of examination expenses under § 2–208 of this title;

(5) except as provided under subsection (a) of this section, all other fees received through the imposition and collection of fees set forth in this article; and

(6) income from investments that the State Treasurer makes for the Insurance Regulation Fund.

§2–115.

(a) The Commissioner shall adopt regulations that may be applied when:

(1) the Governor has declared a state of emergency for the State or an area within the State under § 14–107 of the Public Safety Article;

(2) the President of the United States has issued a major disaster or emergency declaration for the State or an area within the State under the federal Stafford Act; or

(3) a national or public health emergency, that within the Commissioner's discretion affects the State:

(i) is issued:

1. by the President of the United States under § 201, § 202(d), or § 301 of the federal National Emergencies Act; or

2. by the Secretary of Health and Human Services under the federal Public Health Service Act; and

(ii) is based on a serious threat to health resulting from the existence of a deadly agent as defined in § 14–3A–01 of the Public Safety Article.

(b) The regulations may:

(1) apply to any person regulated by the Commissioner under this article or Title 19, Subtitle 7 of the Health – General Article; and

(2) address:

(i) submission of claims or proof of loss;

(ii) grace periods for payment of premiums and performance of other duties by insureds;

(iii) temporary postponement of cancellations, nonrenewals, premium increases, or policy modifications;

(iv) procedures for obtaining nonelective health care services;

(v) time restrictions for filling or refilling prescription drugs;

(vi) time frames applicable to an action by the Commissioner under this article; and

(vii) any other activity necessary to protect the residents of the State.

(c) (1) To activate a regulation adopted under this section, the Commissioner shall issue a bulletin specifying:

(i) that the regulation is activated;

(ii) the line or lines of business to which the regulation applies;

(iii) the geographic areas to which the regulation applies; and

(iv) the period of time for which the regulation applies.

(2) (i) Except as provided under subparagraph (ii) of this paragraph, a regulation activated under paragraph (1) of this subsection may not apply beyond the duration of, or the geographical area included within, the Governor's or President's declaration of a state of emergency or disaster.

(ii) A regulation activated under paragraph (1) of this subsection in response to a national or public health emergency described in subsection (a)(3) of this section may not apply beyond the duration of the President's or Secretary of Health and Human Services' declaration of a national or public health emergency.

(3) The Commissioner:

(i) shall provide a copy of the bulletin to the emergency contact designated by the person subject to the bulletin; and

(ii) may post a copy of the bulletin on the Administration's website.

§2–116.

(a) The Commissioner may send a notice or other communication by electronic means if:

(1) the Commissioner is required to deliver, give, mail, serve, or otherwise provide the notice or other communication in writing;

(2) the recipient has provided an e–mail address to the Commissioner to receive notices or other communications;

(3) the notice or other communication is sent to the e–mail address provided by the recipient; and

(4) the Commissioner maintains proof that the notice was sent to the recipient at the recipient's e–mail address.

(b) If a person is required to send the Commissioner a notice or other communication and the person is not licensed, certified, or otherwise regulated by the Commissioner:

(1) the person may send the notice or other communication by electronic means approved by the Commissioner; and

(2) the Commissioner may not require the person to send the notice or other communication by electronic means.

(c) The Commissioner may require a person who is licensed, certified, or otherwise regulated by the Commissioner to send a notice or other communication by electronic means.

(d) Subject to the provisions of the Maryland Uniform Electronic Transactions Act, a notice or other communication sent in accordance with this section shall be presumed to have been received in the ordinary course.

§2–201.

(a) The Commissioner may bring an action in a court of competent jurisdiction to enforce this article or an order issued by the Commissioner under this article.

(b) The Commissioner shall be represented by the Attorney General, an assistant Attorney General, or another attorney at law designated by the Attorney General.

(c) Whenever the Commissioner believes that a person has committed a violation of this article for which criminal prosecution is provided, the Commissioner shall refer the alleged violation to:

(1) the State's Attorney for the county where the violation allegedly occurred or the person resides; or

(2) the Attorney General, if the alleged violation is statewide and not local in nature.

(d) (1) The Commissioner may investigate any complaint that alleges that a fraudulent claim has been submitted to an insurer.

(2) If the Commissioner finds that a complaint has merit, the Commissioner may refer the complaint to an appropriate law enforcement authority, including the Attorney General, for appropriate action.

(e) The Commissioner may enforce the provisions of this article, and may impose any penalty or remedy authorized by this article, against a person that is under investigation for or charged with a violation of this article if:

(1) the person's certificate of authority, certificate of qualification, license, or registration is no longer in effect; and

(2) the alleged violation occurred no more than 5 years before surrender or lapse of the certificate, license, or registration.

§2–202.

(a) (1) Notwithstanding any other law and except as provided in paragraph (2) of this subsection, the Commissioner has exclusive jurisdiction to enforce by administrative action the laws of the State that relate to the underwriting or rate–setting practices of an insurer.

(2) The Commission on Civil Rights has concurrent jurisdiction with the Commissioner:

(i) over alleged discrimination on the basis of race, creed, color, or national origin; and

(ii) for the enforcement of § 15–1A–22 of this article.

(b) When the Commissioner has exclusive jurisdiction under subsection (a) of this section, the Commission on Civil Rights may:

(1) refer complaints about discriminatory practices to the Commissioner;

(2) appear before the Commissioner as a party at a hearing about discriminatory practices;

(3) make recommendations about discriminatory practices to the Commissioner;

(4) represent a complainant in proceedings under § 2–210 of this subtitle; and

(5) appeal as a party aggrieved by an order or decision of the Commissioner under § 2–215 of this subtitle or § 11–503 of this article.

(c) The Commissioner shall notify the Commission on Civil Rights of any hearing scheduled on a complaint about alleged discriminatory practices.

(d) On request of the Commission on Civil Rights and unless the complainant objects, the Commissioner shall give the Commission on Civil Rights all information about any complaint about alleged discriminatory practices received by the Commissioner.

(e) The Commissioner and the Commission on Civil Rights shall set guidelines for determining when allegations in a complaint about alleged discriminatory practices are sufficient to warrant a hearing.

§2–203.

(a) With respect to an examination, investigation, or hearing conducted by the Commissioner, the Commissioner, deputy commissioner, or an examiner authorized by the Commissioner may:

(1) administer oaths;

(2) examine individuals under oath; and

(3) issue subpoenas for the attendance of witnesses to testify or the production of evidence.

(b) (1) A subpoena issued under this section shall be served:

(i) in the same manner as a subpoena of a circuit court may be served; or

(ii) in the same manner as a service of process in a civil action in a circuit court may be served.

(2) If a person fails to comply with a lawfully served subpoena, the Commissioner immediately shall file a complaint and a copy of the subpoena and

proof of service with the circuit court for the county where the person was required to appear or produce evidence.

(3) On receipt of a complaint and a copy of the subpoena and proof of service, the circuit court shall:

(i) issue an order directing compliance with the subpoena or compelling testimony; and

(ii) impose penalties as if the person had failed to comply with a subpoena of the court.

(c) (1) A person is not excused from attending, testifying, or producing evidence in an examination, investigation, or hearing conducted by or under authority of the Commissioner on the ground that the testimony or evidence may:

(i) tend to incriminate the person; or

(ii) subject the person to a penalty of forfeiture.

(2) Before a person that claims the privilege against self-incrimination is required or allowed to testify or produce evidence, the Commissioner shall consult with the Attorney General and, with the consent of the Attorney General, the person may not be prosecuted or punished in a criminal action because of an act, transaction, matter, or thing about which the person is compelled to produce evidence or testify under oath.

(3) A person that testifies is not exempt from prosecution and punishment for perjury committed while testifying.

(d) (1) A witness is entitled to the fees and mileage reimbursement allowed for testimony in a court.

(2) On submission of an itemized claim, witness fees, mileage, and actual necessary expenses incurred in securing attendance and testimony of a witness shall be paid by:

(i) the person being examined, if the person is found to have violated the law as to the matter about which the witness was subpoenaed; or

(ii) the person that requested the hearing, if the hearing was requested by a person other than the Commissioner.

(e) (1) A person may not willfully testify falsely under oath about any matter that is material to an examination, investigation, or hearing.

(2) A person that violates paragraph (1) of this subsection is guilty of perjury and on conviction shall be punished accordingly.

(f) (1) A person may not willfully fail to:

(i) appear and testify under oath before the Commissioner;

(ii) attend, answer, or produce evidence requested by the Commissioner; or

(iii) give the Commissioner full and truthful information and answer in writing to any material written inquiry of the Commissioner in relation to the subject of an examination, investigation, or hearing.

(2) In addition to or instead of any other applicable penalty, a person that violates paragraph (1) of this subsection is guilty of a misdemeanor and on conviction is subject to a fine not exceeding $1,000 or imprisonment not exceeding 6 months or both.

§2–204.

(a) An order or notice of the Commissioner must be in writing and signed by the Commissioner or an individual authorized by the Commissioner.

(b) (1) An order of the Commissioner shall state:

(i) its effective date;

(ii) its purpose;

(iii) the grounds on which it is based; and

(iv) the provisions of this article under which action is or proposed to be taken.

(2) Failure to designate a particular provision of this article in accordance with paragraph (1)(iv) of this subsection does not deprive the Commissioner of the right to rely on that provision.

(c) An order or notice may be served on a person by:

(1) mailing it to the person at the last known principal place of business of the person, as listed in the records of the Commissioner;

(2) electronic means in accordance with § 2–116 of this title; or

(3) otherwise delivering it to the person.

§2–205.

(a) In this section, "analysis" means a process by which the Commissioner collects and analyzes information from filed schedules, surveys, required reports specified in subsection (b) of this section, and other sources in order to:

(1) develop an understanding of the affairs, transactions, accounts, records, assets, and financial condition of the entities specified in subsection (b) of this section; or

(2) identify or investigate patterns or practices of the entities specified in subsection (b) of this section.

(b) (1) Whenever the Commissioner considers it advisable, the Commissioner shall conduct an analysis or examine the affairs, transactions, accounts, records, assets, and financial condition of each:

(i) authorized insurer;

(ii) management company of an authorized insurer;

(iii) subsidiary owned or controlled by an authorized insurer;

(iv) rating organization; or

(v) authorized health maintenance organization.

(2) The Commissioner shall examine each domestic insurer and health maintenance organization at least once every 5 years.

(c) The Commissioner shall examine the affairs, transactions, accounts, records, and assets of:

(1) each insurer and each health maintenance organization that applies for an original certificate of authority to do business in the State; and

(2) each rating organization that applies for a license to do business in the State.

(d) When examining a reciprocal insurer, the Commissioner may examine the attorney in fact of the reciprocal insurer to the extent that the transactions of the attorney in fact relate to the reciprocal insurer.

(e) The Commissioner may limit the examination of an alien insurer to its insurance transactions and affairs in the United States.

(f) Instead of conducting an examination, the Commissioner may accept a full report, certified by the insurance supervisory official of another state, of the most recent examination of a foreign insurer or health maintenance organization, alien insurer or health maintenance organization, or an out–of–state rating organization.

§2–206.

When advisable to determine compliance with this article, the Commissioner may examine the accounts, records, documents, and transactions that relate to the insurance affairs or proposed insurance affairs of:

(1) an insurance producer, surplus lines broker, general agent, adjuster, public adjuster, or adviser;

(2) a person with the exclusive or dominant right under a contract to manage or control an insurer;

(3) a person that, for the purpose of controlling the management of a domestic insurer, holds the shares of voting stock or policyholder proxies of the domestic insurer as voting trustee or otherwise; or

(4) a person engaged in, proposing to engage in, or helping in the promotion or formation of:

(i) a domestic insurer or insurance holding corporation; or

(ii) a corporation to finance a domestic insurer or the production of its business.

§2–207.

(a) (1) The Commissioner shall conduct an examination of an insurer, health maintenance organization, or private review agent at:

(i) the home office of a domestic insurer, foreign insurer, health maintenance organization, or private review agent;

(ii) the United States branch office of an alien insurer, health maintenance organization, or private review agent; or

(iii) a branch or agency office of the insurer, health maintenance organization, or private review agent.

(2) The Commissioner shall conduct an examination of a person other than an insurer, health maintenance organization, or private review agent at:

(i) the place of business of the person; or

(ii) any place where records of the person are kept.

(b) Each person that is examined and its officers, employees, agents, and representatives shall:

(1) produce and make freely available to the Commissioner or an examiner the accounts, records, documents, files, information, assets, and matters that are in the possession or control of the person and relate to the subject of the examination; and

(2) otherwise help the examination to the extent reasonably possible.

(c) (1) At the expense of the person being examined, the Commissioner may retain an actuary, accountant, or other expert, who is not otherwise a part of the staff of the Administration, if reasonably necessary to conduct an examination under this article.

(2) The actuary, accountant, or other expert may rewrite, post, or balance the accounts of the person being examined.

(d) (1) If the Commissioner considers it necessary to value real estate involved in an examination, the Commissioner may request in writing that the person being examined appoint one or more competent appraisers, approved by the Commissioner, to appraise the real estate.

(2) If the person does not appoint an appraiser within 10 days after the request was delivered to the person, the Commissioner may appoint an appraiser.

(3) The appraisal shall be made promptly, and a copy of the appraisal report shall be provided to the Commissioner.

(4) The person being examined shall pay the reasonable expense of the appraisal.

§2–208. IN EFFECT

(a) Subject to subsection (b) of this section, the expense incurred in an examination made under § 2–205 of this subtitle, § 2–206 of this subtitle for surplus lines brokers and insurance holding corporations, § 23–207 of this article for premium finance companies, § 15–10B–19 of this article for private review agents, § 15–10B–20 of this article, or § 14–610 of this article for discount medical plan organizations and discount drug plan organizations shall be paid by the person examined in the following manner:

(1) the person examined shall pay to the Commissioner the travel expenses, a living expense allowance, and a per diem as compensation for examiners, actuaries, and typists:

(i) to the extent incurred for the examination; and

(ii) at reasonable rates set by the Commissioner;

(2) the Commissioner may present a detailed account of expenses incurred to the person examined periodically during the examination or at the end of the examination, as the Commissioner considers proper; and

(3) a person may not pay and an examiner may not accept any compensation for an examination in addition to the compensation under item (1) of this subsection.

(b) If the Commissioner conducts an examination of an administrative services organization that administers the delivery system for specialty mental health services established under § 15–103(b)(21) of the Health – General Article, the administrative services organization may not use State funds or otherwise pass onto the State the expenses described in subsection (a) of this section.

§2–208. // EFFECTIVE MAY 18, 2025 PER CHAPTER 224 OF 2023 //

The expense incurred in an examination made under § 2–205 of this subtitle, § 2–206 of this subtitle for surplus lines brokers and insurance holding corporations, § 23–207 of this article for premium finance companies, § 15–10B–19 of this article for private review agents, § 15–10B–20 of this article, or § 14–610 of this article for discount medical plan organizations and discount drug plan organizations shall be paid by the person examined in the following manner:

(1) the person examined shall pay to the Commissioner the travel expenses, a living expense allowance, and a per diem as compensation for examiners, actuaries, and typists:

(i) to the extent incurred for the examination; and

(ii) at reasonable rates set by the Commissioner;

(2) the Commissioner may present a detailed account of expenses incurred to the person examined periodically during the examination or at the end of the examination, as the Commissioner considers proper; and

(3) a person may not pay and an examiner may not accept any compensation for an examination in addition to the compensation under item (1) of this section.

§2–209.

(a) The Commissioner or an examiner shall make a complete report of each examination made under § 2–205 of this subtitle or § 23–207, § 15–10B–19, or § 15–10B–20 of this article.

(b) An examination report shall contain only facts:

(1) from the books, records, or documents of the person being examined; or

(2) determined from statements of individuals about the person's affairs.

(c) (1) At least 30 days before adopting a proposed examination report, the Commissioner shall provide a copy of the proposed report to the person that was examined.

(2) If the person requests a hearing in writing within the 30–day period, the Commissioner:

(i) shall grant a hearing on the proposed report; and

(ii) may not adopt the proposed report until after:

1. the hearing is held; and

2. any modifications of the report that the Commissioner considers proper are made.

(d) (1) After an examination report is adopted by the Commissioner, the examination report is admissible as evidence of the facts contained in it in any action brought by the Commissioner against the person examined or an officer or insurance producer of the person.

(2) Regardless of whether a written examination report has been made, served, or adopted by the Commissioner, the Commissioner or an examiner may testify and offer other proper evidence about information obtained during an examination.

(e) The Commissioner may withhold an examination or investigation report from public inspection for as long as the Commissioner considers the withholding to be:

(1) necessary to protect the person examined from unwarranted injury; or

(2) in the public interest.

(f) If the Commissioner considers it to be in the public interest, the Commissioner may publish an examination report or a summary of it in a newspaper in the State.

(g) (1) This subsection applies only to a document, material, or information other than an adopted examination report that:

(i) is in the control or possession of the Commissioner; and

(ii) is obtained or generated during an analysis or examination conducted under § 2–205 or § 2–206 of this subtitle, Title 7 of this article, or § 23–103, § 15–10B–19, or § 15–10B–20 of this article.

(2) A document, material, or information that is subject to this subsection:

(i) is confidential and privileged;

(ii) is not subject to Title 4 of the General Provisions Article;

(iii) is not subject to subpoena; and

(iv) is not subject to discovery or admissible in evidence in any private civil action.

(3) Notwithstanding paragraph (2) of this subsection, the Commissioner may use any document, material, or information that is subject to this subsection to further any regulatory or legal action brought as part of the duties of the Commissioner.

(4) The Commissioner and any person that receives a document, material, or information that is subject to this subsection while acting under the authority of the Commissioner may not be allowed or required to testify in any private civil action concerning the document, material, or information.

(h) (1) Provided that the recipient agrees to maintain the confidentiality and privileged status of the document, material, or information, the Commissioner may share a document, material, or information, including a document, material, or information that is confidential and privileged under subsection (g) of this section, with:

(i) other State, federal, or international regulatory agencies;

(ii) the National Association of Insurance Commissioners or its affiliates or subsidiaries; or

(iii) State, federal, or international law enforcement authorities.

(2) (i) The Commissioner may receive a document, material, or information, including a document, material, or information that is confidential and privileged, from:

1. other State, federal, or international regulatory agencies;

2. the National Association of Insurance Commissioners or its affiliates or subsidiaries; or

3. State, federal, or international law enforcement authorities.

(ii) The Commissioner shall maintain as confidential and privileged any document, material, or information received under this paragraph with notice or the understanding that it is confidential or privileged under the laws of the jurisdiction that is the source of the document, material, or information.

(3) The Commissioner may enter into agreements governing the sharing and use of information consistent with this subsection.

(4) There is no waiver of any applicable privilege or claim of confidentiality with regard to a document, material, or information as a result of:

(i) disclosure of the document, material, or information to the Commissioner under this subsection; or

(ii) sharing of the document, material, or information by the Commissioner under paragraph (1) of this subsection.

(i) (1) The Commissioner shall provide a copy of the adopted examination report to the person that was examined.

(2) The person examined shall present the adopted examination report to its board of directors at the next regularly scheduled meeting of the board.

§2–209.1.

(a) In this section, "supervisory college" means a forum for cooperation and communication among the involved state, federal, and international regulators established for the fundamental purpose of facilitating the effectiveness of supervision of entities that belong to an insurance holding company system.

(b) (1) With respect to any insurer registered under Title 7, Subtitle 6 of this article, the Commissioner may participate in a supervisory college for any domestic insurer that is part of an insurance holding company system with international operations in order to determine compliance by the insurer with this article.

(2) The powers of the Commissioner with respect to a supervisory college include:

(i) initiating the establishment of a supervisory college;

(ii) determining the membership and participation of other supervisors in the supervisory college;

(iii) determining the functions of the supervisory college and the role of other state, federal, and international regulators;

(iv) coordinating the ongoing activities of the supervisory college, including planning meetings, supervisory activities, and processes for sharing information; and

(v) establishing a crisis management plan on the occurrence of any activity, circumstance, event, or series of events involving one or more affiliates of an insurer that has, or is likely to have, a material adverse effect on the financial condition or liquidity of the insurer or its insurance holding company system as a whole.

(3) (i) Each insurer subject to registration under § 7–603 of this article shall be liable for and shall pay the reasonable expenses of the Commissioner's participation in a supervisory college, including travel expenses.

(ii) A supervisory college may be convened as either a temporary or a permanent forum for communication and cooperation among the regulators charged with supervising an insurer or its affiliates, and the Commissioner may establish a regular assessment to an insurer for the payment of expenses under subparagraph (i) of this paragraph.

(4) (i) In order to assess the business strategy, financial position, legal and regulatory position, risk exposure, risk management, and governance processes of an insurer or its affiliates, and as part of the examination of insurers under § 7–605 of this article, the Commissioner may participate in a supervisory college with other regulators charged with supervising an insurer or its affiliates, including other state, federal, and international regulatory agencies.

(ii) Nothing in this section may be construed to delegate to the supervisory college any of the authority of the Commissioner to regulate the insurer or the activities of its affiliates within the State.

(c) The Commissioner may enter into agreements providing the basis for cooperation between the Commissioner and other state, federal, and international regulatory agencies and the activities of the supervisory college in accordance with § 2–209(h) of this subtitle.

§2–209.2.

(a) (1) In this section the following words have the meanings indicated.

(2) "Group–wide supervisor" means a regulatory official:

(i) authorized to engage in conducting and coordinating group–wide supervision activities for an internationally active insurance group; and

(ii) whom the Commissioner determines or acknowledges under this section to have sufficient significant contacts with an internationally active insurance group.

(3) "Internationally active insurance group" means an insurance holding company system that:

(i) includes, as a member of the insurance holding company system, an insurer registered under § 7–601 of this article; and

(ii) has:

1. premiums written in at least three countries;

2. at least 10% of its total gross written premiums from premiums written outside the United States; and

3. based on a 3–year rolling average, total assets of at least $50,000,000,000 or total gross written premiums of at least $10,000,000,000.

(4) "NAIC" means the National Association of Insurance Commissioners.

(b) (1) Subject to paragraph (2) of this subsection, the Commissioner is authorized to act as the group–wide supervisor for an internationally active insurance group in accordance with the provisions of this section.

(2) The Commissioner may acknowledge another regulatory official as the group–wide supervisor for an internationally active insurance group that:

(i) does not have substantial insurance operations in the United States;

(ii) has substantial insurance operations in the United States, but not in the State; or

(iii) has substantial insurance operations in the United States and in the State, if the Commissioner determines based on the factors specified under subsections (d)(2) and (h) of this section that the other regulatory official is the appropriate group–wide supervisor.

(c) An insurance holding company system that does not otherwise qualify as an internationally active insurance group may request that the Commissioner

make a determination or acknowledgment of a group–wide supervisor under this section for the insurance holding company system.

(d) (1) (i) Subject to subparagraph (ii) of this paragraph, in cooperation with other state, federal, and international regulatory agencies, the Commissioner shall identify a single group–wide supervisor for an internationally active insurance group.

(ii) The Commissioner may:

1. determine that the Commissioner is the appropriate single group–wide supervisor for an internationally active insurance group that conducts substantial insurance operations in the State; or

2. acknowledge that a regulatory official from another jurisdiction is the appropriate single group–wide supervisor for an internationally active insurance group.

(2) The Commissioner shall consider the following factors when making a determination or acknowledgment under paragraph (1)(ii) of this subsection:

(i) the place of domicile of the insurers, as members of the internationally active insurance group, that hold the largest share of the internationally active insurance group's written premiums, assets, or liabilities;

(ii) the place of domicile of the top–tiered insurers, as members of the internationally active insurance group;

(iii) the location of the executive offices or largest operational offices of the internationally active insurance group;

(iv) whether another regulatory official is acting or is seeking to act as the group–wide supervisor under a regulatory system that the Commissioner determines to be:

1. substantially similar to the regulatory system provided under the laws of the State; or

2. otherwise sufficient in providing for group–wide supervision, enterprise risk analysis, and cooperation with other regulatory officials; and

(v) whether another regulatory official acting or seeking to act as the group–wide supervisor provides the Commissioner with reasonably reciprocal recognition and cooperation.

(3) In making a decision to acknowledge another regulatory official as the appropriate single group–wide supervisor of an internationally active insurance group under paragraph (1)(ii)2 of this subsection, the Commissioner shall make the decision:

(i) in cooperation with and subject to the acknowledgment of other regulatory officials involved with supervision of insurers that are members of the internationally active insurance group; and

(ii) in consultation with the internationally active insurance group.

(e) (1) Notwithstanding any other provision of law, when another regulatory official is the group–wide supervisor for an internationally active insurance group, the Commissioner shall acknowledge that regulatory official as the group–wide supervisor of the internationally active insurance group.

(2) The Commissioner shall make a determination or acknowledgment under subsection (d)(1)(ii) of this section as to the appropriate single group–wide supervisor for an internationally active insurance group in the event of a material change in the internationally active insurance group that results in:

(i) the insurers domiciled in the State that are members of the internationally active insurance group holding the largest share of the internationally active insurance group's premiums, assets, or liabilities; or

(ii) the State being the place of domicile of the top–tiered insurer or insurers that are members of the internationally active insurance group.

(f) (1) In accordance with § 7–605 of this article, the Commissioner may collect from an insurer registered under Title 7, Subtitle 6 of this article information necessary for the Commissioner to determine whether the Commissioner may:

(i) act as the group–wide supervisor for an internationally active insurance group; or

(ii) acknowledge that another regulatory official is the appropriate regulatory official to act as the group–wide supervisor for an internationally active insurance group.

(2) (i) Subject to subparagraph (ii) of this paragraph, before issuing a determination that an internationally active insurance group is subject to group–wide supervision by the Commissioner, the Commissioner shall notify the insurer registered under Title 7, Subtitle 6 of this article that is a member of the internationally active insurance group and the ultimate controlling person within the internationally active insurance group.

(ii) An internationally active insurance group shall have at least 30 days to provide the Commissioner with additional information pertinent to the Commissioner's pending determination.

(3) The Commissioner shall publish in the Maryland Register and on the Administration's website the identity of internationally active insurance groups that the Commissioner has determined are subject to group–wide supervision by the Commissioner.

(g) (1) If the Commissioner is the appropriate single group–wide supervisor for an internationally active insurance group, the Commissioner may:

(i) assess the enterprise risks within the internationally active insurance group to ensure that:

1. the material financial condition and liquidity risks to the insurers, as members of the internationally active insurance group, are identified by management; and

2. reasonable and effective mitigation measures are in place;

(ii) request from an insurer, as a member of an internationally active insurance group, information necessary and appropriate to assess enterprise risk, including information about the insurers, as members of the internationally active insurance group, regarding:

1. governance;

2. risk assessment;

3. management;

4. capital adequacy; and

5. material intercompany transactions;

(iii) coordinate and, through the authority of the regulatory officials of the jurisdictions where insurers, as members of the internationally active insurance group, are domiciled, compel development and implementation of reasonable measures designed to ensure that the internationally active insurance group is able to recognize and mitigate enterprise risks to insurers, as members of the internationally active insurance group, in a timely manner;

(iv) communicate with other state, federal, and international regulatory agencies for insurers, as members of the internationally active insurance group, and share relevant information, subject to the confidentiality provisions of § 7–106 of this article, through supervisory colleges under § 2–209.1 of this subtitle;

(v) subject to paragraph (2) of this subsection and to provide the basis for, or clarification of, the Commissioner's role as group–wide supervisor, enter into agreements with or obtain documentation from an insurer registered under Title 7, Subtitle 6 of this article, any member of the internationally active insurance group, or any other state, federal, or international regulatory agencies for members of the internationally active insurance group; and

(vi) oversee other group–wide supervision activities, consistent with the authority and purpose of this section, as the Commissioner considers necessary.

(2) (i) Any agreements entered into or documentation obtained under paragraph (1)(v) of this subsection may not serve as evidence in any proceeding that any insurer or person of an insurance holding company system not domiciled or incorporated in the State is doing business in the State or is otherwise subject to jurisdiction in the State.

(ii) Any agreements entered into under paragraph (1)(v) of this subsection shall include provisions for resolving disputes with other regulatory officials.

(h) If the Commissioner acknowledges that another regulatory official from a jurisdiction that is not accredited by the NAIC is the group–wide supervisor, the Commissioner may reasonably cooperate, through supervisory colleges or otherwise, with group–wide supervision undertaken by the group–wide supervisor, if:

(1) the Commissioner's cooperation is in compliance with the laws of the State;

(2) the regulatory official acknowledged as the group–wide supervisor recognizes and cooperates with the Commissioner's activities as a group–

wide supervisor for other internationally active insurance groups where applicable; and

(3) the recognition and cooperation is reasonably reciprocal.

(i) If a regulatory official from a jurisdiction that is not accredited by the NAIC is the group–wide supervisor but does not recognize or cooperate with the Commissioner's activities as a group–wide supervisor or is not reasonably reciprocal, the Commissioner may refuse recognition and cooperation.

(j) The Commissioner may enter into agreements with or obtain documentation from:

(1) an insurer registered under Title 7, Subtitle 6 of this article;

(2) an affiliate of an insurer registered under Title 7, Subtitle 6 of this article; and

(3) other state, federal, and international regulatory agencies for members of the internationally active insurance group, that provide the basis for, or clarify, a regulatory official's role as group–wide supervisor.

(k) A registered insurer subject to this section shall be liable for, and shall pay, the reasonable expenses of the Commissioner's participation in the administration of this section, including the engagement of attorneys, actuaries, and any other professionals and reasonable travel expenses.

(l) The Commissioner may adopt regulations to carry out this section.

§2–210.

(a) (1) The Commissioner may hold hearings that the Commissioner considers necessary for any purpose under this article.

(2) The Commissioner shall hold a hearing:

(i) if required by any provision of this article; or

(ii) except as otherwise provided in this article, on written demand by a person aggrieved by any act of, threatened act of, or failure to act by the Commissioner or by any report, regulation, or order of the Commissioner, except an order to hold a hearing or an order resulting from a hearing.

(b) (1) A demand for a hearing shall state the grounds for the relief to be demanded at the hearing.

(2) Within 30 consecutive days after receiving a demand for a hearing, the Commissioner shall:

(i) grant and, unless postponed by mutual consent of the parties, hold the hearing; or

(ii) issue an order refusing the hearing.

(3) If the Commissioner does not grant or refuse a hearing within the 30–day period, the hearing is deemed to have been refused.

(c) (1) Except as provided in paragraph (2) of this subsection, a hearing held under this section shall be conducted in accordance with Title 10, Subtitle 2 of the State Government Article (Administrative Procedure Act – Contested Cases).

(2) A hearing held under this section is not subject to § 10–216 of the State Government Article.

(d) The Commissioner may delegate to the Deputy Commissioner, an associate deputy commissioner, an associate commissioner, or one other Administration employee who is designated by the Commissioner and admitted to the practice of law in the State the responsibility for holding a hearing under this section or § 4–114 of this article.

§2–211.

(a) (1) At least 10 days before a hearing, the Commissioner shall give notice of the hearing:

(i) to each person specified in the provision of this article under which the hearing is held; or

(ii) if the provision under which the hearing is held does not specify the persons to be notified, to each person directly affected by the hearing.

(2) If not all persons entitled to notice of the hearing are known, the Commissioner may perfect notice by publication in a newspaper of general circulation in the State at least 10 days before the hearing.

(b) The notice of the hearing shall state:

(1) the time and place of the hearing; and

(2) the matters to be considered at the hearing.

§2–212.

(a) (1) Except as provided in paragraph (2) of this subsection, a demand for a hearing stays an order of the Commissioner pending the hearing and an order resulting from it if the Commissioner receives the demand:

(i) before the effective date of the order; or

(ii) within 10 days after the order is served.

(2) Paragraph (1) of this subsection does not apply to an action taken or proposed under an order:

(i) resulting from a hearing;

(ii) resulting from a final decision of the Insurance Commissioner on a complaint in an emergency case under § 15-10A-04 of this article; or

(iii) based on impairment of assets or unsound financial condition of an insurer.

(b) If the Commissioner does not grant a written request for a stay, the aggrieved person may apply to the Circuit Court for Baltimore City for a stay of the proposed action of the Commissioner.

§2–213.

(a) (1) Except as otherwise provided in this subsection, all hearings shall be open to the public in accordance with § 8–505 of the State Government Article.

(2) A hearing held by the Commissioner that relates to a filing under Title 11 of this article is not required to be open to the public.

(3) A hearing held by the Commissioner to determine whether an insurer is being operated in a hazardous manner that could result in its impairment is not required to be open to the public if:

(i) the insurer requests that the hearing not be a public hearing; and

(ii) the Commissioner determines that it is not in the interest of the public to hold a public hearing.

(4) A hearing held by the Commissioner to evaluate the financial condition of an insurer under the risk based capital standards set out in Title 4, Subtitle 3 of this article is not required to be open to the public.

(5) A hearing shall be considered open to the public if a member of the public may observe the hearing virtually through an electronic media platform.

(b) (1) The Commissioner shall allow any party to a hearing to:

(i) subject to paragraph (3) of this subsection, appear in person;

(ii) be represented:

1. by counsel;

2. in the case of an insurer, by a designee of the insurer who:

A. is employed by the insurer in claims, underwriting, or as otherwise provided by the Commissioner; and

B. has been given the authority by the insurer to resolve all issues involved in the hearing; or

3. by a representative authorized under paragraph (2) of this subsection;

(iii) be present while evidence is given;

(iv) have a reasonable opportunity to inspect all documentary evidence and to examine witnesses; and

(v) present evidence.

(2) (i) In this paragraph, "business entity" means a corporation, partnership, limited liability company, or sole proprietorship.

(ii) Subject to subparagraphs (iii), (iv), (v), and (vi) of this paragraph, a business entity may authorize the following to represent it in a hearing under this section:

1. for a corporation, an officer of the corporation or an employee designated by an officer of the corporation;

2. for a partnership, a partner in the partnership or an employee designated by a partner;

3. for a limited liability company, a member of the limited liability company or an employee designated by a member of the limited liability company; or

4. for a sole proprietorship, an employee designated by the owner of the sole proprietorship.

(iii) The business entity must provide proof to the Commissioner that it meets the definition of a "small employer" under § 31–101 of this article.

(iv) The hearing may not be based on an assignment of the claim of another to the business entity.

(v) In the case of a designated employee, the employee:

1. must provide to the Commissioner a power of attorney sworn to by the employer that certifies that the designated employee is an authorized agent of the business entity and may bind the business entity on matters pending before the Commissioner; and

2. may not be an individual who is disbarred or suspended as a lawyer in any state.

(vi) The business entity may not contract with, hire, or employ another business entity to provide appearance services.

(3) (i) Subject to subparagraph (ii) of this paragraph, the Commissioner may direct that a hearing be held virtually.

(ii) The Commissioner may not require a party to participate virtually in a hearing if the party demonstrates that it is unable to exercise any of the rights under paragraph (1)(ii) through (v) of this subsection by appearing virtually.

(iii) The Commissioner shall make available to the parties to a virtual hearing a space within the office of the Maryland Insurance Administration with access to the equipment necessary to allow the parties to participate in the virtual hearing.

(4) On request of a party, the Commissioner shall issue subpoenas to compel attendance of witnesses or production of evidence on behalf of the party.

(c) The Commissioner shall allow any person that was not an original party to a hearing to become a party by intervention if:

(1) the intervention is timely; and

(2) the financial interests of the person will be directly and immediately affected by an order of the Commissioner resulting from the hearing.

(d) Formal rules of pleading or evidence need not be observed at a hearing.

(e) (1) On timely written request by a party to a hearing, the Commissioner shall have a full stenographic record of the proceedings made by a competent reporter at the expense of that party.

(2) If the stenographic record is transcribed, a copy shall be given on request to any other party to the hearing at the expense of that party.

(3) If the stenographic record is not made or transcribed, the Commissioner shall prepare an adequate record of the evidence and proceedings.

§2–214.

(a) In holding a hearing under this subtitle the Commissioner sits in a quasi-judicial capacity.

(b) (1) Within 30 days after a hearing or any rehearing or reargument of matters involved in the hearing, the Commissioner shall issue an order that covers matters involved in the hearing and in any rehearing or reargument.

(2) The Commissioner shall serve a copy of the order on the same persons that were served notice of the hearing.

(c) The order shall contain:

(1) a concise statement of the facts found by the Commissioner;

(2) the Commissioner's conclusions from the facts; and

(3) the information required by § 2-204(b) of this subtitle.

(d) The order may:

(1) affirm, modify, or nullify an action already taken; or

(2) constitute the taking of new action within the scope of the notice of the hearing.

§2–215.

(a) An appeal under this subtitle may be taken only from:

(1) an order resulting from a hearing;

(2) a refusal by the Commissioner to grant a hearing; or

(3) a decision issued under § 15–10A–04 of this article.

(b) An appeal under this subtitle may be taken by:

(1) a party to the hearing;

(2) an aggrieved person whose financial interests are directly affected by the order resulting from a hearing or refusal to grant a hearing; or

(3) a party to the decision issued under § 15–10A–04 of this article.

(c) (1) Subject to paragraph (2) of this subsection, an appeal under this subtitle shall be taken:

(i) to the Circuit Court for Baltimore City; or

(ii) if a party to an appeal is an individual, to the circuit court of the county where the individual resides.

(2) If the appeal is from the suspension or revocation of a certificate of authority of a domestic insurer or license of an insurance producer, adviser, or public adjuster, an appeal may be taken to the circuit court of the county where:

(i) the domestic insurer has its principal place of business; or

(ii) the licensee or certificate holder resides.

(d) To take an appeal, a person shall file a petition for judicial review with the appropriate circuit court within 30 days after:

(1) the order resulting from the hearing was served on the persons entitled to receive it;

(2) the order of the Commissioner denying rehearing or reargument was served on the persons entitled to receive it;

(3) the refusal of the Commissioner to grant a hearing; or

(4) the decision issued under § 15–10A–04 of this article was served on the persons entitled to receive it.

(e) (1) An appeal under this subtitle shall be captioned in accordance with the Maryland Rules.

(2) On application to the court, any person may be added as a party, as the court directs, if:

(i) the financial interests of the person are or may be directly affected by the matter on appeal; or

(ii) the person may be aggrieved by the matter on appeal.

(f) When a petition for judicial review is filed with the appropriate court, the court has jurisdiction over the case and shall determine whether the filing operates as a stay of the order or action from which the appeal is taken.

(g) (1) In an appeal of an order resulting from a hearing, after receiving a copy of the petition for judicial review and within the time specified in the Maryland Rules, the Commissioner shall file in the court in which the appeal is pending:

(i) a copy of the order of the Commissioner from which the appeal is taken;

(ii) a complete transcript, certified by the Commissioner, of the record on which the order was issued; and

(iii) all exhibits and documentary evidence introduced at the hearing.

(2) In an appeal of a refusal by the Commissioner to grant a hearing, within the time specified in the Maryland Rules, the Commissioner shall file in the court in which the appeal is pending certified copies of all documents on file with the Commissioner that directly relate to the matter on appeal.

(3) In an appeal of a decision issued under § 15–10A–04 of this article, after receiving a copy of the petition for judicial review and within the time specified in the Maryland Rules, the Commissioner shall file in the court in which the appeal is pending:

(i) a copy of the decision of the Commissioner from which the appeal is taken;

(ii) a copy of the report of the independent review organization or medical expert; and

(iii) all documentary evidence provided to the Commissioner and the independent review organization or medical expert that directly relates to the matter on appeal.

(h) The court to which an appeal is taken may:

(1) affirm the decision of the Commissioner;

(2) remand the case for further proceedings; or

(3) reverse or modify the decision of the Commissioner if substantial rights of the petitioners may have been prejudiced because administrative findings, inferences, conclusions, or decisions:

(i) violate constitutional provisions;

(ii) exceed the statutory authority or jurisdiction of the Commissioner;

(iii) are made by unlawful procedure;

(iv) are affected by other error of law;

(v) are unsupported by competent, material, and substantial evidence in view of the entire record, as submitted; or

(vi) are arbitrary or capricious.

(i) Costs of an appeal shall be awarded as in civil actions.

(j) (1) Any party, including the Commissioner, may appeal from the judgment of the circuit court to the Appellate Court of Maryland as in other civil cases.

(2) The judgment of the circuit court may be stayed only by order of court on the giving of any security that the court considers proper.

§2–301.

In this subtitle, "Program" means the Consumer Education and Advocacy Program.

§2–302.

(a) There is a Consumer Education and Advocacy Program.

(b) The Commissioner may use the Consumer Affairs Unit of the Administration to carry out the Program.

§2–303.

The purposes of the Program include:

(1) providing information and helping consumers with the procedures for filing a complaint with the Commissioner against any person regulated by this article;

(2) on request, giving information about an insurer to the extent that the information lawfully is disclosable; and

(3) developing an information and assistance system to provide information about and to help consumers with:

(i) personal insurance coverages, including health insurance and life insurance coverages;

(ii) underwriting practices;

(iii) general rating concepts;

(iv) claim procedures of insurers; and

(v) any other relevant services.

§2–303.1.

(a) The Administration shall serve as the single point of entry for consumers to access any and all information regarding health insurance and the delivery of health care as it relates to health insurance, including information prepared or collected by:

(1) the Maryland Department of Health;

(2) the Maryland Health Care Commission;

(3) the Health Services Cost Review Commission;

(4) the Department of Aging; and

(5) the Health Education and Advocacy Unit of the Attorney General's office.

(b) (1) The Administration, in cooperation with the entities listed in subsection (a) of this section and any other person it deems appropriate, shall promote the availability of the information.

(2) The Maryland Health Care Commission shall assist the Administration in presenting the information in a format that is easily understandable for consumers.

(c) Implementation of this section by the Administration shall be funded through the Health Care Regulatory Fund established under § 2–112.3 of this title.

§2–303.2.

(a) The Administration shall prepare annually a comparison guide of medical professional liability insurance premiums.

(b) The comparison guide shall:

(1) list each insurer authorized to provide medical professional liability insurance in the State;

(2) include, for each specialty and territory, the base premium charged by an insurer for physicians with policy limits of $1,000,000 and $3,000,000; and

(3) include the base premium charged by an insurer for a:

(i) hospital;

(ii) medical day care center;

(iii) hospice care program;

(iv) assisted living program; and

(v) freestanding ambulatory care facility as defined in § 19–3B–01 of the Health – General Article.

(c) The Administration shall publish the comparison guide required under subsection (a) of this section on its Web site and in printed form.

§2–304.

(a) To carry out the Program, the Commissioner may employ a staff in accordance with the State budget.

(b) The Commissioner may designate a member of the staff of the Program to represent the interests of consumers in any Administration proceeding that is open to the public, including:

(1) an informational hearing; and

(2) a hearing or review of insurance rates or forms.

§2–305.

(a) The Commissioner may adopt regulations to carry out the Program.

(b) Each year, the Commissioner shall evaluate the Program.

§2–401.

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

(b) "Fraud Division" means the Insurance Fraud Division in the Administration.

(c) "Insurance fraud" means:

(1) a violation of Title 27, Subtitle 4 of this article;

(2) theft, as set out in §§ 7–101 through 7–104 of the Criminal Law Article:

(i) from a person regulated under this article; or

(ii) by a person regulated under this article or an officer, director, agent, or employee of a person regulated under this article;

(3) a violation of § 9–1106 of the Labor and Employment Article; or

(4) any other fraudulent activity that is committed by or against a person regulated under this article and is a violation of:

(i) Title 1, Subtitle 3 of the Agriculture Article;

(ii) Title 19, Subtitle 2 or Subtitle 3 of the Business Regulation Article;

(iii) Title 14, Subtitle 29, § 11–810, or § 14–1317 of the Commercial Law Article;

(iv) the Criminal Law Article other than Title 8, Subtitle 2, Part II or § 10–614;

(v) Title 12, Subtitle 9 of the Financial Institutions Article;

(vi) § 14–127 of the Real Property Article;

(vii) § 6–301 of the Alcoholic Beverages and Cannabis Article;

(viii) § 109 of the Code of Public Local Laws of Caroline County;

(ix) § 4–103 of the Code of Public Local Laws of Carroll County; or

(x) § 8A–1 of the Code of Public Local Laws of Talbot County.

§2–402.

There is an Insurance Fraud Division in the Administration.

§2–403.

(a) The head of the Fraud Division is an Associate Commissioner of Insurance.

(b) (1) The Associate Commissioner of the Fraud Division shall be appointed by the Commissioner with the approval of the Governor.

(2) The Associate Commissioner is an employee of the Administration.

(3) The Associate Commissioner reports directly to and is under the direct supervision of the Commissioner.

(c) The Associate Commissioner of the Fraud Division is unclassified and is entitled to annual compensation as provided in the State budget.

(d) The Associate Commissioner of the Fraud Division is responsible for the operation of the Fraud Division and the exercise of all authority granted to the Fraud Division under this article.

§2–404.

The Commissioner shall request the Secretary of State Police to assign one or more State Police officers to work in coordination with the Fraud Division.

§2–405.

The Fraud Division:

(1) has the authority to investigate each person suspected of engaging in insurance fraud;

(2) if appropriate after an investigation:

(i) shall refer suspected cases of insurance fraud to the Office of the Attorney General or appropriate local State's Attorney to prosecute the person criminally for insurance fraud;

(ii) shall notify the appropriate professional licensing board or disciplinary body of evidence of insurance fraud that involves professionals;

(iii) shall notify the appropriate professional licensing board of evidence of gross overutilization of health care services;

(iv) shall notify the Workers' Compensation Commission of suspected cases of insurance fraud referred to the Office of the Attorney General or appropriate local State's Attorney under subparagraph (i) of this paragraph that involve the payment of compensation, fees, or expenses under the Workers' Compensation Law; and

(v) shall assist local and State law enforcement agencies in the prosecution of automobile theft;

(3) shall compile and abstract information that includes the number of confirmed acts of insurance fraud and the type of acts of insurance fraud;

(4) in exercising its authority under this subtitle, shall cooperate with the Department of State Police, Office of the Attorney General, local State's Attorney in the jurisdiction in which the alleged acts of insurance fraud took place, and appropriate federal and local law enforcement authorities;

(5) shall operate or provide for a toll–free insurance fraud hot line to receive and record information about alleged acts of insurance fraud;

(6) in cooperation with the Office of the Attorney General and Department of State Police, shall conduct public outreach and awareness programs on the costs of insurance fraud to the public; and

(7) shall investigate allegations of civil fraud and, if appropriate after investigation, impose administrative penalties and order restitution in accordance with § 27–408 of this article.

§2–406.

(a) Notwithstanding any other provision of law, a criminal prosecution for engaging in insurance fraud may be brought in any county in the State in which:

(1) an element of the insurance fraud was committed;

(2) the purported insured loss occurred;

(3) the insurance policy in question provides coverage;

(4) the insurer or an agent of the insurer received a false or misleading statement or document;

(5) the defendant or respondent resides; or

(6) money or other benefit was received as a result of the insurance fraud.

(b) For a civil fraud violation, the Commissioner may impose administrative penalties and order restitution under § 27–408(c) of this article when one or more of the occurrences listed in subsection (a) of this section takes place in the State.

(c) If insurance fraud is determined to have occurred in any of the locations listed in subsection (a) of this section, a criminal or civil fraud action for all related violations may be joined in the same action.

§2–408.

The Office of the Attorney General shall report to the Fraud Division on each case not prosecuted and the reasons why the case was not prosecuted.

§2–501.

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

(b) "Assessment" means an assessment that, subject to § 2-505(c)(3) of this subtitle, equals 60% of the Administration's approved annual budget appropriation under this article.

(c) "Fund" means the Insurance Regulation Fund established under § 2-505 of this subtitle.

(d) (1) "Health insurer" means an insurer that holds a certificate of authority issued by the Commissioner to engage in the business of health insurance.

(2) "Health insurer" includes:

(i) a health maintenance organization operating under a certificate of authority issued by the Commissioner under Title 19, Subtitle 7 of the Health - General Article;

(ii) a nonprofit health service plan operating under Title 14, Subtitle 1 of this article; and

(iii) a dental plan operating under Title 14, Subtitle 4 of this article.

(e) "Health insurer assessment portion" means 40% of the assessment.

(f) (1) "Insurer" means an insurer or other entity authorized to engage in the insurance business in the State under a certificate of authority issued by the Commissioner.

(2) "Insurer" includes:

(i) a health maintenance organization operating under a certificate of authority issued by the Commissioner under Title 19, Subtitle 7 of the Health - General Article;

(ii) a nonprofit health service plan operating under Title 14, Subtitle 1 of this article;

(iii) a dental plan operating under Title 14, Subtitle 4 of this article; and

(iv) the Maryland Automobile Insurance Fund.

(g) "Life insurer" means an insurer that holds a certificate of authority issued by the Commissioner to engage in the business of life insurance.

(h) "Life insurer assessment portion" means 26% of the assessment.

(i) "Multiple type insurer" means an insurer that engages in more than one of the following types of insurance:

(1) life;

(2) health; or

(3) property and casualty.

(j) (1) "Premium" has the meaning stated in § 1-101 of this article to the extent it is allocable to this State.

(2) "Premium" includes any amounts paid to a health maintenance organization as compensation on a predetermined basis for providing services to

members and subscribers as specified in Title 19, Subtitle 7 of the Health - General Article to the extent it is allocable to this State.

(k) (1) "Property and casualty insurer" means an insurer that holds a certificate of authority issued by the Commissioner to engage in the business of property and casualty insurance.

(2) "Property and casualty insurer" includes the Maryland Automobile Insurance Fund.

(l) "Property and casualty insurer assessment portion" means 34% of the assessment.

§2–502.

(a) The Commissioner shall collect an annual assessment fee from each insurer as provided in subsection (b) of this section.

(b) The assessment fee shall be calculated as follows:

(1) for each health insurer, the assessment fee is the product of the fraction obtained by dividing the gross direct premium written by the health insurer in the prior calendar year by the total amount of gross direct premium written by all health insurers in the prior calendar year, multiplied by the health insurer assessment portion;

(2) for each life insurer, the assessment fee is the product of the fraction obtained by dividing the gross direct premium written by the life insurer in the prior calendar year by the total amount of gross direct premium written by all life insurers in the prior calendar year, multiplied by the life insurer assessment portion;

(3) for each property and casualty insurer, the assessment fee is the product of the fraction obtained by dividing the gross direct premium written by the property and casualty insurer in the prior calendar year by the total amount of gross direct premiums written by all property and casualty insurers in the prior calendar year, multiplied by the property and casualty insurer assessment portion; and

(4) for each domestic reinsurer subject to § 4–115(b)(2)(ii) and (c)(3) of this article, the assessment fee is the average of the assessment fee paid by the 100 property and casualty insurers with the highest gross direct written premium in the prior calendar year.

(c) For the purpose of calculating the assessment fee in subsection (b) of this section, a multiple type insurer shall be considered either a health insurer, a life

insurer, or a property and casualty insurer based on the majority of premium type written.

(d) Notwithstanding any other provision of this subtitle, the minimum assessment shall be $300 for each authorized insurer.

§2–503.

(a) The Commissioner shall collect the annual assessment fee from each insurer as calculated in § 2-502 of this subtitle.

(b) The assessment fee collected under this section is:

(1) in addition to any penalties or premium tax imposed under this article; and

(2) due and payable to the Commissioner on or before a date determined by the Commissioner each year.

(c) (1) Failure by an insurer to pay the assessment fee on or before the due date shall subject the insurer to the provisions of §§ 4-113 and 4-114 of this article.

(2) In addition to paragraph (1) of this subsection, an assessment fee not paid on or before the due date may be subject to a penalty of 5% and interest at the rate determined under § 13-701(b)(1) of the Tax - General Article from the due date until payment is made to the Commissioner.

(3) If an additional amount is found to be due after the assessment fee has been paid to the Commissioner, the additional amount is subject to interest at 6% from the due date until payment is made to the Commissioner.

(d) The total amount of the assessment fee collected by the Commissioner shall be deposited in the Fund.

(e) This section does not affect any requirement otherwise established by law for the payment of premium taxes by an insurer.

§2–504.

(a) The assessment fee imposed on insurers under this subtitle is in lieu of any life insurance valuation fees and a reduction in specified insurance producer fees that the Commissioner had previously charged and collected under § 2-112 of this title.

(b) In determining adjusted premiums subject to the assessment fee, the Commissioner may use the premiums as stated in the report required under § 2-506(a) of this subtitle.

§2–505.

(a) There is an Insurance Regulation Fund that consists of:

(1) all revenue received through the imposition and collection of the assessment fee under this subtitle;

(2) all revenue received through the imposition and collection of the fees set forth in § 2–112 of this title;

(3) all revenue received through the imposition and collection of the fraud prevention fee under Title 6, Subtitle 2 of this article;

(4) all revenue received through the collection of examination expenses under § 2–208 of this title;

(5) except as provided in § 2–114(a) of this title, all other fees received through the imposition and collection of fees set forth in this article; and

(6) income from investments that the State Treasurer makes for the Fund.

(b) The purpose of the Fund is to pay all the costs and expenses incurred by the Administration that are related to its responsibilities to regulate the insurance activities of all insurers that engage in the insurance business in this State.

(c) (1) All the costs and expenses of the Administration shall be included in the State budget.

(2) Any expenditures from the Fund to cover costs and expenses of the Administration may only be made:

(i) with an appropriation from the Fund approved by the General Assembly in the annual State budget; or

(ii) by the budget amendment procedure provided for in § 7–209 of the State Finance and Procurement Article.

(3) (i) 1. Subject to subsubparagraph 2 of this subparagraph, if, in any fiscal year, the amount of revenue collected by the Commissioner and deposited into the Fund exceeds 105% of the actual appropriations for the Administration, the excess amount shall be carried forward within the Fund.

2. The assessment fee imposed under this subtitle shall be adjusted to maintain the Fund at a level that does not exceed 105% of the Administration's approved annual budget.

(ii) If, in any given fiscal year, the amount of revenue collected by the Commissioner and deposited into the Fund is insufficient to cover the expenditures of the Administration because of an unforeseen emergency and expenditures are made in accordance with the budget amendment procedure provided for in § 7–209 of the State Finance and Procurement Article, an additional assessment for the expenditures may be made.

(d) (1) The State Treasurer is the custodian of the Fund.

(2) The State Treasurer shall deposit payments received from the Commissioner into the Fund.

(e) (1) The Fund is a continuing, nonlapsing fund and is not subject to § 7–302 of the State Finance and Procurement Article, and may not be deemed a part of the General Fund of the State.

(2) No part of the Fund may revert or be credited to:

(i) the General Fund of the State; or

(ii) a special fund of the State, unless otherwise provided by law.

§2–506.

(a) (1) On or before March 1 of each year, each insurer subject to this subtitle shall file with the Commissioner a report of the new and renewal gross direct premiums.

(2) The report shall be filed in a manner and contain the information required by the Commissioner.

(b) If an insurer files its annual statement on or before March 1, and the information required under subsection (a) of this section is included in that annual

statement, the insurer is not required to file a report under subsection (a) of this section.

§2–507.

The Commissioner may adopt regulations necessary to implement any provision of this subtitle.

§3–101.

This subtitle applies to each stock insurer and each mutual insurer that engages in or proposes to engage in the insurance business in the State.

§3–102.

(a) Except as otherwise specifically provided in this article, each domestic insurer shall comply with the applicable provisions of the Corporations and Associations Article that relate to formation, powers vested in, and duties of corporations formed under the general provisions of the Corporations and Associations Article.

(b) Unless a class of corporations to which this subtitle applies is specifically included in a statute passed after December 31, 1963, a domestic insurer is only subject to regulation under this article.

§3–103.

(a) A domestic insurer may be formed for insurance purposes under Title 2 of the Corporations and Associations Article.

(b) A domestic insurer may be formed either as a mutual insurer or stock insurer, as stated in its articles of incorporation.

(c) (1) Each policyholder of a domestic mutual insurer, other than a holder of a reinsurance contract, is a member of the mutual insurer, with each right and obligation of membership.

(2) Each policy shall state the provisions of paragraph (1) of this subsection.

(3) Any person, government, governmental unit, state, or political subdivision may be a member of a domestic, foreign, or alien mutual insurer.

(4) An officer, stockholder, trustee, or legal representative of a member:

(i) may be recognized as acting in a representative capacity for or on behalf of the member for the purpose of the membership; and

(ii) is not personally liable on the insurance contract for acting in that representative capacity.

(5) A Maryland corporation may participate as a member of a mutual insurer incidentally to the purpose for which the corporation is organized.

(d) (1) Each member of a domestic mutual insurer is entitled to one vote, or to the number of votes the bylaws provide, based on:

(i) the insurance in force;

(ii) the number of policies held; or

(iii) the amount of premium paid.

(2) Only the policyholder under a group policy is a member of the mutual insurer and is entitled to vote at the meetings of the mutual insurer.

(e) (1) Except as provided in paragraph (2) of this subsection, the board of directors of a domestic insurer shall have at least nine members.

(2) The board of directors of a domestic financial guaranty insurance company that is prohibited from issuing new policies of financial guaranty insurance shall have at least five members.

§3–104.

(a) The articles of incorporation of each domestic insurer and any amendment to its charter must be submitted to the Commissioner for examination and approval before they may be accepted for record by the Department of Assessments and Taxation.

(b) Articles of incorporation and articles of amendment are not effective unless the Commissioner, by written endorsement on them, has approved the articles as being in accordance with the insurance laws of the State.

§3–105.

(a) A person proposing to form a mutual insurer may not solicit in the State applications or premiums for policies of the proposed mutual insurer until the person provides the Commissioner with specific information about the methods and proposed cost of the promotion.

(b) (1) Before a person proposing to form a mutual insurer solicits applications or premiums for policies, the person shall have funds acquired in accordance with § 3-116 of this subtitle in the amount of:

(i) $125,000, if the person will solicit applications or premiums for one kind of insurance business, as set out in § 4-104 of this article; or

(ii) $250,000, if the person will solicit applications or premiums for two or more kinds of insurance business.

(2) The funds shall be held in cash or in investments authorized for capital and reserve under Title 5, Subtitle 6 of this article.

(c) (1) A person must obtain a license from the Commissioner before the person forms a mutual insurer in the State.

(2) Before issuing a license, the Commissioner shall investigate the record of the applicant.

(3) The Commissioner shall issue a license under this subsection if the Commissioner finds that the applicant is honest and trustworthy.

§3–106.

To qualify for a certificate of authority to engage in the insurance business, a mutual insurer must:

(1) meet the requirements of § 3-105 of this subtitle; and

(2) have received applications and collected cash premiums in an amount that, when added to any other legally available funds, results in unencumbered assets greater than all required reserves and other liabilities at least equal to the amount required by:

(i) Sections 4-104 and 4-105 of this article, if the mutual insurer will be authorized to engage in insurance business on a nonassessable basis; or

(ii) Section 3-107 of this subtitle, if the mutual insurer will be authorized to engage in insurance business on an assessable basis.

§3–107.

(a) A mutual insurer that proposes to or writes assessable policies must comply with all applicable requirements of this article except that the financial requirements of this section apply instead of the requirements of §§ 4-104, 4-105, and 4-106 and Title 5, Subtitle 10 of this article.

(b) (1) The mutual insurer must have applications for insurance on which it shall issue simultaneously, or it must have in force, at least 20 policies to at least 20 members for the same kind of insurance, on at least 200 separate risks, each within the maximum single risk described in subsection (c) of this section.

(2) To transact workers' compensation insurance or employer's liability insurance, the application shall cover at least 2,000 employees, with each employee considered a separate risk when determining the maximum single risk.

(c) (1) The maximum single risk may not exceed the greatest of:

(i) 20% of the admitted assets;

(ii) 3 times the average risk; and

(iii) 1% of the insurance in force.

(2) When determining the maximum single risk, any authorized reinsurance that takes effect simultaneously with the policy shall be deducted from the maximum single risk.

(d) (1) On each insurance application required by subsection (b) of this section, the mutual insurer must have collected:

(i) an annual cash premium; or

(ii) a full premium for the term of the policy, if the policy is for less than 1 year.

(2) The total of the premiums shall be held in cash or in investments authorized for capital and reserve under Title 5, Subtitle 6 of this article.

(e) (1) To qualify for authority to engage in one kind of insurance business allowed to be written on an assessable basis under this article, a mutual insurer must have total assets that:

(i) equal at least $250,000; and

(ii) exceed the amount required for reserves and all other liabilities by at least $125,000.

(2) For purposes of paragraph (1) of this subsection, assets include borrowed surplus under § 3-116 of this subtitle, but exclude borrowed money or other borrowed assets.

(f) To qualify for authority to engage in two or more kinds of insurance business allowed to be written on an assessable basis under this article, a mutual insurer must have assets that:

(1) equal at least $500,000; and

(2) exceed the amount required for reserves and all other liabilities by at least $250,000.

(g) (1) This subsection applies only to a domestic mutual insurer that:

(i) is licensed only for property insurance and casualty insurance, other than motor vehicle physical damage insurance, motor vehicle liability insurance, or workers' compensation insurance; and

(ii) writes assessable policies.

(2) Notwithstanding any other provision of this section, a domestic mutual insurer described by paragraph (1) of this subsection need not have assets or surplus exceeding the amount that the mutual insurer would be required to have if it wrote only one kind of insurance, if the mutual insurer:

(i) restricts its operations to the county where its principal office is located and to the counties of the State that are immediately adjacent to that county;

(ii) is not licensed to engage in the insurance business in another state;

(iii) has been in existence for at least 20 years before July 1, 1968; and

(iv) maintains an automatic reinsurance treaty, filed with and approved by the Commissioner, that reinsures liability coverages issued by the mutual insurer in excess of a net amount of retention that is satisfactory to the Commissioner.

§3–108.

After being authorized to engage in one kind of insurance business, a mutual insurer may be authorized by the Commissioner to engage in additional kinds of insurance business as allowed by § 4-111 of this article if the mutual insurer otherwise complies with this article.

§3–109.

(a) If the minimum surplus of a stock insurer required to be maintained by § 4-105 of this article becomes impaired, or if the assets of a mutual insurer are less than its liabilities and the minimum amount of surplus required to be maintained by §§ 3-106 and 3-107 of this subtitle for authority to engage in the kinds of insurance business being transacted, the Commissioner immediately shall:

(1) determine the amount of deficiency; and

(2) serve notice on the insurer to cure the deficiency within 60 days after service of the notice.

(b) An insurer may cure the deficiency:

(1) in cash or in assets eligible for the investment of the insurer's funds under Title 5, Subtitle 5 or Subtitle 6 of this article;

(2) if a stock insurer, by reducing its capital to an amount not below the minimum required for the kinds of insurance that the stock insurer will transact; or

(3) if a mutual insurer, by amending its certificate of authority to cover only the kinds of insurance for which the mutual insurer has sufficient surplus under this article.

(c) (1) Except as provided in paragraph (2) of this subsection, if an insurer does not cure the deficiency and file proof that it has done so with the Commissioner within the 60-day period:

(i) the insurer is considered insolvent; and

(ii) the Commissioner shall institute delinquency proceedings against the insurer under Title 9, Subtitle 2 of this article.

(2) If the deficiency exists because the Commissioner required increased loss reserves, disallowed certain assets, or reduced the value at which certain assets are carried in the insurer's accounts, the Commissioner, on application and good cause shown, may extend for not more than an additional 60 days the period within which the insurer may cure the deficiency and file proof that it has done so.

(d) The directors of an insurer are individually liable for losses incurred under policies that are issued by the insurer:

(1) after expiration of the period provided for curing a deficiency of the insurer's capital stock or surplus; and

(2) before the deficiency is cured.

§3–110.

(a) (1) Except as provided in § 3-113 of this subtitle for nonassessable policies, each member of a domestic mutual insurer other than a life insurer is contingently liable on a pro rata basis for the discharge of the liabilities of the domestic mutual insurer.

(2) The contingent liability provided for by this subsection shall be expressly stated in each policy.

(b) Termination of the policy of a member does not relieve the member of the contingent liability for the member's proportion, if any, of the obligations of the domestic mutual insurer that accrued while the policy was in force.

(c) The unrealized contingent liability of a member is not an asset of the domestic mutual insurer in determining its financial condition.

§3–111.

(a) The directors of a domestic mutual insurer shall assess its members who, at any time during the 36 months before the notice of assessment is mailed to them under § 3-112(b) of this subtitle, held policies providing for contingent liability, if:

(1) the assets of the domestic mutual insurer at any time are less than its liabilities plus the minimum surplus required to be maintained to transact the kind of insurance being transacted by the domestic mutual insurer; and

(2) the deficiency is not being cured from other sources.

(b) Members assessed under this section are liable to the domestic mutual insurer for the amount assessed.

(c) (1) The total of assessments shall be sufficient to:

(i) cure the deficiency; and

(ii) provide reasonable working funds above the minimum surplus, not exceeding 5% of the domestic mutual insurer's liabilities on the date that the deficiency was determined.

(2) A member's assessment may not exceed the lesser of:

(i) one policy premium; or

(ii) the premium for a full year.

(d) The assessment on a policy with contingent liability shall be computed based on the premiums earned on the policy during the period to which the assessment relates.

(e) A member may not have an offset against an assessment for which the member is liable because of a claim for an unearned premium or loss payable.

§3–112.

(a) The determination by the domestic mutual insurer of the total assessment under § 3-111 of this subtitle and the amount of each member's assessment is considered prima facie correct.

(b) (1) The domestic mutual insurer shall mail to each member, at the member's last address of record with the domestic mutual insurer, notice of:

(i) the amount of the assessment to be paid; and

(ii) the period within which the assessment must be paid.

(2) The period within which the assessment must be paid may not be less than 20 days after notice.

(c) (1) If a member fails to pay the assessment within the period specified in the notice, the domestic mutual insurer may bring suit to collect the assessment.

(2) Failure of the member to receive the notice mailed in accordance with subsection (b) of this section is not a defense in an action to collect the assessment.

§3–113.

(a) If a domestic mutual insurer has surplus funds at least equal to the paid-in capital stock and surplus required of a domestic stock insurer that transacts like kinds of insurance business, the domestic mutual insurer, on receipt of an order of the Commissioner authorizing it to do so, may extinguish the contingent liability of its members as to all its policies in force and may issue nonassessable policies.

(b) Subject to the requirements of this article for issuing nonassessable policies, a foreign or alien mutual insurer may issue nonassessable policies to its members in the State under its articles of incorporation and the laws of its domicile.

(c) A mutual insurer may not issue assessable policies in the State if the mutual insurer issues nonassessable policies in the State or another jurisdiction.

(d) A policy of a domestic mutual insurer that, under an order of the Commissioner, is without contingent liability and therefore is nonassessable by its terms is not subject to assessment for a debt or liability of the domestic mutual insurer.

(e) The Commissioner shall revoke the authority of a mutual insurer to issue nonassessable policies if:

(1) the assets of the mutual insurer at any time are less than the sum of its liabilities and the surplus required for that authority; or

(2) the mutual insurer, by resolution of its board of directors approved by a majority of its members, requests that the authority be revoked.

(f) After revocation of a mutual insurer's authority to issue nonassessable policies, the mutual insurer may not:

(1) issue a nonassessable policy; or

(2) renew a policy that is renewable at the option of the mutual insurer without endorsing the policy to provide for the contingent liability of the policyholder.

§3–114.

(a) A domestic stock insurer or domestic mutual insurer may:

(1) issue any or all of its policies with or without participation in profits, savings, or unabsorbed parts of premiums;

(2) classify policies issued on a participating and nonparticipating basis; and

(3) determine the right to participate and the extent of participation of any class of policies.

(b) The classification of policies or determination of participation under subsection (a) of this section shall be reasonable and may not discriminate unfairly between policyholders within the same classifications.

(c) A life insurer may issue both participating and nonparticipating policies only if the right or absence of the right to participate is reasonably related to the premium charged.

§3–115.

(a) The directors of a domestic mutual insurer periodically may apportion and pay or credit to its members dividends only out of that part of surplus funds that represents net realized savings and net realized earnings in excess of the surplus required by law to be maintained.

(b) A dividend that is otherwise proper may be payable out of the domestic mutual insurer's net realized savings and net realized earnings even though the domestic mutual insurer's total surplus is then less than its total contributed surplus.

§3–116.

(a) (1) A director, officer, or member of a stock insurer or mutual insurer or any other person may lend or advance to the stock insurer or mutual insurer any money necessary to enable it to comply with a surplus requirement or any other requirement of law.

(2) The instrument evidencing a loan or advance under this subsection shall:

(i) be approved as to form and content by the Commissioner; and

(ii) contain provisions that specify that:

1. the instrument is subordinate to policyholders, claimant and beneficiary claims, and all other classes of creditors other than surplus note holders; and

2. interest payments and principal repayments may not be made without prior approval of the Commissioner.

(3) A loan or advance under this subsection and any interest on it:

(i) is payable only out of the surplus remaining after the stock insurer or mutual insurer provides for all reserves and other liabilities; and

(ii) is not otherwise a liability or claim against the stock insurer or mutual insurer or any of its assets.

(b) (1) Proceeds of a loan or advance under this section shall be in the form of cash or other admitted assets having readily determinable values and liquidity satisfactory to the Commissioner.

(2) In each annual statement, a stock insurer or mutual insurer shall report the amount of each loan or advance made under this section.

§3–117.

(a) (1) Except as provided in subsection (d) of this section, an authorized insurer or its subsidiary may not make, directly or indirectly, a loan to a director or executive officer of the authorized insurer unless the loan:

(i) is a bona fide mortgage loan made on a principal residence of the director or executive officer; and

(ii) is approved or ratified by the board of directors of the authorized insurer.

(2) A director or executive officer may not accept, directly or indirectly, a loan prohibited by paragraph (1) of this subsection.

(b) An authorized insurer may not make an advance to a director or executive officer of the authorized insurer for future services to be performed more than 1 year after the date of making the advance.

(c) (1) An authorized insurer or its affiliate or subsidiary may not guarantee, directly or indirectly, the financial obligation of a director or executive officer of the authorized insurer, affiliate, or subsidiary.

(2) A guarantee made in violation of this subsection is void.

(3) This subsection does not prohibit an insurer from making or entering into an insurance contract or surety bond that is authorized by its articles of incorporation for a director or executive officer.

(d) This section does not prohibit a life insurer from making a policy loan to a director or executive officer of the life insurer on a policy or contract of the life insurer in an amount not exceeding the loan value of the policy or contract.

§3–118.

A domestic stock insurer or domestic mutual insurer may not enter into an agreement in which a person agrees to pay all or part of the expenses of management of the domestic stock insurer or domestic mutual insurer in consideration of an agreement to pay to the person commissions on premiums due the domestic stock insurer or domestic mutual insurer or any other compensation for the person's services.

§3–119.

(a) In this section, "equity security" means:

(1) stock or a similar security;

(2) a security convertible, with or without consideration, into stock or a similar security;

(3) a security carrying a warrant or right to subscribe to or purchase stock or a similar security;

(4) any other warrant or right to subscribe to or purchase stock or a similar security; or

(5) any other security that the Commissioner considers to be of a similar nature and necessary or appropriate to treat as an equity security, based on regulations adopted by the Commissioner in the public interest or to protect investors.

(b) (1) Subsections (d), (e), and (f) of this section do not apply to foreign or domestic arbitrage transactions unless those transactions are made in contravention of regulations adopted by the Commissioner to carry out this section.

(2) Subsections (d), (e), and (f) of this section do not apply to equity securities of a domestic stock insurer if:

(i) the securities are registered or required to be registered under § 12 of the Securities Exchange Act of 1934; or

(ii) the domestic stock insurer did not have any class of its equity securities held of record by 100 or more persons on the last business day of the year immediately preceding the year in which equity securities of the insurer otherwise would be subject to subsections (d), (e), and (f) of this section.

(c) (1) The Commissioner:

(i) may adopt regulations necessary to carry out this section; and

(ii) for the purpose of adopting regulations, may classify domestic stock insurers, securities, and other persons or matters within the Commissioner's jurisdiction.

(2) The provisions of subsections (d), (e), and (f) of this section that impose liability may not be applied to an act committed or omitted in good faith in conformity with a regulation of the Commissioner, notwithstanding that the regulation is later amended, rescinded, or determined by judicial or other authority to be invalid for any reason.

(d) (1) A person shall file with the Commissioner, in the form the Commissioner requires, a statement of the amount of all equity securities of a domestic stock insurer of which the person is the beneficial owner within 10 days after the person becomes:

(i) directly or indirectly the beneficial owner of more than 10% of any class of equity security of the domestic stock insurer; or

(ii) a director or officer of the domestic stock insurer.

(2) Within 10 days after the end of each calendar month in which there has been a change in ownership of securities that are subject to reporting under paragraph (1) of this subsection, the person whose ownership has changed shall file with the Commissioner, in the form the Commissioner requires, a statement indicating the person's ownership at the end of the calendar month and the changes in ownership that have occurred during that calendar month.

(e) (1) The purpose of this subsection is to prevent the unfair use of information that may have been obtained by a beneficial owner, director, or officer of a domestic stock insurer because of that person's relationship to the domestic stock insurer.

(2) (i) Except as provided in subparagraph (ii) of this paragraph, any profit realized by a beneficial owner, director, or officer of a domestic stock insurer from a purchase and sale, or a sale and purchase, of an equity security of the domestic stock insurer within a period of less than 6 months inures to and is recoverable by the domestic stock insurer, regardless of the intention of the beneficial owner, director, or officer in entering into the transaction of holding the equity security purchased or of not repurchasing the security sold for more than 6 months.

(ii) An equity security acquired in good faith in connection with a debt contracted prior to the 6-month period is not subject to subparagraph (i) of this paragraph.

(3) (i) A suit to recover any profit obtained in violation of this subsection may be brought in a court of competent jurisdiction by:

1. the domestic stock insurer; or

2. the owner of any security of the domestic stock insurer in the name and on behalf of the domestic stock insurer, if the domestic stock insurer fails or refuses to bring the suit within 60 days after a request to do so or fails to prosecute the suit diligently.

(ii) A suit under this subsection may not be brought more than 2 years after the date the profit was realized.

(4) This subsection may not be construed to apply to:

(i) a transaction in which the beneficial owner was not a beneficial owner both at the time of the purchase and sale, or the sale and purchase, of the security involved; or

(ii) a transaction that the Commissioner exempts by regulation as not within the purpose of this subsection.

(f) (1) A beneficial owner, director, or officer of a domestic stock insurer may not sell, directly or indirectly, an equity security of the domestic stock insurer if the person selling the equity security or the person's principal does not own the equity security sold.

(2) A beneficial owner, director, or officer of a domestic stock insurer may not sell, directly or indirectly, an equity security of the domestic stock insurer owned by the person selling the security or the person's principal if the person or the person's principal:

(i) does not deliver the equity security against the sale within 20 days after the sale; or

(ii) within 5 days after the sale does not deposit the equity security in the mail or other usual channels of transportation.

(3) A person is not considered to have violated this subsection if the person proves that, notwithstanding the exercise of good faith, the person was unable to make the delivery or deposit within the time allowed or proves that to do so would cause undue inconvenience or expense.

(g) (1) The following provisions do not apply to a dealer acting in the ordinary course of the dealer's business and incident to the establishment or maintenance by that dealer of a primary or secondary market, other than on an exchange as defined in the Securities Exchange Act of 1934, for an equity security, except for equity securities held by the dealer in an investment account:

(i) subsection (e) of this section, for any purchase and sale, or sale and purchase, of an equity security of a domestic stock insurer; and

(ii) subsection (f) of this section, for any sale of an equity security of a domestic stock insurer.

(2) By regulation as the Commissioner considers necessary or appropriate in the public interest, the Commissioner may define and require terms and conditions for:

(i) securities held in an investment account; and

(ii) transactions made in the ordinary course of business and incident to the establishment or maintenance of a primary or secondary market.

§3–120.

(a) This section does not apply to mutualization under a court order in connection with the rehabilitation or reorganization of an insurer under Title 9, Subtitle 2 of this article.

(b) A domestic stock insurer, other than a title insurer, may become a mutual insurer under a plan and procedure that is approved by the Commissioner after a hearing.

(c) The Commissioner may not approve a plan or procedure for mutualization unless:

(1) the plan or procedure is equitable to stockholders and policyholders;

(2) the plan is subject to approval by vote of the holders of at least three-fourths of the insurer's outstanding capital stock with voting rights and by vote of at least two-thirds of the insurer's policyholders who vote on the plan in person, by proxy, or by mail under the notice and procedure approved by the Commissioner;

(3) for a life insurer, the right to vote under item (2) of this subsection is limited to holders of policies, other than term or group policies, that have been in force for more than 1 year;

(4) mutualization will result in retirement of shares of the insurer's capital stock at a price not exceeding the fair market value of the stock as determined by competent disinterested appraisers;

(5) the plan provides for the purchase of the stock of an objecting stockholder in the same manner and subject to the same applicable conditions provided by Title 3, Subtitle 2 of the Corporations and Associations Article for the rights of objecting stockholders with respect to consolidation or merger of corporations;

(6) the plan provides for definite conditions to be fulfilled by a designated early date on which the mutualization will be considered effective; and

(7) the mutualization leaves the insurer with surplus funds that are reasonably adequate for the security of its policyholders and to enable the insurer to continue successfully in business in the states where it is then authorized to transact insurance business for the kinds of insurance included in its certificates of authority in those states.

§3–121.

(a) A domestic mutual insurer may become a stock insurer under a plan and procedure that is approved by the Commissioner.

(b) The Commissioner may not approve a plan or procedure for conversion of a mutual insurer to a stock insurer unless:

(1) the plan or procedure is equitable to the insurer's members;

(2) the plan is subject to approval by vote of at least three-fourths of the insurer's current members who vote on the plan in person, by proxy, or by mail at a meeting of members called for that purpose under reasonable notice and procedure approved by the Commissioner;

(3) for a life insurer, the right to vote may be limited to members who hold policies, other than term or group policies, that have been in force for at least 1 year;

(4) the plan provides as to any holder of a surplus note participating in the conversion that:

(i) the rights of the holder shall be governed by the terms of the surplus note; or

(ii) if the terms of the surplus note are silent regarding a conversion and the holder is not also a member, the holder may not vote on the planned conversion;

(5) the equity of each policyholder in the insurer:

(i) is determinable under a fair formula approved by the Commissioner; and

(ii) is based on not less than the insurer's entire surplus, minus contributed or borrowed surplus funds, plus a reasonable present equity in reserves and in all nonadmitted assets;

(6) all current policyholders and all persons that were policyholders of the insurer within 3 years before the date the plan was submitted to the Commissioner are entitled to participate in the purchase of stock or distribution of assets;

(7) the plan gives to each policyholder specified in item (6) of this subsection a preemptive right:

(i) within a designated reasonable period, to acquire the policyholder's proportionate part of all of the proposed capital stock of the insurer; and

(ii) to apply on the purchase of proposed capital stock the amount of the policyholder's equity in the insurer as determined under item (5) of this subsection;

(8) stock is offered to policyholders at a price that is not greater than the price at which the stock will be offered to others in the initial offering, but that is not more than double the par value of the stock;

(9) the plan provides for payment to each policyholder who elects not to apply the policyholder's equity in the insurer for or on the purchase price of stock to which the policyholder is preemptively entitled, in cash in an amount that equals not less than 50% of the amount of the policyholder's equity that was not used for the purchase of stock, and which payment, together with any stock purchased, constitutes full payment and discharge of the policyholder's equity as an owner of the insurer; and

(10) the completed plan provides that the converted insurer will have:

(i) paid-in capital stock equal to not less than the minimum paid-in capital required of a domestic stock insurer that transacts like kinds of insurance business; and

(ii) surplus funds equal to not less than 100% of the required capital.

(c) Within 60 days of the filing of a plan that contains all of the information required under this section and any regulations adopted under this section, the Commissioner shall approve or disapprove the plan.

(d) At the expense of the mutual insurer, the Commissioner may retain any qualified expert who is not a part of the staff of the Commissioner to assist in reviewing the plan.

(e) After written notice to the mutual insurer and any other interested person, the Commissioner may hold a hearing on whether the terms of the plan comply with this section.

(f) (1) If a mutual insurer is insolvent or, in the judgment of the Commissioner, is in a hazardous financial condition, the board of directors of the mutual insurer, by a majority vote, may request by a petition, as provided under paragraph (2) of this subsection, that the Commissioner waive the requirements concerning notice to, and approval by, policyholders of the planned conversion.

(2) The petition by the board of directors shall specify:

(i) the method and basis for issuance of the shares of capital stock of the converted stock insurer to an independent party in connection with an investment by the independent party in an amount sufficient to restore the converted stock insurer to sound financial condition; and

(ii) if the Commissioner finds that the value of the mutual insurer is insufficient to warrant financial consideration, that the conversion shall be accomplished without financial consideration to past, present, or future policyholders.

(3) (i) By written order, the Commissioner may waive the requirements of subsection (b)(2) of this section if the Commissioner finds that the mutual insurer no longer meets statutory requirements with respect to capital, surplus, deposits, or assets.

(ii) Any finding that results in a waiver under this paragraph shall be made after:

1. review of the plan; and

2. A. an audit of the mutual insurer's quarterly or annual financial statement; or

B. a financial examination of the mutual insurer.

(g) The Commissioner may adopt regulations to enforce the provisions of this section.

§3–121.1.

(a) (1) In this section the following words have the meanings indicated.

(2) "Mutual insurance holding company" means a nonstock corporation that:

(i) is incorporated in the State in accordance with a plan of reorganization adopted and approved under this section; and

(ii) is the parent of a reorganized stock insurer.

(3) "Reorganized stock insurer" means the stock corporation into which a mutual insurer is reorganized in accordance with a plan of reorganization adopted and approved under this section.

(b) Subject to the provisions of this section and in accordance with a plan of reorganization approved by the Commissioner, a mutual insurer may:

(1) reorganize as a stock insurer; and

(2) establish a mutual insurance holding company.

(c) A plan of reorganization shall provide that:

(1) all of the initial shares of capital stock of the reorganized stock insurer shall be issued to the mutual insurance holding company.

(2) the mutual insurance holding company shall own a majority of:

(i) the voting shares of the capital stock of the reorganized stock insurer; and

(ii) the total market value of all outstanding shares of the capital stock of the reorganized stock insurer.

(3) the class of capital stock owned by the mutual insurance holding company shall have dividend rights no less favorable than the dividend rights of any other class of stock of the reorganized stock insurer, unless:

(i) at least two-thirds of the board of directors of the mutual insurance holding company determines that such a requirement is not in the best interests of the members; and

(ii) the determination of the board of directors is approved by the Commissioner.

(4) in an initial public offering or initial private equity placement of stock, each eligible member of the mutual insurance holding company shall receive, without payment, nontransferable subscription rights to purchase stock, unless:

(i) at least two-thirds of the board of directors of the mutual insurance holding company determines that a subscription rights offering is not in the best interests of the members; and

(ii) the determination of the board of directors is approved by the Commissioner.

(5) (i) the following individuals may not acquire, by stock option or any other manner, the legal or beneficial ownership of any class of stock of the reorganized stock insurer for 6 months from the date of an initial public offering or initial private equity placement:

1. an officer or director of the mutual insurance holding company;

2. an officer or director of the reorganized stock insurer; and

3. any relative of an officer or director, who resides with the officer or director.

(ii) Notwithstanding subparagraph (i) of this paragraph, any individual who is a policyholder of the reorganized stock insurer may exercise subscription rights in accordance with paragraph (4) of this subsection.

(d) (1) Each policyholder of the reorganized stock insurer shall be a member of the mutual insurance holding company.

(2) On the effective date of the reorganization, the membership interests of a policyholder in the mutual insurer shall become nontransferable membership interests in the mutual insurance holding company.

(3) The plan of reorganization shall provide the terms and conditions under which future policyholders of the reorganized stock insurer shall become members of the mutual insurance holding company.

(4) At least two-thirds of those members of the board of directors of the mutual insurance holding company who are eligible or qualified to purchase a policy from the reorganized stock insurer, shall be members of the mutual insurance holding company.

(e) (1) Except as provided in paragraph (2) of this subsection, each policy of the mutual insurer in effect on the effective date of the reorganization shall remain in effect in accordance with its terms and conditions.

(2) The following rights and obligations under the policy of the mutual insurer shall be void as of the effective date of the reorganization:

(i) voting rights of policyholders;

(ii) except as to the holder of a participating policy, a right of a policyholder to share in the surplus or profits of the insurer; and

(iii) assessment provisions.

(3) A reorganized stock insurer shall continue to pay dividends to the holder of a participating policy that was in force on the effective date of the reorganization, in accordance with the methodology or formula used by the mutual insurer before the reorganization.

(f) The reorganized stock insurer shall have:

(1) paid-in capital stock not less than the minimum paid-in capital required of a domestic stock insurer that:

(i) transacts like kinds of insurance business; and

(ii) started business in the State on the date the mutual insurer received its original certificate of authority in the State; and

(2) surplus funds not less than 100% of the required capital.

(g) (1) The plan of reorganization shall be:

(i) approved by the vote of a majority of the board of directors of the mutual insurer; and

(ii) submitted to a meeting of members and approved by the vote of at least three-fourths of the members who vote on the plan of reorganization in person, by proxy, or by mail.

(2) Notice of the time, place, and purpose of the meeting of members shall be provided in the manner approved by the Commissioner.

(h) The plan of reorganization shall be submitted to the Commissioner for approval at least 60 days before the effective date of the reorganization, together with:

(1) the proposed articles of incorporation and bylaws of the mutual insurance holding company;

(2) the amendments to the articles of incorporation and bylaws of the mutual insurer to reorganize as a stock insurer;

(3) a 5-year plan of operation for the mutual insurance holding company and the reorganized stock insurer, including any plans for:

(i) an initial public offering of stock in the reorganized stock insurer; or

(ii) the transfer of assets or liabilities from the reorganized stock insurer or any subsidiaries of the reorganized stock insurer to the mutual insurance holding company;

(4) a list of the officers and directors of the mutual insurance holding company and the reorganized stock insurer;

(5) a biography of each officer and director of the mutual insurance holding company and the reorganized stock insurer; and

(6) any other documents or information requested by the Commissioner.

(i) (1) Unless disapproved by the Commissioner, a plan of reorganization is approved:

(i) on written notice from the Commissioner; or

(ii) 60 days after the plan and all information required under this section and under any regulations adopted in accordance with this section are submitted to the Commissioner.

(2) (i) Subject to subparagraph (ii) of this paragraph, the Commissioner shall approve the plan of reorganization if the plan of reorganization:

1. complies with this section; and

2. is equitable to the mutual insurer's members.

(ii) In approving a plan of reorganization, the Commissioner may impose additional conditions and requirements that the Commissioner determines are necessary to achieve the purposes of this section.

(3) At the expense of the mutual insurer, the Commissioner may retain a qualified expert who is not a part of the staff of the Commissioner to assist in reviewing the plan of reorganization.

(4) After written notice to the mutual insurer, the Commissioner may hold a hearing on whether the plan of reorganization:

(i) complies with this section; and

(ii) is equitable to the mutual insurer's members.

(j) (1) A mutual insurance holding company is subject to Title 7 of this article.

(2) The Commissioner may require the mutual insurance holding company to file annual statements with the Commissioner in the same manner as an insurer.

(3) The articles of incorporation and any amendments to such articles of the mutual insurance holding company are subject to the approval of the Commissioner in the same manner as those of an insurer.

(k) Compliance with the requirements for a plan of reorganization under this section exempts a mutual insurance holding company from the requirements of Title 7, Subtitle 3 of this article for the purpose of acquiring control of the reorganized stock insurer.

(l) (1) A mutual insurance holding company:

(i) may not dissolve or liquidate except through proceedings under Title 9 of this article or in accordance with § 3–121.2 of this subtitle; and

(ii) shall be a party to any proceeding under Title 9 of this article involving a reorganized stock insurer that is a subsidiary of the mutual insurance holding company.

(2) In any proceeding under Title 9 involving a reorganized stock insurer that is a subsidiary of a mutual insurance holding company, the assets of the mutual insurance holding company shall be deemed to be assets of the estate of the reorganized stock insurer for purposes of satisfying the claims of the reorganized stock insurer's policyholders.

(m) A mutual insurance holding company may become a stock insurer in accordance with § 3–121 of this subtitle or a mutual insurer in accordance with § 3–121.2 of this subtitle.

(n) The Commissioner may adopt regulations to enforce this section.

§3–121.2.

(a) (1) In this section the following words have the meanings indicated.

(2) "Mutual insurance holding company" means a nonstock corporation that:

(i) is incorporated in the State in accordance with a plan of reorganization adopted and approved under § 3–121.1 of this subtitle; and

(ii) is the parent of a reorganized stock insurer.

(3) "Reorganized stock insurer" means the stock corporation into which a mutual insurer is reorganized in accordance with a plan of reorganization adopted and approved under § 3–121.1 of this subtitle.

(b) A mutual insurance holding company that, directly or indirectly, owns 100% of the capital stock of a reorganized stock insurer may convert its mutual insurance holding company system into a mutual insurer in accordance with a plan of conversion adopted and approved under this section.

(c) A plan of conversion shall provide that:

(1) on the effective date of the conversion, the membership interests in the mutual insurance holding company shall become nontransferable membership interests in the converted mutual insurer;

(2) future policyholders of the converted mutual insurer shall be members of the converted mutual insurer;

(3) on the effective date of the conversion, each policy of the reorganized stock insurer shall remain in effect and may be endorsed;

(4) the shares of the reorganized stock insurer and any intermediate stock holding company shall be retired;

(5) the mutual insurance holding company and any intermediate stock holding company shall be dissolved by filing articles of dissolution with the State Department of Assessments and Taxation; and

(6) the converted mutual insurer shall have surplus funds that are reasonably adequate for the security of its policyholders.

(d) (1) A plan of conversion shall be:

(i) approved by the vote of a majority of the board of directors of the mutual insurance holding company and any intermediate stock holding company;

(ii) submitted to a meeting of members of the mutual insurance holding company; and

(iii) approved by the vote of at least 75% of the members who vote on the plan of conversion in person, by proxy, or by mail.

(2) Notice of the time, place, and purpose of the meeting of members required under paragraph (1)(ii) of this subsection shall be provided in the manner approved by the Commissioner.

(e) A plan of conversion shall be submitted to the Commissioner for approval at least 60 days before the effective date of the conversion, together with:

(1) amendments to the articles of incorporation and bylaws of the reorganized stock insurer necessary to convert to a mutual insurer;

(2) a 5–year plan of operation for the converted mutual insurer, including any plans for the transfer of assets or liabilities from the mutual insurance holding company or any intermediate holding company to the converted mutual insurer;

(3) a list of the officers and directors of the converted mutual insurer;

(4) a biographical affidavit of each officer and director of the converted mutual insurer; and

(5) any other documents or information requested by the Commissioner.

(f) (1) Unless disapproved by the Commissioner, a plan of conversion is approved:

(i) on written notice from the Commissioner; or

(ii) 60 days after the date that the plan and all information required under this section and under any regulation adopted in accordance with this section are submitted to the Commissioner.

(2) (i) Subject to subparagraph (ii) of this paragraph, the Commissioner shall approve the plan of conversion if the plan:

1. complies with this section; and

2. is equitable to the members of the mutual insurance holding company and the policyholders of the reorganized stock insurer.

(ii) In approving a plan of conversion, the Commissioner may impose additional conditions and requirements that the Commissioner determines are necessary to achieve the purposes of this section.

(iii) On written notice to the mutual insurance holding company, the Commissioner may hold a hearing necessary to determine if the plan of conversion meets the requirements of this paragraph.

(3) The Commissioner may retain, at the expense of the mutual insurance holding company, a qualified expert who is not a part of the Commissioner's staff to assist in reviewing the plan of conversion.

(g) The Commissioner may adopt regulations to carry out this section.

§3–122.

(a) Except as otherwise provided in this section, the provisions of the Corporations and Associations Article on the consolidation, merger, and share exchange of stock corporations apply to the consolidations, mergers, and share exchanges of domestic stock insurers and domestic and foreign stock insurers.

(b) The articles of consolidation, merger, or share exchange of stock insurers must be submitted to the Commissioner for examination and approval before the articles may be accepted for record by the Department of Assessments and Taxation.

(c) (1) Before approval of the articles of consolidation or merger, the Commissioner shall examine and review the affairs of the stock insurers involved in the consolidation or merger as the Commissioner finds necessary or desirable.

(2) The Commissioner may hold a hearing on the proposed consolidation or merger after giving the notice that the Commissioner considers appropriate.

(d) The Commissioner shall approve the articles of consolidation or merger by written endorsement on them before they become operative if the Commissioner finds that:

(1) the articles comply with the Code; and

(2) the policyholders in the successor stock insurer are protected through adequate reserves and assets for losses and claims then anticipated.

(e) The successor stock insurer shall bear all expenses in connection with proceedings conducted by the Commissioner under this section.

§3–123.

(a) (1) One or more mutual insurers organized under the laws of any state may consolidate or merge with one or more domestic mutual insurers to form a domestic mutual insurer.

(2) The successor mutual insurer may continue the corporate existence of one or more of the domestic parties to the consolidation or merger.

(b) (1) Mutual insurers consolidating or merging to form a domestic mutual insurer under this section shall enter into a written agreement that:

(i) prescribes the terms and conditions of the consolidation or merger;

(ii) states the name of the successor mutual insurer; and

(iii) includes the successor mutual insurer's amended certificate of incorporation, which shall contain the provisions required by this article for the organization of a mutual insurer.

(2) The agreement shall be:

(i) approved by the vote of a majority of the board of directors of each mutual insurer; and

(ii) submitted to a meeting of members and approved by vote of at least two-thirds of those members of each mutual insurer who vote on the plan in person, by proxy, or by mail.

(3) Notice of the time, place, and purpose of the meeting shall be:

(i) mailed to the members of each mutual insurer not less than 20 days before the date of the meeting; or

(ii) published at least once a week for 3 successive weeks in:

1. a newspaper printed in the county where each mutual insurer has its principal office; and

2. a newspaper printed in one of the two largest cities in each state where the successor mutual insurer will be licensed to do business.

(4) The agreement shall be:

(i) executed in duplicate original under corporate seal by officers authorized to do so on behalf of each of the mutual insurers; and

(ii) submitted, with evidence of its approval, to the Commissioner.

(5) If it appears to the Commissioner that the requirements of this section have been complied with, the Commissioner shall certify approval of the agreement by endorsing it.

(6) A duplicate original of the agreement shall be filed with the Commissioner and a duplicate original of the agreement shall be delivered to the successor mutual insurer.

(c) One or more domestic mutual insurers may consolidate or merge under the laws of any state with one or more foreign mutual insurers to form a successor mutual insurer under the laws of one of the foreign states in which one of the mutual insurers has its domicile.

(d) (1) Each domestic mutual insurer consolidating or merging with a foreign mutual insurer shall follow the procedure required by subsection (b) of this section.

(2) Each foreign mutual insurer shall follow the procedure required by the state of its domicile with respect to a consolidation or merger.

(3) The Commissioner shall require a certificate of approval from the insurance supervisory official of the state of domicile of each foreign insurer that is a party to the agreement certifying that the foreign insurer has complied with the laws of that state on consolidation or merger.

(4) Parties to the agreement of consolidation or merger need not hold a certificate of authority in this State at the time of consolidation or merger if:

(i) an application for a certificate of authority has been filed on behalf of the successor insurer, signed by each party to the agreement; and

(ii) the Commissioner believes the successor insurer:

1. meets the applicable solvency requirements; and

2. has complied or agreed to comply with the laws of this State on the admission and authorization of foreign insurers.

(e) (1) An agreement of consolidation or merger is effective:

(i) on an effective date, if any, stated in the agreement, if the effective date is after the date of approval by the Commissioner; or

(ii) on the date on which the last certificate of approval is executed by the insurance supervisory official of the state of domicile of any of the parties to the agreement.

(2) Within 15 days after a consolidation or merger agreement becomes effective, a copy of the agreement shall be filed of record in a public office where articles of incorporation are required to be filed by the laws of the state of domicile of any party to the agreement.

(f) After a consolidation or merger, the following conditions apply:

(1) the successor mutual insurer may require the return of the original policies held by each policyholder in each of the mutual insurers consolidated or merged and may issue replacement policies as the policyholders may be entitled to receive;

(2) all rights and properties of the parties to the agreement shall accrue to and become the rights and properties of the successor mutual insurer, and the successor mutual insurer shall succeed to and assume all the obligations and

liabilities of the consolidated or merged mutual insurers in the same manner as if incurred or contracted by the successor mutual insurer;

(3) the policyholders of the consolidated or merged mutual insurers shall continue to be subject to all the liabilities, claims, and demands existing against them at or before the consolidation or merger;

(4) an action or proceeding that is pending when the consolidation or merger occurs and to which any of the consolidated or merged mutual insurers is a party is not abated or discontinued because of the consolidation or merger, but the action or proceeding may be prosecuted to final judgment as if the successor mutual insurer were substituted for any insurer consolidated or merged by order of the court in which the action or proceeding is pending;

(5) if the successor mutual insurer is a foreign insurer that must comply with the laws of this State on deposits that are required of a foreign insurer, all deposits that were made in this State by any mutual insurer that is a party to the consolidation or merger agreement shall be delivered to the successor mutual insurer; and

(6) for the purpose of complying with the requirements of law relating to the age of an insurer, the successor mutual insurer is deemed to have the age of the eldest mutual insurer that is a party to the consolidation or merger.

(g) (1) When an agreement of consolidation or merger is filed, a certificate shall be filed with the Commissioner that sets forth all fees, commissions, or other compensation or valuable consideration paid or to be paid to any person for securing or promoting the consolidation or merger.

(2) The certificate shall be:

(i) signed by the president or a vice-president of each party to the agreement of consolidation or merger;

(ii) attested by the secretary or an assistant secretary of each party to the agreement; and

(iii) verified by affidavit.

(3) A director or officer of any insurer that is a party to a consolidation or merger may not receive, directly or indirectly, any fee, commission, or other compensation or valuable consideration for helping or promoting the consolidation or merger in any manner other than as stated in the agreement of consolidation or merger.

(h) (1) Before approval of an agreement of consolidation or merger, the Commissioner shall examine and review the affairs of the mutual insurers that are parties to the agreement as the Commissioner finds necessary or desirable.

(2) The Commissioner may hold a hearing on the agreement after giving the notice that the Commissioner considers appropriate.

(3) The Commissioner shall approve the agreement before it becomes operative if the Commissioner finds that:

(i) the agreement complies with the Code; and

(ii) the policyholders and members in the successor mutual insurer are protected through adequate reserves and assets for losses and claims then anticipated.

(4) The successor mutual insurer shall bear all expenses in connection with proceedings conducted by the Commissioner under this subsection.

§3–123.1.

(a) Unless otherwise prohibited under this article and subject to the prior approval of the Commissioner, one or more mutual insurers organized under the laws of any state may form a business combination with one or more domestic mutual insurers for the purpose of purchasing reinsurance or other financial services.

(b) (1) Mutual insurers forming a business combination under this section shall enter into a written agreement that prescribes the terms and conditions of the business combination.

(2) The agreement shall be approved by the vote of the majority of the board of directors of each mutual insurer.

(c) The Commissioner may adopt regulations concerning the formation of business combinations under this section.

§3–124.

(a) A domestic stock insurer may reinsure with another insurer all or substantially all of its insurance in force or a major class of its insurance in force by an agreement of bulk reinsurance.

(b) (1) An agreement of bulk reinsurance is not effective unless it is filed with and approved by the Commissioner.

(2) The Commissioner shall approve the agreement within a reasonable time after it is filed unless the Commissioner finds that the agreement:

(i) is inequitable to the stockholders of the domestic stock insurer; or

(ii) would substantially reduce the protection of or service to the policyholders of the domestic stock insurer.

(3) If the Commissioner does not approve the agreement, the Commissioner shall notify the domestic stock insurer in writing of the disapproval and specify the reasons for disapproval.

§3–125.

(a) After compliance with this section, a domestic mutual insurer may reinsure with a stock insurer or mutual insurer all or substantially all of its insurance in force or a major class of its insurance in force by an agreement of bulk reinsurance.

(b) (1) An agreement of bulk reinsurance is not effective unless it is filed with and approved by the Commissioner in writing after a hearing.

(2) The Commissioner shall approve the agreement within a reasonable time after it is filed if the Commissioner finds that the agreement:

(i) is equitable to each domestic insurer involved; and

(ii) would not reduce substantially the protection of or service to the policyholders of each domestic insurer involved.

(3) If the Commissioner does not approve the agreement, the Commissioner shall notify each insurer involved in writing of the disapproval and specify the reasons for disapproval.

(c) (1) In accordance with reasonable notice and procedure approved by the Commissioner, the plan and agreement for bulk reinsurance must be approved by vote of at least two-thirds of each domestic mutual insurer's members who vote on the agreement at meetings of the members called for that purpose.

(2) For a life insurer, the right to vote may be limited to members with policies, other than term or group policies, that have been in force for more than 1 year.

(d) (1) If the agreement is for reinsurance of a mutual insurer in a stock insurer, the agreement must provide for payment in cash to each member of the insurer who is entitled to payment as on conversion of a mutual insurer to a stock insurer under § 3-121 of this subtitle.

(2) Each member shall be paid the member's equity in the insurance that is reinsured as determined under a fair formula approved by the Commissioner.

(3) Each member's equity shall be based on the member's equity in the reserves, assets, whether or not admitted assets, and surplus, if any, of the mutual insurer to be taken over by the stock insurer.

§3–126.

(a) (1) A foreign insurer authorized to engage in the insurance business in the State may become a domestic insurer by:

(i) complying with all requirements of the law relating to the formation and organization of a domestic insurer; and

(ii) designating its principal place of business in the State.

(2) On becoming a domestic insurer, the insurer:

(i) is entitled to the certificates and licenses to transact insurance business in this State that are issued to domestic insurers;

(ii) shall be recognized in all respects as an insurer formed under the laws of this State as of the date of authorization as an insurer in its original domiciliary state; and

(iii) is subject to the authority and jurisdiction of the State.

(b) (1) When a foreign insurer authorized to engage in the insurance business in this State transfers its corporate domicile to this State or another state by merger, consolidation, or other lawful method, the certificate of authority, appointments of agents, rates, and other issues that are subject to the Commissioner's approval and that are in existence at the time of the transfer remain in effect after the transfer if the insurer at all times remains qualified to engage in the insurance business in this State.

(2) All outstanding policies of a transferring insurer remain in effect and need not be endorsed with the new name of the insurer or the new domiciliary and location of the insurer unless the Commissioner so orders.

(3) A transferring insurer:

(i) may file new policy forms with the Commissioner on or before the effective date of the transfer; or

(ii) if allowed by and under conditions approved by the Commissioner, may use any existing policy form previously filed with the Commissioner with appropriate endorsements.

(4) A foreign insurer that transfers its domicile to another state shall:

(i) notify the Commissioner of the details of the proposed transfer; and

(ii) file promptly with the Commissioner any resulting amendments to corporate documents and other items on file with the Commissioner.

§3–127.

(a) (1) In this section the following words have the meanings indicated.

(2) "Offer to sell" has the meaning stated in the Maryland Securities Act.

(3) "Register" means to register securities with the Division of Securities in the Office of the Attorney General in accordance with §§ 11–502 and 11–504 of the Corporations and Associations Article.

(4) "Sale" has the meaning stated in the Maryland Securities Act.

(b) (1) The filing requirements of subsections (c) and (d) of this section apply to a person that engages in, proposes to engage in, or assists in the promotion or formation of:

(i) a domestic insurer;

(ii) an insurance holding corporation; or

(iii) a corporation that finances:

1. a domestic insurer or the production of its business; or

2. an insurance holding corporation or the production of its business.

(2) This section does not apply to a person that is or will be an affiliate of an authorized insurer that is a member of an insurance holding company registered with the Commissioner under § 7–601 of this article.

(c) Within 5 days after a registration is filed with the Division of Securities, a person that is required to register a proposed sale or offer to sell securities under the Maryland Securities Act shall file with the Commissioner a copy of that registration.

(d) At least 30 days before the proposed sale or offer to sell securities, a person that is exempt under § 11–602(9) and (10) of the Corporations and Associations Article from the registration requirements of §§ 11–502 and 11–504 of the Corporations and Associations Article shall file with the Commissioner the information otherwise required by § 11–502 or § 11–504 of the Corporations and Associations Article.

(e) (1) If the Commissioner determines that a person has engaged in or is about to engage in an act or practice that violates this section, the Commissioner, without notice and before a hearing, may issue and cause to be served on the person an order to cease and desist from engaging in the acts for which filing is required under this section.

(2) (i) Unless postponed by mutual consent of the parties, the Commissioner shall hold a hearing within 30 days after the date of the order.

(ii) The Commissioner shall provide notice of the hearing to each party.

(f) The Commissioner has the enforcement powers listed in §§ 2–201 and 2–203 of this article.

(g) (1) In addition to any penalty otherwise applicable under this article, the Commissioner may impose a civil penalty not exceeding $500 for each violation of this section.

(2) Each day a violation of this section continues is a separate violation.

§3–128.

(a) In this section, "reciprocating state" means a state under the laws of which a prohibition on solicitation similar to that imposed against domestic insurers under this section is imposed on and enforced against insurers domiciled in that state.

(b) A domestic insurer may not knowingly solicit insurance business in a reciprocating state in which the domestic insurer is not licensed as an authorized insurer.

(c) This section does not prohibit advertising through publication or by radio, television, or other broadcasts originating outside the reciprocating state if:

(1) the insurer is licensed to engage in the insurance business in a majority of the states in which the advertising is disseminated; and

(2) the advertising is not specifically directed to residents of the reciprocating state.

(d) This section does not prohibit:

(1) insurance covering persons or risks located in a reciprocating state under contracts solicited and issued in states in which the insurer is then licensed; or

(2) insurance effectuated by the insurer as an unauthorized insurer under the laws of the reciprocating state.

(e) If the Commissioner finds, after a hearing, that a domestic insurer has violated this section, the Commissioner shall suspend or revoke the certificate of authority of the domestic insurer.

§3–201.

In this subtitle, "subscriber" means a person that exchanges a mutual agreement of indemnity with other persons through a common attorney in fact.

§3–202.

Except as expressly provided otherwise in this subtitle, this subtitle applies to foreign reciprocal insurers and to domestic reciprocal insurers.

§3–203.

(a) A reciprocal insurer may be authorized to engage in the insurance business if the reciprocal insurer meets the requirements of this section and is otherwise in compliance with the applicable provisions of this article.

(b) To write assessable policies, a reciprocal insurer must have surplus funds of not less than:

(1) $375,000 for one kind of insurance business; and

(2) $750,000 for two or more kinds of insurance business.

(c) To write nonassessable policies, a reciprocal insurer must:

(1) have surplus funds of not less than:

(i) $750,000 for one kind of insurance business; and

(ii) $1,500,000 for two or more kinds of insurance business; and

(2) comply with the deposit requirements of § 4-106 of this article.

§3–204.

(a) Twenty-five or more persons domiciled in the State may organize a domestic reciprocal insurer and may apply to the Commissioner for a certificate of authority to engage in the insurance business as a reciprocal insurer.

(b) The proposed attorney in fact of the reciprocal insurer shall fulfill the requirements of and shall execute, verify under oath, and file with the Commissioner when applying for a certificate of authority, a declaration that includes:

(1) the name of the reciprocal insurer;

(2) the location of the reciprocal insurer's principal office and of any other office from which policies will be issued;

(3) each kind of insurance business in which the reciprocal insurer intends to engage;

(4) the appointment of the Commissioner as agent for service of process in accordance with § 4-107 of this article;

(5) the name and address of each original subscriber;

(6) the appointment of the proposed attorney in fact and a copy of the power of attorney;

(7) the name and address of each officer and each director of the attorney in fact, if the attorney in fact is a corporation, or of each member of the attorney in fact, if the attorney in fact is a firm;

(8) the powers of the subscribers' advisory committee;

(9) the name and term of office of each member of the subscribers' advisory committee;

(10) a statement that, after deducting any sum payable to the attorney in fact, all money paid to the reciprocal insurer shall be held in the name of the reciprocal insurer for the purposes stated in the subscribers' agreement;

(11) a copy of the subscribers' agreement;

(12) a statement that:

(i) each original subscriber has applied in good faith for insurance of a kind in which the reciprocal insurer intends to engage; and

(ii) the reciprocal insurer has received from each original subscriber the full premium or premium deposit required for the policy applied for, for a term of not less than 6 months, at a rate that has been filed with and approved as adequate by the Commissioner;

(13) a statement of the financial condition of the reciprocal insurer, a schedule of its assets, and a statement that the surplus required by § 3-203 of this subtitle is available; and

(14) a copy of each policy, endorsement, and application form that the reciprocal insurer proposes to issue or use.

(c) When applying for a certificate of authority, the proposed attorney in fact shall pay to the Commissioner the applicable fee required by § 2-112 of this article.

§3–205.

(a) (1) When filing the declaration required by § 3-204 of this subtitle, the attorney in fact of a domestic reciprocal insurer shall file with the Commissioner a bond that:

(i) is in favor of the State for the benefit of all persons damaged as a result of a breach of the conditions of the bond by the attorney in fact;

(ii) is in the penal sum of $100,000;

(iii) is aggregate in form;

(iv) is executed by the attorney in fact and an authorized corporate surety insurer; and

(v) is conditioned that the attorney in fact:

1. will account faithfully for all money and other property of the reciprocal insurer that comes into the possession of the attorney in fact; and

2. will not withdraw or appropriate for the use of the attorney in fact from the funds of the reciprocal insurer, any money or property to which the attorney in fact is not entitled under the power of attorney.

(2) The bond is subject to the approval of the Commissioner.

(b) (1) An action on the bond of the attorney in fact may be brought at any time by:

(i) one or more subscribers who suffer loss through a violation of the conditions of the bond; or

(ii) a receiver or liquidator of the reciprocal insurer.

(2) Any amount recovered in the action shall be deposited in the funds of the reciprocal insurer.

(3) The total liability of the surety insurer under the bond may not exceed the penal sum of the bond.

(c) The bond shall provide that the surety insurer may not cancel the bond unless the surety insurer gives written notice of cancellation to the attorney in fact and the Commissioner at least 30 days before canceling the bond.

§3–206.

After payment of the applicable fee required by § 2-112 of this article, the Commissioner shall issue to the attorney in fact of each reciprocal insurer that meets the requirements of this subtitle a certificate of authority in the name of the reciprocal insurer.

§3–207.

(a) A certificate of authority authorizes a reciprocal insurer to engage in one kind or a combination of kinds of insurance business, except for life insurance and health insurance other than as supplementary coverage in policies of liability insurance.

(b) A certificate of authority authorizes a reciprocal insurer to purchase reinsurance and grant reinsurance as to any kind of insurance business in which the reciprocal insurer is authorized to engage.

§3–208.

In addition to any other grounds for denial, suspension, or revocation of a certificate of authority, the Commissioner may deny, suspend, or revoke a certificate of authority if the attorney in fact of a reciprocal insurer fails to comply with any provision of this article.

§3–209.

A reciprocal insurer:

(1) shall have and use a business name that includes the word "reciprocal", "interinsurer", "interinsurance", "exchange", "underwriters", or "underwriting"; and

(2) may sue and be sued in its own name.

§3–210.

The annual statement of a reciprocal insurer shall:

(1) be made and filed by the attorney in fact of the reciprocal insurer; and

(2) be supplemented by any additional information required by the Commissioner about the affairs and transactions of the attorney in fact as they relate to the reciprocal insurer.

§3–211.

(a) The Commissioner shall determine the financial condition of a reciprocal insurer in accordance with this section.

(b) (1) The surplus deposits of subscribers shall be allowed as assets, except that any premium deposits that are delinquent for 90 days or more shall be charged first against the surplus deposits.

(2) Premium deposits that are delinquent for less than 90 days shall be allowed as assets.

(3) An assessment levied on subscribers, but not collected, may not be allowed as an asset.

(4) The contingent liability of subscribers may not be allowed as an asset.

(c) (1) The Commissioner shall charge as liabilities the same reserves as are required of incorporated insurers that issue nonassessable policies on a reserve basis.

(2) The surplus deposits of subscribers may not be charged as a liability.

(d) The computation of reserves shall be based on premium deposits other than membership fees.

(e) At any time, the Commissioner may require the attorney in fact of a reciprocal insurer to submit an affidavit that shows the amount of annual savings, not already credited to subscribers, that are due but not paid.

§3–212.

(a) The attorney in fact of a reciprocal insurer may be an individual, firm, or corporation.

(b) The attorney in fact of a foreign or alien reciprocal insurer that is authorized to engage in the insurance business in the State is not considered to be doing business in the State within the meaning of any law of the State that applies

to foreign firms or corporations merely because the attorney in fact performs its duties as attorney in fact with respect to the reciprocal insurer's transactions in the State.

(c) The attorney in fact of a reciprocal insurer has the rights and powers provided in the power of attorney given the attorney in fact by the subscribers.

(d) The terms of a power of attorney or agreement collateral to the power of attorney must be reasonable and equitable.

(e) The power of attorney must state:

(1) the powers of the attorney in fact;

(2) that the attorney in fact is authorized to accept service of process on behalf of the reciprocal insurer in an action against the reciprocal insurer on contracts exchanged;

(3) the general services to be performed by the attorney in fact;

(4) the maximum amount to be deducted from advance premiums or deposits to be paid to the attorney in fact and the general items of expense in addition to losses, to be paid by the reciprocal insurer; and

(5) except as to nonassessable policies, a provision for a contingent several liability of each subscriber in the amount specified in § 3-216 of this subtitle.

(f) The power of attorney may:

(1) provide for the right of substitution of the attorney in fact and revocation of the power of attorney;

(2) restrict the exercise of the power of attorney as agreed by the subscribers;

(3) provide for the exercise of any right reserved to the subscribers directly or through their advisory committee; and

(4) contain any other lawful provisions considered advisable.

(g) For a domestic reciprocal insurer, a power of attorney or agreement collateral to the power of attorney is not effective and may not be used until approved by the Commissioner.

§3–213.

(a) An individual, partnership, or corporation of the State may make application, enter into agreement for, hold policies or contracts in or with, and be a subscriber of a domestic, foreign, or alien reciprocal insurer.

(b) (1) In addition to the powers specified in its articles of incorporation, a corporation organized under the laws of the State has full power as a subscriber to exchange insurance contracts through a domestic, foreign, or alien reciprocal insurer.

(2) The right to exchange insurance contracts through a reciprocal insurer is:

(i) incidental to the purposes for which the corporation is organized; and

(ii) as fully granted as the powers expressly conferred on the corporation.

(c) Governments, governmental units, states, political subdivisions of states, boards, associations, estates, trustees, and fiduciaries may exchange reciprocal insurance contracts with each other and with individuals, partnerships, and corporations to the same extent that individuals, partnerships, and corporations may exchange reciprocal insurance contracts.

(d) An officer, representative, trustee, receiver, or legal representative of a subscriber shall be recognized as acting for or on behalf of the subscriber for the purpose of a reciprocal insurance contract and in that capacity is not personally liable on the reciprocal insurance contract.

§3–214.

(a) The advisory committee of a domestic reciprocal insurer that exercises the subscribers' rights shall be chosen under rules that the subscribers adopt.

(b) Not less than two-thirds of the advisory committee shall be subscribers other than the attorney in fact of the reciprocal insurer or a person employed by, representing, or having a financial interest in the attorney in fact.

(c) The advisory committee shall:

(1) supervise the finances of the reciprocal insurer;

(2) supervise the operations of the reciprocal insurer to ensure compliance with the subscribers' agreement and power of attorney;

(3) procure the audit of the accounts and records of the reciprocal insurer and of the attorney in fact at the expense of the reciprocal insurer; and

(4) have any additional powers and functions as conferred by the subscribers' agreement.

§3–215.

(a) Modification of the terms of the subscribers' agreement or power of attorney of a domestic reciprocal insurer shall be made jointly by the attorney in fact of the reciprocal insurer and the subscribers' advisory committee.

(b) A modification described in subsection (a) of this section is not effective retroactively and does not apply to an insurance contract issued before the modification.

§3–216.

(a) (1) Except as to a nonassessable policy, each subscriber has a contingent assessment liability, in the amount stated in the power of attorney or subscriber's agreement, for payment of losses and expenses incurred while the subscriber's policy is in force.

(2) The liability of each subscriber, other than as to a nonassessable policy, for the obligations of the reciprocal insurer is individual, several, and proportionate and is not joint.

(b) (1) The contingent liability of each subscriber shall be at the rate of not less than one additional annual premium or premium deposit stated in the policy but not more than 10 times the annual premium or premium deposit.

(2) The maximum total contingent liability shall be calculated as set forth in § 3-217(e) of this subtitle.

(c) Each assessable policy issued by a reciprocal insurer shall contain a statement of the contingent liability.

§3–217.

(a) Assessments periodically may be levied on the subscribers of a domestic reciprocal insurer liable for assessments, as allowed by the terms of the subscribers' policies, by:

(1) the attorney in fact of the reciprocal insurer, after approval by the subscribers' advisory committee and the Commissioner; or

(2) the Commissioner, in liquidation of the reciprocal insurer.

(b) (1) Subject to paragraph (3) of this subsection, each subscriber's share of a deficiency for which an assessment is made shall be calculated by multiplying:

(i) the premium earned on the subscriber's policy during the period covered by the assessment; by

(ii) the ratio of the total deficiency to the total premiums earned during that period on all policies subject to the assessment.

(2) For purposes of calculating the earned premium under this section:

(i) the gross premium received by the reciprocal insurer for the policy shall be used as a base; and

(ii) deductions may be taken from the gross premium only for charges that do not recur on the renewal or extension of the policy.

(3) Each subscriber's share of a deficiency may not exceed the subscriber's total contingent liability under subsection (e) of this section.

(c) A subscriber may not have an offset against an assessment for which the subscriber is liable because of a claim for an unearned premium or loss payable.

(d) Each subscriber of a domestic reciprocal insurer with contingent liability is liable for and shall pay the subscriber's share of an assessment as calculated and limited in accordance with this subtitle if, while the subscriber's policy is in force or within 3 years after its termination:

(1) the subscriber is notified by the attorney in fact of the reciprocal insurer or the Commissioner of the intent to levy the assessment; or

(2) an order is issued that directs the reciprocal insurer to show cause why a receiver, conservator, rehabilitator, or liquidator of the reciprocal insurer should not be appointed.

(e) One policy or a subscriber to one policy may not be assessed or charged with a total contingent liability for obligations incurred by a domestic reciprocal insurer in 1 calendar year, in excess of the amount set forth in the power of attorney or subscribers' agreement calculated solely on the premium earned on the policy during that year.

§3–218.

(a) If a reciprocal insurer has a surplus of assets over all liabilities at least equal to the minimum capital stock and surplus required of a domestic stock insurer authorized to engage in like kinds of insurance business, on application of the attorney in fact of the reciprocal insurer and as approved by the subscribers' advisory committee, the Commissioner shall issue a certificate that authorizes the reciprocal insurer to:

(1) extinguish the contingent liability of subscribers under its policies then in force in the State; and

(2) omit provisions that impose contingent liability in all policies delivered or issued for delivery in the State as long as the surplus remains unimpaired.

(b) (1) The Commissioner may not authorize a domestic reciprocal insurer to extinguish the contingent liability of any of its subscribers or in any of its policies to be issued unless the reciprocal insurer qualifies to extinguish and does extinguish the contingent liability of all of its subscribers and in all of its policies for all kinds of insurance that the reciprocal insurer transacts.

(2) Notwithstanding paragraph (1) of this subsection, if required by the laws of another state in which the domestic reciprocal insurer is authorized to transact insurance, the domestic reciprocal insurer:

(i) may issue policies that provide for the contingent liability of its subscribers who acquire policies in that state; and

(ii) need not extinguish the contingent liability applicable to policies then in force in that state.

(c) (1) If the surplus described in subsection (a) of this section becomes impaired, the Commissioner immediately shall revoke the certificate that authorizes the reciprocal insurer to issue nonassessable policies.

(2) The revocation does not subject a policy then in force to contingent liability for the remainder of the period for which the premium has been paid.

(3) After revocation of authority to issue nonassessable policies, a reciprocal insurer may not issue or renew a policy without providing for the contingent liability of the subscriber.

§3–219.

(a) (1) The attorney in fact of a reciprocal insurer:

(i) periodically may fix and determine savings to be paid to each subscriber or policyholder on participating policies or contracts from the earned surplus of the reciprocal insurer; and

(ii) after doing so, shall establish an adequate surplus from which the savings are to be paid.

(2) The attorney in fact may not fix or pay savings if the payment of savings will impair the minimum surplus or other required surplus of the reciprocal insurer.

(b) (1) In fixing or paying savings, the attorney in fact may make reasonable classifications of policies or contracts.

(2) Policies or contracts in the same classification shall be treated without unfair discrimination.

(3) If the reciprocal insurer offers an alternative method or plan for savings classifications, the policy or contract shall contain an endorsement that states the class to which it is assigned.

(c) Each reciprocal insurer shall establish a procedure for notifying each policyholder or subscriber about savings fixed and payable under the policyholder's or subscriber's policy or contract.

§3–220.

(a) This section does not apply to bank loans or to loans for which security is given.

(b) The attorney in fact of a domestic reciprocal insurer or another person may advance to the reciprocal insurer on reasonable terms any money that the reciprocal insurer requires periodically in its operations.

(c) (1) The money advanced to a reciprocal insurer:

(i) may not be treated as a liability of the reciprocal insurer; and

(ii) except on liquidation of the reciprocal insurer, may be withdrawn or repaid only out of the reciprocal insurer's realized earned surplus in excess of its minimum required surplus.

(2) A withdrawal or repayment may be made only with the previous approval of the Commissioner.

§3–221.

(a) A domestic reciprocal insurer may merge with another reciprocal insurer or be converted to a stock insurer or mutual insurer if:

(1) at least two-thirds of the subscribers who vote on the merger or conversion after notice vote in favor of the merger or conversion; and

(2) the Commissioner approves the terms of the merger or conversion.

(b) The Commissioner may not approve a plan for merger or conversion unless:

(1) the plan is equitable to subscribers; and

(2) for conversion to a stock insurer, the plan gives each subscriber:

(i) preferential right to acquire stock of the proposed stock insurer proportionate to the subscriber's interest in the reciprocal insurer; and

(ii) a reasonable length of time to exercise the preferential right.

(c) If a domestic reciprocal insurer converts to a stock insurer or mutual insurer, the successor stock insurer or mutual insurer is subject to the same capital

or surplus requirements and has the same rights as a like domestic insurer that transacts like kinds of insurance business.

§3–222.

(a) If the assets of a reciprocal insurer at any time are insufficient to maintain the required surplus and to discharge its liabilities, other than a liability on account of money contributed by the attorney in fact or another person, the attorney in fact of a reciprocal insurer immediately shall:

(1) make up the deficiency; or

(2) subject to the limitations set forth in the power of attorney or subscribers' policies, levy an assessment on the subscribers for the amount needed to cure the deficiency.

(b) A reciprocal insurer is considered insolvent and shall be proceeded against as authorized by this article if:

(1) the attorney in fact fails to cure the deficiency or to make the assessment within 30 days after the Commissioner orders the attorney in fact to do so; or

(2) the deficiency is not cured fully within 60 days after the date the assessment was made.

(c) If liquidation of a reciprocal insurer is ordered, an assessment shall be levied on the subscribers in the amount, subject to the limits provided by this subtitle, that the Commissioner determines to be necessary to discharge all liabilities of the reciprocal insurer, excluding any money contributed by the attorney in fact or another person, but including the reasonable cost of the liquidation.

§3–301.

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

(b) "Act" means the federal Nonadmitted and Reinsurance Reform Act of 2010.

(c) "Admitted insurer" means an insurer that is authorized to engage in the business of insurance in the State.

(d) "Exempt commercial purchaser" has the meaning stated in § 527 of the Act.

(e) "Home state" has the meaning stated in § 527 of the Act.

(f) "Nonadmitted insurance" means property and casualty insurance that may be placed directly or through a surplus lines broker with a nonadmitted insurer that is eligible to accept the insurance.

(g) (1) "Nonadmitted insurer" means an insurer that is not authorized to engage in the business of insurance in the State.

(2) "Nonadmitted insurer" does not include a risk retention group.

(h) "Qualified surplus lines broker" means a person that has obtained a certificate of qualification from the Commissioner to act as a surplus lines broker under this subtitle.

§3–302.

(a) This subtitle does not apply to:

(1) life insurance;

(2) health insurance, except as provided in subsection (c) of this section;

(3) annuities;

(4) reinsurance;

(5) wet marine and transportation insurance, except as provided in subsection (b) of this section;

(6) insurance on a subject that is located, resident, or to be performed wholly outside the State;

(7) insurance on vehicles or aircraft owned and principally garaged outside the State;

(8) insurance on property or operation of railroads engaged in interstate commerce;

(9) insurance:

(i) on aircraft owned or operated by aircraft manufacturers or operated in scheduled interstate flight;

(ii) on cargo of the aircraft described in item (i) of this item; or

(iii) against liability arising out of the ownership, maintenance, or use of the aircraft described in item (i) of this item, other than workers' compensation or employer's liability; or

(10) medical stop–loss insurance, as defined in § 15–129 of this article.

(b) This subtitle applies to wet marine and transportation insurance on:

(1) a pleasure craft under 60 feet in length that is owned and used for pleasure and not for business, hire, or other commercial use;

(2) fishing vessels under 50 gross tons that are not part of a fleet of 3 or more vessels; and

(3) charter or head boats under 50 gross tons that are not part of a fleet of 3 or more vessels.

(c) Subject to § 3–306.2 of this subtitle, this subtitle applies to:

(1) disability insurance that:

(i) provides for lost income, revenue, or proceeds in the event that an illness, accident, or injury results in a disability that impairs an insured's ability to work or otherwise generate income, revenue, or proceeds that the insurance is intended to replace; and

(ii) does not include payment for medical expenses, dismemberment, or accidental death; and

(2) short–term medical insurance that provides limited health insurance benefits for a limited period of time to:

(i) residents of the United States who travel to another country within 30 days after the effective date of coverage; and

(ii) residents of another country who:

1. travel to the United States within 30 days after the effective date of coverage; and

2. are not traveling to the United States for the purpose of attending an institution of higher education, as defined in § 10–101 of the Education Article.

§3–303.

Except as provided in § 3-319(b) of this subtitle, this subtitle does not limit the right of a surplus lines broker to place surplus lines insurance with an alien insurer that has qualified with the nonadmitted insurer information office of the National Association of Insurance Commissioners.

§3–304.

The Commissioner may adopt reasonable regulations consistent with this subtitle to:

(1) carry out this subtitle;

(2) establish procedures for determining the eligibility of particular proposed coverages for placement with surplus lines insurers and maintain a list of the identified coverages;

(3) allow an exempt commercial purchaser to waive the diligent search requirement under § 3–306 of this subtitle for the procurement of a surplus lines insurance policy;

(4) provide for the content and use of the written disclosure required under § 3–308 of this subtitle; and

(5) provide for the periodic review, no less than annually, of information from surplus lines brokers, agents, and insurers and from other sources concerning the availability and affordability of insurance from authorized insurers in the State.

§3–305.

A report, affidavit, or return that must be filed under this subtitle complies with the filing requirement if the report, affidavit, or return is:

(1) mailed and postmarked by the United States Postal Service on or before the filing date;

(2) delivered on or before the filing date to a private delivery service recognized by the Commissioner, if the delivery is evidenced by a receipt; or

(3) transmitted electronically on or before the filing date in a manner approved by the Commissioner.

§3–306.

(a) Surplus lines insurance may be procured from an unauthorized insurer if:

(1) for surplus lines insurance procured through a broker, the surplus lines insurance is procured through a qualified surplus lines broker;

(2) subject to the provisions of § 3–306.1 of this subtitle, a diligent search is made among the authorized insurers that are writing the particular kind and class of insurance in the State;

(3) except for insurance against liability of persons described in § 24–206(1) of this article, the amount of surplus lines insurance procured from an unauthorized insurer is only the excess over the amount that can be procured from authorized insurers;

(4) for insurance against liability of persons described in § 24–206(1) of this article, the insurance cannot be obtained from three or more authorized insurers that are writing on a broad basis that particular kind and class of insurance;

(5) except as provided in subsection (b) of this section, the surplus lines insurance is not procured:

(i) solely to obtain a lower premium rate than would be accepted by an authorized insurer;

(ii) solely to obtain more favorable terms of the insurance contract; or

(iii) to replace coverage on residential property which is insured by an authorized insurer and for which a renewal offer has been made on substantially the same terms and conditions as the current coverage; and

(6) there is compliance with other applicable provisions of this subtitle.

(b) This subtitle does not prohibit a lower premium rate or more favorable terms in the insurance contract of an unauthorized insurer if:

(1) the risk is eligible as surplus lines under subsection (a)(2), (3), and (4) of this section; or

(2) the applicant qualifies as an exempt commercial purchaser who may waive the diligent search that is otherwise required under this section.

(c) (1) This section does not prohibit a surplus lines broker from renewing a risk with a surplus lines insurer if the risk was initially written on a surplus lines basis when there were fewer than three authorized insurers actually writing on a broad basis the particular kind and class of insurance to provide coverage against liability of persons described in § 24–206(1) of this article in the State.

(2) However, even if on the date of renewal three or more authorized insurers are writing on a broad basis the particular kind and class of insurance required by the insured, a risk initially eligible for surplus lines insurance may be renewed on a surplus lines basis if the surplus lines insurer, licensed insurance producer, or surplus lines broker gives to the insured appropriate notice of the possible availability of comparable types of insurance being written by three or more authorized insurers:

(i) each year; and

(ii) sufficiently in advance of the renewal date to allow the insured to determine whether to renew the policy with the surplus lines insurer.

(d) The Commissioner shall participate in the National Insurance Producer Database maintained by the National Association of Insurance Commissioners and its affiliates and subsidiaries.

§3–306.1.

(a) (1) A diligent search required by § 3–306 of this subtitle shall be deemed completed if:

(i) the insured or the surplus lines broker or insurance producer obtains declinations of a risk from three authorized insurers that are writing the particular kind and class of insurance in this State; and

(ii) the declinations are included in the affidavit required under § 3–307 of this subtitle.

(2) In addition to the requirement of paragraph (1)(i) of this subsection, an insurance producer shall obtain a declination from each insurer for which the insurance producer has been appointed that the insurance producer knows, or should know, is actually writing on a broad basis the particular kind and class of insurance sought.

(b) A diligent search may not be required:

(1) for any coverage on a list of eligible surplus lines coverages compiled by the Commissioner; or

(2) if the diligent search is waived by an exempt commercial purchaser in accordance with the Act.

(c) Notwithstanding the renewal provisions of § 3–306(c) of this subtitle, a diligent search shall be required for each renewal of a personal lines insurance policy written through a surplus lines insurer.

(d) Notwithstanding subsection (b)(2) of this section, a surplus lines broker is not required to perform a diligent search to determine whether the full amount or type of insurance can be obtained from admitted insurers when the surplus lines broker is seeking to procure or place nonadmitted insurance for an exempt commercial purchaser if:

(1) the surplus lines broker has disclosed to the exempt commercial purchaser that the insurance may or may not be available from admitted insurers that may be subject to greater protection and regulatory oversight; and

(2) the exempt commercial purchaser subsequently has requested the surplus lines broker in writing to procure nonadmitted insurance from or place the nonadmitted insurance with a nonadmitted insurer.

§3–306.2.

(a) Subject to subsections (b) through (e) of this section, disability insurance and short–term medical insurance under § 3–302(c) of this subtitle may be procured from a nonadmitted insurer if the coverage procured is in excess of coverage available from, or is not available from, an admitted insurer that writes that particular kind and class of insurance in the State.

(b) Procurement of disability insurance under this section from a nonadmitted insurer is subject to:

(1) the diligent search requirements of §§ 3–306 and 3–306.1 of this subtitle; and

(2) all other requirements of this subtitle.

(c) Procurement of short–term medical insurance under this section from a nonadmitted insurer is subject to:

(1) a policy term that:

(i) is less than 3 months; and

(ii) may not be extended or renewed;

(2) the provision of written notice to the applicant, on a form approved by the Commissioner:

(i) stating that coverage may be available under the Affordable Care Act without medical underwriting;

(ii) providing contact information for the Maryland Health Benefit Exchange;

(iii) stating that the short–term medical insurance may be available from an admitted insurer;

(iv) stating that similar coverage may be available from an admitted insurer offering travel insurance, as defined in § 10–101 of this article; and

(v) displaying prominently in the contract and in any application materials provided in connection with enrollment in the coverage in at least 14 point type the following: "This is not qualifying health coverage ("minimum essential coverage") that satisfies the health coverage requirements of the Affordable Care Act. If you don't have minimum essential coverage, you may owe an additional payment with your taxes.";

(3) the diligent search requirements of §§ 3–306 and 3–306.1 of this subtitle; and

(4) all other requirements of this subtitle.

(d) Short–term medical insurance may not be procured from a nonadmitted insurer unless:

(1) the insurance is procured through a qualified surplus lines broker;

(2) if the insurance is offered on a Web site on the Internet, the Web site identifies the qualified surplus lines broker through whom the insurance may be procured; and

(3) the diligent search required under §§ 3–306 and 3–306.1 of this subtitle includes a search of the short–term medical insurance policies offered for sale by admitted insurers.

(e) A short–term medical insurance policy procured from a nonadmitted insurer may not include:

(1) a preexisting condition exclusion, unless the exclusion relates to a condition that was first manifested, treated, or diagnosed before the effective date of the policy; or

(2) a definition of sickness or illness that excludes any sickness or illness that began, existed, or had its origin before the effective date of the policy, unless the sickness or illness was first manifested, treated, or diagnosed before the effective date of the policy.

(f) The Commissioner shall develop and make available on the Administration's Web site a consumer guide on short–term medical insurance that includes information on:

(1) the availability of coverage from admitted insurers; and

(2) the types of coverage and provisions in short–term medical insurance policies that may be important to consumers.

§3–307.

(a) An affidavit that sets forth the facts referred to in § 3–306 of this subtitle and any other facts required by the Commissioner must be personally executed by the surplus lines broker or the originating insurance producer at the time the surplus lines insurance is placed.

(b) The affidavit must be filed with the Commissioner on or before the 45th day after the last day of the calendar quarter in which the surplus lines insurance was placed.

(c) For short–term medical insurance procured from a nonadmitted insurer under this subtitle, the affidavit shall include, for each declining authorized insurer, the reason for the declination.

§3–308.

Each insurance contract or confirmation procured and delivered under this subtitle shall be:

(1) endorsed or stamped conspicuously in boldface type on the first page of the insurance contract or confirmation as follows: "This insurance is issued by a nonadmitted insurer not under the jurisdiction of the Maryland Insurance Commissioner"; and

(2) accompanied by a written disclosure, as prescribed by the Commissioner, that:

(i) is written in clear, plain English;

(ii) explains that the insurer does not possess a certificate of authority from the Commissioner to engage in the insurance business in the State; and

(iii) includes any other information that the Commissioner requires.

§3–309.

(a) An insurance contract procured as surplus lines coverage from an unauthorized insurer in accordance with this subtitle is valid and enforceable as to all parties and shall be accepted and recognized in all matters and respects to the same effect as like insurance contracts issued by authorized insurers.

(b) An insurance contract entered into in violation of this subtitle may be enforced by the insured in accordance with the terms of the insurance contract.

§3–310.

(a) Except as provided in subsection (b) of this section, a person must obtain a certificate of qualification to act as a surplus lines broker before the person acts as a surplus lines broker in the State.

(b) A person is not required to obtain a certificate of qualification to act as a surplus lines broker in the State if:

(1) the State is not the home state of the insured; and

(2) the surplus lines broker has obtained a license or other authorization from the home state of the insured.

§3–311.

An applicant for a certificate of qualification shall:

(1) be qualified as an insurance producer;

(2) hold an insurance producer's license for the kind of insurance being solicited or sold; and

(3) be competent and trustworthy, as determined by the Commissioner.

§3–312.

An applicant for a certificate of qualification shall:

(1) file with the Commissioner an application on the form that the Commissioner provides; and

(2) pay to the Commissioner the fee required by § 2-112 of this article.

§3–313.

(a) Before the Commissioner issues a certificate of qualification to an applicant, the applicant shall file with the Commissioner a bond that:

(1) is subject to approval by the Commissioner;

(2) runs to the State;

(3) is executed by the applicant as principal and by a corporate surety insurer authorized to do business in the State;

(4) is in the penal sum of $10,000; and

(5) is conditioned that the broker will:

(i) conduct business in accordance with this article; and

(ii) remit promptly the taxes required by § 3-324 of this subtitle.

(b) The total liability of the surety insurer under the bond may not exceed the penal sum of the bond.

(c) The surety insurer may not cancel the bond unless, at least 30 days before canceling the bond, the surety insurer files written notice of the cancellation.

§3–314.

The Commissioner shall issue a certificate of qualification to each applicant who meets the requirements of this subtitle.

§3–315.

A qualified surplus lines broker may:

(1) accept and place surplus lines insurance business from an insurance producer with a license in the State for the kind of insurance involved; and

(2) compensate the insurance producer for the surplus lines insurance business.

§3–316.

(a) Unless a certificate of qualification is renewed for a 2–year term as provided in this section, the certificate of qualification expires every other year on the date stated on the certificate of qualification.

(b) At least 1 month before a certificate of qualification expires, the Commissioner shall send to the holder of the certificate of qualification, at the last known address or electronic mail address of the holder on record a notice that states:

(1) the process for renewing the certificate of qualification;

(2) the date by which the Commissioner must receive the renewal application; and

(3) the amount of the renewal fee.

(c) Before a certificate of qualification expires, the holder periodically may renew it for an additional 2–year term, if the holder:

(1) otherwise is entitled to a certificate of qualification;

(2) submits to the Commissioner a renewal application:

(i) on the form that the Commissioner provides; or

(ii) in an electronic format that the Commissioner approves;

(3) pays to the Commissioner the renewal fee required by § 2–112 of this article; and

(4) complies with the bond requirement of § 3–313 of this subtitle.

(d) For an individual, a certificate of qualification renewed under this section shall have an expiration date that is the last day of the month in which the holder of the certificate of qualification was born.

(e) (1) If mailed, an application for renewal of a certificate of qualification shall be considered made in a timely manner if it is postmarked on or before the expiration date of the certificate of qualification.

(2) If submitted electronically, an application for renewal of a certificate of qualification shall be considered made in a timely manner if, on or before the expiration date of the certificate of qualification, the application:

(i) is addressed properly or otherwise directed properly to an information processing system that the Administration has designated or uses for the purpose of receiving electronic applications and from which the Administration is able to retrieve the application;

(ii) is in a form capable of being processed by that system; and

(iii) 1. enters an information processing system outside the control of the sender or of a person that sent the electronic application on behalf of the sender; or

2. enters a region of the information processing system designated or used by the Administration that is under the control of the Administration or an agent of the Administration.

(f) The Commissioner shall renew the certificate of qualification of each holder who meets the requirements of this section.

(g) The Commissioner may adopt regulations to carry out this section.

§3–316.1.

(a) On or before September 30 of the renewal year, a person whose surplus lines broker's certificate of qualification has expired may reinstate the expired certificate of qualification by:

(1) filing with the Commissioner the appropriate reinstatement application;

(2) paying to the Commissioner the applicable reinstatement fee required under subsection (b) of this section; and

(3) complying with the bond requirement of § 3-313 of this subtitle.

(b) (1) The fee for a reinstatement under this section shall be:

(i) the amount charged for a full renewal period for the type of certificate of qualification held by the person seeking the reinstatement; and

(ii) 1. $25 for reinstatement during the period from July 1 through July 31;

2. $50 for reinstatement during the period from August 1 through August 31; and

3. $75 for reinstatement during the period from September 1 through September 30.

(2) The Commissioner may limit the reinstatement fee to the amount of the renewal fee in cases where the reinstatement applicant did not make timely renewal because of temporary incapacity, hospitalization, or other hardship.

(c) A person whose surplus lines broker's certificate of qualification has expired is prohibited from acting as a surplus lines broker until the effective date of reinstatement of the certificate of qualification.

(d) A person who does not comply with subsection (a) of this section on or before September 30 of the year of expiration shall apply for a surplus lines broker's certificate of qualification under § 3-312 of this subtitle and meet any other requirements specified by the Commissioner in regulation.

(e) The Commissioner may adopt regulations to carry out this section.

§3–317.

(a) The Commissioner may suspend or revoke the certificate of qualification of a surplus lines broker:

(1) if the surplus lines broker fails to file the report required by this subtitle;

(2) if the surplus lines broker fails to remit the tax required by this subtitle;

(3) if the surplus lines broker fails to keep records required by this subtitle, or fails to allow the Commissioner to examine those records;

(4) if the surplus lines broker fails to file or falsifies the affidavit required by this subtitle; or

(5) for any applicable ground for suspending or revoking the license of an insurance producer under this article.

(b) The Commissioner may not reinstate the certificate of qualification of a surplus lines broker whose certificate has been suspended or revoked until the broker pays all penalties and delinquent taxes that are owed.

§3–318.

(a) The Commissioner may not approve an insurer as a surplus lines insurer unless the insurer:

(1) is authorized in its domiciliary jurisdiction to write the type of insurance it seeks to write;

(2) has capital and surplus, or their equivalent under the laws of its domiciliary jurisdiction, equal to the greater of:

(i) the minimum capital and surplus required under the laws of its domiciliary jurisdiction; and

(ii) $15,000,000; and

(3) files with the Commissioner:

(i) a written request for approval as a surplus lines insurer to write the type of insurance the insurer seeks to write;

(ii) a certified copy of the insurer's annual statement, on convention form, that shows the amount by line of surplus lines business written on risks located in the State during the period covered by the annual statement; and

(iii) a certificate of compliance issued by the insurance department of the insurer's state of domicile.

(b) (1) For a foreign insurer, the requirements of subsection (a)(2) of this section may be satisfied by the insurer's possessing less than the minimum capital and surplus if the Commissioner makes an affirmative finding of acceptability.

(2) The finding shall be based on the following or similar factors:

(i) quality of management;

(ii) capital and surplus of any parent company;

(iii) company underwriting profit and investment income trends;

(iv) market availability; and

(v) company record and reputation of the foreign insurer in the industry.

(3) The Commissioner may not make an affirmative finding of acceptability if the foreign insurer's capital and surplus is less than $4,500,000.

(c) A surplus lines insurer's approval expires on June 30 each year unless the approval is renewed as provided in this section.

(d) (1) Before an approval expires, an insurer may renew the approval for a 1–year term if the insurer:

(i) files with the Commissioner, in accordance with the procedures established by the Commissioner, an application for renewal of approval as a surplus lines insurer;

(ii) pays to the Commissioner the applicable fee required by § 2–112 of this article; and

(iii) submits to the Commissioner any additional information or documentation that the Commissioner requires, including any information or documentation necessary to determine whether the insurer meets the requirements of subsections (a) and (b) of this section.

(2) The application for renewal of approval as a surplus lines insurer shall be signed by an officer of the insurer certifying that, to the best knowledge and belief of the officer, the insurer is in compliance with all statutes and regulations of the insurer's domiciliary jurisdiction.

(e) An unauthorized insurer shall appoint in writing the Commissioner as agent for the acceptance of service of process.

§3–319.

(a) A surplus lines broker may not place surplus lines insurance with an unauthorized insurer that:

(1) has not been approved by the Commissioner as a surplus lines insurer in accordance with § 3–318 of this subtitle;

(2) for an insurer not domiciled in the State, has not qualified under § 3–303 of this subtitle;

(3) has been determined by the Commissioner to be insolvent or unsafe financially under subsection (b) of this section; or

(4) has been determined by the Commissioner to have refused to pay just claims.

(b) (1) The Commissioner shall direct that surplus lines insurance may not be placed with a surplus lines insurer that has been approved by the Commissioner if the Commissioner determines that the surplus lines insurer:

(i) is not in a safe or solvent financial condition; or

(ii) has refused to pay just claims.

(2) After written notice of a determination made by the Commissioner under paragraph (1) of this subsection is mailed by the Commissioner to qualified surplus lines brokers, surplus lines insurance may not be placed with the surplus lines insurer.

(c) Notwithstanding any other provision of this subtitle, a surplus lines broker may not place surplus lines insurance with an insurer if the broker knows, or reasonably should know, that the insurer is in an unsafe or insolvent financial condition.

(d) A qualified surplus lines broker may not place a risk in an unauthorized insurer that has not previously appointed the Commissioner as agent for the acceptance of service of process.

§3–320.

(a) In any question that arises under the coverage between an unauthorized insurer and the insured, the unauthorized insurer is deemed to have received the premium due it for surplus lines insurance if:

(1) the unauthorized insurer has assumed a surplus lines risk under this subtitle; and

(2) the surplus lines broker who placed the surplus lines insurance has received the premium for the surplus lines insurance.

(b) An unauthorized insurer described in subsection (a) of this section is liable to the insured for losses covered by the surplus lines insurance and, on cancellation, for unearned premiums that may become payable to the insured, whether or not the surplus lines broker is indebted to the unauthorized insurer for the surplus lines insurance or for any other reason.

(c) This section does not affect rights between the unauthorized insurer and the surplus lines broker.

(d) Each unauthorized insurer that assumes a surplus lines direct risk under this subtitle subjects itself to the terms of this section.

§3–321.

(a) (1) On placing surplus lines coverage, a surplus lines broker promptly shall deliver to the insured:

(i) the policy issued by the insurer; or

(ii) if the policy is not available, a binder or cover note that shows:

1. the subject, coverage, conditions, and term of the insurance; and

2. the name and address of the insurer.

(2) If a direct risk is assumed by more than one insurer, the policy, binder, or cover note shall state:

(i) the name and address of each insurer; and

(ii) the proportion of the direct risk assumed by each insurer.

(b) Unless a copy of each binder or cover note has been filed with and approved by the Commissioner, the surplus lines broker, as soon as reasonably possible, shall get the policy from the insurer and deliver it to the insured to replace the binder or cover note previously delivered.

(c) A surplus lines broker promptly shall deliver to the insured an appropriate substitute for or endorsement of the original binder or cover note that accurately shows the current status of the coverage and the responsible insurer if, after issuance and delivery of the original binder or cover note, there is a change in:

(1) the identity of the insurer;

(2) the proportion of the direct risk assumed by an insurer; or

(3) any other material aspect of the insurance coverage.

§3–322.

(a) Each surplus lines broker shall keep separate records and accounts of all business transacted under the surplus lines broker's certificate of qualification, including copies of:

(1) any daily report made by the surplus lines broker; and

(2) each binder or cover note delivered by the surplus lines broker.

(b) The records described by subsection (a) of this section shall be kept by the surplus lines broker for 3 years after the issuance of the coverage to which the record relates and shall be available at any reasonable time during that period for examination by the Commissioner.

§3–324.

(a) This section does not apply to insurance of risks of the State or a political subdivision of the State.

(b) The premiums charged for surplus lines insurance are subject to a premium receipts tax of 3% on all gross premiums, less any returned premiums, charged for surplus lines insurance.

(c) For policies effective before July 21, 2011:

(1) if the policy covers property, risks, or exposures located or to be performed entirely in the State, the premium receipts tax shall be computed on the entire premium at the rate specified in subsection (b) of this section; and

(2) if the policy covers property, risks, or exposures located or to be performed both in and outside the State, the premium receipts tax shall be computed at the rate specified in subsection (b) of this section only on that portion of the premium that is properly allocable to the risks located in the State.

(d) For policies effective on or after July 21, 2011, if the State is the insured's home state, the premium receipts tax shall be computed on the entire premium at the rate specified in subsection (b) of this section.

(e) For policies effective on or after July 21, 2011, only the home state of an insured may receive premium receipts tax payments and reports for nonadmitted insurance.

(f) (1) On delivery of the cover note, certificate of insurance, policy, or other initial confirmation of insurance, a surplus lines broker shall charge the insured the amount of the premium receipts tax in addition to the full amount of the gross premium charged by the insurer for the surplus lines insurance.

(2) The surplus lines broker shall return to the insured the premium receipts tax on any unearned part of the premium.

(g) The surplus lines broker may not:

(1) absorb the premium receipts tax; or

(2) rebate all or part of the premium receipts tax or the surplus lines broker's commission.

(h) The Commissioner shall cooperate with other states to adopt and implement uniform requirements for nonadmitted insurance in compliance with the Act.

(i) For policies effective on or after July 21, 2011, the regulation of nonadmitted insurance is subject to the statutory and regulatory requirements solely of the home state of the insured.

§3–325.

(a) On or before March 15 and September 15 of each year, or at another interval that the Commissioner directs, each surplus lines broker that has transacted surplus lines business in the State during the reporting period shall:

(1) file with the Commissioner a report, on a form the Commissioner prescribes, on business subject to tax during the preceding half calendar year or other interval that the Commissioner directs; and

(2) pay to the Commissioner the total amount of tax stated in the report.

(b) By regulation, the Commissioner shall determine the required content and filing deadlines of the report.

(c) Each report shall be open to public inspection.

(d) A qualified surplus lines broker may credit any examination expense paid or assessed under § 2–208 of this article against the premium receipts tax due to the State.

(e) With respect to surplus lines premium receipts tax due to the State, a surplus lines broker is subject to the provisions of Title 6, Subtitle 1 of this article relating to penalties, interest, audits, assessments, limitations, appeals, and refunds.

§3–326.

(a) A surplus lines broker may not:

(1) knowingly or negligently deliver a false binder or cover note; or

(2) fail to notify the insured promptly of any material change with respect to surplus lines insurance by delivery to the insured of a substitute binder or cover note as provided in § 3-321 of this subtitle.

(b) A violation of subsection (a) of this section is a violation of this article.

(c) A person that violates subsection (a) of this section is guilty of a misdemeanor and on conviction is subject to the penalty provided by § 1-301 of this article or to any greater applicable penalty provided by law.

§3–327.

This subtitle is the Surplus Lines Insurance Law.

§4–101.

(a) (1) Except as otherwise provided in this article, a person may not act as an insurer and an insurer may not engage in the insurance business in the State unless the person has a certificate of authority issued by the Commissioner.

(2) An insurer may not have or maintain in this State an office, representative, or other facility to solicit or service any kind of insurance in another state unless the insurer is then authorized to engage in the same kind of insurance business in this State.

(b) A certificate of authority is not required for an insurer to engage in:

(1) transactions that relate to policies that were lawfully written in the State, or the liquidation of assets and liabilities of the insurer, including the collection of premiums on existing policies, resulting from former authorized operations of the insurer in the State;

(2) transactions that occur after issuance of a policy that covers only subjects of insurance not resident, located, or expressly to be performed in the State at the time of issuance, or that covers property in the course of transportation by land, air, or water to, from, or through the State, including any incidental preparation and storage, and the coverage was lawfully solicited, written, and delivered outside the State;

(3) transactions that relate to surplus lines coverages lawfully written under Title 3, Subtitle 3 of this article; or

(4) reinsurance transactions, except as to domestic reinsurers.

§4–102.

(a) To engage in the insurance business in the State, an insurer must:

(1) be in compliance with its charter powers and with this article; and

(2) be an incorporated stock insurer, incorporated mutual insurer, or reciprocal insurer.

(b) An insurer may not be authorized to engage in the insurance business in the State if the insurer has or uses a name that is so similar to the name of an insurer already so authorized as to tend to cause uncertainty or confusion or that tends to deceive or mislead about the type of organization of the insurer.

(c) (1) A foreign insurer may not be authorized to engage in the insurance business in the State if:

(i) the voting control or ownership of the foreign insurer is held in whole or substantial part by a government or governmental unit; or

(ii) the foreign insurer is operated for or by a government or governmental unit.

(2) For purposes of this subsection, membership in a mutual insurer, subscribership in a reciprocal insurer, ownership of stock of an insurer by the alien property custodian or similar official of the United States, or supervision of an insurer by a public insurance supervisory authority are not considered to be ownership, control, or operation of the insurer.

(d) (1) In this subsection, "Lloyds underwriters" means an aggregation of individuals who, under a common name, engage in the insurance business for profit through an attorney in fact who has authority, within the limits specified in the power of attorney, to obligate the underwriters severally on insurance contracts made or issued by the attorney in fact, in the name of the aggregation of individuals, to and with any person insured.

(2) A Lloyds underwriter may not be organized in the State and a foreign or alien Lloyds underwriter may not be authorized to engage in the insurance business in the State.

(3) This subsection does not restrict the right of insurers to place surplus lines coverages in and to cede reinsurance to foreign or alien Lloyds underwriters, if the surplus lines and reinsurance transactions are otherwise allowed under this article.

§4–103.

(a) Capital and surplus requirements for an insurer shall be based on all the kinds of insurance business that the insurer transacts or will transact, regardless of where the insurance business is transacted.

(b) To qualify for an initial certificate of authority to engage in one kind or a combination of kinds of insurance business, an insurer must have and maintain the capital stock and surplus requirements of:

(1) §§ 4–104 and 4–105 of this subtitle, for a stock insurer;

(2) Title 3, Subtitle 1 of this article, for a mutual insurer;

(3) Title 3, Subtitle 2 of this article, for a reciprocal insurer;

(4) Title 8, Subtitle 4 of this article, for a fraternal benefit society; and

(5) Title 14, Subtitle 1 of this article, for a nonprofit health service plan.

(c) (1) In addition to any other capital and surplus requirements of this article, each insurer's assets and surplus as regards policyholders shall be reasonable in relation to the insurer's outstanding liabilities and adequate to its financial needs.

(2) In determining whether an insurer's assets and surplus as regards policyholders are reasonable in relation to the insurer's outstanding liabilities and adequate to its financial needs, the following factors, among others, shall be considered:

(i) the size of the insurer as measured by its assets, capital and surplus, reserves, premium writings, insurance in force, and other appropriate criteria;

(ii) the extent to which the insurer's business is diversified among the several lines of insurance;

(iii) the number and size of risks insured in each line of insurance;

(iv) the geographical dispersion of the insurer's insured risks;

(v) the nature and extent of reinsurance of the insurer's risks;

(vi) the quality, diversification, and liquidity of the insurer's investment portfolio;

(vii) the recent past and projected future trends in the size of the insurer's surplus as regards policyholders;

(viii) the surplus as regards policyholders maintained by comparable insurers; and

(ix) the financial position of the insurer, after excluding from assets investments in and other transactions with persons that directly or indirectly, through one or more intermediaries, control, are controlled by, or are under common control with another person.

(d) The provisions of this subtitle shall be supplemented by the requirements of Subtitle 3 of this title.

§4–104.

(a) Except as otherwise provided in this article, to qualify for a certificate of authority to engage in one kind of insurance business, an insurer that started business in the State on or before June 30, 1965, must have and maintain paid–in capital stock with a fixed nominal or par value in an amount not less than that applicable under the following schedule:

	Kind of Insurance Business	Minimum Capital Stock Required
(1)	life insurance including annuities and health insurance ……	$200,000
(2)	health insurance ……	$100,000
(3)	property insurance and marine insurance other than wet marine and transportation insurance…	$250,000
(4)	title insurance ……	$250,000
(5)	wet marine and transportation insurance …….	$250,000
(6)	casualty insurance, not including vehicle liability insurance for workers' compensation insurance …	$250,000
(7)	vehicle liability insurance ……	$250,000

(8)	workers' compensation insurance	$250,000
(9)	surety insurance	$250,000

(b) To qualify for a certificate of authority to engage in two or more kinds of insurance business, an insurer that started business in the State on or before June 30, 1965, must have paid–in capital stock with a fixed nominal or par value in an amount not less than the lesser of:

(1) the combined sum of the capital stock required for each of the kinds of insurance business to be authorized; or

(2) $500,000.

(c) Except as otherwise provided in this article, to qualify for a certificate of authority to engage in one kind of insurance business, an insurer that started business in the State during the period from July 1, 1965, to June 30, 1991, both inclusive, must have and maintain paid–in capital stock with a fixed nominal or par value in an amount not less than that applicable under the following schedule:

Kind of Insurance Business		Minimum Capital Stock Required
(1)	life insurance including annuities and health insurance	$500,000
(2)	health insurance	$250,000
(3)	property insurance and marine insurance other than wet marine and transportation insurance...	$250,000
(4)	title insurance	$250,000
(5)	wet marine and transportation insurance	$250,000
(6)	casualty insurance, not including vehicle liability insurance for workers' compensation insurance ...	$250,000
(7)	vehicle liability insurance	$250,000
(8)	workers' compensation insurance	$250,000
(9)	surety insurance	$250,000

(d) To qualify for a certificate of authority to engage in two or more kinds of insurance business, an insurer that started business in the State during the period from July 1, 1965, to June 30, 1991, both inclusive, must have paid–in capital stock with a fixed nominal or par value in an amount not less than $500,000.

(e) Except as otherwise provided in this article, to qualify for a certificate of authority to engage in one kind of insurance business, an insurer that started business in the State on or after July 1, 1991, must have and maintain paid–in capital stock with a fixed nominal or par value in an amount not less than that applicable under the following schedule:

	Kind of Insurance Business	Minimum Capital Stock Required
(1)	life insurance including annuities.....	$1,500,000
(2)	health insurance	$750,000
(3)	property insurance and marine insurance other than wet marine and transportation insurance...	$750,000
(4)	title insurance	$750,000
(5)	wet marine and transportation insurance	$750,000
(6)	casualty insurance, not including vehicle liability insurance for workers' compensation insurance ...	$250,000
(7)	vehicle liability insurance	$750,000
(8)	workers' compensation insurance	$750,000
(9)	surety insurance	$750,000

(f) To qualify for a certificate of authority to engage in two or more kinds of insurance business, an insurer that started business in the State on or after July 1, 1991, must have paid–in capital stock with a fixed nominal or par value in an amount not less than $1,500,000.

(g) On or after July 1, 2001, an insurer that qualified for a certificate of authority to engage in any kind of insurance business on or before June 30, 1991, must have and maintain paid–in capital stock with a fixed nominal or par value in

an amount not less than 150% of that required of an insurer authorized to start insurance business in the State on June 30, 1991.

§4–104.1.

Notwithstanding the provisions of § 4–104 of this subtitle, a title insurer domiciled in this State shall have and maintain paid–in capital stock with a fixed nominal or par value in the amount of:

(1) $500,000 as of July 1, 2010;

(2) $625,000 as of July 1, 2011; and

(3) $750,000 as of July 1, 2012, and each July 1 thereafter.

§4–105.

(a) In addition to the minimum capital stock required by § 4-104 of this subtitle, to qualify for an initial certificate of authority to engage in one kind or a combination of kinds of insurance business, an insurer must have surplus assets or funds in an amount not less than 150% of the minimum capital stock required.

(b) For authority to continue in the insurance business, in addition to the minimum capital stock required by § 4-104 of this subtitle, an insurer that started business in the State on or after July 1, 1966, must maintain surplus assets or funds in an amount not less than 100% of the minimum capital stock required.

(c) (1) For authority to continue in the insurance business, in addition to the minimum capital stock required by § 4-104 of this subtitle, an insurer that started business in the State on or before June 30, 1966:

(i) must maintain surplus assets or funds in an amount not less than 50% of the minimum capital stock required; and

(ii) if authorized to write vehicle liability insurance, must maintain surplus assets or funds in an amount not less than $300,000, whether or not the insurer also is authorized to write other kinds of insurance.

(2) The combined amount of surplus required by items (i) and (ii) of paragraph (1) of this subsection may not exceed the amount of surplus required by subsection (b) of this section of an insurer authorized on or after July 1, 1966, to transact the same kinds of insurance business.

§4–105.1.

Notwithstanding the provisions of § 4–105 of this subtitle, a title insurer domiciled in this State shall have and maintain minimum surplus in the amount of:

(1) $500,000 as of July 1, 2010;

(2) $625,000 as of July 1, 2011; and

(3) $750,000 as of July 1, 2012, and each July 1 thereafter.

§4–106.

(a) Except as provided in subsections (b) and (c) of this section, to qualify for a certificate of authority, an insurer shall deposit and maintain in trust with the Treasurer, for the protection of the insurer's policyholders and creditors, an amount not less than $100,000 in:

(1) cash; or

(2) government securities eligible for the investment of capital funds of domestic insurers as specified in § 5-701(b) of this article.

(b) For a foreign insurer, instead of all or part of the deposit required by subsection (a) of this section, the Commissioner shall accept the current certificate of the insurance supervisory official of another state showing that a like deposit by the foreign insurer is being maintained:

(1) in public custody or in a depository approved by the official; and

(2) in trust for protection of the policyholders and creditors of the foreign insurer in the United States.

(c) For an alien insurer, instead of all or part of the deposit required by subsection (a) of this section, the Commissioner shall accept evidence satisfactory to the Commissioner that the alien insurer maintains in the United States assets available for discharge of its insurance obligations in the United States:

(1) in public depositories, or in trust institutions in the United States approved by the Commissioner; and

(2) in an amount not less than the outstanding liabilities of the insurer arising out of its insurance business in the United States, plus an amount equal to the deposit required under this section for other insurers requesting authority to engage in like kinds of insurance business.

§4–107.

(a) On the form that the Commissioner provides, each insurer applying for a certificate of authority must appoint the Commissioner as attorney for service of process issued against the insurer in the State.

(b) The appointment:

(1) is irrevocable;

(2) binds the insurer and any successor in interest or successor to the assets and liabilities of the insurer; and

(3) remains in effect as long as there is in force in the State a contract made by the insurer or an obligation arising from a contract made by the insurer.

§4–108.

An applicant for an initial certificate of authority shall:

(1) file with the Commissioner an application on the form that the Commissioner provides;

(2) pay to the Commissioner the applicable fees required by § 2-112 of this article; and

(3) file with the Commissioner:

(i) a certified copy of its articles of incorporation with all amendments;

(ii) a certified copy of its bylaws with all amendments;

(iii) a copy of its annual statement as of the immediately preceding December 31;

(iv) for a foreign insurer or alien insurer, a copy of the report of last examination, if any, made of the insurer certified by the insurance supervisory official of the state of domicile of the foreign insurer or the state of entry into the United States of the alien insurer;

(v) for a foreign insurer or alien insurer, a certificate of the insurance supervisory official of the state or country of domicile or state of entry into

the United States of the insurer showing that the insurer is authorized to transact the kinds of insurance business proposed to be transacted in this State;

(vi) for an alien insurer, a copy of the appointment and authority of its United States manager;

(vii) a certificate evidencing a deposit in accordance with § 4-106 of this subtitle; and

(viii) any other information and documents that the Commissioner considers necessary to protect policyholders or ensure compliance with this article.

§4–109.

(a) Within a reasonable time after the filing of a completed application for an initial certificate of authority, the Commissioner shall:

(1) issue an appropriate certificate of authority; or

(2) disapprove the application and state the grounds for disapproval.

(b) On request of an insurer, the Commissioner may issue a certificate of authority limited to a particular type of insurance or insurance coverage within the scope of a kind of insurance.

§4–110.

A certificate of authority shall state the kind or combination of kinds of insurance business that the insurer is authorized to transact in the State.

§4–111.

(a) Except as otherwise provided in this section, a certificate of authority authorizes an insurer to engage in one kind or a combination of kinds of insurance business.

(b) (1) Subject to paragraph (2) of this subsection, an insurer authorized to engage in the business of life insurance may also write annuity contracts but the insurer is not authorized to engage in any other kind of insurance business except health insurance.

(2) The Commissioner shall continue to authorize an insurer authorized to engage in the business of life insurance to engage in other kinds of insurance business, in addition to annuities and health insurance, if the insurer:

(i) was authorized to engage in one kind or a combination of kinds of insurance business in addition to life insurance, health insurance, and annuities immediately before December 31, 1963; and

(ii) is otherwise qualified to engage in that kind or combination of kinds of insurance business.

(c) A reciprocal insurer may not engage in the business of life insurance or health insurance except as supplementary coverage in policies of liability insurance.

§4–112.

(a) A certificate of authority expires on the first June 30 after its effective date unless it is renewed as provided in this section.

(b) At least 2 months before a certificate of authority expires, the Commissioner shall mail to the holder of the certificate of authority, at the last known address of the holder, or by electronic means in accordance with § 2–116 of this article:

(1) a renewal application form; and

(2) a notice that states:

(i) the date on which the current certificate of authority expires;

(ii) the date by which the Commissioner must receive the renewal application for the renewal to be issued and mailed before the certificate of authority expires; and

(iii) the amount of the renewal fee.

(c) Before a certificate of authority expires, the holder of the certificate of authority may renew it for an additional 1-year term, if the holder:

(1) otherwise is entitled to a certificate of authority;

(2) files with the Commissioner a renewal application on the form that the Commissioner provides; and

(3) pays to the Commissioner the appropriate renewal fee required by § 2-112 of this article.

(d) (1) The Commissioner shall renew the certificate of authority of each holder who meets the requirements of this subtitle.

(2) If a certificate holder pays the applicable renewal fee before the certificate of authority expires, the certificate of authority remains in effect until the Commissioner renews or refuses to renew the certificate of authority.

(e) (1) An insurer shall mail, or send by electronic means in accordance with § 2–116 of this article, a renewal application and the applicable renewal fee on or before June 30. An insurer that fails to renew its certificate of authority on or before June 30 may forfeit:

(i) $500 for each day from July 1 through July 10;

(ii) $1,000 for each day from July 11 through July 31; and

(iii) $5,000 for each day after July 31.

(2) In addition to the provisions imposed under paragraph (1) of this subsection, an insurer that fails to renew its certificate of authority on or before June 30 in the previous year shall:

(i) renew its certificate of authority on or before June 1 of the current year; and

(ii) forfeit $3,000 if the insurer fails to renew its certificate of authority on or before June 30 in the current year.

(3) In addition to the monetary penalties imposed under this subsection, on July 1 of each year, for each insurer that fails to file its renewal application and continuation fee on or before June 30, the Commissioner may:

(i) order that the insurer cease and desist from engaging further from the writing of insurance in this State in accordance with § 4–114 of this subtitle; or

(ii) issue an order to require the insurer to show cause why it should be allowed to continue to engage in the insurance business in the State.

(f) In determining the amount of any financial penalty or forfeiture to be imposed under this section, the Commissioner:

(1) shall consider the following factors:

(i) the seriousness of the violation;

(ii) the good faith of the violator;

(iii) the violator's history of previous violations;

(iv) the deleterious effect of the violation on the public and the insurance industry; and

(v) the assets of the violator; and

(2) may determine the appropriate amount of the penalty or forfeiture.

§4–113.

(a) The Commissioner shall deny a certificate of authority to an applicant or refuse to renew, suspend, or revoke a certificate of authority if:

(1) the action is required by any provision of this article;

(2) the insurer no longer meets the requirements for the certificate of authority because of a deficiency in assets or any other reason;

(3) the business of the insurer is fraudulently conducted;

(4) the insurer is insolvent, or its assets are not sufficient for carrying on its business;

(5) the insurer fails to pay taxes on premiums required under this article;

(6) the insurer willfully fails to provide the Commissioner with required information about medical malpractice insurance issued by the insurer in this State or any other state;

(7) the issuance or renewal of a certificate of authority is contrary to the public interest;

(8) the Commissioner finds that the principal management personnel of the insurer is:

(i) untrustworthy or not of good character; or

(ii) so lacking in insurer managerial experience as to make the proposed operation hazardous to the insurance–buying public or to the insurer's stockholders; or

(9) the Commissioner has good reason to believe that the insurer is affiliated, directly or indirectly, through ownership, control, management, reinsurance transactions, or other insurance or business relations with a person whose business operations are or have been marked by the manipulation of assets, accounts, or reinsurance or by bad faith, to the detriment of insureds, stockholders, or creditors.

(b) The Commissioner may deny a certificate of authority to an applicant or, subject to the hearing provisions of Title 2 of this article, refuse to renew, suspend, or revoke a certificate of authority if the applicant or holder of the certificate of authority:

(1) violates any provision of this article other than one that provides for mandatory denial, refusal to renew, suspension, or revocation for its violation;

(2) knowingly fails to comply with a regulation or order of the Commissioner;

(3) is found by the Commissioner to be in unsound condition or in a condition that renders further transaction of insurance business hazardous to the insurer's policyholders or the public;

(4) is engaged in writing policies in a jurisdiction in which it operates on a premium basis that the Commissioner finds to be insufficient, insecure, or impracticable so as to endanger the solvency of the insurer;

(5) refuses or delays payment of amounts due claimants without just cause;

(6) refuses to be examined or to produce its accounts, records, or files for examination by the Commissioner when required;

(7) refuses to provide additional information that the Commissioner considers advisable in considering an application for renewal of the certificate of authority;

(8) fails to pay a final judgment against it in the State within 30 days after the judgment becomes final;

(9) is affiliated with and under the same general management or interlocking directorate or ownership as another insurer that transacts direct insurance in the State without having a certificate of authority to do so, except as allowed to a surplus lines insurer under Title 3, Subtitle 3 of this article;

(10) is found by the Commissioner to have participated, with or without the knowledge of an insurance producer, in selling motor vehicle insurance without an actual intent to sell the insurance, as evidenced by a persistent pattern of filing certificates of insurance together with or closely followed by cancellation notices for the insurance;

(11) except as allowed under § 10–103(c) of this article, is found by the Commissioner to have knowingly participated with a person, acting as an insurance producer, that does not have an appointment from the insurer in accepting insurance contracts that the person has sold, solicited, or negotiated, if committed with sufficient frequency to indicate a general business practice;

(12) has had a certificate of authority revoked or suspended by the insurance regulatory authority of another state;

(13) has violated the provisions of Title 6.5 of the State Government Article;

(14) fails to provide to the Commissioner or an insurance producer any information required by § 10–118 of this article regarding the termination of an appointment of the insurance producer; or

(15) in providing information required by or provided pursuant to § 10–118 of this article regarding the termination of an appointment of an insurance producer, makes an inaccurate statement with actual malice.

(c) (1) On refusal to renew, suspension, or revocation of an insurer's certificate of authority, the Commissioner immediately shall notify:

(i) the insurer; and

(ii) each insurance producer of the insurer in the state of record in the office of the Commissioner.

(2) The refusal to renew, revocation, or suspension of a certificate of authority automatically suspends or revokes the appointment of each insurance producer of the insurer in the State.

(3) The Commissioner shall state in the notice to each insurance producer under paragraph (1) of this subsection that the appointment of the insurance producer has been suspended or revoked.

(4) The Commissioner may publish notice of the revocation of a certificate of authority in a newspaper published in the State.

(d) Instead of or in addition to suspending or revoking a certificate of authority, the Commissioner may:

(1) impose on the holder a penalty of not less than $100 but not more than $125,000 for each violation of this article; and

(2) require the holder to make restitution to any person who has suffered financial injury because of the violation of this article including requiring the holder to:

(i) fulfill any obligation under the policies or contracts of the holder that the holder failed to fulfill in violation of this article; or

(ii) pay a claim or an amount due under an insurance policy or contract not paid in violation of this article.

(e) The Commissioner shall adopt regulations to:

(1) establish standards for the imposition of a penalty under subsection (d) of this section; and

(2) carry out the provisions of subsection (b)(11) of this section.

§4–114.

(a) Without notice and before hearing, the Commissioner may issue and have served on an insurer an order requiring the insurer immediately to cease and desist from writing insurance in the State if it appears to the Commissioner that:

(1) the insurer is:

(i) conducting its business and affairs in a manner that threatens to make it insolvent or that is hazardous to its policyholders, creditors, or the general public; or

(ii) engaged in an act, practice, or transaction that constitutes grounds making the insurer subject to conservation or liquidation proceedings; and

(2) irreparable loss and injury to the property and business of the insurer or the general public has occurred or may occur unless the Commissioner acts immediately.

(b) (1) When an order is served on an insurer under subsection (a) of this section, the Commissioner shall issue and also serve on the insurer notice of a hearing to be held at a place and time not later than 5 days after the date of the order.

(2) If the insurer waives the right to a hearing within 5 days after the date of the order, the hearing shall be held within 30 days after service of the order.

§4–115.

(a) (1) In this section the following words have the meanings indicated.

(2) "Domestic reinsurer" means an authorized insurer that:

(i) operates solely as a reinsurer, as defined in § 5–901 of this article;

(ii) does not have any gross direct written premium; and

(iii) is domiciled in the State.

(3) "Financial guaranty insurance company" means an insurer that derives at least 90% of its gross written premium from the business of financial guaranty insurance and financial guaranty reinsurance.

(4) "Financial guaranty reinsurance company" means an insurer that derives at least 90% of its gross written premium from the business of financial guaranty reinsurance.

(b) (1) Except as provided in paragraph (2) of this subsection, a domestic insurer may not move its home or executive office out of the State without notice to and approval by the Commissioner.

(2) (i) A financial guaranty reinsurance company or financial guaranty insurance company that became domiciled in the State on or before December 31, 1993, is not required to have an office in the State.

(ii) A domestic reinsurer that became domiciled in the State on or before December 31, 1995, is not required to have an office in the State.

(c) (1) A domestic insurer, including a reciprocal insurer, fraternal benefit society, or nonprofit health service plan, with its home or executive office in the State shall keep in the State:

(i) its general ledger accounting records; and

(ii) all of its assets except:

1. real property lawfully owned by the insurer and located outside of the State, personal property appurtenant to the real property, or mortgages on the real property;

2. property of the insurer that is customary and necessary to the operation of the insurer's branch offices outside of the State;

3. securities deposited in a jurisdiction outside of the State as a condition of authority to transact business in that jurisdiction or securities deposited in connection with obtaining surety bonds;

4. securities held either by the insurer or in compliance with regulations adopted by the Commissioner; and

5. transactions or securities involved in transactions authorized by § 5–511(n) and (o) of this article or any other transactions or securities involved in transactions exempted by the Commissioner from this paragraph.

(2) A financial guaranty reinsurance company or financial guaranty insurance company that became domiciled in the State on or before December 31, 1993, and that does not have its home or executive office in the State:

(i) shall keep in the State its entire assets as required by paragraph (1)(ii) of this subsection; and

(ii) may keep its general ledger accounting records outside the State if it makes those records available in the State to the Commissioner within 2 business days after being requested to do so by the Commissioner.

(3) A domestic reinsurer that became domiciled in the State on or before December 31, 1995, and that does not have its home or executive office in the State:

(i) shall keep in the State its entire assets as required by paragraph (1)(ii) of this subsection; and

(ii) may keep its general ledger accounting records outside the State if it makes those records available in the State to the Commissioner within 2 business days after being requested to do so by the Commissioner.

(d) This section does not prohibit the holding of funds or transmission of securities outside of the State to:

(1) secure or record title to the securities; or

(2) sell, lend, buy, redeem, or exchange the securities or alter the provisions of the securities.

§4–116.

(a) (1) On or before March 1 of each year, unless the Commissioner extends the time for good cause, each authorized insurer shall file with the Commissioner a complete statement of its financial condition, transactions, and affairs for the immediately preceding calendar year.

(2) The annual statement shall:

(i) be in the form and have the content approved for current use by the National Association of Insurance Commissioners or its successor organization; and

(ii) contain any additional information that the Commissioner requires.

(3) Unless the Commissioner requires otherwise, the statement of an alien insurer shall relate only to its transactions and affairs in the United States.

(4) Unless the Commissioner extends the time for filing, an authorized insurer that fails to file an annual statement on or before March 10 shall pay a penalty of:

(i) $100 for each day from March 1 to March 10, both inclusive; and

(ii) $150 for each day from March 11 to the day before the Commissioner receives the statement, both inclusive.

(b) At any time, the Commissioner may require an authorized insurer to file an interim statement containing the information that the Commissioner considers necessary.

(c) (1) Except as provided in subsection (d) of this section, on or before June 1 of each year, an authorized insurer shall file with the Commissioner an audited financial report for the immediately preceding calendar year.

(2) The authorized insurer shall have the report prepared by an independent certified public accountant.

(3) The Commissioner may:

(i) set requirements for the form and content of the report; and

(ii) for good cause, extend the time for filing the report.

(4) Unless the Commissioner extends the time for filing, an authorized insurer that fails to file an audited financial report on or before June 10 shall pay a penalty of:

(i) $100 for each day from June 1 to June 10, both inclusive; and

(ii) $150 for each day from June 11 to the day before the Commissioner receives the report, both inclusive.

(d) With 90 days' advance notice, the Commissioner may require an authorized insurer to file an audited financial report earlier than the date specified in subsection (c) of this section.

§4–117.

(a) At the time of payment, if the payment has been specifically authorized by the claimant's attorney, an insurer shall provide written notice to a third party claimant of payment of $2,000 or more in settlement of a third party liability claim for bodily injury if:

(1) the claimant is an individual; and

(2) the payment is delivered to the claimant's attorney by check, draft, or other means.

(b) The notice required by subsection (a) of this section shall be sent by regular mail no more than 5 working days after payment is delivered under subsection (a)(2) of this section to the claimant at the last known address of the claimant.

(c) The insurer may provide notice to the claimant by a copy of the letter of transmittal to the claimant's attorney.

(d) This section may not be construed to create:

(1) a cause of action for any person against an insurer based on the insurer's failure to provide the notice required by this section; or

(2) a defense for any party against a cause of action based on the insurer's failure to provide the notice required by this section.

§4–118.

(a) The Commissioner may not recognize any person as a qualified independent certified public accountant unless the person:

(1) is in good standing:

(i) with the Maryland State Board of Public Accountancy; and

(ii) with the appropriate state board of accountancy of any other state in which the accountant is licensed to practice; or

(2) in the case of a Canadian or British accountant, is a chartered accountant.

(b) Except as otherwise provided in this section, an independent certified public accountant shall be recognized as qualified as long as the accountant conforms to:

(1) for any certified public accountant not licensed in this State, the standards of the accountancy profession, as contained in the Code of Professional Ethics of the American Institute of Certified Public Accountants; or

(2) (i) Title 2 of the Business Occupations and Professions Article; and

(ii) the regulations and rules of professional conduct established by the Maryland State Board of Public Accountancy.

(c) (1) (i) A partner in an accounting firm responsible for preparing an audited financial report under § 4–116 of this subtitle for an insurer may not act in that capacity for more than 5 consecutive years for the same insurer.

(ii) If a partner in an accounting firm responsible for preparing an audited financial report under § 4–116 of this subtitle for an insurer exceeds 5 consecutive years in that capacity, the partner shall be disqualified from acting in the same or similar capacity for that insurer or its insurance subsidiaries or affiliates for a period of not less than 5 consecutive years.

(2) (i) An insurer may apply to the Commissioner for an exception from the prohibition of paragraph (1) of this subsection on the basis of unusual circumstances.

(ii) In determining whether unusual circumstances exist that would justify the granting of an exception, the Commissioner may consider:

1. the number of partners in the accounting firm currently used by the insurer, the expertise of the partners in that firm, and the number of insurance clients of that firm;

2. the premium volume of the insurer; and

3. the number of jurisdictions in which the insurer transacts business.

(d) The Commissioner may not recognize as a qualified independent certified public accountant, or accept any audited financial report prepared in whole or in part by, any individual who:

(1) has been convicted of fraud, bribery, a violation of the Racketeer Influenced and Corrupt Organizations Act, 18 U.S.C. §§ 1961-1968, or any dishonest conduct or practices under federal or State law;

(2) has violated the insurance laws of this State with respect to any audited financial reports previously submitted by that individual;

(3) has violated any provision of Title 2 of the Business Occupations and Professions Article or any regulation or rule of professional conduct established by the State Board of Public Accountancy; or

(4) has demonstrated a pattern or practice of failing to detect or disclose material information in any audited financial reports previously submitted by that individual.

(e) (1) Subject to §§ 2-210 through 2-215 of this article, the Commissioner may hold a hearing to determine whether a certified public accountant is qualified.

(2) After considering the evidence presented at the hearing, the Commissioner shall rule on whether the accountant is qualified for purposes of expressing an opinion on the financial statements in the audited financial report required under § 4-116 of this subtitle.

(3) If the Commissioner finds that the accountant is not qualified, the Commissioner shall require the insurer to replace the accountant with another who is qualified as provided under this section.

§4–201.

(a) In this section, "industrial insured" means an insured that:

(1) procures the insurance of a risk by the services of a full-time employee acting as an insurance manager or buyer or a regularly and continuously retained qualified insurance consultant;

(2) has aggregate annual premiums for insurance on all risks that total at least $100,000; or

(3) has at least 25 full-time employees.

(b) This subtitle does not apply to:

(1) transactions in the State that involve, and are subsequent to the issuance of, a policy that was lawfully solicited, written, and delivered outside of the State that covers only a subject of insurance not resident, located, or expressly to be performed in the State at the time of issuance of the policy;

(2) an individual life insurance policy or individual health insurance policy in force on July 1, 1968;

(3) reinsurance of the liability of an authorized insurer;

(4) insurance against perils of navigation, transit, or transportation on hulls, freights, or disbursements, or other shipowner interest, on goods, wares, merchandise, and all other personal property and interests in personal property in the course of exportation from or importation into a country, or transportation coastwise, including transportation by land or water from point of origin to final destination and including war risks, and on marine builder's risks, dry docks, and marine railways, including insurance of ship repairer's liability, and protection and indemnity insurance, except for insurance covering:

(i) bridges and tunnels;

(ii) pleasure craft that are under 60 feet in length and are owned and used for pleasure and not for business, hire, or other commercial use;

(iii) fishing vessels under 50 gross tons that are not part of a fleet of three or more vessels; or

(iv) charter or head boats under 50 gross tons that are not part of a fleet of three or more vessels;

(5) aircraft insurance;

(6) insurance on property or operations of railroads engaged in interstate commerce;

(7) surplus lines insurance effected in accordance with Title 3, Subtitle 3 of this article;

(8) insurance against legal liability arising out of the ownership, operation, or maintenance of property with a permanent situs outside of the State; or

(9) insurance against loss of or damage to property with a permanent situs outside of the State.

(c) Except for the premium tax requirement of § 4-209 of this subtitle and the reporting requirement of § 4-210 of this subtitle, this subtitle does not apply to an insurer or underwriter issuing an insurance contract to an industrial insured.

§4–202.

(a) The General Assembly finds that:

(1) many residents of the State hold policies issued by insurers and other persons not authorized to do insurance business in the State;

(2) these residents face the often insurmountable obstacle of asserting their legal rights under those policies in forums that are foreign to them and under laws and rules of practice that are unfamiliar to them; and

(3) protection from the acts of insurers and other persons not authorized to do insurance business in the State can be achieved by:

(i) maintaining fair and honest insurance markets;

(ii) protecting the premium tax revenues of the State;

(iii) protecting authorized insurers, which are subject to strict regulation, from unfair competition by unauthorized persons and unauthorized insurers; and

(iv) protecting against evasion of the insurance regulatory laws of the State.

(b) (1) The General Assembly intends to subject certain insurers and other persons to the jurisdiction of the Commissioner, in proceedings before the Commissioner, and to the courts of the State in suits by or for the State and insureds or beneficiaries under insurance contracts.

(2) To carry out this intent, the General Assembly provides for substituted service of process on certain insurers and other persons in any proceeding in a court and substituted service of any notice, order, pleading, or process on certain insurers and other persons in any proceeding before the Commissioner to enforce or effect full compliance with the insurance and tax laws of the State.

(c) In carrying out the intent of this subtitle, the General Assembly declares that it is exercising:

(1) its power to protect the residents of the State;

(2) its power to define what constitutes doing an insurance business in the State; and

(3) its powers and privileges under the McCarran-Ferguson Act.

§4–203.

(a) This section does not apply to:

(1) acceptance of service of process;

(2) surplus lines insurance;

(3) a transaction for which a certificate of authority is not required under § 4-101(b) of this title;

(4) reinsurance, as authorized under Title 5, Subtitle 9 of this article;

(5) an adjuster while providing services with respect to a claim under a policy lawfully solicited, issued, and delivered outside of the State; or

(6) the professional services of an attorney at law.

(b) With respect to a subject of insurance resident, located, or to be performed in the State, a person may not in the State directly or indirectly act as an insurance producer for, or otherwise represent or help on behalf of another, an unauthorized insurer to:

(1) solicit, negotiate, or effect insurance or an annuity contract;

(2) inspect risks;

(3) fix rates;

(4) investigate or adjust losses;

(5) collect premiums; or

(6) transact insurance business in any other manner.

§4–204.

(a) (1) A person may not accept for publication or printing in a newspaper, magazine, or other periodical, or for broadcast on radio or television in the State, an advertisement or other notice that directly or indirectly solicits business for or sets forth the advantages of doing business with an insurer, insurance producer, or other person, unless the person that will publish or broadcast the advertisement or notice has a certificate issued by the Commissioner stating that the insurer, insurance producer, or other person named in the certificate is authorized to transact insurance business in the State.

(2) On application of any person, the Commissioner shall issue the certificate without charge.

(b) A person may not publish or print in a newspaper, magazine, periodical, circular letter, pamphlet, or in any other manner, or broadcast by radio or television in the State, an advertisement or other notice that directly or indirectly solicits business for or sets forth the advantages of doing business with an insurer, insurance producer, or other person that is not authorized to transact insurance business in the State.

(c) A manufacturer, jobber, wholesaler, or retailer may not distribute or cause to be distributed matchbooks or other advertising matter, except newspapers and magazines of general circulation, that directly or indirectly solicits business for or sets forth the advantages of doing business with an insurer, insurance producer, or other person that is not authorized to transact insurance business in the State.

§4–205.

(a) This section does not apply to:

(1) the lawful transaction of surplus lines insurance;

(2) the lawful transaction of reinsurance by insurers;

(3) transactions in the State that involve, and are subsequent to the issuance of, a policy that was lawfully solicited, written, and delivered outside of the State covering only a subject of insurance not resident, located, or expressly to be performed in the State at the time of issuance of the policy;

(4) transactions that involve insurance contracts that are independently procured through negotiations occurring entirely outside of the State and that are reported and on which the premium tax is paid in accordance with §§ 4–210 and 4–211 of this subtitle;

(5) an attorney while acting in the ordinary relation of attorney and client in the adjustment of claims or losses;

(6) unless otherwise determined by the Commissioner, transactions in the State that involve group or blanket insurance or group annuities if the master policy of the group was lawfully issued and delivered in another state in which the person was authorized to engage in insurance business; or

(7) a health care practitioner or set of health care practitioners, as defined in § 15–113 of this article, that accepts capitated payments in accordance with § 15–2102 of this article, but performs no other acts considered acts of an insurance business.

(b) An insurer or other person may not, directly or indirectly, do any of the acts of an insurance business set forth in subsection (c) of this section, except as provided by and in accordance with the specific authorization of statute.

(c) Any of the following acts in the State, effected by mail or otherwise, is considered to be doing an insurance business in the State:

(1) making or proposing to make, as an insurer, an insurance contract;

(2) making or proposing to make, as guarantor or surety insurer, a contract of guaranty or suretyship as a vocation and not merely incidental to another legitimate business or activity of the guarantor or surety insurer;

(3) taking or receiving an application for insurance;

(4) receiving or collecting premiums, commissions, membership fees, assessments, dues, or other consideration for insurance;

(5) issuing or delivering an insurance contract to a resident of the State or a person authorized to do business in the State;

(6) except as provided in subsection (d) of this section, with respect to a subject of insurance resident, located, or to be performed in the State, directly or indirectly acting as an insurance producer for, or otherwise representing or helping on behalf of another, an insurer or other person to:

(i) solicit, negotiate, procure, or effect insurance or the renewal of insurance;

(ii) disseminate information about coverage or rates;

(iii) forward an application;

(iv) deliver a policy or insurance contract;

(v) inspect risks;

(vi) fix rates;

(vii) investigate or adjust claims or losses;

(viii) transact matters arising out of an insurance contract after the insurance contract becomes effective; or

(ix) in any other manner represent or help an insurer or other person to transact insurance business;

(7) doing any kind of insurance business specifically recognized as doing an insurance business under statutes relating to insurance;

(8) doing or proposing to do any insurance business that is substantially equivalent to any act listed in this subsection in a manner designed to evade the statutes relating to insurance; or

(9) as an insurer transacting any other business in the State.

(d) Subsection (c)(6) of this section does not prohibit a full-time salaried employee of a corporate insured from acting as an insurance manager or buyer in placing insurance for the corporate insured.

(e) For purposes of this section, the venue of an act effected by mail is at the point where the matter transmitted by mail is delivered and takes effect.

§4–206.

(a) An unauthorized foreign insurer or unauthorized alien insurer is deemed to have appointed the Commissioner to be the attorney of the unauthorized insurer for purposes of service of process in a proceeding instituted by or for an insured or beneficiary arising out of an insurance contract and to have agreed that service on the Commissioner has the same legal effect as personal service in the State on the unauthorized insurer, if the unauthorized insurer in the State, by mail or otherwise:

(1) issues or delivers insurance contracts to residents of the State or corporations authorized to do business in the State;

(2) solicits applications for insurance contracts;

(3) collects premiums, membership fees, assessments, or other considerations for insurance contracts; or

(4) transacts any other insurance business.

(b) (1) Service of process on the Commissioner under this subsection shall be made by:

(i) delivering to the Commissioner or an individual in apparent charge of the office of the Commissioner two copies of the process; and

(ii) paying to the Commissioner a service of process fee of $15.

(2) Immediately after receipt of process, the Commissioner shall send one copy of the process by certified mail, return receipt requested, bearing a postmark from the United States Postal Service, to the unauthorized insurer at its last known principal place of business.

(3) Service of process under this subsection is sufficient if:

(i) within 10 days after delivering copies of the process to the Commissioner under paragraph (1) of this subsection, the plaintiff or plaintiff's attorney sends notice of the service and a copy of the process by certified mail, return receipt requested, bearing a postmark from the United States Postal Service, to the unauthorized insurer at its last known principal place of business; and

(ii) on or before the date that the unauthorized insurer is required to appear or within any further time that the court allows, the plaintiff or plaintiff's attorney files with the clerk of the court in which the action is pending:

1. the unauthorized insurer's receipt, or the receipt issued by the United States Postal Service, showing the name of the sender of the letter and the name and address of the addressee; and

2. an affidavit of the plaintiff or plaintiff's attorney showing compliance with paragraph (1) of this subsection.

(4) (i) The service of process fee shall be taxed in the costs of the proceeding.

(ii) A court may award reimbursement of the service of process fee to a prevailing plaintiff in any proceeding against an unauthorized insurer.

(iii) The Commissioner:

1. shall account quarterly to the Comptroller for fees collected under this subsection; and

2. after deducting expenses for mailing the process under paragraph (2) of this subsection, shall pay the fees on accounting to the State Treasurer, for the use of the State.

(5) The Commissioner shall keep a record of all process served on the Commissioner under this subsection.

(c) As an alternative to service of process under subsection (b) of this section, service of process is valid if:

(1) service of process is made on any person in the State that, on behalf of an unauthorized foreign insurer or unauthorized alien insurer, is doing an act of insurance business listed in § 4-205(c) of this subtitle;

(2) within 10 days after service of process under item (1) of this subsection, the plaintiff or plaintiff's attorney sends a copy of the process by certified mail, return receipt requested, bearing a postmark from the United States Postal Service, to the unauthorized insurer at its last known principal place of business; and

(3) on or before the date that the unauthorized insurer is required to appear or within any further time that the court allows, the plaintiff or plaintiff's attorney files with the clerk of the court in which the action is pending:

(i) the unauthorized insurer's receipt, or the receipt issued by the United States Postal Service, showing the name of the sender of the letter and the name and address of the addressee; and

(ii) an affidavit of the plaintiff or plaintiff's attorney showing compliance with item (1) of this subsection.

(d) A judgment by default may not be entered until the expiration of 45 days after the date of filing of the affidavit of compliance.

(e) This subtitle does not limit the right to serve any process, notice, or demand on an insurer or another person in any other manner authorized by law.

§4–207.

(a) (1) An unauthorized insurer or person that does an act of insurance business listed in § 4-205(c) of this subtitle is deemed to have appointed irrevocably the Secretary of State to be the attorney of the unauthorized insurer or person in a proceeding in a court by the Commissioner or the State, and on whom may be served any notice, order, pleading, or process in a proceeding before the Commissioner, and which proceeding arises from the unauthorized insurer or person doing an insurance business in the State.

(2) An unauthorized insurer or person that does an act of insurance business listed in § 4-205(c) of this subtitle is deemed to have agreed that service on the Secretary of State under this section has the same legal effect as personal service in the State on the unauthorized insurer or person.

(3) The deemed appointment of the Secretary of State binds the unauthorized insurer or person and any executor, administrator, personal representative, or successor in interest if a corporation, of the unauthorized insurer or person.

(b) (1) Service of process on the Secretary of State in a court proceeding or administrative proceeding under this section shall be made by delivering to the Secretary of State or an individual in apparent charge of the office of the Secretary of State two copies of the process in a court proceeding or the notice, order, pleading, or process in an administrative proceeding.

(2) Immediately after receipt of process in a court proceeding or the notice, order, pleading, or process in an administrative proceeding, the Secretary of State shall mail one copy of the process or notice, order, pleading, or process to the defendant in the court proceeding, or to the person to whom the notice, order, pleading, or process is addressed or directed in the administrative proceeding, at its last known principal place of business.

(3) Service of process under this section is sufficient if:

(i) within 10 days after service on the Secretary of State under paragraph (1) of this subsection, the plaintiff or plaintiff's attorney in a court proceeding or the Commissioner in an administrative proceeding sends notice of the service and a copy of the court process, or the notice, order, pleading, or process in the administrative proceeding, by certified mail, return receipt requested, bearing a postmark from the United States Postal Service, to the defendant in a court proceeding or the person to whom the notice, order, pleading, or process is addressed or directed in the administrative proceeding at its last known principal place of business; and

(ii) on or before the date that the defendant is required to appear or respond in a court or administrative proceeding or within any further time that the court or Commissioner allows, the plaintiff or plaintiff's attorney in a court proceeding or the Commissioner in an administrative proceeding files with the clerk of the court in which the court proceeding is pending or with the Commissioner in an administrative proceeding:

1. the defendant's receipt, or the receipt issued by the United States Postal Service, showing the name of the sender of the letter and the name and address of the addressee; and

2. an affidavit of the plaintiff or plaintiff's attorney in a court proceeding, or the Commissioner in an administrative proceeding, showing compliance with paragraph (1) of this subsection.

(4) A certificate by the Secretary of State that shows service in accordance with paragraph (1) of this subsection and is attached to the original or third copy of the process is sufficient evidence of service.

(5) Service on the Secretary of State under this section is deemed service on the principal.

(6) The Secretary of State shall keep a record of all process served on the Secretary of State under this section that shows the day and time of service.

(c) A judgment or determination, by default, in any court or administrative proceeding in which court process or a notice, order, pleading, or process is served under this section may not be entered until the expiration of 45 days after the date of filing of the affidavit of compliance.

(d) This section does not limit the right to serve any process, notice, order, pleading, or demand on an insurer or another person in any other manner authorized by law.

(e) On request of the Commissioner, the Attorney General may proceed in a court of this State or another state or in a federal court or agency to enforce an order or decision in a court proceeding or in an administrative proceeding before the Commissioner.

§4–208.

(a) This section does not apply to:

(1) lawfully procured surplus lines insurance; or

(2) insurance contracts that are independently procured through negotiations occurring entirely outside of the State and that are reported and on which the premium tax is paid under §§ 4-210 and 4-211 of this subtitle.

(b) An unauthorized insurer may not enforce an insurance contract effective in the State and entered into by the unauthorized insurer.

§4–209.

(a) This section does not apply to:

(1) premiums on lawfully procured surplus lines insurance;

(2) premiums on independently procured insurance on which a tax has been paid under § 4–211 of this subtitle; or

(3) wet marine and transportation insurance.

(b) (1) If an unauthorized insurer effects, continues, or renews insurance on a subject resident, located, or to be performed in the State, the unauthorized insurer shall pay to the Commissioner, before March 1 of the next calendar year, a premium receipts tax of 3% of gross premiums charged for the insurance.

(2) For policies effective before July 21, 2011:

(i) if the policy covers property, risks, or exposures located or to be performed entirely in the State, the premium receipts tax shall be computed on the entire premium at the rate specified in paragraph (1) of this subsection; and

(ii) if the policy covers property, risks, or exposures located or to be performed both in and outside the State, the premium receipts tax shall be computed at the rate specified in paragraph (1) of this subsection only on that portion of the premium that is properly allocable to the risks located in the State.

(3) For policies effective on or after July 21, 2011, if the State is the insured's home state, the premium receipts tax shall be computed on the entire premium at the rate specified in paragraph (1) of this subsection.

(4) Insurance that an unauthorized insurer effects, continues, or renews on a subject resident, located, or to be performed in the State that is procured through negotiations or an application wholly or partly occurring or made in or from within or outside of the State, or for which premiums wholly or partly are remitted directly or indirectly from in or outside of the State, is deemed to be insurance procured, continued, or renewed in the State.

(c) The premium receipts tax under this section is instead of all other State taxes.

(d) If an unauthorized insurer defaults on the payment of the tax under this section, the insured shall pay the tax.

(e) If the tax is not timely paid under subsection (b) of this section, the amount of the tax due shall be increased by a penalty of:

(1) 25% of the tax due; and

(2) an amount computed at the rate of 1% per month or any part of a month after the date the payment was due to the date the payment is made.

§4–210.

(a) In this section, "insured" includes an industrial insured who procures insurance of a risk through a full–time employee acting as a risk manager.

(b) (1) Each insured that procures or causes to be procured insurance with an unauthorized insurer, or an insured or self–insured that procures or continues excess loss, catastrophe, or other insurance with an unauthorized insurer, on a subject of insurance resident, located, or to be performed in the State other than surplus lines insurance, shall file with the Commissioner a report under this section.

(2) Insurance with an unauthorized insurer on a subject of insurance resident, located, or to be performed in the State that is procured through negotiations or an application wholly or partly occurring or made in or from within or outside of the State, or for which the premiums wholly or partly are remitted directly or indirectly from in or outside of the State, is deemed to be insurance procured in the State.

(c) For policies effective before July 21, 2011, a report under this section shall be filed within 60 days after the date that the insurance was procured.

(d) For policies effective on or after July 21, 2011, on or before March 15 and September 15 of each year, or at another interval that the Commissioner directs, each insured shall:

(1) file with the Commissioner a report, on a form the Commissioner prescribes, on business subject to tax during the preceding half calendar year or other interval that the Commissioner directs; and

(2) pay to the Commissioner the total amount of tax stated in the report.

(e) By regulation, the Commissioner shall determine the required content and filing deadlines of the reports.

§4–211.

(a) This section does not apply to wet marine and transportation insurance.

(b) (1) If an insured procures, continues, or renews insurance from an unauthorized insurer that is subject to a report under § 4–210 of this subtitle, a premium receipts tax of 3% of the gross premiums charged for the insurance is levied on the obligation, chose in action, or right represented by the premium charged for the insurance.

(2) If an insurance contract subject to the tax is canceled and rewritten, the additional premium, for purposes of the premium receipts tax, is the premium in excess of the unearned premium of the canceled insurance contract.

(c) If the insured fails to withhold from the premium the amount of the tax levied under this section, the insured is liable for the amount of the tax imposed under subsection (b) of this section and shall pay the tax to the Commissioner.

(d) If the tax imposed under subsection (b) of this section is not timely paid, the amount of the tax due shall be increased by a penalty of:

(1) 25% of the tax due; and

(2) an amount computed at the rate of 1% per month or part of a month after the date the payment is due until the date the payment is made.

(e) If the tax is not timely paid under this section, on request of the Commissioner, the Attorney General shall proceed in a court of this State or another state or in a federal court or agency to recover the tax.

§4–211.1.

(a) (1) In this section the following words have the meanings indicated.

(2) "Act" has the meaning stated in § 3–301 of this article.

(3) "Home state" has the meaning stated in § 3–301 of this article.

(4) "Nonadmitted insurance" has the meaning stated in § 3–301 of this article.

(b) For policies effective on or after July 21, 2011, the placement of nonadmitted insurance is subject to the statutory and regulatory requirements solely of the insured's home state.

(c) The premiums charged for unauthorized insurance are subject to a premium receipts tax in the State on all gross premiums, less any returned premiums, charged for nonadmitted insurance as specified in §§ 4–209 and 4–211 of this subtitle.

(d) For policies effective before July 21, 2011:

(1) if the policy covers property, risks, or exposures located or to be performed entirely in the State, the premium receipts tax shall be computed on the entire premium at the rate specified in subsection (c) of this section; and

(2) if the policy covers property, risks, or exposures located or to be performed both in and outside the State, the premium receipts tax shall be computed at the rate specified in subsection (c) of this section only on that portion of the premium that is properly allocable to the risks located in the State.

(e) For policies effective on or after July 21, 2011, if the State is the insured's home state, the premium receipts tax shall be computed on the entire premium at the rate specified in subsection (c) of this section.

(f) For policies effective on or after July 21, 2011, only the home state of an insured may receive premium receipts tax payments and reports for nonadmitted insurance.

(g) For policies effective on or after July 21, 2011, the regulation of nonadmitted insurance is subject to the statutory and regulatory requirements solely of the home state of the insured.

(h) The Commissioner shall cooperate with other states to adopt and implement uniform requirements for nonadmitted insurance in compliance with the Act.

§4–212.

An unauthorized insurer or person that violates this subtitle is subject to a civil penalty of not less than $100 but not exceeding $125,000 for each violation.

§4–301.

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

(b) "Adjusted RBC report" means an RBC report that has been adjusted by the Commissioner in accordance with § 4–303(b) of this subtitle.

(c) "Corrective order" means an order issued by the Commissioner that specifies corrective actions that the Commissioner has determined are required.

(d) (1) "Domestic insurer" means an insurer:

(i) as defined in subsection (h) of this section; and

(ii) that is formed under the laws of this State.

(2) "Domestic insurer" does not include the Maryland Automobile Insurance Fund.

(e) "Filing date" means March 1 of any given year.

(f) "Foreign insurer" means an insurer:

(1) as defined in subsection (h) of this section; and

(2) that is formed under the laws of a jurisdiction other than this State.

(f–1) "Fraternal benefit society" means a person authorized to transact insurance business in the State under Title 8, Subtitle 4 of this article.

(g) (1) "Health insurer" means an insurer that:

(i) is authorized to write health insurance in the State; and

(ii) receives the majority of its premium from the sale of health insurance.

(2) "Health insurer" includes:

(i) a health maintenance organization operating under a certificate of authority issued by the Commissioner under Title 19, Subtitle 7 of the Health – General Article;

(ii) a nonprofit health service plan operating under Title 14, Subtitle 1 of this article;

(iii) a dental plan operating under Title 14, Subtitle 4 of this article; and

(iv) a provider–sponsored organization operating under Title 19, Subtitle 7A of the Health – General Article.

(3) "Health insurer" does not include a managed care organization operating under Title 15, Subtitle 1 of the Health – General Article.

(h) (1) "Insurer" means an insurer or other entity authorized to engage in the insurance business in the State under a certificate of authority issued by the Commissioner.

(2) "Insurer" includes:

(i) a health maintenance organization operating under a certificate of authority issued by the Commissioner under Title 19, Subtitle 7 of the Health – General Article;

(ii) a nonprofit health service plan operating under Title 14, Subtitle 1 of this article;

(iii) a dental plan operating under Title 14, Subtitle 4 of this article; and

(iv) a provider–sponsored organization operating under Title 19, Subtitle 7A of the Health – General Article.

(3) "Insurer" does not include:

(i) monoline:

1. mortgage guaranty insurers;

2. financial guaranty insurers; or

3. title insurers; or

(ii) managed care organizations operating under Title 15, Subtitle 1 of the Health – General Article.

(i) "Life insurer" means an insurer that:

(1) is authorized to write life insurance in the State; and

(2) receives the majority of its premium from the sale of life insurance.

(j) "NAIC" means the National Association of Insurance Commissioners.

(k) "Negative trend" means, with respect to a life insurer, health insurer, or fraternal benefit society, negative trend over a period of time, as determined in accordance with the "trend test calculation" included in the RBC instructions.

(l) (1) "Property and casualty insurer" means an insurer that:

(i) is authorized to write property insurance or casualty insurance in the State; and

(ii) receives the majority of its premium from the sale of property insurance or casualty insurance.

(2) "Property and casualty insurer" does not include:

(i) a health maintenance organization operating under a certificate of authority issued by the Commissioner under Title 19, Subtitle 7 of the Health – General Article;

(ii) a nonprofit health service plan operating under Title 14, Subtitle 1 of this article;

(iii) a dental plan operating under Title 14, Subtitle 4 of this article;

(iv) a provider–sponsored organization operating under Title 19, Subtitle 7A of the Health – General Article; or

(v) a managed care organization operating under Title 15, Subtitle 1 of the Health – General Article.

(m) "RBC instructions" means the risk based capital instructions developed and adopted by the NAIC.

(n) "RBC level" means an insurer's company action level RBC, regulatory action level RBC, authorized control level RBC, or mandatory control level RBC if:

(1) "company action level RBC" means the product of 2.0 and the authorized control level RBC;

(2) "regulatory action level RBC" means the product of 1.5 and the authorized control level RBC;

(3) "authorized control level RBC" means the number determined under the risk based capital formula in accordance with the RBC instructions; or

(4) "mandatory control level RBC" means the product of .70 and the authorized control level RBC.

(o) "RBC plan" means a comprehensive financial plan that contains the elements specified in § 4–305(b) of this subtitle.

(p) "RBC report" means a report prepared by a domestic insurer and submitted to the Commissioner that details the domestic insurer's RBC levels as of the end of the immediately preceding calendar year.

(q) "Revised RBC plan" means an RBC plan that has been:

(1) rejected by the Commissioner; and

(2) subsequently revised by the insurer, with or without the Commissioner's recommendation.

(r) "Total adjusted capital" means the sum of:

(1) an insurer's statutory capital and surplus as determined in accordance with the statutory accounting principles applicable to the annual financial statements required to be filed under State law and regulations; and

(2) any other items provided for in the RBC instructions.

§4–302.

It is the public policy of the State that, in order to safeguard the solvency of the insurance business in the State:

(1) an insurer should maintain an amount of capital in excess of the minimum RBC levels derived from the risk based capital requirements contained in this subtitle and the attendant formulas, schedules, and instructions; and

(2) additional capital is used and useful in the insurance business and helps to secure an insurer against various risks inherent in, or affecting, the insurance business and not accounted for or only partially measured by the risk based capital requirements contained in this subtitle.

§4–303.

(a) (1) (i) On or before the filing date, each domestic insurer shall prepare and submit to the Commissioner a report of its RBC levels as of the end of the immediately preceding calendar year.

(ii) The RBC report shall be in the form and shall contain the information required by the RBC instructions.

(2) In addition to the requirements of paragraph (1) of this subsection, each domestic insurer shall file its RBC report:

(i) with the NAIC in accordance with the RBC instructions; and

(ii) on written request, with the insurance commissioner of any state in which the insurer is authorized to do business, on or before the later of:

1. 15 days after receipt of the written request to file its RBC report with that state; or

2. the filing date.

(b) If a domestic insurer files an RBC report that, in the judgment of the Commissioner, is inaccurate, the Commissioner shall:

(1) adjust the RBC report to correct the inaccuracy; and

(2) notify the insurer of the adjustment, including a statement of the reason for the adjustment.

§4–304.

(a) (1) A life insurer's or fraternal benefit society's risk based capital shall be determined in accordance with the formula set forth in the RBC instructions.

(2) By applying the factors in the manner set forth in the RBC instructions, the formula shall take into account and may adjust for the covariance between:

(i) the risk with respect to the life insurer's or fraternal benefit society's assets;

(ii) the risk of adverse insurance experience with respect to the life insurer's or fraternal benefit society's liabilities and obligations;

(iii) the interest rate risk with respect to the life insurer's or fraternal benefit society's business; and

(iv) all other business risks and other relevant risks as set forth in the RBC instructions.

(b) (1) Except as provided in subsection (a) of this section, an insurer's risk based capital shall be determined in accordance with the formula set forth in the RBC instructions.

(2) By applying the factors in the manner set forth in the RBC instructions, the formula shall take into account and may adjust for the covariance between:

(i) asset risk;

(ii) credit risk;

(iii) underwriting risk; and

(iv) all other business risks and other relevant risks as set forth in the RBC instructions.

§4–305.

(a) A company action level event occurs:

(1) when an insurer files an RBC report that indicates that:

(i) the insurer has total adjusted capital that is:

1. greater than or equal to its regulatory action level RBC; and

2. less than its company action level RBC;

(ii) in the case of a life insurer or fraternal benefit society, the life insurer or fraternal benefit society has total adjusted capital that:

1. is greater than or equal to its company action level RBC;

2. is less than the product of its authorized control level RBC and 3.0; and

3. has a negative trend;

(iii) in the case of a property and casualty insurer, the property and casualty insurer has total adjusted capital that:

1. is greater than or equal to its company action level RBC;

2. is less than the product of its authorized control level RBC and 3.0; and

3. triggers the trend test calculation included in the property and casualty RBC instructions; or

(iv) in the case of a health insurer, the health insurer has total adjusted capital that:

1. is greater than or equal to its company action level RBC;

2. is less than the product of its authorized control level RBC and 3.0; and

3. triggers the trend test calculation included in the health RBC instructions;

(2) when the Commissioner notifies an insurer of an adjusted RBC report that indicates an event under item (1) of this subsection; or

(3) if an insurer requests a hearing to challenge an adjusted RBC report that indicates an event under item (1) of this subsection, when the Commissioner notifies the insurer that the Commissioner, after a hearing, has rejected the insurer's challenge.

(b) In the event of a company action level event, the insurer shall prepare and submit to the Commissioner an RBC plan that shall:

(1) identify the conditions that contribute to the company action level event;

(2) contain proposals of corrective actions that the insurer intends to take and that would be expected to result in the elimination of the company action level event;

(3) provide projections of the insurer's financial results in the current year and at least the 4 succeeding years that:

(i) project financial results:

1. in the absence of proposed corrective actions; and

2. that give effect to the proposed corrective actions;

(ii) include projections of statutory operating income, net income, capital, and surplus; and

(iii) for both new and renewal business, include separate projections for each major line of business and separately identify each significant income, expense, and benefit component;

(4) identify the key assumptions that impact the insurer's projections and the sensitivity of the projections to the assumptions; and

(5) identify the quality of and the problems associated with the insurer's business, including its assets, anticipated business growth and associated surplus strain, extraordinary exposure to risk, mix of business, and use of reinsurance, as appropriate.

(c) The insurer shall submit the RBC plan to the Commissioner:

(1) within 45 days after the date of the company action level event; or

(2) if the insurer requests a hearing to challenge an adjusted RBC report, within 45 days after notification to the insurer that the Commissioner, after a hearing, has rejected the insurer's challenge.

(d) (1) Within 60 days after an insurer submits an RBC plan to the Commissioner, the Commissioner shall notify the insurer whether the Commissioner has determined that the RBC plan may be implemented or that the RBC plan is unsatisfactory.

(2) If the Commissioner determines that the RBC plan is unsatisfactory, the notification to the insurer:

(i) shall set forth the reasons for the determination; and

(ii) may set forth proposed revisions that will make the RBC plan satisfactory to the Commissioner.

(3) On notification that the RBC plan is unsatisfactory, the insurer shall:

(i) prepare a revised RBC plan, which may incorporate by reference any revisions proposed by the Commissioner; and

(ii) submit the revised RBC plan to the Commissioner.

(4) The insurer shall submit the revised RBC plan required by paragraph (3) of this subsection to the Commissioner:

(i) within 45 days after the notification from the Commissioner; or

(ii) if the insurer requests a hearing to challenge the notification from the Commissioner, within 45 days after notification to the insurer that the Commissioner, after a hearing, has rejected the insurer's challenge.

(e) Subject to the right of the insurer to a hearing, when the Commissioner notifies an insurer that the insurer's RBC plan or revised RBC plan is unsatisfactory, the Commissioner may specify in the notification that the notification constitutes a regulatory action level event.

(f) (1) Each domestic insurer that files an RBC plan or revised RBC plan with the Commissioner shall file a copy of the RBC plan or revised RBC plan with the insurance commissioner of any state in which the insurer is authorized to do business if:

(i) the state has a confidentiality provision substantially similar to § 4-310(a) of this subtitle; and

(ii) the insurance commissioner of that state has notified the insurer in writing of its request for the filing.

(2) On request of an insurance commissioner of another state under this subsection, the insurer shall file a copy of the RBC plan or revised RBC plan with that insurance commissioner by the later of:

(i) 15 days after receipt of the notification to file a copy of its RBC plan or revised RBC plan with that state; or

(ii) the date on which the RBC plan or revised RBC plan is filed under subsection (c) or (d) of this section.

§4–306.

(a) A regulatory action level event occurs when:

(1) an insurer files an RBC report that indicates that the insurer has total adjusted capital that is:

(i) greater than or equal to its authorized control level RBC; and

(ii) less than its regulatory action level RBC;

(2) the Commissioner notifies an insurer of an adjusted RBC report that indicates an event under item (1) of this subsection;

(3) if an insurer requests a hearing to challenge an adjusted RBC report that indicates an event under item (1) of this subsection, the Commissioner notifies the insurer that the Commissioner, after a hearing, has rejected the insurer's challenge;

(4) an insurer fails to file an RBC report by the filing date, unless the insurer has:

(i) provided the Commissioner with a satisfactory explanation for the failure; and

(ii) cured the failure within 10 days after the filing date;

(5) an insurer fails to submit an RBC plan to the Commissioner within the time period specified in § 4-305(c) of this subtitle;

(6) the Commissioner notifies an insurer that:

(i) the RBC plan or revised RBC plan submitted by the insurer is, in the judgment of the Commissioner, unsatisfactory; and

(ii) the notification constitutes a regulatory action level event with respect to the insurer;

(7) the Commissioner notifies an insurer that the insurer has failed to adhere to its RBC plan or revised RBC plan, but only if:

(i) the insurer's failure to adhere to the RBC plan or revised RBC plan has a substantial adverse effect on the ability of the insurer to eliminate the company action level event in accordance with its RBC plan or revised RBC plan; and

(ii) the Commissioner has stated in the notification that the insurer's failure to adhere to the RBC plan or revised RBC plan has a substantial adverse effect on the ability of the insurer to eliminate the company action level event; or

(8) if an insurer requests a hearing to challenge a determination made by the Commissioner under item (6) or (7) of this subsection, the Commissioner notifies the insurer that the Commissioner, after a hearing, has rejected the insurer's challenge.

(b) In the event of a regulatory action level event, the Commissioner shall:

(1) require the insurer to prepare and submit an RBC plan or, if applicable, a revised RBC plan;

(2) perform any examination or analysis that the Commissioner considers necessary of the assets, liabilities, and operations of the insurer, including a review of the insurer's RBC plan or revised RBC plan; and

(3) after any examination or analysis performed under this subsection, issue a corrective order.

(c) In determining the type of corrective action to be taken by the insurer, the Commissioner may take into account all factors that the Commissioner considers relevant with respect to the insurer based on the Commissioner's examination or analysis of the assets, liabilities, and operation of the insurer, including the results of any sensitivity test undertaken pursuant to the RBC instructions.

(d) The insurer shall submit the RBC plan or revised RBC plan to the Commissioner:

(1) within 45 days after the date of the regulatory action level event; or

(2) if an insurer has requested a hearing to challenge an adjusted RBC report or revised RBC plan, within 45 days after notification to the insurer that the Commissioner, after a hearing, has rejected the insurer's challenge.

(e) (1) The Commissioner may retain actuaries, investment experts, and other consultants as necessary in the judgment of the Commissioner to:

(i) review an insurer's RBC plan or revised RBC plan;

(ii) examine or analyze the assets, liabilities, and operation of the insurer; and

(iii) formulate the corrective order to be imposed on the insurer.

(2) The fees, costs, and expenses that relate to any actuaries, investment experts, or other consultants retained under this subsection shall be borne by the affected insurer as directed by the Commissioner.

§4–307.

(a) An authorized control level event occurs when:

(1) an insurer files an RBC report that indicates that the insurer has total adjusted capital that is:

(i) greater than or equal to its mandatory control level RBC; and

(ii) less than its authorized control level RBC;

(2) the Commissioner notifies the insurer of an adjusted RBC report that indicates an event under item (1) of this subsection;

(3) if an insurer requests a hearing to challenge an adjusted RBC report that indicates the event under item (1) of this subsection, the Commissioner notifies the insurer that the Commissioner, after a hearing, has rejected the insurer's challenge;

(4) the insurer fails to respond to a corrective order in a manner satisfactory to the Commissioner; or

(5) if an insurer has requested a hearing to challenge a corrective order issued by the Commissioner:

(i) the Commissioner notifies the insurer that the Commissioner, after a hearing, has rejected the insurer's challenge or modified the corrective order; and

(ii) the insurer fails to respond, in a manner satisfactory to the Commissioner, to the sustained or modified corrective order.

(b) In the event of an authorized control level event, the Commissioner shall:

(1) take any action required under § 4-306(b) of this subtitle for an insurer that experiences a regulatory action level event; or

(2) if the Commissioner considers it to be in the best interest of the policyholders and creditors of the insurer and of the public, take any action that may be necessary to place the insurer under conservation, rehabilitation, or liquidation under Title 9 of this article.

(c) (1) The Commissioner shall have the rights, powers, and duties under Title 9 of this article needed to carry out the requirements of this section.

(2) If the Commissioner takes any action under Title 9 of this article pursuant to an adjusted RBC report as provided in this section, the insurer shall be entitled to the protections afforded to insurers under Title 9 of this article with regard to summary proceedings.

§4–308.

(a) A mandatory control level event occurs when:

(1) an insurer files an RBC report that indicates that the insurer has total adjusted capital that is less than its mandatory control level RBC;

(2) the Commissioner notifies the insurer of an adjusted RBC report that indicates an event under item (1) of this subsection; or

(3) if an insurer requests a hearing to challenge an adjusted RBC report that indicates the event under item (1) of this subsection, the Commissioner notifies the insurer that the Commissioner, after a hearing, has rejected the insurer's challenge.

(b) (1) In the case of a life insurer or fraternal benefit society, if a mandatory control level event occurs with respect to the life insurer or fraternal benefit society, the Commissioner shall take any action that may be necessary to

place the life insurer or fraternal benefit society under conservation, rehabilitation, or liquidation under Title 9 of this article.

(2) In the case of a property and casualty insurer, if a mandatory control level event occurs with respect to the property and casualty insurer, the Commissioner:

(i) shall take any action that may be necessary to place the property and casualty insurer under conservation, rehabilitation, or liquidation under Title 9 of this article; or

(ii) in the case of a property and casualty insurer that is not writing any new business and that is running off its existing business, may allow the property and casualty insurer to continue its run–off under the supervision of the Commissioner.

(3) In the case of a health insurer, if a mandatory control level event occurs with respect to the health insurer, the Commissioner shall take any action that may be necessary to place the health insurer under conservation, rehabilitation, or liquidation under Title 9 of this article.

(c) The Commissioner may delay action under subsection (b) of this section for up to 90 days after the occurrence of the mandatory control level event if the Commissioner finds there is a reasonable expectation that the mandatory control level event may be eliminated within the 90–day period.

(d) (1) The Commissioner shall have the rights, powers, and duties under Title 9 of this article needed to carry out the requirements of this section.

(2) If the Commissioner takes any action under Title 9 of this article pursuant to an adjusted RBC report as provided in this section, the insurer shall be entitled to the protections afforded to insurers under Title 9 of this article with regard to summary proceedings.

§4–309.

(a) An insurer may challenge any of the following determinations made or actions taken by the Commissioner under this subtitle:

(1) notification to an insurer by the Commissioner of an adjusted RBC report;

(2) notification to an insurer by the Commissioner that:

(i) the insurer's RBC plan or revised RBC plan is unsatisfactory; and

(ii) the notification constitutes a regulatory action level event with respect to that insurer;

(3) notification to an insurer by the Commissioner that:

(i) the insurer has failed to adhere to its RBC plan or revised RBC plan; and

(ii) the failure has a substantial adverse effect on the ability of the insurer to eliminate the company action level event with respect to the insurer in accordance with its RBC plan or revised RBC plan; or

(4) notification to an insurer by the Commissioner of a corrective order with respect to the insurer.

(b) (1) At the request of an insurer, the Commissioner shall hold a confidential hearing on the record under § 2-213(a) of this article to determine the validity of a challenge by the insurer.

(2) To request a hearing under this subsection, the insurer shall notify the Commissioner of its request within 5 days after the notification by the Commissioner under subsection (a) of this section.

(3) On receipt of the insurer's request for a hearing, the Commissioner shall hold a hearing within 30 days after the date of the insurer's request.

§4–310.

(a) All RBC reports and RBC plans related to any domestic insurer or foreign insurer that are filed with the Commissioner:

(1) constitute confidential commercial information that might be damaging to the insurer if made available to the insurer's competitors;

(2) shall be kept confidential by the Commissioner; and

(3) may not be made public or be subject to subpoena, other than by the Commissioner and then only for the purpose of enforcement actions taken by the Commissioner under this subtitle or any other provision of this article.

(b) The provisions of this section apply to:

(1) RBC reports, to the extent the information in the RBC report is not required to be set forth in a publicly available annual statement schedule; and

(2) RBC plans, including the results or report of any examination or analysis of an insurer performed in connection with any RBC plan and any corrective order issued by the Commissioner pursuant to the examination or analysis.

(c) It is the public policy of the State that the comparison of an insurer's total adjusted capital to any of its RBC levels:

(1) is a regulatory tool that may indicate the need for possible corrective action with respect to the insurer; and

(2) is not intended as a means to rank insurers generally.

(d) It is the public policy of the State that the RBC instructions, RBC reports, adjusted RBC reports, RBC plans, and revised RBC plans:

(1) are intended solely for use by the Commissioner in monitoring the solvency of insurers and the need for possible corrective action with respect to insurers; and

(2) may not be used by the Commissioner for rate making or considered or introduced as evidence in any rate proceeding or used by the Commissioner to calculate or derive any elements of an appropriate premium level or rate of return for any line of insurance that an insurer or any affiliate is authorized to write.

§4–311.

(a) The provisions of this subtitle are supplemental to other laws of the State, and may not preclude or limit any other powers or duties of the Commissioner.

(b) (1) The Commissioner may adopt regulations to carry out this subtitle.

(2) The Commissioner, in consultation with the Secretary of Health, shall adopt regulations that apply appropriate risk based capital standards to managed care organizations as defined under § 15–101(e) of the Health – General Article.

(c) The Commissioner may exempt from the application of this subtitle any domestic property and casualty insurer that:

(1) writes direct business only in the State;

(2) writes direct annual premiums of $2,000,000 or less; and

(3) assumes no reinsurance in excess of 5% of direct premiums written.

(d) The Commissioner may exempt from the application of this Act any domestic health insurer that:

(1) (i) writes direct business only in the State;

(ii) assumes no reinsurance in excess of 5% of direct premiums written; and

(iii) writes direct annual premiums for comprehensive medical business of $2,000,000 or less; or

(2) covers less than 2,000 lives if the health insurer is:

(i) a nonprofit health service plan that provides coverage solely for dental services; or

(ii) a dental plan organization.

§4–312.

(a) On written request of the Commissioner, a foreign insurer shall:

(1) submit to the Commissioner an RBC report as of the end of the immediately preceding calendar year on the later of:

(i) the date an RBC report would be required to be filed by a domestic insurer under this subtitle; or

(ii) 15 days after the request is received by the foreign insurer; and

(2) promptly submit to the Commissioner a copy of any RBC plan or revised RBC plan that the insurer has filed with the insurance commissioner of any other state.

(b) (1) The Commissioner may require a foreign insurer to file an RBC plan with the Commissioner in the event of a company action level event, regulatory action level event, or authorized control level event with respect to the foreign insurer:

(i) under the risk based capital statute of the foreign insurer's state of domicile if the insurance commissioner of that state fails to require the foreign insurer to file an RBC plan in accordance with that state's risk based capital statute; or

(ii) under this subtitle if there is no risk based capital statute in force in the foreign insurer's state of domicile.

(2) If the foreign insurer fails to file an RBC plan with the Commissioner under this subsection, the Commissioner may order the foreign insurer to cease and desist from writing new insurance business in this State.

(c) If a mandatory control level event occurs with respect to a foreign insurer and a domiciliary receiver has not been appointed with respect to that foreign insurer under the rehabilitation and liquidation statute applicable in the foreign insurer's state of domicile, the Commissioner may file an action in the Circuit Court of Baltimore City under Title 9 of this article to seek the liquidation of any property of the foreign insurer found in the State.

§4–313.

There is no liability on the part of, and no cause of action arises against, the Commissioner or the Administration or its employees or agents for any action taken by them in the performance of their powers and duties under this subtitle.

§4–314.

All notices by the Commissioner to an insurer that may result in regulatory action under this subtitle shall be effective:

(1) if transmitted by registered or certified mail, on the date of mailing; or

(2) if transmitted by any other means, on the date of receipt of notice by the insurer.

§4–401.

(a) This section applies to:

(1) each insurer that provides professional liability insurance to:

(i) a physician, nurse, dentist, podiatrist, optometrist, or chiropractor licensed under the Health Occupations Article; or

(ii) a hospital licensed under the Health – General Article; and

(2) each self–insured hospital.

(b) An entity subject to this section shall report quarterly any claim or action for damages for personal injury if the claim or action:

(1) is claimed to have been caused by an error, omission, or negligence in the performance of the insured's professional services or is based on a claimed performance of the insured's professional services without consent; and

(2) resulted in:

(i) a final judgment in any amount;

(ii) a settlement in any amount; or

(iii) a final disposition that does not result in payment on behalf of the insured.

(c) A report required under this section shall contain the information required under § 4–405(b) of this subtitle.

(d) A report required under this section shall be filed within 90 days after the end of the quarter during which an event described in subsection (b)(2)(i), (ii), or (iii) of this section occurred.

(e) (1) A report that relates to a physician shall be filed with the State Board of Physicians.

(2) A report that relates to a hospital shall be filed with the Secretary of Health.

(3) A report that relates to a nurse, dentist, podiatrist, optometrist, or chiropractor shall be filed with the appropriate licensing board for these health care providers.

(f) (1) Subject to paragraph (2) of this subsection, a report filed in accordance with this section shall be treated as a personal record under § 4–501(e) of the General Provisions Article.

(2) Each report shall be released to the Maryland Health Care Commission.

(g) An insurer that reports under this section or its agents or employees, the State Board of Physicians or its representatives, and any appropriate licensing authority that receives a report under this section shall have the immunity from liability described in § 5–701 of the Courts Article for any action taken by them under this section.

(h) Failure to report to a person specified in subsection (e)(1), (2), or (3) of this section may result in the imposition by a circuit court of a civil penalty of up to $5,000.

§4–402.

(a) Medical files on applicants and claimants that are compiled by insurers under policies of health insurance or life insurance shall be made available for inspection:

(1) on request of the applicant or claimant;

(2) on request of the agent of the applicant or claimant; or

(3) on request of the applicant, to a physician of the applicant's choice.

(b) Information that is provided by a physician shall be made available on request:

(1) after a period of 5 years after the date of the medical examination; or

(2) at any time on written authorization of the physician.

(c) An agent that requests to review the medical file of an applicant or claimant must have an authorization to review medical records signed by the applicant or claimant.

§4–403.

(a) Except as provided in subsection (b), (c), or (d) of this section, an insurer, or an insurance service organization whose functions include the collection of medical data, may not disclose the contents of an insured's medical or claims records.

(b) (1) An insurer may disclose specific medical information or medical data contained in an insured's medical or claims records to:

(i) the insured;

(ii) the insured's agent or representative; or

(iii) on request of the insured, a physician of the insured's choice.

(2) An insurer, or an insurance service organization whose functions include the collection of medical data, may disclose specific medical information or medical data contained in an insured's medical or claims records if the insured authorizes the disclosure.

(c) An insurer, or an insurance service organization whose functions include the collection of medical data, may disclose specific medical information or medical data contained in an insured's medical or claims records without the authorization of the insured:

(1) to a medical review committee, accreditation board, or commission, if the information is requested by or is in furtherance of the purpose of the committee, board, or commission;

(2) in response to legal process;

(3) to a nonprofit health service plan or Blue Cross or Blue Shield plan to coordinate benefit payments under multiple sickness and accident, dental, or hospital medical contracts;

(4) to investigate possible insurance fraud;

(5) for reinsurance purposes;

(6) in the normal course of underwriting, to an insurer information exchange that may not redisclose the information unless expressly authorized by the person to whom the information pertains;

(7) to evaluate an application for or renewal of insurance;

(8) to evaluate and adjust a claim for benefits under a policy or to evaluate and calculate provider fiscal incentives or other types of provider payments;

(9) to evaluate, settle, or defend a claim or suit for personal injury;

(10) in accordance with a cost containment contractual obligation to verify that benefits paid by the insurer were proper contractually;

(11) to a policyholder if:

(i) the policyholder does not further disclose the specific medical information; and

(ii) the information is required for an audit of the billing made by the insurer to the policyholder; or

(12) to the insured's treating providers for the sole purposes of enhancing or coordinating patient care or assisting the treating providers' clinical decision making, provided that:

(i) a disclosure under this item is subject to the additional limitations in § 4–307 of the Health – General Article on disclosure of a medical record developed primarily in connection with the provision of mental health services;

(ii) medical information or medical data contained in an insured's medical or claims records may be disclosed only in accordance with the federal Health Insurance Portability and Accountability Act of 1996, any regulations adopted under the Act, and any other applicable federal privacy laws, and disclosures under this item may not be made in violation of the prohibited uses or disclosures under the federal Health Insurance Portability and Accountability Act of 1996;

(iii) an insurer or an insurance service organization that discloses medical information or medical data contained in an insured's medical or claims records in accordance with this item shall provide a notice consistent with the requirements of 45 C.F.R. § 164.520 specifying the information to be shared, with whom it will be shared, and the specific types of uses and disclosures that the insurer or insurance service organization may make in accordance with this item;

(iv) the notice required by item (iii) of this item shall include an opportunity for the insured to opt–out of the sharing of the insured's medical information or medical data contained in the insured's medical or claims records with the insured's treating providers for the purposes identified in this item; and

(v) if an insurer or an insurance service organization discloses medical information or medical data through an infrastructure that provides organizational and technical capabilities for the exchange of protected health information, as defined in § 4–301 of the Health – General Article, among entities not under common ownership, the insurer is subject to the requirements of §§ 4–302.2 and 4–302.3 of the Health – General Article.

(d) This section does not prohibit the use of medical records, data, or statistics if the use does not disclose the identity of a particular insured or covered person.

(e) An insurer that knowingly violates this section is liable to a plaintiff for any damages recoverable in a civil action, including reasonable attorney's fees.

§4–404.

If a life insurer denies a policy of life insurance to an applicant, the life insurer shall disclose the results of any medical examination administered to determine the applicant's insurability to a physician of the applicant's choice if the applicant so requests.

§4–405.

(a) (1) Each insurer providing professional liability insurance to a health care provider in the State shall submit to the Commissioner information on:

(i) the nature and cost of reinsurance;

(ii) the claims experience, by category, of health care providers;

(iii) the amount of claim settlements and claim awards;

(iv) the amount of reserves for claims incurred and incurred but unreported claims;

(v) the number of structured settlements used in payment of claims; and

(vi) any other information relating to health care malpractice claims prescribed by the Commissioner in regulation.

(2) (i) An insurer subject to the reporting requirement under paragraph (1) of this subsection shall notify the Commissioner of any information that the insurer considers proprietary.

(ii) In accordance with § 4–335 of the General Provisions Article, the Commissioner shall deny inspection of any part of a report submitted under paragraph (1) of this subsection that the Commissioner determines contains confidential commercial information or confidential financial information.

(b) In addition to the information required under subsection (a) of this section, for each claim filed with the Director of the Health Care Alternative Dispute Resolution Office under § 3–2A–04 of the Courts Article, each insurer providing professional liability insurance to a health care provider in the State shall submit to the Commissioner the following information:

(1) (i) name of insurer;

(ii) name of insurer group;

(iii) claim file identification;

(iv) name of person completing form;

(v) telephone number (area code); and

(vi) date form completed;

(2) (i) date of injury;

(ii) date injury reported to insurer; and

(iii) date claim closed;

(3) age and gender of insured person at time of injury;

(4) (i) type of injury;

(ii) description of injury; and

(iii) if the claim is against a health care provider covered under a policy issued or delivered by the insurer completing this form, the name of the health facility where the injury occurred;

(5) (i) type of medical professional liability policy;

(ii) if known, whether the patient was:

1. an inpatient;

2. an emergency room outpatient; or

3. other outpatient;

(iii) physician ISO classification, or equivalent classification;

(iv) health care provider name and license number; and

(v) policy limits for:

1. each claim or medical incident; and

2. annual aggregate;

(6) (i) if known, the facility, office, or county where injury occurred; and

(ii) the case number and the name and location of the court where the suit was filed and the case was tried;

(7) (i) whether settlement was reached or award was made at one of the following stages:

1. arbitration;

2. mediation;

3. before suit was filed;

4. after suit was filed, but before trial;

5. during trial, but before court verdict;

6. court verdict;

7. after verdict; or

8. after appeal was filed;

(ii) if settlement was reached or award was made by court verdict, whether the result was:

1. directed verdict for plaintiff;

2. directed verdict for defendant;

3. judgment notwithstanding the verdict for the plaintiff;

4. judgment notwithstanding the verdict for the defendant;

5. judgment for the plaintiff;

6. judgment for the defendant;

7. for plaintiff, after appeal;

8. for defendant, after appeal; or

9. any other;

(iii) if there was no final judgment or settlement, the date and reason for the final disposition; and

(iv) if the case did go to trial, whether the case was tried by a jury;

(8) with respect to the total amount paid to the claimant:

(i) the amount paid by the insurer;

(ii) the amount paid by the insured due to retention or deductible;

(iii) if known, the amount paid by an excess carrier;

(iv) if known, the amount paid by the insured due to settlement or award in excess of policy limits;

(v) if known, the amount paid by other defendants or contributors; and

(vi) the total amount of settlement or award;

(9) a summary of the occurrence from which the claim or action arose, including:

(i) a description of the misdiagnosis or alleged misdiagnosis made, if any, of the patient's actual condition;

(ii) a description of the procedure giving rise to the claim; and

(iii) a description of the principal injury giving rise to the claim;

(10) (i) whether a structured settlement or periodic payment was used in closing this claim; and

(ii) if a structured settlement or periodic payment was used:

1. the amount of immediate payment;

2. the present value of the projected total future payout (price of annuity if purchased); and

3. the projected total future payout;

(11) if a neutral expert witness is employed under § 3–2A–09(d)(2) of the Courts Article, the findings of a neutral expert witness as to a plaintiff's future medical expenses or future loss of earnings;

(12) if the case was tried to verdict, the amount of noneconomic damages; and

(13) (i) the total allocated loss adjustment expense by fees and expenses paid to defense counsel; and

(ii) the total allocated loss adjustment expense.

(c) The Commissioner:

(1) shall adopt regulations on the submission of information described in this section; and

(2) may adopt regulations that require insurers of other lines of liability insurance to submit reports containing information that is substantially similar to the information described in subsection (a) of this section.

(d) Failure to report in accordance with this section may result in the imposition by the Commissioner of a civil penalty of up to $5,000.

(e) The Commissioner shall report, in accordance with § 2-1257 of the State Government Article, the Commissioner's findings as to the impact of Chapter 5 of the Acts of the 2004 Special Session of the General Assembly and Chapter 477 of the Acts of the General Assembly of 1994 on the availability of health care malpractice and other liability insurance in the State to the Legislative Policy Committee on or before September 1 of each year.

§4–501.

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

(b) "Corporate Governance Annual Disclosure" or "CGAD" means a confidential report submitted by an insurer or the insurance group of which the insurer is a member in accordance with the requirements of this subtitle.

(c) "Insurance group" means those insurers and affiliates included within an insurance holding company system as defined in § 7–101 of this article.

(d) (1) "Insurer" includes:

(i) each person engaged as indemnitor, surety, or contractor in the business of entering into insurance contracts;

(ii) a nonprofit health service plan;

(iii) a health maintenance organization;

(iv) a dental plan organization; and

(v) a managed care organization.

(2) "Insurer" does not include an agency, an authority, or an instrumentality of the United States, its possessions and territories, the Commonwealth of Puerto Rico, the District of Columbia, a state, or a political subdivision of a state.

(e) "NAIC" means the National Association of Insurance Commissioners.

(f) "ORSA Summary Report" has the meaning stated in § 32–101 of this article.

§4–502.

(a) The requirements of this subtitle apply only to insurers domiciled in this State.

(b) Subject to subsection (c) of this section, this subtitle may not be construed to require or impose corporate governance standards and internal procedures beyond those which are required under the Corporations and Associations Article.

(c) This subtitle may not be construed to limit the Commissioner's authority, or the rights or obligations of a third–party under Title 2, Subtitle 2 of this article.

§4–503.

(a) (1) Not later than June 1 each calendar year beginning in 2020, an insurer or the insurance group of which the insurer is a member and for which the State is the lead state shall submit to the Commissioner a Corporate Governance Annual Disclosure that is in the form and contains the information required by regulation.

(2) If an insurer is a member of an insurance group and the State is not the lead state for the insurance group, as determined by the procedures specified in the most recent Financial Analysis Handbook adopted by the NAIC, the insurer shall submit a CGAD to the commissioner of the lead state for the insurance group, in accordance with the laws of the lead state.

(b) A CGAD submitted under subsection (a) of this section shall include a signature of the chief executive officer or corporate secretary of the insurer or the insurance group of which the insurer is a member attesting, to the best of that individual's belief and knowledge, that:

(1) the insurer has implemented a corporate governance structure, policies, and practices; and

(2) a copy of the CGAD has been provided to the insurer's board of directors or the appropriate committee of the board of directors.

(c) On request of the Commissioner, an insurer that is not required to submit a CGAD under subsection (a)(1) of this section shall submit a CGAD to the Commissioner.

(d) (1) Depending on how an insurer or the insurance group of which the insurer is a member has structured its corporate governance system, the insurer or insurance group submitting a CGAD to the Commissioner may provide information regarding its corporate governance structure at:

(i) the ultimate controlling parent level;

(ii) an intermediate holding company level; or

(iii) the individual legal entity level.

(2) In determining the level for which information will be provided under paragraph (1) of this subsection, the insurer or insurance group may consider the following criteria:

(i) the level at which the insurer's or insurance group's risk appetite is determined;

(ii) the level at which factors, such as earnings, capital, liquidity, operations, and reputation of the insurer, are overseen collectively, and at which level the supervision of those factors is coordinated and exercised; or

(iii) the level at which legal liability for failure of general corporate governance duties would be placed.

(3) If the insurer or insurance group determines the level of reporting based on the criteria listed under paragraph (2) of this subsection, the insurer or insurance group shall indicate which of the three criteria was used to determine the level of reporting and explain any subsequent changes in the level for which information is provided.

(e) If a CGAD is submitted to a lead state under subsection (a)(2) of this section, a review of the CGAD and any additional requests for information shall be made through the lead state, as determined by the procedures specified in the most recent Financial Analysis Handbook adopted by the NAIC.

(f) An insurer that includes information substantially similar to the information required under this subtitle in another document submitted to the Commissioner, including proxy statements filed in conjunction with Form B requirements, or other state or federal filings provided to the Administration:

(1) may not be required to duplicate the information in a CGAD; and

(2) shall cross–reference in the CGAD the other document in which the information is included.

§4–504.

(a) (1) Subject to paragraph (2) of this subsection, an insurer or the insurance group of which the insurer is a member shall have discretion over the responses to a CGAD inquiry.

(2) The CGAD shall contain the material information necessary to permit the Commissioner to develop an understanding of the corporate governance structure, policies, and practices of the insurer or insurance group.

(b) The Commissioner may request from an insurer or the insurance group of which the insurer is a member additional information that the Commissioner determines material and necessary.

(c) The insurer or the insurance group of which the insurer is a member shall:

(1) maintain documentation and supporting information; and

(2) make the documentation and supporting information available to the Commissioner on examination or on request of the Commissioner.

§4–505.

(a) Any documents, materials, or other CGAD–related information, including a CGAD, relating to an insurer and in the possession or control of the Commissioner that is obtained by, created by, or disclosed to the Commissioner or any other person under this subtitle:

(1) is confidential and privileged;

(2) is not subject to the Public Information Act;

(3) is not subject to subpoena; and

(4) is not subject to discovery or admissible in evidence in any private civil action.

(b) Except as otherwise provided by this subtitle, the Commissioner may not make public any documents, materials, or other CGAD–related information relating to an insurer without the prior written consent of the insurer.

(c) The Commissioner may use any documents, materials, or other CGAD–related information relating to an insurer in the furtherance of any regulatory or legal action brought as a part of the duties of the Commissioner.

(d) This section may not be construed to require written consent of an insurer before the Commissioner may share or receive confidential documents, materials, or other CGAD–related information that assist in the performance of the regulatory duties of the Commissioner.

(e) The Commissioner and any person that received confidential documents, materials, or other CGAD–related information, through examination or otherwise, while acting under the authority of the Commissioner, or with whom the documents, materials, or other CGAD–related information are shared under this subtitle may not be allowed or required to testify in any private civil action concerning the confidential documents, materials, or other CGAD–related information.

(f) (1) To assist in the performance of the regulatory duties of the Commissioner, the Commissioner may, on request, share documents, materials, or other CGAD–related information, including confidential and privileged documents, materials, or other CGAD–related information as provided under subsection (a) of this section with:

(i) other state, federal, and international financial regulatory agencies, including members of any supervisory college as defined in § 2–209.1 of this article;

(ii) the NAIC; and

(iii) any third–party consultant the Commissioner designates.

(2) The Commissioner may share documents, materials, or other CGAD–related information under paragraph (1) of this subsection if the recipient of the documents, materials, or other CGAD–related information:

(i) agrees in writing to maintain the confidentiality and privileged status of the documents, materials, or other CGAD–related information; and

(ii) verifies in writing that the recipient has the legal authority to maintain confidentiality and privileged status of the documents, materials, or other CGAD–related information.

(g) (1) The Commissioner may receive documents, materials, or other CGAD–related information from:

(i) other state, federal, and international financial regulatory agencies, including members of any supervisory college as defined in § 2–209.1 of this article; and

(ii) the NAIC.

(2) The Commissioner shall maintain as confidential and privileged any documents, materials, or other CGAD–related information received under paragraph (1) of this section that the Commissioner receives with notice or the understanding that the documents, materials, or other CGAD–related information are confidential and privileged under the laws of the jurisdiction that is the source of the documents, materials, or other CGAD–related information.

(h) (1) The sharing of information and documents by the Commissioner under this subtitle may not constitute a delegation of regulatory authority or rulemaking.

(2) The Commissioner is solely responsible for the administration, execution, and enforcement of the provisions of this subtitle.

(i) A waiver of any applicable privilege or claim of confidentiality and privileges in any documents, materials, or other CGAD–related information may not occur as a result of:

(1) the disclosure of the documents, materials, or other CGAD–related information to the Commissioner under this section; or

(2) the sharing of the documents, materials, or other CGAD–related information under this subtitle.

§4–506.

(a) (1) The Commissioner may retain, at an insurer's expense, third–party consultants as may be reasonably necessary to assist the Commissioner in:

(i) reviewing a CGAD and documents, materials, or other CGAD–related information; or

(ii) determining an insurer's compliance with this subtitle.

(2) Third–party consultants retained under paragraph (1) of this subsection may include attorneys, actuaries, accountants, and any other experts not otherwise a part of the Commissioner's staff.

(b) Any person retained under subsection (a) of this section shall:

(1) be under the direction and control of the Commissioner; and

(2) act in a purely advisory capacity.

(c) The NAIC and any third–party consultant shall be subject to the same confidentiality standards and requirements as the Commissioner.

(d) As part of the retention process, a third–party consultant shall verify to the Commissioner, with notice to the insurer, that the third–party consultant:

(1) is free of a conflict of interest with the insurer; and

(2) has internal procedures in place to monitor compliance regarding any conflict and to comply with the confidentiality standards and requirements under this subtitle.

(e) (1) The Commissioner shall enter into a written agreement with the NAIC or a third–party consultant governing sharing and use of documents, materials, or other CGAD–related information submitted to the Commissioner under this subtitle.

(2) The written agreement under paragraph (1) of this subsection shall:

(i) require the written consent of an insurer before making public documents, materials, or other CGAD–related information submitted to the Commissioner under this subtitle;

(ii) specify procedures and protocols for maintaining the confidentiality and security of documents, materials, or other CGAD–related information shared with the NAIC or a third–party consultant under this subtitle;

(iii) specify procedures and protocols for the sharing of documents, materials, or other CGAD–related information by the NAIC only with other state regulators from states in which an insurance group has domiciled insurers;

(iv) specify that the recipient of any documents, materials, or other CGAD–related information:

1. agrees in writing to maintain the confidentiality and privileged status of the documents, materials, or other CGAD–related information; and

2. has verified in writing the legal authority to maintain confidentiality;

(v) specify that:

1. ownership of the documents, materials, or other CGAD–related information shared under this subtitle with the NAIC or a third–party consultant remains with the Commissioner; and

2. the NAIC's or third–party consultant's use of the information is subject to the direction of the Commissioner;

(vi) prohibit the NAIC and any third–party consultant from storing documents, materials, or other CGAD–related information shared under this subtitle in a permanent database after the underlying analysis is completed;

(vii) require the NAIC and any third–party consultant to provide prompt notice to the Commissioner and to the insurer or insurance group of which the insurer is a member regarding any subpoena, request for disclosure, or request for production of the insurer's documents, materials, or other CGAD–related information; and

(viii) require the NAIC and any third–party consultant to consent to intervention by an insurer in any judicial or administrative action in which the NAIC or the third–party consultant may be required to disclose confidential documents, materials, or other CGAD–related information about the insurer shared with the NAIC or the third–party consultant under this subtitle.

§4–507.

(a) Subject to § 2–210 of this article, an insurer that fails to timely submit a CGAD to the Commissioner as required by this subtitle and without just cause is subject to a penalty of $200 for each day the violation continues, up to a maximum of $25,000.

(b) The Commissioner may reduce a penalty imposed on an insurer under subsection (a) of this section if the insurer demonstrates to the Commissioner that the imposition of the penalty would constitute a financial hardship to the insurer.

(c) This section does not limit the authority of the Commissioner to take any other action authorized by this article.

§4–508.

The Commissioner may adopt regulations to carry out this subtitle.

§4–509.

This subtitle may be cited as the Corporate Governance Annual Disclosure Act.

§5–101.

(a) In determining the financial condition of an insurer, the following assets that the insurer owns shall be allowed as admitted assets:

(1) cash that the insurer holds or that it controls while the cash is in transit, and the true balance of any deposit in a solvent bank or trust company;

(2) shares or deposits in a savings and loan association or building and loan association, to the extent that the investment or account is insured by an instrumentality of the United States or of Canada;

(3) in an amount not exceeding the cash surrender value of each individual policy:

(i) premium notes and policy loans, except for collateral assignment loans; and

(ii) accrued interest that is 90 days or more past due on each asset listed in item (i) of this item;

(4) in an amount not exceeding the policy reserve on each individual policy:

(i) collateral assignment loans; and

(ii) accrued interest that is 90 days or more past due on the asset listed in item (i) of this item;

(5) for a life insurer:

(i) the net amount of uncollected premiums that are not more than 90 days past due, unless payable directly or indirectly by an instrumentality of the United States; and

(ii) the net amount of deferred premiums and annuity considerations;

(6) except for life insurance premiums, the amount of premiums in the course of collection that:

(i) are not more than 90 days past due, unless payable directly or indirectly by an instrumentality of the United States; and

(ii) do not include commissions;

(7) to the extent of the unearned premium reserves carried on policies:

(i) installment premiums other than life insurance premiums; and

(ii) notes or similar written obligations not past due taken for premiums other than life insurance premiums;

(8) the full amount of reinsurance that a ceding insurer may recover from a solvent reinsurer under Subtitle 9 of this title;

(9) amounts receivable by an assuming insurer that represent funds that a solvent ceding insurer withholds under a reinsurance treaty;

(10) deposits or equities recoverable from an underwriting association, syndicate, reinsurance fund, or suspended banking institution:

(i) to the extent the deposits or equities are available for payment of losses and claims; or

(ii) at values that the Commissioner determines;

(11) electronic data processing equipment and operating system software amortized over a period of not more than 3 calendar years, to the extent it does not exceed 3% of the insurer's capital and surplus as required to be shown on

the insurer's statutory financial statement, adjusted to exclude deferred tax assets and net positive goodwill;

(12) investments, securities, properties, and loans acquired or held in accordance with this article, and the related items listed in subsection (b) of this section;

(13) positive goodwill recorded under the statutory purchase method of accounting:

(i) to the extent that it does not exceed 10% of the parent insurer's capital and surplus, as required to be shown on the statutory balance sheet, excluding any net positive goodwill, electronic data processing equipment, operating system software, and net deferred tax assets; and

(ii) amortized over a period of not more than 10 calendar years;

(14) other assets that an insurer may list as admitted assets in the annual statement required under this article, unless specifically not admitted under § 5–102 of this subtitle; and

(15) at values determined by the Commissioner, other assets:

(i) that are not inconsistent with this title; and

(ii) that the Commissioner considers available for the payment of losses and claims.

(b) In determining the financial condition of an insurer, the following items related to investments, securities, properties, or loans that the insurer owns shall be allowed as admitted assets:

(1) if it is not more than 90 days past due:

(i) interest that is due or accrued on a bond or evidence of indebtedness that is:

1. not in default; and

2. not valued on a basis that includes accrued interest;

(ii) declared and unpaid dividends on shares of stock, unless the amount of those dividends has otherwise been allowed as an asset;

(iii) interest that is due or accrued on deposits in solvent banks, solvent trust companies, or savings and loan associations insured by an instrumentality of the United States or of Canada; or

(iv) if the Commissioner considers that the interest is a collectible asset, interest that is due or accrued on other assets;

(2) interest that is due or accrued on a collateral loan:

(i) to the extent that the interest does not exceed 1 year's interest on the loan; and

(ii) to the extent that the unpaid balance of the loan plus accrued interest does not exceed the net value of the collateral that would be admitted, less estimated costs to obtain and sell the collateral;

(3) if the interest in its entirety is less than 180 days past due and has not accrued for more than 18 months, interest that is due or accrued on a mortgage loan, in an amount not more than any amount by which the value of the property, reduced by the amount of delinquent taxes and other costs to obtain and sell the property, exceeds the unpaid principal;

(4) rent that is due or accrued on real property if:

(i) the rent is not past due for more than 90 days; or

(ii) the payment is adequately secured by property held in the name of the tenant and conveyed to the insurer as collateral; and

(5) for a title insurer, title plants as provided in § 5-104 of this subtitle.

§5–102.

(a) Notwithstanding § 5-101 of this subtitle, in determining the financial condition of an insurer, the following expressly are not allowed as admitted assets:

(1) organizational expenses, trade names, and other similar intangible assets;

(2) except for policy loans, a secured or unsecured advance to an officer of the insurer;

(3) an advance given only on personal security to an employee or insurance producer of the insurer or to another person;

(4) stock of the insurer owned by it, any material interest in the stock of the insurer, any loan that is secured by the stock of the insurer, or any material proportionate interest in the stock of the insurer acquired or held through the insurer's ownership of an interest in another firm, corporation, or business unit;

(5) except for electronic data processing equipment and operating system software allowed as admitted assets under § 5-101(a)(11) of this subtitle, fixtures, furniture, furnishings, libraries, safes, stationery, supplies, and vehicles; and

(6) the amount, if any, by which the aggregate book value of investments carried in the ledger assets of the insurer exceeds the amount deemed collectible or the aggregate value of those investments as determined under this article.

(b) Notwithstanding subsection (a) of this section, a bona fide mortgage loan to an officer or employee of the insurer may be allowed as an admitted asset if the loan:

(1) is approved and ratified by the board of directors of the insurer;

(2) is secured by a first mortgage on a principal residence of an officer or employee; and

(3) does not exceed the amount allowed for any other mortgage investment under § 5-511(g) of this title.

§5–103.

In determining the financial condition of an insurer, capital stock and liabilities to be charged against the insurer's assets include:

(1) the amount of any capital stock outstanding;

(2) the amount, estimated in accordance with this article, that is needed to pay:

(i) all of the insurer's reported or unreported losses and claims incurred on or before the date of the annual statement required under this article; and

(ii) the expenses of adjustment or settlement of those losses and claims;

(3) any additional reserves that the Commissioner reasonably requires for a specific kind of insurance;

(4) taxes, expenses, and other obligations that are due or accrued at the date of the annual statement required under this article;

(5) as to life insurance and disability insurance and annuity contracts:

(i) reserves on life insurance policies and annuity contracts in force, valued according to the tables of mortality, rates of interest, and applicable methods adopted under this article;

(ii) reserves for disability benefits for active and disabled lives;

(iii) reserves for accidental death benefits;

(iv) reserves for additional benefits that provide long-term home health care and long-term care in a nursing home or other related institution; and

(v) any additional reserves that the Commissioner reasonably requires; and

(6) as to insurance other than as specified in item (5) of this section, the amount of reserves equal to the unearned parts of the gross premiums charged on policies in force, computed in accordance with this article.

§5–104.

(a) (1) In this section the following words have the meanings indicated.

(2) "Backplant" means a title plant that antedates the period of time covered by an existing title plant, or that covers additional parcels of land.

(3) "Title plant" means an integrated and indexed collection of title records consisting of documents, maps, surveys, or entries affecting title to real property or any interest in or encumbrance on the property which has been filed or recorded in the jurisdiction for which the title plant is established or maintained, as well as copies of prior title insurance policies.

(b) A title plant shall be allowed as an admitted asset for a title insurer under § 5-101 of this subtitle subject to the provisions of this section.

(c) (1) The costs specified in this subsection shall be capitalized costs with reference to the valuation of a title plant.

(2) Until a title plant can be used by an insurer to conduct title searches and issue title insurance policies, the costs incurred to construct a title plant, including the costs incurred to obtain, organize, and summarize historical information in an efficient and useful manner shall be capitalized costs. The capitalized costs must be directly related to, and properly identified with, the activities necessary to construct the title plant.

(3) (i) The costs to purchase a title plant, including a purchase of an undivided interest in a title plant, shall be capitalized costs, recorded at cost at the date of acquisition.

(ii) For a title plant acquired separately, the costs shall be measured by the fair market value of the consideration given.

(iii) For a title plant acquired as part of a group of assets, the costs shall be measured first by the fair market value of the consideration given, and then the cost shall be allocated to the title plant based on the fair market value of the title plant in relation to the total fair market value of the group of assets acquired.

(4) The costs to purchase or construct a backplant may be capitalized if the costs are properly identifiable.

(d) (1) The costs specified in this subsection may not be capitalized costs with reference to the valuation of a title plant.

(2) Costs incurred after a title plant is operational to:

(i) convert the information from one storage and retrieval system to another shall not be capitalized costs; or

(ii) modify or modernize the storage and retrieval system shall not be capitalized costs.

(e) The following costs shall be expensed as incurred with reference to the valuation of a title plant:

(1) costs incurred to maintain a title plant; and

(2) costs incurred to perform title searches.

(f) The aggregate carrying value of an investment in a title plant may not exceed the lesser of:

(1) 20% of the admitted assets; or

(2) 40% of the surplus as regards policyholders.

(g) A title insurer may sell:

(1) a title plant and relinquish all rights to future use of the title plant;

(2) an undivided ownership interest in its title plants; and

(3) a copy of a title plant or the right to use a title plant.

(h) Subject to the approval of the Commissioner, a title insurer may:

(1) enter into an agreement with one or more other title insurers authorized to do business in the State for the purpose of jointly participating in the ownership, management, and control of a title plant so as to serve the needs of the insurers; or

(2) hold stock in a corporation that owns and operates a title plant for the purpose of participating in the ownership, management, and control of a title plant.

(i) Except as provided in this section, title insurers shall comply with the investment requirements under Subtitle 6 of this title.

§5–201.

(a) (1) In this section the following words have the meanings indicated.

(2) "Operative date of the valuation manual" has the meaning stated in § 5–201.1 of this subtitle.

(3) "Opinion" means an opinion issued by a qualified actuary and developed in accordance with the standards of practice of the Actuarial Standards Board.

(4) "Qualified actuary" means a member in good standing of the American Academy of Actuaries who meets the qualification standards of the Academy for issuing an opinion required by this section.

(b) This section applies to reserve requirements and opinions relating to reserve requirements for policies, contracts, and benefit agreements of life insurers, nonprofit health service plans, and fraternal benefit societies required before the operative date of the valuation manual.

(c) (1) In addition to the requirement of paragraph (2) of this subsection, the aggregate reserves for all policies, contracts, and benefit agreements of a life insurer may not be less than the aggregate reserves computed under Subtitle 3 of this title.

(2) (i) The aggregate reserves for all policies, contracts, and benefit agreements of a life insurer, nonprofit health service plan, or fraternal benefit society may not be less than the aggregate reserves that a qualified actuary determines to be necessary under subsection (e) of this section.

(ii) By regulation, the Commissioner may provide for a transition period to establish any higher reserves required by this paragraph.

(d) Each life insurer, nonprofit health service plan, and fraternal benefit society that does business in the State shall submit annually the opinion of a qualified actuary as to whether the reserves and related actuarial items held in support of the life insurer's policies, contracts, and benefit agreements are:

(1) computed appropriately;

(2) based on assumptions that satisfy contractual provisions;

(3) consistent with prior reported amounts; and

(4) in compliance with applicable laws of the State.

(e) (1) Except as exempted by regulations adopted by the Commissioner, each life insurer, nonprofit health service plan, and fraternal benefit society shall include with the opinion required by subsection (d) of this section an additional opinion of the same qualified actuary, stating whether the reserves and related actuarial items that are held in support of the policies, contracts, and benefit agreements by the life insurer, nonprofit health service plan, or fraternal benefit society are adequate to meet its obligations under its policies, contracts, and benefit agreements, in light of the assets held with respect to the reserves and related actuarial items.

(2) The obligations of a life insurer, nonprofit health service plan, or fraternal benefit society under its policies, contracts, and benefit agreements include benefits to be provided and associated expenses that may reasonably be expected.

(3) In reviewing the assets held by the life insurer, nonprofit health service plan, or fraternal benefit society with respect to the reserves and related actuarial items, the qualified actuary shall consider the expected investment earnings on the assets and other consideration that the life insurer, nonprofit health service plan, or fraternal benefit society expects to receive and retain under the policies, contracts, and benefit agreements.

(f) (1) A memorandum acceptable to the Commissioner shall be prepared to support each opinion required under this section.

(2) The supporting memorandum shall be in the form and contain the information that is specified by regulation.

(3) The life insurer, nonprofit health service plan, or fraternal benefit society shall:

(i) keep the supporting memorandum in its home office; and

(ii) on request, submit a copy of the memorandum to the Commissioner.

(4) The Commissioner may engage a qualified actuary at the expense of the life insurer, nonprofit health service plan, or fraternal benefit society to review each opinion and prepare a supporting memorandum if:

(i) the life insurer, nonprofit health service plan, or fraternal benefit society fails to provide a supporting memorandum within the period specified by regulation; or

(ii) the Commissioner determines that the supporting memorandum that the life insurer, nonprofit health service plan, or fraternal benefit society provides fails to meet necessary standards or is unacceptable.

(g) (1) Each opinion required by this section shall:

(i) be submitted with the annual statement required by this article and reflect the valuation of the reserve liabilities of the life insurer, nonprofit health service plan, or fraternal benefit society;

(ii) apply to all business in force, including individual and group health insurance plans; and

(iii) be based on standards adopted by the Actuarial Standards Board.

(2) The Commissioner may adopt regulations to establish additional requirements for an opinion.

(3) For a foreign insurer or alien insurer, the Commissioner may accept an opinion that the foreign insurer or alien insurer files with the insurance supervisory official of another state if the Commissioner determines that the opinion reasonably meets the requirements applicable to a life insurer, nonprofit health service plan, or fraternal benefit society domiciled in this State.

(h) (1) Except as provided in subsection (i) of this section, the Commissioner shall keep confidential and may not make public any memorandum or other material that the life insurer, nonprofit health service plan, or fraternal benefit society provides in connection with an opinion issued under this section.

(2) A memorandum or other material provided to the Commissioner is not subject to a subpoena except for defending in a suit that:

(i) seeks damages from any person; and

(ii) is based on an action required by this section.

(i) (1) The Commissioner may release a memorandum or other material provided to the Commissioner:

(i) with the written consent of the life insurer, nonprofit health service plan, or fraternal benefit society that provides the memorandum or material; or

(ii) to the American Academy of Actuaries, if the Academy:

1. requests the memorandum or other material for professional disciplinary proceedings; and

2. sets forth procedures satisfactory to the Commissioner to preserve the confidentiality of the memorandum or other material.

(2) All parts of a memorandum or other material are no longer confidential if any part of the memorandum or material is:

(i) cited by the life insurer, nonprofit health service plan, or fraternal benefit society in its marketing;

(ii) cited before a governmental unit other than a State insurance department; or

(iii) released by the life insurer, nonprofit health service plan, or fraternal benefit society to the news media.

(j) Except for fraud, willful misconduct, or gross negligence, a qualified actuary is not liable for damages to any person other than the life insurer, nonprofit health service plan, fraternal benefit society, or the Commissioner for any act, error, omission, decision, or conduct related to an opinion that the qualified actuary issues under this section.

(k) The Commissioner shall adopt regulations to establish disciplinary action against a life insurer, nonprofit health service plan, fraternal benefit society, or qualified actuary that violates this section.

§5–201.1.

(a) (1) In this section the following words have the meanings indicated.

(2) "Accident and health insurance contract" means a contract, as specified in the valuation manual, that:

(i) incorporates morbidity risk; and

(ii) provides protection against economic loss resulting from accident, sickness, or medical conditions.

(3) "Appointed actuary" means a qualified actuary who is appointed in accordance with the valuation manual to issue an opinion required by this section.

(4) "Company" means an entity that:

(i) 1. has written, issued, or reinsured life insurance policies, accident and health insurance contracts, or deposit–type contracts in the State; and

2. has at least one of the policies or contracts specified in item 1 of this item in force or on claim; or

(ii) 1. has written, issued, or reinsured life insurance policies, accident and health insurance contracts, or deposit–type contracts in any state; and

2. is required to hold a certificate of authority to write life insurance policies, accident and health insurance contracts, or deposit–type contracts in this State.

(5) "Deposit–type contract" means a contract, as specified in the valuation manual, that does not incorporate mortality or morbidity risks.

(6) (i) "Life insurance policy" means a policy, as specified in the valuation manual, that incorporates mortality risk.

(ii) "Life insurance policy" includes:

1. an annuity contract; and

2. a pure endowment contract.

(7) "Operative date of the valuation manual" means the date determined in accordance with § 5–313 of this title.

(8) "Qualified actuary" means an individual who:

(i) is qualified to sign the applicable statement of actuarial opinion in accordance with the American Academy of Actuaries qualification standards for actuaries signing such statements; and

(ii) meets the requirements specified in the valuation manual.

(9) "Valuation manual" means the manual of valuation instructions adopted by the National Association of Insurance Commissioners in the manner specified in § 5–313(b)(1) of this title.

(b) This section applies to each company that, on or after the operative date of the valuation manual:

(1) has outstanding life insurance policies, accident and health insurance contracts, or deposit–type contracts in the State; and

(2) is subject to regulation by the Commissioner.

(c) (1) A company subject to this section shall submit annually the opinion of an appointed actuary as to whether the reserves and related actuarial items held in support of the company's life insurance policies, accident and health insurance contracts, and deposit–type contracts are:

(i) computed appropriately;

(ii) based on assumptions that satisfy contractual provisions;

(iii) consistent with prior reported amounts; and

(iv) in compliance with applicable laws of the State.

(2) The valuation manual shall prescribe the contents of the opinion and any other items considered necessary to the scope of the opinion.

(d) (1) Except as exempted in the valuation manual, a company subject to this section shall include with the opinion required by subsection (c) of this section an additional opinion of the same appointed actuary, stating whether the reserves and related actuarial items that are held in support of the company's life insurance policies, accident and health insurance contracts, and deposit–type contracts are adequate to meet the company's obligations under the life insurance policies, accident and health insurance contracts, and deposit–type contracts, in light of the assets held with respect to the reserves and related actuarial items.

(2) The obligations of a company under its life insurance policies, accident and health insurance contracts, and deposit–type contracts include benefits to be provided and associated expenses that may reasonably be expected.

(3) In reviewing the assets held by a company with respect to the reserves and related actuarial items, the appointed actuary shall consider the expected investment earnings on the assets and other consideration that the company expects to receive and retain under the company's life insurance policies, accident and health insurance contracts, and deposit–type contracts.

(e) (1) A memorandum shall be prepared to support each opinion required under this section.

(2) The supporting memorandum shall be:

(i) in the form and contain the information that is specified in the valuation manual; and

(ii) acceptable to the Commissioner.

(3) The Commissioner may engage a qualified actuary at the expense of a company subject to this section to review each opinion and the basis for the opinion and prepare a supporting memorandum if:

(i) the company fails to provide a supporting memorandum, at the request of the Commissioner, within the period specified in the valuation manual; or

(ii) the Commissioner determines that the supporting memorandum that the company provides fails to meet the standards prescribed by the valuation manual or is otherwise unacceptable to the Commissioner.

(f) (1) Each opinion required by this section shall:

(i) be in the form and contain the information that is specified in the valuation manual;

(ii) be acceptable to the Commissioner;

(iii) be submitted with the annual statement required by this article;

(iv) reflect the valuation of the reserve liabilities of a company subject to this section for each year ending on or after the operative date of the valuation manual;

(v) apply to all life insurance policies, accident and health insurance contracts, and deposit–type contracts subject to subsection (d) of this section and any other actuarial liabilities as may be specified in the valuation manual; and

(vi) be based on standards adopted by the Actuarial Standards Board and any additional standards as may be prescribed in the valuation manual.

(2) For a foreign company or an alien company, the Commissioner may accept an opinion that the foreign or alien company files with the insurance supervisory official of another state if the Commissioner determines that the opinion reasonably meets the requirements applicable to a company domiciled in this State.

(g) Except for fraud or willful misconduct, an appointed actuary is not liable for damages to any person other than the company or the Commissioner for any act, error, omission, decision, or conduct related to the appointed actuary's opinion.

(h) The Commissioner shall adopt regulations to establish disciplinary action against a company or an appointed actuary that violates this section.

§5–202.

(a) If the Commissioner determines that an insurer's unearned premium reserve is inadequate, the Commissioner may require the insurer to increase the unearned premium reserve and maintain it at an adequate level.

(b) If the Commissioner determines that an insurer's loss reserves are inadequate as shown by the insurer's loss experience, the Commissioner shall require the insurer to increase the reserves and maintain them at an adequate level.

§5–203.

(a) An insurer shall maintain active life reserves for all health insurance policies.

(b) The active life reserves:

(1) shall place a sound value on the insurer's liabilities under the health insurance policies;

(2) may not be less than the reserves required by the appropriate standards set forth in regulations that the Commissioner adopts; and

(3) in the aggregate, may not be less than the pro rata gross unearned premiums for the health insurance policies.

§5–205.

(a) Except as provided in subsection (e) of this section, each insurer shall maintain unearned premium reserves on all policies in force with respect to:

(1) insurance against loss or damage to property;

(2) general casualty insurance; and

(3) surety insurance.

(b) The Commissioner may require that, after deducting reinsurance ceded to solvent insurers in the manner provided in this article, the reserves equal the unearned parts of the gross premiums in force that are computed on each respective risk from the policy's date of issue.

(c) Reserves under this section shall be computed:

(1) at the option of the insurer, on a daily pro rata basis or a monthly pro rata basis if the insurance risk does not vary significantly during the contract period; or

(2) over the period of risk in proportion to the amount of insurance protection provided if the period of risk differs significantly from the contract period.

(d) After adopting a method for computing reserves, an insurer may change the method only with the approval of the Commissioner or the insurance supervisory official of the insurer's domicile.

(e) (1) A marine insurance premium on a trip risk not terminated is considered unearned.

(2) The Commissioner may require an insurer to carry reserves for unearned premiums equal to 100% on trip risks written during the month ended as of the date of the insurer's annual statement required by this article.

§5–206.

(a) (1) In this section, "risk premiums" means the amount charged for the assumption of risk.

(2) "Risk premiums" includes title insurance producer commissions.

(3) "Risk premiums" does not include charges for services rendered in the preparation of documents, searching, underwriting, recording of documents, or closing of a risk.

(b) In addition to adequate reserves required by § 5–103 of this title for outstanding losses, a title insurer domiciled in the State shall maintain a statutory reserve or unearned premium reserve of at least an amount computed as follows:

(1) 8% of the total amount of the risk premiums written in the calendar year for the retained liability for title insurance contracts shall be as assigned originally to the reserves; and

(2) during each of the 20 years that follow the year in which the contract is issued, the reserves applicable to the contract shall be reduced in equal 12–month installments in accordance with the following formula:

(i) 35% of the aggregate sum in the year succeeding the year of addition;

(ii) 15% of the aggregate sum in each of the succeeding 2 years;

(iii) 10% of the aggregate sum in the succeeding year;

(iv) 3% of the aggregate sum in each of the succeeding 3 years;

(v) 2% of the aggregate sum in each of the succeeding 3 years; and

(vi) 1% of the aggregate sum in each of the succeeding 10 years.

(c) (1) Each title insurer shall file with its annual statement required under § 4–116 of this article a certification by a member in good standing of the Casualty Actuarial Society, or a member in good standing of the American Academy of Actuaries who has been approved as qualified for signing casualty loss reserve opinions by the Casualty Practice Council of the American Academy of Actuaries, as to the adequacy of its reserves required under this section and § 5–103 of this title.

(2) The actuarial certification required of a title insurer must conform to the National Association of Insurance Commissioners' annual statement instructions for title insurers.

(d) (1) Unearned premium reserves may not be released under subsection (a) of this section to the extent that the release would result in the aggregate reserve falling below the amount required under this section and § 5–103 of this title.

(2) Any amount of unearned premium reserves that may not be released under paragraph (1) of this subsection shall be considered an unearned premium reserve and may not be considered a supplemental reserve.

§5–301.

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

(b) "Accident and health insurance contract" has the meaning stated in § 5–201.1(a) of this title.

(c) "Appointed actuary" means a qualified actuary who is appointed in accordance with the valuation manual to prepare an opinion required by § 5–201.1 of this title.

(d) "Company" has the meaning stated in § 5–201.1(a) of this title.

(e) "Deposit–type contract" has the meaning stated in § 5–201.1(a) of this title.

(f) "Life insurance policy" has the meaning stated in § 5–201.1(a) of this title.

(g) "NAIC" means the National Association of Insurance Commissioners.

(h) "Operative date of the valuation manual" has the meaning stated in § 5–201.1(a) of this title.

(i) (1) "Policyholder behavior" means any action a policyholder, contract holder, or any other person with the right to elect options, including a certificate holder, may take under a life insurance policy, an accident and health insurance contract, or a deposit–type contract issued on or after the operative date of the valuation manual.

(2) "Policyholder behavior" includes behavior relating to lapse, withdrawal, transfer, deposit, premium payment, loan, annuitization, or benefit elections prescribed by a life insurance policy, an accident and health insurance contract, or a deposit–type contract issued on or after the operative date of the valuation manual.

(3) "Policyholder behavior" does not include an event of mortality or morbidity that results in benefits prescribed in their essential aspects by the terms of a life insurance policy, an accident and health insurance contract, or a deposit–type contract issued on or after the operative date of the valuation manual.

(j) "Principle–based valuation" means a reserve valuation that:

(1) uses one or more methods or one or more assumptions determined by a company; and

(2) meets the requirements of § 5–314 of this subtitle.

(k) "Qualified actuary" has the meaning stated in § 5–201.1(a) of this title.

(l) "Tail risk" means a risk that occurs when:

(1) the frequency of low probability events is higher than expected under a normal probability distribution; or

(2) events of very significant size or magnitude are observed.

(m) "Valuation manual" has the meaning stated in § 5–201.1(a) of this title.

§5–301.1.

(a) (1) (i) Subject to subparagraph (ii) of this paragraph, the Commissioner annually shall value or cause to be valued the reserves for all outstanding life insurance policies, annuity contracts, and pure endowment contracts issued by each life insurer doing business in the State before the operative date of the valuation manual.

(ii) For an alien insurer, the valuation required by this subsection shall be limited to the alien insurer's United States business.

(2) To calculate reserves under this subsection, the Commissioner may use group methods and approximate averages for fractions of a year or otherwise.

(3) For a foreign insurer or alien insurer, instead of the valuation of reserves required by paragraph (1) of this subsection, the Commissioner may accept a valuation made or caused to be made by the insurance supervisory official of another state or other jurisdiction if the valuation complies with the minimum standard under this subtitle.

(4) Subject to the approval of the Commissioner, an insurer that has adopted a standard of valuation producing greater aggregate reserves than the aggregate reserves calculated under the minimum standard provided in this subtitle may adopt a lower standard of valuation if it is not lower than the minimum standard provided in this subtitle.

(b) (1) The Commissioner annually shall value or cause to be valued the reserves for all outstanding life insurance policies, accident and health insurance contracts, and deposit–type contracts issued by a company on or after the operative date of the valuation manual.

(2) For a foreign company or an alien company, instead of the valuation of reserves required by paragraph (1) of this subsection, the Commissioner may accept a valuation made or caused to be made by the insurance supervisory official of another state if the valuation complies with the minimum standard under this subtitle.

§5–302.

Except as otherwise provided in §§ 5-305 and 5-306 of this subtitle, the minimum standard for the valuation of a policy or contract issued before the operative date of the Maryland Standard Nonforfeiture Law for Life Insurance is the minimum standard provided by former Article 48A, § 83(2) of the Code in effect on September 30, 1997.

§5–303.

(a) Except as otherwise provided in §§ 5–305 and 5–306 of this subtitle for group annuity contracts and pure endowment contracts issued before the operative date of the Maryland Standard Nonforfeiture Law for Life Insurance:

(1) §§ 5–304 through 5–312 of this subtitle apply only to policies and contracts, as appropriate, issued on or after that operative date and before the operative date of the valuation manual; and

(2) §§ 5–313 and 5–314 of this subtitle do not apply to the policies and contracts.

(b) Sections 5–313 and 5–314 of this subtitle apply to all life insurance policies, accident and health insurance contracts, and deposit–type contracts issued by a company on or after the operative date of the valuation manual.

§5–304.

(a) (1) Except as otherwise provided in §§ 5–305 and 5–306 of this subtitle, the minimum standard for the valuation of life insurance policies, annuity contracts, and pure endowment contracts is:

(i) the Commissioners reserve valuation methods specified in §§ 5–307, 5–308, and 5–311 of this subtitle;

(ii) the applicable tables in subsections (b) through (h) of this section; and

(iii) except as provided in paragraph (2) of this subsection, interest at 3.5% per year.

(2) For a policy or contract issued on or after July 1, 1978 other than an annuity contract or pure endowment contract, the interest rate is:

(i) 4% per year if the policy or contract was issued any time from July 1, 1978 to June 30, 1980, both inclusive; or

(ii) 4.5% per year if the policy or contract was issued on or after July 1, 1980.

(b) For an ordinary policy of life insurance issued on the standard basis, excluding any disability and accidental death benefits in the policy, the applicable table for the minimum standard for the valuation of the policy is:

(1) if the policy was issued before the operative date of § 16–308 of this article, the Commissioners 1941 Standard Ordinary Mortality Table;

(2) if the policy was issued on or after the operative date of § 16–308 of this article but before the operative date of § 16–309 of this article:

(i) the Commissioners 1958 Standard Ordinary Mortality Table; or

(ii) at the election of the insurer, the Commissioners 1958 Standard Ordinary Mortality Table, calculating all modified net premiums and present values referred to in this subtitle for any category of policies issued on female risks according to an age not more than 6 years younger than the actual age of the insured; and

(3) if the policy was issued on or after the operative date of § 16–309 of this article:

(i) the Commissioners 1980 Standard Ordinary Mortality Table or, at the election of the insurer for any one or more specified plans of life insurance, the Commissioners 1980 Standard Ordinary Mortality Table with Ten–Year Select Mortality Factors; or

(ii) any ordinary mortality table, adopted after 1980 by NAIC and approved by a regulation of the Commissioner for use in determining the minimum standard of valuation for the policy.

(c) For an industrial life insurance policy issued on the standard basis, excluding any disability and accidental death benefits in the policy, the applicable table for the minimum standard for the valuation of the policy is:

(1) if the policy was issued before the operative date of § 16–308(d) of this article, the 1941 Standard Industrial Mortality Table; and

(2) if the policy was issued on or after the operative date of § 16–308(d) of this article:

(i) the Commissioners 1961 Standard Industrial Mortality Table; or

(ii) any industrial mortality table, adopted after 1980 by NAIC and approved by regulation of the Commissioner for use in determining the minimum standard of valuation for the policy.

(d) For an individual annuity contract or pure endowment contract, excluding any disability and accidental death benefits in the contract, the applicable table for the minimum standard for the valuation of the contract is, at the option of the insurer:

(1) the 1937 Standard Annuity Mortality Table;

(2) the Annuity Mortality Table for 1949, Ultimate; or

(3) a modification of a table specified by item (1) or (2) of this subsection approved by the Commissioner.

(e) For a group annuity contract or pure endowment contract, excluding any disability and accidental death benefits in the contract, the applicable table for the minimum standard for the valuation of the contract is:

(1) the Group Annuity Mortality Table for 1951;

(2) a modification of the Group Annuity Mortality Table for 1951 approved by the Commissioner; or

(3) at the option of the insurer, any of the tables or modifications of tables specified by subsection (d) of this section for individual annuity contracts and pure endowment contracts.

(f) (1) For total and permanent disability benefits in or supplementary to an ordinary policy or contract, the applicable table for the minimum standard for the valuation of the policy or contract is:

(i) if the policy or contract was issued on or before December 31, 1960, the Class (3) Disability Table (1926);

(ii) if the policy or contract was issued any time from January 1, 1961 to December 31, 1965, both inclusive:

1. the tables specified by item (i) of this paragraph; or

2. at the option of the insurer, the Class (3) Disability Table (1926); and

(iii) if the policy or contract was issued on or after January 1, 1966:

1. the tables of Period 2 disablement rates and the 1930 to 1950 termination rates of the 1952 Disability Study of the Society of Actuaries, with due regard to the type of benefit; or

2. any tables of disablement rates and termination rates adopted after 1980 by NAIC and approved by regulation of the Commissioner for use in determining the minimum standard of valuation for the policy or contract.

(2) For active lives, the table used under this subsection shall be combined with a mortality table allowed for calculating the reserves for life insurance policies.

(g) (1) For accidental death benefits in or supplementary to a policy, the applicable table for the minimum standard for the valuation of the policy is:

(i) if the policy was issued on or before December 31, 1960, the Intercompany Double Indemnity Mortality Table;

(ii) if the policy was issued any time from January 1, 1961 to December 31, 1965, both inclusive:

1. a table specified by item (i) of this paragraph; or

2. at the option of the insurer, the Intercompany Double Indemnity Mortality Table; and

(iii) if the policy was issued on or after January 1, 1966:

1. the 1959 Accidental Death Benefits Table; or

2. an accidental death benefits table adopted after 1980 by NAIC and approved by regulation of the Commissioner for use in determining the minimum standard of valuation for the policy.

(2) The table used under this subsection shall be combined with a mortality table allowed for calculating the reserves for life insurance policies.

(h) For group life insurance, life insurance issued on the substandard basis, long–term home health care and long–term care in a nursing home or other related institution, or any other special benefit, the applicable table for the minimum standard for the valuation of the policy or benefit is any table approved by the Commissioner for use in determining the minimum standard of valuation of the policy.

§5–305.

(a) (1) Except as provided in § 5–306 of this subtitle and subject to paragraph (3) of this subsection, this section applies to:

(i) all individual annuity contracts and pure endowment contracts issued on or after the operative date of this section; and

(ii) all annuities and pure endowments purchased on or after the operative date under group annuity contracts and pure endowment contracts.

(2) This section does not apply to any disability or accidental death benefit in a contract.

(3) The operative date of this section is:

(i) January 1, 1979; or

(ii) the date or dates before January 1, 1979, specified by the insurer in a written notice filed with the Commissioner before January 1, 1979, of the insurer's election of an earlier date or dates.

(b) For an individual annuity contract or pure endowment contract issued on or before June 30, 1980, the applicable table and interest rate for the minimum standard for the valuation of the contract are:

(1) the 1971 Individual Annuity Mortality Table or a modification of that table approved by the Commissioner; and

(2) interest at:

(i) 6% per year for a single premium immediate annuity contract; and

(ii) 4% per year for any other individual annuity contract or pure endowment contract.

(c) For an individual single premium immediate annuity contract issued on or after July 1, 1980, the applicable table and interest rate for the minimum standard for the valuation of the contract are:

(1) (i) the 1971 Individual Annuity Mortality Table;

(ii) an individual annuity mortality table adopted after 1980 by NAIC and approved by regulation of the Commissioner for use in determining the minimum standard of valuation for the contract; or

(iii) a modification of a table specified by subitem (i) or (ii) of this item approved by the Commissioner; and

(2) interest at 7.5% per year.

(d) For an individual annuity contract or pure endowment contract issued on or after July 1, 1980, other than a single premium immediate annuity contract, the applicable table and interest rate for the minimum standard for the valuation of the contract are:

(1) (i) the 1971 Individual Annuity Mortality Table;

(ii) an individual annuity mortality table adopted after 1980 by NAIC and approved by regulation of the Commissioner for use in determining the minimum standard of valuation for the contract; or

(iii) a modification of a table specified in subitem (i) or (ii) of this item approved by the Commissioner; and

(2) interest at:

(i) 5.5% per year for a single premium deferred annuity contract or pure endowment contract; and

(ii) 4.5% per year for any other individual annuity contract or pure endowment contract.

(e) For an annuity or pure endowment purchased on or before June 30, 1980, under a group annuity contract or pure endowment contract, the applicable table and interest rate for the minimum standard for the valuation of the contract are:

(1) the 1971 Group Annuity Mortality Table or a modification of that table approved by the Commissioner; and

(2) interest at 6% per year.

(f) For an annuity or pure endowment purchased on or after July 1, 1980, under a group annuity contract or pure endowment contract, the applicable table and interest rate for the minimum standard for the valuation of the contract are:

(1) (i) the 1971 Group Annuity Mortality Table;

(ii) a group annuity mortality table adopted after 1980 by NAIC and approved by regulation of the Commissioner for use in determining the minimum standard of valuation for the annuity or pure endowment; or

(iii) a modification of a table specified in subitem (i) or (ii) of this item approved by the Commissioner; and

(2) interest at 7.5% per year.

§5–306.

(a) (1) In this section the following words have the meanings indicated.

(2) "Change in fund basis" means a valuation basis under which the interest rate used to determine the minimum valuation standard applicable to each change in a fund held under an annuity or under a guaranteed interest contract is the calendar year statutory valuation interest rate for the year of the change in the fund.

(3) "Guarantee duration" means:

(i) for life insurance, the maximum number of years the life insurance can remain in force on a basis guaranteed in the policy or under options to convert to plans of life insurance with premium rates, nonforfeiture values, or both, that are guaranteed in the original policy; and

(ii) for an annuity or for a guaranteed interest contract:

1. if the annuity or the guaranteed interest contract has a cash settlement option, the number of years for which the contract guarantees interest rates in excess of the calendar year statutory valuation interest rate for life insurance policies with guarantee duration in excess of 20 years; and

2. if the annuity or the guaranteed interest contract does not have a cash settlement option, the number of years from the date of issue or date of purchase to the date annuity benefits are scheduled to commence.

(4) "Issue year basis" means a valuation basis under which the interest rate used to determine the minimum valuation standard for the entire duration of the annuity or of the guaranteed interest contract is the calendar year statutory valuation interest rate for the year of issue or year of purchase of the annuity or guaranteed interest contract.

(b) This section applies to:

(1) all life insurance policies issued on or after the operative date of § 16–309 of this article;

(2) all individual annuity contracts and pure endowment contracts issued on or after January 1, 1983;

(3) all annuities and pure endowments purchased on or after January 1, 1983, under group annuity contracts or pure endowment contracts; and

(4) the net increase, on or after January 1, 1983, in amounts held under guaranteed interest contracts.

(c) Instead of the interest rates specified in §§ 5–304 and 5–305 of this subtitle, the interest rates used to determine the minimum standard for the valuation of a policy, contract, annuity, or pure endowment, or net increase described in subsection (b) of this section shall be:

(1) for a life insurance policy or an individual annuity contract or pure endowment contract, the calendar year statutory valuation interest rate as determined under this section for the calendar year in which the policy or contract was issued;

(2) for an annuity or pure endowment purchased under a group annuity contract or pure endowment contract, the calendar year statutory valuation interest rate as determined under this section for the calendar year in which the annuity or pure endowment was purchased; or

(3) for a net increase in an amount held under a guaranteed interest contract, the calendar year statutory valuation interest rate as determined under this section for the calendar year in which the net increase occurred.

(d) (1) For purposes of the formulas under paragraph (2) of this subsection:

(i) "I" is the calendar year statutory valuation interest rate;

(ii) "R1" is the lesser of R and .09;

(iii) "R2" is the greater of R and .09;

(iv) "R" is the reference interest rate determined under subsection (f) of this section; and

(v) "W" is the weighting factor determined under subsection (e) of this section.

(2) (i) Except as provided in paragraph (3) of this subsection, the calendar year statutory valuation interest rates shall be determined as provided in this paragraph, rounding the results to the nearest 1/4 percent.

(ii) The calendar year statutory valuation interest rate for life insurance is:

$$I = .03 + W(R1 - .03) + W/2(R2 - .09).$$

(iii) The calendar year statutory valuation interest rate for a single premium immediate annuity or for an annuity benefit involving a life contingency arising from another annuity or guaranteed interest contract that has a cash settlement option is:

$$I = .03 + W(R - .03).$$

(iv) Except as provided in subparagraph (iii) of this paragraph, for an annuity or guaranteed interest contract that has a cash settlement option and is valued on an issue year basis:

1. the formula for life insurance under subparagraph (ii) of this paragraph applies if the annuity or guaranteed interest contract has a guarantee duration greater than 10 years; and

2. the formula for single premium annuities under subparagraph (iii) of this paragraph applies if the annuity or guaranteed interest contract has a guarantee duration of 10 years or less.

(v) The formula for single premium annuities under subparagraph (iii) of this paragraph applies to any other annuity or guaranteed interest contract that does not have a cash settlement option.

(vi) The formula for single premium annuities under subparagraph (iii) of this paragraph applies to any other annuity or guaranteed interest contract that has a cash settlement option and is valued on a change in fund basis.

(3) (i) If the calendar year statutory valuation interest rate for a life insurance policy issued in any calendar year determined without reference to this paragraph differs from the corresponding actual rate for a similar policy issued in the immediately preceding calendar year by less than 0.5%, the calendar year statutory valuation interest rate for that life insurance policy shall equal the corresponding actual rate for the immediately preceding calendar year.

(ii) For purposes of this paragraph, the calendar year statutory valuation interest rate for a life insurance policy issued in a calendar year shall be:

1. determined for 1980 using the reference interest rate determined for 1979; and

2. determined for each calendar year since 1980 regardless of when § 16–309 of this article became operative.

(e) (1) (i) In this subsection the following words have the meanings indicated.

(ii) "Plan Type A" means a plan type under which:

1. at any time the policyholder may withdraw funds only:

A. with an adjustment to reflect changes in interest rates or asset values since receipt of the funds by the insurer;

B. without the adjustment required by item A of this item but in installments over 5 years or more; or

C. as an immediate life annuity; or

2. no withdrawal is allowed at any time.

(iii) "Plan Type B" means a plan type under which:

1. before the expiration of the interest rate guarantee:

A. the policyholder may withdraw funds only with an adjustment to reflect changes in interest rates or asset values since receipt of the funds by the insurer;

B. the policyholder may withdraw funds without the adjustment required by item A of this item but in installments over 5 years or more; or

C. no withdrawal of funds is allowed; and

2. at the end of the interest rate guarantee, the policyholder may withdraw funds without the adjustment required by item 1A of this subparagraph in a single sum or installments over less than 5 years.

(iv) "Plan Type C" means a plan type under which a policyholder may withdraw funds before the expiration of the interest rate guarantee in a single sum or in installments over less than 5 years:

1. without adjustment to reflect changes in interest rates or asset values since receipt of the funds by the insurer; or

2. subject only to a fixed surrender charge stipulated in the contract as a percentage of the fund.

(2) For the purposes of this subsection, an insurer:

(i) may elect to value annuities or guaranteed interest contracts that have cash settlement options on an issue year basis or a change in fund basis; and

(ii) shall value annuities or guaranteed interest contracts that do not have cash settlement options on an issue year basis.

(3) The weighting factor in the formulas under subsection (d) of this section shall be determined as provided in this subsection.

(4) The weighting factor for life insurance is determined based on the guarantee duration of the life insurance as follows:

Guarantee Duration	Weighting

(Years)	Factor
10 or less	.50
More than 10, but not more than 20	.45
More than 20	.35

(5) The weighting factor for a single premium immediate annuity or for an annuity benefit involving a life contingency arising from another annuity or guaranteed interest contract that has a cash settlement option is .80.

(6) Except as provided in paragraphs (5) and (8) of this subsection, the weighting factor for an annuity or guaranteed interest contract valued on an issue year basis is determined based on the guarantee duration of the annuity or contract as follows:

Guarantee Duration	Weighing Factor For Plan Type		
(Years)	A	B	C
5 or less	.80	.60	.50
More than 5, but not more than 10:	.75	.60	.50
More than 10 but not more than 20:	.65	.50	.45
More than 20:	.45	.35	.35

(7) Except as provided in paragraphs (5) and (8) of this subsection, the weighting factor for an annuity or guaranteed interest contract valued on a change in fund basis is the weighting factor as determined under paragraph (6) of this subsection, increased by:

(i) for Plan Type A, .15;

(ii) for Plan Type B, .25; and

(iii) for Plan Type C, .05.

(8) The weighting factor as determined under paragraph (6) or (7) of this subsection shall be increased by .05 for:

(i) an annuity or guaranteed interest contract that is valued on an issue year basis, has a cash settlement option, and does not guarantee interest rates on amounts received more than 12 months after issue or purchase; or

(ii) an annuity or guaranteed interest contract that is valued on a change in fund basis and does not guarantee interest rates on amounts received more than 12 months beyond the valuation date.

(f) (1) (i) In this subsection the following words have the meanings indicated.

(ii) "Moody's corporate bond yield average" means Moody's corporate bond yield average – monthly average corporates, as published by Moody's Investors Service, Inc.

(iii) "12–month Moody's corporate bond yield average" means the average of Moody's corporate bond yield average over the 12–month period that ends:

1. for life insurance, on June 30 of the calendar year immediately preceding the year of issue;

2. for an annuity or guaranteed interest contract other than one described in item 3 of this subparagraph, on June 30 of the calendar year of issue or purchase; and

3. for an annuity or guaranteed interest contract that has a cash settlement option, is valued on a change in fund basis, is not a single premium immediate annuity, and is not an annuity benefit involving a life contingency arising from another annuity or guaranteed interest contract that has a cash settlement option, on June 30 of the calendar year of the change in the fund.

(iv) "36–month Moody's corporate bond yield average" means the average of Moody's corporate bond yield average over the 36–month period that ends:

1. for life insurance, on June 30 of the calendar year immediately preceding the year of issue; and

2. for an annuity or a guaranteed interest contract, on June 30 of the calendar year of issue or purchase.

(2) The reference interest rate in the formulas under subsection (d) of this section shall be determined as provided in this subsection.

(3) For life insurance, the reference interest rate is the lesser of:

(i) the 36–month Moody's corporate bond yield average; or

(ii) the 12–month Moody's corporate bond yield average.

(4) For a single premium immediate annuity or for an annuity benefit involving a life contingency arising from another annuity or guaranteed interest contract that has a cash settlement option, the reference interest rate is the 12–month Moody's corporate bond yield average.

(5) Except as provided in paragraph (4) of this subsection, for an annuity or guaranteed interest contract that has a cash settlement option, is valued on an issue year basis, and has a guarantee duration greater than 10 years, the reference interest rate is the lesser of:

(i) the 36–month Moody's corporate bond yield average; or

(ii) the 12–month Moody's corporate bond yield average.

(6) Except as provided in paragraph (4) of this subsection, the reference interest rate is the 12–month Moody's corporate bond yield average for any other annuity or guaranteed interest contract that:

(i) has a cash settlement option, is valued on an issue year basis, and has a guarantee duration of 10 years or less;

(ii) does not have a cash settlement option; or

(iii) has a cash settlement option and is valued on a change in fund basis.

(7) If Moody's corporate bond yield average is no longer published by Moody's Investors Service, Inc. or if NAIC determines that Moody's corporate bond yield average is no longer appropriate to determine the reference interest rate, the Commissioner shall approve by regulation an alternative method adopted by NAIC to determine the reference interest rate.

§5–307.

(a) (1) In this subsection, "guaranteed benefits" means future guaranteed life insurance and endowment benefits.

(2) Except as otherwise provided in paragraph (4) of this subsection and in §§ 5–308 and 5–311 of this subtitle, for the life insurance and endowment benefits of a policy that provides for a uniform amount of insurance and requires the payment of uniform premiums, the reserve according to the Commissioners reserve valuation method shall be the amount, if any, that the present value, at the date of valuation, of the guaranteed benefits under the policy exceeds the present value, at

the date of valuation, of any future modified net premiums for the policy, as determined under paragraph (3) of this subsection.

(3) (i) For purposes of this subsection, the modified net premiums for a policy equal a uniform percentage of the respective contract premiums for the guaranteed benefits under the policy calculated so that the present value, at the date of issue of the policy, of the sum of all the modified net premiums equals the sum of:

1. the present value, at the date of issue, of the guaranteed benefits under the policy; and

2. the amount by which the net level annual premium determined under subparagraph (ii) of this paragraph exceeds a net 1–year term premium for the guaranteed benefits provided for in the first policy year.

(ii) 1. Except as provided in subsubparagraph 2 of this subparagraph, the net level annual premium to be used in the calculation in this paragraph equals a fraction:

A. the numerator of which is the present value, at the date of issue, of the guaranteed benefits provided for after the first policy year; and

B. the denominator of which is the present value, at the date of issue, of an annuity of one per year payable on the first and each subsequent anniversary of the policy on which a premium falls due.

2. The net level annual premium determined under this subparagraph may not exceed the net level annual premium on the 19–year premium whole life plan for insurance of the same amount at an age 1 year higher than the age at issue of the policy for which the reserve is calculated under this subsection.

(4) (i) 1. In this paragraph the following words have the meanings indicated.

2. "Assumed ending date" means the first policy anniversary of a policy on which the sum of any endowment benefit under the policy and any cash surrender value available on that policy anniversary is greater than the excess first year premium.

3. "Excess first year premium" means the amount by which the contract premium in the first policy year of a policy exceeds the premium in the second policy year.

(ii) This paragraph applies to a life insurance policy issued on or after January 1, 1986:

1. for which the contract premium in the first policy year exceeds the premium in the second year;

2. that does not provide a comparable additional benefit in the first year for the excess first year premium; and

3. that provides an endowment benefit or a cash surrender value or a combination in an amount greater than the excess first year premium.

(iii) For a policy described in subparagraph (ii) of this paragraph, except as provided in § 5–311 of this subtitle, the reserve according to the Commissioners reserve valuation method as of any policy anniversary on or before the assumed ending date of the policy shall be the greater of:

1. the reserve calculated under paragraph (2) of this subsection; or

2. the reserve calculated under paragraph (2) of this subsection modified as follows:

A. the net level annual premium determined under paragraph (3)(ii) of this subsection shall be reduced by 15% of the excess first year premium;

B. all present values of benefits and premiums shall be determined without reference to premiums or benefits provided under the policy after the assumed ending date;

C. the policy shall be assumed to mature on the assumed ending date as an endowment; and

D. the cash surrender value provided on the assumed ending date shall be considered as an endowment benefit.

(iv) In making the calculation under subparagraph (iii) of this paragraph, the mortality and interest bases stated in §§ 5–304 and 5–306 of this subtitle shall be used.

(b) (1) This subsection applies to:

(i) life insurance policies that provide for a varying amount of insurance or require the payment of varying premiums;

(ii) group annuity contracts and pure endowment contracts purchased under a retirement plan or plan of deferred compensation, established or maintained by an employer, an employee organization, or both, unless the plan provides individual retirement accounts or individual retirement annuities under § 408 of the Internal Revenue Code;

(iii) disability and accidental death benefits and benefits for long–term home health care and long–term care in a nursing home or other related institution in all policies and contracts; and

(iv) all other benefits, except:

1. life insurance and endowment benefits in life insurance policies; and

2. benefits provided by annuity contracts or pure endowment contracts not described in item (ii) of this paragraph.

(2) For a policy, contract, or benefit to which this subsection applies, the reserve according to the Commissioners reserve valuation method shall be calculated by a method consistent with the principles of subsection (a) of this section, disregarding in the determination of modified net premiums any extra premiums charged because of impairments or special hazards.

§5–308.

(a) (1) Except as provided in paragraph (2) of this subsection, this section applies to all annuity contracts and pure endowment contracts.

(2) This section does not apply to:

(i) group annuity contracts or pure endowment contracts purchased under a retirement plan or plan of deferred compensation, established or maintained by an employer, an employee organization, or both, unless the plan provides individual retirement accounts or individual retirement annuities under § 408 of the Internal Revenue Code; or

(ii) any disability and accidental death benefits and benefits for long-term home health care and long-term care in a nursing home or other related institution included in an annuity contract or pure endowment contract.

(b) (1) (i) For benefits under an annuity contract or pure endowment contract to which this section applies, the reserve according to the Commissioners annuity reserve method shall be the greatest of the amounts determined for each respective contract year under subparagraph (ii) of this paragraph.

(ii) For each contract year, there shall be determined the amount by which the present value, at the date of valuation, of the future guaranteed benefits, including guaranteed nonforfeiture benefits, under the contract at the end of the contract year exceeds the present value, at the date of valuation, of any future valuation considerations derived from future gross considerations that are required by the terms of the contract and become payable prior to the end of the contract year.

(2) For purposes of this subsection:

(i) the future guaranteed benefits shall be determined by using the mortality table, if any, and interest rate specified in the contract for determining guaranteed benefits; and

(ii) the valuation considerations are the portions of the respective gross considerations applied under the terms of the contract to determine nonforfeiture values.

§5–309.

(a) This section does not apply to reserves for disability and accidental death benefits and benefits for long-term home health care and long-term care in a nursing home or other related institution included in a life insurance policy.

(b) An insurer's aggregate reserves for all life insurance policies may not be less than the aggregate reserves calculated in accordance with:

(1) the methods set forth in §§ 5-307, 5-308, 5-311, and 5-312 of this subtitle; and

(2) the mortality tables and rates of interest used in calculating nonforfeiture benefits for those policies.

§5–310.

(a) Subject to subsection (b) of this section, the Commissioner may establish any category of policies, contracts, or benefits for which reserves may be calculated, at the option of the insurer, under a standard that produces greater aggregate reserves for the category than the aggregate reserves calculated using the minimum standard provided in this subtitle.

(b) (1) This subsection does not apply to annuity contracts or pure endowment contracts.

(2) The interest rate used to calculate the reserve for a policy or contract under a standard other than the minimum standard in this subtitle may not be higher than the corresponding interest rate used to calculate any nonforfeiture benefits provided by the policy or contract.

§5–311.

(a) (1) Except as provided in subsection (b) of this section, if in any contract year the gross premium charged by an insurer on a policy or contract is less than the valuation net premium for the policy or contract, the minimum reserve required for the policy or contract is the greater of:

(i) the reserve calculated according to the mortality table, interest rate, and method actually used for the policy or contract; or

(ii) the reserve calculated by using the method actually used for the policy or contract, but:

1. using the minimum valuation standards of mortality and of interest in §§ 5-304 and 5-306 of this subtitle; and

2. in each contract year for which the valuation net premium exceeds the actual gross premium, using the actual gross premium instead of the valuation net premium.

(2) (i) Except as provided in subparagraph (ii) of this paragraph, for purposes of paragraph (1) of this subsection, the valuation net premium for a policy or contract shall be calculated by the method used in calculating the reserve on the policy or contract using the minimum valuation standards of mortality and interest rate under §§ 5-304 and 5-306 of this subtitle.

(ii) For future renewals under a renewable term insurance policy, the modern CSO mortality table published in The Transactions of The Society of Actuaries, Vol. XXVII (1975), shall be used instead of the minimum valuation standard of mortality under § 5-304 of this subtitle.

(3) If the gross premium rates for a policy or contract are not based consistently on a suitable accepted or credible mortality basis or table, the Commissioner may require additional reserves in accordance with § 5-103(3) of this title.

(b) For a life insurance policy described in § 5-307(a)(3)(ii) of this subtitle:

(1) subsection (a) of this section shall be applied substituting the method described in § 5-307 of this subtitle, without regard to § 5-307(a)(4)(iii), for the method actually used in calculating the reserve for the policy; and

(2) the minimum reserve at each policy anniversary of the policy shall be the greater of:

(i) the minimum reserve calculated under § 5-307 of this subtitle, including § 5-307(a)(4)(iii); or

(ii) the minimum reserve calculated under this section.

§5–312.

(a) This section applies to:

(1) a plan of life insurance that provides for future premiums to be determined by the insurer based on estimates of future experience; and

(2) a plan of life insurance or annuity that is of a nature that precludes determining the minimum reserves by the methods described in §§ 5-307, 5-308, and 5-311 of this subtitle.

(b) In accordance with regulations adopted by the Commissioner, the reserves that are held under a plan described in subsection (a) of this section shall:

(1) be appropriate in relation to the benefits and pattern of premiums for that plan; and

(2) be computed by a method that is consistent with the principles of this subtitle.

§5–313.

(a) Except as provided in subsection (e) or (g) of this section, for life insurance policies, accident and health insurance contracts, and deposit–type contracts issued on or after the operative date of the valuation manual, the standard prescribed in the valuation manual is the minimum standard of valuation.

(b) The operative date of the valuation manual is January 1 of the first calendar year following the first July 1 as of which all of the following have occurred:

(1) the valuation manual has been adopted by NAIC by an affirmative vote of at least 42 members or 75% of the members voting, whichever is greater;

(2) the Standard Valuation Law, as amended by NAIC in 2009, or legislation including substantially similar terms and provisions, has been enacted by states representing greater than 75% of the direct premiums written, as reported in the following annual statements submitted for 2008:

(i) life, accident, and health annual statements;

(ii) health annual statements; or

(iii) fraternal annual statements; and

(3) the Standard Valuation Law, as amended by NAIC in 2009, or legislation including substantially similar terms and provisions, has been enacted by at least 42 of the following 55 jurisdictions:

(i) the 50 states of the United States;

(ii) American Samoa;

(iii) the U.S. Virgin Islands;

(iv) the District of Columbia;

(v) Guam; and

(vi) Puerto Rico.

(c) Unless a change in the valuation manual specifies a later effective date, changes to the valuation manual shall be effective on January 1 following the date when the change to the valuation manual has been adopted by NAIC by an affirmative vote representing:

(1) at least 75% of the members of NAIC voting, but not less than a majority of the total membership; and

(2) members of NAIC representing jurisdictions totaling greater than 75% of the direct premiums written, as reported in the following annual statements most recently available before the vote under item (1) of this subsection:

(i) life, accident, and health annual statements;

(ii) health annual statements; or

(iii) fraternal annual statements.

(d) (1) The valuation manual shall specify the following:

(i) the minimum valuation standards for each type of life insurance policy, accident and health insurance contract, and deposit–type contract issued by a company on or after the operative date of the valuation manual;

(ii) the policies and contracts or types of policies and contracts that are subject to the requirements of a principle–based valuation under § 5–314 of this subtitle and the minimum valuation standards consistent with those requirements;

(iii) for policies and contracts subject to a principle–based valuation under § 5–314 of this subtitle:

1. requirements for the format of reports to the Commissioner required under § 5–314(b)(1)(iii) of this subtitle, including the information necessary to determine if the principle–based valuation is appropriate and in compliance with this subtitle;

2. required assumptions for risks over which a company does not have significant control or influence; and

3. procedures for corporate governance and oversight of the actuarial function and a process for appropriate waiver or modification of those procedures;

(iv) any other requirements, including requirements relating to reserve methods, models for measuring risk, generation of economic scenarios, assumptions, margins, use of company experience, risk measurement, disclosure, certifications, reports, actuarial opinions and memoranda, transition rules, and internal controls; and

(v) the data and the form of the data required under § 5–315 of this subtitle, the person to whom the data must be submitted, and any other requirements considered necessary, including requirements relating to data analysis and reporting of analyses.

(2) The minimum valuation standards required under paragraph (1)(i) of this subsection shall be known as:

(i) the Commissioners reserve valuation method for life insurance policies, other than annuity contracts;

(ii) the Commissioners annuity reserve valuation method for annuity contracts; and

(iii) minimum reserves for all other policies or contracts.

(3) For policies and contracts not subject to a principle–based valuation under § 5–314 of this subtitle, the minimum valuation standard shall:

(i) be consistent with the minimum standard of valuation before the operative date of the valuation manual; or

(ii) develop reserves that quantify the benefits and guarantees, and the funding, associated with the policies and contracts and their risks at a level of conservatism that reflects conditions that include unfavorable events that have a reasonable probability of occurring.

(e) In the absence of a specific valuation requirement, or if a specific valuation requirement in the valuation manual is not, in the opinion of the Commissioner, in compliance with this subtitle, a company, with respect to the requirement, shall comply with the minimum valuation standard prescribed by the Commissioner by regulation.

(f) (1) The Commissioner may engage a qualified actuary at the expense of the company to:

(i) perform an actuarial examination of a company and opine on the appropriateness of any reserve assumption or method used by the company; or

(ii) review and opine on a company's compliance with any requirement under this subtitle.

(2) The Commissioner may rely on the opinion of a qualified actuary issued while the qualified actuary was employed by or under contract with the insurance supervisory official of another state.

(g) (1) The Commissioner may require a company to change any assumption or method used by the company if, in the opinion of the Commissioner,

the change is necessary to comply with the requirements of the valuation manual or this subtitle.

(2) The company shall adjust the company's reserves as required by the Commissioner.

§5–314.

(a) For policies and contracts specified in the valuation manual, a company shall establish reserves using a principle–based valuation that:

(1) quantifies the benefits and guarantees, and the funding, associated with the policies or contracts and their risks at a level of conservatism that reflects conditions that include unfavorable events that have a reasonable probability of occurring during the lifetime of the policies or contracts;

(2) for policies or contracts with significant tail risk, reflects conditions appropriately adverse to quantify the tail risk;

(3) incorporates assumptions, risk analysis methods and financial models, and management techniques that are consistent with, but not necessarily identical to, those used within the company's overall risk assessment process, while recognizing potential differences in financial reporting structures and any prescribed assumptions or methods;

(4) incorporates assumptions that:

(i) are prescribed in the valuation manual; or

(ii) if not prescribed in the valuation manual:

1. are established using the company's available experience, to the extent it is relevant and statistically credible; or

2. to the extent that company data is not available, relevant, or statistically credible, are established using other relevant, statistically credible experience; and

(5) provides margins for uncertainty, including adverse deviation and estimation error, such that the greater the uncertainty the larger the margin and resulting reserve.

(b) (1) A company that uses a principle–based valuation for one or more policies or contracts subject to this section shall:

(i) establish procedures for corporate governance and oversight of the actuarial valuation function consistent with those described in the valuation manual;

(ii) provide to the Commissioner and the board of directors of the company an annual certification of the effectiveness of the company's internal controls with respect to the principle–based valuation; and

(iii) develop, and file with the Commissioner on request, a principle–based valuation report that complies with standards prescribed in the valuation manual.

(2) The internal controls under paragraph (1)(ii) of this subsection shall be designed to ensure that:

(i) all material risks inherent in the liabilities and associated assets subject to the principle–based valuation are included in the principle–based valuation; and

(ii) principle–based valuations are made in accordance with the valuation manual.

(3) The annual certification required under paragraph (1)(ii) of this subsection shall be based on the internal controls in place as of the end of the preceding calendar year.

(c) A principle–based valuation may include a prescribed formulaic reserve component.

§5–315.

A company shall submit the mortality data, morbidity data, policyholder behavior, expense experience, and other data as prescribed in the valuation manual.

§5–316.

(a) In this section, "confidential information" means:

(1) a memorandum in support of an opinion submitted under § 5–201.1 of this title and any documents, materials, and other information, including all working papers and copies of all working papers, created, produced, or obtained by or disclosed to the Commissioner or any other person in connection with the memorandum;

(2) any documents, materials, and other information, including all working papers and copies of all working papers, created, produced, or obtained by or disclosed to the Commissioner or any other person in the course of an examination made under § 5–313(f) of this subtitle;

(3) (i) any reports, documents, materials, and other information developed by a company in support of, or in connection with, an annual certification by the company under § 5–314(b)(1)(ii) of this subtitle evaluating the effectiveness of the company's internal controls with respect to a principle–based valuation; and

(ii) any documents, materials, and other information, including all working papers and copies of all working papers, created, produced, or obtained by or disclosed to the Commissioner or any other person in connection with the reports, documents, materials, and information specified in item (i) of this item;

(4) a principle–based valuation report developed under § 5–314(b)(1)(iii) of this subtitle and any documents, materials, and other information, including all working papers and copies of all working papers, created, produced, or obtained by or disclosed to the Commissioner or any other person in connection with the principle–based valuation report; and

(5) (i) any documents, materials, data, and other information submitted to the Commissioner or any other person by a company under § 5–315 of this subtitle;

(ii) any documents, materials, data, and other information, including all working papers and copies of all working papers, created or produced in connection with the documents, materials, data, and information specified in item (i) of this item that include any potentially company–identifying or personally identifiable information, that is provided to or obtained by the Commissioner or any other person; and

(iii) any documents, materials, data, and other information, including all working papers and copies of all working papers, created, produced, or obtained by or disclosed to the Commissioner or any other person in connection with the documents, materials, data, and other information specified in items (i) and (ii) of this item.

(b) Except as otherwise provided in this section, a company's confidential information:

(1) is confidential and privileged;

(2) is not subject to Title 4 of the General Provisions Article; and

(3) is not subject to subpoena or discovery or admissible in evidence in any private civil action.

(c) (1) The Commissioner, and any person who receives confidential information while acting under the authority of the Commissioner, may not testify or be required to testify in any private civil action concerning any confidential information.

(2) The Commissioner may use confidential information of a company in any regulatory or legal action brought against the company as a part of the Commissioner's official duties.

(d) If an examination report or material prepared in connection with an examination made under Title 2, Subtitle 2 of this article is not private and confidential information under Title 2, Subtitle 2 of this article, an examination report or other material prepared in connection with an examination made under § 5–313(f) of this subtitle is not "confidential information" to the same extent as if the examination report or other material had been prepared under Title 2, Subtitle 2 of this article.

(e) (1) Subject to paragraph (2) of this subsection, to assist in the performance of the Commissioner's duties, the Commissioner may share confidential information specified in:

(i) subsection (a)(1) through (5) of this section with:

1. any state, federal, or international regulatory agency and the employees, agents, consultants, and contractors of any state, federal, or international regulatory agency; and

2. NAIC and the employees, agents, consultants, contractors, affiliates, and subsidiaries of NAIC; and

(ii) subsection (a)(1) and (4) of this section with:

1. the Actuarial Board for Counseling and Discipline on a request from the Actuarial Board stating that the confidential information is required for the purpose of professional disciplinary proceedings; and

2. any state, federal, or international law enforcement official and the employees, agents, consultants, and contractors of any state, federal, or international law enforcement official.

(2) Confidential information may be shared by the Commissioner under paragraph (1) of this subsection only if the recipient of the confidential information agrees, and has the legal authority to agree, to maintain the confidentiality and privileged status of any confidential information received in the same manner and to the same extent as required for the Commissioner.

(f) (1) The Commissioner may receive documents, materials, data, and other information, including otherwise confidential or privileged documents, materials, data, and information, from:

(i) NAIC and the employees, agents, consultants, contractors, affiliates, and subsidiaries of NAIC;

(ii) any state, federal, or international regulatory agency or law enforcement official and the employees, agents, consultants, and contractors of the regulatory agency or law enforcement official; and

(iii) the Actuarial Board for Counseling and Discipline.

(2) The Commissioner shall maintain as confidential and privileged any document, material, data, or other information received with notice or the understanding that it is confidential or privileged under the laws of the jurisdiction that is the source of the document, material, data, or other information.

(g) The Commissioner may enter into agreements governing the sharing and use of confidential information consistent with this section.

(h) (1) Any applicable privilege or claim of confidentiality in confidential information is not waived as a result of:

(i) the disclosure of the confidential information to the Commissioner under this section; or

(ii) the sharing of the confidential information as authorized under subsection (e) of this section.

(2) A privilege established under the law of another state that is substantially similar to the privilege established under this section shall be available and enforced in any proceeding in, and in any court of, the State.

(i) Any confidential information specified in subsection (a)(1) and (4) of this section:

(1) is subject to subpoena for defending in an action that:

(i) seeks damages from the appointed actuary submitting the related memorandum in support of an opinion submitted under § 5–201.1 of this title or a principle–based valuation report developed under § 5–314(b)(1)(iii) of this subtitle; and

(ii) is based on an action required by this subtitle or regulations adopted under this subtitle; and

(2) may be released by the Commissioner with the written consent of the company.

(j) All parts of a memorandum in support of an opinion submitted under § 5–201.1 of this title or a principle–based valuation report developed under § 5–314(b)(1)(iii) of this subtitle are no longer confidential information if any part of the memorandum or report is:

(1) cited by the company in its marketing;

(2) publicly volunteered to or before a governmental unit other than a state insurance department; or

(3) released by the company to the news media.

§5–317.

(a) The Commissioner may exempt a specific product form or product line of a domestic company that holds a certificate of authority issued by the Commissioner and is doing business only in the State from the requirements of § 5–313 of this subtitle if:

(1) the Commissioner has issued an exemption in writing to the company;

(2) the exemption has not been revoked in writing by the Commissioner; and

(3) the company computes reserves:

(i) using assumptions and methods used before the operative date of the valuation manual; and

(ii) in accordance with any requirements established by the Commissioner by regulation.

(b) (1) A company that is granted an exemption under subsection (a) of this section is subject to § 5–201 of this title and §§ 5–302 through 5–312 of this subtitle.

(2) With respect to a company that is granted an exemption under subsection (a) of this section, any reference to § 5–313 of this subtitle found in § 5–201.1 of this title and §§ 5–302 through 5–312 of this subtitle is not applicable.

(c) The Commissioner may exempt a domestic company that holds a certificate of authority issued by the Commissioner and is doing business in the State from the requirements of §§ 5–314 and 5–315 of this subtitle if the company meets the life principle–based reserves exemption criteria in the valuation manual.

(d) For purposes of subsection (c) of this section, ordinary life premiums are measured as direct premium plus reinsurance assumed from an unaffiliated company, as reported in the annual statement for the prior calendar year.

(e) (1) A domestic company that meets the requirements of subsection (c) of this section shall:

(i) compute reserves:

1. using assumptions and methods used before the operative date of the valuation manual; and

2. in accordance with any requirements established by the Commissioner in regulation; and

(ii) file, before July 1 of each year, a statement with the Commissioner certifying that the domestic company meets the requirements of subsection (c) of this section for the current calendar year based on premiums and other values from the financial statements for the prior calendar year.

(2) Before September 1 of each year, the Commissioner may reject a statement filed under paragraph (1)(ii) of this subsection and require a domestic company to comply with the valuation manual requirements for life insurance reserves.

§5–401.

(a) (1) Except for securities subject to amortization and except as otherwise provided in this title, an insurer's investments shall be valued, at the discretion of the Commissioner, at:

(i) their appraised value;

(ii) their fair market value; or

(iii) prices that the Commissioner determines represent their fair market value.

(2) If the Commissioner finds that a special investment reserve would be prudent in view of the character of investments, the Commissioner may require the insurer to:

(i) establish and maintain a special investment reserve of a reasonable amount for losses or fluctuations in value; and

(ii) submit a statement or report to the Commissioner on the financial condition of the reserve.

(3) In connection with an examination or required financial statement of an authorized insurer, the Commissioner may:

(i) require the insurer to submit a complete financial statement and audited report of the financial condition of a corporation in which the insurer owns securities; and

(ii) order an examination to be made of a subsidiary or affiliate of the insurer.

(b) (1) An insurer that owns 10% or more of the stock of another insurer shall have its stock valued at book value as shown by the more recent of:

(i) the last annual statement of the other insurer; or

(ii) the last report on examination of the other insurer.

(2) Except as provided in paragraph (3) of this subsection, the book value of a share of common stock of an insurer shall be represented by a fraction:

(i) the numerator of which is the amount of the insurer's capital and surplus, less the value of any outstanding preferred stock; and

(ii) the denominator of which is the number of shares of the insurer's common stock issued and outstanding.

(3) An insurer may value its holdings of stock in a subsidiary insurer in an amount that is not less than the acquisition cost, if the acquisition cost is less than the value determined under paragraph (2) of this subsection.

(c) The stock of a subsidiary of an insurer shall be valued on the basis of only those assets that would be authorized investments for the insurer if the insurer acquired or held them directly.

(d) Real estate that is acquired by foreclosure or by deed in lieu of foreclosure may not be valued at an amount greater than the sum of:

(1) the unpaid principal of any defaulted loan at the date of the foreclosure or deed;

(2) any taxes and expenses that the insurer pays or incurs to protect the investment or in connection with the acquisition, except for uncollected interest on any loan;

(3) the cost of a later addition or improvement by the insurer; and

(4) an amount that the insurer pays later on assessments levied for improvements in connection with the property.

(e) Purchase-money mortgages shall be valued in an amount not exceeding the lesser of:

(1) the acquisition cost of the real property; or

(2) 90% of the value of the real property.

§5–402.

(a) This section applies to a bond or other evidence of indebtedness that:

(1) has a fixed term and rate of interest;

(2) is held by an insurer;

(3) is amply secured; and

(4) is not in default as to principal or interest.

(b) (1) A bond or other evidence of indebtedness subject to this section may be valued:

(i) if purchased at par, at the par value; or

(ii) if purchased above or below par:

1. on the basis of the purchase price adjusted to bring the value to par at maturity and to yield in the meantime the effective rate of interest at which the purchase was made; or

2. according to another accepted method of valuation that the Commissioner approves.

(2) The purchase price may not be valued at a higher figure than the sum of:

(i) the actual market value at the time of purchase; and

(ii) the actual brokerage, transfer, postage, or express charges paid in the acquisition of the bond or other evidence of indebtedness.

(3) Unless otherwise provided by a valuation that the Commissioner establishes or approves, a bond or other evidence of indebtedness may not be carried on its books at above the call price for the entire issue during any period within which the security may be called.

§5–403.

Valuations under this subtitle may not be inconsistent with applicable valuations or methods formulated or approved by the National Association of Insurance Commissioners.

§5–501.

Except for § 5-502 of this subtitle, this subtitle applies only to domestic life insurers.

§5–502.

(a) For purposes of this section, the domicile in the United States of an alien insurer, other than an insurer formed under the laws of Canada, is deemed to be the state where the alien insurer maintains its largest deposit of trusteed assets.

(b) The investment portfolio of a foreign life insurer or alien life insurer shall be:

(1) as allowed by the laws of its domicile; and

(2) of a quality substantially as high as that required under this subtitle for similar funds of like domestic life insurers.

(c) The Commissioner may deny or refuse to renew a certificate of authority to a foreign life insurer or alien life insurer if:

(1) the foreign life insurer or alien life insurer has investments in one person in excess of the limit provided in § 5-507 of this subtitle; or

(2) the Commissioner finds that its investments do not comply in substance with the investment requirements and limitations of this subtitle for domestic life insurers transacting the same kind of insurance business.

§5–503.

(a) The eligibility of an investment shall be determined as of the date of the making or acquisition of the investment.

(b) An investment limitation that is based on the amount of assets or particular funds of a life insurer shall relate to those assets or funds as shown by:

(1) the annual statement of the life insurer as of the December 31 immediately preceding the date of acquisition of the investment by the life insurer; or

(2) a current financial statement of the life insurer that reflects the result of merger or consolidation with another insurer, bulk reinsurance, or change in capitalization.

§5–504.

(a) A life insurer may not purchase an investment or security at a price above its market value.

(b) Subsection (a) of this section does not prohibit a life insurer from acquiring control of another insurer.

(c) This subtitle does not prohibit a life insurer from acquiring other or additional securities or property that is received:

(1) as a dividend;

(2) as a lawful distribution of assets; or

(3) under a lawful and bona fide agreement of bulk reinsurance, merger, or consolidation.

§5–505.

(a) (1) In this section the following words have the meanings indicated.

(2) "Board" means the board of directors of a life insurer.

(3) "Committee" means a committee authorized by the board of directors of a life insurer.

(b) (1) The board shall adopt a written plan for:

(i) acquiring and holding investments; and

(ii) engaging in investment practices.

(2) The plan required under paragraph (1) of this subsection shall specify guidelines for the:

(i) quality, maturity, and diversification of investments; and

(ii) investment strategies that assure that investments and investment practices are appropriate for:

1. the business conducted by the life insurer;

2. the liquidity needs of the life insurer; and

3. the capital and surplus requirements of the life insurer.

(3) Before adopting the plan required under paragraph (1) of this subsection, the board shall review and assess the life insurer's technical investment and administrative capabilities and investment expertise.

(c) (1) The board shall supervise and direct any investments acquired and held under this subtitle.

(2) At least annually, the board by formal resolution shall determine whether all investments have been made in accordance with delegations, standards, limitations, and investment objectives prescribed by the board or committee charged with the responsibility of directing the life insurer's investments.

(d) In order to determine whether the investment activity of the life insurer is consistent with the plan required under subsection (b) of this section, on at least a quarterly basis, the board or committee shall:

(1) receive and review a summary report on the life insurer's investment portfolio, investment activities, and investment practices engaged in under delegated authority; and

(2) review and revise as needed the plan required under subsection (b) of this section.

(e) In the discharge of duties under this section:

(1) the board shall require that the following be made available on a regular basis to the board:

(i) the records of any authorizations or approvals;

(ii) the reports of any action taken under the authority delegated under the plan required under subsection (b) of this section; and

(iii) any other documentation as the board may require; and

(2) each director shall perform their duties as a director, including any duties as a member of a committee:

(i) in good faith;

(ii) in a manner reasonably believed to be in the best interests of the insurer; and

(iii) with that degree of care that an ordinarily prudent person in a like position would use under similar circumstances.

(f) If a life insurer does not have a board, all references to the board in this section shall be deemed to be references to the governing body of the life insurer having authority equivalent to that of a board.

§5–506.

(a) In addition to investments otherwise excluded under this article, a life insurer may not directly or indirectly invest in or lend its funds on the security of:

(1) an investment or security that the Commissioner finds is designed to evade a prohibition of this article; or

(2) issued shares of the life insurer's capital stock, except:

(i) for the purpose of mutualization under Title 3, Subtitle 1 of this article; or

(ii) in connection with a plan approved by the Commissioner for purchase of the shares by employees or insurance producers of the life insurer.

(b) A life insurer may not directly or indirectly make a loan to an officer or director of the life insurer, except:

(1) a policy loan; or

(2) a bona fide mortgage loan on the principal residence of the officer or director that has been approved or ratified by the board of directors of the life insurer.

§5–507.

(a) This section does not apply to:

(1) policy loans made under this subtitle; or

(2) general obligations of the United States, Canada, or a state.

(b) Unless the Commissioner approves, a life insurer may not have at one time any combination of investments in or loans on the security of the obligations, property, or securities of one person in an aggregate amount exceeding 10% of the admitted assets of the life insurer.

§5–508.

(a) A life insurer may lend to its policyholder on the policy as collateral security an amount not exceeding the cash surrender value of the policy.

(b) A policy loan is an eligible reserve investment of a life insurer.

§5–509.

(a) The definitions in § 5-511 of this subtitle apply in this section.

(b) This section does not apply to Canadian securities and investments that are eligible for investment under other provisions of this subtitle.

(c) Subject to the limitations of § 5-511 of this subtitle, a life insurer may acquire foreign investments, or engage in investment practices with persons of or in foreign jurisdictions, of substantially the same types as those that a life insurer is allowed to acquire under this subtitle, other than those of the type prohibited under § 5-506 of this subtitle if, as a result of and after giving effect to the investment:

(1) the aggregate amount of foreign investments then held by the life insurer under this subsection does not exceed 20% of its admitted assets; and

(2) the aggregate amount of foreign investments then held by the life insurer under this subsection in a single foreign jurisdiction does not exceed:

(i) 10% of its admitted assets for a foreign jurisdiction that has a sovereign debt rating of investment grade or higher by a nationally recognized statistical rating organization; or

(ii) 3% of its admitted assets for any other foreign jurisdiction.

(d) (1) Subject to the limitations of § 5-511 of this subtitle, a life insurer may acquire investments or engage in investment practices denominated in foreign currencies, whether or not they are foreign investments acquired under subsection (c) of this section, or additional foreign currency exposure as a result of the termination or expiration of a hedging transaction with respect to investments denominated in a foreign currency, if:

(i) the aggregate amount of investments then held by the life insurer under this subsection denominated in foreign currencies does not exceed 10% of its admitted assets; and

(ii) the aggregate amount of investments then held by the life insurer under this subsection denominated in the foreign currency of a single foreign jurisdiction does not exceed:

1. 10% of its admitted assets for a foreign jurisdiction that has a sovereign debt rating of investment grade or higher by a nationally recognized statistical rating organization; or

2. 3% of its admitted assets for any other foreign jurisdiction.

(2) Notwithstanding paragraph (1) of this subsection, an investment is not considered denominated in foreign currency if the acquiring insurer enters into one or more contracts in derivative transactions and the business entity counterparty agrees under the contract or contracts to exchange all payments made on the foreign currency denominated investment for United States currency at a rate that effectively insulates the investment cash flows against future changes in currency exchange rates during the period the contract or contracts are in effect.

(e) (1) In addition to investments allowed under subsections (c) and (d) of this section, a life insurer that is authorized to do business in a foreign jurisdiction, and that has outstanding insurance, annuity, or reinsurance contracts on lives or risks resident or located in that foreign jurisdiction and denominated in the foreign currency of that jurisdiction, may acquire foreign investments with respect to that foreign jurisdiction, and may acquire investments denominated in the currency of that jurisdiction, subject to the limitations of § 5-511 of this subtitle.

(2) Notwithstanding paragraph (1) of this subsection, investments made under this subsection in obligations of foreign governments, their political subdivisions, and government sponsored enterprises are not subject to the limitations of § 5-511 of this subtitle if those investments carry a rating of investment grade or higher by a nationally recognized statistical rating organization.

(3) The aggregate amount of investments acquired by the life insurer under this subsection may not exceed the greater of:

(i) the amount that the life insurer is required by the law of the foreign jurisdiction to invest in the foreign jurisdiction; and

(ii) 115% of the amount of its reserves, net of reinsurance, and other obligations under the contracts on lives or risks resident or located in the foreign jurisdiction.

(f) (1) In addition to investments allowed under subsections (c) and (d) of this section, a life insurer that is not authorized to do business in a foreign jurisdiction, but which has outstanding insurance, annuity, or reinsurance contracts on lives or risks resident or located in that foreign jurisdiction and denominated in

the foreign currency of that jurisdiction, may acquire foreign investments with respect to that foreign jurisdiction, and may acquire investments denominated in the currency of that jurisdiction, subject to the limitations of § 5-511 of this subtitle.

(2) Notwithstanding paragraph (1) of this subsection, investments made under this subsection in obligations of foreign governments, their political subdivisions, and government sponsored enterprises are not subject to the limitations of § 5-511 of this subtitle if those investments carry a rating of investment grade or higher by a nationally recognized statistical rating organization.

(3) The aggregate amount of investments acquired by the life insurer under this subsection may not exceed 105% of the amount of its reserves, net of reinsurance, and other obligations under the contracts on lives or risks resident or located in the foreign jurisdiction.

(g) (1) Investments acquired under this section shall be aggregated with investments of the same type made under all other provisions of this subtitle, and in a similar manner, for purposes of determining compliance with the limitations, if any, contained in the other provisions of this subtitle.

(2) Investments in obligations of foreign governments, their political subdivisions, and government sponsored enterprises, except for those exempted under subsections (e) and (f) of this section, are subject to the limitations of § 5-511 of this subtitle.

§5–510.

(a) Before investing in other classes or types of investment, each life insurer shall invest and maintain invested, in cash and securities of the classes described in subsection (b) of this section, funds in an amount not less than the minimum paid-in capital stock required under this article for authority to engage in the life insurance business.

(b) The investments required by subsection (a) of this section may be made only in cash or the following classes of securities:

(1) bonds or other evidences of indebtedness of the United States or an agency of the United States if the obligation is guaranteed as to principal and interest by the United States;

(2) bonds or other evidences of indebtedness that are the direct obligations of the State or of a county, district, or municipal corporation of the State; or

(3) bonds or other evidences of indebtedness that are direct obligations of another state.

(c) After satisfying the minimum investment requirements of subsection (a) of this section, each life insurer shall invest and maintain invested additional funds, to bring its investments up to an amount not less than 100% of the life insurer's required reserves, in cash or the classes of securities or investments authorized under § 5-511 of this subtitle.

(d) A life insurer shall maintain the minimum investments required by this section free and clear from any lien or pledge, other than as a deposit required or allowed under § 4-106 of this article.

(e) After satisfying the minimum investment requirements of this subtitle, a life insurer may invest any excess funds without limitation in investments not otherwise prohibited under this subtitle.

§5–511.

(a) (1) In this section and in § 5–509 of this subtitle the following words have the meanings indicated.

(2) "Acceptable collateral" means:

(i) 1. as to securities lending transactions, and for the purpose of calculating counterparty exposure amount, cash, cash equivalents, letters of credit, and direct obligations of, or securities that are fully guaranteed as to principal and interest by, the government of the United States or an agency of the United States, or by the Federal National Mortgage Association or the Federal Home Loan Mortgage Corporation; and

2. as to lending foreign securities, sovereign debt rated I by the Securities Valuation Office of the National Association of Insurance Commissioners;

(ii) as to repurchase transactions, cash, cash equivalents, and direct obligations of, or securities that are fully guaranteed as to principal and interest by, the government of the United States or an agency of the United States, or by the Federal National Mortgage Association or the Federal Home Loan Mortgage Corporation; and

(iii) as to reverse repurchase transactions, cash and cash equivalents.

(3) (i) "Asset–backed security" means a security or other instrument, excluding a mutual fund, evidencing an interest in, or the right to receive payments from, or payable from distributions on, an asset, a pool of assets, or specifically divisible cash flows that are legally transferred to a trust or another special purpose bankruptcy–remote business entity, on the following conditions:

1. the trust or other business entity is established solely for the purpose of acquiring specific types of assets or rights to cash flows, issuing securities and other instruments representing an interest in or right to receive cash flows from those assets or rights, and engaging in activities required to service the assets or rights and any credit enhancement or support features held by the trust or other business entity; and

2. the assets of the trust or other business entity consist solely of interest bearing obligations or other contractual obligations representing the right to receive payment from the cash flows from the assets or rights.

(ii) However, the existence of credit enhancements, such as letters of credit or guarantees, or support features such as swap agreements, do not cause a security or other instrument to be ineligible as an asset–backed security.

(4) "Business entity" includes a sole proprietorship, corporation, association, general or limited partnership, limited liability company, joint–stock company, joint venture, trust, or any other form of business organization, whether for profit or nonprofit.

(5) (i) "Cash equivalent" means a highly liquid investment or security with an original term to maturity of 90 days or less that is:

1. readily convertible to a known amount of cash without penalty;

2. so near maturity that it presents an insignificant risk of change in value; and

3. rated:

A. "P–1" by Moody's Investors Services, Inc.;

B. "A–1" by Standard and Poor's Division of the McGraw Hill Companies, Inc.; or

C. equivalently by a nationally recognized statistical rating organization recognized by the Securities Valuation Office of the National Association of Insurance Commissioners.

(ii) "Cash equivalent" includes a government money market mutual fund and a Class One Money Market Mutual Fund.

(6) (i) "Counterparty exposure amount" means:

1. for an over–the–counter derivative instrument not entered into pursuant to a written master agreement that provides for netting of payments owed by the respective parties:

A. the market value of the over–the–counter derivative instrument if the liquidation of the derivative instrument would result in a final cash payment to the insurer; or

B. zero if the liquidation of the derivative instrument would not result in a final cash payment to the insurer;

2. for over–the–counter derivative instruments entered into pursuant to a written master agreement that provides for netting of payments owed by the respective parties, and the domiciliary jurisdiction of the counterparty is either within the United States or, if not within the United States, is within a foreign (not United States) jurisdiction listed in the purposes and procedures manual of the Securities Valuation Office as eligible for netting, the greater of zero or the net sum payable to the insurer in connection with all derivative instruments subject to the written master agreement upon their liquidation in the event of default by the counterparty pursuant to the master agreement (assuming no conditions precedent to the obligations of the counterparty to make such a payment and assuming no setoff of amounts payable pursuant to any other instrument or agreement).

(ii) For purposes of this paragraph, market value or the net sum payable, as the case may be, shall be determined at the end of the most recent quarter of the insurer's fiscal year and shall be reduced by the market value of acceptable collateral held by the insurer or a custodian on the insurer's behalf.

(7) (i) "Derivative instrument" means an agreement, option, instrument, or a series or combination thereof:

1. to make or take delivery of, or assume or relinquish, a specified amount of one or more underlying interests, or to make a cash settlement in lieu thereof; or

2. that has a price, performance, value, or cash flow based primarily upon the actual or expected price, level, performance, value, or cash flow of one or more underlying interests.

(ii) "Derivative instrument" includes options, warrants used in a hedging transaction and not attached to another financial instrument, caps, floors, collars, swaps, forwards, futures, and any other agreements, options, or instruments substantially similar thereto or any series or combination thereof and any agreements, options, or instruments permitted under regulations adopted under this section.

(iii) "Derivative instrument" does not include collateralized mortgage obligations, other asset–backed securities, principal–protected structured securities, floating rate securities, or instruments that an insurer is otherwise permitted to invest in or receive under this article other than under this subsection, and any debt obligations of the insurer.

(8) "Derivative transaction" means a transaction involving the use of one or more derivative instruments.

(9) "Dollar roll transaction" means two simultaneous transactions with different settlement dates no more than 96 days apart, so that in the transaction with the earlier settlement date, an insurer sells to a business entity, and in the other transaction the insurer is obligated to purchase from the same business entity, substantially similar securities of the following types:

(i) asset–backed securities issued, assumed or guaranteed by the Government National Mortgage Association, the Federal National Mortgage Association, or the Federal Home Loan Mortgage Corporation or their respective successors; and

(ii) other asset–backed securities referred to in Section 106 of Title I of the Secondary Mortgage Market Enhancement Act of 1984 (15 U.S.C. § 77r–1), as amended.

(10) "Domestic jurisdiction" means the United States, Canada, a state, a province of Canada, or a political subdivision of the United States, Canada, a state, or a province of Canada.

(11) "Foreign currency" means a currency other than that of a domestic jurisdiction.

(12) (i) "Foreign investment" means an investment in a foreign jurisdiction, or an investment in a person, real estate, or asset domiciled in a foreign jurisdiction, that is substantially of the same type as those eligible for investment under this section.

(ii) An investment may not be deemed to be foreign if the issuing person, qualified primary credit source, or qualified guarantor is a domestic jurisdiction or a person domiciled in a domestic jurisdiction, unless:

1. the issuing person is a shell business entity; and

2. the investment is not assumed, accepted, guaranteed, or insured or otherwise backed by a domestic jurisdiction or a person, that is not a shell business entity, domiciled in a domestic jurisdiction.

(13) "Foreign jurisdiction" means a jurisdiction other than a domestic jurisdiction.

(14) "Hedging transaction" means a derivative transaction that is entered into and maintained to reduce:

(i) the risk of a change in the value, yield, price, cash flow, or quantity of assets or liabilities that the insurer has acquired or incurred or anticipates acquiring or incurring; or

(ii) the currency exchange rate risk or the degree of exposure as to assets or liabilities that an insurer has acquired or incurred or anticipates acquiring or incurring.

(15) "Lower grade investment" means an investment obligation that is rated four, five, or six by the Securities Valuation Office of the National Association of Insurance Commissioners.

(16) "Medium grade investment" means an investment obligation that is rated three by the Securities Valuation Office of the National Association of Insurance Commissioners.

(17) "Qualified guarantor" means a guarantor against which an insurer has a direct claim for full and timely payment, evidenced by a contractual right for which an enforcement action can be brought in a domestic jurisdiction.

(18) "Qualified primary credit source" means the credit source to which an insurer looks for payment as to an investment and against which an insurer

has a direct claim for full and timely payment, evidenced by a contractual right for which an enforcement action can be brought in a domestic jurisdiction.

(19) (i) "Replication transaction" means a derivative transaction that is intended to replicate the performance of one or more assets that a life insurer is authorized to acquire under this section.

(ii) "Replication transaction" does not include a derivative transaction entered into as a hedging transaction.

(20) "Repurchase transaction" means a transaction in which an insurer purchases securities from a business entity that is obligated to repurchase the purchased securities or equivalent securities from the business entity at a specified price, either within a specified period of time or on demand.

(21) "Reverse repurchase transaction" means a transaction in which an insurer sells securities to a business entity and is obligated to repurchase the sold securities or equivalent securities from the business entity at a specified price, either within a specified period of time or on demand.

(22) "Securities lending transaction" means a transaction in which securities are loaned by an insurer to a business entity that is obligated to return the loaned securities or equivalent securities to the insurer, either within a specified period of time or on demand.

(23) "Shell business entity" means a business entity having no economic substance, except as a vehicle for owning interests in assets issued, owned, or previously owned by a person domiciled in a foreign jurisdiction.

(a–1) Each life insurer shall have and continually maintain an amount equal to its entire reserves, as required by this article, in any combination of the types of assets authorized by subsections (c) through (p) of this section subject to the limit, if any, set for each type or class of investment.

(b) (1) For purposes of this section, the entire reserves of a life insurer is the sum of the amounts listed in paragraph (2) of this subsection less the amount of net uncollected and deferred premiums.

(2) The sum to be used in paragraph (1) of this subsection consists of:

(i) the net present value of all outstanding policies in force, less reinsurance;

(ii) reserves for accidental death benefits and total and permanent disability benefits, less reinsurance;

(iii) the present value of supplementary contracts, including dividends left with the life insurer to accumulate at interest;

(iv) liabilities on canceled policies that are not included in net reserve and on which a surrender value may be demanded, and outstanding policy claims and losses; and

(v) any additional reserves that the Commissioner reasonably requires for the life insurance.

(c) The reserve investments of a life insurer may include:

(1) cash or deposits in checking or savings accounts, under certificates of deposit, or in any other form in a national or State bank or trust company; or

(2) shares or deposits in a savings and loan association or building and loan association to the extent that the investment or account is insured by the Federal Deposit Insurance Corporation.

(d) (1) The reserve investments of a life insurer may include:

(i) interest bearing bonds, notes, certificates of indebtedness, bills, or other direct interest bearing obligations of the United States or Canada or other interest bearing obligations fully guaranteed both as to principal and interest by the United States or Canada;

(ii) interest bearing bonds of a state, a province of Canada, a county or incorporated city of a state, or a municipality of Canada;

(iii) interest bearing bonds of a commission, instrumentality, authority, or political subdivision with legal authority to issue interest bearing bonds, of the United States, Canada, a state, a province of Canada, a county or incorporated city of a state, or a municipality of Canada;

(iv) interest bearing bonds, notes, or other interest bearing obligations of a corporation incorporated under the laws of the United States, Canada, a state, or a province of Canada;

(v) subject to paragraph (2) of this subsection, obligations of the African Development Bank, Asian Development Bank, Inter–American

Development Bank, International Bank for Reconstruction and Development, or International Finance Corporation;

(vi) asset–backed securities rated investment grade by at least one of the nationally recognized statistical rating organizations, and which either trade on a regulated nationally recognized exchange or are traded by a minimum of two registered broker–dealers. To the extent necessary to satisfy the reserve requirements of this subtitle, a life insurer may not have more than 3% of its total admitted assets in the asset–backed securities of any one issuer; and

(vii) interest bearing bonds, notes, or other interest bearing obligations of real estate investment trusts rated investment grade by at least one of the nationally recognized statistical rating organizations, and which either trade on a regulated nationally recognized exchange or are traded by a minimum of two registered broker–dealers. To the extent necessary to satisfy the reserve requirements of this subtitle, a life insurer may not have more than 3% of its total admitted assets in the bonds, notes, or other interest bearing obligations of any one real estate investment trust.

(2) A life insurer may not invest more than 5% of its total admitted assets in obligations of the African Development Bank, Asian Development Bank, Inter–American Development Bank, International Bank for Reconstruction and Development, or International Finance Corporation.

(3) A life insurer may not acquire directly or indirectly through an investment subsidiary an investment under subsection (d), (e), or (f) of this section or § 5–509 of this subtitle, or counterparty exposure under subsection (o) of this section, if as a result of and after giving effect to the investment:

(i) the aggregate amount of medium grade investments and lower grade investments then held by the life insurer would exceed 20% of the life insurer's admitted assets;

(ii) the aggregate amount of lower grade investments then held by the life insurer would exceed 10% of the life insurer's admitted assets;

(iii) the aggregate amount of investments rated five or six by the Securities Valuation Office of the National Association of Insurance Commissioners then held by the life insurer would exceed 3% of the life insurer's admitted assets;

(iv) the aggregate amount of investments rated six by the Securities Valuation Office of the National Association of Insurance Commissioners then held by the life insurer would exceed 1% of the life insurer's admitted assets;

(v) the aggregate amount of medium grade investments and lower grade investments then held by the life insurer that receive as cash income less than the equivalent yield for United States Department of the Treasury issues with a comparative average life, would exceed 1% of the life insurer's admitted assets;

(vi) the following would exceed 1% of the life insurer's admitted assets:

1. the aggregate amount of medium grade investments and lower grade investments issued, assumed, guaranteed, accepted, or insured by any one person; or

2. any asset–backed securities secured by or evidencing an interest in a single asset or pool of assets; or

(vii) the following would exceed one–half of one percent of the life insurer's admitted assets:

1. the aggregate amount of lower grade investments issued, assumed, guaranteed, accepted, or insured by any one person; or

2. any asset–backed securities secured by or evidencing an interest in a single asset or pool of assets.

(e) The reserve investments of a life insurer may include equipment trust obligations or certificates or other secured instruments that evidence:

(1) an interest in transportation or other equipment located wholly or partly within the United States or Canada; and

(2) a right to receive determined parts of rental, purchases, or other fixed obligatory payments received for the use or purchase of the transportation or other equipment.

(f) (1) Subject to paragraph (2) of this subsection, the reserve investments of a life insurer may include dividend–paying stock of a corporation created or existing under the laws of the United States, Canada, a state, or a province of Canada.

(2) To the extent necessary to satisfy the reserve requirements of this subtitle, a life insurer may not have more than:

(i) 10% of its total admitted assets in preferred stock;

(ii) 10% of its total admitted assets in common stock; or

(iii) 5% of its total admitted assets in the stock of any one corporation.

(g) (1) The reserve investments of a life insurer may include loans secured by first mortgages, or deeds of trust, on unencumbered fee–simple or improved leasehold real estate in a state or a province of Canada in an amount not exceeding 85% of the fair market value of the real estate.

(2) A life insurer may not include an amount from an investment made under paragraph (1) of this subsection that exceeds 75% of the fair market value of the real estate in reserve and capital stock investments under this subtitle unless:

(i) the real estate:

1. is primarily improved by a residence; or

2. is farm property used for farming purposes and the loan amount on any one farm property does not exceed $500,000; and

(ii) the loan on the real estate provides for the amortization of principal over a period of not more than 30 years, with payments to be made at least annually.

(3) (i) Notwithstanding paragraph (1) of this subsection, but subject to subparagraph (ii) of this paragraph, a life insurer may include an amount from an investment made under paragraph (1) of this subsection not exceeding 95% of the fair market value of the real estate if:

1. the real estate is improved by a dwelling primarily intended for occupancy by not more than four families; and

2. a mortgage insurance company authorized to do business in this State and not affiliated with the entity making the loan guarantees or insures that part of the loan in excess of 85% of the fair market value of the real estate.

(ii) A life insurer may not place more than 3% of its admitted assets in loans in which the amount of the loan exceeds 90% of the fair market value of the security of the loan.

(4) (i) If a loan is made on real estate improved by a building, the improvements must be insured against loss by fire.

(ii) The fire insurance policy required by subparagraph (i) of this paragraph shall:

1. contain the New York or Massachusetts standard mortgage clause or its equivalent; and

2. be delivered to the mortgagee as additional security for the loan.

(iii) A policy that insures against loss by fire and other coverages satisfies the requirements of this subsection.

(5) The requirements of this section and any other law of the State that require security on a loan, prescribe the nature, amount, or form of security on a loan, or limit the interest rate on a loan do not apply if the reserve investments consist of bonds, notes, or other evidences of indebtedness secured by mortgages or deeds of trust that are guaranteed or insured by an instrumentality of the United States under the National Housing Act, Servicemen's Readjustment Act of 1944, or Bankhead–Jones Farm Tenant Act.

(h) (1) Subject to paragraphs (2) and (3) of this subsection, the reserve investments of a life insurer may include ground rents in any state.

(2) For unexpired redeemable ground rents, any premiums paid must be:

(i) amortized over the period between the date of acquisition and the earliest redemption date; or

(ii) charged off before the redemption date.

(3) For expired redeemable ground rents, any premiums paid must be charged off when acquired.

(4) A life insurer shall carry redeemable ground rents purchased at a discount at an amount not greater than the cost of acquisition.

(i) (1) The reserve investments of a life insurer may include collateral loans secured by pledge of any security listed in subsections (c) through (h) of this section if the current market value of the pledged security at all times during the term of the loan is at least 10% more than the unpaid balance of the loan amount.

(2) Each collateral loan is subject to the power of the life insurer to terminate it if the pledged security depreciates below 10% of the unpaid balance of the loan amount.

(j) (1) For purposes of this subsection, real estate sold under a contract of sale in which title is retained in the life insurer shall be classified as real estate.

(2) Subject to paragraph (3) of this subsection, the reserve investments of a life insurer may include:

(i) real estate for the office and business purposes only of the life insurer, except as authorized by subsections (g) and (h) of this section; or

(ii) property primarily for the use of employees or customers of the life insurer for parking with or without charge.

(3) The equity value of all real estate held under paragraph (2) of this subsection may not exceed 20% of the life insurer's total admitted assets.

(4) A life insurer may purchase and hold real estate under a foreclosure of its own mortgages or a deed in lieu of mortgage foreclosure for not more than 5 years.

(5) Subject to paragraph (6) of this subsection, the Commissioner may grant extensions for periods not exceeding 5 years each of the period within which real estate may be held under paragraph (4) of this subsection, if the Commissioner considers the extensions necessary to serve the best interest of the life insurer and its policyholders.

(6) Before the Commissioner may refuse to grant extensions under paragraph (5) of this subsection, an appraisal of the real estate shall be obtained. If the appraisal shows that the appraised value of the real estate equals or exceeds the book value of the real estate, the Commissioner shall grant extensions for periods not exceeding 5 years each.

(7) With the written approval of the Commissioner, a life insurer may acquire property as partial payment of the consideration for the sale of real estate owned by the life insurer if the transaction causes a net reduction in the investment of the life insurer in real estate.

(8) With the approval of the Commissioner, a life insurer may acquire other real estate if necessary or convenient to enhance the market value of real estate previously acquired or held by the life insurer in accordance with this subsection.

(k) The reserve investments of a life insurer may include interest, rents, or other fixed income due and accrued on:

(1) an investment authorized under subsections (c) through (e) and (g) through (j) of this section; or

(2) policy loans of the life insurer.

(l) (1) The real estate authorized by this subsection to be held as a reserve investment by a life insurer does not include property to be used primarily for mining, recreational, amusement, hotel, or club purposes.

(2) Subject to paragraphs (3) through (6) of this subsection, the reserve investments of a life insurer may include fee–simple or improved leasehold real estate or interests in limited partnerships formed for the development or ownership of fee–simple or improved leasehold real estate, if acquired:

(i) as an investment for the production of income; or

(ii) to be improved or developed as an investment for the production of income.

(3) The cost of each parcel of fee–simple or improved leasehold real estate or each limited partnership interest acquired under this subsection, including the cost to the life insurer of improving or developing the real estate, may not exceed:

(i) 15% of the admitted assets of the life insurer, when added to the book value of all other fee–simple or improved leasehold real estate or limited partnership interests then held by the life insurer under this subsection; and

(ii) 20% of the total admitted assets of the life insurer, when added to the value of all real estate however acquired or held for investment by the life insurer, including home office and branch office properties.

(4) The cost of each parcel of fee–simple or improved leasehold real estate or each limited partnership interest acquired under this section, including the cost to the life insurer of improving or developing the real estate, may not exceed 1% of the admitted assets of the life insurer.

(5) (i) Except as otherwise required by the Commissioner, each parcel of fee–simple or improved leasehold real estate held by a life insurer directly or through a limited partnership under this subsection shall be valued on the books of the life insurer as of December 31 of each year at an amount that includes a write–

down of the cost of the property, excluding the land cost, but including all improvements or development costs, at a rate that averages not less than 2% per year of the cost of the property for each year or part of a year that the property is held.

(ii) The admitted values of each parcel of fee–simple or improved leasehold real estate held under this subsection may not exceed the depreciated value of the property.

(6) A life insurer may not count towards its cash reserves any more than the lesser of:

(i) 75% of the investment value of any limited partnership interest; and

(ii) 75% of the current book value of that limited partnership interest.

(7) (i) Interests in limited partnerships under this subsection shall be valued at the actual cost of the investment adjusted by any additional capital contributions or capital withdrawals.

(ii) The valuation of a limited partnership interest may not exceed the life insurer's proportionate share of the equity of the real estate asset owned by the limited partnership.

(m) The reserve investments of a life insurer may include those investments permitted under § 5–509 of this subtitle.

(n) (1) The reserve investments of a life insurer may include securities lending, repurchase, reverse repurchase, and dollar roll transactions with business entities, subject to the requirements of paragraphs (2) through (9) of this subsection.

(2) (i) The insurer's board of directors shall adopt a written plan that specifies guidelines and objectives to be followed, such as:

1. a description of how cash received will be invested or used for general corporate purposes of the insurer;

2. operational procedures to manage interest rate risk, counterparty default risk, the conditions under which proceeds from reverse repurchase transactions may be used in the ordinary course of business, and the use of acceptable collateral in a manner that reflects the liquidity needs of the transaction; and

3. the extent to which the insurer may engage in these transactions.

(ii) The insurer shall file with the Commissioner the written plan including all changes and amendments to the written plan for use in the State on or before the date the plan becomes effective.

(3) (i) The insurer shall enter into a written agreement for all transactions authorized under this subsection other than dollar roll transactions.

(ii) The written agreement shall require that each transaction terminate no more than 1 year from its inception or on the earlier demand of the insurer.

(iii) The agreement shall be with the business entity counterparty, but for securities lending transactions, the agreement may be with an agent acting on behalf of the insurer, if the agent is a qualified business entity, and if the agreement:

1. requires the agent to enter into separate agreements with each counterparty that are consistent with the requirements of this section; and

2. prohibits securities lending transactions under the agreement with the agent or its affiliates.

(4) (i) Cash received in a transaction under this subsection shall be invested in accordance with this subtitle and in a manner that recognizes the liquidity needs of the transaction or used by the insurer for its general corporate purposes.

(ii) For so long as the transaction remains outstanding, the insurer, its agent, or custodian shall maintain, as to acceptable collateral received in a transaction under this subsection, either physically or through the book entry systems of the Federal Reserve, Depository Trust Company, Participants Trust Company, or other securities depositories approved by the Commissioner:

1. possession of the acceptable collateral;

2. a perfected security interest in the acceptable collateral; or

3. in the case of a jurisdiction outside the United States, title to, or rights of a secured creditor to, the acceptable collateral.

(5) (i) The limitations of § 5–507 of this subtitle do not apply to the business entity counterparty exposure created by transactions under this subsection.

(ii) For purposes of calculations made to determine compliance with this subsection, no effect will be given to the insurer's future obligation to resell securities, in the case of a repurchase transaction, or to repurchase securities, in the case of a reverse repurchase transaction.

(iii) An insurer may not enter into a transaction under this subsection if, as a result of and after giving effect to the transaction:

1. A. the aggregate amount of securities then loaned, sold to, or purchased from any one business entity counterparty under this subsection would exceed 5% of its admitted assets; and

B. in calculating the amount sold to or purchased from a business entity counterparty under repurchase or reverse repurchase transactions, effect may be given to netting provisions under a master written agreement; or

2. the aggregate amount of all securities then loaned, sold to, or purchased from all business entities under this subsection would exceed 40% of its admitted assets.

(6) (i) In a securities lending transaction, the insurer shall receive acceptable collateral having a market value as of the transaction date at least equal to 102% of the market value of the securities loaned by the insurer in the transaction as of that date.

(ii) If at any time the market value of the acceptable collateral is less than the market value of the loaned securities, the business entity counterparty shall be obligated to deliver additional acceptable collateral, the market value of which, together with the market value of all acceptable collateral then held in connection with the transaction, at least equals 102% of the market value of the loaned securities.

(7) (i) In a reverse repurchase transaction, other than a dollar roll transaction, the insurer shall receive acceptable collateral having a market value as of the transaction date at least equal to 95% of the market value of the securities transferred by the insurer in the transaction as of that date.

(ii) If at any time the market value of the acceptable collateral is less than 95% of the market value of the securities so transferred, the business entity counterparty shall be obligated to deliver additional acceptable collateral, the

market value of which, together with the market value of all acceptable collateral then held in connection with the transaction, at least equals 95% of the market value of the transferred securities.

(8) In a dollar roll transaction, the insurer shall receive cash in an amount at least equal to the market value of the securities transferred by the insurer in the transaction as of the transaction date.

(9) (i) In a repurchase transaction, the insurer shall receive as acceptable collateral transferred securities having a market value at least equal to 102% of the purchase price paid by the insurer for the securities.

(ii) If at any time the market value of the acceptable collateral is less than 100% of the purchase price paid by the insurer, the business entity counterparty shall be obligated to provide additional acceptable collateral, the market value of which, together with the market value of all acceptable collateral then held in connection with the transaction, at least equals 102% of the purchase price.

(iii) Securities acquired by an insurer in a repurchase transaction may not be sold in a reverse repurchase transaction, loaned in a securities lending transaction, or otherwise pledged.

(o) (1) The reserve investments of a life insurer may include derivative transactions under this subsection, whether entered into directly or indirectly through an investment subsidiary, under the conditions of paragraphs (2) through (6) of this subsection.

(2) (i) An insurer may use derivative instruments under this subsection to engage in hedging transactions.

(ii) Prior to entering into any derivative transaction, the board of directors of the insurer shall approve a derivative use plan that:

1. describes investment objectives and risk constraints, such as counterparty exposure amounts and collateral arrangements supporting derivative transactions;

2. defines permissible transactions identifying the risks to be hedged, the assets or liabilities being replicated; and

3. requires compliance with internal control procedures that demonstrate the intended hedging characteristics and the ongoing effectiveness of the derivative transaction or combination of the transactions through cash flow testing or other appropriate analyses.

(iii) Whenever the derivative transactions entered into under this subsection are not in compliance with this subsection or, if continued, may now or subsequently, create a hazardous financial condition to the insurer that affects its policyholders, creditors, or the general public, the Commissioner may, after notice and an opportunity for a hearing, order the insurer to take any action as may be reasonably necessary to:

1. rectify a hazardous financial condition; or

2. prevent an impending hazardous financial condition from occurring.

(3) An insurer may enter into hedging transactions under this subsection if, as a result of and after giving effect to the transaction:

(i) the aggregate statement value of options, caps, floors, and warrants not attached to another financial instrument purchased and used in hedging transactions does not exceed 7.5% of its admitted assets;

(ii) the aggregate statement value of options, caps, and floors written in hedging transactions does not exceed 3% of its admitted assets; and

(iii) the aggregate potential exposure of collars, swaps, forwards, and futures used in hedging transactions does not exceed 6.5% of its admitted assets.

(4) An insurer shall include all counterparty exposure amounts in determining compliance with the limitations of § 5–507 of this subtitle.

(5) Each derivative instrument shall be:

(i) traded on a securities exchange;

(ii) entered into with, or guaranteed by, a business entity;

(iii) issued or written by or entered into with the issuer of the underlying interest on which the derivative instrument is based; or

(iv) in the case of futures, traded through a broker that is registered as a futures commission merchant under the Commodity Exchange Act or that has received exemptive relief from registration under Rule 30.10 adopted under the Commodity Exchange Act.

(6) Any asset being replicated is subject to all of the provisions and limitations on the investment as if the replication transaction constituted a direct investment by the life insurer in the replicated asset.

(p) (1) The reserve investments of a life insurer may include money market mutual funds as defined by 17 C.F.R. 270.2A–7 under the Investment Company Act of 1940 (15 U.S.C. 80a–1 et seq.) that may be either of the following:

(i) Government Money Market Mutual Fund, which is a money market mutual fund that:

1. invests only in obligations issued, guaranteed, or insured by the federal government of the United States or collateralized repurchase agreements composed of these obligations; and

2. qualifies for investment without a reserve under the purposes and procedures of the Securities Valuation Office or any successor publication; or

(ii) Class One Money Market Mutual Fund, which is a money market mutual fund that qualifies for investment using the bond class one reserve factor under the purposes and procedures of the Securities Valuation Office or any successor publication.

(2) For purposes of determining whether a money market mutual fund is to be classified as an equity interest or within this subsection, money market funds qualifying for listing within this subsection must conform to the purposes and procedures of the Securities Valuation Office or any successor publication.

§5–512.

(a) A life insurer may allocate to one or more separate investment accounts in accordance with a written agreement any amounts paid to the life insurer that are to be invested by the life insurer in accordance with the agreement and applied to the purchase of guaranteed income benefits under the life insurer's individual or group policies or annuity contracts or to provide other guaranteed benefits incidental to those policies or annuity contracts.

(b) Any income and gains and losses, realized or unrealized, on each separate investment account shall be credited to or charged against the amounts allocated to the account in accordance with the agreement without regard to other income, gains, or losses of the life insurer.

(c) (1) Amounts allocated to separate investment accounts and accumulations on the accounts may be invested and reinvested in any class of investments authorized under this article as life insurance reserve investments.

(2) Preferred and common stock investments of amounts allocated to separate investment accounts may not be included in applying the 10% limitations on investments under § 5–511(f) of this subtitle.

(3) A separate investment account may invest in any investments contractually permitted for the separate investment account and specified in a plan of operation, and the restrictions, limitations, and other provisions of this article relating to investments shall not apply to the investments contained in the separate investment account, provided that prior to delivery or issuance for delivery in the State, the form of the policy or annuity contract and the plan of operation have been filed with and approved by the Commissioner.

(d) Unless a life insurer limits its liability under the guarantee to the interest of the contract holder in the investments, a life insurer may not guarantee:

(1) the value of amounts allocated to a separate investment account; or

(2) the value of investments of the amounts allocated to the separate investment account or the income from the investments.

(e) (1) A life insurer owns the amounts that the life insurer allocates to a separate investment account under this section.

(2) A life insurer may not be or hold itself out to be a trustee of the amounts allocated to the separate investment account.

(3) To the extent provided under the applicable contracts, the part of the assets of the separate investment account equal to the reserves and other contract liabilities with respect to the account may not be chargeable with liabilities arising out of any other business that the insurer may conduct.

(f) At all times, the investments and liabilities of each separate investment account shall be clearly identifiable and distinguishable on the books of the life insurer from other investments and liabilities of the life insurer.

(g) Unless the Commissioner approves, a life insurer may not transfer by sale, exchange, substitution, or otherwise from one investment account to another investment account an investment in any separate investment account or in the general investment account of the life insurer.

(h) (1) In connection with the allocation of investments or expenses or in any other manner, a life insurer may not discriminate unfairly between:

(i) separate investment accounts; or

(ii) a separate investment account and the life insurer's general investment account.

(2) This subsection does not require a life insurer to follow uniform investment policies for its accounts.

(i) (1) Investments made with respect to separate investment accounts shall be valued for the purpose of any valuation required by this article:

(i) at the market value of the investment on the date of the valuation; or

(ii) if there is no readily available market, in accordance with the terms of the written agreement referred to in subsection (a) of this section.

(2) (i) If a separate investment account provides a fixed guaranteed return that is not subject to market value adjustment, the life insurer shall hold assets that equal or exceed the reserve amount that would be required if the separate investment account was an obligation of the life insurer's general account.

(ii) An asset held under subparagraph (i) of this paragraph shall be valued in accordance with §§ 5–401 and 5–402 of this title.

§5–601.

Except for § 5-602 of this subtitle, this subtitle applies to domestic insurers other than life insurers.

§5–602.

(a) For the purposes of this section, the domicile in the United States of an alien insurer, other than an insurer formed under the laws of Canada, is deemed to be the state where the alien insurer maintains its largest deposit of trusteed assets.

(b) The investment portfolio of a foreign insurer or alien insurer, other than a life insurer, shall be:

(1) as allowed by the laws of its domicile; and

(2) of a quality substantially as high as that required under this subtitle for similar funds of like domestic insurers.

(c) The Commissioner may deny or refuse to renew a certificate of authority to a foreign insurer or alien insurer if:

(1) the foreign insurer or alien insurer has investments in one person in excess of the limit provided in § 5-606 of this subtitle; or

(2) the Commissioner finds that its investments do not comply in substance with the investment requirements and limitations of this subtitle for domestic insurers transacting the same kind of insurance business.

§5–603.

(a) The eligibility of an investment shall be determined as of the date of the making or acquisition of the investment.

(b) An investment limitation that is based on the amount of assets or particular funds of an insurer shall relate to the assets or funds as shown by:

(1) the annual statement of the insurer as of the December 31 immediately preceding the date of acquisition of the investment by the insurer; or

(2) a current financial statement of the insurer filed with the Commissioner that reflects the result of merger or consolidation with another insurer, bulk reinsurance, or change in capitalization.

§5–604.

(a) An insurer may not make an investment or loan unless the investment or loan is authorized by:

(1) the board of directors of the insurer; or

(2) a committee authorized by the board of directors of the insurer to supervise or make investments and loans.

(b) The committee described in subsection (a)(2) of this section shall:

(1) record its minutes; and

(2) submit regular reports of the committee to the board of directors.

§5–605.

(a) In addition to investments otherwise excluded under this article, an insurer may not directly or indirectly invest in or lend its funds on security of:

(1) obligations, stock, or other securities of a corporation, association, or other business unit that is insolvent at the time of the acquisition or loan, except securities eligible for investment under § 5–608 of this subtitle;

(2) a mortgage or deed of trust, or real property or an interest in real property, that does not come within the class of investments specified in § 5–608(j), (k), (l), (m), and (n) of this subtitle;

(3) the capital stock of the insurer;

(4) stocks, bonds, or other securities issued by a corporation, other than an insurer, if a majority of the stock having voting powers of the issuing corporation is owned directly or indirectly by or for the benefit of one or more officers or directors of the insurer; or

(5) an investment that the Commissioner finds is against public policy or designed to evade a prohibition of this section.

(b) (1) An insurer may not directly or indirectly invest in or lend its funds on security of stocks, bonds, or other securities issued by a corporation, if a majority of the outstanding stock of the corporation, or a majority of the stock having voting powers of the corporation, is or will be after the acquisition directly or indirectly owned:

(i) by the insurer or by or through one or more of the insurer's officers or directors holding the stock for the benefit of the insurer or its stockholders;

(ii) by a parent corporation or subsidiary of the insurer, the parent corporation, or subsidiary of the parent corporation; or

(iii) by any combination of the insurer, its parent corporation, its subsidiaries, or its stockholders.

(2) Paragraph (1) of this subsection does not prevent an investment in:

(i) the stock, bonds, or other securities of a corporation organized exclusively to hold and operate real estate acquired by the insurer, in accordance with and subject to § 5-608 of this subtitle;

(ii) the stock of another insurer; or

(iii) the stocks, bonds, or other securities of a corporation that is engaged exclusively in a kind of business properly incidental to the insurance business of the insurer, including an investment in the securities of a corporation that is engaged in the financing of insurance premiums or in another incidental business and in the business of holding and operating real estate.

(c) (1) An insurer may not directly or indirectly invest in or lend its funds on security of stocks, shares, bonds, or obligations of a person or governmental or business unit of or in a foreign country or subdivision of a foreign country, unless the foreign investments conform substantially with the limitations imposed by this section on like domestic investments.

(2) The aggregate amount of foreign investments held by an insurer under paragraph (1) of this subsection and under § 5-608(o) and (p) of this subtitle may not exceed the greater of:

(i) 10% of the insurer's total admitted assets;

(ii) one and one-half times the amount of the insurer's reserves and other obligations under the insurance contracts or reinsurance contracts in that country; and

(iii) the amount necessary to enable the insurer to transact insurance business in the foreign country, directly or through a subsidiary corporation.

§5–606.

(a) (1) Except as otherwise specifically provided in this subtitle, an insurer may not have more than 10% of its total admitted assets invested in or lent on the securities of one person.

(2) Paragraph (1) of this subsection does not apply to:

(i) the classes of governmental obligations eligible for minimum capital investments of the insurer, including those obligations eligible under § 5-608(l) of this subtitle; or

(ii) investments in stock of other insurers.

(b) An insurer may not acquire the kind of real property specified in § 5-608(n)(1)(i) and (ii) of this subtitle if the value of the real property, plus the value of all of the real property then held by the insurer, exceeds 10% of the insurer's total admitted assets.

§5–607.

(a) Before investing in other classes of securities or types of investments, each insurer shall invest its funds in securities of the classes described in subsection (b) of this section in an amount equal in value to the minimum capital stock and surplus required of a domestic stock insurer authorized to transact the same kind of insurance business.

(b) (1) Subject to paragraph (2) of this subsection, the investments required by subsection (a) of this section may be made only in the following classes of securities:

(i) bonds or other evidences of indebtedness of the United States or an agency of the United States if the obligation is guaranteed as to principal and interest by the United States;

(ii) bonds or other evidences of indebtedness that are direct obligations of the State or of a county, district, or municipal corporation of the State;

(iii) bonds or other evidences of indebtedness that are direct obligations of another state;

(iv) mortgage loans or deeds of trust, as specified in § 5-608(j) and (k) of this subtitle, on property located in the State; or

(v) ground rents as specified in § 5-608(m) of this subtitle.

(2) At least 60% of the total amount of the required minimum investments must consist of the classes of securities specified in paragraph (1)(i) and (ii) of this subsection.

(c) An insurer shall maintain the minimum investments required by subsection (a) of this section free and clear from any lien or pledge, other than as impressed on:

(1) a deposit with any government in the United States; or

(2) trusteed assets held in trust for the security of the insurer's policyholders and creditors.

(d) (1) After satisfying the minimum investment requirements of subsection (a) of this section, an insurer shall invest, or otherwise acquire or loan on, additional funds to bring its investments up to an amount not less than 50% of the aggregate amount of its unearned premium and loss reserves, in cash or the classes of reserve investments authorized under § 5-608 of this subtitle.

(2) An insurer shall maintain the investments required by this subsection free from any lien or pledge, other than a deposit of securities, cash, or trusteed assets held by a state for the benefit or protection of all or any class of the policyholders and creditors of the insurer.

(3) Except for real property acquired under § 5-608(n) of this subtitle, a security or investment is not eligible for acquisition as a reserve investment unless:

(i) the security or investment is interest-bearing, interest-accruing, or dividend or income-paying;

(ii) the security or investment is not then in default in any respect; and

(iii) the insurer is entitled to the interest or income accruing on the security or investment.

(e) After satisfying the minimum investment requirements of this subtitle, an insurer may invest any part of the remainder of the insurer's funds in, or otherwise acquire or loan, any of the classes of investments eligible under § 5-608 of this subtitle or in other investments that are not prohibited by this subtitle.

§5–608.

(a) (1) In this section the following words have the meanings indicated.

(2) "Dollar roll transaction" means two simultaneous transactions with different settlement dates no more than 96 days apart, so that in the transaction with the earlier settlement date, an insurer sells to a business entity, and in the other transaction the insurer is obligated to purchase from the same business entity, substantially similar securities of the following types:

(i) asset–backed securities issued, assumed, or guaranteed by the Government National Mortgage Association, the Federal National Mortgage

Association, or the Federal Home Loan Mortgage Corporation or their respective successors; and

(ii) other asset–backed securities referred to in Section 106 of Title I of the Secondary Mortgage Market Enhancement Act of 1984 (15 U.S.C. § 77r–1), as amended.

(3) "Fixed charges" include:

(i) interest on funded and unfunded debt amortization of debt discount; and

(ii) rentals for leased properties.

(4) "Institution" includes a corporation, joint stock association, business trust, and statutory trust.

(5) "Net earnings available for fixed charges" means net income after deducting operating and maintenance expenses, taxes other than federal and state income taxes, depreciation, and depletion, and excluding extraordinary nonrecurring items or income or expense appearing in the regular financial statements of the issuing, assuming, or guaranteeing institutions.

(6) "Obligation" includes bonds, debentures, notes, or other evidences of indebtedness.

(7) "Repurchase transaction" means a transaction in which an insurer purchases securities from a business entity that is obligated to repurchase the purchased securities or equivalent securities from the business entity at a specified price, either within a specified period of time or on demand.

(8) "Reverse repurchase transaction" means a transaction in which an insurer sells securities to a business entity and is obligated to repurchase the sold securities or equivalent securities from the business entity at a specified price, either within a specified period of time or on demand.

(9) "Securities lending transaction" means a transaction in which securities are loaned by an insurer to a business entity that is obligated to return the loaned securities or equivalent securities to the insurer, either within a specified period of time or on demand.

(b) (1) (i) If net earnings are determined by relying on consolidated earnings statements of parent and subsidiary institutions:

1. the net earnings shall be determined after providing for the income taxes of subsidiaries and making proper allowance for any minority stock interest; and

2. except as otherwise provided in subparagraph (ii) of this paragraph, the required coverage of fixed charges shall be computed on a basis that includes fixed charges and preferred dividends of subsidiaries other than those payable by the subsidiaries to the parent corporation or to other subsidiaries.

(ii) If the minority common stock interest in the subsidiary corporation is substantial, the fixed charges and preferred dividends may be apportioned in accordance with regulations adopted by the Commissioner.

(2) (i) This paragraph applies to an issuing, assuming, or guaranteeing institution, whether or not in legal existence during the entire 5–year period immediately preceding the date of investment by the insurer, that has at any time during the 5–year period acquired the assets of another institution substantially as an entirety by purchase, merger, consolidation, or otherwise, or has been reorganized pursuant to bankruptcy law.

(ii) In applying the earnings tests under this section, the earnings of the predecessor, constituent, or reorganized institution available for interest and dividends for the part of the period that preceded the acquisition or reorganization may be included in the earnings of the issuing, assuming, or guaranteeing institution for the part of the period determined in accordance with adjusted or pro forma consolidated earnings statements covering that part of the period and giving effect to all stock outstanding and all fixed charges existing immediately after the acquisition or reorganization.

(c) The reserve investments of an insurer shall consist of the classes of assets set forth in this section, subject to any limit set for each type or class of asset.

(d) (1) The reserve investments of an insurer may include:

(i) subject to paragraph (2) of this subsection, obligations issued or guaranteed by the African Development Bank, Asian Development Bank, International Bank for Reconstruction and Development, or International Finance Corporation; and

(ii) bonds or other evidences of indebtedness that:

1. are not in default as to principal or interest;

2. are valid and legally authorized obligations issued, assumed, or guaranteed by the United States, a state, a county, city, town, village, municipality, district, or political subdivision of a state, or a civil division or public instrumentality of any of these entities;

3. by applicable statutory or other legal requirements, are payable, as to both principal and interest, from taxes levied or by law required to be levied on all taxable property or all taxable income within the jurisdiction of the governmental unit or from adequate special revenues pledged or otherwise appropriated or by law required to be provided for the purpose of the payment of obligations; and

4. are not payable solely out of special assessments on properties benefited by local improvements.

(2) An insurer may not invest more than 5% of its total admitted assets in obligations of the African Development Bank, Asian Development Bank, International Bank for Reconstruction and Development, or International Finance Corporation.

(e) (1) This subsection does not apply to obligations eligible for investment under subsection (j), (k), or (l) of this section.

(2) The reserve investments of an insurer may include obligations that are not in default as to principal or interest, that are issued, assumed, or guaranteed by a solvent institution created or existing under the laws of the United States or a state, and that qualify under any of the following items:

(i) subject to paragraph (3) of this subsection, the obligations are secured by adequate collateral security and bear fixed interest, and, during each of any 3, including either of the last 2, of the 5 fiscal years immediately preceding the date of acquisition by the insurer, the net earnings available for fixed charges of the issuing, assuming, or guaranteeing institution must have been not less than one and one–quarter times the total of the institution's fixed charges for the year;

(ii) subject to paragraph (3) of this subsection, the obligations, at the date of acquisition by the insurer, are adequately secured and have investment qualities and characteristics in which speculative elements are not predominant;

(iii) the obligations bear fixed interest and are other than those described in item (i) of this paragraph, and the net earnings available for fixed charges of the issuing, assuming, or guaranteeing institution:

1. for a period of 5 fiscal years immediately preceding the date of acquisition by the insurer, must have averaged each year not less than one and one–half times the institution's average annual fixed charges applicable to the period; and

2. during the last year of the 5–year period, must have been not less than one and one–half times the institution's fixed charges for the year; or

(iv) the obligations are adjustment, income, or other contingent interest obligations, and the net earnings available for fixed charges of the issuing, assuming, or guaranteeing institution for a period of 5 fiscal years immediately preceding the date of acquisition by the insurer:

1. must have averaged each year not less than one and one–half times the sum of the institution's average annual fixed charges plus the institution's average annual maximum contingent interest applicable to the period; and

2. during each of the last 2 years of the 5–year period, must have been not less than one and one–half times the sum of the institution's fixed charges plus maximum contingent interest for the year.

(3) To determine the adequacy of collateral security for purposes of paragraph (2)(i) or (ii) of this subsection not more than one–third of the total value of the required collateral may include stock other than stock meeting the requirements of subsection (f) of this section.

(f) (1) In this subsection, "preferred dividends requirement" means cumulative or noncumulative dividends whether paid or unpaid.

(2) The reserve investments of an insurer may include preferred or guaranteed stock of a solvent institution, created or existing under the laws of the United States or a state, if:

(i) all prior obligations, and prior preferred stock, if any, of the institution at the date of acquisition by the insurer are eligible as investments under this article;

(ii) for preferred stock:

1. the net earnings of the institution available for fixed charges for a period of 5 fiscal years immediately preceding the date of acquisition by the insurer must have averaged each year not less than one and one–half times the

sum of any average annual fixed charges, any average annual maximum contingent interest, and the average annual preferred dividend requirement applicable to the period; and

2. during either of the last 2 years of the 5–year period, the net earnings must have been not less than one and one–half times the sum of the institution's fixed charges, contingent interest, and preferred dividend requirement for the year; and

(iii) for guaranteed stock, the assuming or guaranteeing institution meets the requirements of subsection (e)(2)(iii) of this section construed to include as a fixed charge the amounts of guaranteed dividends of the issue or the rental covering the guarantee of the dividends.

(g) The reserve investments of an insurer may include certificates, notes, or other obligations, adequately secured as to principal and interest, issued by trustees or receivers of an institution created or existing under the laws of the United States or a state, that, or the assets of which, are being administered under the direction of a court having jurisdiction.

(h) The reserve investments of an insurer may include equipment trust obligations or certificates that are adequately secured or other adequately secured instruments that evidence:

(1) an interest in transportation equipment located wholly or partly in the United States; and

(2) a right to receive determined parts of rental, purchase, or other fixed obligatory payments for the use or purchase of the transportation equipment.

(i) The reserve investments of an insurer may include bank and bankers' acceptance and other bills of exchange of the kind and maturities made eligible by law for purchase in the open market by federal reserve banks.

(j) (1) This subsection does not apply to obligations eligible for investment under subsection (e) of this section.

(2) (i) The reserve investments of an insurer may include bonds or evidences of indebtedness that are secured by first mortgages or deeds of trust on unencumbered fee–simple or improved leasehold real property located in the United States.

(ii) For purposes of subparagraph (i) of this paragraph, real property is not considered encumbered because of:

1. the existence of instruments reserving mineral, oil, or timber rights, rights–of–way, sewer rights, or rights in walls;

2. liens for taxes or assessments not yet due;

3. building restrictions or other restrictive covenants; or

4. leases on the real property under which rents or profits are reserved to the owner if the security for the loan is a first lien on the real property and if there is no condition or right of reentry or forfeiture under which the lien may be cut off, subordinated, or otherwise disturbed.

(3) At the time of investment by the insurer, a mortgage loan made or acquired by an insurer on any one property may not exceed 80% of the value of the real property securing the loan.

(4) A mortgage loan may not be made or acquired by an insurer unless an appraisal is made by an appraiser for the purpose of the investment.

(5) A mortgage loan made or acquired by an insurer that is a participation or a part of a series of issue secured by the same mortgage or deed of trust is not a lawful investment under this subsection unless:

(i) the entire series or issue that is secured by the same mortgage or deed of trust is held by the insurer; or

(ii) the insurer holds a pari passu participation interest in the mortgage or deed of trust and has the rights of a first mortgagee.

(6) Except as otherwise provided in this section, an insurer may not invest in or loan on the security of any one property more than the greater of $25,000 or 2% of its total admitted assets.

(7) The total investments of an insurer in the kinds of investments allowed under this paragraph may not exceed 40% of its total admitted assets.

(k) The reserve investments of an insurer may include purchase–money mortgages or like securities received by the insurer on the sale or exchange of real property acquired under subsection (n) of this section.

(l) (1) The reserve investments of an insurer may include bonds, notes, or other evidences of indebtedness secured by mortgages or deeds of trust that are

guaranteed or insured by an instrumentality of the United States under the National Housing Act, Servicemen's Readjustment Act of 1944, or Bankhead–Jones Farm Tenant Act.

(2) The limitations of this section or any other law of the State that require security on a loan, prescribe the nature, amount, or form of security on a loan, or limit the interest rate on a loan do not apply to these insured or guaranteed mortgage loans.

(m) (1) Subject to paragraphs (2) and (3) of this subsection, the reserve investments of an insurer may include ground rents in any state.

(2) For unexpired redeemable ground rents, any premium paid must be amortized over the period between the date of acquisition and redemption date.

(3) For expired redeemable ground rents, any premium paid must be charged off when acquired.

(4) An insurer shall carry redeemable ground rents purchased at a discount at an amount not greater than the cost of acquisition.

(n) (1) Subject to paragraph (2) of this subsection, reserve investments of an insurer may include real estate for the accommodation of business only if the real estate:

(i) consists of the land and the building on the land in which the insurer has its principal office;

(ii) is necessary for the insurer's convenient accommodation in transacting business;

(iii) is acquired to satisfy loans, mortgages, liens, judgments, decrees, or other debts previously owed to the insurer in the course of business;

(iv) is acquired as partial payment of the consideration for the sale of real property owned by the insurer if the transaction causes a net reduction in the investment of the insurer in real property; or

(v) is additional real property and equipment incident to real property that is necessary or convenient to enhance the market value of real property previously acquired or held by the insurer under item (iii) or (iv) of this paragraph.

(2) (i) Subject to subparagraph (ii) of this paragraph, the reserve investments of an insurer may include fee–simple or improved leasehold real estate,

or interests in limited partnerships formed for the development or ownership of fee–simple or improved leasehold real estate, only if the investment:

1. is acquired as an investment for the production of income;

2. is acquired to be improved or developed as an investment for the production of income; and

3. does not include property to be used primarily for mining, recreational, amusement, hotel, or club purposes.

(ii) 1. The cost of each parcel of fee–simple or improved leasehold real estate or limited partnership interest acquired under this paragraph, including the cost to the insurer of improving or developing the real estate, may not exceed:

A. 1% of the admitted assets of the insurer; and

B. in combination with the value of all of the real estate acquired or held by the insurer, 10% of the admitted assets of the insurer.

2. Except as otherwise required by the Commissioner, each parcel of fee–simple or improved leasehold real estate held by an insurer directly or through a limited partnership under this paragraph shall be valued on the books of the insurer as of December 31 each year at an amount that includes the write–down cost of the property, exclusive of land cost, but inclusive of all improvements or development costs, at a rate that averages at least 2% per year of the cost of the property for each year or part of a year that the property is held.

3. The admitted value of each parcel of fee–simple or improved leasehold real estate held under this paragraph may not exceed the depreciated value of the property.

(3) Unless the Commissioner certifies that the interests of the insurer will suffer materially by a forced sale of the real property and the Commissioner extends the time for disposal of the real property in the certificate:

(i) real property acquired under paragraph (1)(i) and (ii) of this subsection must be disposed of within 5 years after the real property ceases to be necessary for the convenient accommodation of the insurer in transacting business; and

(ii) real property acquired under paragraph (1)(iii) and (iv) of this subsection must be disposed of within 5 years after the date of acquisition.

(4) An insurer may not acquire real property under paragraph (1)(i), (ii), or (iv) or (3) of this subsection except with the approval of the Commissioner.

(o) An insurer may invest in or otherwise acquire or loan on Canadian securities and investments that are substantially of the same kinds, classes, and investment grades as those eligible for investment under this subtitle.

(p) (1) Subject to paragraph (2) of this subsection, an insurer that is authorized to do business in a foreign country or possession of the United States or that has outstanding insurance contracts or reinsurance contracts on risks located in a foreign country or possession of the United States may invest in or otherwise acquire or loan on securities and investments in the foreign country or possession that are substantially of the same kinds, classes, and investment grades as those eligible for investment under this subtitle.

(2) The aggregate amount of the investments made under paragraph (1) of this subsection and of the currency of the foreign country or possession held by the insurer may not exceed one and one–half times the greater of:

(i) the amount of the reserves of the insurer and other obligations under any outstanding insurance contracts or reinsurance contracts in that country or possession; and

(ii) the amount that the insurer is required by law to invest in that country or possession.

(q) The reserve investments of an insurer may include stocks or debentures or both of a housing authority organized under the public housing law of the State, to the extent and on the conditions that the Commissioner authorizes, if all of the stock of the housing authority has been or will be originally issued to one or more insurers.

(r) The reserve investments of an insurer may include shares or deposits in a savings and loan association or building and loan association to the extent that the investment or account is insured by the Federal Deposit Insurance Corporation.

(s) (1) Subject to paragraph (2) of this subsection, the reserve investments of an insurer may include dividend–paying common stock of a corporation created or existing under the laws of the United States, Canada, a state, or a province of Canada.

(2) To the extent necessary to satisfy the reserve requirements of this subtitle, an insurer may not have more than:

(i) 10% of its total admitted assets in preferred stock under subsection (f) of this section;

(ii) 10% of its total admitted assets in common stock under this subsection; or

(iii) 5% of its total admitted assets in the stock of any one corporation.

(t) (1) The reserve investments of an insurer may include securities lending, repurchase, reverse repurchase, and dollar roll transactions with business entities, subject to the requirements of paragraphs (2) through (9) of this subsection.

(2) (i) The insurer's board of directors shall adopt a written plan that specifies guidelines and objectives to be followed, such as:

1. a description of how cash received will be invested or used for general corporate purposes of the insurer;

2. operational procedures to manage interest rate risk, counterparty default risk, the conditions under which proceeds from reverse repurchase transactions may be used in the ordinary course of business, and the use of acceptable collateral in a manner that reflects the liquidity needs of the transaction; and

3. the extent to which the insurer may engage in these transactions.

(ii) The insurer shall file with the Commissioner the written plan including all changes and amendments to the written plan for use in the State on or before the date the plan becomes effective.

(3) (i) The insurer shall enter into a written agreement for all transactions authorized under this subsection other than dollar roll transactions.

(ii) The written agreement shall require that each transaction terminate no more than 1 year from its inception or on the earlier demand of the insurer.

(iii) The agreement shall be with the business entity counterparty, but for securities lending transactions, the agreement may be with an

agent acting on behalf of the insurer, if the agent is a qualified business entity, and if the agreement:

1. requires the agent to enter into separate agreements with each counterparty that are consistent with the requirements of this section; and

2. prohibits securities lending transactions under the agreement with the agent or its affiliates.

(4) (i) Cash received in a transaction under this subsection shall be invested in accordance with this subtitle and in a manner that recognizes the liquidity needs of the transaction or used by the insurer for its general corporate purposes.

(ii) For so long as the transaction remains outstanding, the insurer, its agent, or its custodian shall maintain, as to acceptable collateral received in a transaction under this subsection, either physically or through the book entry systems of the Federal Reserve, Depository Trust Company, Participants Trust Company, or other securities depositories approved by the Commissioner:

1. possession of the acceptable collateral;

2. a perfected security interest in the acceptable collateral; or

3. in the case of a jurisdiction outside the United States, title to, or rights of a secured creditor to, the acceptable collateral.

(5) (i) The limitations of § 5–606(a) of this subtitle do not apply to the business entity counterparty exposure created by transactions under this subsection.

(ii) For purposes of calculations made to determine compliance with this subsection, no effect will be given to the insurer's future obligation to resell securities, in the case of a repurchase transaction, or to repurchase securities, in the case of a reverse repurchase transaction.

(iii) An insurer may not enter into a transaction under this subsection if, as a result of and after giving effect to the transaction:

1. A. the aggregate amount of securities then loaned, sold to, or purchased from any one business entity counterparty under this subsection would exceed 5% of its admitted assets; and

B. in calculating the amount sold to or purchased from a business entity counterparty under repurchase or reverse repurchase transactions, effect may be given to netting provisions under a master written agreement; or

2. the aggregate amount of all securities then loaned, sold to, or purchased from all business entities under this subsection would exceed 40% of its admitted assets.

(6) (i) In a securities lending transaction, the insurer shall receive acceptable collateral having a market value as of the transaction date at least equal to 102% of the market value of the securities loaned by the insurer in the transaction as of that date.

(ii) If at any time the market value of the acceptable collateral is less than the market value of the loaned securities, the business entity counterparty shall be obligated to deliver additional acceptable collateral, the market value of which, together with the market value of all acceptable collateral then held in connection with the transaction, at least equals 102% of the market value of the loaned securities.

(7) (i) In a reverse repurchase transaction, other than a dollar roll transaction, the insurer shall receive acceptable collateral having a market value as of the transaction date at least equal to 95% of the market value of the securities transferred by the insurer in the transaction as of that date.

(ii) If at any time the market value of the acceptable collateral is less than 95% of the market value of the securities so transferred, the business entity counterparty shall be obligated to deliver additional acceptable collateral, the market value of which, together with the market value of all acceptable collateral then held in connection with the transaction, at least equals 95% of the market value of the transferred securities.

(8) In a dollar roll transaction, the insurer shall receive cash in an amount at least equal to the market value of the securities transferred by the insurer in the transaction as of the transaction date.

(9) (i) In a repurchase transaction, the insurer shall receive as acceptable collateral transferred securities having a market value at least equal to 102% of the purchase price paid by the insurer for the securities.

(ii) If at any time the market value of the acceptable collateral is less than 100% of the purchase price paid by the insurer, the business entity counterparty shall be obligated to provide additional acceptable collateral, the market

value of which, together with the market value of all acceptable collateral then held in connection with the transaction, at least equals 102% of the purchase price.

(iii) Securities acquired by an insurer in a repurchase transaction may not be sold in a reverse repurchase transaction, loaned in a securities lending transaction, or otherwise pledged.

(10) The provisions of this subsection that apply to insurers also apply to health maintenance organizations.

(u) The reserve investments of an insurer may include any other investments not otherwise prohibited by this subtitle if:

(1) the aggregate amount of the investments made under this subsection does not exceed 4% of the amount of the admitted assets of the insurer at the end of the previous year; and

(2) the investment does not violate any limitations on allowed investments under this section.

§5–609.

(a) Each insurer shall dispose of any investments acquired in violation of the law in force on the date of acquisition of the investment.

(b) In any determination of the financial condition of an insurer with investments acquired in violation of the law, the amount of the value of investments, if wholly ineligible, or the amount of the value of the investments in excess of any limitation prescribed by this subtitle, shall be deducted as a nonadmitted asset of the insurer.

§5–701.

(a) When made through the Commissioner by insurers or health maintenance organizations, the Treasurer shall accept and hold in trust:

(1) deposits required under this article for a certificate of authority to engage in the insurance business in the State;

(2) deposits required under § 19-710(d)(3) of the Health - General Article for a certificate of authority to operate as a health maintenance organization;

(3) deposits of domestic insurers, foreign insurers, or alien insurers required under the laws of another state, province, or country as a prerequisite for authority to engage in the insurance business in the other state, province, or country;

(4) deposits allowed under § 5-704 of this subtitle; and

(5) deposits required under Title 6, Subtitle 3 of this article.

(b) Deposits made under subsection (a) of this section shall be in any combination of:

(1) cash; or

(2) the government securities described in § 5-510(b) or § 5-607(b)(1)(i), (ii), or (iii) of this title, as approved by the Treasurer.

(c) Deposits of government securities shall be registered, both as to principal and interest, in the name of the Treasurer as trustee.

§5–702.

(a) (1) With the consent of the Commissioner, the Treasurer may require an insurer to make deposits of cash or government securities of the kinds described in § 5-701(a) of this subtitle with a depository that the Treasurer designates to receive and hold the deposits.

(2) The Treasurer may designate as a depository any solvent trust company or other solvent financial institution that has trust powers and is domiciled in the State.

(3) The Treasurer may make an appropriate agreement with a depository to ensure the receipt, safekeeping, and release of the cash or government securities deposited under this section.

(4) A deposit made under this section shall be held at the expense of the insurer.

(b) The State is responsible for the safekeeping and return of all cash and government securities deposited under this section.

§5–703.

Deposits made under this subtitle shall be held for the following purposes:

(1) deposits required under this article for a certificate of authority to engage in the insurance business in the State shall be held for the protection of the insurer's policyholders and creditors;

(2) deposits required under § 19-710(d)(3) of the Health - General Article for a certificate of authority to operate as a health maintenance organization shall be held for the protection of the health maintenance organization's members and creditors;

(3) deposits of domestic insurers required under the laws of another state, province, or country as a prerequisite for authority to engage in the insurance business in the other state, province, or country shall be held for the protection of the insurer's policyholders and creditors or for any other purpose specified in the laws requiring the deposits to be made;

(4) deposits allowed under § 5-704 of this subtitle shall be held for the protection of the insurer's policyholders and creditors; and

(5) deposits required under Title 6, Subtitle 3 of this article shall be held for the purposes specified in the notice of the Commissioner requiring the deposits to be made.

§5–704.

(a) An insurer may deposit cash or government securities eligible for deposit under § 5-701(b) of this subtitle in an amount greater than any deposit required or allowed under this article.

(b) (1) All or part of an excess deposit may be released to a solvent insurer on its request as provided in § 5-708(a)(2) of this subtitle.

(2) An excess deposit may be released to an insolvent insurer only as provided in § 5-708(a)(3) of this subtitle.

§5–705.

An insurer shall deposit promptly additional cash or other or additional government securities eligible for deposit under § 5-701(b) of this subtitle in an amount sufficient to cure any deficiency if:

(1) the cash or government securities deposited by the insurer and held on deposit under this subtitle become ineligible for deposit under § 5-701(b) of this subtitle; or

(2) the market value of the deposited cash and government securities falls below the amount required under this article.

§5–706.

(a) A judgment creditor or other claimant of an insurer may not levy on any of the cash or government securities held on deposit under this subtitle for the protection of the insurer's policyholders and creditors.

(b) A judgment creditor or other claimant of an insurer may levy on a deposit required under Title 6, Subtitle 3 of this article if allowed by the notice of the Commissioner requiring the deposit to be made.

§5–707.

While an insurer is solvent and complies with this article, the insurer may:

(1) demand, receive, sue for, and recover the income from the cash and government securities deposited by the insurer under this subtitle;

(2) substitute for any of the deposited cash or government securities, cash or government securities eligible for deposit under § 5-701(b) of this subtitle of equivalent or greater value; and

(3) inspect, at reasonable times, any deposit made by the insurer under this subtitle.

§5–708.

(a) A deposit made by an insurer under this subtitle shall be released and returned:

(1) to the insurer when substantially all liability of the insurer that the deposit secures is extinguished by authorized reinsurance or otherwise;

(2) to the insurer, if solvent, to the extent that the deposit exceeds the amount required to be deposited under this article; or

(3) on order of a court of competent jurisdiction, to the receiver, conservator, rehabilitator, or liquidator of the insurer, or to any other properly designated official who succeeds to the management and control of the insurer's assets.

(b) Except for a release made under subsection (a)(3) of this section, a release of deposited cash or government securities may be made only on application to and written order of the Commissioner.

(c) If the release is made in good faith, the Commissioner is not personally liable for the release of any deposit or part of a deposit.

§5–709.

(a) On completion of a merger or consolidation, an insurer that merges or consolidates with another insurer may:

(1) transfer to the successor insurer any deposit made by the merged or consolidated insurer under this subtitle; or

(2) have released to the successor insurer all or part of a deposit made by the merged or consolidated insurer under this subtitle that is no longer required of the successor insurer under this article.

(b) A transfer or release of a deposit under this section may be made only:

(1) with the approval of the Commissioner; and

(2) on affidavit of the officers of the merged or consolidated insurer and the successor insurer that the liabilities of the merged or consolidated insurer have been extinguished, canceled, or reinsured.

§5–801.

In this subtitle, "trusteed assets" means assets deposited in trust by an alien insurer in accordance with this subtitle.

§5–802.

This subtitle applies to each alien insurer that desires to use Maryland as a state of entry to transact insurance business in the United States.

§5–803.

(a) An alien insurer may use Maryland as a state of entry to transact insurance business in the United States if the alien insurer makes and maintains in Maryland a deposit of assets in trust with a solvent bank or trust company approved by the Commissioner.

(b) The deposit of trusteed assets shall be held for the benefit, security, and protection of the policyholders and creditors of the alien insurer in the United States.

(c) The deposit of trusteed assets, together with other trust deposits of the alien insurer held in the United States for the same purpose, may not be less than the deposits required of an alien insurer under § 4-106(c) of this article.

(d) The deposit of trusteed assets shall consist of cash, securities of the same character and diversification as those eligible for investment of the funds of domestic insurers under Subtitle 5 or 6 of this title, or both cash and securities.

(e) The deposit of trusteed assets shall be maintained as long as any liability of the alien insurer arising out of the transaction of its insurance business in the United States is outstanding.

§5–804.

(a) (1) A deposit of trusteed assets shall be made under a written trust agreement between the alien insurer and the trustee in accordance with this subtitle.

(2) The deposit of trusteed assets shall be authenticated in the manner approved by the Commissioner.

(b) Whether or not then authorized to transact insurance business in Maryland, an alien insurer that uses or proposes to use Maryland as a state of entry to transact insurance business in the United States may make and execute the trust agreement required by this subtitle.

(c) (1) The trust agreement is not effective until filed with and approved in writing by the Commissioner.

(2) The Commissioner may not approve a trust agreement if the Commissioner finds that the trust agreement:

(i) does not comply with law; or

(ii) has terms that do not provide reasonably adequate protection for the alien insurer's policyholders and creditors in the United States.

(d) (1) A trust agreement may be amended.

(2) The amendment is not effective until filed with and approved in writing by the Commissioner as complying with this subtitle.

(e) (1) The Commissioner may withdraw approval of a trust agreement or amendment to a trust agreement if the Commissioner finds, after a hearing, that the requirements under this subtitle for approval of the trust agreement or amendment are no longer met.

(2) The Commissioner shall give notice of the hearing required under paragraph (1) of this subsection to the alien insurer and the trustee of the trust agreement.

§5–805.

(a) (1) For purposes of the trust deposit, title to the trusteed assets is vested in the trustee and its successor.

(2) The trust agreement shall provide that title to the trusteed assets be vested as described in paragraph (1) of this subsection.

(b) The trustee shall:

(1) keep the trusteed assets separate from other assets; and

(2) maintain a record of the trusteed assets sufficient to identify the trusteed assets at all times.

(c) (1) On written request of the Commissioner, the trustee shall file with the Commissioner statements, in the form required by the Commissioner, certifying the character and amount of the trusteed assets.

(2) If the trustee after a reasonable time fails to file a statement requested by the Commissioner under paragraph (1) of this subsection, the Commissioner may suspend or revoke the certificate of authority of the alien insurer that deposited the trusteed assets.

(d) The Commissioner may examine the trusteed assets of an alien insurer at any time in accordance with the conditions and procedures that govern the examination of insurers in general under Title 2 of this article.

§5–806.

(a) Except as otherwise provided in subsections (b) through (e) of this section, the trust agreement shall provide in substance that an alien insurer may not make, and the trustee may not allow, withdrawals of trusteed assets without advance written authorization of the Commissioner.

(b) The trust agreement may provide that, on request of an alien insurer or the United States manager of the alien insurer, all or part of the income, earnings, dividends, or interest accumulations of the trusteed assets may be paid to that manager.

(c) The trust agreement may provide that trusteed assets may be withdrawn and, at the same time, assets of equivalent or greater value to those trusteed assets being withdrawn may be substituted if:

(1) the substituted assets are eligible for investment of the funds of domestic insurers under Subtitle 5 or 6 of this title;

(2) the United States manager of the alien insurer requests the withdrawal in writing in accordance with written authority previously given or delegated by the board of directors or other similar governing body of the alien insurer; and

(3) a copy of that authority has been filed with the trustee.

(d) The trust agreement may provide that:

(1) trusteed assets may be withdrawn to make a deposit that is required by law in a state in which the alien insurer is or becomes authorized to engage in the insurance business, for the protection of the alien insurer's policyholders and creditors in that state or in the United States, to the extent that the withdrawal does not reduce the alien insurer's deposit in this State to an amount less than the minimum deposit required under § 4-106(c) of this article; and

(2) if a withdrawal is authorized under item (1) of this subsection, the trustee shall transfer directly to the depository required to receive the deposit in the other state the assets withdrawn in the amount required to be deposited in the other state, as certified in writing by the insurance supervisory official of the other state.

(e) The trust agreement may provide that trusteed assets may be transferred to a liquidator, conservator, or rehabilitator under an order of a court of competent jurisdiction.

(f) The Commissioner may authorize withdrawal of only those trusteed assets that exceed the amount required by this subtitle.

(g) (1) If the Commissioner determines that an alien insurer is insolvent or that an alien insurer's assets in the United States are less than required under § 4-106(c) of this article, the Commissioner in writing shall order the trustee to suspend

the right of the alien insurer or any other person to withdraw the trusteed assets of the alien insurer.

(2) The trustee shall comply with the order until further order of the Commissioner.

§5–807.

Subject to the Commissioner's approval, a new trustee may be substituted for the original trustee because of a vacancy or for other proper cause.

§5–901.

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

(b) "Ceding insurer" means an insurer that procures insurance for itself from another insurer for all or part of an insurance risk.

(c) "Covered agreement" means an agreement entered into under the federal Dodd–Frank Wall Street Reform and Consumer Protection Act, 31 U.S.C. §§ 313 and 314, that:

(1) is currently in effect or in a period of provisional application; and

(2) addresses the elimination, under specified conditions, of collateral requirements as a condition for:

(i) entering into a reinsurance agreement with a ceding insurer domiciled in the State; or

(ii) allowing the ceding insurer to recognize credit for reinsurance.

(d) "Primary certifying state" means a state other than Maryland:

(1) in which the insurance regulatory agency or its equivalent has designated and assigned a rating to an assuming insurer as a certified reinsurer; and

(2) the designation or rating from which the Commissioner has used to designate or assign a rating to the assuming insurer in this State under § 5–910(b) of this subtitle.

(e) "Qualified jurisdiction" means a jurisdiction that the Commissioner determines meets the requirements of § 5–909 of this subtitle.

(f) "Qualified United States financial institution" means:

(1) for purposes of issuance or confirmation of a letter of credit under § 5–914(c)(3) of this subtitle, an institution that:

(i) is organized or, in the case of a United States office of a foreign banking organization, licensed under the laws of the United States or any state;

(ii) is regulated, supervised, and examined by federal or state authorities having regulatory authority over banks and trust companies; and

(iii) has been determined by either the Commissioner or the securities valuation office of the National Association of Insurance Commissioners to meet the standards of financial condition and standing that are considered necessary and appropriate to regulate the quality of financial institutions whose letters of credit will be acceptable to the Commissioner; or

(2) for purposes of eligibility to act as a fiduciary of a trust under this subtitle, an institution that:

(i) is organized or, in the case of a United States branch or agency office of a foreign banking organization, licensed under the laws of the United States or any state and has been granted authority to operate with fiduciary powers; and

(ii) is regulated, supervised, and examined by federal or state authorities having regulatory authority over banks and trust companies.

(g) "Reciprocal jurisdiction" means a jurisdiction that is:

(1) a jurisdiction outside the United States that:

(i) is subject to an in–force covered agreement with the United States, each within its legal authority; or

(ii) in the case of a covered agreement between the United States and the European Union, is a member state of the European Union;

(2) a jurisdiction in the United States that meets the requirements for accreditation under the NAIC financial standards and accreditation program; or

(3) a qualified jurisdiction, as determined by the Commissioner under § 5–909 of this article, that:

(i) is not otherwise described in item (1) or (2) of this subsection; and

(ii) meets additional requirements, consistent with the terms and conditions of the in–force covered agreement, as the Commissioner specifies by regulation.

(h) "Reinsurer" means an insurer from which a ceding insurer procures insurance for itself for all or part of an insurance risk.

(i) "Trusteed surplus" means funds held in a trust account in excess of the reinsurer's liabilities attributable to reinsurance ceded to the reinsurer by United States ceding insurers in accordance with this subtitle.

§5–902.

(a) This subtitle does not apply to wet marine and transportation insurance.

(b) All laws or parts of laws of the State that are inconsistent with this subtitle are superseded to the extent of the inconsistency.

§5–903.

Credit for reinsurance shall be allowed a domestic ceding insurer as either an asset or a reduction from liability on account of reinsurance ceded if the reinsurer meets the requirements of this subtitle.

§5–904.

(a) Except as provided in §§ 3–124 and 3–125 of this article for bulk reinsurance, an insurer may reinsure all or part of a particular risk.

(b) (1) Credit shall be allowed under subsection (c), (d), or (e) of this section with respect to cessions of those kinds or classes of business that the assuming insurer is licensed or otherwise allowed to write or assume in its state of domicile or, in the case of a United States branch of an alien assuming insurer, in the state through which it is entered and licensed to transact insurance or reinsurance.

(2) Credit shall be allowed under subsection (e) or (f) of this section only if the applicable requirements of § 5–913 of this subtitle have been satisfied.

(c) Credit shall be allowed when the reinsurance is ceded to an assuming insurer that is licensed to transact insurance or reinsurance in this State.

(d) Credit shall be allowed when the reinsurance is ceded to an assuming insurer that is accredited by the Commissioner as a reinsurer in this State in accordance with § 5–906 of this subtitle.

(e) Subject to the requirements of § 5–913 of this subtitle, credit shall be allowed when the reinsurance is ceded to an assuming insurer that maintains a trust fund meeting the requirements of § 5–907 of this subtitle in a qualified United States financial institution for the payment of the valid claims of its United States ceding insurers and their assigns and successors in interest.

(f) Credit shall be allowed when the reinsurance is ceded to an assuming insurer that has been certified by the Commissioner as a reinsurer in this State in accordance with §§ 5–908 and 5–909 of this subtitle and secures its obligations in accordance with the requirements of § 5–911 of this subtitle.

(g) Credit shall be allowed when the reinsurance is ceded to an assuming insurer not meeting the requirements of subsection (c), (d), (e), or (f) of this section, but only as to the insurance of risks located in jurisdictions where the reinsurance is required by the applicable law or regulation of that jurisdiction.

§5–905.

(a) (1) Credit may not be allowed, as an asset or deduction from liability, to a ceding insurer for reinsurance unless the reinsurance contract provides, in substance, that in the event of the insolvency of the ceding insurer, the reinsurance shall be payable under the terms of a contract reinsured by the reinsurer on the basis of reported claims allowed by the court in a liquidation proceeding, without diminution because of the insolvency of the ceding insurer.

(2) Payments made by a reinsurer under paragraph (1)(ii) of this subsection shall be made directly to the ceding insurer or its domiciliary receiver unless:

(i) the reinsurance contract or other written agreement specifically provides another payee of the reinsurance in the event of the insolvency of the ceding insurer; or

(ii) subject to any contractual or statutory requirement of consent by the policyholder, the reinsurer has assumed the policy obligations of the ceding insurer as direct obligations of the reinsurer to the payees under the policies and in substitution for the ceding insurer's obligations to the payees.

(3) (i) Notwithstanding paragraph (2) of this subsection, if a life and health insurance guaranty association has elected to succeed to the rights and obligations of an insolvent insurer under a reinsurance contract, the reinsurer's liability to pay covered reinsured claims shall continue under the reinsurance contract, subject to the payment of premiums to the reinsurer for the reinsurance coverage.

(ii) Payment for a covered reinsured claim under subparagraph (i) of this paragraph shall be made by the reinsurer only at the direction of the life and health insurance guaranty association or its designated successor.

(iii) Payment for a covered reinsured claim made by the reinsurer at the direction of the life and health insurance guaranty association or its designated successor discharges the reinsurer's liability to any other person for payment of the covered reinsured claim.

(b) (1) A reinsurance contract may provide that the domiciliary receiver of an insolvent ceding insurer shall give written notice to the reinsurer of the pendency of a claim made against the insolvent ceding insurer under the contract reinsured within a reasonable time after the claim is filed in the liquidation proceeding.

(2) During the pendency of the claim, the reinsurer, at its own expense, may investigate the claim and interpose, in the liquidation proceeding, any defense that it determines is available to the insolvent ceding insurer or its receiver.

(3) (i) The reinsurer may file a claim against the insolvent ceding insurer for any expense incurred by the reinsurer under paragraph (2) of this subsection.

(ii) The claim may not exceed an amount equal to the proportionate share of the benefit accruing to the insolvent ceding insurer solely as a result of the defense undertaken by the reinsurer.

(iii) If two or more reinsurers are involved in a claim and a majority in interest elect to interpose a defense to the claim, the expense shall be apportioned in accordance with the terms of the reinsurance contract as though the expense had been incurred by the insolvent ceding insurer.

(c) On request of the Commissioner, a ceding insurer shall inform the Commissioner promptly in writing of the cancellation or any other material change of any of its reinsurance contracts or arrangements.

§5–906.

(a) In order for an assuming reinsurer to be eligible for accreditation by the Commissioner, the reinsurer shall:

(1) file with the Commissioner evidence of its submission to this State's jurisdiction;

(2) submit to the Commissioner's authority to examine its books and records;

(3) be licensed to transact insurance or reinsurance in at least one state or, in the case of a United States branch of an alien assuming insurer, be entered through and licensed to transact insurance or reinsurance in at least one state;

(4) file each year with the Commissioner a copy of its annual statement filed with the insurance department of its state of domicile and a copy of its most recent audited financial statement; and

(5) demonstrate to the satisfaction of the Commissioner that the reinsurer has adequate financial capacity to meet its reinsurance obligations and is otherwise qualified to assume reinsurance from domestic insurers.

(b) An assuming insurer is deemed to meet the requirement of subsection (a)(5) of this section as of the time of its application if:

(1) the assuming insurer maintains a surplus as regards policyholders in an amount not less than $20,000,000; and

(2) the Commissioner has not denied the assuming insurer's accreditation within 90 days after submission of its application.

§5–907.

(a) To enable the Commissioner to determine the sufficiency of the trust fund provided for in § 5–904(e) of this subtitle, the assuming insurer shall report each year to the Commissioner information substantially the same as that required to be reported on the National Association of Insurance Commissioners annual statement form by authorized insurers.

(b) The assuming insurer shall submit to examination of its books and records by the Commissioner and bear the expense of examination.

(c) Credit for reinsurance may not be granted under this section unless the form of the trust and any amendments to the trust have been approved by:

(1) the insurance regulatory agency of the state where the trust is domiciled; or

(2) the insurance regulatory agency of another state who, under the terms of the trust instrument, has accepted principal regulatory oversight of the trust.

(d) The form of the trust and any trust amendments shall be filed with the insurance regulatory agency of each state in which the ceding insurer beneficiaries of the trust are domiciled.

(e) The trust instrument shall provide that contested claims shall be valid and enforceable on the final order of any court of competent jurisdiction in the United States.

(f) The trust shall vest legal title to its assets in its trustees for the benefit of the assuming insurer's United States ceding insurers and their assigns and successors in interest.

(g) The trust and the assuming insurer shall be subject to examination as determined by the Commissioner.

(h) The trust shall remain in effect for as long as the assuming insurer has outstanding obligations due under the reinsurance contracts subject to the trust.

(i) Not later than February 28 of each year, the trustee of the trust shall:

(1) report to the Commissioner in writing the balance of the trust and list the trust's investments at the preceding year–end; and

(2) certify the date of termination of the trust, if so planned, or certify that the trust will not expire before the following December 31.

(j) (1) This subsection applies to ceding to a single assuming insurer.

(2) The trust fund shall consist of funds in trust in an amount not less than the assuming insurer's liabilities attributable to reinsurance ceded by United States ceding insurers.

(3) Except as provided in paragraph (4) of this subsection, the assuming insurer shall maintain a trusteed surplus of not less than $20,000,000.

(4) (i) Subject to subparagraphs (ii) and (iii) of this paragraph, at any time after the assuming insurer has permanently discontinued underwriting new business secured by the trust for at least 3 full years, the insurance regulatory agency with principal regulatory oversight of the trust may authorize a reduction in the required trusteed surplus, but only after a finding, based on an assessment of the risk, that the new required surplus level is adequate for the protection of United States ceding insurers, policyholders, and claimants in light of reasonably foreseeable adverse loss development.

(ii) The risk assessment under subparagraph (i) of this paragraph:

1. may involve an actuarial review, including an independent analysis of reserves and cash flows; and

2. shall consider all material risk factors, including, when applicable, the lines of business involved, the stability of the incurred loss estimates, and the effect of the surplus requirements on the assuming insurer's liquidity or solvency.

(iii) The minimum required trusteed surplus under subparagraph (i) of this paragraph may not be reduced to an amount less than 30% of the assuming insurer's liabilities attributable to reinsurance ceded by United States ceding insurers covered by the trust.

(k) (1) This subsection applies to ceding to a group that includes incorporated and individual unincorporated underwriters.

(2) For reinsurance ceded under reinsurance contracts with an inception, amendment, or renewal date on or after January 1, 1993, the trust shall consist of a trusteed account in an amount not less than the respective underwriters' several liabilities attributable to business ceded by United States domiciled ceding insurers to any underwriter of the group.

(3) For reinsurance ceded under reinsurance contracts with an inception date on or before December 31, 1992, and not amended or renewed after that date, notwithstanding any other provisions of this section, the trust shall consist of a trusteed account in an amount not less than the respective underwriters' several insurance and reinsurance liabilities attributable to business written in the United States.

(4) In addition to these trusts, the group shall maintain in trust a trusteed surplus of which $100,000,000 shall be held jointly for the benefit of the

United States domiciled ceding insurers of any member of the group for all years of account.

(5) The incorporated members of the group:

(i) may not be engaged in any business other than underwriting as a member of the group; and

(ii) shall be subject to the same level of regulation and solvency control by the group's domiciliary regulator as are the unincorporated members.

(6) Within 90 days after its financial statements are due to be filed with the group's domiciliary regulator, the group shall provide to the Commissioner:

(i) an annual certification by the group's domiciliary regulator of the solvency of each underwriter member; or

(ii) if a certification is unavailable, financial statements, prepared by independent public accountants, of each underwriter member of the group.

§5–908.

(a) In order to be eligible for certification in accordance with § 5–904(f) of this subtitle, the assuming insurer shall:

(1) be domiciled and licensed to transact insurance or reinsurance in a qualified jurisdiction, as determined under § 5–909 of this subtitle;

(2) maintain minimum capital and surplus, or its equivalent, in an amount the Commissioner determines in accordance with regulations the Commissioner adopts;

(3) maintain financial strength ratings from two or more rating agencies that the Commissioner considers acceptable in accordance with regulations the Commissioner adopts;

(4) agree to submit to the jurisdiction of this State;

(5) appoint the Commissioner as its agent for service of process in this State;

(6) agree to provide security for all of the assuming insurer's liabilities attributable to reinsurance ceded by United States ceding insurers if it resists enforcement of a final United States judgment;

(7) agree to meet applicable information filing requirements as the Commissioner determines both for the initial application for certification and on an ongoing basis; and

(8) satisfy any other requirements for certification that the Commissioner considers relevant.

(b) (1) A group, including incorporated and individual unincorporated underwriters, may be a certified reinsurer if the group, including incorporated and individual unincorporated underwriters, meets all the requirements of this section.

(2) The group shall satisfy its minimum capital and surplus equivalents, net of liabilities, of the group and its members, which shall include a joint central fund that may be applied to any unsatisfied obligation of the group or any of its members, in an amount that the Commissioner determines will provide adequate protection.

(3) The incorporated members of the group may not be engaged in any business other than underwriting as a member of the group.

(4) The incorporated members of the group shall be subject to the same level of regulation and solvency control by the group's domiciliary regulator as are the unincorporated members.

(5) Within 90 days after its financial statements are due to be filed with the group's domiciliary regulator, the group shall provide to the Commissioner:

(i) an annual certification by the group's domiciliary regulator of the solvency of each underwriter member; or

(ii) if a certification is unavailable, financial statements, prepared by independent public accountants, of each underwriter member of the group.

§5–909.

(a) (1) The Commissioner shall maintain and publish a list of qualified jurisdictions under which an assuming insurer, licensed and domiciled in that jurisdiction, is eligible to be considered for certification by the Commissioner as a certified reinsurer.

(2) In order to determine whether the domiciliary jurisdiction of a non–United States assuming insurer is eligible to be recognized as a qualified jurisdiction, the Commissioner shall:

(i) evaluate the appropriateness and effectiveness of the reinsurance supervisory system of the jurisdiction, initially and on an ongoing basis; and

(ii) consider the rights, benefits, and extent of reciprocal recognition afforded by the non–United States jurisdiction to reinsurers licensed and domiciled in the United States.

(3) A qualified jurisdiction shall agree in writing to share information and cooperate with the Commissioner with respect to all certified reinsurers domiciled in that jurisdiction.

(4) The Commissioner may not recognize a jurisdiction as a qualified jurisdiction unless the Commissioner has determined that the jurisdiction adequately and promptly enforces final United States judgments and arbitration awards.

(5) The Commissioner may consider other factors in determining the jurisdiction's eligibility to be recognized as a qualified jurisdiction.

(b) (1) The Commissioner shall consider the list of conditionally qualified and qualified jurisdictions published through the National Association of Insurance Commissioners committee process in determining the qualified jurisdictions in this State.

(2) In determining whether a jurisdiction is a qualified jurisdiction, the Commissioner shall consider the National Association of Insurance Commissioners list of conditionally qualified and qualified jurisdictions:

(i) when the jurisdiction has been evaluated for inclusion on the list; and

(ii) whenever the list is amended.

(3) If the Commissioner approves a jurisdiction as qualified that does not appear on the National Association of Insurance Commissioners list of qualified jurisdictions, the Commissioner shall provide information related to the approval to the National Association of Insurance Commissioners as provided in regulations the Commissioner adopts.

(4) The Commissioner shall recognize as a qualified jurisdiction in this State any state that meets the requirement for accreditation under the National Association of Insurance Commissioners financial standards and accreditation program.

(5) If a certified reinsurer's domiciliary jurisdiction ceases to be a qualified jurisdiction, the Commissioner may indefinitely suspend or revoke the reinsurer's certification.

§5–910.

(a) (1) The Commissioner shall assign a rating to each certified reinsurer based on factors the Commissioner considers relevant, giving due consideration to the financial strength ratings that have been assigned by rating agencies in accordance with regulations the Commissioner adopts.

(2) The Commissioner shall publish a list of all certified reinsurers and their ratings.

(b) If an applicant for certification has been certified as a reinsurer by the insurance regulatory agency of a state accredited by the National Association of Insurance Commissioners, the Commissioner may defer to that insurance regulatory agency or the National Association of Insurance Commissioners committee process to:

(1) designate the assuming insurer as a certified reinsurer in this State;

(2) assign a rating to the assuming insurer; or

(3) both.

(c) (1) A certified reinsurer that ceases to assume new business in this State may request to maintain its certification in inactive status in order to continue to qualify for a reduction in security for its in–force business.

(2) An inactive certified reinsurer shall continue to comply with all applicable requirements of § 5–911 of this subtitle.

(3) The Commissioner shall assign a rating that takes into account, if relevant, the reasons why the reinsurer is not assuming new business.

§5–911.

(a) A certified reinsurer shall secure obligations assumed from United States ceding insurers under this subtitle at a level consistent with its rating, as specified in regulations the Commissioner adopts.

(b) Except as otherwise provided in this section, in order for a domestic ceding insurer to qualify for full financial statement credit for reinsurance ceded to a certified reinsurer, the certified reinsurer shall maintain security in a form the Commissioner considers acceptable and consistent with § 5–914 of this subtitle, or in a multibeneficiary trust in accordance with § 5–907 of this subtitle.

(c) (1) If a certified reinsurer maintains a trust to fully secure its obligations consistent with § 5–907 of this subtitle and chooses to secure its obligations incurred as a certified reinsurer in the form of a multibeneficiary trust, the certified reinsurer shall maintain separate trust accounts for its obligations incurred under reinsurance contracts issued or renewed as a certified reinsurer with reduced security as allowed by this section or comparable laws of other United States jurisdictions and for its obligations subject to § 5–907 of this subtitle.

(2) As a condition of certification under § 5–908 of this subtitle, the certified reinsurer shall bind itself, by the language of the trust and agreement with the commissioner with principal regulatory oversight of each trust account, to fund, on termination of the trust account, out of the remaining surplus of the trust, any deficiency of any other trust account.

(d) The minimum trusteed surplus requirements provided in § 5–907 of this subtitle do not apply with respect to a multibeneficiary trust maintained by a certified reinsurer for the purpose of securing obligations incurred under this section, except that the trust shall maintain a minimum trusteed surplus of $10,000,000.

(e) With respect to obligations incurred by a certified reinsurer under this section, if the security is insufficient, the Commissioner:

(1) shall reduce the allowable credit by an amount proportionate to the deficiency; and

(2) may impose further reductions in allowable credit on finding that there is a material risk that the certified reinsurer's obligations will not be paid in full when due.

(f) (1) For purposes of this section, a certified reinsurer whose certification the Commissioner has revoked, suspended, or placed on inactive status, or has been voluntarily surrendered, for any reason shall be treated as a certified reinsurer required to secure all of its obligations.

(2) If the Commissioner continues to assign a higher rating as allowed by other provisions of this section, the requirement of paragraph (1) of this subsection does not apply to a certified reinsurer in inactive status or to a reinsurer whose certification has been suspended.

§5–912.

(a) After providing notice and an opportunity for hearing to the reinsurer, the Commissioner may suspend or revoke a reinsurer's accreditation or certification if the reinsurer ceases to meet the requirements for accreditation or certification.

(b) The revocation or suspension may not take effect until after the Commissioner's order on hearing unless:

(1) the reinsurer waives its right to a hearing;

(2) the Commissioner's order is based on a regulatory action by the reinsurer's domiciliary jurisdiction or primary certifying state suspending or revoking the reinsurer's eligibility to transact insurance or reinsurance;

(3) the reinsurer voluntarily surrenders its license or certification to transact insurance or reinsurance business in its domiciliary jurisdiction or primary certifying state; or

(4) (i) the Commissioner finds that an emergency requires immediate action by the Commissioner; and

(ii) a court of competent jurisdiction has not stayed the Commissioner's action.

(c) (1) While a reinsurer's accreditation or certification is suspended, a reinsurance contract issued or renewed after the effective date of the suspension does not qualify for credit except to the extent the reinsurer's obligations under the contract are secured in accordance with § 5–914 of this subtitle.

(2) If a reinsurer's accreditation or certification is revoked, credit for reinsurance may not be granted after the effective date of the revocation except to the extent that the reinsurer's obligations under the contract are secured in accordance with § 5–911 or § 5–914 of this subtitle.

§5–913.

(a) If the assuming insurer is not licensed, accredited, or certified to transact insurance or reinsurance in this State, the credit allowed by § 5–904(e) of

this subtitle may not be allowed unless the assuming insurer agrees in the reinsurance contracts:

(1) that in the event of the failure of the assuming insurer to perform its obligations under the terms of the reinsurance contract, the assuming insurer, at the request of the ceding insurer, shall:

(i) submit to the jurisdiction of any court of competent jurisdiction in any state;

(ii) comply with all requirements necessary to give the court jurisdiction; and

(iii) abide by the final decision of the court or of any appellate court in case of an appeal; and

(2) to designate the Commissioner as its resident agent on whom any lawful process may be served in any action, suit, or proceeding instituted by or on behalf of the ceding insurer.

(b) Subsection (a) of this section is not intended to conflict with or override the obligation of the parties to a reinsurance contract to arbitrate their disputes, if this obligation is created in the reinsurance contract.

(c) If the assuming insurer does not meet the requirements of § 5–904(c) or (d) of this subtitle, the credit allowed by § 5–904(e) and (f) of this subtitle may not be allowed unless the assuming insurer agrees in the trust agreements to the following conditions:

(1) notwithstanding any other provision in the trust instrument, if the trust fund is inadequate because it contains an amount less than the amount required by § 5–907(j) of this subtitle, or if the grantor of the trust has been declared insolvent or placed into receivership, rehabilitation, liquidation, or similar proceedings under the laws of its state or country of domicile, the trustee shall comply with an order of the insurance regulatory agency with regulatory oversight over the trust or with an order of a court of competent jurisdiction directing the trustee to transfer to the insurance regulatory agency with regulatory oversight all of the assets of the trust fund;

(2) the assets shall be distributed by and claims shall be filed with and valued by the insurance regulatory agency with regulatory oversight over the trust in accordance with the laws of the state in which the trust is domiciled that are applicable to the liquidation of domestic insurers;

(3) if the insurance regulatory agency with regulatory oversight over the trust determines that the assets of the trust fund or any part of the assets are not necessary to satisfy the claims of the United States ceding insurers of the grantor of the trust, the assets or part shall be returned by the insurance regulatory agency with regulatory oversight to the trustee for distribution in accordance with the trust agreement; and

(4) the grantor shall waive any right otherwise available to it under United States law that is inconsistent with this subsection.

§5–914.

(a) An asset or a reduction from liability for the reinsurance ceded by a domestic insurer to an assuming insurer not meeting the requirements of § 5–904 of this subtitle shall be allowed in an amount not exceeding the liabilities carried by the ceding insurer.

(b) The reduction shall be in the amount of funds held by or on behalf of the ceding insurer, including funds held in trust for the ceding insurer, under a reinsurance contract with the assuming insurer as security for the payment of obligations under the contract, if the security is held:

(1) in the United States subject to withdrawal solely by, and under the exclusive control of, the ceding insurer; or

(2) in the case of a trust, held in a qualified United States financial institution.

(c) The security may be in the form of:

(1) cash;

(2) securities listed by the securities valuation office of the National Association of Insurance Commissioners, including those deemed exempt from filing as defined by the purposes and procedures manual of the securities valuation office, and qualifying as admitted assets;

(3) subject to subsection (d) of this section, clean, irrevocable, unconditional letters of credit, issued or confirmed by a qualified United States financial institution, effective no later than December 31 of the year for which the filing is being made, and in the possession of, or in trust for, the ceding insurer on or before the filing date of the ceding insurer's annual statement; or

(4) any other form of security acceptable to the Commissioner.

(d) Notwithstanding the subsequent failure of the issuing or confirming institution to meet applicable standards of issuer acceptability, a letter of credit meeting applicable standards of issuer acceptability as of the date of its issuance or confirmation under subsection (c)(3) of this section shall continue to be acceptable as security until the letter of credit expires or is extended, renewed, modified, or amended, whichever occurs first.

§5–915.

(a) (1) A ceding insurer shall take steps to manage its reinsurance recoverables proportionate to its own book of business.

(2) (i) A domestic ceding insurer shall notify the Commissioner within 30 days after reinsurance recoverables from any single assuming insurer, or group of affiliated assuming insurers, exceeds or is likely to exceed 50% of the domestic ceding insurer's last reported surplus to policyholders.

(ii) The notification required by subparagraph (i) of this paragraph shall demonstrate that the domestic ceding insurer is safely managing the exposure.

(b) (1) A ceding insurer shall take steps to diversify its reinsurance program.

(2) (i) A domestic ceding insurer shall notify the Commissioner within 30 days after ceding or being likely to cede to any single assuming insurer, or group of affiliated assuming insurers, more than 20% of the ceding insurer's gross written premium in the prior calendar year.

(ii) The notification required by subparagraph (i) of this paragraph shall demonstrate that the domestic ceding insurer is safely managing the exposure.

§5–916.

(a) The Commissioner may adopt:

(1) regulations to carry out this subtitle; and

(2) rules and regulations applicable to reinsurance arrangements described in subsection (b) of this section.

(b) (1) A rule or regulation adopted under subsection (a)(2) of this section may apply only to reinsurance relating to:

(i) life insurance policies with guaranteed nonlevel gross premiums or guaranteed nonlevel benefits;

(ii) universal life insurance policies with provisions resulting in the ability of a policyholder to keep a policy in force over a secondary guarantee period;

(iii) variable annuities with guaranteed death or living benefits;

(iv) long–term care insurance policies; or

(v) other life and health insurance and annuity products as to which the National Association of Insurance Commissioners adopts model regulatory requirements with respect to credit for reinsurance.

(2) A rule or regulation adopted under subsection (a)(2) of this section that applies to reinsurance relating to policies specified under paragraph (1)(i) or (ii) of this subsection may apply to any treaty containing:

(i) policies issued on or after January 1, 2015; or

(ii) policies issued before January 1, 2015, if the risk pertaining to the pre–2015 policies is ceded in connection with the treaty, in whole or in part, on or after January 1, 2015.

(3) A rule or regulation adopted under subsection (a)(2) of this section may require the ceding insurer, in calculating the amounts or forms of security required to be held under regulations adopted under subsection (a)(2) of this section, to use the valuation manual adopted by the National Association of Insurance Commissioners in accordance with § 5–313 of this title, including all amendments adopted by the National Association of Insurance Commissioners and in effect on the date the calculation is made, to the extent applicable.

(4) A rule or regulation adopted under subsection (a)(2) of this section may not apply to a cession to an assuming insurer that:

(i) meets the conditions set forth in § 5–917 of this subtitle;

(ii) is certified in this State in accordance with § 5–904(f) of this subtitle; or

(iii) 1. maintains at least $250,000,000 in capital and surplus when determined in accordance with the National Association of Insurance Commissioners Accounting Practices and Procedures Manual, including all amendments adopted by the National Association of Insurance Commissioners, excluding the impact of any permitted or prescribed practices; and

2. A. is licensed in at least 26 states; or

B. is licensed in at least 10 states and is licensed or accredited in a total of at least 35 states.

(c) The authority of the Commissioner to adopt regulations under subsection (a)(2) of this section does not limit the Commissioner's general authority to adopt regulations under subsection (a)(1) of this section.

§5–917.

(a) Credit shall be allowed when reinsurance is ceded to an assuming insurer that:

(1) has its head office or is domiciled in and licensed in a reciprocal jurisdiction;

(2) has and maintains on an ongoing basis:

(i) minimum capital and surplus, or its equivalent, calculated according to the methodology of its domiciliary jurisdiction, in an amount to be set forth in regulation; or

(ii) if the assuming insurer is an association, including incorporated and individual unincorporated underwriters:

1. minimum capital and surplus equivalents, net of liabilities, calculated according to the methodology applicable in its domiciliary jurisdiction; and

2. a central fund containing a balance in an amount the Commissioner requires by regulation;

(3) maintains a minimum solvency or capital ratio, as the Commissioner requires by regulation;

(4) if the assuming insurer is an association, including incorporated and individual unincorporated underwriters, maintains a minimum solvency or capital ratio:

(i) in the reciprocal jurisdiction where the assuming insurer has its head office or is domiciled; and

(ii) where it is also licensed;

(5) agrees and provides adequate assurance to the Commissioner, in a form the Commissioner specifies by regulation, to provide prompt written notice and explanation to the Commissioner:

(i) if the assuming insurer falls below any minimum requirement set forth in item (2), (3), or, if applicable, (4) of this subsection; or

(ii) if any regulatory action is taken against the assuming insurer for serious noncompliance with applicable law;

(6) consents in writing to:

(i) the jurisdiction of the courts of the State;

(ii) the appointment of the Commissioner as agent for service of process; and

(iii) if the Commissioner requires, include in the reinsurance agreement the appointment of the Commissioner as agent for service of process;

(7) consents in writing to pay all final judgments, wherever enforcement is sought, obtained by a ceding insurer or its legal successor, that have been declared enforceable in the jurisdiction where the judgment was obtained;

(8) agrees to include in each reinsurance agreement a provision requiring the assuming insurer to provide security in an amount equal to 100% of the assuming insurer's liabilities attributable to reinsurance ceded under that agreement if the assuming insurer resists:

(i) enforcement of a final judgment that is enforceable under the law of the jurisdiction where the judgment was obtained; or

(ii) a properly enforceable arbitration award, whether obtained by the ceding insurer or by its legal successor on behalf of the ceding insurer's resolution estate;

(9) confirms that:

(i) the assuming insurer is not participating in any solvent scheme of arrangement that involves the State's ceding insurers; or

(ii) if the assuming insurer enters into a solvent scheme of arrangement:

1. the assuming insurer agrees to notify the ceding insurer and the Commissioner; and

2. the assuming insurer will provide security in an amount equal to 100% of the assuming insurer's liabilities to the ceding insurer, in a form consistent with the requirements of §§ 5–908 through 5–911 and 5–914 of this subtitle and as the Commissioner specifies by regulation;

(10) on request by the Commissioner, provides, on behalf of the assuming insurer and any legal predecessors, documentation to the Commissioner required under regulations the Commissioner adopts;

(11) maintains a practice of prompt payment of claims under reinsurance agreements, in accordance with regulations the Commissioner adopts; and

(12) has a supervisory authority that confirms to the Commissioner on an annual basis that the assuming insurer complies with the requirements of items (2), (3), and, if applicable, (4) of this subsection:

(i) as of the immediately preceding December 31; or

(ii) at the annual date otherwise statutorily reported to the reciprocal jurisdiction.

(b) (1) The Commissioner shall timely create and publish a list of reciprocal jurisdictions.

(2) The Commissioner's list shall:

(i) include any reciprocal jurisdiction as defined in § 5–901(g)(1) and (2) of this subtitle; and

(ii) consider any other reciprocal jurisdiction included on the NAIC list of reciprocal jurisdictions published through the NAIC committee process.

(3) The Commissioner may approve a jurisdiction that does not appear on the NAIC list of reciprocal jurisdictions in accordance with regulations the Commissioner adopts.

(4) (i) The Commissioner may not remove a jurisdiction that meets the requirements of a reciprocal jurisdiction from the list of reciprocal jurisdictions.

(ii) 1. Except as provided in subsubparagraph 2 of this subparagraph, the Commissioner may remove a jurisdiction from the list of reciprocal jurisdictions on a determination that the jurisdiction no longer meets the requirements of a reciprocal jurisdiction in accordance with a process set forth in regulations the Commissioner adopts.

2. The Commissioner may not remove from the list of reciprocal jurisdictions a jurisdiction as defined in § 5–901(g)(1) or (2) of this subtitle.

(5) On removal of a jurisdiction from the list of reciprocal jurisdictions, credit for reinsurance ceded to an assuming insurer that has its home office or is domiciled in that jurisdiction shall be allowed, if otherwise allowed under this subtitle.

(c) (1) The Commissioner shall timely create and publish a list of assuming insurers that have satisfied the conditions set forth in this section and to which cessions shall be granted credit in accordance with this section.

(2) The Commissioner may add an assuming insurer to the list under paragraph (1) of this subsection:

(i) if an NAIC–accredited jurisdiction has added the assuming insurer to a list of assuming insurers; or

(ii) if, on initial eligibility, the assuming insurer submits information to the Commissioner:

1. as required under subsection (a)(5) through (9) of this section; and

2. complies with any additional requirements that the Commissioner may impose by regulation, except to the extent that the requirements conflict with an applicable covered agreement.

(d) (1) If the Commissioner determines that an assuming insurer no longer meets one or more of the requirements under this section, the Commissioner may revoke or suspend the eligibility of the assuming insurer for recognition under this subsection in accordance with procedures set forth in regulation.

(2) While an assuming insurer's eligibility is suspended:

(i) a reinsurance agreement issued, amended, or renewed after the effective date of the suspension may not qualify for credit; but

(ii) credit may be allowed only to the extent that the assuming insurer's obligations under the contract are secured in accordance with § 5–914 of this subtitle.

(3) If an assuming insurer's eligibility is revoked:

(i) credit for reinsurance may not be granted after the effective date of the revocation with respect to:

1. any reinsurance agreements entered into by the assuming insurer after the date of revocation; or

2. any reinsurance agreements entered into prior to the date of revocation; but

(ii) credit for reinsurance may be granted to the extent that the assuming insurer's obligations under the contract are secured in a form acceptable to the Commissioner and consistent with § 5–914 of this subtitle.

(e) Subject to a legal process of rehabilitation, liquidation, or conservation, the ceding insurer or its representative may seek or obtain an order requiring the assuming insurer to post security for all outstanding liabilities if the court in which proceedings are pending determines the order appropriate.

(f) Except as expressly prohibited by this subtitle or other law, this section does not limit or alter the capacity of parties to a reinsurance agreement to agree on requirements for security or other terms in that reinsurance agreement.

(g) (1) Credit may be taken under this section:

(i) only for reinsurance agreements entered into, amended, or renewed on or after the date when the assuming insurer has satisfied the requirements to assume reinsurance under this section; and

(ii) only with respect to losses incurred and reserves reported on or after the later of:

1. the date when the assuming insurer has met all eligibility requirements under subsection (a) of this section; or

2. the effective date of the new reinsurance agreement, amendment, or renewal.

(2) If credit is not available under this section, this section does not alter or impair a ceding insurer's right to take credit for reinsurance if the reinsurance qualifies for credit under another provision of this subtitle.

(3) Except as allowed by the terms of the agreement, this section does not authorize an assuming insurer to withdraw or reduce the security provided under any reinsurance agreement.

(4) This section does not limit or in any way alter the capacity of parties to any reinsurance agreement to renegotiate the agreement.

(h) (1) This section does not preclude an assuming insurer from providing the Commissioner with information on a voluntary basis.

(2) Subsection (a)(6) of this section does not limit or alter the capacity of parties to a reinsurance agreement to agree to alternative dispute resolution mechanisms, except to the extent those agreements are unenforceable under insolvency or delinquency laws.

§5–1001.

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

(b) "Subject of insurance" includes, as to insurance against fire and hazards other than windstorm, earthquake, or other catastrophe hazards, all properties that:

(1) are insured by the same insurer; and

(2) customarily are considered by underwriters to be subject to loss or damage from the same fire or the same occurrence of the hazard insured against.

(c) "Surplus to policyholders" means an insurer's capital, surplus, and voluntary reserves.

§5–1002.

(a) This subtitle does not apply to:

(1) life insurance;

(2) health insurance;

(3) annuities;

(4) title insurance;

(5) wet marine and transportation insurance;

(6) workers' compensation insurance;

(7) employer's liability coverage; or

(8) a policy or type of coverage as to which the maximum possible loss to the insurer cannot be readily ascertained when the policy is issued or the coverage is provided.

(b) As to alien insurers, this subtitle applies only to risks and surplus to policyholders of an alien insurer's United States branch.

§5–1003.

(a) (1) Subject to § 5-1004 of this subtitle and except as provided under § 5-1005 of this subtitle, an insurer may not retain a risk on any one subject of insurance, whether located or to be performed in the State or outside of the State, in an amount exceeding 10% of the insurer's surplus to policyholders.

(2) An insurer's surplus to policyholders shall be determined at the time a risk is assumed from the more recent of:

(i) the last sworn statement of the insurer on file with the Commissioner; or

(ii) the last examination report of the insurer.

(b) In determining the amount of risk retained by an insurer, a deduction shall be made for reinsurance ceded by the insurer for which credit is allowed under § 5-904 of this title.

§5–1004.

(a) A surety insurer may execute transportation or warehousing bonds for federal internal revenue taxes in a net amount not exceeding 20% of the surety insurer's surplus to policyholders, determined under § 5-1003(a)(2) of this subtitle.

(b) The net amount of exposure on any one surety risk shall be deemed within the 10% limit established by § 5-1003(a)(1) of this subtitle if the surety insurer is protected in excess of that amount:

(1) by authorized reinsurance;

(2) by the cosuretyship of another surety insurer authorized to engage in the surety insurance business in the State;

(3) by a deposit of property with the surety insurer in pledge or a conveyance of property to the surety insurer in trust for the protection of the surety insurer;

(4) by a conveyance or mortgage of property for the protection of the surety insurer; or

(5) if a suretyship or guaranty obligation was made on behalf of or on account of a fiduciary holding property in a trust capacity, by a deposit or other disposition of a part of the property held in trust that prohibits the sale, mortgage, or other disposition of the property without the consent of the surety insurer or a court order or decree.

(c) In determining the net amount of exposure on any one surety risk:

(1) when the amount of a suretyship obligation exceeds the actual amount of the judgment that is being appealed and that is secured by a bond, or exceeds the amount of the subject matter in controversy, or exceeds the amount of the estate held by the fiduciary for the performance of whose duties a bond is conditioned, the actual amount of the judgment, the subject matter in controversy, or the estate not subject to the supervision or control of the surety insurer shall be used as the basis for determining whether the risk exceeds the 10% limit established by § 5-1003(a)(1) of this subtitle; and

(2) when the amount of a suretyship obligation required for the performance of a contract exceeds the contract price, the contract price shall be used as the basis for determining whether the risk exceeds the 10% limit established by § 5-1003(a)(1) of this subtitle.

(d) In addition to any other limitation contained in this article, a surety insurer may not be exposed at any one time to risks on suretyship obligations that guaranty the deposits of a single financial institution in an aggregate net amount exceeding 10% of the surety insurer's surplus to policyholders, determined under § 5-1003(a)(2) of this subtitle, unless the surety insurer is protected in excess of that amount as provided in subsection (b) of this section.

§5–1005.

The Commissioner may establish by regulation limits on the risk retained by an insurer for a subject of financial guaranty insurance, including requirements for contingency reserves used in determining compliance with the applicable risk limits.

§6–101.

(a) The following persons are subject to taxation under this subtitle:

(1) a person engaged as principal in the business of writing insurance contracts, surety contracts, guaranty contracts, or annuity contracts;

(2) a managed care organization authorized by Title 15, Subtitle 1 of the Health – General Article;

(3) a for–profit health maintenance organization authorized by Title 19, Subtitle 7 of the Health – General Article;

(4) an attorney in fact for a reciprocal insurer; and

(5) a credit indemnity company.

(b) The following persons are not subject to taxation under this subtitle:

(1) a nonprofit health service plan corporation that meets the requirements established under §§ 14–106 and 14–107 of this article;

(2) a fraternal benefit society;

(3) a surplus lines broker, who is subject to taxation in accordance with Title 3, Subtitle 3 of this article;

(4) an unauthorized insurer, who is subject to taxation in accordance with Title 4, Subtitle 2 of this article;

(5) a nonprofit health maintenance organization authorized by Title 19, Subtitle 7 of the Health – General Article that is exempt from taxation under § 501(c)(3) of the Internal Revenue Code; and

(6) the Maryland Automobile Insurance Fund.

§6–102.

(a) A tax is imposed on all new and renewal gross direct premiums of each person subject to taxation under this subtitle that are:

(1) allocable to the State; and

(2) written during the preceding calendar year.

(b) Premiums to be taxed include:

(1) the consideration for a surety contract, guaranty contract, or annuity contract;

(2) gross receipts received as a result of capitation payments, supplemental payments, and bonus payments, made to a managed care organization for provider services to an individual who is enrolled in a managed care organization;

(3) subscription charges or other amounts paid to a for–profit health maintenance organization on a predetermined periodic rate basis by a person other than a person subject to the tax under this subtitle as compensation for providing health care services to members;

(4) dividends on life insurance policies that have been applied to buy additional insurance or to shorten the period during which a premium is payable;

(5) the part of the gross receipts of a title insurer that is derived from insurance business or guaranty business; and

(6) the amount allocable to travel insurance, excluding any amount received for travel assistance services or cancellation fee waivers, sold to:

(i) an individual primary policyholder who is a resident of the State;

(ii) a primary certificate holder who:

1. is a resident of the State; and

2. elects coverage under a group travel insurance policy; or

(iii) a blanket travel insurance policyholder that:

1. is a resident of the State or has its principal place of business or the principal place of an affiliate or subsidiary in the State; and

2. has purchased blanket travel insurance in the State for eligible blanket group members, subject to any apportionment rules that:

A. apply to the insurer across multiple taxing jurisdictions; or

B. allow the insurer to allocate premiums on an apportioned basis in a reasonable and equitable manner in those jurisdictions.

(c) Premiums not to be taxed include:

(1) premiums on policies covering weekly disability benefits on which premiums are payable weekly; or

(2) credits allowed on premiums under policies of industrial insurance because of payment being made to the home office or a branch office of the insurer.

(d) (1) Gross direct premiums or parts of gross direct premiums that are derived from or reasonably attributable to insurance business in the State shall be allocated to the State.

(2) By regulation, the Commissioner may require or allow a method of allocating gross direct premiums written by a person subject to taxation under this subtitle that justly and fairly determines the part of the gross direct premiums that is derived from or reasonably attributable to the person's insurance business in the State.

(e) (1) Funds accepted by a life insurer under a group contract that provides for an accumulation of funds to buy annuities at future dates may be considered as "gross premiums written":

(i) on receipt of the funds; or

(ii) on the actual application of the funds to buy annuities.

(2) Any funds taxed on receipt and any interest later credited to those funds are not subject to taxation on the purchase of annuities.

(3) Any interest credited to funds that are not taxed on receipt also shall be included in "gross premiums written".

(4) Each life insurer shall elect between alternatives in paragraph (1) of this subsection.

(5) A life insurer may not change an election between alternatives in paragraph (1) of this subsection without the consent of the Commissioner.

(6) If funds that have been taxed as gross premiums are withdrawn before actually applied to buy annuities, the funds are eligible to be included as returned premiums if otherwise eligible under § 6–104(a)(1) of this subtitle.

(f) For purposes of determining the premiums subject to taxation under subsection (b)(6) of this section, a travel insurer shall document the state of residence, which shall be:

(1) for individual policies, the primary policyholder's state, as specified by the primary policyholder during the purchase of the policy;

(2) for group policies, the primary certificate holder's state, as specified during the purchase of the coverage; or

(3) for blanket policies, the state of the principal place of business of the primary blanket policyholder, affiliate, or subsidiary, as specified during the purchase of the policy.

§6–102.1. IN EFFECT

(a) This section applies to:

(1) an insurer, a nonprofit health service plan, a health maintenance organization, a dental plan organization, a fraternal benefit organization, and any other person subject to regulation by the State that provides a product that:

(i) was subject to § 9010 of the Affordable Care Act, as in effect on December 1, 2019; and

(ii) may be subject to an assessment by the State; and

(2) a managed care organization authorized under Title 15, Subtitle 1 of the Health – General Article.

(b) The purpose of this section is to assist in the stabilization of the individual health insurance market by assessing a health insurance provider fee that is attributable to State health risk for calendar years 2019 through 2028, both inclusive, as provided for under subsection (c) of this section.

(c) (1) In calendar year 2019, in addition to the amounts otherwise due under this subtitle, an entity subject to this section shall be subject to an assessment of 2.75% on all amounts used to calculate the entity's premium tax liability under § 6–102 of this subtitle or the amount of the entity's premium tax exemption value for calendar year 2018.

(2) In calendar years 2020 through 2028, both inclusive, in addition to the amounts otherwise due under this subtitle, an entity subject to this section shall be subject to an assessment of 1% on all amounts used to calculate the entity's premium tax liability under § 6–102 of this subtitle or the amount of the entity's premium tax exemption value for the immediately preceding calendar year.

(3) The assessments required in paragraphs (1) and (2) of this subsection are for products that:

(i) were subject to § 9010 of the Affordable Care Act, as in effect on December 1, 2019; and

(ii) may be subject to an assessment by the State.

(4) The calculation of the assessments required under paragraphs (1) and (2) of this subsection shall be made without regard to:

(i) the threshold limits established in § 9010(b)(2)(A) of the Affordable Care Act; or

(ii) the partial exclusion of net premiums provided for in § 9010(b)(2)(B) of the Affordable Care Act.

(d) (1) (i) In each of fiscal years 2021 and 2022, $100,000,000 of the funds collected from the assessment required under this section shall be transferred in accordance with subparagraphs (ii) and (iii) of this paragraph to Medical Care Provider Reimbursements (M00Q01.03) within the Medical Care Programs Administration of the Maryland Department of Health.

(ii) If all or a portion of the funds required to be transferred under subparagraph (i) of this paragraph have been received and are held in the Maryland Health Benefit Exchange Fund established under § 31–107 of this article, the Governor shall transfer the available amount in the Fund.

(iii) If the amount of funds transferred under subparagraph (ii) of this paragraph is less than the amount required to be transferred under subparagraph (i) of this paragraph, the Insurance Commissioner shall transfer the remaining amount from the funds collected from the assessment required under this section.

(2) At the beginning of each of fiscal years 2023 and 2024, the Governor shall transfer the first $8,000,000 of the funds collected from the assessment required under this section to the Community Health Resources Commission.

(3) Notwithstanding § 2–114 of this article, the remainder of the assessment required under this section after any transfers made under paragraphs (1) and (2) of this subsection shall be distributed by the Commissioner to the Maryland Health Benefit Exchange Fund established under § 31–107 of this article.

§6–102.1. ** CONTINGENCY – NOT IN EFFECT – CHAPTERS 597 AND 598 OF 2019 **

(a) (1) This section applies to:

(i) except as provided in paragraph (2) of this subsection, an insurer, a nonprofit health service plan, a health maintenance organization, a dental plan organization, a fraternal benefit organization, and any other person subject to regulation by the State that provides a product that:

1. was subject to the fee under § 9010 of the Affordable Care Act, as in effect on December 1, 2019; and

2. may be subject to an assessment by the State; and

(ii) a managed care organization authorized under Title 15, Subtitle 1 of the Health – General Article.

(2) This section does not apply to a stand–alone dental plan carrier or a stand–alone vision plan carrier.

(b) The purpose of this section is to recoup the aggregate amount of the health insurance provider fee that otherwise would have been assessed under § 9010

of the Affordable Care Act that is attributable to State health risk for calendar year 2019 as a bridge to stability in the individual health insurance market.

(c) (1) In calendar year 2019, in addition to the amounts otherwise due under this subtitle, an entity subject to this section shall be subject to an assessment of 2.75% on all amounts used to calculate the entity's premium tax liability under § 6–102 of this subtitle or the amount of the entity's premium tax exemption value for calendar year 2018.

(2) Notwithstanding § 2–114 of this article, the assessment required under this section shall be distributed by the Commissioner to the Maryland Health Benefit Exchange Fund established under § 31–107 of this article.

§6–103.

The tax rate is:

(1) 0% for premiums for annuities; and

(2) 2% for all other premiums, including:

(i) gross receipts received as a result of capitation payments made to a managed care organization, supplemental payments, and bonus payments; and

(ii) subscription charges or other amounts paid to a for-profit health maintenance organization.

§6–103.1.

Notwithstanding § 2–114 of this article, beginning July 1, 2017, from the tax imposed on the health insurers under this subtitle, $500,000 shall be distributed annually to the Advance Directive Program Fund created under § 5–626 of the Health – General Article.

§6–103.2.

(a) (1) (i) Notwithstanding § 2–114 of this article, beginning January 1, 2015, from the tax described in paragraph (2) of this subsection, a portion shall be distributed annually to the Maryland Health Benefit Exchange Fund established under § 31–107 of this article for the sole purpose of funding the operation and administration of the Maryland Health Benefit Exchange.

(ii) The operation and administration of the Maryland Health Benefit Exchange may include functions delegated by the Maryland Health Benefit Exchange to a third party under law or by contract.

(2) (i) The distribution under paragraph (1) of this subsection shall be allocated from the tax imposed on a person under § 6–102 of this subtitle on premiums for health insurance.

(ii) For purposes of this paragraph, "person" does not include:

1. a managed care organization authorized by Title 15, Subtitle 1 of the Health – General Article; or

2. a for–profit health maintenance organization authorized by Title 19, Subtitle 7 of the Health – General Article.

(b) For State fiscal year 2015 and each State fiscal year thereafter, the amount to be distributed under subsection (a) of this section shall be sufficient to fully fund the operation and administration of the Maryland Health Benefit Exchange for the State fiscal year.

§6–104.

(a) Subject to subsection (b) of this section, in computing the tax under this section, the following deductions from gross direct premiums allocable to the State are allowed:

(1) returned premiums, not including surrender values;

(2) dividends that are:

(i) paid or credited to policyholders; or

(ii) applied to buy additional insurance or to shorten the period during which premiums are payable; and

(3) returns or refunds made or credited to policyholders because of retrospective ratings or safe driver rewards.

(b) Deductions from gross direct premiums are allowed only to the extent that the deductions are properly allocable to premiums subject to tax.

(c) (1) Subject to paragraph (2) of this subsection, any insurer that has its home office in this State shall be entitled to a credit against the total amount of

the taxes payable by the insurer under this subtitle equal to the amount of all retaliatory taxes imposed on the insurer in other states as a result of its payment of the assessment fee required under Title 2, Subtitle 5 of this article.

(2) The aggregate total amount that may be credited to all qualifying insurers under this section may not exceed $1 million in any fiscal year.

(3) If the credit available to insurers under paragraph (2) of this subsection is insufficient to offset the retaliatory taxes attributable to the imposition of the assessment fee under Title 2, Subtitle 5 of this article, the available credit shall be apportioned among those insurers claiming the credit based on the ratio of gross direct written premium allocable to this State of the insurer claiming the credit to the total amount of gross direct written premium allocable to this State written by all insurers claiming the credit.

§6–105.

A person that is subject to taxation under this subtitle may claim a tax credit against the tax imposed for neighborhood and community assistance contributions as provided under § 6-404 of the Housing and Community Development Article.

§6–105.2.

A person subject to the tax imposed under this subtitle may claim a credit against the tax for a certified rehabilitation as provided under § 5A-303 of the State Finance and Procurement Article.

§6–105.3.

A stand–alone dental plan carrier or a stand–alone vision plan carrier that is subject to the health insurance provider fee assessment imposed under § 6–102.1 of this subtitle in calendar year 2024 and each calendar year thereafter is exempt from the health care regulatory assessment under § 2–112.2 of this article and the annual assessment fee under § 2–502 of this article for each year in which the health insurance provider fee is paid.

§6–106.

(a) Each person subject to taxation under this subtitle shall make a declaration of its estimated tax if the person's total tax for the current taxable year reasonably is expected to exceed $1,000.

(b) A person required to make a declaration of estimated tax shall:

(1) file with the Commissioner:

(i) an initial declaration of estimated tax on or before April 15 of the taxable year; and

(ii) a quarterly estimated tax report on or before June 15, September 15, and December 15 after filing the initial declaration; and

(2) pay to the Commissioner at least 25% of the tax estimated for the full taxable year with the initial declaration for that year and with each quarterly report for that year.

§6–107.

(a) On or before March 15 of each year, each person subject to taxation under this subtitle shall:

(1) file with the Commissioner:

(i) a report of the new and renewal gross direct premiums less returned premiums written by the person during the preceding calendar year;

(ii) a report of the gross receipts received as a result of capitation payments, supplemental payments, and bonus payments made to a managed care organization during the preceding calendar year; and

(iii) if the person issues perpetual policies of fire insurance, a report of the average amount of deposits held by the person during the preceding calendar year in connection with perpetual policies of fire insurance issued on property in the State and in force during any part of that year; and

(2) pay to the Commissioner the total amount of taxes imposed by this subtitle, as shown on the face of the report, after crediting the amount of taxes paid with the declaration of estimated tax and each quarterly report filed under § 6-106 of this subtitle.

(b) The reports shall be verified in the manner and contain the information that the Commissioner requires by regulation.

(c) A person that is not otherwise required to file a report with the Commissioner under this section shall file a report and pay the tax due if the person:

(1) claimed a credit for a previous year against the tax imposed under this subtitle for a certified rehabilitation as provided under § 5A-303 of the State Finance and Procurement Article; and

(2) is subject to the recapture of the credit as provided under § 5A-303 of the State Finance and Procurement Article.

(d) From the insurance premium tax revenue, the Administration shall distribute each quarter the amount necessary to administer the insurance premium tax laws in the previous quarter to an administrative account.

§6–108.

(a) A tax not paid when a report or declaration is due to be filed is subject to a penalty of 5% and interest at the rate determined under § 13-604(b) of the Tax - General Article from the date that the report or declaration was due.

(b) If an additional amount is found to be due after a report or declaration has been filed, the additional amount is subject to interest at 6% per year from the due date of the report or declaration until payment is made to the Commissioner.

(c) (1) Subject to paragraph (2) of this subsection, if an insurer that is required under § 2-113 of this article to pay a premium tax on or before the due date in immediately available funds fails to do so, the Commissioner shall assess a penalty and interest as provided in subsection (a) of this section on the unpaid tax from the date the tax is due to the date on which the funds from the tax payment become available to the State.

(2) The Commissioner may waive the penalty and interest on late payments under this subsection if the insurer proves that it:

(i) made a good faith effort to comply with the requirements of § 2-113 of this article; and

(ii) exercised due diligence to initiate payment correctly and on a timely basis.

(3) This subsection does not affect any other requirement of law for the payment of premium taxes or licensing fees by an insurer.

§6–109.

(a) The Commissioner shall examine and audit each report as soon as practicable after receipt.

(b) (1) If the amount of tax computed by the Commissioner is greater than the amount shown on the report, the Commissioner shall:

(i) assess the excess amount; and

(ii) mail, or send by electronic means in accordance with § 2–116 of this article, notice of the assessment to the person that filed the report.

(2) The Commissioner shall make an assessment within 3 years after the date on which the report was due.

(3) The Commissioner may make an assessment at any time if the person failed to file a report or filed a fraudulent report.

(c) (1) If a person required to file a report under this subtitle fails to do so on or before the date the report is due, the Commissioner may:

(i) estimate the tax due by the insurer; and

(ii) assess a tax at no more than twice the estimated amount.

(2) The Commissioner shall mail, or send by electronic means in accordance with § 2–116 of this article, notice of the assessment to the person at:

(i) its mailing or e–mail address, if it has a mailing or e–mail address on file with the Commissioner; or

(ii) any other address of the person that appears on the records of the Commissioner, if there is no mailing or e–mail address on file with the Commissioner.

(3) If the person does not file the report within 15 days after the notice of assessment is mailed or sent electronically:

(i) the assessment is final; and

(ii) the amount of tax due on the assessment, including penalties and interest, shall be collected as other taxes are collected.

§6–110.

(a) A person may appeal to the Maryland Tax Court in accordance with § 13-510 of the Tax - General Article if the person is dissatisfied with:

(1) an assessment under § 6-109 of this subtitle; or

(2) a disallowance by the Commissioner of all or part of a claim for refund.

(b) An appeal under this section must be taken within 60 days after the earlier of delivery or mailing of a notice of:

(1) an assessment under § 6-109 of this subtitle; or

(2) disallowance of a claim for refund under § 13-904 of the Tax - General Article.

§6–111.

(a) If the person subject to taxation under this subtitle dissolves or voluntarily or involuntarily retires from the State, the dissolution or retirement does not defeat the filing of reports and the assessment and collection of taxes imposed by this subtitle with respect to premiums written or deposits held during that part of the calendar year before the dissolution or retirement.

(b) (1) The person shall file the report required by this subtitle within 30 days after dissolution or retirement.

(2) However, if the person is taken over for liquidation or rehabilitation, the person shall file the report within 6 months after the person is taken over.

§6–112.

(a) Except for a property tax, a county or municipal corporation of the State may not impose a tax on a person subject to taxation under this subtitle.

(b) This section does not exempt shares of stock of a domestic corporation from the property tax and assessment merely because the shares are owned by a person subject to taxation under this subtitle.

§6–113.

A declaration or report that must be filed under this subtitle complies with the filing requirement if the declaration or report is:

(1) mailed and postmarked by the United States Postal Service on or before the filing date;

(2) delivered on or before the filing date to a private delivery service recognized by the Commissioner, if the delivery is evidenced by a receipt; or

(3) sent by electronic means in accordance with § 2–116 of this article.

§6–114.

An insurer may claim a credit against the premium tax for wages paid to qualified employees as provided under Title 6, Subtitle 3 of the Economic Development Article.

§6–115.

An insurer may claim a credit against the premium tax payable under this subtitle for:

(1) wages paid to a qualified employee with a disability; and

(2) (i) child care provided or paid for by the insurer for the children of a qualified employee with a disability as provided under § 21–309 of the Education Article; or

(ii) transportation provided or paid for by the insurer for a qualified employee with a disability as provided under § 21–309 of the Education Article.

§6–116.

An insurer may claim a State tax credit against the premium tax payable under this subtitle as provided under § 9-230 of the Tax - Property Article.

§6–117.

An insurer may claim a credit against the premium tax for employer-provided long-term care insurance as provided under § 10-710 of the Tax - General Article.

§6–119.

An insurer may claim a credit against the premium tax for One Maryland project costs and start–up costs as provided under Title 6, Subtitle 4 of the Economic Development Article.

§6–120.

An insurer may claim a credit against the premium tax for the cost of providing commuter benefits to the business entity's employees as provided under § 2-901 of the Environment Article.

§6–121.

(a) (1) In this section the following words have the meanings indicated.

(2) "Nonprofit health maintenance organization" means a health maintenance organization authorized by Title 19, Subtitle 7 of the Health – General Article that is exempt from taxation under § 501(c)(3) of the Internal Revenue Code.

(3) "Premium tax exemption value" means the amount of premium taxes that a nonprofit health maintenance organization would have been required to pay if the nonprofit health maintenance organization were not exempt from taxation under § 6–101(b)(5) of this subtitle.

(b) (1) Beginning in fiscal year 2022, a nonprofit health maintenance organization shall transfer funds in an amount equal to the premium tax exemption value of the nonprofit health maintenance organization to the Commissioner to distribute to the General Fund of the State to be used to support the provision of health care to eligible individuals in the Medical Assistance Program.

(2) Notwithstanding the allocation provided under § 19–803(b) of this article, the amount transferred to the Medical Assistance Program Account by a nonprofit health maintenance organization under paragraph (1) of this subsection:

(i) shall be allocated directly to the Medical Assistance Program Account; and

(ii) shall be counted towards the total allocation required to the Medical Assistance Program Account under § 19–803(b)(3)(ii)2, (iii)2, (iv)2, (v)2, (vi), and (vii) of this article.

(3) Beginning in fiscal year 2008 and annually thereafter, the amount under paragraph (2) of this subsection that is counted towards the total allocation under § 19–803(b)(3)(iv)2, (v)2, (vi), and (vii) of this article that exceeds the amount needed to increase both fee–for–service health care provider rates paid by

the Medical Assistance Program and managed care organization health care provider rates to a level of rates paid to similar providers for the same services under the federal Medicare fee schedule shall be transferred, unless otherwise provided in the State budget, to the Community Health Resources Commission Fund under Title 19, Subtitle 22 of the Health – General Article for the purpose of supporting office–based specialty care, diagnostic testing, and laboratory tests for individuals with family income that does not exceed 200% of the federal poverty level.

(c) A nonprofit health maintenance organization shall transfer to the Medical Assistance Program Account:

(1) on or before August 1, 2005, an amount equal to the premium tax exemption value of the nonprofit health maintenance organization for the last 6 months of fiscal year 2005; and

(2) within 30 days following the end of each calendar quarter, an amount equal to the premium tax exemption value of the nonprofit health maintenance organization for the quarter.

(d) On or before March 1 of each year, a nonprofit health maintenance organization shall file a report with the Commissioner establishing that the nonprofit health maintenance organization transferred funds equal to its premium tax exemption value during the preceding calendar year as required by this section.

§6–122.

An insurer may claim a tax credit for an investment of designated capital as provided under Title 10, Subtitle 4 of the Economic Development Article.

§6–201.

(a) The Commissioner shall collect a fraud prevention fee as provided in this subtitle.

(b) The fraud prevention fee is in addition to any fees, penalties, charges, or premium taxes imposed under this article.

§6–202.

(a) The Commissioner shall collect the fraud prevention fee.

(b) The total amount of the fraud prevention fee collected by the Commissioner shall be deposited in the Insurance Regulation Fund as provided in § 2-505 of this article.

§6–203.

(a) For each insurer, health maintenance organization, nonprofit health service plan, fraternal benefit society, or any entity operating in the State under the regulatory jurisdiction of the Commissioner other than a premium finance company, a fraternal benefit society that collected less than $75,000 in premiums in the preceding calendar year, or a motor club, the fraud prevention fee shall be:

(1) $1,000;

(2) due on or before June 30 of each year; and

(3) if applicable, payable with the certificate of authority or license renewal fee.

(b) For each insurance producer, public adjuster, insurance adviser, or third party administrator qualified, licensed, or registered by the Commissioner, the fraud prevention fee shall be:

(1) $15;

(2) due on or before June 30 of every other year; and

(3) if applicable, payable with the certificate of qualification, license, or registration renewal fee.

(c) Any person that has more than one of the certificates of qualification, licenses, or registrations listed in subsection (b) of this section shall pay the $15 fraud prevention fee only once per renewal period.

§6–204.

The Commissioner may adopt regulations to implement any provision of this subtitle.

§6–301.

(a) This subtitle does not apply to:

(1) personal income taxes;

(2) ad valorem taxes on real or personal property;

(3) special purpose obligations or assessments imposed by another state in connection with particular kinds of insurance other than property insurance; or

(4) assessments imposed by insurance guaranty associations or similar organizations in another state.

(b) Notwithstanding subsection (a) of this section, in determining the propriety and extent of retaliatory action under this subtitle, the Commissioner shall take into consideration deductions from premium taxes or other taxes otherwise payable, allowed for real or personal property taxes paid.

§6–302.

For purposes of this subtitle, the domicile of an alien insurer is:

(1) for an alien insurer formed under the laws of Canada or a province of Canada, the province in which its head office is located; and

(2) for any other alien insurer, the state in which its principal place of business in the United States is located.

§6–303.

(a) When by or pursuant to the laws of any other state or foreign country any taxes, licenses and other fees other than fees similar to the assessment fee established under Title 2, Subtitle 5 of this article, in the aggregate, and any fines, penalties, deposit requirements or other material obligations, prohibitions or restrictions are or would be imposed upon Maryland insurers, or upon the insurance producers or representatives of such insurers, which are in excess of such taxes, licenses and other fees, in the aggregate, or which are in excess of the fines, penalties, deposit requirements or other obligations, prohibitions, or restrictions directly imposed upon similar insurers, or upon the insurance producers or representatives of such insurers, of such other state or country under the statutes of this State, so long as such laws of such other state or country continue in force or are so applied, the same taxes, licenses and other fees, in the aggregate, or fines, penalties or deposit requirements or other material obligations, prohibitions, or restrictions of whatever kind shall be imposed by the Commissioner upon the insurers, or upon the insurance producers or representatives of such insurers, of such other state or country doing business or seeking to do business in Maryland.

(b) For the purposes of this subtitle, any tax, license or other fee or other obligation imposed by a political subdivision or agency of another state or country

upon Maryland insurers or their insurance producers or representatives shall be deemed to be imposed by that state or country.

§6–304.

All taxes imposed by this subtitle that are not paid within 30 days after the Commissioner issues the notice of the amount due are subject to a penalty of 5% and interest at the rate determined under § 13-604 of the Tax - General Article for each month after the date of the notice that the tax was due.

§6–305.

Unless the Administration and the Central Collection Unit of the Department of Budget and Management agree otherwise, the Administration may not refer to the Unit any action to recover money under this subtitle.

§7–101.

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

(b) "Affiliate" means a person that directly or indirectly, through one or more intermediaries, controls, is controlled by, or is under common control with another person.

(c) "Control", "controlling", "controlled by", or "under common control with" means the direct or indirect possession of the power to direct or cause the direction of the management and policies of a person, through ownership of voting securities or of securities convertible into voting securities, by contract other than a commercial contract for goods or nonmanagement services, or otherwise, whether or not the power is exercised or sought to be exercised unless the power is the result of an official position with or corporate office held by the person.

(d) (1) "Enterprise risk" means any activity, circumstance, event, or series of events involving one or more affiliates of an insurer that, if not remedied promptly, is likely to have a material adverse effect on the financial condition or liquidity of the insurer or its insurance holding company system as a whole.

(2) "Enterprise risk" includes anything that would:

(i) cause the insurer's risk based capital to fall to or below a company action level under Title 4, Subtitle 3 of this article; or

(ii) cause the insurer to be in a hazardous financial condition under § 9–102 of this article.

(e) "Group capital calculation instructions" means the group capital calculation instructions adopted by the NAIC, as amended from time to time.

(f) "Insurance holding company" means a person that directly or indirectly controls an insurer or controls a person that controls an insurer.

(g) "Insurance holding company system" means two or more affiliates, at least one of which is an insurer.

(h) "Lead state commissioner" means the lead state insurance commissioner of the insurance holding company system as determined by the procedures in the NAIC Financial Analysis Handbook.

(i) "NAIC" means the National Association of Insurance Commissioners.

(j) "NAIC liquidity stress test framework" means a separate NAIC publication that includes, as adopted by the NAIC and as amended:

(1) a history of the NAIC's development of regulatory liquidity stress testing;

(2) the scope criteria applicable for a specific data year; and

(3) the liquidity stress test instructions and reporting templates for a specific data year.

(k) "Scope criteria" means the designated exposure bases along with minimum magnitudes of exposure for the specified data year, as detailed in the NAIC liquidity stress test framework, used to establish a preliminary list of insurers considered included in the scope of the NAIC liquidity stress test framework for that data year.

(l) "Subsidiary" means an affiliate of a person that, directly or indirectly, through one or more intermediaries, is controlled by that person.

(m) "Ultimate controlling person" means the person within a holding company system that is not controlled by any other person.

§7–102.

(a) The General Assembly finds that the public interest and the interest of policyholders and stockholders may be adversely affected when:

(1) control of an insurer is sought by a person that would use that control adversely to the best interest of policyholders or stockholders;

(2) acquisition of control of an insurer would substantially lessen competition or create a monopoly in the insurance business in the State;

(3) an insurer that is part of an insurance holding company system enters into transactions or relationships with affiliates on terms that are not fair and reasonable; or

(4) an insurer pays to stockholders dividends that jeopardize the financial condition of the insurer.

(b) The purposes of this title include promoting the public interest by:

(1) requiring disclosures in acquisitions or mergers;

(2) requiring disclosures of material transactions, relationships between an insurer and its affiliates, and dividends to stockholders paid by insurers;

(3) requiring disclosures of relevant information about changes in control of insurers;

(4) providing standards governing material transactions between an insurer and its affiliates; and

(5) establishing penalties for failure to disclose and providing for the disapproval of certain transactions.

§7–103.

(a) Except as otherwise specifically provided, the provisions of this title are intended to apply to authorized insurers.

(b) The provisions of this title that apply to an authorized insurer or a domestic insurer also apply to:

(1) a nonprofit health service plan licensed under Title 14, Subtitle 1 of this article; and

(2) a mutual insurance holding company formed under § 3-121.1 of this article.

§7–104.

(a) (1) Control is presumed to exist if a person directly or indirectly owns, directs the voting of, holds with the power to vote, or holds proxies representing 10% or more of the voting securities of another person.

(2) However, control is not presumed to exist if proxies have been obtained by an official of the person solely in connection with voting at a meeting of the owners of the person.

(b) The presumption of control may be rebutted by showing by a preponderance of the evidence that control does not exist in fact.

(c) (1) Notwithstanding the presumption of control, the Commissioner, on application of an insurer, may find that a person presumed to control an insurer or person does not have control of the insurer or person.

(2) In addition, the Commissioner, after notice and an opportunity to be heard, may find that a person not presumed to have control of an insurer or person does have control of the insurer or person.

§7–105.

(a) For purposes of this title, in determining whether an insurer's assets and surplus as regards policyholders are reasonable in relation to the insurer's outstanding liabilities and adequate to its financial needs, the following factors, among others, shall be considered:

(1) the size of the insurer as measured by its assets, capital and surplus, reserves, premium writings, insurance in force, and other appropriate criteria;

(2) the extent to which the insurer's business is diversified among the several lines of insurance;

(3) the number and size of risks insured in each line of insurance;

(4) the geographical dispersion of the insurer's insured risks;

(5) the nature and extent of reinsurance of the insurer's risks;

(6) the quality, diversification, and liquidity of the insurer's investment portfolio;

(7) the recent past and projected future trends in the size of the insurer's surplus as regards policyholders;

(8) the surplus as regards policyholders maintained by comparable insurers;

(9) the quality and liquidity of investments in and other transactions with affiliates;

(10) the adequacy of the reserves of the insurer;

(11) the quality of the earnings of the insurer and the extent to which the reported earnings include extraordinary items; and

(12) the recent past and projected future trends in the size and quality of the insurer's investment portfolio.

(b) The Commissioner may discount an investment or treat an investment under subsection (a)(9) of this section as a nonadmitted asset for purposes of determining the adequacy of surplus as regards policyholders whenever the investment so warrants.

§7–106.

(a) Except as provided in subsections (b) and (c) of this section or otherwise by law, all information and documents that are filed with the Commissioner in compliance with the requirements of this title or that are reported to, obtained by, or otherwise disclosed to the Commissioner or any other person in the course of an examination or investigation made under this title:

(1) are confidential material;

(2) are not subject to subpoena;

(3) may not be made public by the Commissioner, the NAIC, or any other person; and

(4) are not subject to discovery or admissible in evidence in any civil action.

(b) Material that otherwise is confidential under subsection (a) of this section may be made public by any person who has received the prior written consent of the person to whom the material relates.

(c) If, after giving the person to whom the material relates notice and an opportunity to be heard, the Commissioner determines that it is in the interest of the policyholders, stockholders, or the public to make public any material relating to the person that otherwise is confidential under subsection (a) of this section, the Commissioner may make public all or part of the material in an appropriate manner.

(d) (1) In addition to the protections afforded confidential information filed under this title and § 2–209 of this article, the following provisions apply expressly to confidential information that is in the control or possession of the Commissioner and reported or provided to the Commissioner in accordance with § 7–603(i) and (j) of this title.

(2) Except as provided in paragraph (3) of this subsection, the document, material, or information:

(i) is recognized as being proprietary and to contain trade secrets;

(ii) is confidential and privileged;

(iii) is not subject to the Public Information Act;

(iv) is not subject to subpoena; and

(v) is not subject to discovery or admissible in evidence in any private civil action.

(3) The Commissioner may use any document, material, or information that is subject to this subsection to further any regulatory or legal action brought as part of the duties of the Commissioner.

(4) The Commissioner and any person that receives a document, material, or information that is subject to this subsection while acting under the authority of the Commissioner may not be allowed or required to testify in any private civil action concerning the document, material, or information.

(5) Except as provided in paragraph (3) of this subsection, for purposes of the information reported and provided to the Commissioner under § 7–603(i) of this title, the Commissioner shall maintain the confidentiality of the group capital calculation and group capital ratio produced within the calculation and any group capital information received from an insurance holding company supervised by the Federal Reserve Board or any U.S. group–wide supervisor.

(6) Except as provided in paragraph (3) of this subsection, for purposes of the information reported and provided to the Commissioner under § 7–603(j) of this title, the Commissioner shall maintain the confidentiality of the liquidity stress test results and supporting disclosures and any liquidity stress test information received from an insurance holding company supervised by the Federal Reserve Board and non–U.S. group–wide supervisors.

(7) In order to assist in the performance of the Commissioner's duties, the Commissioner:

(i) except as provided in item (ii) of this paragraph, may share documents, materials, or other information, including confidential and privileged information, that may include proprietary and trade secret documents and materials with other state, federal, and international regulatory agencies, the NAIC, any third–party consultants designated by the Commissioner, and state, federal, and international law enforcement authorities, including members of any supervisory college described in § 2–209.1 of this article, if the recipient:

1. agrees in writing to maintain the confidentiality and privileged status of the document, material, or other information; and

2. has verified in writing the legal authority to maintain confidentiality;

(ii) may share only confidential and privileged documents, material, or information reported under § 7–603(h) of this title with the commissioners of states having statutes or regulations substantially similar to this section and who have agreed in writing not to disclose the information;

(iii) 1. may receive documents, materials, or information, including otherwise confidential and privileged documents, materials, and information, that may include proprietary and trade secret information from the NAIC and its affiliates and subsidiaries and from regulatory and law enforcement officials of other foreign or domestic jurisdictions; and

2. shall maintain as confidential and privileged any document, material, or information received with notice or the understanding that it is confidential or privileged under the laws of the jurisdiction that is the source of the document, material, or information; and

(iv) shall enter into written agreements with the NAIC and any third–party consultant designated by the Commissioner governing the sharing and use of information provided in accordance with this title and consistent with this section.

(8) An agreement entered into under paragraph (7)(iv) of this subsection shall:

(i) specify procedures and protocols regarding confidentiality and security of information shared with the NAIC or a third–party consultant designated by the Commissioner under this title, including procedures and protocols for the sharing of the information by the NAIC with other state, federal, or international regulators;

(ii) provide that the recipient agrees in writing to maintain the confidentiality and privileged status of the documents, materials, and other information and has verified in writing the legal authority to maintain the confidentiality;

(iii) specify that ownership of information shared with the NAIC or a third–party consultant under this title remains with the Commissioner and the use of the information is subject to the direction of the Commissioner;

(iv) excluding documents, material, or information reported under § 7–603(j) of this title, prohibit the NAIC or a third–party consultant designated by the Commissioner from storing the information shared under this title in a permanent database after the underlying analysis is completed;

(v) require prompt notice to be given to an insurer whose confidential information in the possession of the NAIC or a third–party consultant designated by the Commissioner is subject to a request or subpoena to the NAIC or a third–party consultant designated by the Commissioner for disclosure or production;

(vi) require the NAIC or a third–party consultant designated by the Commissioner to consent to intervention by an insurer in any judicial or administrative action in which the NAIC or a third–party consultant designated by the Commissioner may be required to disclose confidential information about the insurer shared by the NAIC or a third–party consultant designated by the Commissioner; and

(vii) for documents, material, or information reported under § 7–603(j) of this title, provide for the notification of the identity of the consultant to the applicable insurers, in the case of an agreement involving a third–party consultant.

(9) (i) The sharing of information by the Commissioner under this title may not constitute a delegation of regulatory authority or rulemaking.

(ii) The Commissioner is solely responsible for the administration, execution, and enforcement of this title.

(10) A waiver of any applicable privilege or claim of confidentiality in the documents, materials, or information may not occur as a result of disclosure to the Commissioner or as a result of sharing as authorized in this section.

(11) The group capital calculation and resulting group capital ratio required under § 7–603(i) of this title and the liquidity stress test along with its results and supporting disclosures required under § 7–603(j) of this title are regulatory tools for assessing group risks and capital adequacy and group liquidity risks, respectively, and are not intended as a means to rank insurers or insurance holding company systems generally.

(12) Disclosure of group capital calculation, group capital ratio, liquidity stress test results, or supporting disclosures by any insurer, broker, or other person engaged in any manner of the insurance business is subject to the following:

(i) except as provided in item (ii) of this paragraph or as otherwise required by this title, the direct or indirect disclosure, in any written, electronic, or other manner as an advertisement, an announcement or a statement containing a representation, or a statement with regard to the group capital calculation, group capital ratio, the liquidity stress test results, or supporting disclosures for the liquidity stress test of any insurer or any insurer group, or of any component derived in the calculation by any insurer, broker, or other person engaged in any manner in the insurance business would be misleading and is therefore prohibited; and

(ii) the insurer may publish announcements in a written publication if:

1. any materially false statement with respect to the group capital calculation, resulting group capital ratio, an inappropriate comparison of any amount to an insurer's or insurance group's group capital calculation or resulting group capital ratio, liquidity stress test result, supporting disclosures for the liquidity stress test, or an inappropriate comparison of any amount to an insurer's or insurance group's liquidity stress test result or supporting disclosures is published in any written publication and the insurer is able to demonstrate to the Commissioner with substantial proof the falsity of the statement or the inappropriateness of the comparison; and

2. the sole purpose of the announcements is to rebut the materially false statement or inappropriate comparison.

§7–107.

An insurer aggrieved by an order of the Commissioner under this title has the right to a hearing and the right to appeal from the action of the Commissioner under §§ 2-210 through 2-215 of this article.

§7–108.

The powers, remedies, procedures, and penalties provided in this title are in addition to any other powers, remedies, procedures, and penalties otherwise provided by law.

§7–109.

All laws and parts of laws of the State that are inconsistent with this title are superseded to the extent of the inconsistency.

§7–201.

(a) In addition to any other investment allowed elsewhere in this article, a domestic insurer, either alone or with another person, may invest in or otherwise acquire a subsidiary that engages in or is registered to engage in one or more of the following insurance businesses or business activities that are ancillary to an insurance business:

(1) conducting an insurance business that is authorized by the jurisdiction where the subsidiary is incorporated;

(2) acting as an insurance producer for its parent, its parent's insurer subsidiaries, or its parent's intermediate insurer subsidiaries;

(3) investing, reinvesting, or trading in securities for itself, its affiliate, its parent, or another subsidiary of its parent;

(4) managing an investment company that is subject to the Investment Company Act of 1940, including managing related sales and services of the investment company;

(5) acting as a broker–dealer that is subject to the Securities Exchange Act of 1934;

(6) providing investment advice to governments, governmental units, corporations, or other organizations or groups;

(7) performing other services related to the operations of an insurance business, including actuarial, loss prevention, safety engineering, data processing, accounting, claims, appraisal, and collection services;

(8) owning and managing assets that its parent may own and manage;

(9) acting as administrative agent for a governmental unit that performs an insurance function;

(10) financing insurance premiums;

(11) conducting any other business activity that is reasonably ancillary to an insurance business; or

(12) owning one or more corporations engaged exclusively in or organized to engage exclusively in one or more of the business activities specified in this section.

(b) Subject to the approval of the Commissioner and to the provisions of this title, a domestic mutual insurer may acquire or form a subsidiary insurance holding company.

§7–202.

(a) The investments authorized in this section are in addition to investments in common stock, preferred stock, debt obligations, and other securities allowed elsewhere in this article.

(b) In calculating investments under this section, a domestic insurer:

(1) shall exclude investments in domestic or foreign insurance subsidiaries; and

(2) with respect to investments in all other subsidiaries, shall include:

(i) the net total of money spent, obligations assumed, and other consideration given to acquire or form the subsidiary, including organizational expenses and contributions to capital and surplus of the subsidiary, whether or not represented by the purchase of capital stock or issuance of other securities; and

(ii) the amount spent after the subsidiary is acquired or formed to acquire additional common stock, preferred stock, debt obligations, and other securities and all contributions to the capital or surplus of the subsidiary.

(c) A domestic insurer may invest any amount in common stock, preferred stock, debt obligations, and other securities of one or more subsidiaries if:

(1) the amount does not exceed the lesser of 10% of the domestic insurer's assets and 50% of the domestic insurer's surplus as regards policyholders; and

(2) after the investment, the domestic insurer has remaining surplus as regards policyholders that:

(i) bears a reasonable relation to the domestic insurer's outstanding liabilities; and

(ii) is adequate to meet the domestic insurer's financial needs.

(d) (1) For purposes of this subsection, total liabilities are calculated in the same manner that total liabilities are calculated for the annual statement required by the National Association of Insurance Commissioners.

(2) This subsection applies only to a domestic insurer whose total liabilities are less than 10% of its assets.

(3) For purposes of this subsection, in calculating assets and surplus as regards policyholders remaining after an investment, a domestic insurer shall treat the investment as if it were a nonadmitted asset.

(4) A domestic insurer subject to this subsection may invest any amount in common stock of one or more of its subsidiaries if, after the investment, the domestic insurer has remaining assets and surplus as regards policyholders that:

(i) bear a reasonable relation to the domestic insurer's outstanding liabilities; and

(ii) are adequate to meet the domestic insurer's financial needs.

(5) A domestic insurer subject to this subsection may invest any amount in preferred stock and debt obligations of one or more of its subsidiaries if, after the investment, the domestic insurer has remaining surplus as regards policyholders that:

(i) bears a reasonable relation to the domestic insurer's outstanding liabilities; and

(ii) is adequate to meet the domestic insurer's financial needs.

(e) (1) In this subsection, "total investment" includes:

(i) a direct investment by the domestic insurer in an asset other than securities of its subsidiaries; and

(ii) the domestic insurer's proportionate share of any investment in an asset by a subsidiary of the insurer, calculated by multiplying the amount of the subsidiary's investment by the percentage of the domestic insurer's ownership of the subsidiary.

(2) A domestic insurer may invest any amount in common stock, preferred stock, debt obligations, and other securities of one or more subsidiaries engaged or organized to engage exclusively in the ownership and management of assets authorized as investments for the domestic insurer or one or more insurance subsidiaries, to the extent that each subsidiary limits its investments in any asset so that the investments will not cause the amount of the total investment of the domestic insurer to exceed any of the investment limitations applicable to the domestic insurer under subsection (c) of this section or under Title 5, Subtitles 5 and 6 of this article.

(f) Notwithstanding the limitations specified in subsections (c), (d), and (e) of this section, and treating the investment as if it were a nonadmitted asset, with the approval of the Commissioner, a domestic insurer may invest any amount in common stock, preferred stock, debt obligations, and other securities of one or more subsidiaries if, after the investment, the domestic insurer has remaining surplus as regards policyholders that:

(1) bears a reasonable relation to the domestic insurer's outstanding liabilities; and

(2) is adequate to meet the domestic insurer's financial needs.

§7–203.

(a) (1) Except as provided in subsection (b) of this section, within 3 years after a domestic insurer ends its control of a subsidiary, the domestic insurer shall dispose of all investments in the subsidiary that were made under § 7-202 of this subtitle.

(2) The Commissioner may extend the time for disposal of the investments.

(b) A domestic insurer is not required to dispose of an investment under subsection (a) of this section if, after the investment is made:

(1) the investment meets the requirements for investment under another provision of this article; and

(2) the domestic insurer notifies the Commissioner that the investment meets the other requirements.

§7–301.

(a) Except as otherwise provided in this section, this subtitle applies to any purchase, exchange, merger, or other transaction that would result in the acquisition of direct or indirect control of a domestic insurer or of an insurance holding company controlling a domestic insurer.

(b) This subtitle does not apply to an offer for or invitation for tender of voting securities, or to an agreement to exchange securities for or otherwise to acquire control of a domestic insurer or of an insurance holding company controlling a domestic insurer, to the extent that the Commissioner determines that this subtitle is not intended to apply to the transaction and exempts the transaction from this subtitle by regulation or order.

(c) This subtitle does not apply to a securities broker who, while acting in the usual and customary broker's function, holds less than 20% of the voting securities of an insurer or of a person controlling an insurer.

(d) This subtitle does not apply to the issuer of securities that makes a tender offer for, invites tenders of, enters into an agreement to exchange securities for, or otherwise acquires any voting security or security convertible into voting security of a domestic insurer or of an insurance holding company controlling a domestic insurer.

§7–302.

With respect to a transaction subject to this subtitle, a person must comply with all requirements of this subtitle before the person:

(1) makes a tender offer for, invites tenders of, enters into an agreement to exchange securities for, or otherwise acquires any voting security or

security convertible into voting security of a domestic insurer, or a person, including an insurance holding company, that controls a domestic insurer; or

(2) makes an agreement to merge with or otherwise to acquire control of a domestic insurer, or a person, including an insurance holding company, that controls a domestic insurer.

§7–303.

(a) With respect to a transaction subject to this subtitle, a person seeking to acquire control of a domestic insurer must file with the Commissioner the pre–acquisition notification required under Subtitle 4 of this title.

(b) The pre–acquisition notification must be filed at least 30 days before a transaction subject to this subtitle is proposed to become effective.

(c) The Commissioner may impose sanctions under § 7–405 of this title for failure to file the information required under subsection (a) of this section.

(d) (1) Any person that controls a domestic insurer seeking to divest its controlling interest in the domestic insurer shall file a confidential notice of its proposed divestiture with the Commissioner at least 30 days before the proposed divestiture and provide a copy of the notice to the insurer.

(2) The Commissioner shall determine those instances in which the party seeking to divest a controlling interest in an insurer must file for and obtain approval of the transaction.

(3) The information regarding the divestiture shall remain confidential until the conclusion of the transaction unless, in the Commissioner's discretion, the Commissioner determines that confidential treatment will interfere with enforcement of this section.

(4) Unless the Commissioner determines otherwise, this subsection does not apply if the statement required by subsection (a) of this section is filed.

§7–304.

(a) A person seeking to acquire control of a domestic insurer must file a statement with the Commissioner and provide a copy to the domestic insurer.

(b) The statement must be filed at least 60 days before a transaction subject to this subtitle is proposed to become effective.

(c) The statement required by subsection (a) of this section must contain:

(1) the name and address of each individual, by or for whom the transaction subject to this subtitle is to be made, and background information about the individual, including:

(i) the principal occupation of and all offices and positions held by the individual during the past 10 years; and

(ii) other than minor traffic offenses, crimes of which the individual has been convicted during the past 10 years;

(2) the name and address of each person that is not an individual, by or for whom the transaction subject to this subtitle is to be made, and background information about the person, including:

(i) the nature of the person's business operations and those of its predecessors during the past 10 years or any shorter period that the person and any predecessors have existed;

(ii) a description of the business that the person and its subsidiaries intend to do;

(iii) a list of the person's current directors and executive officers, individuals who have been selected to hold those positions, and individuals who perform or will perform functions appropriate to those positions; and

(iv) for each individual listed under item (iii) of this item:

1. the principal occupation of and all offices and positions held by the individual during the past 10 years; and

2. other than minor traffic offenses, crimes of which the individual has been convicted during the past 10 years;

(3) fully audited financial information about the earnings and financial condition of each acquiring person and any predecessor for the past 5 fiscal years or any shorter period that each acquiring person and any predecessor have existed;

(4) similar unaudited financial information dated within 90 days before the statement is filed;

(5) (i) copies of all actual or proposed tender offers, invitations for tender, exchange offers, and agreements to acquire or exchange that relate to any security described in this subtitle;

(ii) if distributed, copies of any additional soliciting materials that relate to the actions described in item (i) of this item;

(6) the source and amount of the funds or other consideration for a transaction subject to this subtitle and, if a part of the funds or other consideration has been or is to be borrowed or otherwise obtained for a transaction subject to this subtitle, a description of that transaction and the names of the parties to that transaction;

(7) any plans or proposals to liquidate the domestic insurer or insurance holding company controlling a domestic insurer, sell its assets, merge it with any person, or make any other major change in its business or corporate structure or management;

(8) with regard to any security connected with a transaction subject to this subtitle:

(i) the number of shares each acquiring person proposes to acquire;

(ii) the terms of the offer, invitation, agreement, or transaction subject to this subtitle; and

(iii) a statement of the method by which the fairness of the proposal was determined;

(9) the name and address of each person and each of that person's affiliates holding the following securities, the amount held in each class of the securities, and, for the past 2 years, the dates, amounts, and prices of sales and purchases of the securities by the person or affiliate:

(i) beneficially owned voting securities of the domestic insurer;

(ii) voting securities of the domestic insurer in which there is a right to acquire beneficial ownership;

(iii) beneficially owned securities that may be converted into voting securities of the domestic insurer; and

(iv) securities in which there is a right to acquire beneficial ownership that may be converted into voting securities of the domestic insurer;

(10) the names of the parties to and details of any contracts, arrangements, or understandings about securities of the domestic insurer or insurance holding company controlling the domestic insurer, including contracts, arrangements, or understandings providing for:

(i) transfers of the securities;

(ii) joint ventures;

(iii) loan or option arrangements;

(iv) puts or calls;

(v) loan guarantees;

(vi) guarantees against loss or guarantees of profits;

(vii) divisions of losses or profits; and

(viii) giving or withholding of proxies;

(11) a description of the purchase of any security described in this subtitle during the 12 calendar months immediately preceding the filing of the statement by an acquiring person, including:

(i) the dates of purchase;

(ii) the names of the purchasers; and

(iii) the consideration paid or agreed to be paid;

(12) a description of any recommendations to purchase any security subject to this subtitle made during the 12 calendar months immediately preceding the filing of the statement by:

(i) an acquiring person; or

(ii) any other person, based on interviews with or at the suggestion of the acquiring person;

(13) the terms of any agreements made or proposed to be made with brokers, securities dealers, service organizations, or other persons, including the amount of any fees, commissions, or other compensation to be paid, for soliciting shares for tender;

(14) an agreement by the person required to file the statement under this section that the person will provide the annual report specified in § 7–603(h) of this title for as long as control exists;

(15) an acknowledgment by the person required to file the statement under this section that the person and all affiliates in the insurance holding company system will provide information to the Commissioner on request as necessary to evaluate enterprise risk to the insurer; and

(16) other information necessary or appropriate in the public interest or for the protection of policyholders that the Commissioner requires by regulation.

(d) (1) If the person required to file a statement under this section is a partnership, limited partnership, syndicate, or other group, the statement also shall include the information required by subsection (c) of this section for:

(i) each partner of the partnership or limited partnership;

(ii) each member of the syndicate or group; and

(iii) each person controlling a partner or member.

(2) If a person required to file the statement under this section is a corporation or if a person referred to in paragraph (1) of this subsection is a corporation, the statement also shall include the information required by subsection (c) of this section for:

(i) the corporation;

(ii) each officer and director of the corporation; and

(iii) each person that directly or indirectly is the beneficial owner of more than 10% of the outstanding voting securities of the corporation.

(3) If any material change occurs in the facts set forth in the statement filed with the Commissioner and provided to the insurer under this section, an amendment, together with copies of any documents or other materials necessary to describe the amendment, shall be filed with the Commissioner and provided to the insurer within the earlier of 2 business days after:

(i) the change occurs; or

(ii) the person that filed the statement learns of the change.

(e) A person that is required to file a statement under this section instead may file with the Commissioner, in addition to any other materials that the Commissioner requests:

(1) a registration statement filed under the Securities Act of 1933;

(2) a disclosure containing similar information filed under the Securities Exchange Act of 1934; or

(3) a registration or disclosure that contains similar information filed under another State law.

(f) (1) Except as provided in paragraph (2) of this subsection, on request of the person filing the statement, the Commissioner may not make public the name of a lender listed under subsection (c)(6) of this section as a source of funds, unless the transaction is made in the lender's ordinary course of business.

(2) The Commissioner may make public the name of a lender under paragraph (1) of this subsection if the Commissioner considers the disclosure to be in the public interest.

(g) The Commissioner shall provide the statement filed under this section to the person to be acquired on the date the attempt to acquire is made public.

§7–305.

(a) At the time a person files the statement required by § 7-304 of this subtitle, the person shall:

(1) file with the Commissioner:

(i) all invitations for tenders or advertisements making a tender offer or inviting tenders of voting securities of the domestic insurer or insurance holding company controlling the domestic insurer made by or for the person; and

(ii) any agreement to:

1. exchange or otherwise acquire securities of the domestic insurer or insurance holding company controlling the domestic insurer; or

2. merge with or otherwise acquire control of the domestic insurer or insurance holding company controlling the domestic insurer; and

(2) send to the domestic insurer or insurance holding company controlling the domestic insurer:

(i) copies of the documents specified in item (1) of this subsection; and

(ii) any information contained in the statement filed under § 7-304 of this subtitle that the Commissioner requires by regulation.

(b) (1) By regulation, the Commissioner may set requirements that the Commissioner considers necessary or appropriate in the public interest or for the protection of policyholders for the contents of:

(i) additional materials inviting tender offers after the initial invitations; and

(ii) amendments to agreements described in subsection (a)(1)(ii) of this section.

(2) The additional materials and amendments shall contain the information that the Commissioner requires.

(3) The person required to file a statement under § 7-304 of this subtitle shall file with the Commissioner the additional materials and amendments required by paragraph (1) of this subsection and send copies to the domestic insurer or insurance holding company controlling the domestic insurer no later than the date that:

(i) copies of the material are first published or sent or given to security holders; or

(ii) the amendment is entered into.

§7–306.

(a) A transaction subject to this subtitle may not be made unless, within 60 days after the statement required by § 7–304 of this subtitle is filed with the

Commissioner or within any extension of that period, the Commissioner approves the transaction or does not disapprove the transaction.

(b) Subject to subsection (c) of this section, the Commissioner shall disapprove a proposed transaction subject to this subtitle if the Commissioner finds that:

(1) after the transaction, the domestic insurer could not satisfy the requirements for the issuance of a certificate of authority to engage in the insurance business which it intends to transact or is licensed to transact in the State, taking into consideration the financial and managerial resources and future prospects of the domestic insurer;

(2) the transaction may substantially lessen competition in insurance in the State or tend to create a monopoly;

(3) the financial condition of an acquiring person might jeopardize the financial stability of the domestic insurer or prejudice the interests of its policyholders or, in the case of an acquisition of control, the interests of any remaining stockholders who are unaffiliated with the acquiring person;

(4) the acquiring person has plans or proposals that are unfair or prejudicial to policyholders for liquidating the domestic insurer, selling its assets, merging it with another person, or making any other major change in its business or corporate structure or management;

(5) it would not be in the interest of policyholders, shareholders, or the public to allow the acquiring person to control the domestic insurer based on the competence, experience, and integrity of the persons that would control the operations of the domestic insurer;

(6) any party to an agreement to merge with a domestic insurer is not itself an insurer; or

(7) the interests of the domestic insurer's policyholders and stockholders might otherwise be prejudiced, impaired, or not properly protected.

(c) In disapproving a transaction based on a finding under subsection (b)(2) of this section:

(1) the Commissioner may not disapprove a transaction subject to this subtitle if the Commissioner finds that any of the situations meeting the criteria of § 7–405(b) of this title exist;

(2) the Commissioner may condition the approval of a transaction subject to this subtitle on the removal of the basis of disapproval under subsection (b)(2) of this section within a specified period of time; and

(3) the disapproval is subject to § 7–405(c) of this title and the informational requirements under § 7–403(c) of this title.

§7–307.

At the expense of the acquiring person, the Commissioner may retain attorneys, actuaries, accountants, and other experts not otherwise a part of the Commissioner's staff as are reasonably necessary to help the Commissioner in reviewing the proposed transaction subject to this subtitle.

§7–308.

(a) The courts of the State have jurisdiction over:

(1) each person that does not reside in, is not domiciled in, or is not authorized to do business in the State that files a statement with the Commissioner under this subtitle; and

(2) all actions arising out of a violation of this subtitle.

(b) (1) A person that is subject to the jurisdiction of the courts of the State under subsection (a)(1) of this section is deemed to appoint the Commissioner as attorney for service of process in any proceeding arising out of a violation of this subtitle.

(2) Copies of all process shall be served on the Commissioner.

(3) The Commissioner shall send a copy of the process by registered mail to the person at the person's last known address.

§7–309.

A person violates this title if:

(1) the person fails to file the statement required by this subtitle;

(2) without the Commissioner's approval during the 60–day period under § 7–306(a) of this subtitle, or after the Commissioner's disapproval, the person makes or attempts to make an acquisition of actual or presumed control of, or a

merger with, a domestic insurer or a person, including an insurance holding company, that controls a domestic insurer; or

(3) without the Commissioner's approval during the 30–day period under § 7–303(d) of this subtitle, or after the Commissioner's disapproval, the person divests or attempts to divest actual or presumed control of a domestic insurer or a person, including an insurance holding company, that controls a domestic insurer.

§7–401.

Except as provided in § 7-402 of this subtitle, this subtitle applies to any acquisition, agreement, arrangement, or activity, including the acquisition of voting securities or assets, bulk reinsurance, and merger, that results in a person acquiring directly or indirectly the control of an authorized insurer.

§7–402.

This subtitle does not apply to:

(1) an acquisition that is subject to the approval or disapproval of the Commissioner under Subtitle 3 of this title;

(2) a purchase of securities solely for investment purposes if the securities are not used for voting or otherwise to cause, or attempt to cause, the substantial lessening of competition in any insurance market in the State;

(3) a purchase of securities that results in a presumption of control under § 7-104 of this title, but the commissioner of the insurer's state of domicile:

(i) accepts a disclaimer of control or affirmatively finds that control does not exist; and

(ii) informs the Commissioner of the disclaimer or finding;

(4) an acquisition:

(i) in which both the acquiring and acquired persons are not, either directly or through affiliates, primarily engaged in the insurance business; and

(ii) for which a pre-acquisition notification:

1. is filed with the Commissioner under § 7-403 of this subtitle; or

2. is not required because the acquisition otherwise is excluded from this subtitle by another provision of this subsection;

(5) an acquisition in which the acquiring and acquired persons already are affiliated;

(6) considering "market" to be the direct written insurance premium in the State for a line of business as contained in the annual statement required to be filed by authorized insurers, an acquisition that would not result immediately in:

(i) an increase in any market share;

(ii) a combined market share of the acquiring and acquired insurers, their affiliates, and the person resulting from a merger that exceeds 5% of any one market; or

(iii) in any one market:

1. a market share increase of more than 2%; and

2. a combined market share of the acquiring and acquired insurers, their affiliates, and the person resulting from a merger that exceeds 12%;

(7) an acquisition for which a pre-acquisition notification would be required under this subtitle only because of the resulting effect on the ocean marine insurance line of business; or

(8) an acquisition as to which the commissioner of the state of domicile of the acquired insurer affirmatively finds and informs the Commissioner that:

(i) the acquired insurer is in failing condition;

(ii) there is a lack of feasible alternatives to improving the failing condition of the acquired insurer; and

(iii) the public benefits from improving the acquired insurer's condition through the acquisition outweigh the public benefits from not lessening competition.

§7–403.

(a) (1) The acquiring person in an acquisition subject to this subtitle must file a pre-acquisition notification with the Commissioner.

(2) The acquired person in an acquisition subject to this subtitle may file a pre-acquisition notification.

(b) The pre-acquisition notification must be filed at least 30 days before the acquisition subject to this subtitle is proposed to become effective.

(c) (1) The pre-acquisition notification must be in the form and contain the information required by the National Association of Insurance Commissioners relating to those markets that, under § 7-402(6) of this subtitle, cause the acquisition not to be exempt from this subtitle.

(2) The Commissioner may require a pre-acquisition notification to contain:

(i) additional material and information that the Commissioner considers necessary to determine whether the proposed acquisition, if effective, would violate § 7-405(a)(1)(i) of this subtitle; and

(ii) the opinion of an economist about the competitive impact of the acquisition in the State, together with a summary of the education and experience of the economist indicating the economist's ability to make an informed opinion.

§7–404.

(a) The waiting period for an acquisition subject to this subtitle:

(1) begins on the day the Commissioner receives the pre-acquisition notification; and

(2) ends on the earlier of:

(i) 30 days after the period begins; or

(ii) the day on which the Commissioner ends the waiting period.

(b) (1) During the waiting period for an acquisition subject to this subtitle, the Commissioner may require that additional information relevant to the proposed acquisition be filed.

(2) If the Commissioner requires additional information, the waiting period shall be extended to the earlier of:

(i) 30 days after the Commissioner receives the additional information; or

(ii) the day on which the Commissioner ends the waiting period.

§7–405.

(a) (1) Except as provided in subsection (b) of this section, the Commissioner may enter an order under this section with respect to an acquisition subject to this subtitle if:

(i) there is substantial evidence that the effect of the acquisition may be substantially to lessen competition in any line of insurance in the State or tend to create a monopoly; or

(ii) the insurer fails to file adequate information in compliance with § 7–403 of this subtitle.

(2) The order may:

(i) require an acquiring or acquired insurer, its affiliates, or the person resulting from a merger to cease and desist from doing business in the State with respect to the line of insurance involved in the violation; or

(ii) deny the application of an acquiring or acquired insurer for a certificate of authority.

(b) The Commissioner may not enter an order under this section with respect to an acquisition subject to this subtitle if:

(1) the acquisition will yield substantial economies of scale or economies in resource utilization that cannot be achieved feasibly in any other way, and public benefits from those economies outweigh the public benefits from not lessening competition; or

(2) the acquisition will increase substantially the availability of insurance, and public benefits from that increase outweigh the public benefits from not lessening competition.

(c) (1) In determining whether a proposed acquisition subject to this subtitle would violate subsection (a)(1)(i) of this section, the Commissioner shall consider an acquisition that involves two or more insurers, including insurers under common ownership, management, or control, that compete in the same product and geographical market to be prima facie evidence of violation of subsection (a)(1)(i) of this section if the acquiring and acquired insurers, their affiliates, or the person resulting from a merger:

(i) have a share of the market that exceeds the total of the two columns in the table under item (ii) of this paragraph, if more than two insurers are parties to the acquisition; or

(ii) have the following shares of the market:

Insurer A	Insurer B
5%	4% or more
10%	3% or more
15%	2% or more

(2) By treating the insurer with the largest share of the market as insurer "A", the Commissioner may interpolate percentages not shown in the table under paragraph (1)(ii) of this subsection proportionately to the percentages that are shown.

(3) In the absence of sufficient information to the contrary:

(i) the relevant product market is the direct written insurance premium for a line of business as the line appears in the annual statement required to be filed by insurers doing business in the State; and

(ii) the relevant geographical market is the State.

(4) In determining the relevant product and geographical markets, the Commissioner shall consider, among other things:

(i) any definitions or guidelines adopted by the National Association of Insurance Commissioners; and

(ii) any information submitted by parties to the acquisition.

(d) (1) Before the Commissioner enters an order under this section, the Commissioner shall:

(i) give the parties notice of a hearing on the proposed order before the end of the waiting period under § 7–404 of this subtitle and at least 15 days before the hearing is scheduled; and

(ii) hold the hearing.

(2) (i) The Commissioner shall enter an order after the conclusion of the hearing and no later than 60 days after the end of the waiting period.

(ii) The order shall be accompanied by a written decision of the Commissioner, findings of fact, and conclusions of law.

(e) (1) An order under this section may not become final earlier than 30 days after it is issued.

(2) Before an order becomes final, an insurer that is subject to the order may submit to the Commissioner a plan to remedy the anticompetitive impact of the acquisition within a reasonable time.

(3) Based on the plan or other information, the Commissioner may set conditions to be met while the anticompetitive impact is being remedied, and the order vacated or modified.

(f) An order under this section does not apply if the acquisition is not consummated.

(g) A person that violates a cease and desist order issued by the Commissioner under this section, after notice and hearing and on order of the Commissioner, is subject to a penalty not exceeding $10,000 for each day of violation or suspension or revocation of the person's certificate of authority or both.

§7–406.

A person required to file a pre-acquisition notification under this subtitle or Subtitle 3 of this title that fails to file the notification and that also fails to demonstrate a good faith effort to comply with the filing requirement is subject to a penalty not exceeding $50,000.

§7–501.

(a) This section does not apply to:

(1) a transaction that is preempted by federal law; or

(2) a transaction as to which:

(i) the laws of the jurisdiction in which the nonprofit health service plan is domiciled authorize the commissioner of that jurisdiction to investigate and approve an acquisition of direct or indirect control of a nonprofit health service plan by conversion, merger, consolidation, exercise of a right to acquire, or otherwise; and

(ii) the Commissioner:

1. receives notice from the commissioner of the other jurisdiction about the acquisition; and

2. has the right to request information and documents about that acquisition.

(b) A person shall comply with the procedures required by Subtitles 3 and 4 of this title to the extent applicable before the person seeks control of a foreign nonprofit health service plan that is authorized to do business in the State under Title 4 of this article by:

(1) making a tender for, inviting tenders of, entering into an agreement to exchange securities for, or acquiring in the open market or otherwise any voting security of the plan;

(2) entering into any other agreement about voting securities under which the person directly or indirectly would control the plan by conversion or by exercise of a right to acquire voting securities of the plan; or

(3) entering into an agreement to merge or consolidate with or otherwise to acquire control of the plan.

(c) Approval by the Commissioner of an acquisition under this section is governed by § 7-306 of this title.

§7–502.

(a) This section applies to a nonprofit health service plan or insurer that is being merged or consolidated with or acquired by another person.

(b) Current financing money that, in accordance with regulations adopted by the Health Services Cost Review Commission, is provided by a nonprofit health service plan or insurer to a hospital for discounted hospital rates is deemed to be security for the outstanding charges that the nonprofit health service plan or insurer

owes to the hospital for bills or claims for services that the hospital provided before the merger, consolidation, or acquisition.

§7–601.

(a) (1) Except as provided in subsection (b) of this section, each authorized insurer that is a member of an insurance holding company system shall register with the Commissioner in accordance with the requirements of this subtitle.

(2) The Commissioner may allow or require any authorized insurer that is part of an insurance holding company system to register and file the information and material required under this subtitle for an affiliated insurer that is required to register under this subsection.

(b) Subsection (a)(1) of this section does not apply to a foreign insurer that is organized in a jurisdiction that has adopted by statute or regulation disclosure requirements and standards substantially similar to those in this title.

(c) This subtitle does not apply to an insurer or affiliate to the extent that the Commissioner determines that this subtitle is not intended to apply to the insurer or affiliate and exempts the insurer or affiliate from this subtitle by regulation or order.

§7–602.

(a) Except as provided in subsection (b) of this section, each insurer subject to registration under this subtitle shall register with the Commissioner within 15 days after the insurer becomes subject to registration and, for each subsequent year, annually on or before May 1.

(b) If the Commissioner extends the time for registration for good cause, the insurer shall register on or before the date the Commissioner sets.

§7–603.

(a) Each insurer subject to registration shall file the registration statement on the form provided by the Commissioner, containing the following current information:

(1) the corporate and capital structure, general financial condition, ownership, and management of the insurer and of any person controlling the insurer;

(2) the identity and relationship of each member of the insurance holding company system;

(3) any pledge of the insurer's stock, including stock of a subsidiary or controlling affiliate, for a loan made to any member of the insurance holding company system;

(4) the following agreements in force, and transactions currently outstanding or that have occurred during the previous calendar year between the insurer and the insurer's affiliates:

(i) loans, other investments, purchases, sales, and exchanges of securities of the affiliates by the insurer or of the insurer by its affiliates;

(ii) purchases, sales, and exchanges of assets;

(iii) transactions not in the ordinary course of business;

(iv) except for insurance contracts entered into in the ordinary course of the insurer's business, guarantees or undertakings for the benefit of an affiliate that result in an actual contingent exposure to liability of the insurer's assets;

(v) management agreements, service contracts, and cost–sharing arrangements;

(vi) reinsurance agreements;

(vii) dividends and other distributions to shareholders; and

(viii) consolidated tax allocation agreements;

(5) statements that the insurer's board of directors oversees corporate governance and internal controls and that the insurer's officers or senior management have approved, implemented, and continue to maintain and monitor corporate governance and internal control procedures;

(6) on request from the Commissioner and in accordance with subsection (f) of this section, financial statements of or within an insurance holding company system, including all affiliates;

(7) any other matters about transactions between the insurer and its affiliates that the registration statement form requires; and

(8) a summary outlining all items in the current registration statement that represent changes from the prior registration statement.

(b) Each affiliate in an insurance holding company system shall give an insurer subject to registration under this subtitle that is in the same insurance holding company system complete and accurate information if that information is reasonably necessary to enable the insurer to comply with this subtitle.

(c) Each insurer required to register under this subtitle shall, on request of the insurance commissioner of any state where the insurer is authorized to do business, file with that commissioner a copy of the registration statement summary required by subsection (a)(8) of this section.

(d) The Commissioner may allow or require affiliated insurers subject to registration under this subtitle to file a consolidated registration statement.

(e) The Commissioner may require an insurer that is a member of an insurance holding company system and that is not subject to registration under this subtitle to provide to the Commissioner a copy of the registration statement or other information that the insurer files with the commissioner of the insurer's domiciliary jurisdiction.

(f) (1) Financial statements required under subsection (a)(6) of this section may include annual audited financial statements filed with the U.S. Securities and Exchange Commission under the Securities Act of 1933, as amended, or the Securities Exchange Act of 1934, as amended.

(2) An insurer required to file financial statements under subsection (a) of this section may satisfy the request by providing the Commissioner with the most recently filed parent corporation financial statements that have been filed with the U.S. Securities and Exchange Commission.

(g) (1) Except as provided in paragraph (3) of this subsection and unless otherwise provided by the Commissioner through regulation or order, a sale, a purchase, an exchange, a loan or an extension of credit, an investment, or a guarantee involving 0.5% or less of an insurer's admitted assets as of the December 31 immediately preceding the transaction is not material for purposes of this section.

(2) Information need not be disclosed on the registration statement filed under subsection (a) of this section if the information is not material.

(3) Paragraph (1) of this subsection does not apply for purposes of the group capital calculation or the liquidity stress test framework.

(h) (1) Beginning in 2015, the ultimate controlling person of every insurer subject to registration shall file an annual enterprise risk report on or before July 1 of each year unless the Commissioner extends the time for filing for good cause.

(2) The enterprise risk report shall, to the best of the ultimate controlling person's knowledge and belief, identify the material risks within the insurance holding company system that could pose enterprise risk to the insurer.

(3) The enterprise risk report shall be filed with the lead state commissioner of the insurance holding company system as defined and determined by the procedures in the NAIC Financial Analysis Handbook.

(4) The Commissioner may share the enterprise risk report filed under paragraph (1) of this subsection with an insurance regulatory agency in a state that has laws or regulations that the Commissioner determines are substantially similar to § 2–209(g) and (h) of this article, only if the agency agrees in writing to maintain the confidentiality and privileged status of the report.

(i) (1) (i) Except as provided in paragraph (2) of this subsection, the ultimate controlling person of each insurer subject to registration under this subtitle shall concurrently file with the registration statement an annual group capital calculation as directed by the lead state commissioner of the insurance group.

(ii) 1. The report shall be completed in accordance with the NAIC group capital calculation instructions.

2. The NAIC group capital calculation instructions may authorize the lead state commissioner to allow a controlling person that is not the ultimate controlling person to file the group capital calculation.

(iii) The report shall be filed with the lead state commissioner of the insurance holding company system as determined by the lead state commissioner in accordance with the procedures in the NAIC Financial Analysis Handbook.

(2) The following insurance holding company systems are exempt from filing the group capital calculation:

(i) an insurance holding company system that:

1. has only one insurer within its holding company structure;

2. only writes business and is only licensed in its domestic state; and

3. assumes no business from any other insurer;

(ii) an insurance holding company system that is required to perform a group capital calculation specified by the Federal Reserve Board, unless the Federal Reserve Board cannot share the calculation with the lead state commissioner after the lead state commissioner makes a request under the terms of information sharing agreements in effect at the time the request is made;

(iii) an insurance holding company system whose non–U.S. group–wide supervisor is located within a reciprocal jurisdiction as described in § 5–917 of this article that recognizes the U.S. state regulatory approach to group supervision and group capital;

(iv) an insurance holding company system that provides information to the lead state that meets the requirements for accreditation under the NAIC financial standards and accreditation program, either directly or indirectly through the group–wide supervisor, who has determined that the information is satisfactory to allow the lead state to comply with the NAIC group supervision approach, as detailed in the NAIC Financial Analysis Handbook; and

(v) an insurance holding company system whose non–U.S. group–wide supervisor that is not in a reciprocal jurisdiction recognizes and accepts, as the lead state commissioner specifies by regulation, the group capital calculation as the world–wide group capital assessment for U.S. insurance groups that operate in that jurisdiction.

(3) Notwithstanding paragraph (2)(iii), (iv), and (v) of this subsection, the lead state commissioner shall require the group capital calculation for U.S. operations of any non–U.S.–based insurance holding company system if, after any necessary consultation with other supervisors or officials, the lead state commissioner determines that the group capital calculation is appropriate for prudential oversight and solvency monitoring purposes or for ensuring the competitiveness of the insurance marketplace.

(4) Notwithstanding the exemptions from filing the group capital calculation stated in paragraph (2) of this subsection, the lead state commissioner may exempt the ultimate controlling person from filing the annual group capital calculation or may accept a limited group capital filing or report in accordance with criteria the lead state commissioner specifies by regulation.

(5) If the lead state commissioner determines that an insurance holding company system no longer meets one or more of the requirements for an exemption from filing the group capital calculation under this subsection, the insurance holding company system shall file the group capital calculation at the next

annual filing date unless the lead state commissioner grants an extension based on reasonable grounds shown.

(j) (1) The ultimate controlling person of every insurer that is subject to registration under this section and included in the scope of the NAIC liquidity stress test framework shall file the results of a specific year's liquidity stress test concurrently with the registration statement.

(2) The filing shall be made to the lead state insurance commissioner of the insurance holding company system as determined by the procedures in the NAIC Financial Analysis Handbook in accordance with paragraph (3) of this subsection.

(3) (i) 1. The NAIC liquidity stress test framework includes scope criteria applicable to a specific data year.

2. The scope criteria are reviewed at least annually by the Financial Stability Task Force or its successor.

3. Any changes to the NAIC liquidity stress test framework or to the data year for which the scope criteria are to be measured shall be effective on January 1 of the year following the calendar year when the changes are adopted.

(ii) Insurers meeting at least one threshold of the scope criteria are considered included in the scope of the NAIC liquidity stress test framework for the specified data year unless the lead state commissioner, in consultation with the NAIC Financial Stability Task Force or its successor, determines that the insurer should not be included in the scope of the framework for that data year.

(iii) Insurers that do not trigger at least one threshold of the scope criteria are considered excluded from the scope of the NAIC liquidity stress test framework for the specified data year, unless the lead state commissioner, in consultation with the NAIC Financial Stability Task Force or its successor, determines that the insurer should be included in the scope of the framework for that data year.

(iv) On request by an insurer, the lead state commissioner may consult with the Financial Stability Task Force or its successor to address the insurer's experience of being included in or excluded from the scope of the NAIC liquidity stress test framework on a frequent basis.

(v) The performance of, and filing of the results from, a specific year's liquidity stress test shall comply with the NAIC liquidity stress test

framework's instructions and reporting templates for that year and any lead state insurance commissioner determinations, in consultation with the Financial Stability Task Force or its successor, included in the framework.

§7–604.

The Commissioner shall terminate the registration requirement for each insurer that demonstrates that it is no longer a member of an insurance holding company system.

§7–605.

(a) (1) To verify the information required in the insurer's registration statement and in the annual enterprise risk report, and any addition or amendment to the registration statement or the annual enterprise risk report, and in addition to the powers granted under §§ 2–205 through 2–209 of this article relating to the examination of insurers, the Commissioner may order an insurer subject to registration under this subtitle to produce:

(i) those records, books, or papers in the possession of the insurer or its affiliates that are necessary to verify the registration statement; and

(ii) additional information relevant to the registration statement.

(2) The Commissioner shall examine the materials produced under this subsection at the time and place prescribed in §§ 2–205 through 2–209 of this article.

(b) (1) The Commissioner may conduct an examination under subsection (a) of this section only:

(i) if the examination of the insurer under §§ 2–205 through 2–209 of this article is inadequate, or the interests of the policyholders of the insurer are being adversely affected; and

(ii) within 3 years after the filing of the registration statement or the addition or amendment to the registration statement.

(2) In a matter involving fraud, the 3–year limitation period of this subsection does not apply.

(c) (1) The Commissioner may retain, at the insurer's expense, the services of accountants, attorneys, actuaries, and other experts not otherwise a part

of the Commissioner's staff as may be reasonably necessary to assist in the conduct of an examination under subsection (a) of this section.

(2) The accountants, attorneys, actuaries, and other experts retained under this subsection are under the direction and control of the Commissioner and act only in an advisory capacity.

(d) An insurer that produces materials for an examination under subsection (a) of this section is liable for and shall pay the expense of the examination in accordance with § 2–208 of this article.

(e) With regard to an examination under subsection (a) of this section, the Commissioner has the authority provided under § 2–203 of this article.

§7–606.

(a) An insurer, a member of an insurance holding company system, or any other person may file with the Commissioner a disclaimer of affiliation with an authorized insurer that fully discloses:

(1) all material relationships and bases for affiliation between the person filing the disclaimer and the authorized insurer; and

(2) the basis for disclaiming the affiliation.

(b) (1) Within 30 days after receipt of a filing under subsection (a) of this section, the Commissioner shall give all parties in interest notice and an opportunity to be heard.

(2) Within 30 days after the close of the notice period under paragraph (1) of this subsection, the Commissioner may disallow a disclaimer based on specific findings of fact.

(3) If within 30 days after the close of the notice period the Commissioner has not disallowed the disclaimer, the disclaiming party is relieved of its duty to register or report under this subtitle, and the insurer is relieved of any duty to register or report under this subtitle that arises out of the insurer's relationship with the person filing the disclaimer.

(4) In the event of disallowance, the disclaiming party may request an administrative hearing, which shall be granted.

§7–607.

(a) Failure to file the registration statement, summary, or enterprise risk report required by this subtitle in the time specified in this subtitle is a violation of this title.

(b) (1) An insurer that does not file a registration statement or summary required under § 7–603(a) of this subtitle on or before May 1 or the date the Commissioner sets in accordance with § 7–602(b) of this subtitle, may be subject to a penalty of up to:

(i) $500 for each day from May 1 through May 10;

(ii) $1,000 for each day from May 11 through May 31; and

(iii) $5,000 for each day after May 31.

(2) In determining the amount of any financial penalty to be imposed under this section, the Commissioner shall consider the following factors:

(i) the seriousness of the violation;

(ii) the good faith of the violator;

(iii) the violator's history of previous violations;

(iv) the deleterious effect of the violation on the public and the insurance industry; and

(v) the assets of the violator.

§7–608.

Whenever it appears to the Commissioner that a person has committed a violation of § 7–603(h) of this subtitle that prevents a full understanding of the enterprise risk to the insurer by affiliates or by the insurance holding company system, the violation may serve as an independent basis for disapproving dividends or distributions and placing the insurer under an order of supervision in accordance with § 7–804 of this title.

§7–701.

(a) This subtitle applies to insurers that are subject to registration under Subtitle 6 of this title.

(b) This subtitle does not authorize an insurer that is a member of an insurance holding company system to enter into a transaction that otherwise would be contrary to law for an insurer that is not a member of the same insurance holding company system.

§7–702.

Each transaction within an insurance holding company system to which an insurer subject to registration under Subtitle 6 of this title is a party is subject to the following standards:

(1) the terms shall be fair and reasonable in light of the purposes of this title;

(2) the records of each party shall clearly and accurately disclose the precise nature and details of the transaction, including accounting information necessary to support the reasonableness of the charges or fees to the parties;

(3) after the transaction, including any dividend or distribution to shareholder affiliates, the insurer has assets and surplus as regards policyholders that:

(i) bear a reasonable relation to the insurer's outstanding liabilities; and

(ii) are adequate to meet the insurer's financial needs;

(4) charges or fees for services performed shall be reasonable;

(5) expenses incurred and payments received shall be allocated to the insurer in conformity with customary insurance accounting practices consistently applied; and

(6) agreements, including management agreements, service contracts, tax allocation agreements, or cost–sharing agreements, shall include the provisions that the Commissioner requires by regulation.

§7–703.

(a) (1) Before a domestic insurer and another member of the same insurance holding company system enter into any of the transactions specified in subsection (d) of this section, including amendments or modifications of affiliate agreements previously filed under this section, the domestic insurer shall notify the Commissioner in writing of its intention to enter into the transaction.

(2) The notice for amendments or modifications shall include the reasons for the amendments or modifications and the projected financial impact of the amendments or modifications on the domestic insurer.

(3) A domestic insurer that intends to terminate an agreement or other transaction previously filed under this section shall provide the Commissioner with written notice within 30 days after the termination of the agreement or other transaction.

(b) The insurer shall notify the Commissioner under subsection (a) of this section:

(1) at least 30 days before the transaction is to be entered into; or

(2) if the Commissioner allows a shorter notice period, within the time that the Commissioner sets.

(c) A domestic insurer and another member of the same insurance holding company system may enter into, amend, or modify a transaction or an agreement under this section only if, within the notice period under subsection (b) of this section, the Commissioner does not disapprove the transaction.

(d) The following transactions are subject to subsections (a), (b), and (c) of this section:

(1) a sale, purchase, exchange, loan, or extension of credit, if, as of the December 31 immediately preceding the transaction, the amount of the transaction equals or exceeds:

(i) with respect to a life insurer, 3% of the insurer's admitted assets; and

(ii) with respect to an insurer other than a life insurer, the lesser of 3% of the insurer's admitted assets and 25% of surplus as regards policyholders;

(2) a loan or extension of credit by an insurer to a person that is not an affiliate if:

(i) the parties have an agreement or understanding that the proceeds of the transaction, as a whole or in substantial part, are to be used to make loans or extensions of credit to purchase assets of or to make investments in an affiliate of the insurer; and

(ii) as of the December 31 immediately preceding the transaction, the amount of the transaction equals or exceeds:

1. with respect to a life insurer, 3% of the insurer's admitted assets; and

2. with respect to an insurer other than a life insurer, the lesser of 3% of the insurer's admitted assets and 25% of surplus as regards policyholders;

(3) in accordance with subsection (h) of this section, a reinsurance agreement, or a modification to a reinsurance agreement, including an agreement that requires as consideration the transfer of assets from an insurer to a person that is not its affiliate, if, as of the December 31 immediately preceding the transaction, the amount of the reinsurance premium or change in the insurer's liabilities or the projected reinsurance premium or change in the insurer's liabilities in any of the next 3 years equals or exceeds 5% of the insurer's surplus as regards policyholders;

(4) all reinsurance pooling agreements;

(5) a management agreement, service contract, tax allocation agreement, or cost–sharing arrangement;

(6) subject to subsection (i) of this section, guarantees made by a domestic insurer;

(7) direct or indirect investments in a person that controls the insurer or an affiliate of the insurer in an amount that, together with its present holdings in the investments, exceeds 2.5% of the insurer's surplus as regards policyholders;

(8) notwithstanding item (7) of this subsection, any direct or indirect investment in or acquisition of a subsidiary of the insurer; and

(9) a material transaction, as specified by regulation, that the Commissioner determines may adversely affect the interests of the insurer's policyholders.

(e) In reviewing transactions under subsection (d) of this section, the Commissioner shall consider whether a transaction:

(1) complies with the standards stated in § 7–702 of this subtitle; or

(2) potentially adversely affects the interests of policyholders.

(f) (1) A transaction that does not conform to this section is a violation of this title.

(2) In addition to the sanctions in §§ 7–802, 7–803, 7–805, and 7–807 of this title, the Commissioner may set aside and rescind a transaction that the Commissioner finds does not conform to this section at the initiative of the Commissioner or otherwise under applicable law.

(3) Within 90 days after the date that the Commissioner receives information about a transaction that the Commissioner finds does not conform to this section, the Commissioner shall give the insurer notice of the proposed action to set aside or rescind the transaction and an opportunity for a hearing.

(g) (1) A domestic insurer and another member of the same insurance holding company system may not enter into a transaction that is part of a plan or series of like transactions if the purpose of making separate transactions is to avoid exceeding limitations under this section and the review of the transaction that otherwise would occur.

(2) If the Commissioner determines that separate transactions were entered into during any 12–month period in violation of paragraph (1) of this subsection, the Commissioner may impose any sanction authorized by §§ 7–802, 7–803, 7–805, and 7–807 of this title.

(h) A reinsurance agreement subject to subsection (d)(3) of this section includes an agreement that requires as consideration the transfer of assets from an insurer to a nonaffiliate if an agreement or understanding exists between the insurer and nonaffiliate that any portion of the assets will be transferred to one or more affiliates of the insurer.

(i) (1) A guarantee that is quantifiable as to amount is not subject to the notice requirements of subsection (d)(6) of this section unless the guarantee exceeds the lesser of 0.5% of the insurer's admitted assets or 10% of the insurer's surplus as regards policyholders as of the December 31 immediately preceding the guarantee.

(2) All guarantees made by a domestic insurer that are not quantifiable as to amount are subject to the notice requirements of subsection (d)(6) of this section.

§7–704.

A domestic insurer shall notify the Commissioner within 30 days after making any investment in one corporation if the total investment in the corporation by the domestic insurer's insurance holding company system exceeds 10% of the corporation's voting securities.

§7–705.

(a) Except as provided in § 7-706 of this subtitle, before an insurer subject to registration under Subtitle 6 of this title pays a dividend or makes a distribution to its shareholders, the insurer shall notify the Commissioner of its intention to pay the dividend or make the distribution.

(b) The insurer shall notify the Commissioner under subsection (a) of this section:

(1) within 5 business days after the declaration; and

(2) at least 10 days before the payment or distribution date.

(c) The Commissioner shall keep the notice required by subsection (a) of this section confidential until the payment or distribution date.

(d) If the Commissioner finds that, after the payment or distribution to shareholders under this section, the insurer's surplus as regards policyholders would be inadequate or could lead the insurer to a hazardous financial condition, the Commissioner may order that the dividend not be paid.

§7–706.

(a) (1) In this section, "earned surplus" means the part of surplus that, after deduction of all losses, represents the net earnings, gains, or profits that have not been distributed to shareholders as dividends, transferred to stated capital, transferred to capital surplus, or applied to other purposes allowed by law.

(2) In this section, "earned surplus" does not include unrealized capital gains or reevaluation of assets.

(b) In this section, "extraordinary dividend" or "extraordinary distribution" includes any dividend or distribution of cash or other property with a fair market value, that when combined with the fair market value of any other dividends or distributions made in the preceding 12 months exceeds the lesser of:

(1) 10% of the insurer's surplus as regards policyholders as of December 31 of the preceding year; or

(2) (i) for a life insurer, the net gain from operations of the insurer not including:

1. realized capital gains for the 12-month period ending December 31 of the preceding year; and

2. pro rata distributions of any class of the insurer's own securities; or

(ii) for an insurer that is not a life insurer, the net investment income of the insurer not including:

1. realized capital gains for the 12-month period ending December 31 of the preceding year; and

2. pro rata distributions of any class of the insurer's own securities.

(c) (1) In determining whether a dividend or distribution is extraordinary under this section, an insurer that is not a life insurer may carry forward net investment income from the 3 calendar years prior to the preceding calendar year that has not already been paid out as dividends.

(2) The amount carried forward under paragraph (1) of this subsection shall be computed by taking the net investment income from the 3 calendar years prior to the preceding calendar year:

(i) not including realized capital gains; and

(ii) minus dividends paid in the preceding 3 calendar years.

(d) An insurer that is not a life insurer may pay an extraordinary dividend only out of earned surplus.

(e) A domestic insurer may not pay an extraordinary dividend or make any other extraordinary distribution to its shareholders unless:

(1) the insurer provides notice of the declaration to the Commissioner at least 30 days before the declaration is made; and

(2) the Commissioner has approved or not disapproved the declaration within the 30 days following notice.

(f) (1) Notwithstanding any other provision of law, an insurer may declare an extraordinary dividend or extraordinary distribution conditioned on the Commissioner's approval.

(2) A conditional declaration confers no rights on shareholders unless, within 30 days after the Commissioner receives the notice under subsection (e) of this section, the Commissioner either approves the payment or distribution, or does not disapprove the payment or distribution.

§7–801.

Any person that obtains control of a domestic insurer is subject to the jurisdiction of the courts of the State with regard to any action, whether initiated by the Commissioner or otherwise, arising out of a violation of this title.

§7–802.

(a) In addition to any other penalty provided by law, a person that willfully violates this title or any regulation adopted under this title is subject to a penalty of up to $10,000 for the first day of violation and up to $1,000 for each additional day that the violation continues.

(b) In determining the amount of any financial penalty to be imposed under this section, the Commissioner shall consider the following factors:

(1) the seriousness of the violation;

(2) the good faith of the violator;

(3) the violator's history of previous violations;

(4) the deleterious effect of the violation on the public and the insurance industry; and

(5) the assets of the violator.

(c) Before imposing a penalty under this subsection, the Commissioner:

(1) shall give the person that allegedly committed the violation notice and an opportunity for hearing; and

(2) must find that the person willfully committed the violation.

§7–802.1.

(a) A director or an officer of an insurance holding company system who knowingly participates in, assents to, or allows any of the officers or agents of an insurer to engage in transactions or investments that have not been properly reported or submitted under Subtitles 6 and 7 of this title, shall pay, in the director's or officer's individual capacity, a civil penalty in accordance with § 7–802 of this subtitle, after notice and an opportunity for hearing before the Commissioner.

(b) In determining the amount of the civil penalty, the Commissioner shall take into account the factors in § 7–802(b) of this subtitle.

(c) (1) Whenever it appears to the Commissioner that an insurer subject to this title, or a director, an officer, an employee, or an agent of the insurer, has engaged in a transaction or entered into a contract that is subject to Subtitle 7 of this title and that would not have been approved if the approval had been requested, the Commissioner may order the insurer to cease and desist immediately any further activity under that transaction or contract.

(2) After notice and an opportunity for hearing, the Commissioner also may order the insurer to void any contracts and restore the status quo if, in the Commissioner's judgment, the action is in the best interest of the policyholders, the creditors, or the public.

§7–803.

(a) Any violation of this title is an unfair trade practice in the business of insurance and is subject to the provisions of Title 27 of this article.

(b) In addition to any other penalty provided by law, with respect to a person that engages in an unfair trade practice, the Commissioner, after giving the person notice and an opportunity for a hearing, may take any or all of the following actions:

(1) deny the person's application for a license or certificate of authority, refuse to renew or revoke the person's license or certificate of authority, or suspend the person's license or certificate of authority for a period not exceeding 1 year;

(2) proceed against the person in a court of competent jurisdiction in or outside the State to enjoin an act that would violate this title or to invalidate a transaction made in violation of this title; or

(3) order compliance with this title, including the filing of evidence of compliance and periodic reports about that compliance, and enforce those orders by

denying, refusing to renew, suspending, or revoking any license or certificate of authority or otherwise under the laws of the State.

§7–804.

If the Commissioner finds that a violation of this title impairs the financial condition of a domestic insurer so as to threaten insolvency or make the further transaction of business hazardous to policyholders, creditors, shareholders, or the public, the Commissioner may institute proceedings in accordance with Title 9, Subtitle 2 of this article to take possession of the domestic insurer's property and conduct its business.

§7–805.

(a) If a person acquires or offers to acquire stock of an insurer or of an insurance holding company in violation of Subtitle 3 of this title, the following persons may petition a court of competent jurisdiction in the State for injunctive and other appropriate relief:

(1) the issuer of the stock;

(2) a stockholder of the issuer;

(3) if the issuer is an insurance holding company, a stockholder of a subsidiary that is an insurer;

(4) a stockholder of the insurer; or

(5) the Commissioner.

(b) Whenever it appears to the Commissioner that an insurer or a director, an officer, an employee, or an agent of the insurer has committed or is about to commit a violation of this title or any regulation or order of the Commissioner under this title, the Commissioner may petition a court of competent jurisdiction in the State for an order enjoining the insurer or the director, officer, employee, or agent from violating or continuing to violate this title or any regulation or order, and for other equitable relief that the nature of the case and the interest of the insurer's policyholders, creditors, and shareholders or the public may require.

(c) (1) No security that is the subject of an agreement or arrangement regarding acquisition, or that is acquired or to be acquired contrary to this title or any regulation or order of the Commissioner under this title, may be voted at any shareholder's meeting, or may be counted for quorum purposes, and any action of

shareholders requiring the affirmative vote of a percentage of shares may be taken as though the securities were not issued and outstanding.

(2) An action taken at the meeting may not be invalidated by the voting of the securities, unless the action would materially affect control of the insurer or unless the courts of this State have so ordered.

(3) If an insurer or the Commissioner has reason to believe that any security of the insurer has been or is about to be acquired contrary to this title or any regulation or order of the Commissioner under this title, the insurer or the Commissioner may petition a court of competent jurisdiction in the State:

(i) to enjoin any offer, request, invitation, agreement, or acquisition made contrary to Subtitle 4 of this title or any regulation or order of the Commissioner under that subtitle;

(ii) to enjoin the voting of any security so acquired;

(iii) to void any vote of the security already cast at any meeting of shareholders; and

(iv) for other equitable relief that the nature of the case and the interest of the insurer's policyholders, creditors, and shareholders or the public may require.

(d) (1) In any case where a person has acquired or is proposing to acquire any voting securities in violation of this title or any regulation or order of the Commissioner under this title, a court of competent jurisdiction in the State, on notice that the court considers appropriate, on the application of the insurer or the Commissioner, may seize or sequester any voting securities of the insurer owned directly or indirectly by the person and issue an order appropriate to carry out this title.

(2) Notwithstanding any other law, for the purposes of this section, the location of the ownership of the securities of domestic insurers shall be deemed to be in the State.

§7–806.

(a) (1) Except as provided in paragraph (2) of this subsection, when an order for liquidation, conservation, or rehabilitation of a domestic insurer is entered, the receiver appointed under the order may recover for the domestic insurer the following distributions and payments made within 1 year before the petition for liquidation, conservation, or rehabilitation was filed:

(i) from any parent corporation, holding company, affiliate, or person that otherwise controlled the domestic insurer, the amount of distributions, other than distributions of shares of the same class of stock, paid by the domestic insurer on its capital stock; and

(ii) any payment in the form of a bonus, termination settlement, or extraordinary lump sum salary adjustment made by the domestic insurer or its subsidiaries to a director, officer, or employee.

(2) A distribution is not recoverable under this section if the parent or affiliate shows that when the distribution was paid:

(i) the distribution was lawful and reasonable; and

(ii) the domestic insurer did not know and could not reasonably have known that the distribution might adversely affect the ability of the domestic insurer to fulfill its contractual obligations.

(3) The maximum amount recoverable under this section is the amount needed in excess of all other available assets of the impaired or insolvent domestic insurer to pay the contractual obligations of the impaired or insolvent domestic insurer and to reimburse any guaranty funds.

(b) (1) A person that was a parent corporation, holding company, or person that otherwise controlled the domestic insurer or affiliate when a distribution was paid is liable for an amount not exceeding the distribution received.

(2) A person that otherwise controlled the domestic insurer when a distribution was declared is liable for an amount not exceeding the amount that the person would have received in an immediate distribution.

(3) Two or more persons that are liable with respect to the same distribution are jointly and severally liable.

(4) To the extent that a person liable to pay claims under this subsection is insolvent or otherwise fails to pay claims due, the liable person's parent corporation or holding company and any other person that otherwise controlled the liable person when the distribution was paid are jointly and severally liable for any resulting deficiency in the amount recovered from the domestic insurer's parent corporation or holding company or any other person that otherwise controlled the domestic insurer.

§7–807.

(a) (1) Whenever it appears to the Commissioner that any insurer or any director, officer, employee, or agent of the insurer has committed a willful violation of this title or any regulation adopted or order issued under this title, the Commissioner may institute criminal proceedings in a court of competent jurisdiction against the insurer or the responsible director, officer, employee, or agent.

(2) Any insurer that willfully violates this title or any regulation adopted or order issued under this title may be fined in accordance with subsection (b) of this section.

(b) (1) Any officer, director, employee, or agent of an insurance holding company system who willfully and knowingly subscribes to or makes or causes to be made any false statement, report, or filing with the intent to deceive the Commissioner in the performance of the Commissioner's duties under this article is guilty of a misdemeanor and on conviction is subject to a fine not exceeding $100,000 or imprisonment not exceeding 5 years or both.

(2) Any fines imposed under this section shall be paid by the officer, director, employee, or agent in his or her individual capacity.

§8–101.

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

(b) "Control", "controlling", "controlled by", or "under common control with" means the direct or indirect possession of the power to direct or cause the direction of the management and policies of a person, through ownership of voting securities or of securities convertible into voting securities, by contract other than a commercial contract for goods or nonmanagement services, or otherwise, whether or not the power is exercised or sought to be exercised.

(c) "Controlled insurer" means an insurer that is under the control of a controlling insurance producer.

(d) "Controlling insurance producer" means an insurance producer that has control of a controlled insurer.

§8–102.

This subtitle applies only to authorized insurers that issue policies covered by the Property and Casualty Insurance Guaranty Corporation.

§8–103.

(a) This subtitle does not affect the rights of policyholders, claimants, or creditors of a controlled insurer, or other third parties.

(b) This subtitle does not affect the responsibility of any person to comply with applicable provisions of Title 7 of this article.

§8–104.

(a) (1) Control is presumed to exist if a person directly or indirectly owns, directs the voting of, holds with the power to vote, or holds proxies representing 10% or more of the voting securities of another person.

(2) However, control is not presumed to exist if proxies have been obtained by an official of the person solely in connection with voting at a meeting of the owners of the person.

(b) The presumption of control may be rebutted by showing by a preponderance of the evidence that control does not exist in fact.

(c) (1) Notwithstanding the presumption of control, the Commissioner, on application of an insurer, may find that a person presumed to control an insurer does not have control of the insurer.

(2) In addition, the Commissioner, after notice and an opportunity to be heard, may find that a person not presumed to have control of an insurer does have control of the insurer.

§8–105.

(a) In this section, "independent casualty actuary" means a casualty actuary who:

(1) is a member of the American Academy of Actuaries; and

(2) is not affiliated with, an employee of, a principal of, the direct or indirect owner of, or in any way in the control of a controlled insurer or a controlling insurance producer.

(b) If a controlling insurance producer, when the insurance business is placed, is acting in a transaction on behalf of an insured for compensation, commission, or other valuable consideration, the controlling insurance producer may not directly or indirectly place insurance business with its controlled insurer unless the requirements of this section are met.

(c) There shall be a written contract between the controlling insurance producer and controlled insurer that has been approved by the board of directors of the controlled insurer.

(d) (1) If insurance business is placed through a controlling insurance producer, the controlling insurance producer shall deliver written notice to the prospective insured before the effective date of the policy, disclosing the relationship between the controlling insurance producer and the controlled insurer.

(2) The disclosure shall be signed by the prospective insured and retained in the underwriting file until the filing of the examination report for the period during which the policy is in effect.

(3) If insurance business is placed through a sub-insurance producer that is not a controlling insurance producer, the controlling insurance producer shall retain in the controlling insurance producer's records a signed statement from the sub-insurance producer that:

(i) the sub-insurance producer is aware of the relationship between the controlling insurance producer and the controlled insurer;

(ii) the sub-insurance producer has delivered to the prospective insured written notice disclosing that relationship; and

(iii) the disclosure has been signed by the prospective insured and will be retained by the sub-insurance producer for 3 years.

(e) At least quarterly, the controlling insurance producer shall pay to the controlled insurer all money that the controlling insurance producer collected for the account of the controlled insurer, net of commissions, cancellations, and other adjustments.

(f) (1) In addition to any other required loss reserve certification, the controlled insurer on or before April 1 of each year shall file with the Commissioner an opinion of:

(i) an independent casualty actuary; or

(ii) another independent loss reserve specialist acceptable to the Commissioner.

(2) The opinion shall:

(i) report loss ratios for each line of insurance business written; and

(ii) attest that loss reserves are adequate for losses incurred and outstanding as of year end on insurance business placed by the controlling insurance producer, including losses incurred but not reported.

(g) The controlled insurer shall report annually to the Commissioner:

(1) the amount of commission it paid to the controlling insurance producer;

(2) the percentage that amount represents of the net premiums written; and

(3) comparable amounts and percentages paid to noncontrolling insurance producers for placement of the same kinds of insurance.

(h) (1) The controlled insurer shall have an audit committee of the board of directors composed of independent directors.

(2) Before approval of the annual financial statement, the audit committee shall meet to review the adequacy of the controlled insurer's loss reserves with:

(i) management;

(ii) the controlled insurer's independent certified public accountants; and

(iii) another independent loss reserve specialist acceptable to the Commissioner or an independent casualty actuary.

§8–106.

(a) In this section, "reinsurance intermediary" means a person that acts as an insurance producer in:

(1) soliciting, negotiating, or procuring a reinsurance contract or binder for a ceding insurer; or

(2) accepting a reinsurance contract or binder for an assuming insurer.

(b) This section does not apply to a reinsurance intermediary that makes a complete written disclosure to the parties of its relationship with the assuming or ceding insurer before completion of the transaction.

(c) A reinsurance intermediary that has control of an assuming insurer may not directly or indirectly place insurance business with the assuming insurer in a transaction in which the reinsurance intermediary acts as an insurance producer for the ceding insurer.

(d) A reinsurance intermediary that has control of a ceding insurer may not directly or indirectly accept business from the ceding insurer in a transaction in which the reinsurance intermediary acts as an insurance producer for the assuming insurer.

§8–107.

(a) (1) With respect to insurance business placed by its controlling insurance producer, the controlled insurer may not engage in a pattern of charging premiums that are unjustifiably lower than those being charged by the controlled insurer or other insurers for similar risks written during the same period and placed by noncontrolling insurance producers.

(2) When determining whether premiums are unjustifiably lower than those prevailing in the market, the Commissioner shall take into consideration applicable industry or actuarial standards at the time the insurance business was written.

(b) With respect to insurance business placed by its controlling insurance producer, the controlled insurer shall establish underwriting procedures and may not deviate from them.

(c) A controlled insurer's capitalization at the time insurance business is placed by the controlling insurance producer and with respect to that insurance business shall comply with:

(1) criteria set by the Commissioner; and

(2) all applicable insurance laws.

§8–108.

The controlling insurance producer shall keep records sufficient to:

(1) demonstrate that the controlling insurance producer's dealings with its controlled insurer were fair and comply with Title 7 of this article; and

(2) disclose accurately the nature and details of the controlling insurance producer's transactions with its controlled insurer, including any information that is necessary to support the charges or fees to the respective parties.

§8–109.

(a) If the Commissioner has reason to believe that a controlling insurance producer has violated or is violating this subtitle, the Commissioner shall:

(1) serve on the controlling insurance producer a statement of charges and notice of hearing; and

(2) hold a hearing subject to §§ 2-210 through 2-214 of this article.

(b) An order of the Commissioner is subject to judicial review under § 2-215 of this article.

(c) The controlling insurance producer shall reimburse the Property and Casualty Insurance Guaranty Corporation for any payments made by the Property and Casualty Insurance Guaranty Corporation for losses, loss adjustment, and administrative expenses on the insurance business placed by the controlling insurance producer in excess of gross earned premiums and investment income earned on premiums and loss reserves for the insurance business if the Commissioner finds that:

(1) the controlling insurance producer violated this subtitle; and

(2) the violation substantially contributed to the insolvency of the controlled insurer.

(d) This section does not affect the right of the Commissioner to impose any other penalty provided in this article.

§8–201.

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

(b) "Certificate of qualification" means a certificate of qualification issued by the Commissioner to act as a managing general agent.

(c) (1) "Managing general agent" means a person:

(i) that:

1. manages all or part of the insurance business of an insurer, including the management of a separate division, department, office, or subsidiary of the insurer; and

2. with or without authority, separately or with affiliates, directly or indirectly produces or underwrites gross direct written premiums at least equal to 5% of the insurer's policyholder surplus for any quarter or year, as reported in the insurer's most recently filed quarterly report or annual statement; and

(ii) that:

1. negotiates or binds ceding reinsurance contracts for the insurer;

2. adjusts or pays claims of more than $500; or

3. maintains loss reserves from which claims may be paid.

(2) "Managing general agent" does not include:

(i) an employee of the insurer;

(ii) a United States manager of the United States branch of an alien insurer;

(iii) an attorney in fact authorized by and acting for the subscribers of a reciprocal insurer under a power of attorney;

(iv) an authorized insurance producer acting for a surety insurer that engages exclusively in the business of issuing bail bonds; or

(v) an underwriting manager that, by contract:

1. manages all the insurance operations of the insurer;

2. is under common control with the insurer and is subject to Title 7, Subtitle 6 of this article; and

3. is not compensated based on the volume of premiums written.

(d) "Underwrite" means to accept or reject risks for an insurer.

§8–202.

A person must obtain a certificate of qualification before the person acts as a managing general agent in the State.

§8–202.1.

An applicant for a certificate of qualification must be:

(1) licensed as an insurance producer under Title 10, Subtitle 1 of this article; and

(2) competent and trustworthy, as determined by the Commissioner.

§8–203.

An applicant for a certificate of qualification shall:

(1) file with the Commissioner an application on the form that the Commissioner provides; and

(2) pay to the Commissioner the fee required by § 2-112 of this article.

§8–204.

The Commissioner shall issue a certificate of qualification to each applicant who meets the requirements of this subtitle.

§8–205.

(a) A certificate of qualification expires on the first June 30 after its effective date unless it is renewed as provided in this section.

(b) Before a certificate of qualification expires, the holder of the certificate of qualification may renew it for an additional 1-year term, if the holder:

(1) otherwise is entitled to a certificate of qualification; and

(2) pays to the Commissioner the renewal fee required by § 2-112 of this article.

(c) The Commissioner shall renew the certificate of qualification of each holder who meets the requirements of this section.

§8–206.

(a) The Commissioner shall deny or refuse to renew a certificate of qualification if the applicant or holder of the certificate of qualification:

(1) has willfully violated this article or another law of the State that relates to insurance;

(2) has intentionally misrepresented or concealed a material fact in an application for a certificate of qualification;

(3) has obtained or attempted to obtain a certificate of qualification by misrepresentation, concealment, or other fraud;

(4) has misappropriated, converted, or unlawfully withheld money that belongs to an insurer, insurance producer, beneficiary, or insured;

(5) has willfully and materially misrepresented the provisions of a policy;

(6) has committed fraudulent or dishonest practices in the insurance business;

(7) has participated, with or without the knowledge of an insurer, in selling motor vehicle insurance without the intention to sell the insurance, as evidenced by a persistent pattern of filing certificates of insurance together with or closely followed by cancellation notices for the insurance;

(8) has been convicted by final judgment in any state or federal court of a crime involving moral turpitude;

(9) has knowingly participated in writing or issuing substantial over-insurance of property insurance risks;

(10) has failed to pass an examination required by this subtitle;

(11) has willfully failed to comply with or has willfully violated a proper order or regulation of the Commissioner;

(12) has failed or refused to pay over on demand money that belongs to an insurer, insurance producer, or other person entitled to the money;

(13) has otherwise shown a lack of trustworthiness or competence to act as a managing general agent;

(14) is not or does not intend to carry on business in good faith and represent to the public that the person is a managing general agent;

(15) has been denied a license or certificate as a managing general agent or has had a license or certificate suspended or revoked in another state;

(16) has intentionally or willfully made or issued, or caused to be made or issued, a statement that materially misrepresents or makes incomplete comparisons about the terms or conditions of a policy or contract issued by an authorized insurer, for the purpose of inducing or attempting to induce the owner of the policy or contract to forfeit or surrender it or allow it to lapse in order to replace it with another; or

(17) has transacted insurance business that was directed to the applicant or holder for consideration by a person whose license or certificate to engage in the insurance business at the time was suspended or revoked, and the applicant or holder knew or should have known of the suspension or revocation.

(b) The Commissioner shall deny a certificate of qualification to an applicant or refuse to renew, suspend, or revoke a certificate of qualification if the applicant or holder of the certificate of qualification:

(1) is insolvent;

(2) is conducting business fraudulently;

(3) unreasonably refuses or delays payment to claimants of amounts due them;

(4) fails to pay any final judgment entered against the applicant or holder in the State within 60 days after the judgment becomes final;

(5) has a certificate of qualification revoked or suspended by the insurance regulatory authority in another state;

(6) is found by the Commissioner to be in:

(i) an unsound condition; or

(ii) a condition that makes further transaction of business hazardous to policyholders or the public; or

(7) refuses to:

(i) be examined;

(ii) produce its accounts, records, and files for examination by the Commissioner; or

(iii) provide additional information that the Commissioner requests while considering an application for renewal of a certificate of qualification.

(c) The Commissioner may suspend or revoke a certificate of qualification for any ground listed in § 10-126 of this article.

(d) Instead of or in addition to denying, refusing to renew, suspending, or revoking a certificate of qualification, the Commissioner may:

(1) impose a penalty of not less than $100 but not exceeding $50,000 for each violation of this article;

(2) require that restitution be made to any person that has suffered financial injury because of the violation of this article; and

(3) impose any other penalty authorized by this article.

(e) This section does not limit the rights of policyholders or claimants.

§8–207.

(a) By regulation, the Commissioner may require a managing general agent to maintain a bond or other security in an amount set by the Commissioner to protect the insurer and policyholders or to maintain an errors and omissions policy issued by an authorized insurer, or both.

(b) A managing general agent is subject to examination under §§ 2-205 through 2-209 of this article.

§8–208.

(a) A managing general agent may not place business with an insurer or maintain loss reserves from which claims against an insurer may be paid unless a written contract is in force between the managing general agent and insurer.

(b) At a minimum, the contract shall:

(1) state the responsibilities of each party and specify the division of responsibilities for shared functions;

(2) provide that the insurer may:

(i) terminate the contract for cause on written notice to the managing general agent; and

(ii) suspend the managing general agent's underwriting authority during a dispute about the termination;

(3) require the managing general agent to:

(i) give accounts to the insurer detailing all transactions; and

(ii) remit to the insurer at least monthly all money due under the contract;

(4) require that:

(i) all money collected for the account of the insurer be held by the managing general agent in a fiduciary capacity in a federally insured financial institution; and

(ii) all payments for the insurer be made from this account;

(5) prohibit the managing general agent from keeping more than 3 months' estimated claims payments and allocated loss adjustment expenses;

(6) require the managing general agent to:

(i) keep separate records of business written for the insurer; and

(ii) allow the insurer and the Commissioner to have access to those records;

(7) require the managing general agent to keep all books, records, and accounts in a form acceptable to the Commissioner;

(8) prohibit the managing general agent from wholly or partly assigning the contract;

(9) state appropriate underwriting guidelines, including:

(i) maximum annual volume of premiums;

(ii) types or classifications of risks that may be written;

(iii) maximum limits of liability;

(iv) applicable exclusions;

(v) territorial limitations;

(vi) provisions for cancellation of policies; and

(vii) maximum periods of policies;

(10) subject to all applicable laws about policy cancellation and nonrenewal, grant the insurer the right to cancel or nonrenew any policy underwritten by the managing general agent;

(11) require the managing general agent, when conducting business or entering into contracts on behalf of or for the benefit of the insurer, to comply with all applicable insurance laws and regulations; and

(12) address the timely transmission of data for any electronic claims files.

(c) (1) This subsection applies if:

(i) the contract provides for a sharing of profits by the managing general agent; and

(ii) the managing general agent has the authority to determine the amount of interim profits by establishing loss reserves, controlling claims payments, or any other method.

(2) Interim profits may not be paid to a managing general agent subject to this subsection:

(i) until:

1. at least 1 year after the profits are earned, for property insurance business; or

2. at least 5 years after the profits are earned, for casualty insurance business; and

(ii) until the profits have been verified by the insurer under § 8-210 of this subtitle.

(d) If the contract allows the managing general agent to settle claims for the insurer:

(1) the managing general agent shall report all claims to the insurer in a timely manner;

(2) the managing general agent shall give to the insurer a copy of any claim file that:

(i) is requested by the insurer;

(ii) involves a coverage dispute;

(iii) potentially exceeds the managing general agent's settlement authority;

(iv) remains open for more than 6 months after the date the managing general agent receives the claim; or

(v) is settled in an amount of more than $500;

(3) the insurer may:

(i) terminate for cause any settlement authority granted to the managing general agent if the insurer gives the managing general agent 30 days' notice of the termination; and

(ii) suspend the settlement authority during a dispute about the cause for termination; and

(4) all claims files are property of the insurer except, if the Commissioner obtains an order of liquidation, rehabilitation, reorganization, or conservation against an insurer, the claims files become the property of the person appointed liquidator, rehabilitator, conservator, or receiver.

§8–209.

(a) A managing general agent may not:

(1) commit the insurer to participate in insurance or reinsurance syndicates;

(2) appoint or hire an insurance producer to solicit, procure, or negotiate insurance contracts for the insurer without ensuring that the insurance producer is licensed under Title 10, Subtitle 1 of this article;

(3) take an action that would violate § 27-503 of this article if taken directly by the insurer;

(4) without the insurer's written approval, pay or commit the insurer to pay a claim, net of reinsurance, that exceeds 1% of the insurer's policyholder surplus as of December 31 of the immediately preceding calendar year;

(5) without the insurer's prior written approval, collect any payment from a reinsurer;

(6) commit the insurer to a claim settlement with a reinsurer;

(7) employ an individual who also is employed by the insurer;

(8) allow an agent or employee of the managing general agent to serve on the insurer's board of directors; or

(9) appoint a submanaging general agent unless:

(i) approval of the appointment is obtained from the Commissioner and from the insurer for whom the managing general agent acts; and

(ii) the submanaging general agent complies with any requirements imposed by the Commissioner under § 8-213 of this subtitle.

(b) (1) Except as provided in paragraph (2) of this subsection, a managing general agent may not bind reinsurance or retrocessions for an insurer.

(2) A managing general agent may bind facultative reinsurance contracts under obligatory facultative agreements if the contract with the insurer contains reinsurance underwriting guidelines for reinsurance both assumed and ceded, including:

(i) a list of reinsurers with which the automatic agreements are in effect;

(ii) the coverages and amounts or percentages that may be reinsured; and

(iii) commission schedules.

§8–210.

(a) (1) An insurer shall maintain independent financial examinations, in a form acceptable to the Commissioner, of each managing general agent with whom the insurer has done business.

(2) The insurer shall keep records for at least 5 years.

(b) (1) If, by contract, an insurer allows a managing general agent to maintain loss reserves, the insurer annually shall get an opinion, attesting to the adequacy of the loss reserves established, from an independent actuary who is a member in good standing of the American Academy of Actuaries.

(2) The insurer shall keep the report of the actuary for at least 5 years.

(c) At least twice a year, an insurer shall conduct a review of the underwriting and claims processing operations of its managing general agent.

(d) (1) Within 30 days after entering into or terminating a contract with a managing general agent, an insurer shall notify the Commissioner in writing of doing so.

(2) The notice of entering into a contract shall include:

(i) a statement of the duties and responsibilities of the managing general agent;

(ii) the lines of insurance that the managing general agent is contractually authorized to negotiate, procure, or bind for the insurer;

(iii) a copy of the contract; and

(iv) any other information or documentation that the Commissioner requests.

(e) Unless the relationship between an insurer and managing general agent is controlled by and disclosed under Title 7, Subtitle 6 or 7 of this article, the insurer may not have on its board of directors an officer, director, employee, agent, or shareholder of its managing general agent.

(f) (1) Each insurer shall review its books and records each quarter to determine if any insurance producer has become a managing general agent.

(2) If the insurer determines that an insurance producer has become a managing general agent:

(i) the insurer promptly shall notify the insurance producer and the Commissioner of the determination; and

(ii) the insurer and insurance producer must comply fully with the provisions of this subtitle within 30 days after the determination.

(g) The Commissioner may adopt regulations to carry out this section.

§8–211.

(a) The acts of a managing general agent are deemed to be the acts of the insurer for whom the managing general agent is acting.

(b) If a managing general agent becomes insolvent, the obligations of the managing general agent with respect to policyholders of an insurer shall be assumed by that insurer.

§8–212.

(a) Unless the insurer to which a contract relates gives written consent, the contract between a managing general agent and an insurer obtained by the Commissioner during an examination or investigation under this subtitle, or reported or filed under this subtitle:

(1) shall be treated confidentially;

(2) is not subject to subpoena; and

(3) may not be made public by the Commissioner, the National Association of Insurance Commissioners, or any other person.

(b) The Commissioner may publish all or part of a contract between a managing general agent and an insurer in the manner that the Commissioner

considers appropriate if, after giving the managing general agent and insurer notice and an opportunity to be heard, the Commissioner finds that the interest of the policyholders or the public will be served by publication of the contract.

§8–213.

The Commissioner may require a submanaging general agent appointed by a managing general agent to comply with any provision of this subtitle that applies to a managing general agent.

§8–301.

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

(b) (1) "Administrator" means a person that, to the extent that the person is acting for an insurer or plan sponsor, has:

(i) control over or custody of premiums, contributions, or any other money on behalf of a life insurer or with respect to a plan, for any period of time; or

(ii) discretionary authority over the adjustment, payment, or settlement of benefit claims on behalf of a life insurer or under a plan or over the investment of a life insurer's or a plan's assets.

(2) "Administrator" does not include a person that:

(i) with respect to a particular plan:

1. is, or is an employee of, the plan sponsor;

2. is, or is an employee, insurance producer, or managing general agent of, an insurer or health maintenance organization that insures or administers the plan; or

3. is an insurance producer that solicits, procures, or negotiates a plan for a plan sponsor and that has no authority over the adjustment, payment, or settlement of benefit claims under the plan or over the investment or handling of the plan's assets;

(ii) is retained by the Life and Health Insurance Guaranty Corporation to administer a plan underwritten by an impaired insurer that is subject to an order of conservation, liquidation, or rehabilitation;

(iii) is a participant or beneficiary of a plan that provides for individual accounts and allows a participant or beneficiary to exercise investment control over assets in the participant's or beneficiary's account, and the participant or beneficiary exercises that investment control;

(iv) administers only plans that are subject to ERISA and that do not provide benefits through insurance, unless any of the plans administered is a multiple employer welfare arrangement as defined in § 514(b)(6)(A)(ii) of ERISA;

(v) is, or is an employee of, a bank, savings bank, trust company, savings and loan association, or credit union that is regulated under the laws of this State, another state, or the United States;

(vi) is, or is an employee of, a person that is registered as:

1. an investment adviser under the Investment Advisers Act of 1940 or the Maryland Securities Act;

2. a broker–dealer or transfer agent under the Securities Exchange Act of 1934 or the Maryland Securities Act; or

3. an investment company under the Investment Company Act of 1940; or

(vii) is, or is an employee of, the Maryland Health Benefit Exchange, including the Maryland Health Benefit Exchange's Consolidated Services Center.

(c) "Employee organization" means:

(1) a labor union or other labor organization;

(2) an agency or employee representation committee, association, group, or plan:

(i) in which employees participate; and

(ii) that exists for the purpose, wholly or partly, of dealing with employers about a plan or other matters incidental to employment relationships; or

(3) an employees' beneficiary association that is organized for the purpose, wholly or partly, to establish a plan.

(d) (1) "Employer" means a person that, in relation to a plan, acts directly as an employer or indirectly in the interest of an employer.

(2) "Employer" includes a group or association of employers acting for an employer.

(e) "ERISA" means the federal Employee Retirement Income Security Act of 1974.

(f) (1) "Plan" means a fund or other arrangement that is established, maintained, or contributed to by an employer, employee organization, or both, to the extent that the fund or arrangement was established or is maintained for the purpose of:

(i) providing for participants or beneficiaries, any of whom are residents of the State, through the purchase of insurance or otherwise:

1. medical, surgical, or hospital care or benefits;

2. benefits in the event of sickness, accident, disability, death, or unemployment;

3. vacation benefits;

4. apprenticeship or other training programs;

5. child care centers;

6. scholarship funds;

7. prepaid legal services;

8. severance pay arrangements;

9. supplemental retirement income payments; or

10. life insurance; or

(ii) providing retirement income to or allowing the deferral of income by employees, any of whom are residents of the State, until or after the termination of covered employment.

(2) "Plan" does not include a fund or arrangement established or maintained solely for the purpose of complying with the workers' compensation laws of the State.

(g) "Plan sponsor" means:

(1) the employer, for a plan established or maintained by a single employer;

(2) the employee organization, for a plan established or maintained by an employee organization; or

(3) the association, committee, joint board of trustees, or other similar group of representatives of the parties that establish or maintain the plan, for a plan established or maintained by two or more employers or jointly by one or more employers and one or more employee organizations.

§8–302.

The Commissioner may adopt regulations necessary to carry out this subtitle.

§8–303.

(a) A person must register with the Commissioner before the person acts as or represents itself as an administrator in the State.

(b) A person that would be an administrator subject to this subtitle but for the exemption under § 8-301(b)(2)(iv) of this subtitle shall provide to the Commissioner:

(1) written notice that the person operates in the State; and

(2) evidence satisfactory to the Commissioner that the person is complying with any applicable bonding requirements imposed by ERISA.

§8–304.

(a) To register as an administrator, an applicant must present evidence satisfactory to the Commissioner that the applicant:

(1) has not been convicted of:

(i) a felony;

(ii) a misdemeanor involving moral turpitude;

(iii) a violation of this subtitle;

(iv) an attempt or conspiracy to commit any of the violations listed in items (i) through (iii) of this item; or

(v) a crime in which any other violation listed in this item is an element;

(2) has obtained the bond required by § 8–306 of this subtitle or has qualified for one of the applicable exemptions from the bonding requirement;

(3) has met any applicable examination requirements adopted by the Commissioner under subsection (b) of this section; and

(4) for the administration of health benefit plans in the State, uses only the uniform claim forms adopted by the Commissioner under § 15–1003 of this article.

(b) (1) The Commissioner may develop appropriate testing procedures to measure an applicant's familiarity with this subtitle.

(2) To develop testing procedures, the Commissioner shall consult with representatives of administrators, employee organizations, and employers.

§8–305.

An applicant for registration shall:

(1) file with the Commissioner an application on the form that the Commissioner requires; and

(2) pay to the Commissioner an application fee of $250.

§8–306.

(a) The bond required for an administrator under this subtitle must:

(1) provide protection to the plans or the life insurer, for which the administrator acts as an administrator, against loss because of acts of fraud or dishonesty on the part of the administrator, directly or through connivance with others; and

(2) be issued by an authorized corporate surety insurer that is an acceptable surety on federal bonds under authority granted by the Secretary of the Treasury.

(b) (1) Subject to this section, the amount of the bond shall be determined at the time an application for registration or renewal of registration is filed.

(2) To determine the amount of the bond:

(i) the average amount of money that the administrator and any predecessor of the administrator handled at any one time during the immediately preceding calendar year shall be considered; and

(ii) the average amount of money that the administrator expects to handle at any one time during the current calendar year shall be considered.

(3) The amount of the bond:

(i) may not be less than 10% of the average amount of money that the administrator expects to handle at any one time for the life insurer or all the plans that the administrator expects to administer during the coming year; and

(ii) subject to paragraph (4) of this subsection, may not be less than $5,000 or more than $500,000.

(4) After a hearing held under Title 2 of this article, the Commissioner may set the amount of the bond to exceed $500,000, up to 10% of the average amount of money that the administrator expects to handle at any one time for all the plans that the administrator expects to administer during the coming year.

(c) Subject to approval by the Commissioner, the bond may be an individual bond or a blanket bond that covers a group or class.

(d) (1) An applicant need not file evidence of a bond as a condition of registration or renewal of registration if:

(i) the applicant only administers plans under which benefits are paid only from the general assets of an employee organization or of an employer; or

(ii) the applicant:

1. is a corporation organized and doing business under the laws of the United States or a state;

2. is authorized under the laws of the United States or a state to exercise trust powers or to engage in business as an insurer;

3. is subject to supervision or examination by a federal or State authority; and

4. at all times has a combined capital and surplus that exceeds $1,000,000 or any greater amount set by regulation of the Commissioner.

(2) The Commissioner may waive the requirement for an applicant to file evidence of a bond as a condition of registration or renewal of registration if the Commissioner finds that:

(i) other arrangements, including providing letters of credit or similar instruments, would be adequate to protect the interests of plan participants and beneficiaries; or

(ii) the overall financial condition of the applicant would be adequate to protect the interests of plan participants and beneficiaries.

(e) Notwithstanding any other provision of the Code, an applicant that complies with this section and is registered as an administrator under this subtitle is not subject to any other bonding requirement imposed by the law of the State for the same activities that required the applicant to be registered and bonded under this subtitle.

§8–307.

The Commissioner shall register each applicant who meets the requirements of this subtitle.

§8–308.

(a) A registration expires 2 years from the date of issuance unless it is renewed as provided in this section.

(b) Before a registration expires, the registrant may renew it for an additional 2–year term, if the registrant:

(1) otherwise is entitled to be registered;

(2) files with the Commissioner a renewal application on the form that the Commissioner requires;

(3) pays to the Commissioner a renewal fee of $50; and

(4) except as provided in § 8–306(d) of this subtitle, files with the Commissioner evidence of a bond in compliance with § 8–306 of this subtitle.

(c) An application for renewal of a registration shall be considered made in a timely manner if it is postmarked on or before the date the registration expires.

(d) The Commissioner shall renew the registration of each registrant that meets the requirements of this section.

§8–308.1.

(a) Within 1 year after the expiration date, a person whose third party administrator's registration has expired may reinstate the expired registration by:

(1) filing with the Commissioner the appropriate reinstatement application;

(2) subject to subsection (b) of this section, paying to the Commissioner a reinstatement fee of $100; and

(3) complying with the bond requirement of § 8–306 of this subtitle.

(b) The Commissioner may limit the reinstatement fee to the amount of the renewal fee in cases where the reinstatement applicant did not make timely renewal because of temporary incapacity, hospitalization, or other hardship.

(c) A person whose third party administrator's registration has expired is prohibited from acting as a third party administrator until the effective date of reinstatement of the registration.

(d) A person who does not comply with subsection (a) of this section within 1 year after the expiration date shall apply for a third party administrator's registration under § 8–305 of this subtitle and meet any other requirements specified by the Commissioner in regulation.

(e) The Commissioner may adopt regulations to carry out this section.

§8–309.

(a) Subject to the hearing provisions of Title 2 of this article, the Commissioner may deny a registration to an applicant or refuse to renew, suspend, or revoke the registration of a registrant if the applicant or registrant:

(1) makes a material misstatement in an application for registration;

(2) fraudulently or deceptively obtains or attempts to obtain a registration for the applicant or registrant or for another;

(3) has been convicted of a felony or of a misdemeanor involving moral turpitude;

(4) in connection with the administration of a plan or with activities on behalf of a life insurer, commits fraud or engages in illegal or dishonest activities;

(5) has violated this article or another law of the State that relates to insurance; or

(6) knowingly fails to comply with a regulation adopted by or an order of the Commissioner.

(b) This section does not limit any regulatory power of the Commissioner under Title 2 of this article.

§8–310.

An administrator shall discharge the administrator's duties with respect to a plan or a life insurer:

(1) solely in the interest of providing to the plan's participants and beneficiaries the benefits to which they are entitled under the plan or on behalf of a life insurer;

(2) for the exclusive purpose of providing benefits to the plan's participants and beneficiaries and defraying reasonable expenses of administering the plan or on behalf of a life insurer;

(3) with the care, skill, prudence, and diligence that a prudent person acting in a similar capacity and under similar circumstances would use to conduct an enterprise of similar character and with similar aims;

(4) if applicable, by diversifying the investments of the plan or the life insurer to minimize the risk of large losses, unless under the circumstances it is clearly prudent not to do so; and

(5) in accordance with the documents and instruments governing the plan or the life insurer to the extent that the documents and instruments are not inconsistent with this subtitle.

§8–311.

(a) A person may not act as an administrator without a written agreement between the administrator and the plan sponsor or insurer.

(b) An administrator shall retain the agreement required by this section as an official record of the administrator for the duration of the agreement and for 3 years after termination of the agreement.

§8–312.

(a) An administrator shall maintain adequate books and records about each plan administered by the administrator or about activities of the administrator on behalf of a life insurer:

(1) in accordance with prudent standards of record keeping; and

(2) for the duration of the agreement required by § 8–311 of this subtitle.

(b) Subject to any restrictions in the agreement required by § 8–311 of this subtitle on the proprietary rights of the parties in the books and records, the plan sponsor or insurer has the right to reasonable access to the books and records that is sufficient to allow the plan sponsor or insurer to fulfill its contractual obligations to the plan participants and beneficiaries.

(c) If an administrator ceases to administer a plan or ceases to act on behalf of a life insurer, the administrator:

(1) shall deliver the books and records about the plan or about activities on behalf of the life insurer that are in the administrator's possession to the administrator's successor, the plan sponsor, or the insurer; or

(2) for 3 years after the administrator ceases to administer the plan or act on behalf of the life insurer:

(i) shall retain the books and records about the plan or about activities on behalf of the life insurer; and

(ii) shall provide access to the plan sponsor and insurer as provided under subsection (b) of this section.

§8–313.

(a) At least 30 days before the change is effective, an administrator of a plan that provides pharmaceutical benefits shall notify in writing all pharmacies under contract with the plan of any of the following changes in the pharmaceutical benefit program rules or requirements:

(1) exclusion of coverage for classes of drugs as specified by contract;

(2) changes in prior or preauthorization procedures; or

(3) selection of new prescription claims processors.

(b) An administrator that fails to provide advance notice under subsection (a) of this section shall honor and pay in full any claim under the program rules or requirements that existed before the change for 30 days after the postmarked date of the notice.

§8–314.

On request of the Commissioner, an administrator shall submit to the Commissioner a copy of any errors and omissions policy covering the administrator.

§8–315.

(a) A provision in an agreement or instrument that relates to the administration of a plan that purports to relieve an administrator from responsibility or liability for a duty or requirement imposed under this subtitle is void as against public policy.

(b) Notwithstanding subsection (a) of this section:

(1) a plan may purchase insurance for its administrators or for itself to cover liability or losses that occur because of an act or omission of an administrator if the insurance allows recourse by the insurer against the administrator in a case of breach of responsibility under this subtitle by the administrator;

(2) an administrator may purchase insurance to cover the administrator's possible liability under this subtitle if the insurance is obtained for and paid from the administrator's own account; or

(3) an employer or an employee organization may purchase insurance to cover possible liability of one or more persons that act as administrators with respect to a plan.

§8–316.

(a) With respect to a plan or the life insurer, an administrator, directly or indirectly:

(1) may not deal with the assets of the plan or the life insurer in the administrator's own interest or for the administrator's own account;

(2) in a transaction involving the plan or the life insurer, may not act in any capacity on behalf of or represent in any capacity a party whose interests are adverse to the interests of the life insurer, the plan, or the plan's participants or beneficiaries;

(3) other than commissions or service fees received from an insurer, may not receive consideration for the administrator's own personal account from a party dealing with the plan or the life insurer in connection with a transaction involving the assets of the plan or the life insurer; or

(4) may not knowingly participate in or attempt to conceal an act or omission of another administrator involved in the administration of that plan or in activities on behalf of the life insurer, knowing that the act or omission of the other administrator would be a violation of this subtitle.

(b) An administrator may not procure the bond required by this subtitle from a surety insurer or other company or through an insurance producer in whose business operations the administrator has direct or indirect control or significant financial interest.

(c) Notwithstanding subsection (a)(1) of this section, an administrator is not considered to have dealt with the assets of a plan in the administrator's own interest or for the administrator's own account solely because:

(1) the administrator held the assets, at interest for the benefit of the administrator, for an administratively reasonable period of time before remitting the assets to an insurer or other payee; or

(2) the compensation that the administrator receives for services necessary for establishing or operating the plan does not exceed reasonable compensation.

§8–317.

A person may not knowingly allow another person to act as an administrator with respect to a plan in violation of this subtitle.

§8–318.

(a) A person may not discharge, fine, suspend, expel, discipline, or discriminate against a plan participant or beneficiary:

(1) for exercising a right to which the participant or beneficiary is entitled under this subtitle; or

(2) for the purpose of interfering with a right to which the participant or beneficiary may become entitled under this subtitle.

(b) A person may not discharge, fine, suspend, expel, discipline, or discriminate against a person, whether or not the person is a plan participant or beneficiary, because the person:

(1) has given information or testified in an inquiry or proceeding that relates to this subtitle; or

(2) is about to give information or testify in an inquiry or proceeding that relates to this subtitle.

(c) A person may not, by fraud, force, violence, or the threat of force or violence, restrain, coerce, or intimidate or attempt to restrain, coerce, or intimidate a plan participant or beneficiary for the purpose of interfering with or preventing the exercise of a right to which the plan participant or beneficiary is or may become entitled under this subtitle.

§8–319.

(a) (1) A person aggrieved by the conduct of a person registered or required to be registered under this subtitle may file a written complaint with the Commissioner.

(2) On receipt of a complaint, the Commissioner shall investigate the complaint.

(b) The Commissioner may investigate any person if the Commissioner has reasonable cause to believe that the person has violated any provision of this subtitle or a regulation adopted under it.

(c) Without limitation of the powers granted to the Commissioner under Title 2 of this article, in connection with an investigation under this section, the Commissioner may:

(1) examine the books and records of a person registered under this subtitle or any other person that the Commissioner believes has violated this subtitle or a regulation adopted under it;

(2) subpoena documents and other evidence; and

(3) summon and examine under oath a person whose testimony the Commissioner requires.

(d) For the purpose of conducting an investigation under this section, the Commissioner may not require an administrator to submit to the Commissioner, more than once in a 12-month period, any books or records of a plan administered by the administrator unless the Commissioner has reasonable cause to believe that a violation of this subtitle or a regulation adopted or order issued under it exists.

(e) Subject to subsection (f) of this section, the Commissioner may make available information about a matter that may be subject to an investigation to:

(1) the National Association of Insurance Commissioners;

(2) a unit of state or federal government; and

(3) a person that is the subject of the investigation.

(f) Unless disclosure is required by a court of competent jurisdiction in a legal proceeding, the Commissioner shall keep confidential and may not disclose a trade secret or commercial information contained in:

(1) an administrator's books, records, or other documents; or

(2) data provided by the administrator, including the identity and address of persons covered by a plan.

§8–320.

(a) To enforce this subtitle and any regulation adopted under it, the Commissioner may issue an order that requires the violator to:

(1) cease and desist from the violation and further similar violations; and

(2) take specific affirmative action to correct the violation, including:

(i) the restitution of money, property, or other assets to a person aggrieved by the violation;

(ii) the restoration to the plan or the life insurer of profits realized by the administrator that have been made through use of assets of the plan or the life insurer by the administrator; and

(iii) the removal of the administrator that committed the violation.

(b) (1) The Commissioner may file a petition in the circuit court of any county to enforce an order issued under this section.

(2) In an action brought by the Commissioner under this section, the Commissioner may recover for the use of the State reasonable attorney's fees and the costs of the action.

(c) (1) In addition to any other enforcement action taken by the Commissioner under this section, the Commissioner may impose a civil penalty of not more than $10,000 for each violation of this article committed by an administrator.

(2) Notwithstanding paragraph (1) of this subsection, the Commissioner may impose a civil penalty of not more than $1,000 per day for each day that a person is in violation of § 8–303(a) of this subtitle.

(3) In determining the amount of the civil penalty imposed under this subsection, the Commissioner shall consider:

(i) the seriousness of the violation;

(ii) the good faith of the violator;

(iii) the violator's history of previous violations;

(iv) the deleterious effect of the violation on the plan and its participants and beneficiaries;

(v) the assets of the violator; and

(vi) any other factors that relate to the determination of a financial penalty.

(d) This section does not limit any regulatory power of the Commissioner under Title 2 of this article.

§8–321.

(a) With respect to a plan or activities on behalf of a life insurer, an administrator who breaches a responsibility imposed on the administrator by this subtitle:

(1) is personally liable for the restitution of money, property, or other assets to a person aggrieved by the violation and for the restoration to the plan of any profits realized by the administrator that have been made through use of assets of the plan by the administrator; and

(2) is subject to any other equitable or remedial relief that a court considers appropriate, including removal of the administrator.

(b) In addition to any liability that an administrator may have under subsection (a) of this section, the administrator is liable for a breach of responsibility under this subtitle by another administrator with respect to the same plan if the administrator:

(1) knowingly participates in or knowingly attempts to conceal an act or omission of the other administrator involved in the administration of the same plan, knowing that the act or omission of the other administrator would be a violation of this subtitle;

(2) by the administrator's failure to comply with § 8–310 of this subtitle, has enabled the other administrator to violate this subtitle; or

(3) knows of a violation of this subtitle by the other administrator, unless the administrator makes reasonable efforts under the circumstances to remedy the violation.

(c) (1) An administrator is not liable under this subtitle, by reason of a breach of responsibility, for a loss to a participant's or beneficiary's account if:

(i) the plan provides for individual accounts and allows a participant or beneficiary to exercise investment control over assets in the participant's or beneficiary's account;

(ii) the participant or beneficiary exercises that control; and

(iii) the loss or breach results from the participant's or beneficiary's exercise of that investment control.

(2) An administrator is not liable for a violation of this subtitle if the violation was committed before the administrator became an administrator or after the administrator ceased to be an administrator.

§8–321.1.

A third party administrator shall comply with § 27–803 of this article.

§8–321.2.

A third–party administrator shall comply with Title 33 of this article.

§8–322.

A person that intentionally violates this subtitle or a regulation adopted under it is guilty of a misdemeanor and on conviction is subject to a fine not exceeding $10,000 or imprisonment not exceeding 1 year or both.

§8–401.

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

(b) "Benefit contract" means the agreement for provision of benefits authorized by § 8-432 of this subtitle.

(c) "Benefit member" means an adult member who is designated by the laws or rules of a society to be a benefit member under a benefit contract.

(d) "Certificate" means the document issued as written evidence of a benefit contract.

(e) "Laws" means a society's articles of incorporation, constitution, and bylaws, however designated.

(f) "Lodge" means subordinate member units of a society, known as camps, courts, councils, branches, or by any other designation.

(g) "Premiums" means premiums, rates, dues, or other required contributions by whatever name known that are payable under a certificate.

(h) "Rules" means all rules, regulations, or resolutions adopted by the supreme governing body or board of directors of a society which are intended to have general application to the members of the society.

(i) Unless the context requires otherwise, "society" means fraternal benefit society.

§8–402.

(a) (1) An incorporated society, order, or supreme lodge without capital stock is deemed to be a fraternal benefit society if it:

(i) is conducted solely for the benefit of its members and their beneficiaries;

(ii) is not conducted for profit;

(iii) is operated on a lodge system with ritualistic form of work;

(iv) has a representative form of government; and

(v) provides for benefits to be paid in accordance with this subtitle.

(2) An incorporated or unincorporated society, order, or supreme lodge without capital stock that is exempted under § 8-404(a)(2) of this subtitle is deemed to be a fraternal benefit society.

(b) A society is deemed to be operating on a lodge system if it operates under a system by which the society:

(1) has a supreme legislative or governing body and subordinate lodges or branches, by whatever name known;

(2) by its laws, requires the subordinate lodges or branches to hold regular meetings at least once each month in furtherance of the purposes of the society; and

(3) elects, initiates, or admits members in accordance with its laws, rituals, and rules.

(c) A society is deemed to have a representative form of government if:

(1) (i) the society provides in its laws for a supreme legislative or governing body composed of:

1. representatives elected by the members of the society or by delegates elected directly or indirectly by the members; and

2. any other individuals required by the laws of the society;

(ii) election of delegates may be accomplished by mail;

(iii) the elected representatives of the society:

1. are a majority of the supreme legislative or governing body;

2. have at least two-thirds of the votes; and

3. have at least the number of votes required to amend the laws of the society;

(iv) at least once every 4 years:

1. the supreme legislative or governing body of the society meets; and

2. officers, representatives, or delegates of the society are elected;

(v) each insured member is eligible for election to act or serve as a delegate to the meeting;

(vi) the society has a board of directors that:

1. is responsible for the management of the affairs of the society between meetings of the supreme legislative or governing body;

2. is subject to control by the supreme legislative or governing body;

3. except when a vacancy is filled between meetings of the supreme legislative or governing body, is elected by the supreme legislative or governing body; and

4. has powers and duties delegated by the laws of the society;

(vii) the officers of the society are elected by the supreme legislative or governing body or by the board of directors; and

(viii) the members, officers, representatives, or delegates of the society may not vote by proxy; or

(2) (i) the society provides in its laws for a supreme legislative or governing body composed of:

1. a board composed of individuals elected by the members, either directly or by their representatives in intermediate assemblies; and

2. any other individuals required by the laws of the society;

(ii) election of the board may be accomplished by mail;

(iii) the term of an elected board member may not exceed 4 years;

(iv) the individuals elected to the board:

1. are a majority of the board; and

2. have at least the number of votes required to amend the laws of the society;

(v) vacancies on the board between elections are filled as prescribed by the laws of the society;

(vi) an individual filling the unexpired term of an elected board member is considered to be an elected member; and

(vii) the board meets at least quarterly to conduct the business of the society.

§8–403.

(a) (1) Except as otherwise provided in this section, societies are:

(i) governed exclusively by this subtitle; and

(ii) exempt from the other insurance laws of the State.

(2) A statute enacted after December 31, 1963, does not apply to societies unless the statute expressly states that it applies to them.

(b) (1) In addition to the provisions of this subtitle, the following provisions of this article apply to societies to the extent not in conflict with the express provisions and reasonable implications of this subtitle:

(i) Title 1 of this article;

(ii) Title 2, Subtitle 1 of this article, including § 2–112 of this article;

(iii) Title 2, Subtitle 2 of this article;

(iv) § 3–117 of this article;

(v) § 3–127 of this article;

(vi) § 4–102(b) of this article;

(vii) § 4–113(a)(7), (8), and (9) of this article;

(viii) § 4–203 of this article;

(ix) § 4–204 of this article;

(x) § 5–103 of this article;

(xi) § 5–201 of this article;

(xii) Title 6, Subtitle 2 of this article;

(xiii) Title 9, Subtitle 2 of this article;

(xiv) § 10–120 of this article;

(xv) Title 15, Subtitle 9 of this article;

(xvi) Title 27 of this article;

(xvii) § 1–301 of this article; and

(xviii) Title 4, Subtitle 3 of this article.

(2) In addition to the provisions of this subtitle, societies are subject to the provisions of Title 13, Subtitle 5 of the Estates and Trusts Article.

§8–404.

(a) Except as provided in this section, this subtitle and the other insurance laws of the State do not apply to:

(1) a grand or subordinate lodge or society, order, or association that:

(i) was doing business in the State on December 31, 1963;

(ii) provides benefits exclusively through local or subordinate lodges; and

(iii) does not issue benefit certificates;

(2) an order, society, or association that:

(i) 1. limits its membership to individuals engaged in one or more crafts or hazardous occupations in the same or similar lines of business; and

2. insures only its members and their families and dependents; or

(ii) 1. as to individual health insurance policies, offers those policies in this State only to members of the Mennonite Church and their dependents and families;

2. was formed as a fraternal benefit society under the laws of the State of Indiana prior to January 1, 1966 for the purpose of providing mutual aid in affiliation with the Mennonite Church; and

3. is registered as a foreign corporation under § 7–202 of the Corporations and Associations Article;

(3) a society or auxiliary of an order, society, or association described in item (2) of this subsection;

(4) a domestic society that:

(i) limits its membership to employees of a particular municipal area or a designated firm, business house, or corporation;

(ii) provides for individual death benefits not exceeding $400 per year or disability benefits not exceeding $350 per year or both; and

(iii) does not issue benefit certificates;

(5) a domestic society or association that:

(i) has a purely religious, charitable, or benevolent purpose;

(ii) provides for individual death benefits not exceeding $400 per year or disability benefits not exceeding $350 per year or both;

(iii) does not issue benefit certificates; and

(iv) has a membership of not more than 1,000 individuals; and

(6) any association, whether or not a fraternal benefit society:

(i) that was organized before 1880;

(ii) the members of which are officers or enlisted, regular or reserve, active, retired, or honorably discharged members of the uniformed services; and

(iii) a principal purpose of which is to provide insurance and other benefits to its members and the dependents or beneficiaries of its members.

(b) Except for an organization described in subsection (a)(2) or (3) of this section, a society that is exempt from this subtitle may not give, allow, or promise to give or allow to any person compensation for obtaining new members.

(c) The provisions of this subtitle relating to medical examination, valuation of benefit certificates, and incontestability do not apply to a society that:

(1) provides benefits in case of death or disability resulting solely from accident; and

(2) does not obligate itself to pay natural death or sickness benefits.

(d) By examination or otherwise, the Commissioner may require information from any society or association that will enable the Commissioner to determine whether the society or association is exempt from this subtitle.

§8–405.

(a) A society organized or authorized to transact business under this subtitle is deemed to be a charitable and benevolent institution.

(b) The funds of a society organized or authorized to transact business under this subtitle are exempt from all taxes, except taxes on real estate and office equipment.

§8–406.

(a) An incorporated society authorized to transact insurance business in the State on December 31, 1963, may exercise all the rights, powers, and privileges prescribed in this subtitle and in the charter or articles of incorporation of the society to the extent consistent with this subtitle.

(b) A domestic society is not required to reincorporate.

§8–407.

(a) (1) Each society authorized to do business in the State must appoint the Commissioner as attorney for service of process issued against the society and any successor in interest in the State.

(2) The appointment of the Commissioner shall:

(i) be made in writing; and

(ii) state that:

1. any process against the society that is served on the Commissioner has the same legal effect as if served on the society; and

2. the appointment remains in effect as long as any liability of the society remains outstanding in the State.

(b) A copy of an appointment made under this section and certified by the Commissioner is deemed sufficient evidence of the appointment and shall be admitted in evidence with the same effect as if it were the original.

§8–410.

(a) Seven or more individuals, acting as incorporators, may form a society under this subtitle.

(b) (1) Each incorporator of a society must be a citizen of the United States.

(2) A majority of the incorporators must be citizens of the State.

§8–411.

(a) The incorporators shall sign and acknowledge the articles of incorporation.

(b) The articles of incorporation shall include:

(1) the purpose for which the society is being formed and the manner in which its corporate powers are to be exercised;

(2) the name of the society;

(3) the name, address, and state of residence of each incorporator; and

(4) the name, address, residence, and official title of each officer, trustee, director, and any other individual who will have general control of the management of the affairs and funds of the society for the first year and until the first election.

(c) (1) The powers set forth in the articles of incorporation may not exceed the powers granted to societies by this subtitle.

(2) The purposes of a society may include any lawful social, intellectual, educational, charitable, benevolent, moral, fraternal, or religious activity.

(d) The name of a society may not be misleadingly or confusingly similar to the name of any other society or insurer.

§8–412.

(a) The incorporators shall file with the Commissioner:

(1) the articles of incorporation of the society;

(2) certified copies of the society's laws and rules;

(3) copies of all proposed:

(i) forms of certificates;

(ii) applications for certificates; and

(iii) circulars to be issued by the society; and

(4) a bond conditioned on the return to applicants of advance premiums if the organization of the society is not completed within 1 year.

(b) The Commissioner may require any additional information that the Commissioner considers necessary.

(c) The bond required under subsection (a) of this section must:

(1) be issued by a surety insurer approved by the Commissioner; and

(2) be in the amount required by the Commissioner, but not less than $300,000 nor more than $1,500,000.

(d) Each document filed shall be in the English language.

§8–413.

(a) Each society that applies on or after July 1, 1968, for an initial certificate of authority under this subtitle must have working capital of at least $125,000.

(b) After issuance of its initial certificate of authority, a society described in subsection (a) of this section shall maintain unencumbered assets that exceed all liabilities by $100,000.

§8–414.

If a society complies with this subtitle, the Commissioner shall:

(1) certify, retain, and record the articles of incorporation of the society; and

(2) provide the incorporators with a preliminary certificate of authority that authorizes the society to solicit members as provided in this subtitle.

§8–415.

(a) (1) After receiving a preliminary certificate of authority from the Commissioner, a society may solicit members for the purposes of completing its organization.

(2) Until the society complies with the requirements of subsection (b) of this section, the society may not:

(i) incur any liability other than for the return of an advance premium;

(ii) issue any certificate; or

(iii) pay, allow, or offer or promise to pay or allow any death or disability benefit.

(b) Each society shall:

(1) secure bona fide applications for death benefits in an aggregate amount of at least $500,000 on at least 500 lives;

(2) receive from each applicant evidence of insurability satisfactory to the society;

(3) have on file certificates of examination or acceptable declarations of insurability approved by the society's chief medical examiner;

(4) collect from each applicant the amount of at least one regular monthly premium under the society's table of rates as provided by the society's laws, and issue to each applicant a receipt for the amount received;

(5) collect premiums as provided in item (4) of this subsection in an aggregate amount of at least $150,000 and credit the premiums to the funds from which benefits are to be paid;

(6) establish at least ten subordinate lodges or branches into which the applicants are admitted;

(7) submit to the Commissioner, under the oath of the president, secretary, or an equivalent officer of the society, the name, address, date of admission,

and amounts of benefits and premiums of each applicant, and the name and number of the subordinate branch of which the applicant is a member; and

(8) submit to the Commissioner, under oath of the treasurer or an equivalent officer of the society, a statement that at least 500 applicants have paid the premiums required by items (4) and (5) of this subsection.

(c) All advance premiums shall be held in trust during the period of organization and, if the society has not qualified for a certificate of authority within 1 year, the premiums shall be returned to the applicants.

§8–416.

(a) Except as provided in subsection (b) of this section, unless a society receives a certificate of authority as provided in § 8-417 of this subtitle, the preliminary certificate of authority of the society, its articles of incorporation, and each action taken under the authority of the preliminary certificate of authority are void 1 year after the preliminary certificate of authority is issued.

(b) For good cause shown, the Commissioner may extend the preliminary certificate of authority for an additional period not exceeding 1 year.

§8–417.

(a) Before the Commissioner issues a certificate of authority, the Commissioner may make any examination and require any additional information that the Commissioner considers necessary.

(b) On presentation of satisfactory evidence that the society has complied with this subtitle, the Commissioner shall issue to the society a certificate of authority that authorizes the society to transact business under this subtitle.

(c) The certificate of authority is prima facie evidence that the society existed on the date of the certificate of authority.

(d) The Commissioner shall record the certificate of authority in the office of the Commissioner.

§8–418.

(a) A society may adopt and amend laws to:

(1) govern the society;

(2) admit society members;

(3) manage society affairs; and

(4) fix and readjust the rates of society members.

(b) (1) The laws of the society may provide that subordinate lodges or branches and their officers and members may not waive any provisions of the laws of the society.

(2) A provision adopted in accordance with this subsection is binding on the society and each member and beneficiary of a member.

(c) Except as prohibited by this subtitle, a society has any other power necessary and incidental to accomplish the purposes for which it is established.

§8–419.

(a) A society may amend the society's laws, in accordance with the provisions of those laws, by:

(1) action of its supreme legislative or governing body at a regular or special meeting of the body; or

(2) referendum.

(b) (1) An amendment by referendum may be approved in accordance with the laws of a society, by the vote of:

(i) the society's voting members;

(ii) the delegates or representatives of the society's voting members; or

(iii) the society's local lodges or branches.

(2) An amendment may not be adopted by referendum unless, within 6 months after it is submitted for adoption, a majority of all the voting members of the society have consented to the amendment.

(c) (1) An amendment to the laws of a society may not take effect unless the Commissioner approves.

(2) The Commissioner shall approve an amendment if the Commissioner finds that the amendment was adopted properly and is not inconsistent with the laws of the State or the society.

(3) The Commissioner's approval or disapproval shall be in writing and mailed to the secretary or equivalent officer of the society at the society's principal office.

(4) The Commissioner shall include in a notice of disapproval a statement of the reasons for the disapproval.

(5) Unless disapproved by the Commissioner, an amendment is deemed approved 60 days after it is filed with the Commissioner.

(d) (1) Within 90 days after approval by the Commissioner, each amendment or a synopsis of it shall be mailed by the society to each member of the society or published in full in the official publication of the society.

(2) The affidavit of an individual authorized by the society to mail an amendment or synopsis, stating that the amendment or synopsis was addressed properly and mailed, is prima facie evidence that the amendment or synopsis was provided to the addressee.

(e) A printed copy of the laws as amended, certified by the secretary or equivalent officer of the society, is prima facie evidence of the amendment.

§8–420.

(a) (1) The officers, trustees, directors, or other individuals who have general control of the management of the affairs and funds of the society shall be elected by the supreme legislative or governing body of the society.

(2) The election shall be held within 1 year after a permanent certificate of authority is issued under § 8-417 of this subtitle.

(b) The officers of a grand, supreme, or subordinate lodge or branch of a society are not personally liable for payment of a benefit provided by the society.

(c) (1) An individual may be indemnified and reimbursed by a society for expenses reasonably incurred by, and liabilities imposed on, the individual in connection with or arising out of any threatened, pending, or completed action, suit, or proceeding, whether civil, criminal, administrative, or investigative, in which the individual may be involved because the individual is or was a director, officer,

employee, or agent of the society or of any firm, corporation, or organization in which the individual served in any capacity at the request of the society.

(2) An individual may not be indemnified or reimbursed:

(i) in relation to any matter in an action, suit, or proceeding as to which the individual is finally adjudged to be or have been guilty of breach of a duty as a director, officer, employee, or agent of the society; or

(ii) in relation to any matter in a threatened or pending action, suit, or proceeding that has been made the subject of a compromise settlement, unless the individual:

1. acted in good faith for a purpose the individual reasonably believed to be in, or not opposed to, the best interests of the society; and

2. in a criminal action or proceeding, had no reasonable cause to believe that the individual's conduct was unlawful.

(3) The determination of whether the conduct of an individual met the standard required to justify indemnification and reimbursement in relation to any matter described in paragraph (2) of this subsection may be made only by:

(i) the supreme governing body or board of directors of the society by a majority vote of a quorum that consists of individuals who were not parties to the action, suit, or proceeding; or

(ii) a court of competent jurisdiction.

(4) The termination of an action, suit, or proceeding by judgment, order, settlement, conviction, or on a plea of no contest, as to an individual shall not in itself create a conclusive presumption that the individual did not meet the standard of conduct required to justify indemnification and reimbursement.

(5) The right of indemnification and reimbursement under this subsection shall not be exclusive of other rights to which an individual may be entitled as a matter of law, and shall inure to the benefit of the individual's heirs, executors, and administrators.

(d) A society may purchase and maintain insurance on behalf of any individual who is or was a director, officer, employee, or agent of the society, or who is or was serving at the request of the society as a director, officer, employee, or agent of any other firm, corporation, or organization against any liability asserted against the individual and incurred by the individual in any such capacity or arising out of

the individual's status as such, whether or not the society would have the power to indemnify the individual against such liability under this section.

(e) No director, officer, employee, member, or volunteer of a society serving without compensation, shall be liable, and no cause of action may be brought, for damages resulting from the exercise of judgment or discretion in connection with the duties or responsibilities of the individual for the society unless the act or omission involved willful or wanton misconduct.

§8–421.

(a) (1) A society may admit to membership an individual who:

(i) is older than 14 1/2 years old; and

(ii) gives the society evidence of insurability acceptable to the society.

(2) A minor who is admitted to the society is:

(i) bound by the terms of the application and certificate and by the laws and rules of the society; and

(ii) entitled to the rights and privileges of membership as though the individual were an adult at the time of application.

(b) A society also may admit general or social members who do not have a voice or vote in the management of the society's insurance affairs.

(c) The members of a grand, supreme, or subordinate lodge or branch of a society are not personally liable for payment of a benefit provided by the society.

(d) A society shall specify in its laws or rules the rights and privileges of each membership class.

(e) Membership rights in a society are personal to the member and not assignable.

§8–422.

(a) The principal office of a domestic society shall be located in the State.

(b) Meetings of the supreme legislative or governing body of a society may be held in any state, district, province, or territory where the society has at least five subordinate branches.

(c) The minutes of the proceedings of the supreme legislative or governing body and of the board of directors or equivalent body of a society shall be in English.

(d) A society may provide in its laws or rules for grievance or complaint procedures for members.

§8–423.

(a) A certificate of authority of a society expires on the first June 30 after its effective date unless it is renewed as provided in this section.

(b) At least 1 month before a certificate of authority expires, the Commissioner shall mail to the holder of the certificate of authority, at the last known address of the holder, or send by electronic means in accordance with § 2–116 of this article:

(1) a renewal application form; and

(2) a notice that states:

(i) the date on which the current certificate of authority expires;

(ii) the date by which the Commissioner must receive the renewal application for the renewal to be issued and mailed before the certificate of authority expires; and

(iii) the amount of the renewal fee.

(c) Before a certificate of authority expires, the holder of the certificate of authority may renew it for an additional 1-year term, if the holder:

(1) otherwise is entitled to a certificate of authority;

(2) files with the Commissioner a renewal application on the form that the Commissioner provides; and

(3) pays to the Commissioner the fee for renewal of certificates of authority of insurers required by § 2-112 of this article.

(d) (1) The Commissioner shall renew the certificate of authority of each holder who meets the requirements of this subtitle.

(2) If a certificate holder pays the applicable renewal fee before the certificate of authority expires, the certificate of authority remains in effect until the Commissioner renews or refuses to renew the certificate of authority.

§8–424.

(a) A foreign or alien society may not transact insurance business in the State unless the society has a certificate of authority issued by the Commissioner.

(b) A foreign or alien society that desires to transact insurance business in the State must have the qualifications required of domestic societies organized under this subtitle.

(c) A foreign or alien society may be authorized to transact insurance business in the State if the society:

(1) shows that its assets are invested in accordance with this subtitle; and

(2) files with the Commissioner:

(i) a certified copy of its charter or articles of incorporation;

(ii) a copy of its constitution and laws, certified by its secretary or equivalent officer;

(iii) a power of attorney as required by § 8-407 of this subtitle;

(iv) a statement of the society's insurance business that is:

1. under oath of its president and secretary or equivalent officers;

2. in the form required by the Commissioner;

3. verified by an examination made by the insurance supervisory official of its home state or another state, territory, province, or country; and

4. satisfactory to the Commissioner;

(v) a certificate of compliance from the proper official of its home state, territory, province, or country that the society is legally incorporated and authorized to transact insurance business in that state, territory, province, or country;

(vi) copies of its forms of certificates; and

(vii) any additional information that the Commissioner considers necessary.

(d) Each foreign or alien society authorized to do insurance business in the State shall file with the Commissioner, within 90 days after enactment, a certified copy of each amendment of, or addition to, its articles of incorporation, constitution, or laws.

(e) (1) The Commissioner may deny a certificate of authority to a foreign or alien society applicant or suspend or revoke a certificate of authority of a foreign or alien society if, on investigation, the Commissioner finds that the society:

(i) has exceeded its powers;

(ii) has failed to comply with any provision of this subtitle;

(iii) is not fulfilling its contracts in good faith;

(iv) is conducting its insurance business fraudulently; or

(v) is conducting its insurance business in a manner hazardous to its members, creditors, or the public.

(2) If the Commissioner makes a finding under subsection (a) of this section, the Commissioner shall:

(i) notify the society of the finding;

(ii) state in writing the reasons for dissatisfaction; and

(iii) require the society to show cause on or before a specified date why its certificate of authority should not be denied, suspended, or revoked.

(3) If, on or before the date specified in the notice, the society does not show good and sufficient reason why its certificate of authority should not be denied, suspended, or revoked, the Commissioner may:

(i) deny or suspend the certificate of authority until satisfactory evidence is provided to the Commissioner that the denial or suspension should be withdrawn; or

(ii) revoke the certificate of authority.

(f) The provisions of subsection (e) of this section do not prevent a foreign or alien society from continuing in good faith all contracts made in the State during the time the society was legally authorized to transact insurance business in the State.

§8–427.

(a) A society authorized to do insurance business in the State may provide for the payment of:

(1) life insurance benefits;

(2) annuity benefits;

(3) health insurance benefits;

(4) monument or tombstone benefits to the memory of a deceased member of the society; and

(5) such other benefits as authorized for life insurers and which are not inconsistent with this subtitle.

(b) (1) A society shall specify in its laws those persons who may receive benefits through the society.

(2) (i) For all coverages, the member shall be the applicant or the insured.

(ii) If the member is the applicant, there shall be a bona fide familial or other dependent relationship between the member and the insured or beneficiary.

(3) (i) Every society, by its laws, may limit the scope of beneficiaries only to the extent required by federal law governing fraternal benefit societies.

(ii) The society may specify the terms and conditions on which benefits certificates may be assigned.

(c) A society may not provide benefits through group insurance coverages.

(d) A member who applies for additional benefits more than 6 months after becoming a benefit member shall provide additional evidence of insurability acceptable to the society.

§8–428.

(a) In this section, "eligible children" means children under the minimum age for adult membership but not more than 18 years old at the time of application.

(b) A society may provide for benefits on the lives of eligible children:

(1) in accordance with § 8-427 of this subtitle;

(2) in accordance with the laws or rules of the society; and

(3) on application of an adult.

(c) (1) A society may organize and operate branches for eligible children.

(2) A society may not require eligible children to be members of or be initiated in a local lodge.

(3) Eligible children may not participate in the management of the society.

(d) (1) On obtaining the minimum age for adult beneficial membership under the laws of the society, eligible children insured under certificates issued under this section shall be transferred to and become members of the adult branch of the society if the children otherwise meet the eligibility requirements of the society.

(2) If a child fails to meet the adult eligibility requirements of the society, the transfer is effective only as to the child's insurance account.

(e) A society may provide for:

(1) the designation and changing of designation of beneficiaries in certificates;

(2) the regulation of certificates; and

(3) all rights, obligations, and liabilities incident to the certificates.

§8–429.

(a) For certificates issued before January 1, 1998, the value of every paid-up nonforfeiture benefit and the amount of any cash surrender value, loan or other option granted shall comply with the provisions of law applicable on December 31, 1997.

(b) (1) Each paid-up nonforfeiture benefit and the amount of any cash surrender value, loan, or other option granted under a certificate may not be less than the corresponding amount ascertained under the laws of the State that apply to life insurers issuing policies containing like insurance benefits based on the same tables.

(2) This subsection applies to certificates issued on or after January 1, 1998, for which reserves are computed on:

(i) the Commissioners 1941 Standard Ordinary Mortality Table;

(ii) the Commissioners 1941 Standard Industrial Table;

(iii) the Commissioners 1958 Standard Ordinary Mortality Table;

(iv) the Commissioners 1980 Standard Mortality Table; or

(v) any more recent table authorized for use under § 5-304(b) of this article.

§8–430.

(a) (1) A member of a society may change the beneficiary in a certificate at any time in accordance with the laws or rules of the society.

(2) By its laws or rules, a society:

(i) may limit the scope of beneficiaries; and

(ii) shall provide that a beneficiary may not have or get a vested interest in the proceeds of a certificate until the certificate becomes due and payable under the insurance contract.

(b) (1) A society may provide for the payment of funeral benefits, not exceeding $5,000, to the extent of that part of any payment under a certificate that

reasonably appears to be due to a person equitably entitled to reimbursement of expenses incurred by the burial of a member.

(2) (i) Subject to subparagraph (ii) of this paragraph, if at the death of a member there is no lawful beneficiary to whom the insurance benefits are payable, the society shall pay to the personal representative of the deceased member the insurance benefits under the certificate, less any funeral benefits paid under paragraph (1) of this subsection.

(ii) If the owner of the certificate is other than the insured, the proceeds shall be payable to that owner.

§8–431.

Benefits to be paid by a society are not subject to attachment, garnishment, or other process and may not be seized, appropriated, or applied by any process or operation of law to pay a debt or liability of a member, beneficiary, or other person with a right to the benefit, whether before or after payment.

§8–432.

(a) (1) Each society authorized to do business in the State shall issue to each member entitled to benefits a certificate that specifies the amount of benefits provided under the certificate.

(2) The certificate, any rider or endorsement attached to the certificate, the laws of the society, the application for membership, any declaration of insurability signed by the applicant, and all amendments to each of these documents constitute the agreement between the society and the member as of the date of issuance of the certificate.

(3) The certificate shall state that the documents listed in paragraph (2) of this subsection constitute the agreement between the society and the member as of the date of issuance of the certificate.

(4) A copy of the application for membership and of any declaration of insurability shall be endorsed on or attached to the certificate.

(b) (1) Each statement purporting to be made by an applicant for insurance is a representation and not a warranty.

(2) A waiver of this subsection is void.

(c) (1) Subject to paragraph (2) of this subsection, an amendment to the laws made after the date of issuance of the certificate:

(i) binds the member and each beneficiary; and

(ii) governs the agreement between the society and the member as though the amendments were made before and were in force on the date that the member applied for membership.

(2) An amendment does not destroy or diminish the benefits that the society contracted to give the member or owner as of the date of issuance of the certificate.

(d) A copy of a document listed in this section, certified by the secretary or equivalent officer of the society, is evidence of the terms and conditions of the document.

§8–433.

(a) (1) After December 31, 1997, a benefit certificate may not be delivered or issued for delivery in the State unless the form has been:

(i) filed with the Commissioner; and

(ii) approved by the Commissioner in the manner provided for like policies issued by life insurers in the State.

(2) Unless disapproved by the Commissioner, a benefit certificate is deemed approved 60 days after the date the form is filed with the Commissioner.

(b) (1) Each life, accident, health, or disability insurance certificate and each annuity certificate issued on or after January 1, 1998, shall meet requirements not inconsistent with this subtitle for like policies and annuities issued by life insurers in the State.

(2) Unless the benefit certificate contains provisions that are more favorable to the member, each benefit certificate shall contain in substance each of the following standard provisions:

(i) a statement of:

1. the amount of rates, premiums, or other required contributions, however named, that are payable by the insured under the certificate; and

2. the member's share of a deficiency if reserves are impaired; and

(ii) a provision that:

1. for payment of any premium after the first, the member is entitled to a grace period of not less than a full month or, at the option of the society, 30 days;

2. the certificate shall continue in full force during the grace period;

3. if the certificate becomes a claim during the grace period before the overdue payment is made, the amount of the overdue payment may be deducted in a settlement under the certificate;

4. recites fully or sets forth the substance of all sections of the laws or rules of the society that are in force on the date of issuance of the certificate, the violation of which will result in the termination or reduction of benefits payable under the certificate; and

5. if the laws of the society provide for expulsion or suspension, a member who is expelled or suspended has the privilege of maintaining the insurance in force by continuing payment of the required premium, unless the expulsion or suspension is for:

A. nonpayment of a premium; or

B. a material misrepresentation in the member's application for membership that is discovered within the contestable period.

(c) Certificates issued on the lives of individuals below the society's minimum age for adult membership:

(1) may provide for transfer of control of ownership to the insured at an age specified in the certificate;

(2) may require approval of an application for membership in order to effect the transfer;

(3) may provide in all other respects for the regulation, government, and control of the certificate and all rights, obligations, and liabilities incident to and connected with the certificate; and

(4) shall specify ownership rights to the certificate prior to any transfer of the certificate.

(d) A society may specify the terms and conditions on which benefit certificates may be assigned.

§8–437.

(a) A society may create, maintain, and operate charitable, benevolent, or educational institutions for the benefit of:

(1) society members;

(2) families and dependents of society members; and

(3) children insured by the society.

(b) (1) For the purposes of an institution authorized by subsection (a) of this section, a society may own, hold, or lease personal or real property inside or outside the State.

(2) The property shall be reported in each annual statement of the society, but may not be allowed as an admitted asset of the society.

(c) (1) Subject to paragraph (2) of this subsection, a society may charge a reasonable fee for maintenance, treatment, and proper attendance in an institution authorized by subsection (a) of this section.

(2) A society may not operate an institution authorized under subsection (a) of this section for profit.

(d) A society may not own or operate a funeral home or undertaking establishment.

(e) A society shall maintain a separate accounting for any income and disbursements under this section and report them in its annual statement.

(f) The purposes of a society as specified in its laws, and as provided in this section and § 8-411(c)(2) of this subtitle, may be carried out:

(1) directly by the society; or

(2) indirectly:

(i) with respect to activities regulated by the Insurance Commissioner, through a subsidiary or affiliate operating under a certificate of authority, certificate of qualification, or other license issued by the Commissioner; and

(ii) for all other activities, through subsidiary corporations and affiliated organizations.

§8–438.

(a) A society may consolidate or merge with another society as provided in this section.

(b) The society shall file with the Commissioner:

(1) a certified copy of the written contract that contains the terms and conditions of the consolidation or merger;

(2) a statement verified under oath by the president and secretary or equivalent officers of each society party to the contract that shows the financial condition of the society on a date set by the Commissioner, but not before December 31 preceding the date of the contract;

(3) a certificate verified under oath by the officers described in item (2) of this subsection that states that the consolidation or merger was approved by a two-thirds vote of the supreme legislative or governing body of each society; and

(4) evidence that, at least 60 days before the approval of the supreme legislative or governing body of each society, the text of the contract was mailed to each member of each society or was published in full in the official publication of that society.

(c) The affidavit of an officer of the society or an individual authorized by the society to mail a notice or document, stating that the text of the contract was properly addressed and mailed, is prima facie evidence that the text was provided to the addressee.

(d) The Commissioner shall approve the contract and issue a certificate of approval if the Commissioner finds that:

(1) the society has complied with the provisions of this section;

(2) the financial statements are correct; and

(3) the consolidation or merger is equitable to the members of each society party to the contract.

(e) (1) Unless a society party to the contract is incorporated under the laws of another state, the contract is effective on approval.

(2) If a society party to the contract is incorporated under the laws of another state, the consolidation or merger is not effective:

(i) until it is approved under the laws of the other state and a certificate of the approval is filed with the Commissioner; or

(ii) if the laws of the other state do not provide for approval, until it is approved by the insurance supervisory official of the other state and a certificate of the approval is filed with the Commissioner.

§8–439.

(a) When a consolidation or merger becomes effective, each right, franchise, and interest of the consolidated or merged society in an asset vests in the successor society, without the need for any other instrument.

(b) A conveyance of real property may be evidenced by a proper deed.

(c) The title to or any interest in real property vested under the laws of the State in a consolidated or merged society does not revert and is not in any way impaired because of the consolidation or merger, but vests absolutely in the successor society.

§8–440.

(a) A domestic society may convert to and be licensed as a mutual life insurer by complying with the applicable requirements of Title 3, Subtitle 1 of this article if the plan of conversion is approved by the Commissioner.

(b) (1) The plan of conversion shall be in writing and shall set forth the terms and conditions of the conversion.

(2) The board of directors shall submit the plan of conversion to the supreme legislative or governing body of the society at a regular or special meeting, by giving a complete copy of the plan with the notice of the meeting.

(3) Notice shall be given as provided in the applicable laws of the society for a regular or special meeting.

(4) The affirmative vote of two-thirds of the members of the body is necessary for approval of the plan.

(c) (1) Conversion to a mutual life insurer may not take effect unless approved by the Commissioner.

(2) The Commissioner may approve the conversion if the Commissioner finds that the proposed change conforms to the requirements of law and is not prejudicial to the certificate holders of the society.

§8–441.

(a) Subject to subsection (b) of this section, a domestic society may cede wholly or partly any individual risk by reinsurance agreement to an insurer that:

(1) is not a fraternal benefit society;

(2) has the power to make reinsurance; and

(3) is authorized to do insurance business in the State or is approved by the Commissioner.

(b) A domestic society may not reinsure substantially all of its insurance in force without the written permission of the Commissioner.

(c) (1) Except as provided in paragraph (2) of this subsection, a ceding domestic society may take credit for the reserves on risks ceded under this section to the extent reinsured.

(2) A ceding domestic society may not be allowed credit, as an admitted asset or as a deduction from liability, for reinsurance made, ceded, renewed, or that otherwise became effective after December 31, 1963, unless the reinsurance is payable by the assuming insurer on the basis of the liability of the ceding society under the contracts reinsured without diminution because of the insolvency of the ceding society.

(d) Notwithstanding the limitations in this section, a society may reinsure the risks of another society in a consolidation or merger approved by the Commissioner under § 8-438 of this subtitle.

§8–442.

(a) (1) All assets of a society shall be held, invested, and disbursed for the use and benefit of the society.

(2) A society member or beneficiary of a member does not have and may not acquire individual rights in the assets of the society and is not entitled to any apportionment or the surrender of any part of the assets except as provided in the insurance contract.

(b) A society may create, maintain, invest, disburse, and apply special funds as necessary to carry out any purpose allowed by the laws of the society.

(c) (1) This subsection applies only to a society with admitted assets that are less than the sum of its accrued liabilities and reserves under all of its certificates when valued according to standards required for certificates issued after December 31, 1963.

(2) A society described in paragraph (1) of this subsection shall state distinctly, in each law of the society regarding payments by members, the purpose of the payments and the proportion of the payments that may be used for expenses.

(3) A society described in paragraph (1) of this subsection may not use any money collected for mortuary or disability purposes, or its net earnings, for expenses.

(d) (1) A society, pursuant to resolution of its supreme governing body, may establish and operate one or more separate accounts and issue contracts on a variable basis, subject to the provisions of law regulating life insurers establishing such accounts and issuing such contracts.

(2) To the extent the society considers it necessary in order to comply with any applicable federal or State laws, or any rules issued under applicable federal or State laws, the society:

(i) may adopt special procedures for the conduct of the business and affairs of a separate account;

(ii) for persons having beneficial interests in an account, may provide special voting and other rights, including special rights and procedures relating to investment policy, investment advisory services, selection of certified public accountants, and selection of a committee to manage the business and affairs of the account; and

(iii) may issue contracts on a variable basis to which §§ 8-432(c) and 8-446 of this subtitle shall not apply.

§8–443.

For the purpose of compliance with standards set out in this article regarding required reserves and required surplus, a society shall invest its funds only in investments that are authorized by, and subject to the limitations of, the laws of the State for the investment of assets of life insurers under Title 5 of this article.

§8–444.

(a) Each society transacting insurance business in the State shall:

(1) file with the Commissioner an annual statement as provided in § 4-116 of this article;

(2) pay to the Commissioner a fee of $25 for filing the annual statement; and

(3) prepare a synopsis of the annual statement that explains the condition of the society as disclosed by the annual statement.

(b) On or before June 1 of each year the synopsis required by subsection (a)(3) of this section shall be:

(1) printed and mailed to each benefit member of the society; or

(2) published in the society's official publication.

(c) (1) A society that fails to file the annual statement required under subsection (a) of this section shall pay a penalty of $100 each day until the annual statement is filed.

(2) In addition to the penalty provided in paragraph (1) of this subsection, the Commissioner, after notice to the society, shall suspend the society's authority to do business in the State until the annual statement is filed.

§8–445.

(a) Standards of valuation for certificates issued before January 1, 1998, shall be those provided by the laws applicable on December 31, 1997.

(b) (1) The minimum standards of valuation for certificates issued on or after January 1, 1998, shall be based on the following tables:

(i) for certificates of life insurance:

1. the Commissioners 1941 Standard Ordinary Mortality Table;

2. the Commissioners 1941 Standard Industrial Mortality Table;

3. the Commissioners 1958 Standard Ordinary Mortality Table;

4. the Commissioners 1980 Standard Ordinary Mortality Table; or

5. any more recent table authorized for use under § 5-304(b) of this article; and

(ii) for annuity and pure endowment certificates, total and permanent disability benefits, accidental death benefits, and noncancelable accident and health benefits, the tables that are authorized for use by life insurers in the State.

(2) Valuation of all certificates issued on or after January 1, 1998, shall be under valuation methods and standards, including interest assumptions, in accordance with the laws of the State applicable to life insurers issuing policies containing like benefits.

(c) The Commissioner may:

(1) accept other standards for valuation if the Commissioner finds that the reserves produced by those other standards will not be less in the aggregate than reserves computed in accordance with the minimum valuation standard prescribed in this section; and

(2) vary the standards of mortality applicable to all benefit contracts on substandard lives or other extra hazardous lives by any society authorized to do business in the State.

(d) (1) With the consent of the commissioner of insurance of the state of domicile of the society, and subject to any conditions the commissioner may impose, a society may establish and maintain reserves on its certificates that exceed the reserves required under this section.

(2) The contractual rights of any benefit member may not be affected by a society establishing and maintaining reserves under paragraph (1) of this subsection.

§8–446.

(a) Each society shall provide in its laws that:

(1) if the reserves of the society as to all or any class of certificates become impaired, the board of directors or equivalent body of the society may require that the owner of each certificate pay the amount of the owner's equitable proportion of the deficiency as determined by the board of directors or equivalent body and approved by the commissioner of the domiciliary state; and

(2) if the owner does not pay the owner's share of the deficiency, that share:

(i) shall stand as an indebtedness against the certificate and is subject to interest not exceeding the rate specified for certificate loans under the certificate; or

(ii) instead of or in combination with item (i) of this paragraph, the owner of the certificate may accept a proportionate reduction in benefits under the certificate.

(b) The society may specify the manner of the election and which alternative is to be presumed if no election is made.

§8–449.

(a) Except as otherwise provided in this section, a person must obtain a license issued under Title 10, Subtitle 1 of this article before the person acts as an insurance producer for a fraternal benefit society.

(b) Subsection (a) of this section does not apply to a regular salaried officer or employee of a licensed society who:

(1) devotes substantially all of the officer's or employee's services to activities other than soliciting insurance contracts; and

(2) does not receive, for soliciting insurance contracts, a commission or other compensation that is directly dependent on the amount of business obtained.

(c) (1) Subsection (a) of this section does not apply to a fraternal benefit insurance producer or representative of a society that devotes, or intends to devote, less than 50% of the person's time to selling, soliciting and negotiating insurance contracts for the society.

(2) For the purposes of paragraph (1) of this subsection, a person is presumed to be devoting, or intending to devote, 50% or more of the person's time to selling, soliciting or negotiating insurance contracts for a society if, in the preceding calendar year, the person has sold, solicited and negotiated:

(i) life insurance contracts that, in the aggregate, exceed $200,000 of coverage for all lives insured for the preceding calendar year;

(ii) a permanent life insurance contract offering more than $10,000 of coverage on an individual life;

(iii) a term life insurance contract offering more than $50,000 of coverage on an individual life;

(iv) any insurance contracts other than life that the society may write that insure the lives of more than 25 individuals; or

(v) any variable life insurance or variable annuity contract.

§8–461.

(a) The Commissioner or a person appointed by the Commissioner shall examine the affairs of each domestic society at least once every 3 years.

(b) In conducting an examination under this section:

(1) the Commissioner or person appointed by the Commissioner shall have free access to all books, documents, and records that relate to the business of the society; and

(2) the Commissioner may subpoena and examine under oath any person, including the officers, agents, and employees of the society, in relation to the affairs, transactions, and condition of the society.

(c) (1) A summary of the report of the Commissioner about the examination and any recommendations or statements of the Commissioner that accompany the report:

(i) shall be read at the first meeting of the board of directors or equivalent body of the society after the receipt of the report; and

(ii) if the Commissioner directs, shall be read at the first meeting of the supreme legislative or governing body of the society after the receipt of the report.

(2) A copy of the report, recommendations, and statements of the Commissioner shall be provided by the society to each member of the society's board of directors or other governing body.

(d) The expense of each examination or of each valuation, including the compensation and expenses of examiners, shall be paid by the society examined or the society whose certificates are valued, on statements provided by the Commissioner.

§8–462.

(a) The Commissioner or a person appointed by the Commissioner may examine any foreign or alien society that transacts or applies for admission to transact business in the State.

(b) In conducting an examination under this section, the Commissioner or person appointed by the Commissioner shall have free access to all books, documents, and records that relate to the business of the society.

(c) Instead of conducting an examination, the Commissioner may accept the examination of the insurance department of the state or jurisdiction where the society is organized.

(d) The compensation and expenses of the examiners making an examination or valuation shall be paid by the society examined or the society whose certificate obligations are valued, on statements provided by the Commissioner.

§8–463.

(a) Subject to subsection (b) of this section, during or after an examination or investigation of a domestic, foreign, or alien society, the Commissioner may not make public or allow to become public a financial statement, report, or finding that affects the status, standing, or rights of the society.

(b) The Commissioner may make public or allow to become public a financial statement, report, or finding described in subsection (a) of this section after:

(1) a copy of the financial statement, report, or finding has been served on the society at its principal office; and

(2) the society has been given a reasonable opportunity to answer the financial statement, report, or finding.

§8–464.

(a) The Commissioner shall take action under subsection (b) of this section if, on investigation, the Commissioner finds that a domestic society:

(1) has exceeded its powers;

(2) has failed to comply with this subtitle;

(3) is not fulfilling its contracts in good faith;

(4) has a membership of less than 400 after an existence of 1 year or more;

(5) is conducting its insurance business fraudulently; or

(6) is conducting its insurance business in a manner hazardous to its members, creditors, the public, or the business.

(b) If the Commissioner makes a finding under subsection (a) of this section, the Commissioner shall:

(1) notify the society of the finding;

(2) state in writing the reasons for dissatisfaction; and

(3) require the society to show cause on or before a specified date why:

(i) the society should not be enjoined from conducting any insurance business until the violation has been corrected; or

(ii) an action seeking a mandatory injunction should not be commenced against the society.

(c) (1) If, on or before the date specified in the notice, the society does not present good and sufficient reason why it should not be enjoined from conducting insurance business or why an action seeking a mandatory injunction should not be

commenced, the Commissioner may present the facts relating to the violation to the Attorney General.

(2) On request of the Commissioner, the Attorney General may commence:

(i) an action to enjoin the society from conducting insurance business; or

(ii) an action seeking a mandatory injunction.

(3) The court shall schedule a hearing and notify the officers of the society of the hearing.

(4) If, after a full hearing, the court finds that a violation has occurred under subsection (a) of this section, the court shall pass an order:

(i) enjoining the society from conducting insurance business;

(ii) liquidating the society; or

(iii) appointing the Commissioner as receiver of the society.

(d) A society enjoined from conducting insurance business under this section may not conduct insurance business until:

(1) the Commissioner finds that the violation has been corrected;

(2) the costs of the action have been paid by the society, if the court finds that the society was in default;

(3) the court has dissolved the injunction; and

(4) the Commissioner has reinstated the society's certificate of authority.

(e) If a court orders a society to be liquidated:

(1) the society may not conduct any further insurance business; and

(2) the receiver of the society immediately shall:

(i) take possession of the books, papers, money, and other assets of the society; and

(ii) close the affairs of the society and distribute its funds to those entitled to the funds under the direction of the court.

(f) This section also applies to a society that voluntarily determines to discontinue business.

§8–465.

A decision or finding of the Commissioner made under this subtitle is subject to judicial review in accordance with § 2-215 of this article.

§8–466.

An unincorporated or voluntary association may not transact business in the State as a society.

§8–467.

(a) A society doing insurance business in the State may not make or allow unfair discrimination between insured members of the same class and equal life expectancy in:

(1) the premiums charged for certificates of insurance;

(2) the dividends or other benefits payable on certificates of insurance; or

(3) any other terms and conditions of the contracts the society makes.

(b) (1) This subsection applies to:

(i) a society;

(ii) a person acting for the society;

(iii) an insurance producer that acts on behalf of a fraternal benefit society; and

(iv) a person acting for an insurance producer that acts on behalf of a fraternal benefit society.

(2) A person may not offer, promise, allow, give, set off, or pay, directly or indirectly, any valuable consideration or inducement to or for insurance on any risk authorized to be taken by a society that is not specified in the certificate.

(c) A society member may not receive or accept, directly or indirectly:

(1) a rebate of all or part of a premium payable on a certificate;

(2) a rebate of a fraternal benefit agent's commission on a premium payable on a certificate;

(3) any favor, advantage, or share in the dividends or other benefits to accrue on the insurance contract; or

(4) any other valuable consideration or inducement not specified in the insurance contract.

§8–468.

(a) A person may not cause or allow to be made, issued, or circulated in any form:

(1) a misrepresentation or false or misleading statement about the terms, benefits, or advantages of a fraternal insurance contract issued or to be issued in the State;

(2) a misrepresentation or false or misleading statement about the financial condition of a society;

(3) a false or misleading estimate or statement about the dividends or shares of surplus paid or to be paid by a society on an insurance contract or policy; or

(4) an incomplete comparison of an insurance contract of one society with an insurance contract of another society or insurer for the purpose of inducing the lapse, forfeiture, or surrender of an insurance contract.

(b) A comparison of insurance contracts is incomplete if:

(1) the comparison does not compare in detail:

(i) the gross rates, and the gross rates less any dividend or other reduction allowed at the date of the comparison; and

(ii) any increase in cash values, and all the benefits provided by each contract for the possible duration of the contract as determined by the life expectancy of the insured; or

(2) the comparison omits from consideration:

(i) any benefit or value provided in the contract;

(ii) any differences as to amount or period of rates; or

(iii) any differences in limitations, conditions, or provisions that directly or indirectly affect the benefits under the contract.

(c) In making a determination of the incompleteness or misleading character of a comparison or statement, it is presumed that the insured did not know the contents of the contract involved.

(d) (1) A person that violates subsection (a) of this section or knowingly receives compensation or a commission as a result of a violation of subsection (a) of this section is guilty of a misdemeanor and on conviction is subject to a fine not exceeding $1,000 or imprisonment not exceeding 90 days or both.

(2) (i) In addition to the penalties provided by paragraph (1) of this subsection, a person that violates subsection (a) of this section is liable for a civil penalty of three times the sum received by the violator as compensation or commission from the violation.

(ii) A person or society aggrieved by the violation may file a civil action for the person's or society's own use and benefit to recover a civil penalty under this paragraph.

§8–501.

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

(b) "License" means a license issued by the Commissioner to act as a reinsurance intermediary.

(c) "Qualified financial institution" means an institution that:

(1) is organized or, in the case of a United States office of a foreign banking organization, licensed under the laws of the United States or a state;

(2) is regulated, supervised, and examined by the United States or any state by authorities with regulatory authority over banks and trust companies; and

(3) has been determined by the Commissioner or the securities valuation office of the National Association of Insurance Commissioners to meet the standards of financial condition and standing considered necessary and appropriate to regulate the quality of financial institutions whose letters of credit will be acceptable to the Commissioner.

(d) (1) "Reinsurance broker" means a person that solicits, negotiates, or places reinsurance cessions or retrocessions for a ceding insurer without the authority to bind reinsurance for the ceding insurer.

(2) "Reinsurance broker" does not include an officer or employee of the ceding insurer.

(e) "Reinsurance intermediary" means a reinsurance broker or a reinsurance manager.

(f) (1) "Reinsurance manager" means a person that:

(i) acts as an insurance producer for a reinsurer; and

(ii) 1. has authority to bind the reinsurer; or

2. manages all or part of the assumed reinsurance business of the reinsurer, including the management of a separate division, department, or underwriting office.

(2) "Reinsurance manager" does not include:

(i) an employee of the reinsurer;

(ii) a United States manager of the United States branch of an alien reinsurer;

(iii) an underwriting manager that, by contract:

1. manages all or part of the reinsurance operations of the reinsurer;

2. is under common control with the reinsurer; and

3. is not compensated based on the volume of premiums written; or

(iv) the manager of a group, association, pool, or organization of insurers that:

1. engages in joint underwriting or joint reinsurance; and

2. is subject to examination by the insurance regulatory authority of the state where the manager's principal business office is located.

(g) "Reinsurer" means a person that engages in the business of reinsurance as:

(1) an authorized insurer; or

(2) an accepted reinsurer approved by the Commissioner.

§8–502.

The Commissioner may adopt regulations to carry out this subtitle.

§8–503.

(a) This section does not apply to a lawyer admitted to the bar of the State while acting within the scope of the profession of the lawyer.

(b) (1) Except as otherwise provided in paragraph (2) of this subsection, before a person acts as a reinsurance manager or reinsurance broker in the State, the person:

(i) in the case of a person that maintains an office in the State:

1. must obtain a license under this subtitle; or

2. must qualify as an insurance producer under Title 10, Subtitle 1 of this article; or

(ii) in the case of a person that maintains an office in another state:

1. must obtain a license under this subtitle or under a law of another state that is substantially similar to this subtitle; or

2. must qualify as an insurance producer under Title 10, Subtitle 1 of this article or under a law of another state that is substantially similar to Title 10, Subtitle 1 of this article.

(2) Before a person acts as a reinsurance manager for a reinsurer domiciled in the State, the person must:

(i) obtain a license under this subtitle; or

(ii) qualify as an insurance producer under Title 10, Subtitle 1 of this article.

(3) This subsection applies to a person that maintains an office in the State either directly or as a member or employee of a firm or association or as an officer, director, or employee of a corporation that maintains an office in the State.

§8–504.

(a) The Commissioner may require a reinsurance manager to:

(1) file a bond from an insurer in an amount acceptable to the Commissioner for the protection of each reinsurer that the reinsurance manager represents; and

(2) maintain an errors and omissions policy in an amount acceptable to the Commissioner.

(b) (1) The bond required under subsection (a)(1) of this section must be written by an insurer that is authorized to write surety insurance in the State and is acceptable to the Commissioner.

(2) Subject to the approval of the Commissioner, a reinsurance manager may provide security other than a bond, including an irrevocable letter of credit, to satisfy the requirements of subsection (a)(1) of this section.

§8–505.

(a) (1) On the form that the Commissioner provides, each nonresident applicant for a license must appoint the Commissioner as attorney for service of process issued against the applicant in the State.

(2) The appointment:

(i) is irrevocable;

(ii) binds the applicant and any successor in interest; and

(iii) remains in effect as long as there is in force in the State a contract made by the applicant or an obligation arising from a contract made by the applicant.

(b) (1) Each nonresident applicant for a license shall provide the Commissioner with the name and address of a resident of the State on whom notice and orders of the Commissioner and process issued against the applicant may be served.

(2) (i) A nonresident licensee promptly shall notify the Commissioner of a change in its designated agent for service.

(ii) A change is not effective until acknowledged by the Commissioner.

§8–506.

(a) An applicant for a license shall:

(1) file with the Commissioner an application on the form that the Commissioner provides; and

(2) pay to the Commissioner an application fee of $25.

(b) The application form shall require:

(1) for a firm or association, the name of each member of the firm or association and of each employee of the firm or association who will act as a reinsurance intermediary under the license; and

(2) for a corporation, the name of each officer of the corporation and of each employee and director of the corporation who will act as a reinsurance intermediary under the license.

§8–507.

(a) The Commissioner shall issue a license to each applicant that:

(1) meets the requirements of this subtitle; and

(2) pays the applicable fee for a license for an insurance producer under § 2-112 of this article.

(b) (1) In this subsection, "controlling person" means a person that directly or indirectly has the power to direct, or cause to be directed, the management, control, or activities of a reinsurance intermediary.

(2) The Commissioner may refuse to issue a license if the Commissioner finds that the applicant, an individual named on the application, a member, principal, officer, or director of the applicant, or a controlling person of the applicant:

(i) is not trustworthy to act as a reinsurance intermediary;

(ii) has given cause for revocation or suspension of a license; or

(iii) has failed to comply with a requirement for issuance of a license.

(3) On written request, the Commissioner shall provide a summary of the basis for the refusal to issue a license.

(4) The summary of the basis for refusal is privileged and is not a public document under Title 10, Subtitle 6 of the State Government Article.

§8–508.

(a) A license issued to an individual authorizes the individual to act as a reinsurance intermediary.

(b) A license issued to a firm or association authorizes each member of the firm or association, and each employee of the firm or association who is listed on the license, to act as a reinsurance intermediary.

(c) A license issued to a corporation authorizes each officer of the corporation, and each employee or director of the corporation who is listed on the license, to act as a reinsurance intermediary.

§8–509.

(a) A license expires on the first July 1 after its effective date and in an odd-numbered year, unless it is renewed for a 2-year term as provided in this section.

(b) At least 1 month before a license expires, the Commissioner shall mail to the licensee, at the last known address of the licensee, or send by electronic means in accordance with § 2–116 of this article:

(1) a renewal application form; and

(2) a notice that states:

(i) the date by which the Commissioner must receive the renewal application for the renewal to be issued and mailed before the license expires; and

(ii) the amount of the renewal fee.

(c) Before a license expires, the licensee may renew it for an additional 2-year term, if the licensee:

(1) otherwise is entitled to be licensed;

(2) files with the Commissioner a renewal application on the form that the Commissioner provides; and

(3) pays to the Commissioner the applicable renewal fee for an insurance producer under § 2-112 of this article.

(d) The Commissioner shall renew the license of each licensee who meets the requirements of this section.

§8–510.

To add a name to or delete a name from a license, the licensee shall:

(1) submit to the Commissioner the change in the form that the Commissioner requires; and

(2) pay to the Commissioner a fee of $10.

§8–511.

(a) Subject to the hearing provisions of §§ 2-210 through 2-214 of this article, the Commissioner may deny, refuse to renew, suspend, or revoke a reinsurance intermediary's license, or a reinsurance intermediary's insurance

producer license, if the reinsurance intermediary has violated this subtitle or § 10-126 of this article.

(b) Instead of or in addition to the penalties provided in subsection (a) of this section, the Commissioner:

(1) may impose a penalty not exceeding $5,000 for each violation of this subtitle;

(2) may bring a civil action for the benefit of an insurer or reinsurer and its policyholders and creditors to recover compensatory damages or may seek other appropriate relief; and

(3) may impose any other penalty authorized by this article.

(c) An order of the Commissioner issued under this section is subject to judicial review in accordance with § 2-215 of this article.

(d) A receiver appointed under Title 9, Subtitle 2 of this article may bring a civil action to recover damages or for other appropriate sanctions for the benefit of an insurer if the receiver determines that:

(1) a reinsurance intermediary or other person has failed to comply materially with this subtitle; and

(2) the failure has caused an insurer under an order of rehabilitation or liquidation to suffer a loss or damage.

(e) This section is not intended to limit the rights of policyholders or claimants of an insurer or reinsurer.

§8–512.

A reinsurance intermediary may be examined under §§ 2-205 through 2-209 of this article.

§8–513.

(a) A person may not act as a reinsurance broker for an authorized insurer without a written authorization agreement between the reinsurance broker and the authorized insurer that states the responsibilities of the parties.

(b) The authorization agreement required by this section shall provide that:

(1) on written notice, the authorized insurer may terminate at any time the authority of the reinsurance broker to act for it; and

(2) the reinsurance broker shall:

(i) render accounts to the authorized insurer detailing all material transactions, including information necessary to support the commissions, charges, and other fees received by or owed to the reinsurance broker;

(ii) remit all funds due to the authorized insurer within 30 days after receipt;

(iii) hold in a fiduciary capacity in a qualified financial institution all funds collected for the account of the authorized insurer;

(iv) keep all books, records, and accounts in accordance with § 8-514 of this subtitle;

(v) comply with all written standards established by the authorized insurer for the cession or retrocession of all risks; and

(vi) disclose to the authorized insurer any relationship of the reinsurance broker with a reinsurer to which business is ceded or retroceded.

§8–514.

(a) A reinsurance broker shall keep a record of each transaction that relates to a contract of reinsurance transacted by the reinsurance broker for at least 10 years after the contract expires.

(b) For each contract of reinsurance, the record required by this section shall include:

(1) the type of contract, limits, underwriting restrictions, classes or risks, and territory;

(2) the period of coverage, including effective and expiration dates, cancellation provisions, and required notice of cancellation;

(3) the requirements for reporting and settling balances;

(4) the rate used to compute the reinsurance premium;

(5) the names and addresses of assuming reinsurers;

(6) the rates of all reinsurance commissions, including commissions on any retrocessions handled by the reinsurance broker;

(7) proof of placement;

(8) details of retrocessions handled by the reinsurance broker, including the identity of retrocessionaires and the percentage of each contract assumed or ceded;

(9) financial records, including premium and loss accounts; and

(10) any related correspondence and memoranda.

(c) In addition to the records required by this section, a reinsurance broker shall keep written evidence that the assuming reinsurer:

(1) has agreed to accept the risk, if the reinsurance broker, while acting for a ceding authorized insurer, procured a reinsurance contract directly from an assuming reinsurer; and

(2) has delegated binding authority to its representative, if the reinsurance broker, while acting for a ceding authorized insurer, procures a reinsurance contract from a representative, other than an employee, of an assuming reinsurer.

(d) (1) An authorized insurer shall have reasonable access to and the right to copy and audit all accounts and records maintained by the reinsurance broker that relate to business transactions with the authorized insurer.

(2) The reinsurance broker shall maintain accounts and records in a form usable by the authorized insurer.

§8–515.

(a) (1) A person may not act as a reinsurance manager for a reinsurer without a written contract that:

(i) states the responsibilities of the reinsurance manager and the reinsurer; and

(ii) is approved by the board of directors of the reinsurer.

(2) A reinsurance manager may not assign the contract required under this section.

(b) At least 30 days before a reinsurer assumes or cedes business through a reinsurance manager, a copy of the contract required under this section shall be filed with the Commissioner for approval.

(c) The contract required by this section:

(1) shall state the rates, terms, and purposes of commissions, charges, and other fees that the reinsurance manager may impose against the reinsurer; and

(2) shall provide that:

(i) the reinsurer shall have reasonable access to and the right to copy all accounts and records maintained by the reinsurance manager that relate to business transactions with the reinsurer;

(ii) the reinsurance manager shall maintain accounts and records in a form usable by the reinsurer;

(iii) the reinsurance manager may not retain for more than 3 months estimated claims payments and allocated loss adjustment expenses;

(iv) the reinsurer may:

1. terminate the contract for cause on written notice to the reinsurance manager; and

2. suspend immediately the authority of the reinsurance manager to assume or cede business during the pendency of a dispute about the termination of the contract; and

(v) the reinsurance manager shall:

1. render accounts to the reinsurer detailing all material transactions, including information necessary to support the commissions, charges, and other fees received by or owed to the reinsurance manager;

2. remit to the reinsurer at least monthly all funds due under the contract;

3. hold in a fiduciary capacity in a qualified financial institution all funds collected for the account of the reinsurer;

4. keep a separate bank account for each reinsurer that the reinsurance manager represents;

5. comply with the written underwriting and rating standards established by the authorized insurer for the acceptance, rejection, or cession of all risks;

6. provide annually to the reinsurer a statement of the reinsurance manager's financial condition prepared by an independent certified accountant; and

7. disclose to the reinsurer any relationship of the reinsurance manager with an authorized insurer before ceding or assuming business with the authorized insurer in accordance with the reinsurance contract.

(d) (1) If the contract required by this section allows the reinsurance manager to settle claims for the reinsurer:

(i) all claims shall be reported to the reinsurer in a timely manner;

(ii) the reinsurance manager shall provide the reinsurer with a copy of each claim file that:

1. is requested by the reinsurer;

2. involves a coverage dispute;

3. may exceed the reinsurance manager's settlement authority;

4. remains open for more than 6 months after the date the reinsurance manager receives the claim;

5. has the potential to exceed the lesser of an amount determined by the Commissioner or a limit set by the reinsurer; or

6. is closed by payment of the lesser of the amount determined by the Commissioner or the limit set by the reinsurer;

(iii) 1. the settlement authority granted to a reinsurance manager under the contract may be terminated for cause on 30 days' notice from the reinsurer to the reinsurance manager or on termination of the contract; and

2. the reinsurer may suspend the settlement authority of the reinsurance manager during the pendency of a dispute about the cause for termination;

(iv) except as provided in paragraph (2) of this subsection, all claim files are joint property of the reinsurer and reinsurance manager; and

(v) the reinsurer shall have reasonable access to and the right to copy the claim files on a timely basis.

(2) If the Commissioner obtains an order of liquidation, rehabilitation, reorganization, or conservation against a reinsurer, the files become the sole property of the liquidator, rehabilitator, conservator, or receiver.

(e) If the contract required by this section allows a sharing of interim profits by the reinsurance manager, the interim profits may not be paid until:

(1) (i) 1 year after the end of each underwriting period for property insurance business;

(ii) 5 years after the end of each underwriting period for casualty insurance business; or

(iii) a longer period that the Commissioner sets for a specific line of insurance; and

(2) the adequacy of reserves on remaining claims is verified as provided in § 8-520(a)(3) of this subtitle.

§8–516.

(a) A reinsurance manager shall keep a record of each transaction that relates to a contract of reinsurance transacted by the reinsurance manager for at least 10 years after the contract expires.

(b) For each contract of reinsurance, the record required by this section shall include:

(1) the type of contract, limits, underwriting restrictions, classes or risks, and territory;

(2) the period of coverage, including effective and expiration dates, cancellation provisions, required notice of cancellation, and disposition of outstanding reserves on covered risks;

(3) the requirements for reporting and settling balances;

(4) the rate used to compute the reinsurance premium;

(5) the names and addresses of assuming reinsurers;

(6) the rates of all reinsurance commissions, including commissions on any retrocessions handled by the reinsurance manager;

(7) proof of placement;

(8) details of retrocessions handled by the reinsurance manager, including the identity of retrocessionaires and the percentage of each contract assumed or ceded;

(9) financial records, including premium and loss accounts; and

(10) any related correspondence and memoranda.

(c) In addition to the records required by this section, a reinsurance manager shall keep written evidence that the assuming reinsurer:

(1) has agreed to accept the risk, if the reinsurance manager, while acting for a ceding authorized insurer, procured a reinsurance contract directly from an assuming reinsurer; and

(2) has delegated binding authority to its representative, if the reinsurance manager, while acting for a ceding authorized insurer, procures a reinsurance contract from a representative, other than an employee, of an assuming reinsurer.

§8–517.

The acts of a reinsurance manager are considered to be the acts of the reinsurer on whose behalf the reinsurance manager is acting.

§8–518.

(a) A reinsurance manager:

(1) except as provided in subsection (b) of this section, may not cede retrocessions for a reinsurer;

(2) may not commit a reinsurer to participate in reinsurance syndicates;

(3) may not appoint or hire an insurance producer to solicit, procure, or negotiate reinsurance contracts for a reinsurer without ensuring that the insurance producer is qualified under Title 10, Subtitle 1 of this article;

(4) may not take an action that would constitute a violation of § 27-503 of this article if taken directly by a reinsurer;

(5) without the reinsurer's prior written approval, may not pay or commit a reinsurer to pay a claim, net of reinsurance, that exceeds the lesser of 1% of the reinsurer's policyholder surplus as of the preceding calendar year and an amount specified by the reinsurer;

(6) subject to subsection (b) of this section and without the reinsurer's prior written approval:

(i) may not collect a payment from a retrocessionaire; or

(ii) may not commit a reinsurer to a claim settlement with a retrocessionaire;

(7) may not appoint a subreinsurance manager; or

(8) may not employ an individual who is also employed by a reinsurer that transacts business with the reinsurance manager, unless the reinsurance manager is under common control with the reinsurer and is subject to Title 7 of this article.

(b) A reinsurance manager may cede facultative reinsurance contracts under obligatory facultative agreements if the contract between the reinsurance manager and reinsurer contains reinsurance underwriting guidelines for the retrocessions, including:

(1) a list of reinsurers with which any automatic agreements are in effect;

(2) the coverages and amounts or percentages that may be reinsured; and

(3) commission schedules.

§8–519.

(a) An authorized insurer shall obtain annually a copy of statements of the financial condition of each reinsurance broker that transacts business with the authorized insurer.

(b) An authorized insurer may not:

(1) engage the services of a person to act as a reinsurance broker on its behalf unless the person has complied with this subtitle; or

(2) employ an individual who also is employed by a reinsurance broker that transacts business with the authorized insurer, unless the reinsurance broker is under common control with the authorized insurer and is subject to Title 7 of this article.

(c) An authorized insurer that violates any provision of this subtitle is subject to the disciplinary and penalty provisions of §§ 4-113 and 4-114 of this article.

§8–520.

(a) (1) In this subsection, "actuary" means an individual who is a member in good standing of the American Academy of Actuaries.

(2) A reinsurer shall obtain annually a copy of statements by an independent certified accountant in a form acceptable to the Commissioner of the financial condition of each reinsurance manager that transacts business with the reinsurer.

(3) If a reinsurance manager is allowed by contract to maintain loss reserves, a reinsurer shall obtain annually the opinion of an independent actuary attesting to the adequacy of the loss reserves established for losses incurred and outstanding on business produced by the reinsurance manager.

(4) A reinsurer shall conduct at least semiannually an on-site review of the underwriting and claims processing operations of the reinsurance manager.

(5) A reinsurer shall notify the Commissioner, in writing, within 30 days after terminating a contract with a reinsurance manager.

(b) (1) A reinsurer may not engage the services of a person to act as a reinsurance manager on its behalf unless the person has complied with this subtitle.

(2) Unless the relationship between the reinsurer and the reinsurance manager is controlled by and disclosed under § 8-106 of this title or Title 7, Subtitles 6 and 7 of this article, a reinsurer may not have on its board of directors an officer, director, employee, agent, or controlling shareholder of its reinsurance manager.

(c) The binding authority for all retrocessional contracts or participation in reinsurance syndicates shall rest with an officer of the reinsurer who is not affiliated with the reinsurance manager.

(d) (1) Subject to the hearing provisions of Title 2 of this article, if a reinsurer violates any provision of this subtitle, the reinsurer may be:

(i) refused approval as an accepted reinsurer; or

(ii) disapproved as an accepted reinsurer under Title 5, Subtitle 9 of this article.

(2) In addition to removal as an accepted reinsurer under Title 5, Subtitle 9 of this article, a reinsurer is subject to a civil penalty not exceeding $5,000 for each violation of this subtitle.

§8–601.

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

(b) "Activities of daily living" includes bathing, continence, dressing, eating, toileting, and transferring.

(c) "Chronically ill" means that an individual:

(1) is unable to perform at least two activities of daily living;

(2) requires substantial supervision to protect the individual from threats to health and safety due to severe cognitive impairment; or

(3) has a level of disability similar to that described in item (1) of this subsection.

(d) "Credit enhancer" includes an authorized insurer that provides to a viatical settlement provider stop loss coverage, an annuity policy, an insurance policy, or similar coverage.

(e) "Financing entity" means a person:

(1) that is an underwriter, a placement agent, a lender, a purchaser of securities, a purchaser of a policy or certificate from a viatical settlement provider, a credit enhancer, or an entity that has a direct ownership interest in a policy or certificate that is the subject of a viatical settlement contract; and

(2) (i) whose principal activity related to the transaction is providing funds to effect the viatical settlement or purchase of one or more viaticated policies;

(ii) that has an agreement in writing with one or more registered viatical settlement providers to finance the acquisition of viatical settlement contracts; or

(iii) that is a qualified institutional buyer, as that term is defined in Rule 144A of the federal Securities Act of 1933.

(f) "Fraudulent viatical settlement act" means a fraudulent insurance act as described in § 27–403(6) of this article.

(g) "Policy" means an individual or group policy, group certificate, contract, or arrangement of life insurance that affects the rights of a resident of the State or that bears a reasonable relation to the State, regardless of whether delivered or issued for delivery in the State.

(h) "Related provider trust" means a titling trust or other trust that:

(1) is established by a registered viatical settlement provider or a financing entity for the sole purpose of holding the ownership or beneficial interest in purchased policies in connection with a financing transaction; and

(2) has a written agreement with the registered viatical settlement provider under which:

(i) the viatical settlement provider is responsible for ensuring compliance with all statutory and regulatory requirements; and

(ii) the trust agrees to make all records and files related to viatical settlement transactions available to the Commissioner as if those records and files were maintained directly by the registered viatical settlement provider.

(i) "Special purpose entity" means a corporation, partnership, trust, limited liability company, or other similar entity formed solely to provide, either directly or indirectly, access to institutional capital markets for a financing entity or a registered viatical settlement provider.

(j) "Terminally ill" means that an individual has an illness or sickness that can reasonably be expected to result in death in 24 months or less.

(k) (1) "Viatical settlement broker" means an insurance producer who:

(i) is licensed under Title 10, Subtitle 1 of this article to sell life insurance; and

(ii) on behalf of a viator and for a fee, commission, or other valuable consideration offers or attempts to negotiate viatical settlement contracts between a viator and one or more viatical settlement providers.

(2) "Viatical settlement broker" does not include an attorney, certified public accountant, or financial planner accredited by a nationally recognized accreditation agency, who is retained to represent the viator and whose compensation is not paid directly or indirectly by the viatical settlement provider.

(l) (1) "Viatical settlement contract" means a written agreement that establishes the terms under which compensation or anything of value will be paid, which compensation or value is less than the expected death benefit of the policy, in return for the viator's assignment, transfer, sale, devise, or bequest of the death benefit or ownership of any part of the policy.

(2) "Viatical settlement contract" includes:

(i) a contract for a loan or other financing transaction with a viator secured primarily by a policy, other than a loan by a life insurer under the terms of the policy or a loan secured by the cash value of a policy; and

(ii) an agreement with a viator to transfer ownership or change the beneficiary designation at a later date regardless of the date that compensation is paid to the viator.

(3) "Viatical settlement contract" does not include a contract entered into or effectuated between a viatical settlement provider and a financing entity, a related provider trust, or a special purpose entity.

(m) (1) "Viatical settlement provider" means a person, other than a viator, that enters into or effectuates a viatical settlement contract.

(2) "Viatical settlement provider" does not include an individual who enters into or effectuates no more than one agreement in a calendar year for the transfer of policies for any value less than the expected death benefit.

(n) "Viaticated policy" means a policy that has been acquired by a viatical settlement provider under a viatical settlement contract.

(o) (1) "Viator" means the owner or certificate holder of a policy who enters or seeks to enter into a viatical settlement contract.

(2) "Viator" does not include an accredited investor or qualified institutional buyer, as defined in Regulation D, Rule 501, or Rule 144A of the federal Securities Act of 1933.

§8–602.

This subtitle applies only to a viatical settlement contract between a viator and a viatical settlement provider.

§8–603.

(a) A person must register with the Commissioner before the person acts as or represents itself as a viatical settlement provider in the State.

(b) (1) Except for an individual listed in § 8-601(k)(2) of this subtitle, only an individual who is a viatical settlement broker may negotiate viatical settlement contracts between a viator and one or more settlement providers.

(2) Not later than 30 days after negotiating a viatical settlement contract on behalf of a viator, a viatical settlement broker shall register with the Commissioner in accordance with § 8-604 of this subtitle.

(c) Employees and agents of a registered viatical settlement provider or a registered viatical settlement broker may not be required to be separately registered except in accordance with regulations adopted by the Commissioner.

§8–604.

An applicant for registration shall:

(1) file with the Commissioner an application on the form that the Commissioner requires; and

(2) pay to the Commissioner a registration fee set by the Commissioner.

§8–605.

(a) Notwithstanding the manner in which the viatical settlement broker is compensated, a viatical settlement broker is deemed to represent only the viator and owes a fiduciary duty to the viator to act according to the viator's instructions and in the best interest of the viator.

(b) For purposes of this subtitle, a viator may not be limited to an owner or certificate holder of a policy that insures the life of an individual who is terminally ill or chronically ill.

§8–605.1.

(a) At the time of each application for a viatical settlement, a viatical settlement broker shall provide to the viator a written disclosure that, at a minimum, contains a description of the services required by statute to be provided by the viatical settlement broker to the viator.

(b) A viatical settlement broker may not purchase a policy that is the subject of a viatical settlement brokerage contract between the viatical settlement broker and a viator directly or indirectly through:

(1) a person owning or controlling an interest in the viatical settlement broker; or

(2) a person in which any interest is owned or controlled by the viatical settlement broker.

(c) A viatical settlement broker shall submit to the viator all offers, counteroffers, acceptances, and rejections relating to the placement of the viator's policy within 72 hours after receipt by the viatical settlement broker.

(d) (1) A viatical settlement broker shall provide to the viator a written disclosure of the amount and method of calculating the viatical settlement broker's

compensation, including anything of value received by a viatical settlement broker for the placement of a policy.

(2) A viatical settlement broker shall provide the disclosure required under this subsection no later than 72 hours before the viatical settlement contract is signed by all parties to the contract.

§8–606.

(a) Before an offer to purchase a policy can be made to a viator, a viatical settlement provider shall:

(1) provide the viator with a disclosure statement that:

(i) contains the disclosures required in subsections (b) and (c) of this section; and

(ii) has been signed by the viatical settlement provider; and

(2) receive from the viator the disclosure statement signed by the viator.

(b) Before an offer to purchase a policy can be made to the viator, a viatical settlement provider shall provide to the viator a disclosure statement that contains the following disclosures:

(1) there are possible alternatives to viatical settlement contracts, including any accelerated death benefits or policy loans offered under the viator's policy;

(2) some or all of the proceeds of the viatical settlement may be taxable under federal or State income tax law, and assistance should be sought from a professional tax adviser;

(3) proceeds of the viatical settlement could be subject to the claims of creditors;

(4) receipt of the proceeds of a viatical settlement may adversely affect the viator's eligibility for Medicaid or other government benefits or entitlements, and advice should be obtained from the appropriate government agencies;

(5) (i) the viator has the right to rescind a viatical settlement contract for 15 calendar days after receipt of the viatical settlement proceeds by the

viator, subject to repayment of all viatical settlement proceeds and any premiums and loan interest paid by the viatical settlement provider; and

(ii) if the insured dies during the rescission period, the viatical settlement contract shall be deemed to have been rescinded, subject to repayment of all viatical settlement proceeds and any premiums, loans, and loan interest to the viatical settlement provider;

(6) funds will be sent to the viator within 3 business days after the viatical settlement provider has received the insurer's or group administrator's acknowledgment that ownership of or interest in the policy has been transferred and the beneficiary has been designated;

(7) entering into a viatical settlement contract may cause other rights or benefits, including conversion rights and waiver of premium benefits that may exist under the policy, to be forfeited by the viator, and assistance should be sought from a financial adviser; and

(8) (i) the insured may be contacted by either the viatical settlement provider or the viatical settlement broker or its authorized representative for the purpose of determining the insured's health status; and

(ii) this contact is limited to:

1. once every 3 months if the insured has a life expectancy of more than 1 year; and

2. not more than once per month if the insured has a life expectancy of 1 year or less.

(c) (1) Disclosure to a viator also shall include distribution of a brochure that describes the process of viatical settlements and contains a description of the statutory fiduciary duty of a viatical settlement broker to a viator.

(2) The National Association of Insurance Commissioners form for the brochure shall be used unless a brochure is:

(i) developed by the Commissioner; or

(ii) developed by a viatical settlement broker or viatical settlement provider and approved by the Commissioner.

(d) The disclosure statement shall contain the following language: "All medical, financial, or personal information solicited or obtained by a viatical

settlement provider or viatical settlement broker about an insured, including the insured's identity or the identity of family members, a spouse, or a significant other may be disclosed as necessary to effect the viatical settlement between the viator and the viatical settlement provider. If you are asked to provide this information, you will be asked to consent to the disclosure. The information may be provided to someone who buys the policy or provides funds for the purchase. You may be asked to renew your permission to share information every 2 years.".

(e) A viatical settlement provider or viatical settlement broker shall provide the viator with a copy of the disclosure statement signed by the viator and the viatical settlement provider or viatical settlement broker, at the time that an application for a viatical settlement contract is provided to the viator.

(f) (1) A viatical settlement provider shall provide the viator with at least the disclosures required by this subsection no later than the date that the viatical settlement contract is signed by all parties.

(2) The disclosures shall be conspicuously displayed in the viatical settlement contract or in a separate document signed by the viator and the viatical settlement provider or viatical settlement broker.

(3) The disclosures required under this subsection shall provide the following information:

(i) a statement of the affiliation, if any, between the viatical settlement broker, viatical settlement provider, and the insurer that issued the policy to be viaticated;

(ii) the name, address, and telephone number of the viatical settlement provider;

(iii) if the policy to be viaticated has been issued as a joint policy or involves family riders or any coverage of a life other than the insured under the policy to be viaticated, the viator shall be informed of the possible loss of coverage on the other lives under the policy and shall be advised to consult with an insurance producer or the insurer issuing the policy for advice on the proposed viatical settlement;

(iv) 1. the dollar amount of the current death benefit payable to the viatical settlement provider under the policy; and

2. if known, the availability of any additional guaranteed insurance benefits, the dollar amount of any accidental death and

dismemberment benefits under the policy, and the viatical settlement provider's interest in those benefits; and

(v) 1. the name, business address, and telephone number of the independent third party escrow agent; and

2. the fact that the viator or owner may inspect or receive copies of the relevant escrow or trust agreements or documents.

(g) If the viatical settlement provider transfers ownership or changes the beneficiary of the policy, the viatical settlement provider shall communicate the change in ownership or beneficiary to the insured within 20 days after the change.

§8–607.

(a) A registration expires at the end of every other year on the anniversary of the registration unless it is renewed as provided in this section.

(b) Before a registration expires, the registrant may renew it for an additional 2-year term, if the registrant:

(1) otherwise is entitled to be registered;

(2) files with the Commissioner a renewal application on the form that the Commissioner requires; and

(3) pays to the Commissioner a renewal fee of $50.

(c) An application for renewal of a registration shall be considered made in a timely manner if it is postmarked on or before the anniversary date of the registration of the year of renewal.

§8–608.

Subject to the hearing provisions of Title 2 of this article, the Commissioner may deny a registration to an applicant or refuse to renew, suspend, or revoke the registration of a registrant if the applicant or registrant:

(1) knowingly makes a material misstatement in an application for registration;

(2) fraudulently or deceptively obtains or attempts to obtain a registration for the applicant or registrant or for another;

(3) has been convicted of a felony or of a misdemeanor involving moral turpitude;

(4) in connection with the viatical settlement contract and related insurance application, commits fraud or engages in illegal or dishonest activities;

(5) otherwise has shown a lack of trustworthiness or competence to act as a viatical settlement broker or viatical settlement provider; or

(6) violates any provision of this subtitle or a regulation adopted under it.

§8–609.

Instead of or in addition to suspending or revoking a registration, the Commissioner may:

(1) impose on the holder a penalty not exceeding $125,000 for each violation of this subtitle; and

(2) require the holder to make restitution to any person that has suffered financial injury because of the violation of this subtitle.

§8–610.

(a) It is a violation of this subtitle for a viatical settlement broker or viatical settlement provider to:

(1) violate any provision of this subtitle or any regulation adopted under this subtitle;

(2) fail to register with the Commissioner in accordance with this subtitle before acting or representing itself as a viatical settlement broker or viatical settlement provider;

(3) fail to provide a viator with a disclosure statement in accordance with this subtitle;

(4) fail to allow a viator to rescind a viatical settlement contract up to at least 15 calendar days after the receipt of the viatical settlement proceeds by the viator; and

(5) fail to deliver to a viator the viatical settlement proceeds in accordance with this subtitle.

(b) It is a violation of this subtitle for a person to enter into a viatical settlement contract within a 2-year period commencing with the date of issuance of the insurance policy to be acquired under the viatical settlement contract unless:

(1) the viator certifies to the viatical settlement provider that within the 2-year period:

(i) the policy was issued on the viator's exercise of conversion rights arising out of a group or individual policy;

(ii) the total time covered under the conversion policy and the prior policy is at least 24 months;

(iii) the time covered under the group policy is calculated without regard to any change in insurance carriers; and

(iv) the coverage under the group policy has been continuous and under the same group sponsorship;

(2) the viator submits independent evidence to the viatical settlement provider that within the 2-year period the insured became terminally ill or chronically ill; or

(3) the viator submits independent evidence to the viatical settlement provider that within the 2-year period the viator or insured disposed of ownership interests in a closely held corporation.

(c) Any copies of certification or independent evidence required under subsection (b) of this section shall be:

(1) submitted to the insurer when the viatical settlement provider submits a request to the insurer for verification of coverage; and

(2) accompanied by a letter of attestation from the viatical settlement provider that the copies of certification or independent evidence required under subsection (b) of this section are true and correct copies of the documents received by the viatical settlement provider.

§8–610.1.

(a) An insurer shall respond to a request for verification of coverage submitted by a viatical settlement provider or a viatical settlement broker under this subtitle, including verification of whether the insurer intends, at the time of the

request, to pursue an investigation regarding possible fraud affecting the validity of a policy, within 30 days after the request is received, if the following documents are submitted with the request:

(1) an authorization signed by the viator; and

(2) a "Verification of Coverage for Life Insurance Policies" form adopted by the Commissioner under subsection (d) of this section that has been completed by the viatical settlement provider or viatical settlement broker.

(b) An insurer may not charge a fee for responding to a request for verification of coverage submitted by a viatical settlement provider or a viatical settlement broker that exceeds $50.

(c) (1) An insurer may send an acknowledgment of receipt of a request for verification of coverage to the viator and, if the viator is other than the insured, to the insured.

(2) The acknowledgment may contain a general description of any accelerated death benefit that is available under the policy.

(d) The Commissioner shall adopt by regulation a "Verification of Coverage for Life Insurance Policies" form.

§8–611.

(a) Viatical settlement contracts and applications for viatical settlement contracts shall contain the following statement or a substantially similar statement:

"Any person who knowingly presents false information in an application for insurance or an application for a viatical settlement contract has committed a fraudulent viatical settlement act and on conviction is subject to fines, imprisonment, or both, under § 27-408 of the Insurance Article of the Annotated Code of Maryland."

(b) The absence of a statement as required in subsection (a) of this section does not constitute a defense in any prosecution for a fraudulent viatical settlement act.

§9–101.

The provisions of this subtitle that apply to authorized insurers also apply to nonprofit health service plans and health maintenance organizations.

§9–102.

(a) In determining whether the continued operation of an authorized insurer engaging in insurance business in the State would be hazardous to policyholders or creditors of the authorized insurer or the general public, the Commissioner may consider:

(1) adverse findings reported in financial condition and market conduct examination reports, audit reports, and actuarial opinions, reports, or summaries;

(2) the Insurance Regulatory Information System and other financial analysis solvency tools and reports of the National Association of Insurance Commissioners;

(3) whether the authorized insurer has made adequate provision, according to presently accepted actuarial standards of practice, for the anticipated cash flows required by the contractual obligations and related expenses of the insurer, when considered in light of the assets held by the insurer with respect to such reserves and related actuarial items including, but not limited to, the investment earnings on such assets and the considerations anticipated to be received and retained under such policies and contracts;

(4) the ability of an assuming reinsurer to perform, including whether the reinsurance program of the authorized insurer provides sufficient protection for its remaining surplus, after taking into account the cash flow of the authorized insurer and classes of business written by the authorized insurer and the financial condition of the assuming reinsurer;

(5) whether in the last 12–month period or any shorter period, the authorized insurer's operating loss, calculated to include net capital gain or loss, change in non–admitted assets, and cash dividends paid to stockholders, is greater than 50% of that part of the authorized insurer's policyholder surplus that is in excess of the minimum required surplus;

(6) whether the authorized insurer's operating loss in the last 12–month period or any shorter period, excluding net capital gains, is greater than 20% of the authorized insurer's policyholder surplus that is in excess of the minimum required surplus;

(7) whether a reinsurer, obligor, or any entity within the authorized insurer's insurance holding system is insolvent, threatened with insolvency, or delinquent in the payment of a monetary or other obligation, and which, in the opinion of the Commissioner, may affect the solvency of the insurer;

(8) contingent liabilities, pledges, or guarantees that, either individually or collectively, involve a total amount that the Commissioner believes may affect the solvency of the authorized insurer;

(9) whether a controlling person of the authorized insurer is delinquent in transmission or payment of net premiums to the insurer;

(10) the age and collectibility of receivables;

(11) whether the management of the authorized insurer, including an officer, director, or any other person that has direct or indirect control over operation, fails to possess and demonstrate the competence, fitness, and reputation considered necessary to serve the authorized insurer in a position of control;

(12) whether the management of the authorized insurer has failed to respond to inquiries about the condition of the authorized insurer or has responded to an inquiry with false or misleading information;

(13) whether the authorized insurer has failed to meet financial and holding company filing requirements in the absence of a reason satisfactory to the Commissioner;

(14) whether the management of the authorized insurer has:

(i) filed a false or misleading sworn financial statement;

(ii) released a false or misleading financial statement to a lending institution or the general public;

(iii) made a false or misleading entry in the books of the authorized insurer; or

(iv) omitted an entry of a material amount in the books of the authorized insurer;

(15) whether the authorized insurer has grown so rapidly that it lacks adequate financial and administrative capacity to meet its obligations in a timely manner;

(16) whether the authorized insurer has experienced or will experience in the foreseeable future cash flow or liquidity problems;

(17) whether the management of an authorized insurer has established reserves that do not comply with minimum standards established by the

State's insurance laws, statutory accounting standards, sound actuarial principles, and standards of practice;

(18) whether the management of an authorized insurer persistently engages in material under–reserving that results in adverse development;

(19) whether transactions among affiliates, subsidiaries, or controlling persons for which the insurer receives assets or capital gains, or both, do not provide sufficient value, liquidity, or diversity to assure the authorized insurer's ability to meet its outstanding obligations as they mature; or

(20) any other finding determined by the Commissioner to be hazardous to policyholders, creditors of the authorized insurer, or the general public.

(b) In determining whether the financial condition of an authorized insurer would cause its continued operation in the State to be hazardous to policyholders or creditors of the authorized insurer or the general public, the Commissioner may:

(1) disregard a credit or amount receivable resulting from transactions with a reinsurer that is insolvent, impaired, or otherwise subject to a delinquency proceeding;

(2) make appropriate adjustments, including disallowance, consistent with the National Association of Insurance Commissioners Accounting Policies and Procedures Manual and State laws and regulations, to asset values attributable to investments in or transactions with parents, subsidiaries, or affiliates of the authorized insurer;

(3) refuse to recognize the stated value of accounts receivable if the ability to collect the receivables is highly speculative because of the age of the account or financial condition of the debtor; or

(4) increase the liability of the authorized insurer in an amount equal to any contingent liability, pledge, or guarantee not otherwise included in the statement of liability if there is a substantial risk that the authorized insurer will have to discharge the liability, pledge, or guarantee within the next 12–month period.

§9–103.

If the Commissioner determines that the continued operation of an authorized insurer may be hazardous to policyholders or creditors of the authorized insurer or the general public, the Commissioner may issue an order that requires the authorized insurer to:

(1) reduce the total amount of present and potential liability for benefits under policies through reinsurance;

(2) reduce, suspend, or limit the volume of business being accepted or renewed;

(3) reduce general insurance and commission expenses by specified methods;

(4) increase capital and surplus;

(5) suspend or limit the declaration and payment of dividends to policyholders or stockholders;

(6) file reports in a form acceptable to the Commissioner about the market value of its assets;

(7) limit or withdraw from certain investments or discontinue certain investment practices to the extent that the Commissioner considers necessary;

(8) document the adequacy of premium rates in relation to risks insured;

(9) file, in addition to regular annual statements, interim financial reports on the form adopted by the National Association of Insurance Commissioners or in another form required by the Commissioner;

(10) correct corporate governance practice deficiencies and adopt and utilize governance practices acceptable to the Commissioner;

(11) provide a business plan to the Commissioner in order to continue to transact business in the State; or

(12) notwithstanding any other provision of law limiting the frequency or amount of premium rate adjustments, adjust rates for any nonlife insurance product written by the authorized insurer that the Commissioner considers necessary to improve the financial condition of the insurer.

§9–104.

An authorized insurer aggrieved by an order of the Commissioner under this subtitle has the right to a hearing and the right to appeal from the action of the Commissioner in accordance with §§ 2-210 through 2-215 of this article.

§9–201.

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

(b) "Ancillary state" means a state other than a domiciliary state.

(c) "Creditor" means a person with a claim against an impaired insurer.

(d) "Delinquency proceeding" means a proceeding under this subtitle to liquidate, rehabilitate, reorganize, or conserve an insurer or other entity subject to this subtitle.

(e) "Domiciliary state" means:

(1) the state in which an insurer is incorporated or organized; or

(2) the state of entry of an alien insurer.

(f) "Federal home loan bank" means a federal home loan bank established under the Federal Home Loan Bank Act, 12 U.S.C. §§ 1421 through 1449.

(g) "Foreign country" means territory outside of any state.

(h) "General assets" means:

(1) all property that is not specifically mortgaged, pledged, deposited, or otherwise encumbered for the security or benefit of specified persons or a limited class of persons;

(2) to the extent that property of an insurer is specifically encumbered, the amount of the property or its proceeds that exceeds the amount necessary to discharge the encumbrance; and

(3) assets held in trust and assets held on deposit for the security or benefit of all policyholders and creditors in the United States.

(i) "Impaired insurer" means:

(1) a stock insurer whose assets, less all liabilities and required reserves, do not equal or exceed the capital stock and surplus required for authority to engage in insurance business as a stock insurer;

(2) a mutual insurer, reciprocal insurer, dental plan organization, or nonprofit health service plan whose assets, less liabilities and required reserves, do

not equal or exceed the minimum surplus required under this article for authority to engage in insurance business as a mutual insurer, reciprocal insurer, dental plan organization, or nonprofit health service plan; or

(3) as determined by the Commissioner, an insurer that does not have the financial ability to pay an obligation within 30 days after it becomes due.

(j) "Insurance business" includes any of the acts of an insurance business specified in § 4–205 of this article.

(k) "Insurer–member" means an insurer that is a member of a federal home loan bank.

(l) "Receiver" includes a conservator, rehabilitator, and liquidator.

(m) "Reciprocal state" means a state other than this State in which the substance and effect of the provisions of this subtitle are in force, including the requirement that the Commissioner or equivalent insurance supervisory official be the receiver of an insurer subject to a delinquency proceeding and a provision for avoidance of fraudulent conveyances and preferential transfers.

(n) (1) "Secured claim" means a claim that:

(i) is secured by mortgage, trust deed, pledge, deposit as security, escrow, or otherwise; or

(ii) has become a lien on specific assets through judicial process.

(2) "Secured claim" does not include a special deposit claim or a claim against general assets.

(o) (1) "Special deposit claim" means a claim secured by a deposit required by law for the security or benefit of a limited class of persons.

(2) "Special deposit claim" does not include a claim against general assets.

(p) (1) Except as provided in paragraph (2) of this subsection, "state" means a state of the United States, the District of Columbia, or Puerto Rico.

(2) When capitalized, "State" means Maryland.

(q) "Transfer" means:

(1) the sale or other direct or indirect disposition of property or an interest in property;

(2) the fixing of a lien on property or an interest in property; or

(3) the retention of a security title to property delivered to a debtor.

§9–202.

(a) Sections 9-201(b), (d), (e), (f), (g), (j), (k), (l), (m), and (n), 9-203, 9-207(a), 9-218, 9-219, 9-220, 9-226(f) and (g), and 9-227(a), (e), (f), (g), (h), and (i) of this subtitle are the "Uniform Insurers Liquidation Act".

(b) (1) The Uniform Insurers Liquidation Act shall be interpreted and construed to effectuate its general purpose to make uniform the laws of those states that enact it.

(2) To the extent that a provision of the Uniform Insurers Liquidation Act conflicts with other provisions of this subtitle, the provision of the Uniform Insurers Liquidation Act controls.

§9–203.

(a) This subtitle applies to a person that:

(1) has done, purports to do, is doing, or is licensed to do an insurance business; and

(2) is subject to the insurance supervisory authority of, or to liquidation, rehabilitation, reorganization, or conservation by, the Commissioner or equivalent insurance supervisory official of another state.

(b) The provisions of this subtitle that apply to insurers also apply to:

(1) a corporation that operates a nonprofit health service plan under Title 14, Subtitle 1 of this article;

(2) an insurer that is doing or has done insurance business in the State and against whom claims arising from that insurance business may exist now or in the future;

(3) a person that purports to do insurance business in the State;

(4) an insurer that has an insured resident or located in the State;

(5) a person organized or in the process of organizing with intent to do insurance business in the State; and

(6) a person that does, or has done, any of the acts of an insurance business specified in § 4-205 of this article.

§9–204.

A delinquency proceeding is the exclusive method of liquidating, rehabilitating, reorganizing, or conserving an insurer.

§9–205.

The Commissioner, deputy commissioner, special deputy commissioner, or any person acting as receiver in a rehabilitation, liquidation, or conservation as a result of a court order issued on or after January 1, 1985, shall have the immunity from liability described in § 5-410 of the Courts Article.

§9–206.

(a) (1) This subsection applies even if a paper or instrument:

(i) is not executed by the Commissioner or a deputy, employee, or attorney of record of the Commissioner; and

(ii) is not connected with the commencement of an action or proceeding by or against the Commissioner or with the subsequent conduct of the action or proceeding.

(2) Subject to subsection (b) of this section, the Commissioner may not be required to pay to a public officer in the State a fee for filing, recording, or issuing a transcript or certificate or for authenticating a paper or instrument that relates to the exercise by the Commissioner of a power or duty of the Commissioner under this subtitle.

(b) (1) The Commissioner or deputy commissioner, when acting as receiver or ancillary receiver under this subtitle, shall pay all court costs out of the assets of the insurer before any distribution to creditors or termination of rehabilitation.

(2) In all cases, these costs and those specified in subsection (a) of this section shall:

(i) be charged in the accounts of the Commissioner to the court; or

(ii) be paid by the insurer as a condition of termination of the action or proceeding.

§9–207.

(a) (1) In a delinquency proceeding in which the Commissioner has been appointed receiver, the Commissioner may:

(i) appoint one or more special deputy commissioners to act for the Commissioner; and

(ii) employ counsel, clerks, and assistants.

(2) Compensation of the special deputies, counsel, clerks, and assistants and all expenses of taking possession of the insurer and of conducting the delinquency proceeding:

(i) shall be set by the Commissioner, subject to approval by the court; and

(ii) shall be paid out of the assets or funds of the insurer.

(3) Within the limits of duties imposed on a special deputy concerning a delinquency proceeding, the special deputy:

(i) shall possess all powers given to the receiver; and

(ii) in the exercise of those powers, is subject to all the duties imposed on the receiver concerning the delinquency proceeding.

(b) In a civil proceeding filed against a special deputy commissioner appointed under this subtitle, the special deputy commissioner is entitled to representation by the Attorney General as specified in Title 12, Subtitle 3, Part II of the State Government Article.

§9–208.

A delinquency proceeding may be brought against:

(1) an insurer that is doing or has done insurance business in the State and against whom claims arising from that insurance business may exist now or in the future;

(2) a person that purports to do insurance business in the State;

(3) an insurer that has insureds resident or located in the State;

(4) a person organized, or in the process of organizing, with intent to do insurance business in the State;

(5) a corporation that operates a nonprofit health service plan under Title 14, Subtitle 1 of this article; and

(6) a person that does, or has done, any of the acts of an insurance business specified in § 4-205 of this article.

§9–209.

(a) The Circuit Court of Baltimore City:

(1) has exclusive original jurisdiction over delinquency proceedings; and

(2) may issue all necessary and proper orders to carry out this subtitle.

(b) If service is made in accordance with the Maryland Rules or other applicable law, a court with subject matter jurisdiction over an action brought under this subtitle also has jurisdiction over:

(1) a person, including an insurance producer and another person that has written policies, that has acted in any manner on behalf of an insurer against which a delinquency proceeding has been commenced, in an action resulting from or incidental to the person's relationship with the insurer;

(2) a reinsurer that at any time has entered into a contract of reinsurance with an insurer against which a delinquency proceeding has been commenced, or an insurance producer for the reinsurer, in an action on or incidental to the reinsurance contract;

(3) an officer, director, manager, trustee, organizer, promoter, or attorney in fact of an insurer against which a delinquency proceeding has been

commenced, in an action resulting from or incidental to the person's relationship with the insurer;

(4) a person that, at the time of or after commencement of the delinquency proceeding, held or was in control of assets in which the receiver claims an interest on behalf of the insurer, in an action concerning the assets; and

(5) a person obligated to the insurer in any way, in an action on or incidental to the obligation.

(c) The venue of all delinquency proceedings is in Baltimore City.

§9–210.

(a) The Commissioner shall commence a delinquency proceeding against an insurer by applying to the court for an order that directs the insurer to show cause why the court should not grant the relief requested.

(b) (1) The court may consider an application for commencement of a delinquency proceeding only if the application is filed by the Commissioner in the name of the State.

(2) After a hearing under the terms of the show–cause order, the court:

(i) shall either grant or deny the application; and

(ii) may order other relief as the nature of the case and the interests of the policyholders, creditors, stockholders, members, subscribers, or the public may require.

§9–211.

(a) The Commissioner may apply to the court for an order that directs the Commissioner to conserve or rehabilitate a domestic insurer or an alien insurer domiciled in the State, if the domestic insurer or alien insurer:

(1) is an impaired insurer;

(2) has refused to submit to the Commissioner or a deputy or examiner of the Commissioner, for reasonable examination, any of the property, books, records, accounts, or affairs of the insurer, or of a subsidiary or related company of the insurer within the insurer's control;

(3) has concealed or removed its assets or records;

(4) has failed to comply with an order of the Commissioner to make good an impairment of capital or surplus or both;

(5) without first obtaining the written approval of the Commissioner:

(i) has transferred or attempted to transfer substantially all of its property or business; or

(ii) has entered into a transaction that merges, consolidates, or reinsures substantially all of its property or business in or with the property of another insurer;

(6) has willfully violated its charter, articles of incorporation, a State law, or an order of the Commissioner;

(7) after reasonable notice, has failed promptly and effectively to terminate the employment, status, and influence over the management of the insurer of a person that has executive authority in fact over the insurer and has refused to be examined under oath about the affairs of the insurer in the State or elsewhere;

(8) has been or is the subject of an application for appointment of a receiver, trustee, custodian, sequestrator, or similar fiduciary of the insurer or its property in an action not filed under this article, regardless of whether the appointment:

(i) has been made;

(ii) might deny the courts of the State of jurisdiction; or

(iii) might prejudice an orderly delinquency proceeding under this subtitle;

(9) has consented to the order for conservation or rehabilitation through a majority of its directors, stockholders, members, or subscribers;

(10) has failed to pay a final judgment rendered against it in the State on an insurance contract issued or assumed by the insurer, within 60 days after the latest of:

(i) the day on which the judgment became final;

(ii) the day on which the time for taking an appeal expired; and

(iii) the day on which an appeal was dismissed before final termination;

(11) after examination by the Commissioner, is found to be in a condition in which further transaction of its business will be hazardous to its policyholders, bondholders, creditors, or the public;

(12) has failed to remove a person that has executive authority in fact over the insurer after the Commissioner has found that person to be dishonest or untrustworthy in a manner that might affect the business of the insurer;

(13) has reasonable cause to know, or should know, that there has been:

(i) embezzlement from the insurer;

(ii) wrongful sequestration or diversion of assets of the insurer;

(iii) forgery or fraud that affects the insurer; or

(iv) other illegal conduct in, by, or with respect to the insurer;

(14) is controlled directly or indirectly by a person that the Commissioner finds to be untrustworthy; or

(15) has failed to file a financial report required by law within the time allowed by law and, after written demand by the Commissioner, has failed to give an immediate adequate explanation.

(b) (1) If the appointment of the Commissioner as receiver is not then in effect, and even if no previous order has directed the Commissioner to rehabilitate a domestic insurer or the United States branch of an alien insurer that has trusteed assets in the State, the Commissioner may apply to the court for an order that appoints the Commissioner as receiver and that directs the Commissioner to liquidate the business of the domestic insurer or the United States branch of the alien insurer if the domestic insurer or alien insurer:

(i) has not done business for at least 1 year;

(ii) is an impaired insurer and has commenced voluntary liquidation or dissolution, or attempts to commence or prosecute an action or proceeding to liquidate its business or affairs, to dissolve its corporate charter, or to

procure the appointment of a receiver, trustee, custodian, or sequestrator under any law except this article;

(iii) is doing business in a fraudulent manner; or

(iv) is in a condition in which further rehabilitation efforts on any grounds specified in subsection (a) of this section appear to be futile.

(2) If at any time during a rehabilitation proceeding the Commissioner determines that further efforts to rehabilitate the domestic insurer or alien insurer would be useless, the Commissioner may apply to the court for an order of liquidation.

(c) The Commissioner may apply to the court for an order that appoints the Commissioner as receiver or ancillary receiver, and that directs the Commissioner to conserve the assets of a foreign insurer that are located in the State:

(1) on any ground specified in subsection (a) or (b) of this section; or

(2) on the ground that the assets of the foreign insurer have been sequestrated in the jurisdiction in which the foreign insurer is domiciled or in another jurisdiction.

(d) The Commissioner may apply to the court for an order that appoints the Commissioner as receiver or ancillary receiver, and that directs the Commissioner to conserve the assets of an alien insurer that are located in the State:

(1) on any ground specified in subsection (a) or (b) of this section;

(2) on the ground that the alien insurer has failed to comply within the time designated by the Commissioner with an order of the Commissioner to make good an impairment of the trusteed funds of the alien insurer; or

(3) on the ground that the assets of the alien insurer have been sequestrated in the jurisdiction in which the alien insurer is domiciled or in another jurisdiction.

(e) The Commissioner may apply to the court for an order that appoints the Commissioner as ancillary receiver and that directs the Commissioner to liquidate the business of a foreign insurer that has assets, business, or claims in this State on appointment in the domiciliary state of the foreign insurer of a receiver or other officer by whatever name called to liquidate the business of the foreign insurer.

§9–212.

(a) (1) An order to rehabilitate a domestic insurer, or an alien insurer domiciled in the State, shall:

(i) appoint the Commissioner as rehabilitator;

(ii) direct the Commissioner:

1. to take possession of the property of the insurer and conduct the business of the insurer under the general supervision of the court; and

2. to take action as the court directs to remove the causes and conditions that have made rehabilitation necessary;

(iii) vest title to all property of the insurer in the rehabilitator; and

(iv) require the rehabilitator to make accountings to the court that:

1. are at intervals as the court specifies in its order, but not less frequently than two times each year; and

2. include the opinion of the rehabilitator about the likelihood of success of the rehabilitation.

(2) Issuance of an order of rehabilitation:

(i) does not constitute an anticipatory breach of any contract of the insurer; and

(ii) is not grounds for retroactive revocation or retroactive cancellation of a contract of the insurer, unless the rehabilitator revokes or cancels the contract.

(b) (1) Subject to paragraph (2) of this subsection, the Commissioner, or an interested person on due notice to the Commissioner, may apply to the court at any time for an order that:

(i) terminates a rehabilitation proceeding; and

(ii) allows the insurer to resume possession of its property and the conduct of its business.

(2) An order under this subsection may not be issued unless, after a hearing, the court determines that:

(i) the purposes of the rehabilitation proceeding have been fully accomplished; and

(ii) § 9-223 of this subtitle has been satisfied.

(c) (1) An order to liquidate the business of a domestic insurer shall direct the Commissioner promptly:

(i) to take possession of the property of the insurer;

(ii) to liquidate the business of the insurer;

(iii) to deal with the property and business of the insurer in the name of the Commissioner or in the name of the insurer, as the court directs; and

(iv) to notify all creditors that may have claims against the insurer to present their claims.

(2) The Commissioner may apply for, and the court may issue, an order to dissolve the corporate existence of a domestic insurer:

(i) on application of the Commissioner for an order to liquidate the domestic insurer; or

(ii) at any time after the court has granted the order of liquidation.

(3) An order to liquidate the business of the United States branch of an alien insurer that has trusteed assets in the State shall:

(i) be on the same terms as those required for a domestic insurer under paragraph (1) of this subsection; but

(ii) include only the assets of the business of the United States branch of the alien insurer.

(d) An order to conserve the assets of a foreign insurer or alien insurer shall require the Commissioner promptly to take possession of and conserve the property of the insurer in the State, subject to further direction by the court.

(e) An order to liquidate the assets in the State of a foreign insurer shall require the Commissioner promptly to take possession of and liquidate the property of the insurer in the State, subject to further direction by the court and with due regard to the rights and powers of the domiciliary receiver as provided in this subtitle.

§9–213.

(a) In this section, "appointed receiver" means a person, other than the Commissioner, that the court appoints as a conservator, rehabilitator, or receiver under this section.

(b) (1) On motion of the court or the Commissioner, the court may issue an order that appoints or substitutes a person other than the Commissioner as conservator, rehabilitator, or receiver:

(i) on initial application by the Commissioner for an order to appoint the Commissioner as conservator, rehabilitator, or receiver under this subtitle; or

(ii) at any time during the course of a conservatorship, rehabilitation, or receivership under this subtitle.

(2) An appointed receiver has the same powers and duties that the Commissioner has under this subtitle as conservator, rehabilitator, or receiver.

(c) (1) In addition to any other report required by the court, the court shall require an appointed receiver at least quarterly to file with the Commissioner and court a report about:

(i) the status of the conservatorship, rehabilitation, or receivership; and

(ii) the activities of the appointed receiver since the last report filed under this paragraph.

(2) The report required under paragraph (1) of this subsection at a minimum shall include:

(i) information of the character required by Title 13 of the Maryland Rules that applies to receivers generally;

(ii) any other information necessary to provide a complete report on the financial affairs and condition of the conservatorship, rehabilitation, or receivership;

(iii) a complete account of all efforts by the appointed receiver since the last report:

1. to sell or dispose of the remaining business, assets, or policies of the insurer; or

2. to otherwise bring to a prompt conclusion the conservatorship, rehabilitation, or receivership; and

(iv) copies of any actuarial or other evaluations of the insurance business and assets under the control of the appointed receiver.

(3) The report shall be audited unless for good cause the court waives the audit.

(d) Subject to any protective order that the court considers appropriate, information filed under seal shall be provided to both the Commissioner and the affected guaranty association.

(e) The appointed receiver shall give the Commissioner and any guaranty association that may be obligated to pay claims during the conservatorship, rehabilitation, or receivership full access to all documents and records related to the conservatorship, rehabilitation, or receivership that are in the possession of the appointed receiver.

(f) The Commissioner may be a party to a conservatorship, rehabilitation, or receivership for which there is an appointed receiver.

(g) (1) Subject to approval of the court, the Commissioner and any guaranty association that may be obligated to pay claims during the conservatorship, rehabilitation, or receivership may negotiate for sale of all or part of the assets or book of business of the insurer placed in conservatorship, rehabilitation, or receivership.

(2) The appointed receiver:

(i) shall cooperate fully in any sales negotiation under paragraph (1) of this subsection; and

(ii) may object to the terms of a sale of the assets or book of business of the insurer that results from the negotiation.

(3) After notice and an opportunity to be heard, the court may limit the efforts of the Commissioner or guaranty association to undertake or continue negotiations for the sale of the assets or book of business of the insurer if the negotiations would impair the ability of the appointed receiver to engage in similar negotiations or discharge other responsibilities.

(h) (1) If the Commissioner determines that an appointed receiver is not adequately discharging the duties and responsibilities of the position, the Commissioner may file with the court an application that seeks to discharge the appointed receiver and to appoint the Commissioner as conservator, rehabilitator, or receiver or to appoint a new appointed receiver.

(2) If the Commissioner establishes by a preponderance of the evidence that grounds exist for discharge of an appointed receiver, the court shall grant the application of the Commissioner to discharge the appointed receiver and to appoint the Commissioner as conservator, rehabilitator, or receiver or to appoint a new appointed receiver.

§9–214.

Within 15 days after appointment as receiver or conservator for an insurer against which a delinquency proceeding has been commenced, the receiver or conservator shall notify each policyholder of the insurer, by letter or other means approved by the court, of the commencement of the delinquency proceeding and of the possibility that the insurance of the policyholder may be canceled.

§9–215.

(a) On application of the Commissioner at any time, the court may issue ex parte an order that:

(1) directs the Commissioner to take possession and control of all or part of:

(i) the property, books, accounts, documents, and other records of an insurer; and

(ii) the premises that the insurer occupies for the transaction of its business; and

(2) enjoins the insurer and its officers, directors, stockholders, members, subscribers, agents, and all other persons from the transaction of its business without written consent of the Commissioner.

(b) (1) The court shall specify the duration of a seizure order issued under this section.

(2) The duration of the seizure order shall be the time that the court considers necessary for the Commissioner to determine the condition of the insurer.

(3) On motion of the court or either party and after notice that the court considers appropriate, the court may hold hearings and extend, shorten, or modify the terms of the seizure order.

(4) If the Commissioner fails to commence a delinquency proceeding after having had a reasonable opportunity to do so, the court shall vacate the seizure order.

(5) An order of the court under a delinquency proceeding vacates the seizure order.

(c) Issuance of a seizure order under this section does not constitute an anticipatory breach of any contract of the insurer.

(d) (1) At any time after issuance of an ex parte order under this section, an insurer subject to the order may petition the court for a hearing and review of the order.

(2) Within 15 days after receipt of the petition, the court shall hold the hearing and review the order.

(e) (1) If at any time after issuance of a seizure order the court determines that a person whose interest is or will be substantially affected by the order did not appear at the hearing and has not been served, the court may order that notice be given to that person.

(2) The order that notice be given does not stay the effect of any other order previously issued by the court.

(f) At any time during a delinquency proceeding, the court may issue an injunction or order to prevent:

(1) interference with the Commissioner or the delinquency proceeding;

(2) waste of the assets of the insurer;

(3) commencement or prosecution of an action;

(4) obtaining of preferences, judgments, attachments, or other liens; or

(5) levy against the insurer or all or part of its assets.

(g) (1) Except when disclosure is necessary to comply with a court order, all documents and records that relate to a proceeding under this section, including records of the insurer, files of the Administration, and court records and papers, are confidential.

(2) The clerk of the court shall hold all documents and records filed with the court in a proceeding under this section in a confidential file.

(3) After hearing arguments from the parties, the court may order that a document or record be made public.

(h) Notwithstanding any other provision of law, the Commissioner may not be required to post a bond as a prerequisite for issuance of an order under this section.

(i) (1) (i) After the 14th day following the filing of a delinquency proceeding, a federal home loan bank may not be stayed or prohibited from exercising its rights regarding collateral pledged by an insurer–member.

(ii) If a federal home loan bank exercises its rights regarding collateral pledged by an insurer–member who is subject to a delinquency proceeding, the federal home loan bank shall repurchase any outstanding capital stock:

1. that exceeds the amount of federal home loan bank stock that the insurer–member is required to hold as a minimum investment; and

2. to the extent the federal home loan bank in good faith determines the repurchase to be:

A. permissible under applicable laws, regulations, regulatory obligations, and the federal home loan bank's capital plan; and

B. consistent with the federal home loan bank's current capital stock practices applicable to its entire membership.

(2) After the appointment of a receiver for an insurer–member, the federal home loan bank, within 10 business days after a request from the receiver, shall provide a process and establish a timeline for the following:

(i) the release of collateral that exceeds the amount required to support secured obligations remaining after any repayment of loans, as determined in accordance with the applicable agreements between the federal home loan bank and the insurer–member;

(ii) the release of any of the insurer–member's collateral remaining in the federal home loan bank's possession after full repayment of all outstanding secured obligations of the insurer–member;

(iii) the payment of any fees owed by the insurer–member to the federal home loan bank;

(iv) the operation of deposits and other accounts of the insurer–member with the federal home loan bank; and

(v) the possible redemption or repurchase of federal home loan bank stock or excess stock of any class that an insurer–member is required to own.

(3) On request of a receiver for an insurer–member, the federal home loan bank shall provide any options available to the insurer–member to renew or restructure a loan, subject to:

(i) market conditions;

(ii) the terms of any outstanding loans made to the insurer–member;

(iii) the applicable policies of the federal home loan bank; and

(iv) the federal home loan bank's compliance with federal laws and regulations.

§9–216.

An appeal may be taken to the Appellate Court of Maryland from:

(1) an order that grants or refuses rehabilitation, liquidation, or conservation; and

(2) any other order in a delinquency proceeding that has the character of a final order as to the particular part of the delinquency proceeding covered by the order.

§9–217.

(a) To facilitate the rehabilitation, liquidation, conservation, or dissolution of an insurer under this subtitle, the Commissioner, subject to the approval of the court, may:

(1) borrow money;

(2) execute, acknowledge, and deliver notes or other evidences of indebtedness for the loan;

(3) secure the repayment of the loan by the mortgage, pledge, assignment, or transfer in trust of all or part of the property of the insurer; and

(4) take any other action necessary and proper to consummate the loan and to provide for its repayment.

(b) The Commissioner is not obligated personally or in an official capacity to repay a loan made under this section.

§9–218.

(a) Whenever under this subtitle a receiver is to be appointed in a delinquency proceeding for a domestic insurer or alien insurer, the court shall:

(1) appoint the Commissioner as receiver; and

(2) order the Commissioner promptly to take possession of the assets of the domestic insurer or alien insurer and to administer the assets under the orders of the court.

(b) (1) Subject to paragraph (2) of this subsection, beginning on the date of issuance of an order that directs the Commissioner to rehabilitate or liquidate a domestic insurer or to liquidate the United States branch of an alien insurer domiciled in the State, the Commissioner as domiciliary receiver is vested by operation of law with title to and may take possession of all of the property, contracts, rights of action, books, and records of the domestic insurer or alien insurer, wherever located.

(2) An ancillary receiver in a reciprocal state has the rights and powers as to assets located in that state that are specified in this subtitle for an ancillary receiver appointed in this State.

(c) The filing of the order that directs possession to be taken, or a certified copy of the order, in an office where instruments affecting title to property are

required to be filed provides the same notice as would be provided by a deed, bill of sale, or other evidence of title that is so filed.

(d) (1) The Commissioner as domiciliary receiver shall administer properly all assets that come into the possession or control of the Commissioner.

(2) If considered desirable to protect the assets, the court at any time may require a bond from the Commissioner or Deputy Commissioner.

(3) On taking possession of the assets of a domestic insurer or alien insurer and subject to the direction of the court, the Commissioner immediately shall:

(i) conduct the business of the domestic insurer or alien insurer; or

(ii) take action authorized by this subtitle to rehabilitate, liquidate, or conserve the affairs or assets of the domestic insurer or alien insurer.

§9–219.

(a) (1) Whenever under this subtitle an ancillary receiver is to be appointed in a delinquency proceeding for an insurer not domiciled in the State, the court shall appoint the Commissioner as ancillary receiver.

(2) The Commissioner shall file a petition requesting appointment as ancillary receiver under § 9-211(e) of this subtitle if:

(i) the Commissioner finds that there are sufficient assets of the insurer located in the State to justify the appointment of an ancillary receiver; or

(ii) ten or more persons resident in the State with claims against the insurer file a petition with the Commissioner requesting the appointment of an ancillary receiver.

(b) For the purpose of liquidating an insurer domiciled in a reciprocal state, the domiciliary receiver:

(1) is vested by operation of law with title to all of the property, contracts, and rights of action, and all of the books and records of the insurer located in this State;

(2) immediately may recover balances due from local insurance producers and obtain possession of any books and records of the insurer found in this State;

(3) subject to subsection (c)(1) of this section, may recover other assets of the insurer located in this State; and

(4) may sue in this State to recover any assets of the insurer to which the domiciliary receiver is entitled under the law of this State.

(c) (1) On appointment of an ancillary receiver in this State, the ancillary receiver:

(i) has the sole right to recover other assets of the insurer specified in subsection (b)(3) of this section during the ancillary receivership proceeding;

(ii) shall:

1. as soon as practicable liquidate from the securities of the ancillary receiver those special deposit claims and secured claims that are proved and allowed in an ancillary proceeding in this State; and

2. pay the necessary expenses of the ancillary proceeding; and

(iii) shall transfer promptly all remaining assets to the domiciliary receiver.

(2) Subject to paragraph (1) of this subsection, the ancillary receiver and deputies of the ancillary receiver have the same powers and are subject to the same duties concerning administration of the assets of the insurer as a receiver of an insurer domiciled in this State.

§9–220.

(a) During pendency of a delinquency proceeding in this State or a reciprocal state, an attachment, garnishment, execution, or similar action or proceeding may not be commenced or maintained in a court of this State against the impaired insurer or its assets.

(b) A lien obtained or an action or proceeding prohibited by subsection (a) of this section is void as against any rights arising in the delinquency proceeding, if the lien was obtained or the action or proceeding commenced within 4 months before or at any time after commencement of a delinquency proceeding.

§9–221.

(a) A transfer of or lien on the property of an insurer is voidable if the transfer or lien is:

(1) made or created within 4 months before the issuance of a show–cause order under this subtitle;

(2) made or created with the intent to give a creditor a preference or to enable the creditor to obtain a greater percentage of the debt than another creditor of the same class; and

(3) accepted by the creditor having reasonable cause to believe that the preference will occur.

(b) Each director, officer, employee, stockholder, member, subscriber, and any other person acting on behalf of an insurer that is concerned in a voidable transfer under subsection (a) of this section and each person that, as a result of the voidable transfer, receives any property of the insurer or benefits from the voidable transfer:

(1) is personally liable; and

(2) shall account to the Commissioner.

(c) The Commissioner as receiver in a delinquency proceeding may:

(1) avoid a transfer of or lien on the property of an insurer that a creditor, stockholder, subscriber, or member of the insurer might have avoided; and

(2) recover the transferred property or its value from the person that received it unless that person was a bona fide holder for value before the date of issuance of a show–cause order under this subtitle.

(d) (1) Except as provided in paragraph (2) of this subsection, the receiver for an insurer–member may not void any transfer of, or any obligation to transfer, money or any other property arising under or in connection with:

(i) a federal home loan bank security agreement;

(ii) a pledge, a security, collateral, or a guarantee agreement; or

(iii) any other similar arrangement or credit enhancement relating to a federal home loan bank security agreement made in the ordinary course of business and in compliance with the applicable federal home loan bank agreement.

(2) The receiver may void a transfer under this section if the transfer was made with intent to hinder, delay, or defraud:

(i) the insurer–member;

(ii) the receiver for the insurer–member; or

(iii) existing or future creditors.

(e) This section may not affect a receiver's rights regarding advances to an insurer–member in delinquency proceedings under 12 C.F.R. § 1266.

§9–222.

(a) (1) The Commissioner shall deposit money collected in a delinquency proceeding in a State or national bank, savings bank, or trust company.

(2) Deposits made by the Commissioner under paragraph (1) of this subsection have priority of payment equal to any other priority specified by the banking laws of this State if the depository:

(i) is an institution organized and supervised under the laws of this State; and

(ii) becomes insolvent or liquidates voluntarily or involuntarily.

(3) The Commissioner may deposit all or part of the money collected in a national bank or trust company as a trust fund.

(b) To the extent that an investment or account is insured by the Federal Deposit Insurance Corporation, the Commissioner may invest in shares or deposits in a savings and loan association or building and loan association.

§9–223.

Unless an insurer has repaid to all guaranty associations all payments of or on account of the contractual obligations of the insurer, including all expenses of and interest on the obligations, or unless a guaranty association has approved a plan of repayment by the insurer, an insurer subject to a delinquency proceeding may not:

(1) be released from the delinquency proceeding unless it is converted into a judicial proceeding to rehabilitate or liquidate;

(2) be allowed to solicit or accept new business;

(3) be allowed to request or accept the restoration of a suspended or revoked license or certificate of authority; or

(4) be returned, or have any of its assets returned, to the control of its stockholders or private management.

§9–224.

(a) In this section, "association" means:

(1) the Property and Casualty Insurance Guaranty Corporation;

(2) the Life and Health Insurance Guaranty Corporation; or

(3) a similar organization in another state.

(b) Within 120 days after a court of the State makes a final determination that an insurer is an impaired insurer, the Commissioner as receiver shall apply to the court for approval of a proposal to disperse to the association entitled to disbursements unsecured assets out of the marshalled assets of the impaired insurer as those assets become available.

(c) The proposal for disbursement at a minimum shall provide for:

(1) adequate cash reserves for payment of expenses of administration and priority claims;

(2) disbursements of the assets marshalled to date and subsequent disbursements of assets as they become available;

(3) equitable allocation of disbursements to each of the associations that is entitled to disbursements; and

(4) the securing by the Commissioner from each association entitled to disbursements under this section an agreement to return to the Commissioner any assets previously disbursed that may be required to pay:

(i) claims of secured creditors; and

(ii) claims that fall within the priorities specified in § 9-227(b) of this subtitle in accordance with those priorities.

(d) An association may not be required to obtain a bond.

(e) The proposal for disbursement shall require that disbursement be made to the association:

(1) in an amount at least equal to the payments made or to be made by the association for which the association could assert claims against the Commissioner; and

(2) in the amount of available assets, if the assets available for disbursement do not equal or exceed the amount of the payments made or to be made by the association.

(f) (1) Notice of the application for approval of the proposal for disbursement shall be given to the associations and insurance commissioners of each state.

(2) Notice is deemed to have been given if sent by certified mail at least 30 days before submission of the application to the court.

(3) The court may approve the proposal if:

(i) the required notice has been given under this subsection; and

(ii) the proposal complies with subsection (c)(1) and (4) of this section.

§9–225.

(a) Within 3 years after the date of the issuance of an order of rehabilitation or liquidation of a domestic mutual insurer or domestic reciprocal insurer, the Commissioner may file with the court:

(1) a petition for assessment; and

(2) a report that states:

(i) the reasonable value of the assets of the mutual insurer or reciprocal insurer;

(ii) the liabilities of the mutual insurer or reciprocal insurer to the extent determined by the Commissioner at the time of the report;

(iii) as provided in § 3-111 of this article, the aggregate amount of any assessment that the Commissioner considers reasonably necessary to pay in full:

1. all claims;

2. the costs and expenses of the collection of assessments; and

3. the costs and expenses of the delinquency proceeding; and

(iv) any other information about the affairs or the property of the mutual insurer or reciprocal insurer that the Commissioner considers material.

(b) (1) On the filing and reading of the report and petition specified in subsection (a) of this section, the court ex parte may order the Commissioner to assess all members or subscribers of the mutual insurer or reciprocal insurer who may be subject to assessment, in an aggregate amount as the court finds reasonably necessary to pay in full:

(i) all valid claims that are timely filed and proved in the delinquency proceeding;

(ii) the costs and expenses of imposing and collecting the assessments; and

(iii) the costs and expenses of the delinquency proceeding.

(2) The order shall require the Commissioner to assess each member or subscriber for the member's or subscriber's proportion of the aggregate assessment in accordance with a reasonable classification of the members or subscribers and a formula made by the Commissioner and approved by the court.

(3) The court may order an additional assessment on all members or subscribers who may be subject to assessment on the filing and reading of an amendment or supplement to the report and petition specified in subsection (a) of this section if the amendment or supplement is filed within 3 years after the date of issuance of the order of rehabilitation or liquidation.

(4) After issuance of an order under this subsection, the Commissioner shall assess each member or subscriber in accordance with the order.

(c) (1) The total of all assessments against a member or subscriber with respect to a policy, whether imposed under this subtitle or another provision of this article:

(i) may not be more than as specified in the policy of the member or subscriber; and

(ii) shall be as limited under this article.

(2) An assessment may not be imposed against a member or subscriber with respect to a nonassessable policy that is issued in accordance with this article.

(d) The assessment of a member or subscriber is presumed correct if made by the Commissioner in accordance with a court order that:

(1) fixes the aggregate amount of the assessment against all members or subscribers; and

(2) approves the classification and formula made by the Commissioner under subsection (b) of this section.

(e) (1) The Commissioner shall mail, or send by electronic means in accordance with § 2–116 of this article, to each member or subscriber at the last address of record with the insurer a notice that:

(i) states the amount of the assessment to be paid by the member or subscriber;

(ii) specifies when the assessment should be paid; and

(iii) requires payment not less than 20 days after the Commissioner mails the notice.

(2) In a proceeding to collect an assessment, it is not a defense that a member or subscriber failed to receive the notice or failed to receive the notice within the time specified in the notice for payment of the assessment.

(3) If a member or subscriber fails to pay the assessment within the period specified in the notice, the Commissioner may obtain an order in the delinquency proceeding that requires the member or subscriber to show cause at a

time and place fixed by the court why judgment for the amount of the assessment and all costs should not be entered against the member or subscriber.

(4) A copy of the order and petition for assessment shall be served on the member or subscriber within the time and in the manner designated in the order.

(5) After service of a copy of the order and petition is made on the member or subscriber:

(i) if the member or subscriber fails to appear at the time and place specified in the order, the court shall enter judgment against the member or subscriber as requested in the petition; or

(ii) if the member or subscriber appears in the manner and form required by law in response to the order, the court shall hear and determine the matter and enter judgment.

(6) The Commissioner may collect the assessment through any other lawful means.

§9–226.

(a) (1) If on issuance of an order of liquidation under this subtitle or at any time during a liquidation proceeding the insurer is not clearly solvent, the court, after notice it considers proper and a hearing, shall issue an order that the insurer is an impaired insurer.

(2) Notwithstanding any previous notice given to creditors, after issuance of an order under paragraph (1) of this subsection, the Commissioner shall notify each person that may have a claim against the insurer that the claim is forever barred unless the person files the claim with the Commissioner at a place and within the time specified in the notice.

(3) The time specified in the notice:

(i) shall be as set by the court for filing claims; but

(ii) may not be less than 6 months after issuance of the order that the insurer is an impaired insurer.

(4) The notice shall be given in the manner and for the reasonable period of time that the court orders.

(b) (1) Each claimant shall set forth in reasonable detail:

(i) the amount of the claim or the basis on which the amount can be determined;

(ii) the facts on which the claim is based; and

(iii) any priority asserted by the claimant.

(2) Each claim shall:

(i) be verified by the affidavit of the claimant or a person authorized to act on behalf of the claimant who has knowledge of the facts; and

(ii) be supported by any documents that may be material to the claim.

(3) Each claim filed in the State shall be filed with the domiciliary receiver or ancillary receiver in the State on or before the last date specified under this subtitle for filing of claims.

(c) The receiver shall:

(1) report a claim to the court:

(i) within 10 days after receiving the claim; or

(ii) within an additional period set by the court for good cause shown; and

(2) recommend in the report action to be taken on the claim.

(d) (1) On receipt of the report of the receiver, the court shall:

(i) set a time for hearing the claim; and

(ii) direct the claimant or receiver to give notice as the court determines to each person that appears to the court to be interested in the claim.

(2) The notice given in accordance with this subsection shall:

(i) specify the time and place of the hearing; and

(ii) state concisely:

1. the amount and nature of the claim;

2. any priority asserted by the claimant; and

3. the recommendation of the receiver about the claim.

(e) (1) At the hearing specified under subsection (d) of this section:

(i) each person with an interest in the claim may appear; and

(ii) the court shall issue an order in which the court allows, allows in part, or disallows the claim.

(2) An order under this subsection is a final order subject to appeal.

(f) (1) In a delinquency proceeding commenced in this State against a domestic insurer, a claimant who resides in a reciprocal state may file a claim with:

(i) any ancillary receiver in the reciprocal state; or

(ii) the domiciliary receiver.

(2) Each claim filed under this subsection must be filed on or before the last date set for the filing of claims in the delinquency proceeding in the domiciliary state.

(3) A controverted claim of a claimant who resides in a reciprocal state may be proved:

(i) in this State; or

(ii) if an ancillary proceeding has been commenced in the reciprocal state, in the ancillary proceeding.

(4) If the claimant elects to prove a claim in the ancillary proceeding, and if the same notice and opportunity to be heard is given the domiciliary receiver of this State as is provided under subsection (g) of this section for an ancillary proceeding in this State, the final allowance of the claim by the courts of the ancillary state shall be accepted in this State as conclusive as to:

(i) the amount of the claim; and

(ii) any priority of the claim against special deposits or other security located in the ancillary state.

(g) (1) In a delinquency proceeding in a reciprocal state against an insurer domiciled in that state, a claimant who resides in this State may file a claim with:

(i) any ancillary receiver appointed in this State; or

(ii) the domiciliary receiver.

(2) Each claim filed under this subsection must be filed on or before the last date set for the filing of claims in the delinquency proceeding in the domiciliary state.

(3) A controverted claim of a claimant who resides in this State may be proved:

(i) in the domiciliary state, as provided by the law of the domiciliary state; or

(ii) if an ancillary proceeding has been commenced in this State, in the ancillary proceeding.

(4) If the claimant elects to prove the claim in this State, the claimant shall:

(i) file the claim with the ancillary receiver; and

(ii) give written notice to the domiciliary receiver by certified mail, return receipt requested, bearing a postmark from the United States Postal Service, or by personal service at least 40 days before the date set for the hearing.

(5) The notice shall contain:

(i) a concise statement of the amount of the claim;

(ii) the facts on which the claim is based; and

(iii) any priority asserted by the claimant.

(6) The domiciliary receiver may appear or be represented in any proceeding in this State that involves adjudication of the claim if, within 30 days after the claimant gives the notice required by this subsection, the domiciliary receiver gives written notice of an intent to contest the claim:

(i) to the ancillary receiver and to the claimant; and

(ii) by certified mail, return receipt requested, bearing a postmark from the United States Postal Service, or by personal service.

(7) The final allowance of the claim by the courts of this State shall be accepted as conclusive as to:

(i) the amount of the claim; and

(ii) any priority of the claim against special deposits or other security located in this State.

§9–227.

(a) In this section, "preferred claim" means a claim that is given priority of payment from the general assets of an insurer under the law of the State or the United States.

(b) (1) The first $500 of compensation or wages owed to an officer or employee of an insurer for services rendered within 3 months before the commencement of a delinquency proceeding against the insurer shall be paid before payment of any other debt or claim.

(2) Subject to paragraph (3) of this subsection, the Commissioner may pay the compensation required to be paid under this subsection as soon as practicable after commencement of the delinquency proceeding.

(3) At all times, the Commissioner shall reserve funds that the Commissioner believes are sufficient for expenses of administration.

(4) The priority required under this subsection is instead of any other similar priority that may be authorized by law as to wages or compensation.

(c) Priority over all other claims in a liquidation proceeding, other than claims for wages specified in subsection (b) of this section, expenses of administration, and taxes, shall be given to:

(1) claims by policyholders, beneficiaries, insureds, or holders of funding agreements issued under § 16–113 of this article, that arise from and within the coverage of and are not in excess of the applicable limits of policies and insurance contracts issued by the insurer;

(2) liability claims against insureds that are within the coverage of and are not in excess of the applicable limits of policies and insurance contracts issued by the insurer; and

(3) claims of:

(i) the Property and Casualty Insurance Guaranty Corporation;

(ii) the Life and Health Insurance Guaranty Corporation; and

(iii) any similar organization in another state.

(d) Notwithstanding the provisions of subsections (b) and (c) of this section, if there are known or potential claims due the federal government, the following shall be the priority of distribution:

(1) expenses of administration;

(2) the following claims without priority among them:

(i) claims made by policyholders, beneficiaries, insureds, or holders of funding agreements issued under § 16–113 of this article, that arise from and within the coverage of and are not in excess of the applicable limits of policies and insurance contracts issued by the insurer;

(ii) liability claims against insureds that are within the coverage of and are not in excess of the applicable limits of policies and insurance contracts issued by the insurer; and

(iii) claims of:

1. the Property and Casualty Insurance Guaranty Corporation;

2. the Life and Health Insurance Guaranty Corporation; and

3. any similar organization in another state;

(3) claims of the federal government not included in item (2) of this subsection;

(4) the first $500 of compensation or wages owed to an officer or employee of an insurer for services rendered within 3 months before the commencement of a delinquency proceeding against the insurer, which shall be instead of any other similar priority that may be authorized by law as to wages or compensation;

(5) claims for taxes and debts due any state or local government; and

(6) all other claims of general creditors not falling within any other priority under this subsection.

(e) (1) The owners of special deposit claims against an insurer for which a receiver is appointed in this State or another state have priority against their special deposits as provided by the law that governs the creation and maintenance of special deposits.

(2) If there is a deficiency in a special deposit so that the claims secured by the special deposit are not fully discharged, the claimants may share in the general assets after general creditors, and claimants against other special deposits who have received smaller percentages from their respective special deposits, have been paid percentages of their claims equal to the percentage paid from the special deposit.

(f) (1) The owner of a secured claim against an insurer for which a receiver has been appointed in this State or another state may:

(i) surrender the security and file the claim as a general creditor; or

(ii) have the claim discharged by resort to the security.

(2) If the owner of a secured claim has the claim discharged by resort to the security, any deficiency shall be treated as a claim against the general assets of the insurer on the same basis as the claims of unsecured creditors.

(3) The amount of a deficiency is conclusive if adjudicated:

(i) in an ancillary proceeding under this subtitle; or

(ii) by a court of competent jurisdiction in a proceeding in which the domiciliary receiver has had notice and an opportunity to be heard.

(4) If the amount of a deficiency is not conclusive, the amount shall be determined in a delinquency proceeding in the domiciliary state.

(g) (1) Current financing money that, in accordance with regulations adopted by the Health Services Cost Review Commission, are provided by an insurer, nonprofit health service plan, or health maintenance organization to a hospital for discounted hospital rates are deemed to be security for the amount of outstanding charges owed by the insurer, nonprofit health service plan, or health maintenance organization to the hospital for bills or claims for services provided by the hospital before the delinquency proceeding.

(2) A hospital that retains any current financing money as security under this subsection:

(i) is deemed to be the owner of a secured claim against the insurer, nonprofit health service plan, or health maintenance organization for which a receiver has been appointed; and

(ii) may discharge its claim against the insurer, nonprofit health service plan, or health maintenance organization as provided under subsection (f) of this section.

(h) (1) In a delinquency proceeding against an insurer domiciled in the State, claims owing to residents of ancillary states are preferred claims if similar claims are preferred under the law of this State.

(2) All claims owing to residents of ancillary states or nonresidents have equal priority of payment from general assets regardless of where the general assets are located.

(i) In a delinquency proceeding against an insurer domiciled in a reciprocal state, claims owing to residents of this State are preferred claims if similar claims are preferred under the law of that state.

§9–228.

(a) (1) Subject to paragraph (2) of this subsection, contingent and unliquidated claims may not share in a distribution of the assets of an insurer that has been adjudicated to be an impaired insurer by an order issued under this subtitle.

(2) If properly presented, a contingent and unliquidated claim shall be considered and may be allowed to share if:

(i) the claim becomes absolute against the insurer on or before the last day for filing claims against the assets of the insurer; or

(ii) there is a surplus and the liquidation is subsequently conducted on the basis that the insurer is solvent.

(b) If an insurer has been adjudicated to be an impaired insurer, a person that has a cause of action against an insured of the insurer under a liability policy issued by the insurer has the right to file a claim in the liquidation proceeding, even if the claim may be contingent, and the claim may be allowed if:

(1) a reasonable inference may be made from proof presented on the claim that the person would be able to obtain a judgment in a cause of action against the insured;

(2) the person provides suitable proof, unless for good cause shown the court directs otherwise, that no further valid claim against the insurer arising out of the cause of action can be made other than the claim already presented; and

(3) the total liability of the insurer to all claimants arising out of the same act of the insured is not greater than the maximum liability of the insurer were the insurer not in liquidation.

(c) (1) A judgment against an insured after the date of issuance of a liquidation order may not be considered in the liquidation proceeding as evidence of liability or of the amount of damages.

(2) A judgment against an insured by default or collusion before issuance of a liquidation order may not be considered in the liquidation proceeding as conclusive evidence of the liability of the insured to a person with a cause of action against the insured or the amount of damages to which the person is entitled.

(d) (1) Except as provided in paragraph (2) of this subsection, a claim of a person that has a secured claim may not be allowed at a sum greater than the difference between:

(i) the value of the claim without security; and

(ii) the value of the security itself on:

1. the date of issuance of the liquidation order; or

2. another date set by the court for determining rights and liabilities as provided in subsection (e) of this section.

(2) If the claimant surrenders the security to the Commissioner, the claim shall be allowed in the full amount for which it is valued.

(e) Subject to the provisions of this subtitle on the rights of claimants holding contingent claims, and unless otherwise directed by the court, the rights and liabilities of an insurer, the creditors, policyholders, stockholders, members, and subscribers of the insurer, and other persons interested in the estate of the insurer are fixed on the date on which the order that directs the liquidation of the insurer is filed in the office of the clerk of the court that issued the order.

§9–229.

(a) Except as provided in subsection (b) of this section, in all cases of mutual debts and credits between an insurer and another person in connection with a delinquency proceeding, the debts and credits shall be offset and the balance only shall be allowed or paid.

(b) An offset may not be allowed in favor of another person if:

(1) on the date of issuance of a liquidation order or otherwise, as specified in § 9-228(e) of this subtitle, the obligation of the insurer to the person would not entitle the person to share as a claimant in the assets of the insurer;

(2) the obligation of the insurer to the person was purchased by or transferred to the person for use as an offset; or

(3) the obligation of the person is to pay:

(i) an assessment imposed on the members of a mutual insurer or the subscribers of a reciprocal insurer; or

(ii) a balance on the subscription to the capital stock of a stock insurer.

§9–229.1.

(a) (1) In this section the following words have the meanings indicated.

(2) "Commodity contract" means:

(i) a contract for the purchase or sale of a commodity for future delivery on, or subject to the rules of, a board of trade designated as a contract market by the Commodity Futures Trading Commission under the federal Commodity Exchange Act or board of trade outside the United States;

(ii) an agreement that is:

1. subject to regulation under § 19 of the federal Commodity Exchange Act; and

2. commonly known to the commodities trade as a margin account, margin contract, leverage account, or leverage contract; or

(iii) an agreement or transaction that is:

1. subject to regulation under § 4c(b) of the federal Commodity Exchange Act; and

2. commonly known to the commodities trade as a commodity option.

(3) "Contractual right" means any right, whether or not evidenced in writing, arising under:

(i) statutory law, common law, or law merchant;

(ii) a rule or bylaw of a national securities exchange, national securities clearing organization, or securities clearing agency; or

(iii) a rule, bylaw, or resolution of the governing body of a contract market or its clearing organization.

(4) "Forward contract" means a contract, other than a commodity contract, for the purchase, sale, or transfer of:

(i) a commodity, as defined in § 1 of the federal Commodity Exchange Act; or

(ii) any similar good, article, service, right, or interest that presently is or in the future becomes the subject of dealing in the forward contract trade, or a product or by–product thereof, with a maturity date more than 2 days after the date the contract is entered into, including, but not limited to, a repurchase transaction, reverse repurchase transaction, consignment, lease, swap, hedge transaction, deposit, loan, option, allocated transaction, unallocated transaction, or a combination of these or an option on any of them.

(5) (i) "Netting agreement" means a contract or agreement, including terms and conditions incorporated by reference in the contract or agreement, that:

1. documents one or more transactions between the parties to the contract or agreement for or involving one or more qualified financial contracts; and

2. provides for the netting or liquidation of qualified financial contracts or the present or future payment obligations or payment entitlements under qualified financial contracts, including liquidation or close–out values relating to the obligations or entitlements, among the parties to the netting agreement.

(ii) "Netting agreement" includes a master agreement that, together with all schedules, confirmations, definitions, and addenda to and transactions under any thereof, shall be treated as one netting agreement.

(6) "Qualified financial contract" means a commodity contract, forward contract, repurchase agreement, reverse repurchase agreement, securities contract, swap agreement, or any similar agreement that the Commissioner determines by regulation or order to be a qualified financial contract for purposes of this subtitle.

(7) (i) "Repurchase agreement" or "reverse repurchase agreement" means an agreement, including related terms, that provides for the transfer of certificates of deposit, eligible bankers' acceptances, or securities that are direct obligations of, or that are fully guaranteed as to principal and interest by, the United States or an agency of the United States against the transfer of funds by the transferee of the certificates of deposit, eligible bankers' acceptances, or securities with a simultaneous agreement by the transferee to transfer to the transferor certificates of deposit, eligible bankers' acceptances, or securities as described above in this subparagraph at a certain date not later than 1 year after the transfers or on demand, against the transfer of funds.

(ii) For purposes of the definitions of "repurchase agreement" and "reverse repurchase agreement" in subparagraph (i) of this paragraph, the items that may be subject to a repurchase agreement or a reverse repurchase agreement include mortgage–related securities, a mortgage loan, and an interest in a mortgage loan, and do not include any participation in a commercial mortgage loan unless the Commissioner determines by regulation or order to include the commercial mortgage loan participation.

(8) (i) "Securities contract" means a contract for the purchase, sale, or loan of a security, including:

1. an option for the repurchase or sale of a security, certificate of deposit, or group or index of securities, including an interest therein or based on the value thereof;

2. an option entered into on a national securities exchange relating to foreign currencies; or

3. the guarantee of a settlement of cash or securities by or to a securities clearing agency.

(ii) In subparagraph (i) of this paragraph, "security" includes a mortgage loan, mortgage–related securities, and an interest in any mortgage loan or mortgage–related security.

(9) "Swap agreement" means an agreement, including the terms and conditions incorporated by reference in the agreement, that is a rate swap agreement, basis swap, commodity swap, forward rate agreement, interest rate future, interest rate option, forward foreign exchange agreement, spot foreign exchange agreement, rate cap agreement, rate floor agreement, rate collar agreement, currency swap agreement, cross–currency rate swap agreement, currency future, currency option, or any other similar agreement, and includes any combination of agreements and an option to enter into an agreement.

(b) Notwithstanding any other provision of State law, a person may not be stayed or otherwise prohibited from exercising:

(1) a contractual right to terminate, liquidate, or close out any netting agreement or qualified financial contract with an insurer because of:

(i) the insolvency, financial condition, or default of the insurer at any time, provided that the right is enforceable under applicable law other than this subtitle; or

(ii) the commencement of a delinquency proceeding under this subtitle;

(2) any right under a pledge, security, collateral, or guarantee agreement or any other similar security arrangement or credit support document relating to a netting agreement or qualified financial contract; or

(3) subject to any provision of § 9-229(b) of this subtitle, any right to offset or net out any termination value, payment amount, or other transfer obligation arising under or in connection with a netting agreement or qualified financial contract if the counterparty or its guarantor is organized under the laws of the United

States, a state, or a foreign jurisdiction approved by the Securities Valuation Office of the National Association of Insurance Commissioners as eligible for netting.

(c) (1) Notwithstanding a provision in a netting agreement that the nondefaulting party is not required to pay any net or settlement amount due to the defaulting party, on termination of the netting agreement, the net or settlement amount, if any, owed by a nondefaulting party to an insurer against which an application or petition has been filed under this subtitle, shall be transferred to or on the order of the receiver for the insurer, even if the insurer is the defaulting party.

(2) Any limited two-way payment provision in a netting agreement with an insurer that has defaulted shall be deemed to be a full two-way payment provision as against the defaulting insurer.

(3) Any such net or settlement amount shall be a general asset of the insurer, except to the extent such net or settlement amount is subject to one or more secondary liens or encumbrances.

(d) In making a transfer of a netting agreement or qualified financial contract of an insurer subject to a delinquency proceeding under this subtitle, the receiver shall:

(1) transfer to one party, other than an insurer subject to a delinquency proceeding under this subtitle, all netting agreements and qualified financial contracts between a counterparty or an affiliate of a counterparty and the insurer that is the subject of the delinquency proceeding, including:

(i) all rights and obligations of each party under each netting agreement and qualified financial contract; and

(ii) all property, including any guarantees or credit support documents, securing any claims of each party under each netting agreement and qualified financial contract; or

(2) transfer none of the netting agreements, qualified financial contracts, rights, obligations, or property referred to in item (1) of this subsection, with respect to the counterparty and any affiliate of the counterparty.

(e) (1) If a receiver for an insurer makes a transfer of one or more netting agreements or qualified financial contracts, the receiver shall use its best efforts to notify any person who is party to the netting agreements or qualified financial contracts of the transfer by 12:00 p.m., the receiver's local time, on the business day following the transfer.

(2) In this subsection, "business day" means a day other than a Saturday, a Sunday, or any day on which either the New York Stock Exchange or the Federal Reserve Bank of New York is closed.

(f) (1) Notwithstanding any provision of this subtitle other than paragraph (2) of this subsection, a receiver may not avoid a transfer of money or other property arising under or in connection with a netting agreement or qualified financial contract, or any pledge, security, collateral, or guarantee agreement or any other similar security arrangement or credit support document relating to a netting agreement or qualified financial contract, that is made before the commencement of a delinquency proceeding under this subtitle.

(2) A transfer may be avoided under § 9-221 of this subtitle if the transfer was made with actual intent to hinder, delay, or defraud the insurer, a receiver appointed for the insurer, or existing or future creditors.

(g) (1) In exercising any of its power under this subtitle to disaffirm or repudiate a netting agreement or qualified financial contract, a receiver shall take action with respect to each netting agreement or qualified financial contract and all transactions entered into in connection with each netting agreement or qualified financial contract, in its entirety.

(2) Notwithstanding any other provision of this subtitle, any claim of a counterparty against the estate arising from a receiver's disaffirmance or repudiation of a netting agreement or qualified financial contract that has not been previously affirmed in the liquidation or immediately preceding rehabilitation proceeding shall be determined and shall be allowed or disallowed:

(i) as if the claim had arisen before the date of the filing of the petition for liquidation; or

(ii) if a rehabilitation proceeding is converted to a liquidation proceeding, as if the claim had arisen before the date of the filing of the petition for rehabilitation.

(3) (i) The amount of the claim identified in paragraph (2) of this subsection shall be the actual direct compensatory damages determined as of the date of the disaffirmance or repudiation of the netting agreement or qualified financial contract.

(ii) In subparagraph (i) of this paragraph, "actual direct compensatory damages" does not include punitive or exemplary damages, damages for lost profits or lost opportunity, or damages for pain and suffering, but does include

normal and reasonable costs of cover or other reasonable measures of damages used in the derivatives market for the contract and agreement claims.

(h) All rights of counterparties under this subtitle shall apply to netting agreements and qualified financial contracts entered into on behalf of:

(1) the general account; or

(2) separate accounts if the assets of each separate account are available only to counterparties to netting agreements and qualified financial contracts entered into on behalf of that separate account.

(i) This section does not apply to a person that is an affiliate of the insurer that is the subject of a delinquency proceeding under this subtitle.

§9–230.

(a) This section may not be construed to abridge otherwise existing legal rights, including the right to resist a petition for liquidation, other delinquency proceedings, or other orders.

(b) In a delinquency proceeding or in an investigation preliminary to the delinquency proceeding, an officer, manager, director, trustee, owner, employee, or agent of an insurer, another person with authority over any part of the affairs of the insurer, or a person that exercises control directly or indirectly over an activity of the insurer through a holding company or other affiliate of the insurer shall:

(1) reply promptly in writing to an inquiry from the Commissioner in which the Commissioner requests a written reply;

(2) make available to the Commissioner any accounts, books, documents, information, records, or property of or relating to the insurer that is in the control, custody, or possession of the person; and

(3) otherwise cooperate with the Commissioner.

(c) A person may not obstruct or interfere with the Commissioner in the conduct of a delinquency proceeding or in an investigation preliminary or incidental to the delinquency proceeding.

(d) An officer, manager, director, trustee, owner, employee, or agent of an insurer, another person with authority over any part of the affairs of the insurer, or a person that exercises control directly or indirectly over an activity of the insurer through a holding company or other affiliate of the insurer may not fail to cooperate

with the Commissioner under subsection (b) of this section, obstruct or interfere with the Commissioner in the conduct of a delinquency proceeding or in an investigation preliminary or incidental to a delinquency proceeding, or violate an order of the Commissioner issued under this subtitle.

(e) (1) A person that violates subsection (d) of this section is guilty of a misdemeanor and on conviction is subject to a fine not exceeding $10,000 or imprisonment not exceeding 1 year or both.

(2) After a hearing before the Commissioner, a person that violates subsection (d) of this section is subject to a civil penalty not exceeding $10,000 and to the revocation or suspension of any insurance license issued by the Commissioner.

§9–231.

(a) In this section, "chief executive officer" means a person charged by the board of directors or trustees of an insurer to administer and implement policies and procedures of the insurer.

(b) The provisions of this section that apply to insurers also apply to:

(1) a corporation that operates a nonprofit health service plan under Title 14, Subtitle 1 of this article;

(2) a dental plan organization, as defined in § 14-401 of this article;

(3) a surplus lines insurer; and

(4) a health maintenance organization.

(c) (1) A chief executive officer shall immediately provide the Commissioner and all members of the board of directors or the trustees of an insurer with written notice that the insurer is an impaired insurer, if the chief executive officer:

(i) knows that the insurer is an impaired insurer; and

(ii) for a period of 60 days, has been unable to remedy the impairment.

(2) A director, officer, or trustee of an insurer who knows that the insurer is an impaired insurer shall immediately notify the chief executive officer of the impairment.

(d) Notice provided to the Commissioner under this section has the confidentiality specified in § 7-106 of this article.

(e) If a person knows that the action will result in or contribute to an insurer becoming an impaired insurer, the person may not:

(1) conceal property that belongs to the insurer;

(2) transfer or conceal property of the person or property that belongs to the insurer in contemplation of a delinquency proceeding;

(3) conceal, destroy, mutilate, alter, or falsify a document that relates to the property of the insurer;

(4) withhold a document from a receiver, trustee, or other officer of the court entitled to its possession under this subtitle; or

(5) give, obtain, or receive anything of value for acting or forbearing to act in a delinquency proceeding.

(f) (1) In addition to any other applicable penalty provided in this article, a person that violates subsection (e) of this section is guilty of a misdemeanor and on conviction is subject to a fine not exceeding $50,000 or imprisonment not exceeding 3 years or both.

(2) In addition to any other applicable penalty provided in this article, a person that violates subsection (c) of this section is subject to a civil penalty not exceeding $50,000.

(g) The Commissioner may issue a cease and desist order in accordance with § 27-103 of this article against a person that violates subsection (c) or subsection (e) of this section.

§9–232.

A director or officer of an insurer, association, or fraternal benefit society that receives a premium or assessment on behalf of the insurer, association, or fraternal benefit society and, at the time of receipt, knows that the insurer, association, or fraternal benefit society is insolvent is guilty of a misdemeanor and on conviction is subject to a fine not exceeding $500 or imprisonment not exceeding 6 months or both.

§9–301.

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

(b) "Account" means:

(1) the title insurance account;

(2) the motor vehicle insurance account;

(3) the workers' compensation account; or

(4) the account for all other insurance to which this subtitle applies.

(c) "Corporation" means the Property and Casualty Insurance Guaranty Corporation.

(d) (1) "Covered claim" means an insolvent insurer's unpaid obligation, including an unearned premium:

(i) that:

1. A. for insurance other than insurance that covers members of a purchasing group, arises out of a policy of the insolvent insurer issued to a resident or payable to a resident on behalf of an insured of the insolvent insurer; or

B. for insurance that covers members of a purchasing group, arises out of insurance that covers the members of the purchasing group to the extent that the insurance is obtained by the purchasing group, the insurance is written by an authorized insurer, and the claim is made by a person residing or located in the State; or

2. arises out of a surety bond issued by the insolvent insurer for the protection of a third party that is a resident;

(ii) that is presented on or before the last date fixed for the filing of claims in the domiciliary delinquency proceeding as a claim to the corporation or to the receiver in the State;

(iii) that:

1. except for a surety bond claim, was incurred or existed before, on, or within 30 days after the determination of insolvency; or

2. for a surety bond claim that arises out of a surety bond issued by a domestic insurer, was incurred or existed before, on, or within 18

months after the determination of insolvency, whether or not the surety bond is issued for no stated period or for a stated period; and

(iv) that arises out of a policy or surety bond of the insolvent insurer issued for a kind of insurance to which this subtitle applies.

(2) "Covered claim" does not include:

(i) an amount due a reinsurer, insurer, insurance pool, or underwriting association, as a subrogation recovery or otherwise; or

(ii) an amount due that arises out of insurance covering the members of a purchasing group if the insurance obtained by the purchasing group is written by an unauthorized insurer.

(3) (i) "Covered claim" does not include a first party claim by an insured whose net worth exceeds $50,000,000 on December 31 of the year before the year in which the insurer becomes an insolvent insurer.

(ii) For purposes of this paragraph, the net worth of an insured is deemed to include the aggregate net worth of the insured and all of its subsidiaries calculated on a consolidated basis.

(4) Notwithstanding any other provision of this subtitle, "covered claim" does not include:

(i) a claim filed with the Corporation after the earlier of:

1. 18 months after the date of the order of liquidation; or

2. the final date set by the court for the filing of claims against the liquidator or receiver of an insolvent insurer; or

(ii) a claim filed with the Corporation or a liquidator for protection afforded under the insured's policy for losses that are incurred but not reported.

(e) "Insolvent insurer" means an insurer:

(1) that is authorized to transact insurance business or authorized to issue surety bonds in the State when the policy or surety bond is issued or when the event giving rise to the claim occurs; and

(2) against whom a court of competent jurisdiction in the insurer's state of domicile has passed a final order of liquidation with a finding of insolvency.

(f) (1) "Member insurer" means an authorized insurer that writes a kind of insurance, including the exchange of reciprocal or interinsurance contracts, to which this subtitle applies.

(2) "Member insurer" includes the Maryland Automobile Insurance Fund.

(g) (1) "Net direct written premiums" means direct gross premiums written in the State on policies or surety bonds to which this subtitle applies, less return premiums on the policies or surety bonds and dividends paid or credited to policyholders, or principals or obligees of surety bonds on the direct business.

(2) "Net direct written premiums" does not include:

(i) premiums on contracts between insurers or reinsurers; or

(ii) premiums received by insurers under the Maryland Property Insurance Availability Act.

(h) "Resident" means:

(1) an individual domiciled in the State; or

(2) a corporation or entity whose principal place of business is in the State.

(i) (1) "Surety bond" means insurance that guarantees the performance of contracts, other than policies, and that guarantees and executes bonds, undertakings, and contracts of suretyship.

(2) "Surety bond" does not include mortgage guaranty, financial guaranty, or other forms of insurance offering protection against investment risks.

§9–302.

The purposes of this subtitle are:

(1) to provide a mechanism for the prompt payment of covered claims under certain policies and to avoid financial loss to residents of the State who are claimants or policyholders of an insolvent insurer; and

(2) to provide for the assessment of the cost of payments of covered claims and protection among insurers.

§9–303.

This subtitle applies to all kinds of direct insurance, except:

(1) life insurance;

(2) health insurance;

(3) mortgage guaranty insurance;

(4) annuities;

(5) insurance written on a surplus lines basis under Title 3, Subtitle 3 of this article;

(6) insurance written by a risk retention group; and

(7) insurance written by an unauthorized insurer.

§9–304.

(a) (1) There is a Property and Casualty Insurance Guaranty Corporation.

(2) The Corporation is a private, nonprofit, nonstock corporation.

(b) As a condition of its authority to transact insurance business in the State, each member insurer must be and remain a member of the Corporation.

(c) The Corporation shall:

(1) perform its functions in accordance with a plan of operation established and approved under § 9–307 of this subtitle; and

(2) exercise its powers through a Board of Directors established under § 9–305 of this subtitle.

(d) For administration and assessment purposes, the Corporation shall be divided into the following four separate accounts:

(1) the title insurance account;

(2) the motor vehicle insurance account;

(3) the workers' compensation account; and

(4) the account for all other insurance to which this subtitle applies.

(e) Except as otherwise provided in this subtitle, the Corporation has perpetual existence and the powers, privileges, and immunities granted by the applicable provisions of the Corporations and Associations Article.

(f) (1) The Corporation is not and may not be deemed a department, unit, agency, or instrumentality of the State for any purpose.

(2) All debts, claims, obligations, and liabilities of the Corporation, whenever incurred, shall be the debts, claims, obligations, and liabilities of the Corporation only and not of the State or the State's agencies, instrumentalities, officers, or employees.

(g) (1) The money of the Corporation is not part of the General Fund of the State.

(2) The State may not budget for or provide General Fund appropriations to the Corporation.

(3) The debts, claims, obligations, and liabilities of the Corporation are not a debt of the State or a pledge of the credit of the State.

§9–305.

(a) (1) The Board of Directors of the Corporation consists of at least five members but not more than nine members.

(2) The members of the Board shall be elected from among the member insurers.

(3) The terms of the members of the Board shall be as set by the plan of operation.

(4) A vacancy on the Board shall be filled for the remainder of the term by a majority vote of the remaining members of the Board.

(b) (1) The Board of Directors shall elect a chairman from among its members and appoint three of its members to be an executive committee.

(2) The Board may elect other officers.

(c) When electing members of the Board of Directors or filling vacancies on the Board, consideration shall be given to, among other things, whether all member insurers are fairly represented.

(d) A member of the Board of Directors may be reimbursed by the Corporation for expenses incurred in carrying out duties as a member of the Board.

§9–306.

(a) (1) Except as to surety bonds, the Corporation shall be obligated to the extent of the covered claims existing on or before the determination of insolvency or arising:

(i) within 30 days after the determination of insolvency;

(ii) before the policy expiration date, if that date is less than 30 days after the determination of insolvency; or

(iii) before the insured replaces the policy or causes its cancellation, if the insured does so within 30 days after the determination of insolvency.

(2) Except as provided in paragraph (3) of this subsection, the obligation of the Corporation under this subsection shall include only that amount of each covered claim that is in excess of $100 and less than $300,000.

(3) The Corporation shall pay the full amount of any covered claim arising out of a workers' compensation policy.

(4) The Corporation is not obligated to a policyholder or claimant in an amount in excess of the obligation of the insolvent insurer under the policy out of which the claim arises.

(b) (1) As to surety bonds, the Corporation shall be obligated to the extent of the covered claims existing on or before the determination of insolvency, or arising within 18 months after the determination of insolvency, whether or not the surety bonds are issued with no stated period or for a stated period.

(2) The obligation of the Corporation under this subsection shall include only that amount of each covered claim payable to each claimant that is in excess of $100 and less than $300,000.

(3) The Corporation is not liable for an aggregate amount in excess of $1,000,000 under any one surety bond.

(4) If the covered claims are in excess of $1,000,000 under any one surety bond, the Corporation shall make a prorated payment on account of each covered claim in the ratio that the covered claim bears to the total amount of all covered claims under the surety bond.

(5) The Corporation is not obligated to a claimant in an amount in excess of the obligation of the insolvent insurer under the surety bond out of which the claim arises.

(c) The Corporation shall be deemed the insurer to the extent of the Corporation's obligation on the covered claims and, to that extent, shall have the rights, duties, and obligations that the insolvent insurer would have had if the insurer had not become insolvent.

(d) (1) The Corporation shall:

(i) allocate claims paid and expenses incurred among the four accounts separately; and

(ii) assess member insurers separately for each account in amounts necessary to pay:

1. the obligation of the Corporation under subsection (a) or (b) of this section after an insolvency;

2. the expense of handling covered claims after an insolvency; and

3. other expenses authorized by this subtitle.

(2) The Corporation shall assess each member insurer in the proportion that the net direct written premiums of the member insurer for the preceding calendar year on the kinds of insurance covered by the account bears to the net direct written premiums of all member insurers for the preceding calendar year on the kinds of insurance covered by the account.

(3) The Corporation shall give each member insurer at least 30 days' notice of an assessment before it is due.

(4) The Corporation may not assess a member insurer in any year on an account in an amount greater than 2% of that member insurer's net direct written premiums for the preceding calendar year on the kinds of insurance covered by the account.

(5) In any 1 year, if the sum of the maximum assessment for an account and the other assets of the Corporation in the account does not provide an amount sufficient to make all necessary payments from that account, the funds available shall be prorated and the unpaid part shall be paid as soon as funds are available.

(6) The Corporation may exempt or defer, wholly or partly, the assessment of a member insurer if the assessment would cause the member insurer's financial statement to reflect amounts of capital or surplus less than the minimum amounts required for a certificate of authority by any jurisdiction in which the member insurer is authorized to transact insurance business.

(7) A member insurer may set off against an assessment the authorized payments made on covered claims and expenses incurred in paying those covered claims if they are chargeable to the account for which the assessment is made.

(e) (1) The Corporation:

(i) shall investigate claims brought against the Corporation and adjust, compromise, settle, and pay covered claims to the extent of the Corporation's obligation and deny all other claims;

(ii) may review settlements, releases, and judgments to which the insolvent insurer or its insureds were parties to determine the extent to which the settlements, releases, and judgments may be properly contested;

(iii) shall notify persons as the Commissioner directs under § 9-308(b)(1) of this subtitle;

(iv) shall handle claims through its employees or through one or more insurers or other persons designated as servicing facilities;

(v) shall reimburse each servicing facility for obligations of the Corporation paid by the facility and for expenses incurred by the facility while handling claims on behalf of the Corporation; and

(vi) shall pay other expenses of the Corporation that are authorized by this subtitle.

(2) (i) Designation of a servicing facility by the Corporation is subject to the approval of the Commissioner.

(ii) A member insurer may decline designation as a servicing facility.

(f) The Corporation may:

(1) employ or retain persons necessary to handle claims and perform other duties of the Corporation;

(2) borrow money necessary to carry out the purposes of this subtitle in accordance with the plan of operation;

(3) sue or be sued;

(4) negotiate and become a party to contracts necessary to carry out the purposes of this subtitle;

(5) perform any other act necessary or proper to carry out the purposes of this subtitle; and

(6) refund to the member insurers in proportion to the contribution of each member insurer to an account, the amount by which the assets of the account at the end of any calendar year exceed the liabilities of that account as estimated by the Board of Directors for the coming year.

(g) (1) To the extent appropriate or necessary for the Corporation, or a similar association or corporation in another state, to carry out its duties under this subtitle, the Corporation may bring an action against a third party administrator, producer, agent, attorney, or other representative of an insolvent insurer to obtain custody and control of all files and records, regardless of format, related to claims information that involves the insolvent insurer.

(2) In an action brought under this subsection, the Corporation:

(i) has the absolute right through emergency equitable relief to obtain custody and control of all claims information in the custody or control of the third party administrator, producer, agent, attorney, or other representative of the insolvent insurer, regardless of where the claims information is physically located; and

(ii) is not subject to any defense, lien, or other legal or equitable ground that might be asserted against the liquidator of the insolvent insurer for refusal to surrender claims information.

(3) If an action is required under this subsection after refusal to provide claims information in response to a written demand for the claims information, the court shall award the Corporation its costs, expenses, and reasonable attorney fees incurred in bringing the action.

(4) This subsection does not affect the rights and remedies that the custodian of the applicable claims information may have against the insolvent insurer if those rights and remedies do not conflict with the right of the Corporation to custody and control of the claims information under this subsection.

§9–307.

(a) (1) (i) The Corporation shall submit to the Commissioner a plan of operation and any amendments to it necessary or suitable to ensure the fair, reasonable, and equitable administration of the Corporation.

(ii) The plan of operation and any amendments to it take effect when approved in writing by the Commissioner.

(2) (i) If the Corporation fails to submit suitable amendment to the plan of operation, the Commissioner, after notice and hearing, shall adopt reasonable regulations as necessary or advisable to carry out this subtitle.

(ii) Regulations adopted under this paragraph shall continue in effect until modified by the Commissioner or superseded by an amendment to the plan of operation submitted by the Corporation and approved by the Commissioner.

(b) Each member insurer shall comply with the plan of operation.

(c) The plan of operation shall:

(1) establish procedures for the performance of the powers and duties of the Corporation specified in § 9-306 of this subtitle;

(2) establish procedures for handling the assets of the Corporation;

(3) establish the amounts to be reimbursed and the method of reimbursing members of the Board of Directors under § 9-305 of this subtitle;

(4) establish procedures for filing claims with the Corporation;

(5) establish acceptable forms of proof of covered claims;

(6) establish regular places and times for meetings of the Board of Directors;

(7) establish procedures for keeping records of the financial transactions of the Corporation, its agents, and the Board of Directors;

(8) provide that a member insurer that is aggrieved by a final action or decision of the Corporation may appeal to the Commissioner within 30 days after the action or decision; and

(9) contain any additional provisions necessary or proper to perform the powers and duties of the Corporation.

(d) (1) Notice of a claim to the receiver or liquidator of an insolvent insurer shall be deemed notice to the Corporation or its agent.

(2) The receiver or liquidator periodically shall submit to the Corporation a list of claims of which the receiver or liquidator has received notice.

(e) (1) The plan of operation may provide that any or all of the powers and duties of the Corporation, except those under § 9-306(d) and (f)(2) of this subtitle, may be delegated to a person that performs or will perform functions similar to those of the Corporation or its equivalent.

(2) A person to which powers and duties are delegated under the plan of operation shall be:

(i) reimbursed as a servicing facility would be reimbursed; and

(ii) paid for its performance of the functions of the Corporation.

(3) A delegation under this subsection may:

(i) take effect only with the approval of the Board of Directors and Commissioner; and

(ii) be made only to a person that extends protection not substantially less favorable and effective than that provided by this subtitle.

§9–308.

(a) The Commissioner:

(1) shall notify the Corporation of the existence of an insolvent insurer not later than 3 days after the Commissioner receives notice of the determination of insolvency; and

(2) on request of the Board of Directors, shall provide the Corporation with a statement of the net direct written premiums of each member insurer.

(b) (1) (i) The Commissioner may require that the Corporation notify each insured, or each principal and specific obligee named in a surety bond, of each insolvent insurer and any other known interested party of the determination of insolvency and of their rights under this subtitle.

(ii) The notification required under subparagraph (i) of this paragraph may be by mail at the last known address of the interested party, but if sufficient information for notification by mail is not available, notification by publication in a newspaper of general circulation is sufficient.

(2) The Commissioner:

(i) after notice and hearing, may suspend or revoke the certificate of authority of a member insurer that fails to pay an assessment when due or fails to comply with the plan of operation; or

(ii) subject to paragraph (3) of this subsection, may impose a penalty on a member insurer that fails to pay an assessment when due.

(3) A penalty imposed under paragraph (2)(ii) of this subsection may not exceed 5% of the unpaid assessment per month and may not be less than $100 per month.

(4) If the Commissioner determines that claims are being handled unsatisfactorily, the Commissioner may revoke the designation of a person as a servicing facility.

(c) A final action or order of the Commissioner under this subtitle is subject to judicial review.

§9–309.

(a) (1) A person recovering from the Corporation under this subtitle is deemed to have assigned to the Corporation the person's rights under the policy to the extent of the person's recovery from the Corporation.

(2) Each insured or claimant seeking the protection of this subtitle shall cooperate with the Corporation to the same extent as the insured or claimant would have been required to cooperate with the insolvent insurer.

(3) The Corporation does not have a cause of action against the insured of the insolvent insurer for any sum the Corporation has paid out except for a cause of action that the insolvent insurer would have had if the sum had been paid by the insolvent insurer.

(4) Payment of a claim of the Corporation does not operate to reduce the liability of an insured to the receiver, liquidator, or statutory successor for an unpaid assessment of an insolvent insurer operating on a plan with assessment liability.

(b) (1) The receiver, liquidator, or statutory successor of an insolvent insurer is bound by the settlement of a covered claim by the Corporation or its representatives.

(2) The court having jurisdiction shall grant a covered claim priority equal to that to which the claimant would have been entitled in the absence of this subtitle against the assets of the insolvent insurer.

(3) The court having jurisdiction shall grant the expenses of the Corporation or similar organization in handling claims the same priority as the liquidator's expenses.

(c) (1) The Corporation periodically shall file with the receiver or liquidator of the insolvent insurer:

(i) statements of the covered claims paid by the Corporation; and

(ii) estimates of anticipated claims on the Corporation.

(2) The statements and estimates filed under paragraph (1) of this subsection shall preserve the rights of the Corporation against the assets of the insolvent insurer.

(d) An insurer may not assert a claim of subrogation against an insured of an insolvent insurer, but may assert a claim against the receiver of the insolvent insurer.

§9–310.

(a) (1) A person with a claim against an insurer under a policy or surety bond that is also a covered claim against an insolvent insurer shall exhaust first the person's rights under the policy or surety bond.

(2) The amount payable on a covered claim under this subtitle shall be reduced by the amount of any recovery under the policy or surety bond.

(b) (1) Except as provided in paragraph (2) of this subsection, a person with a claim that may be recovered under more than one insurance guaranty corporation or its equivalent shall seek recovery first:

(i) if the claim is a first party claim for damage to property with a permanent location, from the corporation or its equivalent of the location of the property; and

(ii) if the claim is any other claim, from the corporation or its equivalent of the residence of the insured.

(2) A person with a claim under a surety bond that may be recovered under more than one insurance guaranty corporation or its equivalent shall seek recovery first from the corporation or its equivalent of the place of performance of the obligation described in the surety bond.

(c) A recovery under this subtitle shall be reduced by the amount of recovery from any other insurance guaranty corporation or its equivalent.

§9–310.1.

(a) Any obligation of the Corporation to defend an insured shall cease on payment by the Corporation, by settlement releasing the insured or on a judgment, of an amount equal to the lesser of the Corporation's covered claim obligation limit or the applicable policy limit.

(b) (1) In this subsection, "affiliate" means a person that directly or indirectly, through one or more intermediaries, controls, is controlled by, or is under common control with another person.

(2) Notwithstanding any other provision of this subtitle, except for a claim for benefits under workers' compensation coverage, any obligation of the Corporation to any and all persons shall cease when $10,000,000 has been paid in the aggregate:

(i) by the Corporation and one or more insurance guaranty corporations or associations similar to the Corporation in other states or property casualty insurance security funds that obtain contributions from insurers on a pre-insolvency basis in other states;

(ii) to or on behalf of an insured and its affiliates; and

(iii) on covered claims or on claims allowed arising under one or more policies of one insolvent insurer.

(3) If the Corporation determines that there may be more than one claimant with a covered claim or allowed claim against the Corporation or any insurance guaranty corporations or associations similar to the Corporation in other states or any property casualty insurance security funds in other states, arising under one or more policies of one insolvent insurer, the Corporation may establish a plan to allocate amounts payable by the Corporation in the manner that the Corporation in its discretion considers equitable.

§9–311.

(a) The Corporation is subject to examination and regulation by the Commissioner.

(b) By March 30 of each year, the Board of Directors shall submit to the Commissioner a financial report for the preceding calendar year in the form that the Commissioner approves.

§9–312.

Except for taxes on real or personal property, the Corporation is exempt from the payment of all fees and taxes levied by the State or a subdivision of the State.

§9–313.

The rate and premium charged for a policy or surety bond to which this subtitle applies:

(1) shall include an amount sufficient to recoup, over a reasonable length of time of not less than 3 years, the amount paid to the Corporation by the

member insurer less any amount returned to the member insurer by the Corporation; and

(2) may not be considered excessive because the rate and premium contain an amount reasonably calculated to recoup assessments paid by the member insurer.

§9–314.

(a) A member insurer, the Corporation or its agents or employees, the Board of Directors, and the Commissioner or the Commissioner's representatives shall have the immunity from liability described in § 5-412 of the Courts Article.

(b) Notwithstanding subsection (a) of this section, the Corporation is not and may not be deemed a department, unit, agency, or instrumentality of the State.

§9–315.

(a) To allow proper defense by the Corporation of pending causes of action, each proceeding in which an insolvent insurer is a party or is obligated to defend a party in a court in the State shall be stayed for 60 days after the date of the determination of insolvency.

(b) As to a covered claim arising from a judgment under an order, decision, verdict, or finding based on the default of the insolvent insurer or its failure to defend an insured, the Corporation, on its own behalf or on behalf of the insured, may:

(1) apply to have the judgment, order, decision, verdict, or finding set aside by the same court or administrator that made it; and

(2) defend against the covered claim on the merits.

§9–316.

(a) The Commissioner shall terminate by order the operation of the Corporation as to a kind of insurance covered by this subtitle for which the Commissioner has found after a hearing that there is in effect a statutory or voluntary plan:

(1) that is permanent and is adequately funded or for which adequate funding is provided; and

(2) that extends or will extend to policyholders and residents protection and benefits with respect to insolvent insurers not substantially less

favorable and effective to those policyholders and residents than the protection and benefits provided under this subtitle for that kind of insurance.

(b) (1) By an order issued under subsection (a) of this section, the Commissioner shall authorize insurers to stop paying the Corporation as to the same kind of insurance for which the operation of the Corporation is terminated under the order.

(2) Notwithstanding paragraph (1) of this subsection, assessments and payments shall continue as necessary to liquidate covered claims of insurers determined to be insolvent before the order and to liquidate the related expenses not covered by the other plan.

(c) (1) If the Commissioner orders the termination of the operation of the Corporation as to all kinds of insurance within its scope, the Corporation as soon as possible after the termination shall:

(i) discharge first the functions of the Corporation as to prior insurer insolvencies not covered by the other plan, including the payment of expenses related to the discharge of these functions; and

(ii) distribute, in accordance with paragraph (2) of this subsection, the balance of money and assets remaining to the insurers that are then writing in the State policies of the kinds of insurance covered by this subtitle and that had made payments to the Corporation.

(2) The Corporation shall distribute the balance of money and assets remaining to the insurers pro rata on the basis of the aggregate of the payments made by the respective insurers during the period of 5 years immediately preceding the date of the order.

(3) When the distribution as to all kinds of insurance covered by this subtitle is complete, this subtitle shall terminate.

§9–401.

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

(b) "Account" means:

(1) the health account;

(2) the life insurance account; or

(3) the annuity account.

(c) "Association" means the Corporation or any similar organization that has been formed in another state that serves the same purpose as the Corporation for the other state.

(d) "Contractual obligation" means an obligation under a policy or contract or certificate under a group policy or contract for which coverage is provided under § 9–403 of this subtitle.

(e) "Corporation" means the Life and Health Insurance Guaranty Corporation.

(f) "Covered policy" or "covered contract" means a policy or contract to which this subtitle applies.

(g) (1) "Health benefit plan" means:

(i) a hospital or medical expense policy or certificate;

(ii) a health maintenance organization subscriber contract or group master certificate; or

(iii) any other similar health contract.

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

(i) accident–only insurance;

(ii) credit insurance;

(iii) dental–only insurance;

(iv) vision–only insurance;

(v) Medicare supplement insurance;

(vi) benefits for long–term care, home health care, community–based care, or any combination of these benefits;

(vii) disability insurance;

(viii) coverage for on–site medical clinics; or

(ix) specified disease, hospital confinement indemnity, or limited benefit health insurance if the types of coverage:

1. do not provide coordination of benefits; and

2. are provided under separate policies or certificates.

(h) "Impaired insurer" means a member insurer that:

(1) after July 1, 1971, is not an insolvent insurer and is placed under an order of rehabilitation or conservation by a court of competent jurisdiction; or

(2) is determined by the Commissioner after July 1, 1971, to be unable or potentially unable to fulfill its contractual obligations.

(i) "Individual" means a natural person covered under an individual policy or contract or covered as a member or an enrollee under a group policy or contract.

(j) "Insolvent insurer" means a member insurer that, after July 1, 1971, is placed under an order of liquidation by a court of competent jurisdiction with a finding of insolvency.

(k) (1) "Member insurer" means an authorized insurer or a health maintenance organization that is licensed or that holds a certificate of authority to transact in the State any kind of insurance or health maintenance organization business to which this subtitle applies.

(2) "Member insurer" includes an insurer or a health maintenance organization whose license or certificate of authority in the State may have been suspended, revoked, not renewed, or voluntarily withdrawn.

(3) "Member insurer" does not include:

(i) a fraternal benefit society;

(ii) a mandatory State pooling plan;

(iii) a mutual assessment company or other entity that operates on an assessment basis; or

(iv) an insurance exchange.

(l) "Moody's corporate bond yield average" means the monthly average yield on corporate bonds as published by Moody's Investors Service, Inc.

(m) (1) "Owner" means the owner or holder of a policy or contract who is:

(i) identified as the legal owner under the terms of the policy or contract or who is otherwise vested with legal title to the policy or contract through a valid assignment completed in accordance with the terms of the policy or contract; and

(ii) properly recorded as the owner of the policy or contract on the books of the member insurer.

(2) "Owner" does not include a person who has only a beneficial interest in a policy or contract.

(n) "Person" includes an individual, a corporation, a limited liability company, a partnership, an association, a governmental body or entity, or a voluntary organization.

(o) (1) "Premiums" means amounts received on covered policies or contracts, less premiums, considerations, and deposits returned, and less dividends and experience credits.

(2) "Premiums" does not include amounts for policies or contracts, or for parts of policies or contracts, for which coverage is not provided under § 9–403(g) of this subtitle.

(p) "Resident" means a person that resides in the State on the date of entry of a court order that determines a member insurer to be an impaired insurer or a court order that determines a member insurer to be an insolvent insurer and to whom a contractual obligation is owed.

(q) "Structured settlement annuity" means an annuity purchased in order to fund periodic payments for a plaintiff or any other claimant in payment for or with respect to personal injury suffered by the plaintiff or other claimant.

(r) "Supplemental contract" means an agreement entered into for the distribution of policy or contract proceeds.

§9–402.

Subject to certain limitations, the purpose of this subtitle is to protect persons specified in § 9–403(a) through (f) of this subtitle who are policy owners, contract owners, certificate holders, beneficiaries, enrollees, payees, and assignees of life, health, annuity, and supplemental policies, plans, or contracts specified in § 9–403(g)

of this subtitle against failure in the performance of contractual obligations due to the impairment or insolvency of the member insurer that issued the policies, plans, or contracts.

§9–403.

(a) This subtitle is intended to provide coverage to a person who is a resident of this State and, in special circumstances, to a nonresident.

(b) (1) For contracts other than structured settlement annuities, subject to paragraph (2) of this subsection, coverage shall be provided under this subtitle for the policies or contracts specified in subsection (g) of this section to a person who is:

(i) a resident and an owner of or certificate holder or enrollee under the policy or contract; or

(ii) a nonresident and an owner of or certificate holder or enrollee under the policy or contract, if:

1. the member insurer that issued the policy or contract is domiciled in this State;

2. the state in which the nonresident resides has an insurance guaranty corporation or its equivalent similar to the Corporation established by § 9–405 of this subtitle; and

3. the nonresident is not eligible for coverage by the insurance guaranty corporation or its equivalent in the state in which the nonresident resides because the insurer or health maintenance organization was not licensed in that state at the time specified in that state's guaranty corporation or association law.

(2) Coverage shall be provided under this subtitle for the policies or contracts specified in paragraph (1) of this subsection to a beneficiary, assignee, or payee, including a health care provider rendering services covered under health insurance policies, contracts, or certificates, of a person covered under paragraph (1) of this subsection, regardless of the person's residence.

(c) Except as provided in subsections (a), (d), and (e) of this section, this subtitle shall provide coverage to a person who is a payee under a structured settlement annuity or beneficiary of a payee if the payee is deceased, if:

(1) (i) the payee is a resident, regardless of where the contract owner resides; or

(ii) the payee is not a resident and:

1. the contract owner of the structured settlement annuity is a resident; or

2. A. the contract owner of the structured settlement annuity is not a resident;

B. the insurer that issued the structured settlement annuity is domiciled in this State; and

C. the state in which the contract owner resides has an association similar to the Corporation; and

(2) the payee or beneficiary, and the contract owner are not eligible for coverage by the association of the state in which the payee or contract owner resides.

(d) This subtitle does not provide coverage to:

(1) a person who is a payee or beneficiary of a contract owner who is a resident of this State, if the payee or beneficiary is provided any coverage by the association of another state;

(2) a person who otherwise would receive coverage under this subtitle, if the person is provided coverage under the laws of another state; or

(3) a person who acquires the right to receive payments through a structured settlement factoring transaction, as defined in 26 U.S.C. § 5891(c)(3)(A), regardless of whether the transaction occurred before or after the effective date of 26 U.S.C. § 5891(c)(3)(A).

(e) To determine coverage under this section under circumstances in which a person could be covered by the association of more than one state, whether as an owner, a payee, an enrollee, a beneficiary, or an assignee, this subtitle shall be construed in conjunction with other state laws to result in coverage by only one association.

(f) (1) To determine coverage under this section, a person may be a resident of only one state.

(2) To determine coverage under this section, a person shall be treated as a resident of the state of domicile of the insurer or health maintenance organization that issued the relevant policy or contract if:

(i) the person is a citizen of the United States and is a resident of a foreign country; or

(ii) the person is a resident of a United States possession, territory, or protectorate that does not have an association similar to the Corporation.

(g) (1) Except as provided in paragraph (2) of this subsection or otherwise limited by this subtitle, coverage shall be provided under this subtitle to persons specified in subsections (b) and (c) of this section for the following policies and contracts issued by member insurers:

(i) direct, nongroup life insurance, health insurance, which for the purposes of this subtitle includes health maintenance organization subscriber contracts and group master certificates, annuities, including structured settlement annuities, and supplemental policies or contracts to any of these; or

(ii) certificates under direct, group policies or contracts, and supplemental policies or contracts to any of these.

(2) Coverage may not be provided under this subtitle for:

(i) any part of a policy or contract that is not guaranteed by the member insurer, or under which the risk is borne by the policyholder or contract holder;

(ii) a policy or contract of reinsurance, unless assumption certificates have been issued;

(iii) except for a part of a policy or contract, including a rider, that provides long–term care or any other health insurance benefits, any part of a policy or contract to the extent that the rate of interest on which it is based or the interest rate, crediting rate, or similar factor determined by use of an index or other external reference stated in the policy or contract employed in calculating returns or changes in value:

1. averaged over the period of 4 years before the date on which the Corporation becomes obligated with respect to the policy or contract, exceeds a rate of interest determined by subtracting 2 percentage points from Moody's corporate bond yield average for the 4–year period before the date on which the Corporation became obligated or, if the policy or contract was issued less than 4 years before the Corporation became obligated, for that period; or

2. on or after the date on which the Corporation becomes obligated with respect to the policy or contract, exceeds the rate of interest determined by subtracting 3 percentage points from the most recent published Moody's corporate bond yield average;

(iv) a plan or program of an employer, association, or similar entity to provide life, health, or annuity benefits to its employees or members to the extent that the plan or program is self–funded or uninsured, including benefits payable by an employer, association, or similar entity under:

1. a multiple employer welfare arrangement, as defined in 29 U.S.C. § 1002(40);

2. a minimum premium group insurance plan;

3. a stop–loss group insurance plan; or

4. an administrative services only contract;

(v) any part of a policy or contract to the extent that it provides dividends or experience rating credits or provides that a fee or allowances be paid to any person, including the policy or contract holder, in connection with the service to or administration of the policy or contract;

(vi) a policy or contract issued in the State by a member insurer at a time when it was not licensed or did not have a certificate of authority to issue the policy or contract in the State;

(vii) an annuity contract or group annuity certificate that is not issued to and owned by an individual, except to the extent of annuity benefits guaranteed to an individual by an insurer under the annuity contract or group certificate, including the following contracts:

1. unallocated funding agreements;

2. unallocated annuity contract benefits;

3. deposit administration contracts; or

4. guaranteed investment contract accounts;

(viii) a policy issued by an organization as provided in § 1–202(3) of this article;

(ix) an annuity agreement issued under § 16–114 of this article;

(x) a portion of a policy or contract to the extent that the assessments required by § 9–409 of this subtitle with respect to the policy or contract are preempted by federal or state law;

(xi) an obligation that does not arise under the express written terms of the policy or contract issued by the member insurer to the enrollee, certificate holder, contract owner, or policy owner, including without limitation:

1. claims made on marketing materials;

2. claims based on side letters, riders, or other documents that were issued by the member insurer without meeting applicable policy form or contract filing or approval requirements;

3. misrepresentations of or regarding policy or contract benefits;

4. extra–contractual claims; and

5. a claim for penalties or consequential or incidental damages;

(xii) subject to paragraph (3) of this subsection, a portion of a policy or contract to the extent that it provides for interest or other changes in value to be determined by the use of an index or other external reference stated in the policy or contract, but which have not been credited to the policy or contract, or as to which the policy or contract owner's rights are subject to forfeiture, as of the date the member insurer becomes an impaired insurer or insolvent insurer under this subtitle, whichever is earlier;

(xiii) a policy or contract providing any hospital, medical, prescription drug, or other health care benefits under any of the following provisions or regulations adopted under one of the following provisions:

1. Title 42, Chapter 7, Subchapter XVIII, Part C or Part D of the United States Code ("Medicare Part C & D");

2. Title 42, Chapter 7, Subchapter XIX of the United States Code ("Medicaid"); or

3. Title 15, Subtitle 3 of the Health – General Article; or

(xiv) a structured settlement annuity benefit to which a payee, or beneficiary of a payee if the payee is deceased, has transferred the rights in a structured settlement factoring transaction, as defined in 26 U.S.C. § 5891(c)(3)(A), regardless of whether the transaction occurred before or after the effective date of 26 U.S.C. § 5891(c)(3)(A).

(3) If a policy's or contract's interest or changes in value are credited less frequently than annually, then to determine the values that have been credited and are not subject to forfeiture under this subsection, the interest or change in value determined by using the procedures defined in the policy or contract will be credited as if the contractual date of crediting interest or changing values was the date of impairment or insolvency, whichever is earlier, and will not be subject to forfeiture.

§9–404.

(a) (1) This subtitle shall be liberally construed to carry out its purpose as specified in § 9–402 of this subtitle.

(2) Section 9–402 of this subtitle is an aid and guide to the interpretation of this subtitle.

(b) The words "policy" and "contract" are used interchangeably throughout this subtitle.

(c) A person may be a resident of only one state. For a person other than an individual, that state is the state in which its principal place of business is located.

(d) (1) Subject to paragraph (2) of this subsection, for a plan sponsor or person other than an individual, its principal place of business is the single state in which the individuals who establish policy for the direction, control, and coordination of the operations of the entity, as a whole, primarily exercise that function, as determined by the Corporation in its reasonable judgment by considering the following factors:

(i) the state in which the primary executive and administrative headquarters of the entity is located;

(ii) the state in which the principal office of the chief executive officer of the entity is located;

(iii) the state in which the board of directors, or similar governing person or persons, of the entity conducts the majority of its meetings;

(iv) the state in which the executive or management committee of the board of directors, or similar governing person or persons, of the entity conducts the majority of its meetings;

(v) the state from which the management of the overall operations of the entity is directed; and

(vi) for a benefit plan sponsored by affiliated companies comprising a consolidated corporation, the state in which the holding company or controlling affiliate has its principal place of business, as determined under the factors in this paragraph.

(2) For a plan sponsor, if more than 50% of the participants in the benefit plan are employed in a single state, that state is deemed to be the principal place of business of the plan sponsor.

(3) For an association, a committee, a joint board of trustees, or any other similar group of representatives of the parties who establish or maintain a benefit plan when there is no specific or clear designation of a principal place of business, the principal place of business is the principal place of business of the employer or employee organization that has the largest investment in the benefit plan in question.

§9–405.

(a) (1) There is a Life and Health Insurance Guaranty Corporation.

(2) The Corporation is a private, nonprofit, nonstock corporation.

(3) The Corporation is established to enable the guaranty of payment of benefits and continuation of coverages.

(b) As a condition of its authority to transact insurance or health maintenance organization business in the State, each member insurer must be and remain a member of the Corporation.

(c) The Corporation shall:

(1) perform its functions in accordance with the plan of operation established and approved under § 9–410 of this subtitle; and

(2) exercise its powers through the Board of Directors established under § 9–406 of this subtitle.

(d) For administration and assessment purposes, the Corporation shall maintain:

(1) the health account;

(2) the life insurance account; and

(3) the annuity account.

(e) The Corporation is under the immediate supervision of the Commissioner and subject to the applicable insurance laws of the State.

(f) Except as otherwise provided in this subtitle, the Corporation has perpetual existence and the powers, privileges, and immunities granted by the applicable provisions of the Corporations and Associations Article.

(g) (1) The Corporation is not and may not be deemed a department, unit, agency, or instrumentality of the State for any purpose.

(2) All debts, claims, obligations, and liabilities of the Corporation, whenever incurred, shall be the debts, claims, obligations, and liabilities of the Corporation only and not of the State or the State's agencies, instrumentalities, officers, or employees.

(h) (1) The money of the Corporation is not part of the General Fund of the State.

(2) The State may not budget for or provide General Fund appropriations to the Corporation.

(3) The debts, claims, obligations, and liabilities of the Corporation are not a debt of the State or a pledge of the credit of the State.

§9–406.

(a) (1) The Board of Directors of the Corporation consists of at least 7 members but not more than 11 members.

(2) The members of the Board shall be elected from among the member insurers.

(3) The terms of the members of the Board shall be as set by the plan of operation.

(4) A vacancy on the Board shall be filled for the remainder of the term by a majority vote of the remaining members of the Board.

(b) (1) The Board of Directors shall elect a chairman and appoint an executive committee.

(2) The Board may elect other officers.

(c) When electing members of the Board of Directors or filling vacancies on the Board, consideration shall be given to, among other things, whether all member insurers are fairly represented.

(d) A member of the Board of Directors:

(1) may be reimbursed by the Corporation for expenses incurred in carrying out duties as a member of the Board; but

(2) may not otherwise receive compensation from the Corporation for the member's service.

(e) (1) The Board of Directors has general oversight authority over funds provided under this subtitle to the Board of Directors or Corporation.

(2) At any time or in any manner as the Board may direct, a receiver, liquidator, rehabilitator, or conservator appointed under this subtitle shall make a detailed accounting of expenditures to the Board.

§9–407.

(a) For a member insurer that is an impaired insurer, the Corporation, subject to any conditions imposed by the Corporation that do not impair the contractual obligations of the impaired insurer and that are approved by the Commissioner, may:

(1) guarantee, assume, reissue, or reinsure, or cause to be guaranteed, assumed, reissued, or reinsured, any or all of the covered policies or contracts of the impaired insurer; and

(2) provide money, pledges, loans, notes, guarantees, or other appropriate means to:

(i) carry out item (1) of this subsection; and

(ii) ensure payment of the contractual obligations of the impaired insurer, pending action under item (1) of this subsection.

(b) For a member insurer that is an insolvent insurer, the Corporation may:

(1) (i) guarantee, assume, reissue, or reinsure, or cause to be guaranteed, assumed, reissued, or reinsured, any or all of the covered policies or contracts of the insolvent insurer; or

(ii) ensure payment of the contractual obligations of the insolvent insurer; and

(2) provide money, pledges, loans, notes, guarantees, or other appropriate means to discharge the Corporation's duties under item (1) of this subsection.

(c) If the Corporation fails to act within a reasonable period of time with respect to the impaired insurer or insolvent insurer, the Commissioner shall have the powers and duties of the Corporation under this subtitle.

(d) (1) Premiums due for coverage after entry of an order of liquidation of an insolvent insurer shall belong to and be payable at the direction of the Corporation.

(2) If the liquidator of an insolvent insurer requests, the Corporation shall provide a report to the liquidator regarding premium collection by the Corporation.

(3) The Corporation shall be liable for unearned premiums due to policy or contract owners arising after the entry of the order.

(e) (1) In carrying out its duties under subsection (b) of this section, the Corporation may request that policy liens, contract liens, moratoriums on payments, or other similar means be imposed.

(2) Policy liens, contract liens, moratoriums on payments, or other similar means may be imposed if the Commissioner approves the specific policy liens, contract liens, moratoriums on payments, or other similar means after finding that:

(i) the amounts that can be assessed under this subtitle are less than the amounts needed to ensure full and prompt performance of the impaired insurer's contractual obligations; or

(ii) the economic or financial conditions, as they affect member insurers, are sufficiently adverse to render the imposition of policy liens, contract liens, moratoriums on payments, or other similar means to be in the public interest.

(3) (i) Before being obligated under subsection (b) of this section, the Corporation may request that temporary moratoriums or liens on payments of cash values and policy loans be imposed.

(ii) If the Commissioner approves, the temporary moratoriums or liens requested by the Corporation under this paragraph may be imposed.

(f) The Corporation is not liable under this section for a covered policy of a foreign insurer or alien insurer whose domiciliary jurisdiction or state of entry provides, by statute or regulation, protection for residents of this State substantially similar to that provided under this subtitle for residents of other states.

(g) On request of the Commissioner, the Corporation may give help and advice to the Commissioner about rehabilitation, payment of claims, continuations of coverage, or the performance of other contractual obligations of an impaired insurer.

(h) (1) The Corporation has standing to appear or intervene before any court or agency with jurisdiction over an impaired insurer or insolvent insurer as to which the Corporation is or may become obligated under this subtitle.

(2) The standing extends to all matters germane to the powers and duties of the Corporation, including proposals for reinsuring, reissuing, modifying, or guaranteeing the covered policies of the impaired insurer or insolvent insurer and the determination of the covered policies and contractual obligations.

(i) (1) A person receiving benefits under this subtitle, whether the benefits are payments of contractual obligations or continuation of coverage, is deemed to have assigned all rights under or causes of action relating to the covered policy to the Corporation to the extent of the benefits received because of this subtitle.

(2) The Corporation may require a payee, enrollee, policy or contract owner, beneficiary, insured, or annuitant to assign to the Corporation all rights to the extent of benefits received under the covered policy as a condition precedent to the receipt of any rights or benefits under this subtitle.

(3) The Corporation is subrogated to the rights assigned under this subsection against the assets of the impaired insurer or insolvent insurer.

(4) The subrogation rights of the Corporation under this subsection have the same priority against the assets of the impaired insurer or insolvent insurer as those of the person entitled to receive benefits under this subtitle.

(j) In carrying out its duties in connection with guaranteeing, assuming, reissuing, or reinsuring policies or contracts under subsections (a) and (b) of this section, the Corporation may, subject to approval of the Commissioner, issue substitute coverage for a policy or contract that provides an interest rate, a crediting rate, or a similar factor determined by use of an index or other external reference stated in the policy or contract employed in calculating returns or changes in value by issuing an alternative policy or contract, if:

(1) in lieu of the index or other external reference provided for in the original policy or contract, the alternative policy or contract provides for:

(i) a fixed interest rate;

(ii) payment of dividends with minimum guarantees; or

(iii) a different method for calculating interest or changes in value;

(2) there is no requirement for evidence of insurability, waiting period, or other exclusion that would not have applied under the original policy or contract; and

(3) the alternative policy or contract is substantially similar to the original policy or contract in all other material terms.

(k) (1) Subject to paragraphs (2) and (3) of this subsection and unless the contractual obligations of the impaired insurer or insolvent insurer are reduced or excluded under subsection (e) of this section or § 9–403(g)(2) of this subtitle, the contractual obligations of the impaired insurer or insolvent insurer for which the Corporation is or may become liable shall be as great as, but no greater than, the contractual obligations that the impaired insurer or insolvent insurer would have had in the absence of the impairment or insolvency.

(2) The Corporation is not liable for health care received after the date of the impairment or insolvency unless the health care was in progress on the date of the impairment or insolvency or unless other health care coverage is not available from another insurer, health maintenance organization, or nonprofit health service plan.

(3) Benefits for which the Corporation may become liable may not exceed the lesser of:

(i) the contractual obligations for which the member insurer is or would have been liable if it were not an impaired insurer or insolvent insurer; or

(ii) with respect to any one life, regardless of the number of policies or contracts:

1. $300,000 in life insurance death benefits, but not more than $100,000 in net cash surrender and net cash withdrawal values for life insurance;

2. for health insurance benefits:

A. $500,000 for health benefit plans;

B. $300,000 for disability insurance and $300,000 for long–term care insurance, as defined in § 18–101 of this article; and

C. $100,000 for coverages not included as disability insurance, health benefit plans, or long–term care insurance, including any net cash surrender and net cash withdrawal values under items A and B of this item; and

3. A. $250,000 in the present value of annuity benefits, including net cash surrender and net cash withdrawal values; and

B. with respect to each payee under a structured settlement annuity, or beneficiary of the payee if the payee is deceased, $250,000 in present value annuity benefits, in the aggregate, including any net cash surrender and net cash withdrawal values.

(4) (i) Except as provided in subparagraph (ii) of this paragraph, the Corporation may not, with respect to any one life, be liable for coverage greater than an aggregate of $300,000 for the benefits described in paragraph (3)(ii)1, 2, and 3 of this subsection.

(ii) The Corporation may not, with respect to any one life, be liable for coverage greater than an aggregate of $500,000 for health benefit plans under paragraph (3)(ii)2A of this subsection.

(l) The Corporation may join an organization of one or more other state associations of similar purposes, to further the purposes and administer the powers and duties of the Corporation.

(m) In this subtitle, benefits provided by a long–term care rider to a life insurance policy or annuity contract shall be considered the same type of benefits as the base life insurance policy or annuity contract to which the rider relates.

§9–407.1.

(a) At any time within 180 days after the date of an order of liquidation, the Corporation may elect to succeed to the rights and obligations of the ceding member insurer that relate to policies, contracts, or annuities covered, in whole or in part, by the Corporation, in each case under any one or more reinsurance contracts entered into by the insolvent insurer and its reinsurers and selected by the Corporation.

(b) Any assumption under subsection (a) of this section is effective as of the date of the order of liquidation.

(c) The election shall be effected by the Corporation or the National Organization of Life and Health Insurance Guaranty Associations on its behalf sending written notice, return receipt requested, to the affected reinsurers.

(d) To facilitate the earliest practicable decision about whether to assume any of the contracts of reinsurance, and in order to protect the financial position of the estate, the receiver and each reinsurer of the ceding member insurer shall make available on request to the Corporation or to the National Organization of Life and Health Insurance Guaranty Associations on its behalf as soon as possible after commencement of formal delinquency proceedings:

(1) copies of in–force contracts of reinsurance and all related files and records relevant to the determination of whether the contracts should be assumed; and

(2) notices of any defaults under the reinsurance contracts or any known event or condition that, with the passage of time, could become a default under the reinsurance contracts.

(e) (1) This subsection applies to reinsurance contracts assumed by the Corporation.

(2) The Corporation is responsible for all unpaid premiums due under a reinsurance contract assumed by the Corporation for periods both before and after the date of the order of liquidation, and is responsible for the performance of all

other obligations to be performed after the date of the order of liquidation, in each case which relate to policies, contracts, or annuities covered, in whole or in part, by the Corporation.

(3) The Corporation may charge policies, contracts, or annuities covered in part by the Corporation, through reasonable allocation methods, the costs for reinsurance in excess of the obligations of the Corporation and shall provide notice and an accounting of these charges to the liquidator.

(4) The Corporation is entitled to any amounts payable by the reinsurer under the reinsurance contracts with respect to losses or events that occur in periods after the date of the order of liquidation and that relate to policies, contracts, or annuities covered, in whole or in part, by the Corporation, if on receipt of any amounts payable, the Corporation is obliged to pay to the beneficiary under the policy, contract, or annuity on account of which the amounts were paid a portion of the amount equal to the lesser of:

(i) the amount received by the Corporation; and

(ii) the excess of the amount received by the Corporation over the amount equal to the benefits paid by the Corporation on account of the policy, contract, or annuity less the retention of the insurer applicable to the loss or event.

(f) (1) (i) Within 30 days after the Corporation's election, the Corporation and each reinsurer under contracts assumed by the Corporation shall calculate the net balance due to or from the Corporation under each reinsurance contract as of the election date with respect to policies, contracts, or annuities covered, in whole or in part, by the Corporation.

(ii) The calculation under subparagraph (i) of this paragraph shall give full credit to all items paid by either the member insurer or its receiver or the reinsurer prior to the election date.

(2) Within 5 days after the completion of the calculation under paragraph (1) of this subsection, the reinsurer shall pay the receiver any amounts due for losses or events before the date of the order of liquidation, subject to any setoff for premiums unpaid for periods before the date, and the Corporation or reinsurer shall pay any remaining balance due the other, in each case.

(3) Any disputes over the amounts due to either the Corporation or the reinsurer shall be resolved by arbitration under the terms of the affected reinsurance contracts or, if the contract contains no arbitration clause, as otherwise provided by law.

(4) If the receiver has received any amounts due to the Corporation under subsection (e)(4) of this section, the receiver shall remit those amounts to the Corporation as promptly as practicable.

(g) If the Corporation or receiver, on the Corporation's behalf, within 60 days after the election date, pays the unpaid premiums due for periods both before and after the election date that relate to policies, contracts, or annuities covered, in whole or in part, by the Corporation, the reinsurer is not entitled to:

(1) terminate the reinsurance contracts for failure to pay premiums for the reinsurance contracts that relate to policies, contracts, or annuities covered, in whole or in part, by the Corporation; or

(2) set off any unpaid amounts due under other contracts, or unpaid amounts due from parties other than the Corporation, against amounts due the Corporation.

(h) During the period from the date of the order of liquidation until the election date or, if the election date does not occur, until 180 days after the date of the order of liquidation:

(1) (i) neither the Corporation nor the reinsurer shall have any rights or obligations under reinsurance contracts that the Corporation has the right to assume under subsections (a) through (g) of this section, whether for periods before or after the date of the order of liquidation; and

(ii) the reinsurer, the receiver, and the Corporation shall, to the extent practicable, provide each other data and records reasonably requested; and

(2) if the Corporation has elected to assume a reinsurance contract, the parties' rights and obligations shall be governed by subsections (a) through (g) of this section.

(i) If the Corporation does not elect to assume a reinsurance contract by the election date under subsections (a) through (g) of this section, the Corporation shall have no rights or obligations, in each case for periods both before and after the date of the order of liquidation, with respect to the reinsurance contract.

(j) When policies, contracts, or annuities, or covered obligations with respect to policies, contracts, or annuities, are transferred to an assuming insurer, reinsurance on the policies, contracts, or annuities may also be transferred by the Corporation, in the case of contracts assumed under subsections (a) through (g) of this section, if:

(1) unless the reinsurer and the assuming insurer agree otherwise, the reinsurance contract transferred does not cover any new policies of insurance, health maintenance organization subscriber contracts and group master certificates, or annuities in addition to those transferred;

(2) the obligations described in subsections (a) through (g) of this section no longer apply with respect to matters arising after the effective date of the transfer; and

(3) notice is given in writing, return receipt requested, by the transferring party to the affected reinsurer at least 30 days before the effective date of the transfer.

(k) (1) The provisions of this section supersede the provisions of any state law or of any affected reinsurance contract that provides for or requires any payment of reinsurance proceeds, on account of losses or events that occur in periods after the date of the order of liquidation, to the receiver of the insolvent insurer or any other person.

(2) The receiver remains entitled to any amounts payable by the reinsurer under the reinsurance contracts with respect to losses or events that occur in periods before the date of the order of liquidation, subject to applicable setoff provisions.

(l) (1) Except as otherwise provided in this section, this section does not alter or modify the terms and conditions of any reinsurance contract.

(2) This section does not:

(i) abrogate or limit any rights of any reinsurer to claim that the reinsurer is entitled to rescind a reinsurance contract;

(ii) give a policyholder, contract owner, enrollee, certificate holder, or beneficiary an independent cause of action against a reinsurer that is not otherwise set forth in the reinsurance contract;

(iii) limit or affect the Corporation's rights as a creditor of the estate against the assets of the estate; or

(iv) apply to reinsurance agreements covering property or casualty risks.

§9–408.

The Corporation may:

(1) enter into contracts that are necessary or proper to carry out the provisions and purposes of this subtitle;

(2) sue or be sued and take any other legal actions necessary or proper for the recovery of unpaid assessments under § 9–409 of this subtitle;

(3) borrow money to carry out the purposes of this subtitle, provided that any notes or other evidences of indebtedness of the Corporation not in default are legal investments for domestic insurers and may be carried as admitted assets;

(4) employ or retain persons as necessary to handle the financial transactions of the Corporation and perform other functions that are necessary or proper under this subtitle;

(5) negotiate and contract with liquidators, rehabilitators, conservators, or ancillary receivers to carry out the powers and duties of the Corporation;

(6) take any legal action necessary to avoid payment of improper claims;

(7) for the purposes of this subtitle and to the extent approved by the Commissioner, exercise the powers of a domestic life insurer, health insurer, or health maintenance organization, except that the Corporation may not issue policies or contracts other than those issued to perform the contractual obligation of an impaired insurer or insolvent insurer;

(8) in accordance with the terms and conditions of the policy or contract, file for actuarially justified rate or premium increases for any policy or contract for which the Corporation provides coverage under this subtitle; and

(9) perform any other act necessary or proper to carry out this subtitle.

§9–409.

(a) Members of the Corporation are subject to assessment as provided in this section.

(b) (1) To provide the funds necessary to carry out the powers and duties of the Corporation, the Board of Directors shall assess member insurers, separately for each account, at the times and for the amounts that the Board finds necessary.

(2) The Board shall give 30 days' written notice to a member insurer before payment of an assessment is due.

(3) The Board shall collect the assessments when due.

(c) There are two classes of assessments to be made for the following purposes:

(1) Class A assessments, to be used to meet administrative costs and other general expenses not related to a particular impaired insurer or insolvent insurer; and

(2) Class B assessments, to be used to carry out the powers and duties of the Corporation with respect to an impaired insurer or insolvent insurer.

(d) (1) (i) The Board shall determine the amount of a Class A assessment.

(ii) The Board may make a Class A assessment on a pro rata or nonpro rata basis.

(iii) If made on a pro rata basis, the Board may provide that the assessment be credited against future Class B assessments.

(iv) Except for assessments related to long–term care insurance, the amount of a Class B assessment shall be allocated for assessment purposes among the accounts according to an allocation formula that is based on:

1. the premiums or reserves of the impaired insurer or insolvent insurer; or

2. on another standard that the Board considers in its sole discretion to be fair and reasonable under the circumstances.

(2) (i) The amount of a Class B assessment for long–term care insurance written by the impaired insurer or insolvent insurer shall be allocated according to a methodology included in the plan of operation and approved by the Commissioner.

(ii) The methodology used to allocate the amount under subparagraph (i) of this paragraph shall provide for 50% of the assessment to be allocated to accident and health member insurers and 50% to be allocated to life and annuity member insurers.

(3) The Board shall make Class B assessments against member insurers for each account in the proportion that the amount of premiums received on business in the State by each assessed member insurer on policies or contracts covered by each account for the most recent calendar year for which information is available preceding the year in which the member insurer became impaired or insolvent, bears to the amount of premiums received on business in the State for those calendar years by all assessed member insurers.

(4) The Board may assess member insurers on a nonpro rata basis without regard to paragraph (3) of this subsection if the amount of a Class B assessment representing the aggregate liability of the Corporation for a single impairment or insolvency is not greater than the Class A assessment in the same calendar year against authorized insurers in the same line of business as the liability for the impaired insurer or insolvent insurer.

(5) (i) The Board may not make assessments for funds to meet the requirements of the Corporation with respect to an impaired insurer or insolvent insurer until necessary to carry out the purposes of this subtitle.

(ii) Because exact determinations may not always be possible, the Board shall make classifications of assessments and computation of assessments under this subsection with a reasonable degree of accuracy.

(e) (1) If, in the opinion of the Board, payment of an assessment would endanger the ability of a member insurer to meet its contractual obligations, the Corporation may abate or defer, wholly or partly, the assessment of the member insurer.

(2) If an assessment against a member insurer is wholly or partly abated or deferred, the amount by which the assessment is abated or deferred shall be assessed against the other member insurers in a manner consistent with the basis for assessments set forth in this section.

(f) (1) In a calendar year, the total of all assessments against a member insurer for each account may not exceed 2% of the member insurer's premiums in the State on policies covered by the account.

(2) If an assessment against a member insurer is reduced because of paragraph (1) of this subsection, the Board shall assess the amount of the reduction against the other member insurers in a manner consistent with the basis for assessments set forth in this section.

(3) If the maximum assessments in a calendar year against all member insurers plus the other assets of the Corporation in any account are insufficient to provide in the account the amount necessary to carry out the responsibilities of the Corporation, the Board shall make additional assessments as necessary against member insurers as soon as allowed by this subtitle.

(g) (1) If approved by the Commissioner, the Board may refund to member insurers, by an equitable method set by the plan of operation, in proportion to the contribution of each member insurer to that account, the amount by which the assets of the account exceed the amount that the Board finds necessary to carry out the obligations of the Corporation during the coming year.

(2) For the purpose of this subsection, assets include assets accruing from net realized gains and income from investments.

(3) If refunds are impracticable, the Board may retain a reasonable amount in an account for the continuing expenses of the Corporation and for future losses.

(h) In determining premium rates and policy owner dividends for any kind of insurance or health maintenance organization business within the scope of this subtitle, a member insurer may consider the amount reasonably necessary to meet its assessment obligations under this subtitle.

(i) (1) The Corporation shall issue to each member insurer that pays an assessment under this subtitle a certificate of contribution for the amount of the assessment.

(2) The certificate of contribution shall be in the form that the Commissioner requires.

(3) All outstanding certificates of contribution are of equal dignity and priority without reference to amounts or dates of issue.

(4) The member insurer may show a certificate of contribution in the member insurer's financial statement as an asset in the form and for the amount, if any, and the period of time that the Commissioner approves.

§9–410.

(a) (1) (i) The Corporation shall submit to the Commissioner a plan of operation and any amendments necessary or suitable to it to ensure the fair, reasonable, and equitable administration of the Corporation.

(ii) 1. The plan of operation and any amendments to it take effect when approved in writing by the Commissioner.

2. Unless disapproved by the Commissioner within 30 days after submission, a plan of operation and any amendments to the plan shall be deemed approved on the 31st day after the date on which the plan was submitted.

(2) (i) If the Corporation fails to submit suitable amendments to the plan of operation, the Commissioner, after notice and hearing, shall adopt reasonable regulations as necessary or advisable to carry out this subtitle.

(ii) Regulations adopted under this paragraph shall continue in effect until modified by the Commissioner or superseded by an amendment to the plan of operation submitted by the Corporation and approved by the Commissioner.

(b) Each member insurer shall comply with the plan of operation.

(c) The plan of operation shall:

(1) establish procedures for handling the assets of the Corporation;

(2) establish the amounts to be reimbursed and the method of reimbursing members of the Board of Directors under § 9–406 of this subtitle;

(3) establish regular places and times for meetings of the Board of Directors;

(4) establish procedures for keeping records of the financial transactions of the Corporation, its agents, and the Board of Directors;

(5) establish procedures for choosing the Board of Directors and submitting the choices to the Commissioner;

(6) establish any additional procedures for assessments under § 9–409 of this subtitle; and

(7) contain any additional provisions necessary or proper to perform the powers and duties of the Corporation.

(d) (1) The plan of operation may provide that any or all of the powers and duties of the Corporation, except those under §§ 9–408(3) and 9–409 of this subtitle, may be delegated to a person that performs or will perform functions similar to those of the Corporation or its equivalent in two or more states.

(2) A person to which powers and duties are delegated under the plan of operation shall be:

(i) reimbursed for any payments made on behalf of the Corporation; and

(ii) paid for its performance of the functions of the Corporation.

(3) A delegation under this subsection may:

(i) take effect only with the approval of the Board of Directors and Commissioner; and

(ii) be made only to a person that extends protection not substantially less favorable and effective than that provided by this subtitle.

§9–411.

(a) (1) The Commissioner:

(i) shall notify the Board of Directors of the existence of an impaired insurer not later than 3 days after a determination of impairment is made or the Commissioner receives notice of impairment;

(ii) on request of the Board of Directors, shall provide the Corporation with a statement of the premiums in the State and other appropriate states for each member insurer;

(iii) when an impairment is declared and the amount of the impairment is determined, shall serve a demand on the impaired insurer to make good the impairment within a reasonable time; and

(iv) shall be appointed as:

1. the liquidator or rehabilitator in a liquidation or rehabilitation proceeding involving a domestic member insurer; or

2. the conservator or ancillary receiver in a liquidation proceeding involving a member insurer that is a foreign insurer in its domiciliary jurisdiction or an alien insurer in its state of entry.

(2) (i) Notice to the impaired insurer under paragraph (1)(iii) of this subsection is deemed notice to its shareholders.

(ii) Failure of the impaired insurer to comply promptly with a demand to make good the impairment does not excuse the Corporation from the performance of its duties and powers under this subtitle.

(b) (1) The Commissioner:

(i) after notice and hearing, may suspend or revoke the license or certificate of authority to transact business in the State of any member insurer that fails to pay an assessment when due or fails to comply with the plan of operation; or

(ii) on behalf of the Corporation, may impose a penalty on a member insurer that fails to pay an assessment when due.

(2) A penalty imposed under paragraph (1)(ii) of this subsection may not exceed 5% of the unpaid assessment per month and may not be less than $100 per month.

(c) (1) Within 30 days after an action of the Board of Directors or Corporation, a member insurer may appeal the action to the Commissioner.

(2) A final action or order of the Commissioner under this subtitle is subject to judicial review.

(d) The liquidator, rehabilitator, or conservator of an impaired insurer may notify all interested persons of the effect of this subtitle.

§9–412.

(a) (1) The Commissioner and Board of Directors have the powers and duties described in this section to help in the detection and prevention of member insurer impairments or insolvencies.

(2) The Corporation may help the Commissioner in detecting and preventing member insurer impairments or insolvencies as provided in this section.

(b) (1) The Commissioner shall examine a member insurer if the Commissioner has reasonable cause to believe that the member insurer may be unable or potentially unable to fulfill its contractual obligations.

(2) On a majority vote, the Board of Directors shall notify the Commissioner of any information that indicates that a member insurer may be unable or potentially unable to fulfill its contractual obligations.

(c) (1) On a majority vote, the Board of Directors may request that the Commissioner order an examination of a member insurer that the Board in good faith believes may be unable or potentially unable to fulfill its contractual obligations.

(2) The Commissioner may conduct the examination.

(3) The examination may be conducted as a National Association of Insurance Commissioners examination or may be conducted by a person that the Commissioner designates.

(4) The cost of an examination shall be paid by the Corporation.

(5) The examination report shall be treated as are other examination reports.

(6) An examination report may not be released to the Board of Directors before its release to the public, but this does not excuse the Commissioner from the duty to comply with subsection (d) of this section.

(7) The Commissioner shall notify the Board of Directors when the examination is completed.

(8) (i) The request for an examination shall be kept on file by the Commissioner.

(ii) A request for examination may not be open to public inspection before the release of the examination report to the public, and shall be released at that time only if the examination discloses that the examined member insurer is unable or potentially unable to meet its contractual obligations.

(d) The Commissioner shall report to the Board of Directors when the Commissioner has reasonable cause to believe that a member insurer, examined at the request of the Board of Directors, may be unable or potentially unable to fulfill its contractual obligations.

(e) (1) On a majority vote, the Board of Directors may make reports and recommendations to the Commissioner on any matter germane to the solvency, liquidation, rehabilitation, or conservation of a member insurer.

(2) A report or recommendation made under this subsection is not a public document.

(f) On a majority vote, the Board of Directors may make recommendations to the Commissioner for the detection and prevention of member insurer impairments or insolvencies.

(g) At the conclusion of a member insurer impairment or insolvency in which the Corporation carried out its duties or exercised its powers under this subtitle, the Board of Directors shall prepare and submit to the Commissioner a report on the history and causes of the impairment or insolvency, based on the information available to the Corporation.

§9–413.

The Corporation may recommend an individual to serve as a special deputy to act for the Commissioner and under the Commissioner's supervision in the liquidation, rehabilitation, or conservation of a member insurer.

§9–414.

(a) This subtitle may not be construed to reduce the liability for unpaid assessments of the insureds of an impaired insurer or insolvent insurer operating under a plan with assessment liability.

(b) Assessable premiums may not be reduced because of § 9–403(g)(2)(iii) of this subtitle relating to interest limitations and because of § 9–407(k) of this subtitle relating to limitations with respect to an individual policyholder.

(c) (1) The Corporation shall keep records of all negotiations and meetings in which the Corporation or its representatives are involved to discuss the activities of the Corporation in carrying out its powers and duties under §§ 9–407 and 9–408 of this subtitle.

(2) Records of the negotiations or meetings described in paragraph (1) of this subsection shall be made public only:

(i) after the termination of a liquidation, rehabilitation, or conservation proceeding involving an impaired insurer or insolvent insurer;

(ii) after the termination of the impairment or insolvency of a member insurer; or

(iii) by court order.

(3) This subsection does not limit the duty of the Corporation to submit a report of its activities under § 9–415 of this subtitle.

(d) (1) In this subsection, "assets attributable to covered policies" means that proportion of the impaired insurer's or insolvent insurer's assets that the amount of the reserves that should have been established for the covered policies bears to the amount of the reserves that should have been established for all policies written by the impaired insurer or insolvent insurer.

(2) For the purpose of carrying out its obligations under this subtitle, the Corporation is considered a creditor of the impaired insurer or insolvent insurer to the extent of the impaired insurer's or insolvent insurer's assets attributable to covered policies reduced by any amounts to which the Corporation is entitled as subrogee under § 9–407(i) of this subtitle.

(3) The assets attributable to covered policies of the impaired insurer or insolvent insurer shall be used to continue the covered policies and pay the contractual obligations of the impaired insurer or insolvent insurer as required by this subtitle.

(e) (1) (i) Before the termination of a liquidation, rehabilitation, or conservation proceeding, the court may consider the contributions of the respective parties, including the Corporation, the stockholders, contract owners, certificate holders, enrollees, and policy owners of the impaired insurer or insolvent insurer, and any other party with a bona fide interest, in making an equitable distribution of the ownership rights of the impaired insurer or insolvent insurer.

(ii) In making a determination under subparagraph (i) of this paragraph, the court shall consider the welfare of the policyholders, contract owners, certificate holders, and enrollees of the continuing or successor member insurer.

(2) A distribution to any stockholders of an impaired insurer or insolvent insurer may not be made until all of the assessments levied by the Corporation with respect to the impaired insurer or insolvent insurer have been fully recovered by the Corporation.

(f) It is a prohibited unfair method of competition, subject to Title 27 of this article (Unfair Trade Practices), for a person to make use in any manner of the protection afforded by this subtitle in the sale of insurance or health maintenance organization coverage.

(g) (1) Subject to the limitations of paragraphs (2) and (4) of this subsection, if an order for liquidation or rehabilitation of a member insurer domiciled in the State has been entered, the receiver appointed under the order shall have a right to recover on behalf of the member insurer, from any affiliate that controlled the member insurer, the amount of distribution, other than stock dividends paid by

the member insurer on its capital stock, made at any time during the 5 years preceding the petition for liquidation or rehabilitation.

(2) A dividend described in paragraph (1) of this subsection is not recoverable if the member insurer shows that:

(i) the distribution was lawful and reasonable when paid; and

(ii) the member insurer did not know and could not reasonably have known that the distribution might adversely affect the ability of the member insurer to fulfill its contractual obligations.

(3) (i) A person that was an affiliate that controlled the member insurer when the distributions described in paragraph (1) of this subsection were paid is liable up to the amount of distributions the person received.

(ii) A person that was an affiliate that controlled the member insurer when the distributions described under paragraph (1) of this subsection were declared is liable up to the amount of distributions the person would have received if the distributions had been paid immediately.

(iii) Two or more persons that are liable with respect to the same distributions are jointly and severally liable.

(4) The maximum amount recoverable under this subsection is the amount needed in excess of all other available assets of the impaired insurer or insolvent insurer to pay the contractual obligations of the impaired insurer or insolvent insurer.

(5) If a person liable under paragraph (3) of this subsection is insolvent, all of its affiliates that controlled it when the dividend was paid are jointly and severally liable for any resulting deficiency in the amount recovered from the insolvent affiliate.

(h) (1) A member insurer or insurance producer may not deliver a policy or contract that at the time of delivery exceeds the limitations imposed by § 9–407(k)(3) of this subtitle, or that is not subject to coverage under § 9–403 of this subtitle, unless the member insurer or insurance producer, before or at the time of delivery, provides the policyholder, certificate holder, enrollee, or contract holder with a separate written notice as provided in paragraph (2) of this subsection.

(2) The notice required under this subsection shall disclose clearly and conspicuously that:

(i) the policy or contract is not covered by, or exceeds the limitations of liability applicable to, the Corporation; and

(ii) the Corporation is not a department or unit of the State, and the liabilities or debts of the Corporation are not liabilities or debts of the State.

(3) The Commissioner shall adopt regulations establishing a standard form to be used by insurance producers and member insurers to conform with the provisions of this subsection.

§9–415.

(a) The Corporation is subject to examination and regulation by the Commissioner.

(b) By May 1 of each year, the Board of Directors shall submit to the Commissioner:

(1) a financial report for the preceding calendar year in the form that the Commissioner approves; and

(2) a report of its activities during the preceding calendar year.

§9–416.

Except for taxes on real property, the Corporation is exempt from the payment of all fees and taxes levied by the State or a subdivision of the State.

§9–417.

(a) A member insurer or its agents or employees, the Corporation or its agents or employees, members of the Board of Directors, and the Commissioner or the Commissioner's representatives shall have the immunity from liability described in § 5–413 of the Courts Article for any action or omission taken by them in the performance of their powers and duties under this subtitle.

(b) The immunity under subsection (a) of this section shall extend to:

(1) the Corporation as a participant in an organization of one or more other state associations of similar purposes to the Corporation; and

(2) the agents or employees of an organization in which the Corporation is a participant under item (1) of this subsection.

§9–418.

(a) To allow proper legal action by the Corporation on any matter germane to its powers or duties, each proceeding in which the impaired insurer is a party in a court in the State shall be stayed for 60 days after the date an order of liquidation, rehabilitation, or conservation is final.

(b) If a court enters a judgment under a decision, order, verdict, or finding based on default, the Corporation may:

(1) apply to have the judgment, decision, order, verdict, or finding set aside by the same court that made it; and

(2) defend against the suit on the merits.

§9–419.

This subtitle is the Life and Health Insurance Guaranty Corporation Act.

§10–101.

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

(b) "Authorized representative" means an independent contractor of a travel retailer.

(c) "Business entity" means a corporation, professional association, partnership, limited liability company, limited liability partnership, or other legal entity.

(d) "Home state" means any state in which an insurance producer:

(1) maintains the insurance producer's principal place of residence or principal place of business; and

(2) is licensed to act as a resident insurance producer.

(e) (1) "License" means a document issued by the Commissioner to act as an insurance producer for the kind or subdivision of insurance or combination of kinds or subdivisions of insurance specified in the document.

(2) "License" includes a limited lines license.

(f) "Limited line credit insurance" includes:

(1) credit life insurance;

(2) credit health insurance;

(3) credit property insurance;

(4) credit unemployment insurance;

(5) credit involuntary unemployment benefit insurance;

(6) mortgage life insurance;

(7) mortgage guaranty insurance;

(8) mortgage disability insurance;

(9) guaranteed automobile protection (GAP) insurance; and

(10) any other form of insurance that:

(i) is offered in connection with an extension of credit;

(ii) is limited to partially or wholly extinguishing that credit obligation; and

(iii) the Commissioner determines should be designated a form of limited line credit insurance.

(g) "Limited line credit insurance producer" means a person who sells, solicits, or negotiates one or more forms of limited line credit insurance coverage to individuals through a master, corporate, group, or individual policy.

(h) "Limited lines insurance" means:

(1) limited line credit insurance;

(2) the lines of insurance described in §§ 10–122 through 10–125 of this subtitle;

(3) insurance sold in connection with, and incidental to, the rental of a motor vehicle under Subtitle 6 of this title; or

(4) any other line of insurance that the Commissioner considers necessary to recognize for the purpose of complying with § 10–119(d) of this subtitle.

(i) "Limited lines insurance producer" means a person authorized by the Commissioner to sell, solicit, or negotiate limited lines insurance.

(j) "Limited lines travel insurance producer" means, with respect to travel insurance:

(1) a licensed managing general agent; or

(2) a licensed insurance producer, including a limited lines insurance producer.

(k) "Offer and disseminate" means, with respect to limited lines travel insurance, to:

(1) provide general information, including a description of coverage and price;

(2) process applications; and

(3) collect premiums.

(l) (1) "Title insurance producer" means a person that, for compensation, solicits, procures, or negotiates title insurance contracts.

(2) "Title insurance producer" includes a person that provides escrow, closing, or settlement services that may result in the issuance of a title insurance contract.

(3) "Title insurance producer" does not include:

(i) individuals employed and used by title insurance producers for the performance of clerical and similar office duties;

(ii) a financial institution as defined in § 1–101(j) of the Financial Institutions Article that does not solicit, procure, or negotiate title insurance contracts for compensation; or

(iii) a title insurance insurer that is licensed under this article.

(m) "Title insurance producer independent contractor" means a person that:

(1) is licensed to act as a title insurance producer;

(2) provides escrow, closing, or settlement services that may result in the issuance of a title insurance contract as an independent contractor for, or on behalf of, a licensed and appointed title insurance producer; and

(3) is not an employee of the licensed and appointed title insurance producer.

(n) "Trade name" means a name, symbol, or word, or combination of two or more of these that a person uses to:

(1) identify its business, occupation, or self in a business capacity; and

(2) be distinguished from another business, occupation, or person.

(o) (1) "Travel insurance" means insurance coverage for personal risk incident to planned travel, including:

(i) interruption or cancellation of a trip or an event;

(ii) loss of baggage or personal effects;

(iii) damage to accommodations or a rental vehicle;

(iv) sickness, accident, disability, or death occurring during travel, if issued as incidental to the coverage provided by item (i), (ii), (iii), (v), (vi), or (vii) of this paragraph;

(v) emergency evacuation;

(vi) repatriation of remains; and

(vii) any other contractual obligations to indemnify or pay a specified amount to the traveler on determinable contingencies related to travel as the Commissioner approves.

(2) "Travel insurance" does not include a major medical plan that provides comprehensive medical protection for a traveler on a trip lasting 6 months or longer, such as an individual working outside the United States or uniformed services personnel being deployed.

(p) "Travel retailer" means a business entity that makes, arranges, or offers travel services.

(q) "Uniform application" means the current version of the NAIC uniform application for resident and nonresident insurance producer licensing.

(r) "Uniform business entity application" means the current version of the NAIC uniform business entity application for resident and nonresident business entities.

§10–102.

(a) This subtitle applies to insurance producers, all kinds of insurance and annuities, and all types of insurers, including:

(1) nonprofit health service plans;

(2) dental plan organizations;

(3) health maintenance organizations; and

(4) fraternal benefit societies.

(b) This subtitle does not apply to:

(1) reinsurance;

(2) except as provided in §§ 10-116(c) and 10-119 of this subtitle, surplus lines transactions, which are subject to Title 3, Subtitle 3 of this article;

(3) a person while employed by an insured to administer or help to administer the insurance or risk management program of the person's employer, if the person is not authorized to accept any compensation from an insurance producer or insurer; or

(4) a licensed insurance adviser while employed under contract by an insured and acting for the insured, if the insurance adviser is not authorized to accept any compensation from an insurance producer or insurer.

§10–103.

(a) In this section, the term "insurer" does not include an insurer's officers, directors, employees, subsidiaries, or affiliates.

(b) The licensing requirements of this section do not apply to:

(1) an insurer;

(2) an officer, director, or employee of an insurer or of an insurance producer who does not receive any commission on policies written or sold to insure risks residing, located or to be performed in the State if:

(i) the activities of the officer, director, or employee are executive, administrative, managerial, clerical, or a combination of these, and are only indirectly related to the sale, solicitation, or negotiation of insurance;

(ii) the function of the officer, director, or employee relates to underwriting, loss control, inspection, or the processing, adjusting, investigating, or settling of a claim on a contract of insurance; or

(iii) the officer, director, or employee is acting in the capacity of a special agent or agency supervisor assisting insurance producers where the individual's activities are limited to providing technical advice and assistance to licensed insurance producers and do not include the sale, solicitation, or negotiation of insurance;

(3) an individual who performs administrative services related to mass marketed property and casualty insurance, provided that no commission is paid to the individual for the services;

(4) an employer, association, the officers, directors, and employees of an employer or association, or the trustees of an employee trust plan if:

(i) the employer, association, officers, directors, and employees, or trustees are engaged in the administration or operation of a program of employee benefits for the employer's or association's own employees or the employees of its subsidiaries or affiliates;

(ii) the program involves the use of insurance issued by an insurer; and

(iii) the employer, association, officers, directors, and employees, or trustees are not in any manner compensated, directly or indirectly, by the insurer issuing the contracts;

(5) an employee of an insurer or organization employed by an insurer who is:

(i) engaged in the inspection, rating, or classification of risks or in the supervision of the training of insurance producers; and

(ii) not individually engaged in the sale, solicitation, or negotiation of insurance;

(6) a person whose activities in the State are limited to advertising without the intent to solicit insurance in the State through communications in printed publications or other forms of electronic mass media if:

(i) the distribution of the printed publications or other forms of electronic mass media is not limited to residents of the State; and

(ii) the person does not sell, solicit, or negotiate insurance that would insure risks residing, located, or to be performed in the State;

(7) a person who is not a resident of the State who sells, solicits, or negotiates a contract of insurance for commercial property and casualty risks to an insured with risks located in more than one state insured under the contract if:

(i) the person is otherwise licensed as an insurance producer to sell, solicit, or negotiate that insurance in the state where the insured maintains its principal place of business; and

(ii) the contract insures risks located in that state; or

(8) a salaried, full-time employee who counsels or advises the employee's employer relative to the insurance interests of the employer or of the subsidiaries or business affiliates of the employer, provided that the employee does not sell or solicit insurance or receive a commission.

(c) Except as otherwise provided in this article or §§ 10–14A–03 and 10–14B–03 of the State Government Article, before a person acts as an insurance producer in the State, the person must obtain:

(1) a license in the kind or subdivision of insurance for which the person intends to act as an insurance producer; and

(2) if acting for an insurer, an appointment from the insurer.

(d) (1) Except as otherwise provided in this subsection, an insurance producer may not sell, solicit, or negotiate any insurance on behalf of an insurer for which the insurance producer does not have an appointment.

(2) Without an appointment, an insurance producer may:

(i) submit to an insurer an informal inquiry for any kind of life insurance, health insurance, or annuity for which the insurance producer has a license if the insurer has a certificate of authority for the kind of insurance about which the inquiry is made; and

(ii) solicit an application for any kind of life insurance, health insurance, or annuity for which the insurance producer has a license if the insurer to which the application is submitted has a certificate of authority for the kind of insurance requested in the application.

(e) Before a business entity may accept in its own name compensation for acting as an insurance producer in the State, the business entity must obtain:

(1) a license in the kind or subdivision of insurance for which the business entity intends to act as an insurance producer; and

(2) an appointment for the kind or subdivision of insurance for which it intends to act as an insurance producer on behalf of an insurer.

§10–104.

(a) This section applies to:

(1) a license to act as an insurance producer for insurance other than life insurance, health insurance, or annuities;

(2) a limited lines license to act as an insurance producer for limited line credit insurance other than credit life insurance or credit health insurance; and

(3) a limited lines license to act as an insurance producer for a line of insurance described in §§ 10–122 through 10–125 of this subtitle.

(b) To qualify for a license to which this section applies, an individual applicant must meet the requirements of this section.

(c) An applicant must be of good character and trustworthy based on the standards of § 10–126 of this subtitle.

(d) An applicant must be at least 18 years of age.

(e) An applicant may not have committed any act that the Commissioner finds would warrant denial of a license under § 10–126 of this subtitle.

(f) (1) In the case of an applicant for a limited lines license to act as an insurance producer for limited line credit insurance, the applicant shall complete successfully a program of instruction that is:

(i) provided by an insurer that sells, solicits, or negotiates limited line credit insurance; and

(ii) designed to provide a comprehensive and accurate explanation of the product.

(2) (i) The insurer that provides the program of instruction shall retain records relating to the program of instruction while in use and for a period of at least 5 years after its last use.

(ii) The records shall include:

1. copies of the instructional materials; and

2. a list of the applicants and producers who have successfully completed the program of instruction.

(iii) The insurer shall make available to the Commissioner the records relating to the program of instruction at the request of the Commissioner.

(g) Except as otherwise provided in this section, the applicant must pass an examination given by the Commissioner under this subtitle.

(h) An applicant for a limited lines license to act as an insurance producer for limited line credit insurance need not meet the examination requirements of subsection (g) of this section.

(i) An applicant may be licensed as to any particular kind or kinds of insurance.

§10–105.

(a) To qualify for a license as an insurance producer for life insurance, health insurance, annuities, nonprofit health service plans, dental plan organizations, health maintenance organizations, or fraternal benefit societies an individual applicant must meet the requirements of this section.

(b) An applicant must be of good character and trustworthy based on the standards of § 10–126 of this subtitle.

(c) An applicant must be at least 18 years of age.

(d) An applicant may not have committed any act that the Commissioner finds would warrant denial of a license under § 10–126 of this subtitle.

(e) (1) In the case of an applicant for a limited lines license to act as an insurance producer for credit life insurance or credit health insurance, the applicant shall successfully complete a program of instruction that is:

(i) provided by an insurer that sells, solicits, or negotiates limited line credit insurance; and

(ii) designed to provide a comprehensive and accurate explanation of the product.

(2) (i) The insurer that provides the program of instruction shall retain records relating to the program of instruction while in use and for a period of at least 5 years after its last use.

(ii) The records shall include:

1. copies of the instructional materials; and

2. a list of the applicants and producers who have successfully completed the program of instruction.

(iii) The insurer shall make the records relating to the program of instruction available to the Commissioner at the request of the Commissioner.

(f) Before taking a written examination, an applicant shall pay the application fee required under § 2–112(a)(6)(vi) of this article.

(g) (1) Except as otherwise provided in this subsection, the applicant must pass an examination given by the Commissioner under this subtitle.

(2) The following applicants are not required to take an examination:

(i) an applicant for a license to act as an insurance producer only for selling credit life insurance or credit accident and health insurance or both to a borrower of money or buyer of goods in connection with a loan or credit transaction;

(ii) an applicant for a license to act as an insurance producer for a dental plan organization if the applicant for compensation solicited, procured, or negotiated contracts for dental plan organizations continuously from July 1, 1988, to June 30, 1989;

(iii) an applicant for a license to act as an insurance producer for a nonprofit health service plan if the applicant for compensation solicited, procured, or negotiated contracts for nonprofit health service plans continuously from July 1, 1988, to June 30, 1989; or

(iv) an applicant for a license to act as an insurance producer for a health maintenance organization if the applicant for compensation solicited, procured, or negotiated contracts for health maintenance organizations continuously from July 1, 1988, to June 30, 1989.

(h) An applicant may be licensed as to any particular kind or kinds of insurance.

§10–106.

(a) This section does not apply to a motor vehicle rental company that applies for a limited lines license to sell insurance in connection with, and incidental to, the rental of a motor vehicle under Subtitle 6 of this title.

(b) To qualify for a license as an insurance producer, a business entity must designate a licensed insurance producer to act as the business entity's principal contact with the Administration.

(c) The designated insurance producer shall:

(1) provide to the Administration at the time of designation the insurance producer's name, business address, business telephone number, business facsimile number, and business electronic mail address;

(2) notify the Insurance Administration in writing of any change in the information required by item (1) of this subsection within 10 days after the change;

(3) compile and maintain, to the extent reasonably possible, a list of locations where records of the business entity are maintained; and

(4) on request, cooperate with any investigation conducted by the Administration unless the cooperation is subject to a legal privilege asserted by the designated insurance producer or the business entity.

§10–107.

(a) An individual applicant may not be required to take an examination that relates to any kind of insurance other than as requested by the applicant.

(b) If an individual applicant requests, the examination shall be administered to allow the applicant to be tested in more than one kind of insurance in one day.

(c) An individual applicant for an examination specified in this subtitle or Subtitle 2 or Subtitle 4 of this title shall pay the fee required under this article in the manner specified by the Commissioner.

§10–108.

(a) An individual applicant who otherwise qualifies for a license for insurance other than life insurance, health insurance, or annuities is entitled to be examined as provided in this section.

(b) To determine the competence of an individual applicant as to the kind or subdivision of insurance for which the applicant wants to become licensed, the applicant shall pass a written examination that relates to that kind or subdivision of insurance.

(c) The Commissioner shall adopt reasonable regulations that specify:

(1) the scope, type, conduct, and grading of the written examinations; and

(2) the frequency, times, and locations within the State where the written examinations will be held.

(d) Before taking a written examination, an individual applicant shall pay the application fee required under § 2–112(a)(6)(vi) of this article.

(e) All written examinations shall be graded within 30 days following the date of the examination.

(f) An individual applicant who fails an examination may not take another examination until at least 4 days after the date of the last examination that the applicant failed.

§10–109.

(a) An individual applicant who otherwise qualifies for a license for life insurance, health insurance, annuities, nonprofit health service plans, dental plan organizations, or health maintenance organizations is entitled to be examined as provided in this section.

(b) (1) Each individual applicant must pass a personal written examination to determine:

(i) the competence of the applicant as to life insurance, health insurance, or annuities or to any subdivision of them, including contracts for nonprofit health service plans, vision plans, dental plan organizations, and health maintenance organizations; and

(ii) the familiarity of the applicant with the applicable laws of the State.

(2) Each examination must be graded within 30 days after the date of the examination.

(c) An individual applicant who fails an examination may not take another examination until at least 4 days after the date of the last examination that the applicant failed.

(d) The Commissioner shall adopt reasonable regulations that specify:

(1) the scope, type, conduct, and grading of the written examinations; and

(2) the frequency, times, and places in the State where the written examinations will be held.

§10–110.

(a) The Commissioner may appoint an advisory board for life and health insurance and an advisory board for property and casualty insurance to assist the Commissioner in reviewing continuing education courses, examinations, and other matters relating to the education and qualification of insurance producers.

(b) (1) If the Commissioner appoints a life and health insurance advisory board, the life and health insurance advisory board shall consist of at least eight members.

(2) Each member of the advisory board shall be experienced in the business of life insurance or health insurance.

(3) The advisory board:

(i) may include insurance producers and employees or officers of insurers; and

(ii) shall include at least two members who are insurance producers with valid licenses issued in the State in that kind of insurance.

(c) (1) If the Commissioner appoints a property and casualty insurance advisory board, the property and casualty insurance advisory board shall consist of at least eight members.

(2) Each member of the advisory board shall be experienced in the business of property insurance or casualty insurance.

(3) The advisory board:

(i) may include insurance producers and employees or officers of insurers; and

(ii) shall include at least two members who are insurance producers with valid licenses issued in the State in that kind of insurance.

(d) (1) The term of a member of an advisory board under this section is 4 years.

(2) A member who is appointed after a term has begun serves only for the rest of the term.

(3) A member is eligible for reappointment.

(4) The Commissioner may stagger the terms of members of each advisory board under this section.

(e) A member of an advisory board under this section:

(1) may not receive compensation; but

(2) if authorized by the Commissioner, is entitled to reimbursement for expenses under the Standard State Travel Regulations, as provided in the State budget.

(f) The Commissioner may adopt regulations to carry out this section.

§10–111.

(a) A person who applies for a license as a resident insurance producer shall:

(1) in the case of an applicant who is an individual, submit to the Commissioner a uniform application and declare under penalty of refusal, suspension, or revocation of the license that the statements made in the uniform application are true, correct, and complete to the best of the individual's knowledge and belief;

(2) in the case of an applicant that is a business entity, submit to the Commissioner a uniform business entity application;

(3) pay the applicable fee required by § 2–112 of this article for a license;

(4) file on the form and in the manner that the Commissioner provides:

(i) any trade name to be used by the applicant;

(ii) the business address of the applicant; and

(iii) the name and residence address of each individual who holds a license and does business under the trade name; and

(5) submit to the Commissioner any additional information or documentation that the Commissioner requires, including any information or documentation to determine the professional competence, good character, and trustworthiness of the applicant.

(b) (1) This subsection does not apply to a motor vehicle rental company that applies for a limited lines license to sell insurance in connection with, and incidental to, the rental of a motor vehicle under Subtitle 6 of this title.

(2) In addition to any other information required on the application, an applicant that is a business entity must:

(i) identify the licensed insurance producer who is designated to act as the business entity's principal contact with the Administration; and

(ii) provide the name and address of each licensed producer employed by the business entity, each individual who has direct control over its fiscal management, and each owner, member, or manager of the business entity and each director of a business entity that is a corporation.

§10–112.

(a) (1) The Commissioner shall issue a license in a kind or subdivision of insurance or a combination of kinds or subdivisions of insurance to each applicant who meets the requirements of this subtitle.

(2) An applicant may qualify for a license in one or more of the following kinds of insurance:

(i) life insurance;

(ii) accident and health or sickness insurance;

(iii) property insurance;

(iv) casualty insurance;

(v) variable life and variable annuity products;

(vi) personal lines of property and casualty insurance;

(vii) limited line credit insurance; and

(viii) any other kind or subdivision of insurance permitted under State law or regulations.

(b) A license shall contain:

(1) the licensee's name, address, and personal identification number;

(2) the date of issuance;

(3) the kind or subdivision of insurance or combination of kinds or subdivisions of insurance for which the licensee is authorized to act as an insurance producer;

(4) the expiration date; and

(5) any other information that the Commissioner considers necessary.

(c) (1) To help the Department of Assessments and Taxation in identifying new businesses in the State, by August 31 of each year the Commissioner shall provide to the Department of Assessments and Taxation a list of insurance producers that were issued licenses during the previous fiscal year.

(2) The list shall include:

(i) the name and mailing address of each person issued a license; and

(ii) the federal tax identification number of each person or, if the person does not have a federal tax identification number, the Social Security number of the person.

(3) The Commissioner shall provide the list free of charge.

§10–113.

(a) A license authorizes the holder of the license to act as an insurance producer for the kind or subdivision of insurance or combination of kinds or subdivisions of insurance specified in the license.

(b) The holder of a license may not use any name other than the name in which the license is issued or a trade name filed with the Commissioner under this subtitle to engage in any activity for which a license is required, including the execution of any document related to marketing, negotiation, selling, or issuance of insurance.

(c) A license does not create any actual, apparent, or inherent authority in the holder to represent or commit an insurer.

§10–114.

Insurance producers may conduct insurance business as a business entity if each individual who solicits, negotiates, or accepts insurance business from the public holds a license in the kind or subdivision of insurance for which the individual acts as an insurance producer and, if applicable, an appointment from an insurer.

§10–115.

(a) (1) Licenses expire every other year on the date stated on the license unless renewed as provided in this section.

(2) If a license expires under paragraph (1) of this subsection, the appointments held by the insurance producer shall be terminated as of the day of the expiration of the license.

(b) At least 1 month before a license expires, the Commissioner shall send to the holder of the license, at the last known address or electronic mail address of the holder on record a notice that states:

(1) the process for renewing the license;

(2) the date by which the Commissioner must receive the renewal application; and

(3) the amount of the renewal fee.

(c) Subject to subsection (g) of this section, before a license expires, the holder of the license may renew it for an additional 2–year term, if the holder:

(1) otherwise is entitled to a license;

(2) files with the Commissioner a renewal application:

(i) on the form that the Commissioner provides; or

(ii) in an electronic format that the Commissioner approves;

(3) completes the continuing education requirements established under § 10–116 of this subtitle; and

(4) pays to the Commissioner the renewal fee required by § 2–112 of this article.

(d) A license renewed under this section shall have an expiration date that is the last day of the month in which the holder of the license was born.

(e) (1) If mailed, an application for renewal of a license shall be considered made in a timely manner if it is postmarked on or before the expiration date of the license.

(2) If submitted electronically, an application for renewal of a license shall be considered made in a timely manner if, on or before the expiration date of the license, the application:

(i) is addressed properly or otherwise directed properly to an information processing system that the Administration has designated or uses for the purpose of receiving electronic applications and from which the Administration is able to retrieve the application;

(ii) is in a form capable of being processed by that system; and

(iii) 1. enters an information processing system outside the control of the sender or of a person that sent the electronic application on behalf of the sender; or

2. enters a region of the information processing system designated or used by the Administration that is under the control of the Administration or an agent of the Administration.

(f) (1) The Commissioner shall renew the license of each holder who meets the requirements of this section.

(2) If the holder of a license complies with subsections (b) and (c) of this section before the license expires, the license remains in effect until the decision of the Commissioner regarding the application for renewal is final.

(g) (1) A license is considered renewed for purposes of this subsection if the license is issued to a person for the period immediately following a period for which the person previously possessed the same or a substantially similar license.

(2) Before a license may be renewed under this section, the Commissioner shall verify through the Office of the Comptroller that the applicant has paid all undisputed taxes and unemployment insurance contributions payable to the Comptroller or the Secretary of Labor or that the applicant has provided for payment in a manner satisfactory to the unit responsible for collection.

(h) The Commissioner may adopt regulations to:

(1) carry out this section; and

(2) develop a staggered system of renewals for licenses of insurance producers.

§10–116.

(a) (1) Subject to subsections (b) and (c) of this section, the Commissioner shall require an insurance producer to receive continuing education as a condition of renewing the license of the insurance producer.

(2) An insurance producer shall complete the continuing education required under paragraph (1) of this subsection not later than 15 days before the expiration date of the insurance producer's license.

(3) (i) The Commissioner may not require an individual who holds a license to receive more than 24 hours of continuing education per renewal period.

(ii) If the individual holds a title insurance producer license, the Commissioner may not require the insurance producer to receive more than 16 hours of continuing education per renewal period.

(iii) If an insurance producer has held a license for 25 or more consecutive years as of October 1, 2008, the Commissioner may not require the insurance producer to receive more than 8 hours of continuing education per renewal period.

(iv) The Commissioner may not require an insurance producer to receive more than 16 hours of continuing education in a renewal period if the insurance producer is also a licensed funeral director or licensed mortician who:

1. sells only life insurance policies or annuity contracts that fund a pre–need contract as defined in § 7–101 of the Health Occupations Article; and

2. is not a viatical settlement broker as defined in § 8–601 of this article.

(v) Of the required hours of continuing education per renewal period required under subparagraphs (i), (ii), (iii), and (iv) of this paragraph, at least 3 hours shall relate directly to ethics.

(4) Subject to paragraph (5) of this subsection, an insurance producer may satisfy the continuing education requirements of this subsection by submitting to the Commissioner or Commissioner's designee:

(i) proof that the insurance producer has completed the required hours of continuing education for the applicable renewal period; or

(ii) proof that the insurance producer has completed at least 8 hours of continuing education for the applicable renewal period and an affidavit that, over the previous 25 consecutive years, the insurance producer continually:

1. has held a license in the State; and

2. has been employed in the selling of insurance in the State.

(5) (i) To increase the level of education of insurance producers, an insurance producer shall obtain continuing education in the kind or subdivision of insurance for which the insurance producer has received a license.

(ii) Each insurance producer who possesses a license to sell health insurance and who sells long–term care insurance shall receive continuing education that directly relates to long–term care insurance.

(iii) Each insurance producer who possesses a license to sell property and casualty insurance and who sells flood insurance shall receive continuing education that directly relates to flood insurance.

(iv) Each insurance producer who possesses a license to sell property and casualty insurance and who sells, solicits, or negotiates bail bonds shall receive continuing education that directly relates to bail bond insurance.

(v) Each insurance producer who possesses a license to sell health insurance and who markets the Senior Prescription Drug Assistance Program or assists a Medicare beneficiary to enroll in the Senior Prescription Drug Assistance Program shall receive continuing education that directly relates to the Senior Prescription Drug Assistance Program.

(6) If continuing education is required, the Commissioner may grant a waiver to an insurance producer who has requested a waiver for reasons that the Commissioner determines warrant the waiver.

(7) An insurer may not prohibit one of its insurance producers from obtaining continuing education credits from any course approved by the Commissioner.

(b) The following individuals are exempt from the continuing education requirements under this section:

(1) employees of a health maintenance organization who are employed solely to solicit membership in the health maintenance organization under

a contract between the health maintenance organization and the Maryland Department of Health;

(2) attorneys at law of the State who are qualified as title insurance producers and who do not hold a license in any other kind or subdivision of insurance;

(3) individuals who hold only a limited lines license to act as an insurance producer for limited line credit insurance; and

(4) insurance producers who hold only a limited lines license in any type of insurance designated by the Commissioner.

(c) A nonresident licensee shall be deemed to have met the continuing education requirements of this section if:

(1) the nonresident licensee satisfies the continuing education requirements of the home state of the nonresident licensee; and

(2) the home state of the nonresident licensee allows an insurance producer who is a resident of this State to satisfy the continuing education requirements of the home state on the same basis by meeting the continuing education requirements of this State.

(d) (1) The Commissioner may review all continuing education courses submitted and approve or disapprove courses.

(2) The Commissioner may not disapprove a continuing education course solely on the basis of the methodology or technology used to deliver instruction to individuals taking the course.

(d–1) (1) An insurance producer may obtain all or part of the credit hours of continuing education required for renewal of a license under this section from correspondence courses or online courses approved by the Commissioner.

(2) This subsection applies to all insurance producers who are required to receive continuing education as a condition of license renewal under this section, regardless of the kind or subdivision of insurance for which the insurance producer has received a license.

(e) (1) The Commissioner shall adopt regulations to carry out this section.

(2) The regulations adopted by the Commissioner under paragraph (1) of this subsection shall require providers of continuing education to submit

evidence of course completion to the Commissioner or the Commissioner's designee within 10 days after completing a course of continuing education.

(f) This section does not limit the authority of the Commissioner to review, approve, or disapprove continuing education courses, examinations, and other matters relating to the education and qualification of insurance producers.

§10–116.1.

(a) For up to 1 year after the expiration date, a person whose license has expired may reinstate the expired license by:

(1) filing with the Commissioner the appropriate reinstatement application;

(2) paying to the Commissioner:

(i) the applicable renewal fee under § 2-112 of this article; and

(ii) a reinstatement fee of $100; and

(3) submitting proof of completion of the continuing education requirements in § 10-116 of this subtitle.

(b) A person whose license has expired is prohibited from conducting any insurance business until the effective date of reinstatement of the license.

(c) (1) If a person applies for reinstatement of an expired license within 60 days after the license expired, the Commissioner shall reinstate the license retroactively, with the reinstatement effective on the date that the person's license expired.

(2) If a person applies for reinstatement of an expired license more than 60 days after the license expired, the Commissioner shall reinstate the person's license prospectively, with the reinstatement effective on the date that the license is reinstated.

(d) A person who does not comply with subsection (a) of this section on or before 1 year after the expiration date shall apply for a license under § 10-111 of this subtitle and meet the requirements specified by the Commissioner in regulation.

(e) The Commissioner may adopt regulations to carry out this section.

(f) The Commissioner may waive the reinstatement procedures of this section for an insurance producer who is unable to comply with the renewal and reinstatement procedures due to:

(1) service in the uniformed services; or

(2) other extenuating circumstances, including a long–term medical disability.

§10–117.

(a) To change, add to, or delete from a license, the insurance producer shall file with the Commissioner in the form that the Commissioner requires the change or addition to or deletion from the license.

(b) (1) A licensee shall file with the Commissioner by any means acceptable to the Commissioner a change in legal name, trade name, electronic mail address, or address within 30 days of the change.

(2) If a licensee fails to timely file with the Commissioner a change in legal name, trade name, electronic mail address, or address, the licensee is in violation of § 10–126(a)(1) of this subtitle.

§10–118.

(a) In this section, "producer register" means a register of appointed insurance producers who are authorized to sell, solicit, or negotiate contracts of insurance on behalf of an insurer.

(b) (1) An insurer authorized to transact the business of insurance in the State shall maintain a producer register.

(2) Within 30 days of the insurer appointing an insurance producer, the insurer shall include the following information in the insurer's producer register:

(i) the insurance producer's name;

(ii) the license number assigned to the insurance producer by the Commissioner;

(iii) the date that the insurer appointed the insurance producer; and

(iv) any additional information that the Commissioner may require.

(3) An insurer shall send written documentation of the appointment to the insurance producer.

(c) A licensed insurance producer that has been appointed by an insurer shall maintain:

(1) documentation of the insurer's appointment; and

(2) a list of the insurers that have appointed the producer.

(d) (1) The insurer's producer register and the producer's record relating to an appointment:

(i) shall be open to inspection and examination by the Commissioner; and

(ii) may be maintained electronically.

(2) Except as provided in paragraph (3) of this subsection, an insurance producer may not act on behalf of an insurer unless the insurance producer has received written documentation of the appointment from the insurer.

(3) An insurer may initially accept an application for life insurance, health insurance, or an annuity from an insurance producer who is not appointed by the insurer and is not on the insurer's producer register if, within 30 days of accepting the application, the insurer:

(i) rejects the application in accordance with § 27-501 of this article; or

(ii) appoints the insurance producer and enters in the insurer's producer register the information required by subsection (b) of this section.

(e) (1) (i) When there is any termination of the appointment, employment, contract, or other insurance business relationship with an insurance producer, the insurer shall, within 30 days following the effective date of the termination, update the insurer's producer register by entering the effective date of the termination.

(ii) An insurer or authorized representative of an insurer shall notify the Commissioner of the termination of an appointment when the termination,

in whole or in part, is a result of the belief that the producer has engaged or is engaging in any of the activities set forth in § 10-126 of this subtitle, including any finding made by a court, governmental unit, or self-regulatory organization authorized by law that:

1. the insurance producer has violated § 10-126 of this subtitle; or

2. the insurance producer has engaged in any activities that are set forth in § 10-126 of this subtitle.

(iii) On written request of the Commissioner, the insurer shall provide additional information, documents, records, or other data pertaining to:

1. the termination; or

2. the activities of the insurance producer if the insurance producer was terminated for cause due to a reason set forth in § 10-126 of this subtitle.

(2) If the appointment of an insurance producer is terminated because the insurance producer failed to renew the insurance producer's license and the license is reinstated under § 10-116.1(c)(1) of this subtitle, an insurer may reappoint the insurance producer retroactively, with the appointment effective on the date that the license expired.

(f) An insurer or authorized representative of an insurer promptly shall notify the Commissioner, in a format acceptable to the Commissioner, of any additional information that:

(1) the insurer discovers on further review or investigation; and

(2) would have been reportable to the Commissioner under subsection (e) of this section if the insurer had then known of its existence.

(g) (1) Within 15 days after providing notice to the Commissioner that is required by subsection (e) of this section, an insurer shall mail a copy of the notice to the insurance producer:

(i) at the last known address of the insurance producer; and

(ii) by certified mail, return receipt requested, postage prepaid or by overnight delivery using a nationally recognized carrier.

(2) Within 30 days after an insurance producer receives original or additional notice, the insurance producer may file with the Commissioner written comments concerning the substance of the notice.

(3) If an insurance producer files comments with the Commissioner, the insurance producer shall, by the same means, simultaneously send a copy of the comments to the reporting insurer.

(4) If the Commissioner receives comments from an insurance producer, the Commissioner shall:

(i) make the comments part of the Commissioner's file on the subject; and

(ii) include a copy of the comments with every copy of a report about the insurance producer that is distributed or disclosed for any reason permitted by subsection (i) of this section.

(h) (1) This subsection applies to:

(i) an insurer;

(ii) an authorized representative of an insurer;

(iii) an insurance producer;

(iv) the Commissioner; and

(v) an organization of which the Commissioner is a member that compiles information required under this section and makes it available to other insurance commissioners or regulatory or law enforcement agencies.

(2) In the absence of actual malice, a person to whom this subsection applies and the agents and employees of the person are not subject to civil liability of any nature as a result of:

(i) any statement or information required by or provided under this section; or

(ii) any information relating to any statement that may be requested in writing by the Commissioner from an insurer or insurance producer.

(3) If a party brings an action against a person that may have immunity under paragraph (2) of this subsection for making a statement required by

or under this section or providing any information relating to any statement that may be requested by the Commissioner, the party bringing the action shall plead specifically in any allegation that paragraph (2) of this subsection does not apply because the person making the statement or providing the information did so with actual malice.

(4) This subsection does not abrogate or modify any existing statutory or common law privileges or immunities.

(i) (1) This subsection applies only to any document, material, or other information in the control or possession of the Insurance Administration that is:

(i) furnished by an insurer or insurance producer or an employee or agent acting on behalf of the insurer or insurance producer under this section; or

(ii) otherwise obtained by the Commissioner in an investigation under this section.

(2) Any document, material, or other information that is subject to this subsection is:

(i) confidential and privileged;

(ii) not subject to Title 4 of the General Provisions Article;

(iii) not subject to subpoena; and

(iv) not subject to discovery or admissible in evidence in any private civil action.

(3) Notwithstanding paragraph (2) of this subsection, the Commissioner may use any document, material, or other information that is subject to this section to further any regulatory or legal action brought as part of the duties of the Commissioner.

(4) The Commissioner and any person who received any document, material, or other information to which this subsection applies while acting under the authority of the Commissioner may not be allowed or required to testify in any private civil action concerning the document, material, or information.

(5) (i) Provided that the recipient agrees to maintain any confidentiality and privileged status, the Commissioner may share a document,

material, or other information, including a document, material, or other information that is confidential and privileged under this subsection, with:

1. other State, federal, or international regulatory agencies;

2. the National Association of Insurance Commissioners and its affiliates or subsidiaries; or

3. State, federal, or international law enforcement authorities.

(ii) If the Commissioner determines that a confidential document, material, or other information that has been shared through a database or other electronic filing system is inaccurate or incomplete in any way, the Commissioner shall update the information in the database or other electronic filing system so that the information is accurate and complete.

(6) (i) The Commissioner may receive a document, material, or information, including a document, material, or information that is otherwise confidential and privileged, from:

1. the National Association of Insurance Commissioners or its affiliates or subsidiaries; or

2. regulatory and law enforcement officials of other foreign or domestic jurisdictions.

(ii) The Commissioner shall maintain as confidential and privileged any document, material, or information received under this paragraph with notice or the understanding that it is confidential or privileged under the laws of the jurisdiction that is the source of the document, material, or information.

(7) The Commissioner may enter into agreements governing sharing and use of information consistent with this subsection.

(8) There is no waiver of any applicable privilege or claim of confidentiality in a document, material, or information as a result of:

(i) disclosure of the document, material, or information to the Commissioner under this section; or

(ii) sharing of the document, material, or information by the Commissioner under paragraph (5) of this subsection.

(9) This subtitle does not prohibit the Commissioner from releasing final adjudicated actions, including for–cause terminations, that are open to public inspection under Title 10, Subtitle 6 of the State Government Article, to a database or other clearinghouse service maintained by the National Association of Insurance Commissioners or its affiliates or subsidiaries.

(j) The Commissioner may adopt regulations to carry out this section.

§10–119.

(a) Except as otherwise provided in this section, the Commissioner shall waive any license application requirements for an applicant who is not a resident of this State if:

(1) the applicant has a valid license from the home state of the applicant; and

(2) the home state of the applicant awards nonresident licenses to residents of this State on the same basis.

(b) (1) Subject to paragraph (2) of this subsection and unless denied a license under § 10–126 of this subtitle, a person that is not a resident of this State may obtain a nonresident license to act as an insurance producer if:

(i) the person currently is licensed as a resident insurance producer and in good standing in the person's home state;

(ii) the person has submitted or transmitted to the Commissioner the application for licensure that the person submitted to the person's home state or a completed uniform application;

(iii) the person has paid the applicable fee under § 2–112 of this article; and

(iv) the person's home state awards nonresident insurance producer licenses to residents of this State on the same basis.

(2) An individual who applies for an insurance producer license in this State who was previously licensed for the same lines of authority in another state need not comply with the examination requirements of §§ 10–104, 10–105, and 10–107 through 10–109 of this subtitle if:

(i) the person currently is licensed as an insurance producer in the home state of the person;

(ii) the application is received by the Commissioner within 90 days after the cancellation of the applicant's previous license and the prior state issues a certification that, at the time of cancellation, the applicant was in good standing in that state; or

(iii) the state's producer database records, maintained by the National Association of Insurance Commissioners, its affiliates or subsidiaries, indicate that the producer is or was licensed in good standing for the line of authority requested.

(c) In order to maintain a nonresident license in the State, a person must be:

(1) currently licensed as a resident insurance producer in the person's home state; and

(2) in good standing in the person's home state.

(d) The Commissioner may verify the licensing status of a nonresident insurance producer through the producer database maintained by the National Association of Insurance Commissioners, its affiliates or subsidiaries.

(e) Notwithstanding any other provision of this subtitle, a person licensed as a limited line credit insurance producer or other type of limited lines insurance producer in the person's home state is entitled to receive a nonresident limited lines insurance producer license under subsection (b) of this section granting the same scope of authority as granted under the license issued by the person's home state.

(f) (1) Notwithstanding any other provision of this subtitle, a person licensed as a surplus lines broker in the person's home state is entitled to receive a nonresident certificate of qualification as a surplus lines broker under subsection (b) of this section.

(2) Except for subsection (b) of this section, nothing in this section supersedes any provision of Title 3, Subtitle 3 of this article.

(g) (1) A nonresident insurance producer who moves from one state to another state or a resident producer who moves from this State to another state shall:

(i) file with the Commissioner a change of address; and

(ii) provide to the Commissioner certification from the new resident state within 30 days after the change of legal residence.

(2) The Commissioner may not charge a fee or require a license application following a change of legal residence.

(h) (1) A person licensed as an insurance producer in another state who moves to this State shall apply to become licensed as a resident insurance producer under § 10–111 of this subtitle within 90 days after establishing legal residence in this State.

(2) If the person applies to become licensed as a resident insurance producer within 90 days after establishing legal residence in the State, the person need not comply with the examination requirements of §§ 10–104, 10–105, and 10–107 through 10–109 of this subtitle to obtain a license for any line of authority that the person previously held in the prior state, except where the Commissioner determines otherwise by regulation.

(i) The Commissioner may cancel the license of a nonresident insurance producer after receiving notice that the person is no longer licensed in the person's home state.

§10–120.

(a) Without regard to the examination requirements of this subtitle, the Commissioner may issue a temporary license to act as an insurance producer to an individual if the individual:

(1) is otherwise qualified; and

(2) is:

(i) the surviving spouse, next of kin, personal representative, or appointee of the personal representative, of a deceased insurance producer;

(ii) the spouse, next of kin, employee, or legal guardian of a mentally or physically disabled insurance producer; or

(iii) an employee of a firm, or an officer or employee of a corporation, of a deceased or disabled insurance producer.

(b) Before a person acts as a temporary insurance producer in the State, the person must obtain:

(1) a temporary license in the kind or subdivision of insurance for which the person intends to act as an insurance producer; and

(2) if applicable, an appointment from an insurer.

(c) An applicant for a temporary license shall:

(1) file with the Commissioner an application on the form that the Commissioner provides; and

(2) pay to the Commissioner the applicable fee required by § 2-112 of this article.

(d) Within 30 days after the date an application is received, the Commissioner shall:

(1) issue a temporary license to the applicant; or

(2) refuse in writing to issue a temporary license, stating the reasons for the refusal.

(e) A temporary license issued under subsection (a) of this section expires 15 months after its effective date.

§10–121.

(a) (1) In this section the following words have the meanings indicated.

(2) "Controlling person" means an individual who exercises day–to–day direct control over the operation of a title agency doing business in the State, irrespective of whether the person is an officer, a manager, or an owner.

(3) "Entity authorization" means a resolution or consent document executed in accordance with the formalities and governing provisions of the particular business entity and verified under oath.

(4) "Owner" means a person that individually, or through one or more ownership tiers, ultimately holds a 10% or more equity interest in the business entity applying for a title insurance producer license or renewal of a title insurance producer license.

(5) "Title agency" has the meaning stated in § 10–125(a)(4) of this subtitle.

(6) "Trust money" means a deposit, a payment, or any other money that a person entrusts to a licensed title insurance producer in connection with the provision of escrow, closing, or real estate settlement services relating to property within the State.

(7) "Trust money controller" means a person within a title agency who has day–to–day direct control over trust money.

(b) (1) Except as provided in paragraph (2) of this subsection, only a licensed title insurance producer may exercise control over trust money.

(2) Paragraph (1) of this subsection does not apply to trust money that is entrusted to:

(i) a law firm as defined in § 10–125 of this subtitle; or

(ii) a title insurer.

(c) A person may not convert or misappropriate money received or held in escrow or trust while:

(1) acting as a title insurance producer; or

(2) providing any escrow, closing, or settlement services.

(d) (1) Each controlling person and each trust money controller shall hold a license to act as a title insurance producer and, if applicable, an appointment with a title insurer.

(2) If an applicant for a license is a business entity, the application shall be accompanied by an entity authorization that:

(i) identifies each controlling person;

(ii) designates each person that will be a trust money controller for the title agency;

(iii) identifies each owner; and

(iv) identifies each officer, director, manager, general partner, or other person designated by the business entity to act as the business entity's principal contact with the Administration.

(3) When the application of a business entity for a license as a title insurance producer is submitted, the Commissioner shall investigate the character of each person identified as a controlling person and each person identified as a trust money controller in the entity authorization included with the application.

(e) (1) In addition to meeting any of the applicable requirements for a license to act as an insurance producer under this subtitle, a business entity applicant for a license as a title insurance producer shall file with the Commissioner:

(i) a blanket fidelity bond covering appropriate employees and title insurance producer independent contractors; and

(ii) 1. a blanket surety bond; or

2. a letter of credit.

(2) Unless the Commissioner approves a lesser amount, each bond or letter of credit shall be for $150,000.

(3) The Commissioner may adopt regulations that specify when it is appropriate for a bond or letter of credit to be less than $150,000.

(4) Notwithstanding paragraph (2) of this subsection, the Commissioner may waive the requirement for a bond or letter of credit if the Commissioner finds that bonds are not generally available or reasonably affordable.

(5) The Commissioner shall make a specific finding that states the reason for accepting a bond or letter of credit for less than $150,000.

(f) (1) The surety bond or letter of credit shall be for the benefit of any person that suffers a loss if the title insurance producer converts or misappropriates money received or held in escrow or trust while:

(i) acting as a title insurance producer; or

(ii) providing any escrow, closing, or settlement services.

(2) The fidelity bond shall be for the benefit of the employer of the title insurance producer who suffers any loss as described in paragraph (1) of this subsection.

(3) The total liability of the surety insurer under each bond or letter of credit may not exceed $150,000.

(g) The title insurance producer shall file the bond or letter of credit with the Commissioner:

(1) after the Commissioner notifies the title insurance producer of the approval of the application for a license; and

(2) before the Commissioner issues the license.

(h) (1) Each bond or letter of credit shall remain in force until:

(i) the surety insurer is released from liability by the Commissioner; or

(ii) the bond or letter of credit is canceled by the surety insurer.

(2) A surety insurer shall notify the title insurance producer and the Commissioner at least 30 days before canceling a bond or letter of credit.

(3) If a surety insurer fails to notify the title insurance producer and the Commissioner as required by paragraph (2) of this subsection, the bond or letter of credit remains in effect until the surety insurer notifies the title insurance producer and the Commissioner.

(4) A cancellation under this subsection does not affect any liability that occurred during the life of the bond or letter of credit and before the date of cancellation.

(i) Before the Commissioner renews the license of a title insurance producer, the title insurance producer shall submit satisfactory evidence of compliance with this section.

(j) (1) If a title insurance producer has been charged with a violation of this section or this article that could result in suspension or revocation of the license of the title insurance producer, the Commissioner may seek an immediate restraining order from a circuit court to prohibit the title insurance producer from providing title insurance, escrow, closing, or settlement services.

(2) A restraining order issued by a court under this subsection is effective until:

(i) the court lifts the restraining order; or

(ii) the charges are dismissed or adjudicated.

(k) (1) (i) Except as provided in paragraph (5) of this subsection, the title insurer shall during each calendar year conduct an annual review of the underwriting, claims, and escrow practices of each title insurance producer appointed by the insurer as a principal agent as designated in the title insurance agency contract between the insurer and the producer.

(ii) The annual review shall include a review of the title insurance producer's or agency's policy issuing and processing operations.

(iii) The annual review may be conducted:

1. at the place of business of the title insurance producer;

2. remotely by using mail, overnight delivery, or electronic means; or

3. using any combination of items 1 and 2 of this subparagraph.

(iv) If the title insurance producer or agency does not maintain separate bank or trust accounts for each title insurer it represents, the title insurer shall verify that the funds held on its behalf are reasonably ascertainable from the books of account and records of the title insurance producer or agency.

(v) Subject to the requirement under paragraph (3) of this subsection to report suspected violations that the title insurer has reasonable cause to believe have occurred, if the title insurance producer or title agency holds an appointment with more than one title insurer, the title insurer may limit its review to files, separately held accounts, and written documentation relating to its title insurance policies.

(2) A written report setting forth the results of the annual review shall be prepared by the title insurer and is subject to examination under § 2–205 of this article.

(3) If, as a result of the annual review, a title insurer has reasonable cause to believe that a title insurance producer or agency has engaged in any of the prohibited activities set forth in § 10–126 of this subtitle, the title insurer shall report in writing the suspected violation to the Commissioner in the report prepared under paragraph (2) of this subsection in a form and format created by the Commissioner.

(4) The annual review required under this section is in addition to any examination conducted by the Commissioner to determine compliance with the

accounts maintained for the benefit of the Maryland Affordable Housing Trust under § 22–105 of this article.

(5) The title insurer is not required to perform the annual review of a title insurance producer for the calendar year during which the title insurance producer is initially appointed if the appointment is made on or after June 30 of that calendar year.

(l) (1) A title insurance producer shall notify any title insurer with whom the title insurance producer holds an appointment whenever a person licensed under this subtitle becomes employed by, or associated with, the title insurance producer.

(2) The bonding requirements of this subtitle relating to title insurance producers do not apply to an employee or officer of an authorized title insurer.

(m) (1) A title insurance producer shall notify the Commissioner, and any insurer with whom the title insurance producer holds an appointment, if an individual licensed under this subtitle leaves the employment of or ends an association with the title insurance producer.

(2) The title insurance producer required to provide notice under this subsection shall notify the Commissioner within 5 working days after the day the individual leaves employment or ends the association.

(3) The notice required under this subsection shall be:

(i) in writing; and

(ii) sent by certified mail or by electronic means in accordance with § 2–116 of this article.

(n) Notwithstanding subsections (e) and (g) of this section, a title insurance producer independent contractor who provides escrow closing or settlement services that may result in the issuance of a title insurance contract for or on behalf of a title insurance producer is not required to file a blanket fidelity bond, blanket surety bond, or letter of credit with the Commissioner.

(o) In addition to any requirements under this subtitle, title insurance producers shall comply with this section.

§10–121.1.

(a) A title insurance producer may not use or accept the services of a title insurance producer independent contractor unless the title insurance producer independent contractor:

(1) holds an appointment with the title insurer with which the contract of title insurance may be placed; and

(2) is covered under the title insurance producer's:

(i) blanket fidelity bond; and

(ii) blanket surety bond or letter of credit.

(b) (1) A title insurance producer that uses the services of a title insurance producer independent contractor is:

(i) the legal principal of the title insurance producer independent contractor; and

(ii) liable for all actions of the title insurance producer independent contractor, including unintentional conduct, that occurs within the scope of the title insurance producer's independent contractor's employment.

(2) When a mortgage or deed of trust is executed in a transaction in which a title insurance producer independent contractor is acting for or on behalf of a title insurance producer, there shall be included on or with the recorded mortgage or deed of trust the name, address, and license number of the title insurance producer independent contractor and the title insurance producer for which the title insurance producer independent contractor is acting.

§10–122.

(a) Without regard to the examination requirements of this subtitle, the Commissioner may issue a limited lines license to an individual who or a business entity that sells travel insurance.

(b) A limited lines license issued under this section authorizes the holder to act as an insurance producer only as to travel insurance.

(c) The Commissioner may require and provide special forms requiring information the Commissioner considers proper in connection with the application for or renewal of limited lines licenses issued under this section.

(d) (1) (i) Notwithstanding any other law, a travel retailer may offer and disseminate travel insurance on behalf of and under the license of a limited lines travel insurance producer only if the provisions of this paragraph are met.

(ii) The limited lines travel insurance producer or travel retailer shall provide in writing to a purchaser of travel insurance:

1. a description of the material terms or the actual terms of the insurance coverage;

2. a description of the process for filing a claim;

3. a description of the review or cancellation process for the travel insurance policy;

4. a disclosure that:

A. the offered insurance coverage may duplicate certain provisions of insurance coverage already provided by the purchaser's homeowner's insurance, renter's insurance, health insurance, or similar insurance coverage; and

B. the purchase of travel insurance would make the travel insurance coverage primary to any other duplicate or similar coverage;

5. the identity and contact information of the insurer and limited lines travel insurance producer; and

6. contact information for filing a complaint with the Commissioner.

(iii) 1. At the time of licensure, the limited lines travel insurance producer shall establish and maintain a register, on a form the Commissioner requires, of each travel retailer that offers and disseminates travel insurance on behalf of the limited lines travel insurance producer.

2. The limited lines travel insurance producer shall:

A. submit the register for inspection by the Commissioner as the Commissioner requires; and

B. include in the register the name, address, and contact information of the travel retailer and an officer or a person who directs or

controls the travel retailer's operations, and the travel retailer's federal tax identification number.

3. The limited lines travel insurance producer shall also certify that each travel retailer on the register maintained by the limited lines travel insurance producer complies with 18 U.S.C. § 1033.

(iv) 1. The limited lines travel insurance producer shall designate one of its employees who holds a limited lines license under this section as a designated responsible person to ensure the limited lines travel insurance producer's compliance with the laws and regulations for travel insurance in the State.

2. The designated responsible person described in subsubparagraph 1 of this subparagraph or the president, secretary, treasurer, and any other officer or person of the limited lines travel insurance producer who directs or controls the operations of the limited lines travel insurance producer shall comply with fingerprinting requirements applicable to insurance producers in the State.

(v) The limited lines travel insurance producer shall be in good standing with the Commissioner with respect to its license.

(vi) 1. The limited lines travel insurance producer shall require each employee or authorized representative of the travel retailer whose duties include offering and disseminating travel insurance to receive a program of instruction or training, which shall be subject to review by the Commissioner.

2. The training material shall contain, at a minimum, instruction on the types of insurance offered, ethical sales practices, and required disclosures to prospective customers.

(2) A travel retailer offering or disseminating travel insurance on behalf of a limited lines travel insurance producer shall make available to a prospective purchaser brochures or other written materials that:

(i) provide the identity and contact information of the limited lines travel insurance producer overseeing the activities of the travel retailer;

(ii) explain that the purchase of travel insurance is not required in order to purchase any other product or service from the travel retailer; and

(iii) explain that a travel retailer:

1. is allowed to provide general information about the insurance offered and disseminated by the travel retailer, including a description of the coverage and price; but

2. is not qualified or authorized to answer technical questions about the terms and conditions of the insurance offered by the travel retailer or to evaluate the adequacy of the customer's existing insurance coverage.

(3) A travel retailer's employee or authorized representative who is not licensed as a limited lines travel insurance producer under this section may not:

(i) evaluate or interpret the technical terms, benefits, and conditions of the offered travel insurance coverage;

(ii) evaluate or provide advice concerning a prospective purchaser's existing insurance coverage; or

(iii) hold himself or herself out as a limited lines travel insurance producer, any other insurance producer, or an insurance expert.

(4) (i) A travel retailer whose insurance related activities, and those of its employees or authorized representatives, are limited to offering and disseminating travel insurance on behalf of and under the direction of a limited lines travel insurance producer under this section may receive compensation when listed on a register maintained by the limited lines travel insurance producer in accordance with paragraph (1)(iii) of this subsection.

(ii) A travel retailer may not compensate an employee or authorized representative for insurance related activities in a manner that is based primarily on the number of customers who purchase travel insurance coverage.

(iii) This section may not be construed to prohibit payment of compensation to a travel retailer or its employees or authorized representatives for activities under the limited lines travel insurance producer's license that are incidental to the travel retailer's or its employee's or authorized representative's overall compensation.

(5) The limited lines travel insurance producer:

(i) is responsible for the acts of the travel retailer; and

(ii) shall use reasonable means to ensure compliance by the travel retailer with this section.

§10–123.

On application, the Commissioner shall issue to an individual qualified in accordance with this subtitle a license that is limited to the business of selling motor vehicle insurance coverages only, including bodily injury liability, property damage liability, and automobile physical damage.

§10–124.

(a) Without regard to the examination requirements of this subtitle, the Commissioner may issue a limited lines license to an individual who is employed by a health maintenance organization solely to solicit membership in the health maintenance organization under a contract:

(1) between the health maintenance organization and the Maryland Department of Health; and

(2) in accordance with which the Maryland Department of Health obtains prepaid comprehensive health care services for recipients of medical assistance under § 15–105 of the Health – General Article.

(b) The annual license fee is provided in § 2–112 of this article.

§10–125.

(a) (1) In this section the following words have the meanings indicated.

(2) "Attorney" means an individual admitted to practice law by the Supreme Court of Maryland of the State.

(3) (i) "Law firm" means an association of attorneys in a law partnership, professional corporation, sole proprietorship, or other business entity who:

1. are primarily engaged in the practice of law; and

2. solicit, procure, or negotiate title insurance contracts only as an incident to the practice of law.

(ii) "Law firm" includes a sole practitioner.

(iii) "Law firm" does not include:

1. an attorney or an association of attorneys who own, operate, or share an interest in a title agency; or

2. an attorney who is employed by a title agency as a title insurance producer.

(4) (i) "Title agency" means a business entity, other than a law firm, formed for the primary purpose of soliciting, procuring, or negotiating title insurance contracts and providing settlement services.

(ii) "Title agency" includes a sole proprietor, partnership, or corporation.

(b) Subject to this section, the Commissioner may issue a limited lines license to an attorney who solicits, procures, or negotiates title insurance contracts to act as a title insurance producer.

(c) All licensing provisions of this subtitle apply to:

(1) an attorney who solicits, procures, or negotiates title insurance contracts; and

(2) title agencies even if the title agency is established or owned by an attorney or an association of attorneys.

(d) Notwithstanding any other provision of this subtitle:

(1) (i) the licensing, bonding, and examination requirements of this subtitle relating to title insurance producers do not apply to law firms; and

(ii) except as otherwise provided in paragraph (2) of this subsection, the bonding and examination requirements of this subtitle relating to title insurance producers do not apply to attorneys.

(2) The bonding requirements of this subtitle are applicable to:

(i) an attorney or an association of attorneys who own, operate, or share an interest in a title agency; and

(ii) an attorney who is employed by a title agency as a title insurance producer.

§10–126.

(a) The Commissioner may deny a license to an applicant under §§ 2–210 through 2–214 of this article, or suspend, revoke, or refuse to renew or reinstate a license after notice and opportunity for hearing under §§ 2–210 through 2–214 of this article if the applicant or holder of the license:

(1) has willfully violated this article or another law of the State that relates to insurance;

(2) has intentionally misrepresented or concealed a material fact in the application for a license;

(3) has obtained or attempted to obtain a license by misrepresentation, concealment, or other fraud;

(4) has misappropriated, converted, or unlawfully withheld money belonging to an insurer, insurance producer, beneficiary, or insured;

(5) has willfully and materially misrepresented the provisions of a policy;

(6) has committed fraudulent or dishonest practices in the insurance business;

(7) has participated, with or without the knowledge of an insurer, in selling motor vehicle insurance without an actual intent to sell the insurance, as evidenced by a persistent pattern of filing certificates of insurance together with or closely followed by cancellation notices for the insurance;

(8) has been convicted by final judgment in any state or federal court of a felony or crime involving moral turpitude;

(9) has knowingly participated in writing or issuing substantial over–insurance of property insurance risks;

(10) has failed an examination required by this subtitle;

(11) has willfully failed to comply with or has willfully violated a proper order, subpoena, or regulation of the Commissioner or the insurance regulatory authority of another state;

(12) has failed or refused to pay over on demand money that belongs to an insurer, insurance producer, or other person entitled to the money;

(13) has otherwise shown a lack of trustworthiness or competence to act as an insurance producer;

(14) is not or does not intend to carry on business in good faith and represent to the public that the person is an insurance producer;

(15) has been denied a license or certificate in another state or has had a license or certificate suspended or revoked in another state;

(16) has intentionally or willfully made or issued, or caused to be made or issued, a statement that materially misrepresents or makes incomplete comparisons about the terms or conditions of a policy or contract issued by an authorized insurer, for the purpose of inducing or attempting to induce the owner of the policy or contract to forfeit or surrender it or allow it to lapse in order to replace it with another;

(17) has transacted insurance business that was directed to the applicant or holder for consideration by a person whose license or certificate to engage in the insurance business at the time was suspended or revoked, and the applicant or holder knew or should have known of the suspension or revocation;

(18) has solicited, procured, or negotiated insurance contracts for an unauthorized insurer, including contracts for nonprofit health service plans, dental plan organizations, and health maintenance organizations;

(19) has knowingly employed or knowingly continued to employ an individual acting in a fiduciary capacity who has been convicted of a felony or crime of moral turpitude within the preceding 10 years;

(20) has forged another's name to an application for insurance or to any document related to an insurance transaction;

(21) has improperly used notes or any other reference material to complete an examination for a license;

(22) has failed to pay income tax or related interest or penalty under:

(i) an assessment under the Tax – General Article that is final and no longer subject to review by the tax court; or

(ii) an order of the tax court that is final and no longer subject to judicial review; or

(23) in providing information under § 10–118 of this subtitle regarding the termination of an appointment with an insurer, has made an inaccurate statement with actual malice.

(b) (1) The Commissioner may deny a license to an applicant business entity under §§ 2–210 through 2–214 of this article, or suspend, revoke, or refuse to renew or reinstate a license of a business entity after notice and opportunity for hearing under §§ 2–210 through 2–214 of this article, if an individual listed in paragraph (2) of this subsection has:

(i) violated any provision of this subtitle;

(ii) been convicted of a felony, a crime of moral turpitude, or any criminal offense involving dishonesty or breach of trust; or

(iii) had any professional license suspended or revoked for a fraudulent or dishonest practice.

(2) This subsection applies in any case that involves a business entity if the violation was committed by an individual who is:

(i) an insurance producer;

(ii) 1. in the case of a limited liability company, an officer, director, member, or manager;

2. in the case of a partnership, a partner; and

3. in the case of a corporation, a director, officer, or owner; or

(iii) an individual with direct control over the fiscal management of the business entity.

(c) Instead of or in addition to suspending or revoking the license, the Commissioner may impose on the holder of the license a penalty of not less than $100 but not exceeding $5,000 for each violation of this article.

(d) Instead of or in addition to suspending or revoking the license, the Commissioner may require that restitution be made to any citizen who has suffered financial injury because of the violation of this article.

(e) If the license is suspended under this section, the Commissioner may require the individual to pass an examination and file a new application before the suspension is lifted.

(f) (1) Within 30 days after the final disposition of the matter, an insurance producer shall report to the Commissioner any adverse administrative action taken against the insurance producer:

(i) in another jurisdiction; or

(ii) by another governmental unit in this State.

(2) The report shall include a copy of the order, consent order, and any other relevant legal documents.

(g) (1) (i) In this subsection, the term "charging document" means a written accusation alleging that a defendant has committed an offense.

(ii) In this subsection, the term "charging document" includes:

1. a citation;

2. an indictment;

3. an information; and

4. a statement of charges.

(2) This subsection does not apply to a misdemeanor violation of the Maryland Vehicle Law or the vehicle law of another jurisdiction.

(3) If an insurance producer is prosecuted for a crime in any jurisdiction, the insurance producer shall report the prosecution to the Commissioner within 30 days after the insurance producer's initial appearance before a court, including an appearance before:

(i) a judicial officer of the District Court due to an arrest;

(ii) the District Court in response to a summons;

(iii) the circuit court due to execution of a warrant; or

(iv) the circuit court in person or by written notice of counsel in response to a summons.

(4) The report shall include a copy of:

(i) the charging document;

(ii) any order issued by a court; and

(iii) any other relevant legal documents.

(h) An individual is subject to denial or suspension of a license under § 10–119.3 of the Family Law Article if the individual:

(1) is in arrears in the payment of child support amounting to more than 120 days under the most recent order; or

(2) has failed to comply with a subpoena issued by the Child Support Administration under § 10–108.6 of the Family Law Article.

§10–127.

An insurer may not cancel a policy for nonpayment of premiums if the premium due on the policy has been paid to the insurance producer.

§10–128.

(a) This section does not apply to:

(1) reinsurance;

(2) life insurance, health insurance, or annuity contracts;

(3) insurance of:

(i) rolling stock, vessels, or aircraft of a common carrier used in interstate or foreign commerce;

(ii) a motor vehicle principally garaged and used outside the State; or

(iii) liability or other risks, incident to the ownership, maintenance, or operation of a subject of insurance under item (i) or (ii) of this item;

(4) insurance of property while transported in interstate or in foreign trade, or any liability or risk incident to the transportation;

(5) insurance of wet marine and transportation risks;

(6) bid bonds issued in connection with public or private contracts;

(7) policies or endorsements issued through:

(i) insurance producers compensated only by salary;

(ii) insurers not using insurance producers in the general solicitation of business;

(iii) mutual insurers or other insurers not customarily using insurance producers compensated by commission if no commission is payable to an insurance producer on the policy or endorsement; or

(iv) insurers or groups of insurers under common management or control that are represented exclusively by insurance producers who represent only the insurers or groups of insurers;

(8) reciprocal insurers; or

(9) insurance written through:

(i) the Maryland Automobile Insurance Fund; or

(ii) the Maryland Property Insurance Availability Program.

(b) This section does not alter the requirements of § 10-119 of this subtitle.

(c) (1) Notwithstanding any other provision of law of this State or of policy forms, and subject to paragraph (2) of this subsection, an insurance producer that is a resident of this State may not be required to sign or countersign a policy covering a subject of insurance resident, located, or to be performed in this State.

(2) A policy covering a subject of insurance resident, located, or to be performed in this State shall be signed or countersigned by an insurance producer that is a resident of this State if:

(i) the policy is written by an insurance producer that is a resident of another state and is qualified as a nonresident insurance producer in this State; and

(ii) the law of the other state requires a signature or countersignature by an insurance producer that is a resident of that state on a policy written by an insurance producer that is not a resident in that state.

(3) A policy is not invalid because it does not have the required signature or countersignature.

(d) (1) A person may not sign or countersign a policy or endorsement subject to this section unless the person:

(i) is a licensed insurance producer;

(ii) is a resident of this State;

(iii) is compensated by commissions on policies subject to this section; and

(iv) is not an employee or officer of the insurer issuing the policy.

(2) This section does not prevent an insurance producer from:

(i) delegating the duty of signing or countersigning to employees of the insurance producer that are not also employees of lending institutions; or

(ii) directing the payment of commissions on policies subject to this section to a corporation or partnership insurance agency or otherwise.

(e) An insurance producer may not countersign a policy or endorsement unless the policy or endorsement states, as applicable:

(1) the rates or premiums;

(2) a description of the property insured; and

(3) the name and address of the insured.

(f) If the law of another state requires an insurance producer that is a resident of that state to keep part of the commission paid on a policy written, countersigned, or delivered by the insurance producer in that state on request of a nonresident insurance producer of that state, an insurance producer that is a resident of this State and that signs or countersigns a policy written by an insurance producer that is a resident of the other state and qualified as a nonresident insurance producer

in this State covering a subject of insurance resident, located, or to be performed in this State shall keep an equal pro rata part of any commission on the policy.

§10–128.1.

The Commissioner shall adopt regulations establishing the minimum length of time for which and the manner in which an independent insurance producer is required to maintain records of insurance transactions conducted by the insurance producer.

§10–129.

A person other than an independent insurance producer may not be represented to the public as an independent insurance producer.

§10–130.

(a) Except as otherwise provided in §§ 10–102, 10–119, and 10–122 of this subtitle and § 10–602 of this title, a commission, fee, reward, rebate, or other consideration for selling, soliciting, or negotiating insurance may not be paid, directly or indirectly, to a person other than a licensed insurance producer.

(b) Except as otherwise provided in this article, for life insurance or health insurance this section does not prohibit payment to or receipt by a person who formerly held a license and, if the person acted on behalf of an insurer, an appointment of:

(1) commissions on renewal premiums on existing policies; or

(2) other deferred commissions.

(c) Unless the payment would violate § 27–209 or § 27–212 of this article, an insurer or insurance producer may pay or assign commissions, service fees, or other valuable consideration to an insurance agency or to persons who do not sell, solicit, or negotiate insurance in the State.

§10–131.

A person that violates § 10-103(b) or (c), § 10-130, or § 10-133 of this subtitle is guilty of a misdemeanor and on conviction is subject to a fine not exceeding $500 or imprisonment not exceeding 6 months or both for each violation.

§10–132.

A title insurance producer that willfully or knowingly violates § 10-121 of this subtitle is guilty of a misdemeanor and on conviction is subject to a fine not exceeding $50,000 or imprisonment not exceeding 1 year or both.

§10–133.

(a) In this section, "medical professional liability insurance" means insurance providing coverage against damages due to medical injury arising out of the performance of professional services rendered or which should have been rendered by a health care provider.

(b) A licensed insurance producer may not enter into an exclusive appointment agreement with an authorized insurer that issues medical professional liability insurance.

§10–201.

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

(b) "Adviser" means a person that, for compensation:

(1) examines or offers to examine a policy, annuity contract, or pure endowment contract for the purpose of giving, or gives or offers to give, advice or information about:

(i) the terms, conditions, benefits, coverage, or premium of a policy, annuity contract, or pure endowment contract; or

(ii) the advisability of changing, exchanging, converting, replacing, surrendering, continuing, or rejecting a policy, annuity contract, or pure endowment contract or of accepting or procuring a policy, annuity contract, or pure endowment contract from an insurer; or

(2) represents to the public that the person gives or is engaged in the business of giving advice or information to holders of policies or annuity contracts by use of the title "insurance adviser", "insurance specialist", "insurance counselor", "insurance analyst", "policyholders' adviser", "policyholders' counselor", "refund company", or other similar title:

(i) in or on advertisements, cards, signs, circulars, letterheads, or elsewhere; or

(ii) in any other manner in which public announcements are made.

(c) "License" means a license issued by the Commissioner to act as an adviser.

§10–202.

(a) (1) In this section the following words have the meanings indicated.

(2) "Guaranteed investment contract" means an agreement between an insurer and an entity listed in subsection (b)(5)(ii)2 of this section that:

(i) permits withdrawals by the purchaser for specified purposes; and

(ii) contains a general obligation of the insurer to repay a deposit plus interest.

(3) "Synthetic investment contract" means an agreement between an insurer and an entity listed in subsection (b)(5)(ii)2 of this section that:

(i) permits withdrawals by the purchaser for specified purposes; and

(ii) contains a limited obligation of the insurer to repay a deposit plus interest that is supported by a portfolio of fixed income securities identified in the agreement and owned by the purchaser.

(b) This subtitle does not apply to:

(1) an officer, employee, insurance producer, or other representative of an authorized insurer while acting for the authorized insurer;

(2) an insurance producer that holds a license while acting as an insurance producer for a client;

(3) an attorney at law of the State while acting within the scope of the legal profession;

(4) a licensed public adjuster while acting within the scope of the public adjuster's license; and

(5) an individual:

(i) who is employed by an investment adviser registered with the Securities and Exchange Commission;

(ii) whose only clients in the State each:

1. has assets of not less than $5,000,000; and

2. is one of the following types of institutional investors, whether acting for itself or as a trustee or fiduciary with investment control:

A. an investment company, as defined in the Investment Company Act of 1940;

B. an investment adviser registered with the Securities and Exchange Commission;

C. an adviser, as defined in § 10-201 of this subtitle;

D. a federal covered adviser, as defined in the Maryland Securities Act, Title 11 of the Corporations and Associations Article;

E. a broker-dealer;

F. a bank, trust company, or savings and loan association;

G. a collective investment fund or common trust fund maintained by a bank or trust company;

H. an insurer;

I. an employee benefit plan;

J. a governmental agency or instrumentality; or

K. any other type of institutional investor, as designated by the Commissioner; and

(iii) whose business activities in the State that would otherwise be subject to regulation under this subtitle are limited to acting as an adviser with respect to guaranteed investment contracts or synthetic investment contracts.

(c) This section may not be construed to afford coverage for guaranteed investment contracts or synthetic investment contracts under the Life and Health Insurance Guaranty Corporation Act, Title 9, Subtitle 4 of this article.

§10–203.

(a) Except as otherwise provided in this subtitle or §§ 10–14A–03 and 10–14B–03 of the State Government Article, a person must obtain a license before the person acts as an adviser in the State.

(b) An insurance producer or other representative of an authorized insurer that, while acting for an authorized insurer, uses a title similar to those listed in § 10-201(b)(2) of this subtitle in close conjunction with all or part of the name of the authorized insurer need not obtain a license if the insurance producer or other representative certifies to the Commissioner that the insurance producer or representative has completed successfully a course submitted to and approved by the Commissioner.

§10–204.

(a) To qualify for a license, an applicant must be an individual who meets the requirements of this section.

(b) An applicant must be trustworthy and competent to act as an adviser so as not to jeopardize the public interest.

(c) A license may be issued to:

(1) a resident of the State who takes and passes the examination required under subsection (d) of this section;

(2) a resident of the State who:

(i) is a member in good standing of the Society of Actuaries or the Casualty Actuarial Society;

(ii) has been conferred the Chartered Property Casualty Underwriter (C.P.C.U.) designation by The American Institute for Property and Liability Underwriters, Inc. and is a member in good standing of the Society of Chartered Property and Casualty Underwriters;

(iii) has been conferred the Chartered Life Underwriter (C.L.U.) designation by The American College of Life Underwriters and is a member

in good standing of The American Society of Chartered Life Underwriters and Chartered Financial Consultants;

(iv) has been conferred the Certified Employee Benefit Specialist (C.E.B.S.) designation by the International Foundation of Employee Benefit Plans and is a member in good standing of the International Society of Certified Employee Benefit Specialists;

(v) is currently certified by the Certified Financial Planner Board of Standards to use the marks Certified Financial Planner and CFP; or

(vi) has completed successfully a course of study equivalent to any course of study required for membership in good standing in any society or professional entity listed in items (i) through (v) of this item as approved by the Commissioner and has been conferred the Certified Insurance Counselor designation by The Society of Certified Insurance Counselors; or

(3) (i) a nonresident of the State who is licensed as an insurance adviser in the nonresident's state of residence; or

(ii) if the Commissioner determines that the applicant is otherwise qualified to act as an insurance adviser, a nonresident of Maryland whose state of residence does not issue:

1. an insurance adviser's license; or

2. the equivalent of an insurance adviser's license.

(d) (1) The Commissioner shall determine the trustworthiness and competency of each applicant to act as an adviser in the State.

(2) To determine the trustworthiness and competency of an applicant described in subsection (c)(1) of this section, the Commissioner shall require the applicant to take and pass, to the satisfaction of the Commissioner, an examination.

(3) A nonresident applicant shall satisfy the Commissioner of the applicant's trustworthiness and competency by filing a certification from an appropriate official of the applicant's state of residence certifying that the applicant holds a currently valid license or certificate to act as an insurance adviser in the applicant's state of residence.

(e) (1) Before taking the examination required under subsection (d) of this section, an applicant shall pay the application fee required by § 2-112 of this article.

(2) After an applicant has been notified that the applicant has passed the examination, the applicant shall pay the applicable license fee required by § 2-112 of this article.

(3) An applicant who is not required to take an examination shall pay the applicable license fee required by § 2-112 of this article.

§10–205.

An applicant for a license shall file with the Commissioner an application on the form that the Commissioner provides.

§10–206.

An applicant for a license shall file with the Commissioner a bond that:

(1) is approved by the Commissioner as to form and sufficiency of security;

(2) is executed by the applicant and an authorized surety insurer;

(3) is in the penal sum of $1,000;

(4) is conditioned on the applicant faithfully performing the duties of an adviser;

(5) runs to the State; and

(6) specifically authorizes the State to recover the penal sum of the bond if the applicant is guilty of fraudulent or dishonest practices while acting as an adviser.

§10–207.

The Commissioner shall issue a license to each applicant who meets the requirements of this subtitle.

§10–208.

A license does not authorize the licensee to:

(1) adjust losses; or

(2) receive compensation from an insurer or insurance producer for the sale or placement of insurance.

§10–210.

A licensee may conduct an insurance advisory business as a sole proprietorship, partnership, association, or corporation if:

(1) each individual who acts as an adviser is licensed under this subtitle; and

(2) the trade name of the business is registered with the Commissioner.

§10–211.

(a) A license expires every other year on the date stated on the license unless renewed as provided in this section.

(b) At least 1 month before a license expires, the Commissioner shall send to the holder of the license, at the last known address or electronic mail address of the holder on record a notice that states:

(1) the process for renewing the license;

(2) the date by which the Commissioner must receive the renewal application; and

(3) the amount of the renewal fee.

(c) Before a license expires, the holder of the license periodically may renew it for an additional 2–year term, if the holder:

(1) otherwise is entitled to a license;

(2) files with the Commissioner a renewal application:

(i) on the form that the Commissioner provides; or

(ii) in an electronic format that the Commissioner approves;

(3) pays to the Commissioner the renewal fee required by § 2–112 of this article;

(4) is in compliance with the bond requirement of § 10–206 of this subtitle; and

(5) if the Commissioner determines that an examination is advisable to determine the trustworthiness or competence of a holder, passes an examination given by the Commissioner.

(d) A license renewed under this section shall have an expiration date that is the last day of the month in which the holder of the license was born.

(e) (1) If mailed, an application for renewal of a license shall be considered made in a timely manner if it is postmarked on or before the expiration date of the license.

(2) If submitted electronically, an application for renewal of a license shall be considered made in a timely manner if, on or before the expiration date of the license, the application:

(i) is addressed properly or otherwise directed properly to an information processing system that the Administration has designated or uses for the purpose of receiving electronic applications and from which the Administration is able to retrieve the application;

(ii) is in a form capable of being processed by that system; and

(iii) 1. enters an information processing system outside the control of the sender or of a person that sent the electronic application on behalf of the sender; or

2. enters a region or the information processing system designated or used by the Administration that is under the control of the Administration or an agent of the Administration.

(f) (1) The Commissioner shall renew the license of each holder who meets the requirements of this section.

(2) If the holder of a license files an application for renewal before the license expires, the license shall remain in effect until:

(i) the Commissioner issues a renewal license; or

(ii) 5 days after the Commissioner refuses to renew the license and gives notice of the refusal to the holder.

(g) The Commissioner may adopt regulations to carry out this section.

§10–211.1.

(a) On or before September 30 of the renewal year, a person whose insurance adviser's license has expired may reinstate the expired license by:

(1) filing with the Commissioner the appropriate reinstatement application;

(2) paying to the Commissioner the applicable reinstatement fee required under subsection (b) of this section; and

(3) complying with the bond requirement of § 10-206 of this subtitle.

(b) (1) The fee for a reinstatement under this section shall be:

(i) the amount charged for a full renewal period for the type of license held by the person seeking the reinstatement; and

(ii) 1. $25 for reinstatement during the period from July 1 through July 31;

2. $50 for reinstatement during the period from August 1 through August 31; and

3. $75 for reinstatement during the period from September 1 through September 30.

(2) The Commissioner may limit the reinstatement fee to the amount of the renewal fee in cases where the reinstatement applicant did not make timely renewal because of temporary incapacity, hospitalization, or other hardship.

(c) A person whose insurance adviser's license has expired is prohibited from acting as an insurance adviser until the effective date of reinstatement of the license.

(d) A person who does not comply with subsection (a) of this section on or before September 30 of the year of expiration shall apply for an insurance adviser's license under § 10-205 of this subtitle and meet any other requirements specified by the Commissioner in regulation.

(e) The Commissioner may adopt regulations to carry out this section.

§10–212.

(a) Subject to the hearing provisions of Title 2 of this article, the Commissioner may suspend or revoke a license if the licensee:

(1) has violated this article;

(2) has violated any law while acting as an adviser;

(3) has made a material misstatement in the application for the license;

(4) has been guilty of fraudulent or dishonest practices; or

(5) has demonstrated incompetency or untrustworthiness to act as an adviser.

(b) (1) Any licensee or any person aggrieved may file with the Commissioner a verified complaint that states facts that show sufficient grounds to suspend or revoke a license.

(2) On the filing of a complaint, the Commissioner, after notice and hearing, shall determine whether to suspend or revoke the license.

(c) An adviser whose license has been revoked may not obtain another license or renew a license for at least 1 year after:

(1) the date of revocation, if there is no judicial review; or

(2) the final determination in the judicial proceeding confirming the revocation, if there is judicial review.

§10–213.

If an application for a license is denied or a license is suspended or revoked, the Commissioner immediately shall give notice to the applicant or licensee by:

(1) registered mail addressed to the applicant's or licensee's last address of record with the Commissioner; or

(2) electronic means in accordance with § 2–116 of this article.

§10–214.

(a) The Commissioner at any time may require a licensee to provide information that the Commissioner considers necessary about the business methods, policies, contracts, or transactions of the licensee.

(b) Within 10 days after receiving a written request for information under this section, the licensee shall provide the Commissioner with the information in the form that the Commissioner requires.

§10–215.

(a) An agreement between an adviser and another person that relates to the giving of advice or information of the type given by advisers is not enforceable by or for the adviser unless:

(1) the agreement is in writing;

(2) the agreement is executed personally in duplicate by the person to be charged or by the legal representative of the person;

(3) a duplicate of the agreement is delivered to and kept by the person when it is signed by that person;

(4) the agreement plainly states the amount of the fee paid or to be paid by the person and the services to be performed by the adviser; and

(5) the agreement is in the form that the Commissioner currently approves.

(b) (1) All forms of statements, receipts, and agreements used by licensees must be filed with and approved by the Commissioner as:

(i) conforming to the requirements of this section;

(ii) not inconsistent with law; and

(iii) not misleading in any way.

(2) The Commissioner may disapprove a form if the Commissioner finds that the form:

(i) contains any provision or any title, heading, backing, or other indication of its contents that is likely to be misleading; or

(ii) omits any provision that the Commissioner requires to make the form clear and not misleading.

§10–301.

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

(b) "Bail bond" means a written obligation of a defendant, with or without a surety or collateral security, that:

(1) is conditioned on the appearance of the defendant as required; and

(2) provides for the payment of a penal sum according to its terms.

(c) "Bail bondsman" means an authorized insurance producer of a surety insurer.

(d) "Collateral security" means any property deposited, pledged, or encumbered to secure the performance of a bail bond.

(e) "License" means a license issued by the Commissioner to provide bail bondsman services.

(f) "Provide bail bondsman services" means to provide any service in the bail bondsman trade.

(g) (1) "Surety" means a person, other than the defendant, that guarantees the appearance of the defendant by executing a bail bond.

(2) "Surety" includes an uncompensated or accommodation surety.

(h) "Surety insurer" means a person that, for compensation, directly or through an authorized insurance producer, acts as a surety on a bail bond.

§10–302.

Except as provided in § 10–309 of this subtitle, this subtitle does not apply to bail bondsmen that provide bail bondsman services under § 5–203 of the Criminal Procedure Article.

§10–303.

The Commissioner shall adopt regulations to carry out this subtitle.

§10–304.

(a) Except as provided in §§ 10–14A–03 and 10–14B–03 of the State Government Article, an individual must obtain a license before the individual provides bail bondsman services in the State.

(b) A license issued by the Commissioner under this subtitle is identical to a license issued under Subtitle 1 of this title.

§10–305.

An applicant for a license must be an individual who meets the requirements for acting as a property and casualty insurance producer under Subtitle 1 of this title.

§10–306.

The Commissioner shall set licensing fees that are sufficient to cover the expenses of licensing bail bondsmen under this subtitle.

§10–307.

Each bail bondsman must comply with any continuing education requirements that the Commissioner sponsors or approves.

§10–308.

Each year, each bail bondsman must certify to the Commissioner, on a form that the Commissioner requires, that the majority of the bail bondsman's income is from providing bail bondsman services.

§10–309.

(a) This section applies to bail bondsmen licensed under this subtitle and to bail bondsmen that provide bail bondsman services under § 5–203 of the Criminal Procedure Article.

(b) A bail bondsman may arrange to accept payment for the premium charged for a bail bond in installments.

(c) If a bail bondsman arranges to accept payment for the premium charged for a bail bond in installments, the installment agreement:

(1) shall be in a form adopted by the Commissioner;

(2) shall include:

(i) the total amount of the premium owed;

(ii) the amount of any down payment made;

(iii) the balance amount owed to the bail bondsman or the bail bondsman's insurer;

(iv) the amount and due date of each installment payment; and

(v) the total number of installment payments required to pay the amount due; and

(3) may not include a confessed judgment clause that waives a consumer's right to assert a legal defense to an action.

(d) If a bail bondsman arranges to accept payment of the premium charged for a bail bond in installments, the bail bondsman shall:

(1) secure a signed affidavit of surety by the defendant or the insurer containing the information required under subsection (c) of this section and provide the affidavit of surety to the court;

(2) take all necessary steps to collect the total amount owed by the insured, including seeking remedies provided by law for the collection of debts; and

(3) keep and maintain records of all collection attempts, installment agreements, and affidavits of surety.

(e) (1) The bail bondsman shall keep and maintain the records required under this section in an office that is generally accessible to the public during normal business hours.

(2) The bail bondsman shall make the records required under this section available to the Commissioner for inspection.

(3) Each year, each bail bondsman shall certify to the Commissioner that the records required to be kept and maintained under this section are accurate and true.

(f) If a bail bondsman violates any provision of this section, the Commissioner may take any actions authorized under § 10–126 of this title.

§10–401.

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

(b) "Business entity" has the meaning stated in § 10–101 of this title.

(c) "Home state" means:

(1) the state where a public adjuster's principal place of residence or principal place of business is located; or

(2) the state a public adjuster designates under § 10–409(a)(2) of this subtitle.

(d) "Immediate family member" means a public adjuster's:

(1) spouse;

(2) child;

(3) child's spouse;

(4) parent;

(5) spouse's parent;

(6) sibling; or

(7) sibling's spouse.

(e) "License" means a license issued by the Commissioner to act as a public adjuster.

(f) "Marketing" means the distribution of advertising materials regarding the services of a public adjuster.

(g) (1) "Public adjuster" means a person who for compensation or any other thing of value:

(i) acts or aids, solely in relation to first–party claims arising under an insurance policy that insures the real or personal property of the insured, on behalf of the insured in negotiating for, or effecting the settlement of, a claim for loss or damage covered by an insurance policy;

(ii) except as provided in § 10–403 of this subtitle, directly or indirectly solicits for employment as a public adjuster of insurance claims, solicits business, or represents oneself to the public as a public adjuster of first–party insurance claims for losses or damages arising out of insurance policies that insure real or personal property; or

(iii) investigates or adjusts losses, or advises an insured about first–party claims for losses or damages arising out of an insurance policy that insures real or personal property for another person engaged in the business of adjusting losses or damages covered by an insurance policy, for the insured.

(2) "Public adjuster" does not include a person that investigates, adjusts, or appraises claims for loss or damage covered by a motor vehicle insurance policy.

§10–402.

This subtitle does not apply to:

(1) an adjuster for or an insurance producer or employee of an insurer or group of insurers under common control or ownership that, as representative of the insurer or group, adjusts losses or damages under policies issued by the insurer or group;

(2) an insurance producer that acts as an adjuster without compensation for an insured for whom the insurance producer is acting as an insurance producer;

(3) an attorney at law who does not:

(i) regularly act as a public adjuster; and

(ii) represent to the public by sign, advertisement, or otherwise that the attorney at law acts as a public adjuster;

(4) a person who negotiates or settles claims arising under:

(i) a life, health, or motor vehicle insurance policy; or

(ii) an annuity contract;

(5) a person employed only for the purpose of obtaining facts surrounding a loss or furnishing technical assistance to a public adjuster, including

a photographer, an estimator, a private investigator, an engineer, and a handwriting expert;

(6) a licensed health care provider, or an employee of a licensed health care provider, who prepares or files a health claim form on behalf of a patient; or

(7) a person who settles subrogation claims between insurers.

§10–403.

(a) Except as otherwise provided in this subtitle or §§ 10–14A–03 and 10–14B–03 of the State Government Article, a person must obtain a license before the person acts as a public adjuster in the State.

(b) Marketing on behalf of a public adjuster, as defined in § 10–401 of this subtitle, does not require a license.

(c) A person that violates this section is guilty of a misdemeanor and on conviction is subject to a fine not exceeding $500 or imprisonment not exceeding 6 months or both for each violation.

§10–404.

(a) To qualify for a license, an applicant must be:

(1) an individual who meets the requirements of subsection (b) of this section; or

(2) a business entity that meets the requirements of subsection (c) of this section.

(b) (1) An individual applicant must be trustworthy and competent to transact business as a public adjuster so as to safeguard the interests of the public.

(2) Except as otherwise provided in this subsection, an individual applicant shall:

(i) pass a written examination given by the Commissioner under this subtitle in order to determine the competency of the applicant to act as a public adjuster; and

(ii) pay the license fee required by § 2–112 of this article.

(3) The examination requirement of paragraph (2) of this subsection does not apply to an individual who was licensed as a public adjuster in the State on June 30, 1985.

(4) An individual applicant who fails an examination may not take another examination until at least 14 days after the date of the last examination that the applicant failed.

(c) A business entity applicant must:

(1) be trustworthy and competent to transact business as a public adjuster so as to safeguard the interests of the public;

(2) employ one or more individual licensed public adjusters; and

(3) pay the applicable license fee required by § 2–112 of this article.

§10–405.

(a) An applicant for an initial license shall file with the Commissioner an application on the form that the Commissioner provides.

(b) The application form shall require:

(1) the name and address of the applicant;

(2) whether any other insurance license or certificate has been issued to the applicant;

(3) for a business entity applicant:

(i) the name of the individual licensed public adjuster employed by the business entity who is designated to act as the business entity's principal contact with the Administration; and

(ii) the name and address of each licensed public adjuster employed by the business entity, each individual who has direct control over its fiscal management, each owner, partner, member, or manager of the business entity, and each director of a business entity that is a corporation; and

(4) any other information that the Commissioner requires of applicants to enable the Commissioner to determine the trustworthiness and competence of the applicant to transact business as a public adjuster so as to safeguard the interests of the public.

(c) An application shall be signed under oath:

(1) in the case of an individual applicant, by the applicant; or

(2) in the case of an applicant that is a business entity, by an individual who has direct control over its fiscal management, an owner, partner, member, or manager of the business entity, or a director of a business entity that is a corporation.

§10–406.

The Commissioner shall issue a license to each applicant who meets the requirements of this subtitle.

§10–407.

The Commissioner may adopt regulations that specify:

(1) the scope, type, conduct, and grading of the written examination; and

(2) the frequency, times, and locations within the State where the written examination will be held.

§10–408.

(a) A license expires every other year on the date stated on the license unless renewed as provided in this section.

(b) At least 1 month before a license expires, the Commissioner shall send to the holder of the license, at the last known address or e–mail address of the holder on record a notice that states:

(1) the process for renewing the license;

(2) the date by which the Commissioner must receive the renewal application for the renewal to be issued and mailed before the license expires; and

(3) the amount of the renewal fee.

(c) Before a license expires, the holder of the license may renew it for an additional 2–year term, if the holder:

(1) otherwise is entitled to a license;

(2) files with the Commissioner a renewal application:

(i) on the form that the Commissioner provides; or

(ii) in an electronic format that the Commissioner approves;

(3) completes the continuing education requirements under subsection (e) of this section; and

(4) pays to the Commissioner the renewal fee required by § 2–112 of this article.

(d) A license renewed under this section for an individual shall have an expiration date that is the last day of the month in which the license holder was born.

(e) (1) The Commissioner shall require a public adjuster who is not a business entity to receive continuing education as a condition of renewing a license of the public adjuster.

(2) A public adjuster shall complete the continuing education required under paragraph (1) of this subsection not later than 30 days before the expiration date of the public adjuster's license.

(3) The public adjuster shall successfully complete 24 credit hours of approved continuing education for each 2–year license period as a condition for license renewal unless the Commissioner modifies the requirement by regulation.

(4) Of the required hours of continuing education required for a renewal period under paragraph (3) of this subsection, at least 3 hours shall relate directly to ethics.

(5) The Commissioner may grant a waiver to a public adjuster who has requested a waiver for reasons that the Commissioner determines warrant the waiver.

(6) This subsection may not apply to a holder of a license who has not been licensed for 1 full year before the end of the applicable continuing education period.

(f) A nonresident license holder shall be deemed to have met the continuing education requirements of this section if:

(1) the nonresident license holder satisfies the continuing education requirements of the home state of the nonresident license holder; and

(2) the home state of the nonresident license holder allows a public adjuster who is a resident of this State to satisfy the continuing education requirements of the home state on the same basis by meeting the continuing education requirements of this State.

(g) (1) If mailed, an application for renewal of a license shall be considered made in a timely manner if it is postmarked on or before the expiration date of the license.

(2) If submitted electronically, an application for renewal shall be considered made in a timely manner if, on or before the expiration date of the license, the application:

(i) is addressed properly or otherwise directed properly to an information processing system that the Administration has designated or uses for the purpose of receiving electronic applications and from which the Administration is able to retrieve the application;

(ii) is in a form capable of being processed by that system; and

(iii) 1. enters an information processing system outside the control of the sender or of a person that sent the electronic application on behalf of the sender; or

2. enters a region of the information processing system designated or used by the Administration that is under the control of the Administration or an agent of the Administration.

(h) (1) The Commissioner shall renew the license of each holder who meets the requirements of this section.

(2) If the holder of a license files an application for renewal before the license expires, the license shall remain in effect until:

(i) the Commissioner issues a renewal license; or

(ii) 5 days after the Commissioner refuses in writing to renew the license and serves notice of the refusal on the holder.

(i) The Commissioner may adopt regulations to carry out this section.

§10–408.1.

(a) For up to 1 year after the expiration date, a person whose public adjuster's license has expired may reinstate the expired license by:

(1) filing with the Commissioner the appropriate reinstatement application;

(2) paying to the Commissioner the applicable reinstatement fee required under subsection (b) of this section; and

(3) submitting proof of completion of the continuing education requirements in § 10–408 of this subtitle.

(b) (1) The fee for a reinstatement under this section shall be:

(i) the amount charged for a full renewal period for the type of license held by the person seeking the reinstatement; and

(ii) a reinstatement fee of $100.

(2) The Commissioner may limit the reinstatement fee to the amount of the renewal fee in cases where the reinstatement applicant did not make timely renewal because of service in the uniformed services, temporary incapacity, hospitalization, or other hardship.

(c) A person whose public adjuster's license has expired is prohibited from acting as a public adjuster until the effective date of reinstatement of the license.

(d) (1) If a person applies for reinstatement of an expired license within 60 days after the license expired, the Commissioner shall reinstate the license retroactively, with the reinstatement effective on the date that the person's license expired.

(2) If a person applies for reinstatement of an expired license more than 60 days after the license expired, the Commissioner shall reinstate the person's license prospectively, with the reinstatement effective on the date that the license is reinstated.

(e) A person who does not comply with subsection (a) of this section on or before 1 year after the expiration date shall apply for a license under § 10–405 of this subtitle and meet the requirements specified by the Commissioner in regulation.

(f) The Commissioner may adopt regulations to carry out this section.

§10–409.

(a) (1) Except as otherwise provided in this section, the Commissioner shall waive the license requirements for an applicant who is not a resident of the State if:

(i) the applicant has a valid public adjuster license from the home state of the applicant; and

(ii) the home state of the applicant awards nonresident public adjuster licenses to residents of the State on the same basis.

(2) If neither the state where the public adjuster maintains a principal place of residence nor the state where the public adjuster maintains a principal place of business has a law governing public adjusters substantially similar to this subtitle, the public adjuster may declare another state where the public adjuster is licensed and acts as a public adjuster to be the public adjuster's home state for purposes of this subtitle.

(b) Unless denied a license under § 10–410 of this subtitle, a person who is not a resident of the State may obtain a nonresident license to act as a public adjuster if:

(1) the person currently is licensed as a resident public adjuster and in good standing in the person's home state;

(2) the person files an application on the form that the Commissioner provides;

(3) the person has paid the applicable fee pursuant to § 2–112 of this article; and

(4) the person's home state awards nonresident public adjuster licenses to residents of this State on the same basis.

(c) A person who is not a resident of this State and whose home state does not issue a public adjuster license must meet the license requirements of §§ 10–404 and 10–405 of this subtitle.

§10–409.1.

(a) Except as otherwise expressly provided by law, a person may not pay, allow, or give, or offer to pay, allow, or give, directly or indirectly, any valuable consideration to an insured as an inducement to use the services of a public adjuster.

(b) A public adjuster may pay a commission, service fee, or any other valuable consideration to a person only if that person is required to be licensed, and is licensed, as a public adjuster.

(c) A person may not accept a commission, service fee, or any other valuable consideration if the person is required to be licensed, but is not licensed, as a public adjuster.

§10–410.

(a) The Commissioner may deny a license to an applicant or suspend, revoke, or refuse to renew or reinstate a license after notice and opportunity for a hearing under §§ 2–210 through 2–214 of this article if the applicant or licensee:

(1) has violated this article;

(2) has made a material misstatement in the application for the license;

(3) has engaged in fraudulent or dishonest practices;

(4) has demonstrated incompetency or untrustworthiness to act as a public adjuster;

(5) has misappropriated, converted, or unlawfully withheld money that belongs to an insurer, insurance producer, insured, or other person;

(6) has willfully and materially misrepresented the provisions of a policy;

(7) has been convicted of a felony, a crime of moral turpitude, or any criminal offense involving dishonesty or breach of trust;

(8) has willfully failed to comply with or has willfully violated a proper order or regulation of the Commissioner;

(9) has failed or refused to pay on demand money that belongs to an insurer, insurance producer, insured, or other person entitled to the money;

(10) is not carrying on or does not intend to carry on business in good faith while representing to the public that the person is a public adjuster;

(11) has been denied a license or has had a license suspended or revoked in another state; or

(12) has knowingly employed or knowingly continued to employ an individual acting in a fiduciary capacity who has been convicted within the preceding 10 years of a felony or crime of moral turpitude.

(b) (1) The Commissioner may deny a license to a business entity applicant or suspend, revoke, or refuse to renew or reinstate the license of a business entity after notice and opportunity for a hearing under §§ 2–210 through 2–214 of this article, if an individual listed in paragraph (2) of this subsection:

(i) violates any provision of this article;

(ii) is convicted of a felony, a crime of moral turpitude, or any criminal offense involving dishonesty or breach of trust; or

(iii) has any professional license suspended or revoked for a fraudulent or dishonest practice.

(2) The sanctions provided for under this subsection may be imposed on a business entity if the violation was committed by an individual who:

(i) is a public adjuster employed by the business entity;

(ii) 1. in the case of a limited liability company, is an officer, director, member, or manager;

2. in the case of a partnership, is a partner; and

3. in the case of a corporation, is a director, officer, or controlling owner; or

(iii) has direct control over the fiscal management of the business entity.

(c) Instead of or in addition to suspending or revoking the license of a public adjuster, the Commissioner may impose on the licensee a penalty of not less than $100 but not exceeding $5,000 for each violation of this article.

(d) Instead of or in addition to suspending or revoking the license, the Commissioner may require that restitution be made to any citizen who has suffered financial injury because of the violation of this article.

(e) If the license is suspended under this section, the Commissioner may require the individual to pass an examination and file a new application before the suspension is lifted.

§10–411.

(a) A contract for public adjuster services shall:

(1) be in writing;

(2) be titled "Public Adjuster Contract"; and

(3) contain the following:

(i) the legible full name of the public adjuster signing the contract, as specified in the records of the Administration;

(ii) the permanent business address and phone number of the public adjuster in the public adjuster's home state;

(iii) the license number issued by the Administration to the public adjuster;

(iv) the insured's full name, street address, insurance company name, and policy number, if known or on notification;

(v) a description of the loss and the location of the loss, if applicable;

(vi) a description of services to be provided to the insured;

(vii) the signatures of the public adjuster and the insured;

(viii) the dates when the contract was signed by the public adjuster and the insured, respectively;

(ix) notification to the insured that:

1. the public adjuster may incur out–of–pocket expenses on behalf of the insured; and

2. these expenses incurred by the public adjuster and approved by the insured will be reimbursed to the public adjuster from the insurance proceeds; and

(x) the full salary, fee, commission, compensation, or other consideration the public adjuster is to receive for services.

(b) (1) The public adjuster contract may specify that the public adjuster be named as a co–payee on an insurer's payment of a claim.

(2) If the compensation is based on a share of the insurance settlement, the public adjuster contract shall specify the exact percentage to be paid.

(3) (i) A compensation provision in a public adjuster contract may not be redacted in any copy of the contract provided to the Commissioner.

(ii) A redaction of a compensation provision constitutes an omission of material fact in violation of this subtitle.

(c) If the insurer, within 72 hours after the time the loss is reported to the insurer, either pays or commits in writing to pay to the insured the policy limit of the insurance policy, the public adjuster:

(1) may not receive a commission consisting of a percentage of the total amount paid by an insurer to resolve a claim;

(2) shall inform the insured that loss recovery amount might not be increased by the insurer; and

(3) may be entitled only to reasonable compensation from the insured for services the public adjuster provides on behalf of the insured, based on the time spent on a claim and expenses incurred by the public adjuster, until the claim is paid or the insured receives a written commitment to pay from the insurer.

(d) (1) A public adjuster shall provide to the insured a written disclosure signed by the public adjuster and the insured concerning any direct or indirect financial interest that the public adjuster or any immediate family member of the public adjuster has with any other party that is involved in any aspect of the claim, other than the salary, fee, commission, or other consideration established in the written contract with the insured.

(2) The disclosure shall include any ownership of, or any compensation expected to be received from, any construction firm, salvage firm,

building appraisal firm, motor vehicle repair shop, or any other firm that provides estimates for work, or that performs any work, in conjunction with damages caused by the insured loss on which the public adjuster is engaged.

(e) A public adjuster contract may not contain any provision that:

(1) allows the public adjuster's percentage fee to be collected when money is due from, but not yet paid by, an insurance company;

(2) allows a public adjuster to collect the entire fee from the first check issued by an insurance company, rather than as a percentage of each check issued by an insurance company;

(3) requires the insured to authorize an insurance company to issue a check only in the name of the public adjuster; or

(4) precludes either party from pursuing any civil remedy.

(f) Before the signing of the public adjuster contract, the public adjuster shall provide the insured with a separate disclosure document signed by the insured regarding the claim process that substantially states:

"(1) Property insurance policies obligate the insured to present a claim to the insurance company for consideration. There are three types of adjusters that could be involved in that process. The definitions of the three types are:

(i) "Company adjuster" means an insurance adjuster who is an employee of an insurance company. A company adjuster represents the interest of the insurance company and is paid by the insurance company. A company adjuster will not charge you a fee.

(ii) "Independent adjuster" means an insurance adjuster who is hired on a contractual basis by an insurance company to represent the insurance company's interest in the settlement of the claim. An independent adjuster is paid by your insurance company. An independent adjuster will not charge you a fee.

(iii) "Public adjuster" means an insurance adjuster who does not work for any insurance company. A public adjuster works for the insured to assist in the preparation, presentation, and settlement of a claim. The insured hires a public adjuster by signing a contract agreeing to pay the public adjuster a fee or commission based on a percentage of the settlement, or another method of compensation.

(2) The insured is not required to hire a public adjuster to help the insured meet the insured's obligations under the policy but has the right to do so.

(3) The insured has the right to initiate direct communications with the insured's attorney, the insurer, the insurer's adjuster, the insurer's attorney, or any other person regarding the settlement of the insured's claim.

(4) A public adjuster is not a representative or an employee of the insurer.

(5) The salary, fee, commission, or other consideration of a public adjuster is the obligation of the insured, not the insurer.".

(g) (1) The public adjuster contract shall be executed in duplicate to provide an original contract to the public adjuster and an original contract to the insured.

(2) The public adjuster's original contract shall be available at all times for inspection without notice by the Commissioner.

(3) A contract with an electronic signature shall constitute an original contract.

(h) The public adjuster contract shall contain a statement that:

(1) the insured has the right to rescind or cancel the contract within 10 business days after the date the contract was signed;

(2) the notice of rescission or cancellation shall be in writing and mailed or delivered to the public adjuster at the address stated in the contract within the time period specified in item (1) of this subsection;

(3) if the insured exercises the right to rescind or cancel the contract, the public adjuster shall, within 15 business days after the public adjuster receives the notice, return anything of value given by the insured under the contract; and

(4) provides a notice to the insured that a public adjuster, or anyone acting on behalf of a public adjuster, may not solicit or attempt to solicit a client between the hours of 8:00 p.m. and 8:00 a.m.

(i) The public adjuster shall give the insured written notice of the insured's rights under the Maryland Consumer Protection Act.

§10–412.

A public adjuster who receives, accepts, or holds any funds on behalf of an insured toward the settlement of a claim for loss or damage shall deposit the funds in a noninterest–bearing escrow or trust account in a financial institution that is federally insured in the public adjuster's home state or where the loss occurred.

§10–413.

(a) (1) A public adjuster shall maintain a complete record of each transaction entered into as a public adjuster.

(2) The records required by this section shall include:

(i) the name of the insured;

(ii) the date, location, and amount of the loss;

(iii) a copy of the contract between the public adjuster and the insured;

(iv) the name of the insurer and the amount, expiration date, and number of each policy carried with respect to the loss;

(v) an itemized statement of the insured's recoveries;

(vi) an itemized statement of all compensation received by the public adjuster, from any source, in connection with the loss;

(vii) a register of all money received, deposited, disbursed, or withdrawn in connection with a transaction with an insured, including:

1. fees, transfers, and disbursements from a trust account; and

2. all transactions concerning all interest–bearing accounts;

(viii) the name of the public adjuster who executed the public adjuster contract;

(ix) the name of the attorney representing the insured, if applicable; and

(x) the name of the claims representative of the insurance company.

(b) (1) The records shall be:

(i) maintained for at least 5 years after the termination of the transaction with an insured; and

(ii) open to examination by the Commissioner at all times.

(2) Any records required to be maintained under this section may be stored in an electronic format.

(c) Records submitted to the Commissioner in accordance with this section that contain information that the public adjuster identifies in writing as proprietary:

(1) shall be treated as confidential by the Commissioner; and

(2) may not be subject to Title 4, Subtitle 2 of the General Provisions Article.

§10–414.

(a) A public adjuster is obligated to:

(1) serve with objectivity and complete loyalty the interest of the client alone;

(2) render to the insured the information, counsel, and service that will best serve the insured's insurance claim needs and interests, within the knowledge, understanding, and opinion in good faith of the public adjuster; and

(3) disburse insurance settlement payments received on behalf of the insured within 15 business days after the date of the payment from an insurer.

(b) A public adjuster may not allow an unlicensed employee or representative of the public adjuster to conduct business for which a license is required under this subtitle.

(c) Unless full written disclosure has been made to the insured in accordance with § 10–411 of this subtitle, a public adjuster may not have a direct or indirect financial interest in any aspect of a claim, other than the salary, fee, commission, or other consideration established in the written contract with the insured.

(d) A public adjuster may not acquire any interest in salvage of property subject to a public adjuster contract with the insured unless the public adjuster obtains written permission from the insured.

(e) A public adjuster, or anyone acting on behalf of a public adjuster, may not solicit or attempt to solicit a client between the hours of 8:00 p.m. and 8:00 a.m.

(f) (1) A public adjuster who enters into a public adjuster contract during, or within 72 hours after, the loss giving rise to an insurance claim shall provide notice to the Commissioner that the public adjuster has entered into the contract.

(2) The notice required under paragraph (1) of this subsection shall be:

(i) provided to the Commissioner within 1 business day after the public adjuster enters into the contract; and

(ii) in a form and manner the Commissioner determines.

§10–415.

(a) A public adjuster shall adhere to the following general ethical requirements:

(1) a public adjuster may not undertake the adjustment of any claim if the public adjuster is not competent and knowledgeable as to the terms and conditions of the insurance coverage, or that otherwise exceeds the public adjuster's current expertise;

(2) a public adjuster may not make a statement that the public adjuster knows to be false or with reckless disregard as to the statement's truth or falsity concerning the qualifications or integrity of any person engaged in the business of insurance to any insured client or potential insured client;

(3) a public adjuster may not represent or act as a company adjuster or as an independent adjuster on the same claim;

(4) the public adjuster contract may not be construed to prevent an insured from pursuing any civil remedy after the rescission or cancellation period under § 10–411(h) of this subtitle; and

(5) a public adjuster may not enter into a contract or accept a power of attorney that vests in the public adjuster the effective authority to choose the persons who shall perform repair work.

(b) A public adjuster may not agree to any loss settlement without the insured's knowledge and consent.

§10–416.

(a) (1) A public adjuster shall report to the Commissioner, within 30 days after the final disposition of the matter, any administrative action taken against the public adjuster in another jurisdiction, or by another governmental unit in the State.

(2) The report shall include:

(i) a copy of any order;

(ii) any consent to an order; and

(iii) any other relevant legal documents.

(b) (1) Within 30 days after the initial pretrial hearing date, a public adjuster shall report to the Commissioner any criminal prosecution of the public adjuster undertaken in any jurisdiction.

(2) The report shall include:

(i) a copy of the initial filed complaint;

(ii) any order resulting from the hearing; and

(iii) any other relevant legal documents.

§10–501.

In this subtitle, "adjuster" or "appraiser" means a person that:

(1) is employed by an insurer as, solicits business as, or represents to an insurer that the person is an adjuster or appraiser of claims for loss or damage covered by a motor vehicle insurance policy; or

(2) under a contract, performs adjustments or appraisals for loss or damage covered by another form of security provided for under § 17-103(a)(2) of the Transportation Article.

§10–502.

This subtitle does not:

(1) require an insurer to pay an amount for motor vehicle repair services or repair products necessary to properly and fairly repair a motor vehicle that is greater than the usual and customary charges for equivalent services or products charged by similar contractors or repair shops within a reasonable geographic or trade area of the address of the claimant or insured; or

(2) prohibit an insurer from requiring a claimant or an insured to obtain an appraisal by driving a damaged motor vehicle to a facility that is owned or leased by or under contract to the insurer and is used exclusively for damage appraisals.

§10–503.

(a) An adjuster, appraiser, or insurance producer or employee of an insurer may not:

(1) recommend the use of a specific repair service or source for the repair or replacement of property damage to a motor vehicle without informing the claimant or insured that the claimant or insured does not have to use the recommended repair service or source;

(2) require that an appraisal or repair be made in a specific repair shop;

(3) require that a claimant or insured use a specific contractor or repair shop for a repair service or repair product; or

(4) intimidate, coerce, or threaten a claimant or insured to use a specific contractor or repair shop for a repair service or repair product.

(b) An adjuster or appraiser may not accept a gratuity or other form of remuneration from a repair service for recommending that repair service to a claimant or insured.

§10–504.

A person that intentionally violates this subtitle is subject to:

(1) a civil penalty not exceeding $1,000 for each violation; and

(2) denial, suspension, or revocation of any license held under this article.

§10–601.

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

(b) "Authorized representative" means an independent contractor of a motor vehicle rental company.

(c) (1) "Motor vehicle rental company" means any person that is in the business of providing motor vehicles to the public under a rental agreement for a period of 180 days or less.

(2) "Motor vehicle rental company" does not include a peer–to–peer car sharing program as defined in § 19–520 of this article.

(d) "Rental agreement" means any written agreement containing the terms and conditions that govern the use of a vehicle provided by a motor vehicle rental company under the provisions of Title 18 of the Transportation Article.

(e) "Renter" means any person obtaining the use of a vehicle from a motor vehicle rental company under the terms of a rental agreement.

(f) "Vehicle" means a motor vehicle:

(1) of the private passenger type, including passenger vans, minivans, and sport utility vehicles; or

(2) of the cargo type, including cargo vans, pickup trucks, and trucks that do not require the operator to possess a commercial driver's license.

§10–602.

(a) A motor vehicle rental company shall hold a limited lines license to sell insurance in connection with, and incidental to, the rental of a vehicle before the company or its employees or authorized representatives may sell or offer any policies of insurance in this State to a renter in connection with, and incidental to, a rental agreement.

(b) A limited lines license to sell insurance in connection with, and incidental to, the rental of a vehicle issued under this subtitle shall also authorize any employee and any authorized representative of the motor vehicle rental company who is trained, under § 10–604(a)(4) of this subtitle, to act on behalf of, and under the supervision of, a motor vehicle rental company, with respect to the kinds of insurance specified in § 10–604(b)(2) of this subtitle.

(c) The acts of an employee or authorized representative offering or selling insurance coverage on behalf of a motor vehicle rental company shall be deemed the acts of the motor vehicle rental company for the purposes of this subtitle.

(d) A motor vehicle rental company holding a limited lines license to sell insurance in connection with, and incidental to, the rental of a vehicle issued under this subtitle is not required to treat premiums collected from a renter that purchased insurance from the motor vehicle rental company as funds received in a fiduciary capacity if:

(1) the insurer represented by the motor vehicle rental company has consented in a written agreement, signed by an officer of the insurer, that the premiums do not need to be segregated from other funds received by the motor vehicle rental company in connection with the vehicle rental; and

(2) the charges for insurance coverage are itemized but not billed to the renter separately from the charges for the vehicle rental.

(e) An employee or an authorized representative of a motor vehicle rental company who offers or sells insurance coverage on behalf of the motor vehicle rental company:

(1) may be compensated for offering or selling insurance coverage under this subtitle; but

(2) may not be compensated in a manner that is based solely on the number of customers who purchase rental vehicle insurance.

(f) This subtitle may not be construed to prohibit payment of compensation to an employee or an authorized representative of a motor vehicle rental company who offers or sells insurance coverage on behalf of the motor vehicle rental company for activities that are incidental to the employee's overall activities.

(g) A motor vehicle rental company that holds a limited lines license to sell insurance in connection with, and incidental to, the rental of a vehicle issued under this subtitle shall:

(1) maintain a register, on a form the Commissioner requires, containing:

(i) the names of each employee or authorized representative who offers limited lines insurance on behalf of the motor vehicle rental company; and

(ii) the business addresses of all locations in the State where employees or authorized representatives offer limited lines insurance on behalf of the motor vehicle rental company; and

(2) submit the register for inspection by the Commissioner as the Commissioner requires.

§10–603.

(a) The Commissioner shall issue to a motor vehicle rental company, or a franchisee of a motor vehicle rental company, a limited lines license authorizing the motor vehicle rental company to offer or sell insurance in connection with, and incidental to, the rental of a vehicle if the motor vehicle rental company:

(1) meets the requirements of § 10-604 of this subtitle;

(2) pays the fees for insurance producers required under § 2-112 of this article that are applicable to an insurance producer license; and

(3) submits to the Commissioner any additional information or documentation that the Commissioner requires, including any information or documentation to determine the professional competence, good character, and trustworthiness of the motor vehicle rental company.

(b) A limited lines license to sell insurance in connection with, and incidental to, the rental of a vehicle issued under this subtitle is subject to the same term and renewal conditions specified for an insurance producer license under § 10–115 of this title.

§10–604.

(a) A limited lines license to sell insurance in connection with, and incidental to, the rental of a vehicle issued under this subtitle authorizes the motor vehicle rental company to offer or sell, in connection with, and incidental to, a motor vehicle rental agreement in which the rental period does not exceed 30 days, the insurance products specified in paragraph (b) of this section if:

(1) the policies have been filed with and approved by the Commissioner;

(2) the motor vehicle rental company holds an appointment with each authorized insurer, under § 10–118 of this title, that the motor vehicle rental company intends to represent;

(3) prior to completion of the rental transaction, an employee or authorized representative of the motor vehicle rental company provides to the renter disclosures approved by the Commissioner that:

(i) summarize, clearly and correctly, the material terms of coverage, including limitations or exclusions;

(ii) identify the authorized insurer or insurers;

(iii) specify that the policies offered by the motor vehicle rental company may provide a duplication of coverage already provided by a renter's personal automobile insurance policy, homeowner's insurance policy, personal liability insurance policy, or other source of coverage;

(iv) specify that the purchase of the coverages offered by the motor vehicle rental company is not required in order for the renter to rent a vehicle;

(v) describe the process by which the renter can file a claim; and

(vi) specify that any excess liability coverage purchased by the renter may duplicate coverage required to be provided under § 18–102(a)(2) of the Transportation Article;

(4) the motor vehicle rental company provides a training program, approved by the Commissioner, for any employee or authorized representative who sells, solicits, or negotiates insurance coverage under this subtitle that includes:

(i) instruction about the kinds of insurance specified in subsection (b) of this section that can be offered to renters;

(ii) instruction that the trainee shall inform a renter that the purchase of any insurance from the motor vehicle rental company is not required in order for the renter to rent a vehicle; and

(iii) instruction that the trainee shall inform a renter that the renter may have insurance policies that already provide the coverage being offered by the motor vehicle rental company; and

(5) an employee or authorized representative who offers or sells insurance coverage on behalf of the motor vehicle rental company informs a renter that the policies offered by the motor vehicle rental company may duplicate coverage already provided by the renter's personal automobile insurance policy, homeowner's insurance policy, personal liability insurance policy, or other source of coverage.

(b) A limited lines license to sell insurance in connection with, and incidental to, the rental of a vehicle issued under this subtitle authorizes the motor vehicle rental company to offer or sell insurance policies under this subtitle that are:

(1) in excess of or optional to the coverages required to be provided by the motor vehicle rental company under Title 17 of the Transportation Article and any related regulations; and

(2) one of the following kinds of insurance:

(i) bodily injury liability;

(ii) property damage liability;

(iii) uninsured motorist insurance; or

(iv) if approved by the Commissioner, any other insurance coverage that is appropriate in connection with the rental of a vehicle.

§10–605.

(a) Except as provided in subsection (b) of this section, an insurance policy sold in connection with, and incidental to, the rental of a vehicle under the provisions of this subtitle is primary to any other valid and collectible coverage.

(b) Any insurance sold to a renter under the provisions of this subtitle is not primary to the coverages provided by the motor vehicle rental company on the rental vehicle under § 17-103(b) of the Transportation Article.

§10–606.

(a) The Commissioner may suspend, revoke, or refuse to renew a limited lines license to sell insurance in connection with, and incidental to, the rental of a vehicle issued under this subtitle after notice and opportunity for a hearing under

Title 2, Subtitle 2 of this article if the motor vehicle rental company or an employee or authorized representative of the motor vehicle rental company has:

(1) willfully violated this article or another law of the State that relates to insurance;

(2) operated without a limited lines license to sell insurance in connection with, and incidental to, the rental of a motor vehicle as required under this subtitle;

(3) failed to provide required disclosures;

(4) offered or sold unapproved insurance products;

(5) failed to hold an appointment with the insurer;

(6) failed to train employees and authorized representatives selling or soliciting, or negotiating the sale of, insurance products on behalf of the motor vehicle rental company; or

(7) misrepresented pertinent facts or policy provisions that relate to the coverage offered or sold pursuant to this subtitle.

(b) A motor vehicle rental company and its employees and authorized representatives may not advertise, represent, or otherwise hold itself out as an authorized insurer, or as an insurance producer, for any kind or subdivision of insurance.

(c) Instead of, or in addition to, suspending or revoking the limited lines license to sell insurance in connection with, and incidental to, the rental of a vehicle, the Commissioner may:

(1) impose on the motor vehicle rental company a penalty of not less than $100 but not more than $2,500 for each violation of this subtitle; and

(2) require that restitution be made to any person who has suffered financial injury because of the violation of this article.

§10–607.

The Commissioner may adopt regulations to carry out the provisions of this subtitle, including regulations concerning the form and content of required disclosures to renters, the training requirements for employees and authorized representatives of motor vehicle rental companies, and the qualifications of the

individuals who provide training for employees and authorized representatives of motor vehicle rental companies.

§10–6A–01.

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

(b) "Authorized representative" means an independent contractor of a peer–to–peer car sharing program.

(c) "Car sharing period" has the meaning stated in § 19–520 of this article.

(d) "Peer–to–peer car sharing program" means a peer–to–peer car sharing program, as defined in § 19–520 of this article, that sells or offers a motor vehicle liability insurance policy issued by an insurer under § 19–520 of this article.

(e) "Peer–to–peer car sharing program agreement" has the meaning stated in § 19–520 of this article.

(f) "Shared vehicle driver" has the meaning stated in § 19–520 of this article.

(g) "Vehicle" means a motor vehicle:

(1) of the private passenger type, including passenger vans, minivans, and sport utility vehicles; or

(2) of the cargo type, including cargo vans, pickup trucks, and trucks that do not require the operator to possess a commercial driver's license.

§10–6A–02.

(a) A peer–to–peer car sharing program shall hold a limited lines license to sell insurance in connection with, and incidental to, the reservation of a shared motor vehicle through the peer–to–peer car sharing program before the peer–to–peer car sharing program or its employees or authorized representatives may sell or offer any policies of insurance in the State to a shared vehicle driver in connection with, and incidental to, a peer–to–peer car sharing program agreement.

(b) A limited lines license issued under this subtitle to sell insurance in connection with, and incidental to, the peer–to–peer car sharing program agreement shall authorize any employee and any authorized representative of the peer–to–peer car sharing program who is trained, under § 10–6A–04(a)(4) of this subtitle, to act on

behalf of, and under the supervision of, a peer–to–peer car sharing program, with respect to the kinds of insurance specified in § 10–6A–04(b)(2) of this subtitle.

(c) The acts of an employee or authorized representative offering or selling insurance coverage on behalf of a peer–to–peer car sharing program shall be deemed the acts of the peer–to–peer car sharing program for the purposes of this subtitle.

(d) A peer–to–peer car sharing program holding a limited lines license issued under this subtitle to sell insurance in connection with, and incidental to, the peer–to–peer car sharing program agreement is not required to treat premiums collected from a shared vehicle driver who purchased insurance from the peer–to–peer car sharing program as funds received in a fiduciary capacity if:

(1) the insurer represented by the peer–to–peer car sharing program has consented in a written agreement, signed by an officer of the insurer, that the premiums do not need to be segregated from other funds received by the peer–to–peer car sharing program under the peer–to–peer car sharing program agreement; and

(2) the charges for insurance coverage are itemized but not billed to the shared vehicle driver separately from the charges for the car sharing period.

(e) An employee or an authorized representative of a peer–to–peer car sharing program who offers or sells insurance coverage on behalf of the peer–to–peer car sharing program:

(1) may be compensated for offering or selling insurance coverage under this subtitle; but

(2) may not be compensated in a manner that is based solely on the number of customers who purchase motor vehicle liability insurance.

(f) This subtitle may not be construed to prohibit payment of compensation to an employee or an authorized representative of a peer–to–peer car sharing program who offers or sells insurance coverage on behalf of the peer–to–peer car sharing program for activities that are incidental to the employee's overall activities.

(g) A peer–to–peer car sharing program that holds a limited lines license to sell insurance in connection with, and incidental to, the peer–to–peer car sharing of a motor vehicle issued under this subtitle shall:

(1) maintain a register, on a form the Commissioner requires, containing:

(i) the names of each employee or authorized representative who offers limited lines insurance on behalf of the peer–to–peer car sharing program; and

(ii) the business addresses of all locations where employees or authorized representatives offer limited lines insurance on behalf of the peer–to–peer car sharing program for car sharing agreements entered into in the State; and

(2) submit the register for inspection by the Commissioner as the Commissioner requires.

§10–6A–03.

(a) The Commissioner shall issue to a peer–to–peer car sharing program, or a franchisee of a peer–to–peer car sharing program, a limited lines license authorizing the peer–to–peer car sharing program to offer or sell insurance in connection with, and incidental to, a peer–to–peer car sharing program agreement if the peer–to–peer car sharing program:

(1) meets the requirements of § 10–6A–04 of this subtitle;

(2) pays the fees for insurance producers required under § 2–112 of this article that are applicable to an insurance producer license; and

(3) submits to the Commissioner any additional information or documentation that the Commissioner requires, including any information or documentation needed to determine the professional competence, good character, and trustworthiness of the peer–to–peer car sharing program.

(b) A limited lines license to sell insurance in connection with, and incidental to, the peer–to–peer car sharing of a motor vehicle issued under this subtitle is subject to the same term and renewal conditions specified for an insurance producer license under § 10–115 of this title.

§10–6A–04.

(a) A limited lines license to sell insurance in connection with, and incidental to, the peer–to–peer car sharing program agreement issued under this subtitle authorizes the peer–to–peer car sharing program to offer or sell, in connection with, and incidental to, a peer–to–peer car sharing program agreement, the insurance products specified in subsection (b) of this section if:

(1) the policies have been filed with and approved by the Commissioner as compliant with § 19–520(d) of this article;

(2) the peer–to–peer car sharing program holds an appointment with each authorized insurer, under § 10–118 of this title, that the peer–to–peer car sharing program intends to represent;

(3) prior to completion of the peer–to–peer car sharing transaction, an employee or authorized representative of the peer–to–peer car sharing program provides to the shared vehicle driver disclosures approved by the Commissioner that:

(i) summarize, clearly and correctly, the material terms of coverage, including limitations or exclusions;

(ii) identify the authorized insurer or insurers;

(iii) specify that the policies offered by the peer–to–peer car sharing program may provide a duplication of coverage already provided by a shared vehicle driver's personal automobile insurance policy, homeowner's insurance policy, personal liability insurance policy, or other source of coverage;

(iv) specify that the purchase of the coverage offered by the peer–to–peer car sharing program is not required in order for the shared vehicle driver to participate in the peer–to–peer car share;

(v) describe the process by which the shared vehicle driver can file a claim; and

(vi) specify that any excess liability coverage purchased by the shared vehicle driver may duplicate coverage required to be provided under § 18.5–102 of the Transportation Article;

(4) the peer–to–peer car sharing program provides a training program, approved by the Commissioner, for each employee or authorized representative who sells, solicits, or negotiates insurance coverage under this subtitle that includes:

(i) instruction about the kinds of insurance specified in subsection (b) of this section that can be offered to shared vehicle drivers;

(ii) instruction that the employee or authorized representative is required to inform a shared vehicle driver that the purchase of any insurance from the peer–to–peer car sharing program is not required in order for the shared vehicle driver to participate in the peer–to–peer car share; and

(iii) instruction that the employee or authorized representative is required to inform a shared vehicle driver that the shared vehicle driver may have insurance policies that already provide the coverage being offered by the peer–to–peer car sharing program; and

(5) an employee or authorized representative who offers or sells insurance coverage on behalf of the peer–to–peer car sharing program informs a shared vehicle driver that the policies offered by the peer–to–peer car sharing program may duplicate coverage already provided by the shared vehicle driver's personal automobile insurance policy, homeowner's insurance policy, personal liability insurance policy, or other source of coverage.

(b) A limited lines license to sell insurance in connection with, and incidental to, a peer–to–peer car sharing program agreement issued under this subtitle authorizes the peer–to–peer car sharing program to offer or sell insurance policies under this subtitle that are:

(1) in the amount of, in excess of, or optional to the coverages required to be provided under § 19–520(d)(1) of this article; and

(2) one of the following kinds of insurance:

(i) bodily injury liability;

(ii) property damage liability;

(iii) uninsured motorist insurance; or

(iv) if approved by the Commissioner, any other insurance coverage that is appropriate in connection with a peer–to–peer car sharing program agreement.

§10–6A–06.

(a) The Commissioner may refuse to issue a limited lines license or suspend, revoke, or refuse to renew a limited lines license to sell insurance in connection with, and incidental to, a peer–to–peer car sharing program agreement issued under this subtitle after notice and opportunity for a hearing under Title 2, Subtitle 2 of this article if the peer–to–peer car sharing program or an employee or authorized representative of the peer–to–peer car sharing program has:

(1) willfully violated this article or another State law that relates to insurance;

(2) operated without a limited lines license to sell insurance in connection with, and incidental to, a peer–to–peer car sharing program agreement as required under this subtitle;

(3) failed to provide required disclosures;

(4) offered or sold unapproved insurance products;

(5) failed to hold an appointment with the insurer;

(6) failed to train employees and authorized representatives selling or soliciting, or negotiating the sale of, insurance products on behalf of the peer–to–peer car sharing program; or

(7) misrepresented pertinent facts or policy provisions that relate to the coverage offered or sold under this subtitle.

(b) A peer–to–peer car sharing program and its employees and authorized representatives may not advertise, represent, or otherwise hold itself out as an authorized insurer, or as an insurance producer, for any kind or subdivision of insurance.

(c) Instead of, or in addition to, suspending or revoking a limited lines license to sell insurance in connection with, and incidental to, a peer–to–peer car sharing program agreement, the Commissioner may:

(1) impose on the peer–to–peer car sharing program a penalty of not less than $100 but not more than $2,500 for each violation of this subtitle; and

(2) require that restitution be made to any person who has suffered financial injury because of the violation of this article.

§10–6A–07.

The Commissioner may adopt regulations to carry out the provisions of this subtitle, including regulations concerning:

(1) the form and content of required disclosures to shared vehicle drivers;

(2) the training requirements for employees and authorized representatives of a peer–to–peer car sharing program; and

(3) the qualifications of the individuals who provide training for employees and authorized representatives of a peer–to–peer car sharing program.

§10–701.

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

(b) "Covered customer" means a customer who elects to purchase coverage under a policy of portable electronics insurance issued to a vendor.

(c) "Customer" means a person who purchases or leases portable electronics or purchases service related to the use of portable electronics.

(d) "Location" means:

(1) a physical location in the State; or

(2) a website, call center site, or similar location where coverage under a policy of portable electronics insurance is offered or sold to residents of the State.

(e) (1) "Portable electronics" means:

(i) an electronic device, including its accessories, that:

1. is easily or conveniently transported by hand by an individual; and

2. is used for communication, viewing, listening, recording, gaming, computing, or global positioning; and

(ii) any other electronic device that is portable in nature that the Commissioner approves.

(2) "Portable electronics" includes:

(i) cellular or satellite phones;

(ii) pagers;

(iii) personal global positioning satellite units;

(iv) portable computers;

(v) portable audio listening, video viewing, or recording devices;

(vi) digital cameras;

(vii) video camcorders;

(viii) portable gaming systems;

(ix) docking stations; and

(x) automatic answering devices.

(3) "Portable electronics" does not include telecommunications switching equipment, transmission wires, cell site transceiver equipment, or other equipment and systems used by telecommunications companies to provide telecommunications service to consumers.

(f) (1) "Portable electronics insurance" means insurance that provides coverage for the repair or replacement of portable electronics, including coverage against one or more of the following causes of loss:

(i) loss by disappearance;

(ii) theft;

(iii) mechanical failure;

(iv) malfunction;

(v) damage; and

(vi) any other applicable peril, as approved by the Commissioner.

(2) "Portable electronics insurance" does not include:

(i) a service contract governed by Title 14, Subtitle 4 of the Commercial Law Article that does not include coverage for loss by disappearance or theft;

(ii) a policy of insurance covering a seller's or a manufacturer's obligations under a warranty; or

(iii) a homeowner's, renter's, motor vehicle, or similar policy that covers loss or theft of portable electronics.

(g) "Portable electronics transaction" means:

(1) the sale or lease of portable electronics by a vendor to a customer; or

(2) the sale of service related to the use of portable electronics by a vendor to a customer.

(h) "Supervising entity" means a business entity that is:

(1) an authorized insurer; or

(2) a licensed insurance producer that is appointed by an insurer to supervise the administration of a portable electronics insurance program.

(i) "Vendor" means a person in the business of leasing, selling, or providing portable electronics, or selling or providing service related to the use of portable electronics, to customers in the State.

§10–702.

This subtitle does not apply to:

(1) a service contract governed by Title 14, Subtitle 4 of the Commercial Law Article that does not include coverage for loss by disappearance or theft;

(2) a policy of insurance covering a seller's or a manufacturer's obligations under a warranty; or

(3) a homeowner's, renter's, motor vehicle, or similar policy that covers loss or theft of portable electronics.

§10–703.

(a) A vendor shall hold a limited lines license to sell coverage under a policy of portable electronics insurance before the vendor or the employees of or authorized representatives of the vendor may sell or offer to sell coverage under a policy of portable electronics insurance to a customer.

(b) A limited lines license issued under this subtitle shall also authorize any salaried or hourly employee or authorized representative of the vendor to sell coverage under a policy of portable electronics insurance to a customer only if the employee or authorized representative is:

(1) trained under § 10–705 of this subtitle to act on behalf of the vendor; and

(2) acting under the supervision of the vendor.

(c) The acts of an employee or authorized representative offering to sell or selling coverage under a policy of portable electronics insurance shall be deemed the acts of the vendor for the purposes of this subtitle.

(d) (1) A vendor may bill and collect premiums from covered customers for coverage under a policy of portable electronics insurance.

(2) A vendor that bills and collects premiums under this section is not required to maintain the premiums collected in a segregated account if:

(i) the vendor's appointing insurer agrees in writing that segregation of funds is not required;

(ii) the vendor remits the funds collected to the appointing insurer or that insurer's appointed insurance producer within 60 days after receipt; and

(iii) the funds received by the vendor from a covered customer for the sale of portable electronics insurance are held in trust by the vendor in a fiduciary capacity for the benefit of the vendor's appointing insurer.

(3) (i) Except as provided in subparagraph (ii) of this paragraph, the premiums for coverage under a policy of portable electronics insurance shall be separately itemized from the charges for the purchase or lease of the portable electronics.

(ii) If portable electronics insurance coverage is included in the price of the purchase or lease of portable electronics or related services, the vendor shall provide clear and conspicuous written notice to the customer that the portable electronics insurance coverage is included with the portable electronics or related services.

(e) (1) A vendor may receive compensation for billing and collection services under a policy of portable electronics insurance.

(2) A vendor or an authorized representative of the vendor may compensate the employees of the vendor or of the authorized representative in a manner that does not depend solely on the sale of portable electronics insurance.

§10–704.

(a) The Commissioner shall issue to a vendor a limited lines license authorizing the vendor to sell or offer to sell coverage under a policy of portable electronics insurance to a customer if the vendor:

(1) meets the requirements of § 10–705 of this subtitle;

(2) pays the fees for insurance producers required under § 2–112 of this article that are applicable to an insurance producer license; and

(3) submits to the Commissioner a sworn application for a limited lines license under this subtitle on the form required by the Commissioner.

(b) (1) Subject to paragraph (2) of this subsection, a vendor shall provide the name, residence address, and any other information required by the Commissioner for an officer or employee of the vendor who is designated by the vendor as the person responsible for the vendor's compliance with the requirements of this subtitle.

(2) If the vendor derived more the 25% of its total revenue in the preceding year from the sale of portable electronics insurance, the vendor shall provide the information required in paragraph (1) of this subsection for all officers, directors, and shareholders of record under the federal securities law.

(c) (1) The supervising entity shall maintain a registry of all vendor locations that are authorized to sell or offer portable electronics insurance coverage in the State.

(2) On request by the Commissioner, the registry shall be open to inspection and examination no later than 10 days after the request.

(d) A limited lines license under this subtitle is subject to the same term and renewal conditions that are specified for an insurance producer license under § 10–115 of this title.

§10–705.

(a) A limited lines license to offer or sell coverage under a policy of portable electronics insurance to a customer issued under this subtitle authorizes a vendor or an authorized representative of the vendor to sell coverage under a policy of portable electronics insurance to customers at each location at which the vendor engages in portable electronics transactions in the State if:

(1) the portable electronics insurance policies have been filed with and approved by the Commissioner;

(2) the vendor holds an appointment under § 10–118 of this title with each authorized insurer that the vendor intends to represent;

(3) at each location where coverage under a policy of portable electronics insurance is offered or sold to customers, the vendor provides to the customers disclosures approved by the Commissioner that:

(i) summarize the material terms of the coverage under the policy of portable electronics insurance including:

1. the identity of the insurer;

2. the premium to be paid;

3. any applicable deductible;

4. the major features of the benefits of the coverage; and

5. the key terms and conditions of coverage including whether the portable electronics may be repaired or replaced with similar make and model reconditioned or nonoriginal manufacturer parts or equipment;

(ii) 1. state that portable electronics insurance may duplicate insurance coverage already provided by a customer's homeowner's insurance policy, renter's insurance policy, or other source of insurance coverage; and

2. state that the purchase of coverage under a policy of portable electronics insurance would make this coverage primary to any other coverage, including duplicate coverage;

(iii) state that the purchase of coverage under a policy of portable electronics insurance is not required in order to enter into the portable electronics transaction;

(iv) describe the process for filing a claim if the customer elects to purchase coverage under a policy of portable electronics insurance including a description of:

1. any requirement to pay a deductible;

2. any requirement to return portable electronics;

3. the maximum fee applicable if the customer fails to comply with a return requirement; and

4. any requirement to file a proof of loss;

(v) state that:

1. the customer may cancel coverage under the portable electronics insurance at any time; and

2. if the customer cancels coverage under the portable electronics insurance, any unearned premium will be refunded to the person paying the premium in accordance with applicable law; and

(vi) provide the toll–free consumer hotline telephone number of the Administration; and

(4) the vendor provides a training program, approved by the Commissioner, for any employee or authorized representative who sells coverage under a policy of portable electronics insurance to customers under this subtitle that includes instruction:

(i) about the portable electronics insurance offered to customers of the vendor;

(ii) that the employee or authorized representative may not represent or imply to a customer that purchase of coverage under a policy of portable electronics insurance is required in order to purchase portable electronics;

(iii) that portable electronics insurance may duplicate insurance coverage already provided by a customer's homeowner's insurance policy, renter's insurance policy, or other source of insurance coverage; and

(iv) about the other disclosures required by item (3) of this subsection.

(b) (1) The training required under subsection (a)(4) of this section may be provided in electronic form.

(2) If training is conducted in electronic form, the supervising entity shall implement a supplemental education program about the portable electronics insurance product that is conducted and overseen by licensed insurance producers employed by the supervising entity.

§10–706.

Coverage under a policy of portable electronics insurance sold under this subtitle is primary to any other valid and collectible coverage.

§10–707.

(a) The Commissioner may suspend, revoke, or refuse to renew a limited lines license issued under this subtitle after notice and opportunity for a hearing under Title 2, Subtitle 2 of this article if the vendor or an employee or authorized representative of the vendor has:

(1) willfully violated this article or another law of the State that relates to insurance;

(2) operated without a limited lines license as required under this subtitle;

(3) failed to provide the disclosures required under § 10–705 of this subtitle;

(4) offered or sold unapproved insurance products;

(5) failed to hold an appointment with an insurer;

(6) failed to train employees or authorized representatives as required under § 10–705 of this subtitle; or

(7) misrepresented pertinent facts or policy provisions concerning a policy of portable electronics insurance.

(b) A vendor and the employees and authorized representatives of the vendor may not advertise, represent, or otherwise hold themselves out as an authorized insurer or as an insurance producer for any kind or subdivision of insurance, except as provided in this subtitle.

(c) Instead of, or in addition to, suspending or revoking a limited lines license issued under this subtitle, the Commissioner may:

(1) impose on the vendor a penalty of not more than $2,500 for each violation of this subtitle; and

(2) require that restitution be made to any person who has suffered financial injury because of a violation of this subtitle.

§10–708.

The Commissioner may adopt regulations to carry out this subtitle, including regulations concerning:

(1) the form and content of required disclosures to customers;

(2) the training requirements for employees and authorized representatives of vendors; and

(3) the qualifications of the individuals who provide training.

§10–801.

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

(b) "Authorized representative" means an independent contractor of an owner of a self–service storage facility.

(c) "Business entity" has the meaning stated in § 5–511 of this article.

(d) "Designated responsible producer" means an individual who:

(1) holds a limited lines license under this subtitle; and

(2) is designated by the owner as responsible for the owner's compliance with insurance laws, rules, and regulations of the State.

(e) "Occupant" means a person or the person's sublessee, successor, or assignee who is entitled to the use of a leased space at a self–service storage facility.

(f) "Owner" means the owner of a self–service storage facility.

(g) (1) "Personal property" means movable property that is not affixed to land.

(2) "Personal property" includes:

(i) goods, wares, merchandise, household items, and furnishings;

(ii) a vehicle, as defined in § 11–176 of the Transportation Article; and

(iii) watercraft and motorized watercraft.

(h) "Self–service storage facility" means any real property that is used for renting or leasing storage space in which the occupants themselves customarily store and remove personal property on a self–service basis.

(i) "Self–service storage producer" means:

(1) an owner of a self–storage facility who holds a limited lines license under this subtitle; or

(2) a designated responsible producer.

§10–802.

(a) The Commissioner shall issue a limited lines license as a self–service storage producer to:

(1) an owner of a self–service storage facility who meets the requirements of this subtitle; and

(2) an individual who:

(i) is designated by the owner as responsible for the owner's compliance with insurance laws, rules, and regulations of the State; and

(ii) meets the requirements of this subtitle.

(b) A limited lines license as a self–service storage producer authorizes the licensee to offer or sell insurance only:

(1) in connection with and incidental to the rental of storage space at a self–service storage facility on a master, a corporate, a commercial, a group, or an individual policy basis; and

(2) with respect to personal property insurance that provides coverage to occupants at the self–service storage facility, for the loss of or damage to stored personal property that occurs at the self–service storage facility.

(c) An owner of a self–service storage facility may not offer or sell insurance under this subtitle unless the owner, as a business entity:

(1) holds a limited lines license under this subtitle; and

(2) has a designated responsible producer.

(d) An owner of a self–service storage facility is not required to be licensed under this subtitle merely to display and make available to prospective occupants brochures and other promotional materials created by or on behalf of an authorized insurer provided that the owner does not engage in the sale, solicitation, or negotiation of insurance advertised in the brochures and promotional materials.

§10–803.

(a) An applicant for a limited lines license as a self–service storage producer shall file a written application with the Commissioner in the form the Commissioner requires.

(b) The application shall include:

(1) the physical address of the company headquarters of the self–service storage producer; and

(2) a list of all self–service storage facilities where the self–service storage producer will conduct business under the limited lines license.

§10–804.

(a) A self–service storage producer is not required to have a separate limited lines license for each self–service storage facility where insurance is offered or sold.

(b) A self–service storage producer shall notify the Commissioner of:

(1) any additional locations of self–service storage facilities in the State where the self–service storage producer will do business under the limited lines license within 30 days after commencing business at those locations; and

(2) those locations of self–service storage facilities in the State where the self–service storage producer will cease to do business under the limited lines license within 30 days after ceasing business at those locations.

§10–805.

A self–service storage producer is not required to meet the continuing education requirements for insurance producers under Subtitle 1 of this title.

§10–806.

A self–service storage producer may not offer or sell insurance under this subtitle unless:

(1) the self–service storage producer makes readily available to prospective occupants brochures or other written materials that:

(i) summarize the material terms of insurance coverage offered to occupants, including the identity of the insurer and the price, benefits, deductibles, exclusions, and conditions of the insurance;

(ii) disclose that the policies offered by the self–service storage producer may provide coverage that is comparable to coverage already provided by an occupant's homeowner's insurance policy, renter's insurance policy, vehicle insurance policy, watercraft insurance policy, or other type of property insurance coverage;

(iii) state whether the purchase of coverage under a policy offered under this subtitle would make the coverage primary to any other coverage, including duplicate coverage;

(iv) state that the purchase of insurance coverage is not required as a condition of rental at a self–service storage facility if the occupant presents evidence of other applicable insurance coverage;

(v) describe the process for filing a claim; and

(vi) include contact information for filing a complaint with the Commissioner;

(2) all costs related to the insurance are stated in writing;

(3) evidence of coverage in a form approved by the Commissioner is provided to each occupant who purchases the coverage;

(4) the insurance is provided by an insurer authorized to transact the applicable kinds of insurance in the State; and

(5) as a condition of the sale of insurance, the self–service storage producer:

(i) requires the occupant to execute a document acknowledging the amount of coverage under the policy purchased; and

(ii) if the occupant has contents in the leased space of a value greater than the coverage under the policy:

1. advises the occupant in writing to contact a property and casualty insurance producer licensed under Subtitle 1 of this title to obtain additional coverage to reflect the value of the contents in the leased space; and

2. requires the occupant to acknowledge receipt of the notice under item 1 of this item.

§10–807.

(a) An employee or authorized representative of a self–service storage producer may act on behalf of and under the supervision of the self–service storage producer in matters relating to the conduct of business under a limited lines license issued under this subtitle if the employee or authorized representative receives the training under § 10–808 of this subtitle.

(b) The conduct of an employee or authorized representative of a self–service storage producer acting within the scope of employment or agency is considered to be the conduct of the self–service storage producer for purposes of this subtitle.

(c) The designated responsible producer:

(1) is responsible for the acts of the employees or authorized representatives of the owner who offer or sell limited lines insurance, as authorized under this subtitle, on behalf of the owner;

(2) shall use reasonable means to ensure compliance by the employees or authorized representatives with this subtitle;

(3) shall maintain a register, on a form the Commissioner requires, of each employee or authorized representative of the owner who offers limited lines insurance on behalf of the owner; and

(4) shall submit the register for inspection by the Commissioner within 30 days after receiving a request by the Commissioner for inspection.

§10–808.

(a) Each self–service storage producer shall provide a training program approved by the Commissioner for employees and authorized representatives of the self–service storage producer.

(b) The training program required by subsection (a) of this section shall:

(1) include general information about homeowners, renters, business, and similar insurance that an occupant may have that may provide coverage for property located in a self–storage facility;

(2) include information about the material terms of insurance coverage offered to occupants under this subtitle, including the price, benefits, deductibles, exclusions, and conditions of the insurance;

(3) provide basic instruction about the provisions of this subtitle; and

(4) include any other information the Commissioner may require.

§10–809.

A self–service storage producer or any of its employees or authorized representatives may not:

(1) offer or sell insurance except in connection with and incidental to the rental of space at a self–service storage facility; or

(2) advertise, represent, or otherwise hold themselves out as authorized insurers or licensed insurance producers.

§10–810.

(a) The Commissioner may suspend, revoke, or refuse to renew a limited lines license issued under this subtitle after notice and opportunity for a hearing under Title 2, Subtitle 2 of this article if the self–service storage producer or an employee or authorized representative of the self–service storage producer who offers or sells limited lines insurance on behalf of the self–service storage producer has:

(1) willfully violated this article or another law of the State that relates to insurance;

(2) operated without a limited lines license as required under this subtitle;

(3) failed to provide the disclosures required under § 10–806 of this subtitle;

(4) offered or sold unapproved insurance products;

(5) failed to train employees or authorized representatives as required under § 10–808 of this subtitle; or

(6) misrepresented pertinent facts or policy provisions concerning a policy for a self–service storage facility.

(b) Instead of, or in addition to, suspending or revoking a limited lines license issued under this subtitle, the Commissioner may:

(1) impose on the self–service storage producer a penalty of not more than $2,500 for each violation of this subtitle; and

(2) require that restitution be made to any person who has suffered financial injury because of a violation of this subtitle.

§10–811.

This subtitle may not be construed to prohibit:

(1) an insurer from paying and a self–service storage producer from receiving a commission, service fee, or any other valuable consideration dependent on the sale of insurance; or

(2) the payment of compensation by the self–service storage producer to an employee or authorized representative who offers or sells limited lines insurance that is incidental to the employee's or authorized representative's overall compensation and not dependent on the sale of insurance.

§10–812.

The Commissioner may adopt regulations to carry out this subtitle, including regulations concerning:

(1) the form and content of required disclosures to customers;

(2) the training requirements for employees or authorized representatives who offer or sell limited lines insurance under this subtitle; and

(3) the qualifications of the individuals who provide the training required under § 10–808 of this subtitle.

§11–101.

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

(b) "Advisory organization" means a group, association, or other organization of insurers, located within or outside the State, that helps insurers that make their own filings or rating organizations in rate making, by collecting and providing loss or expense statistics or by submitting recommendations, but that does not make filings under this title.

(c) "Rate" means rate of premium, policy or membership fee, or another charge made by an insurer for or in connection with an insurance contract or policy.

(d) "Rating organization" means a person licensed under § 11-218 of this title.

(e) "Supplementary rate information" includes a manual or plan of rates, statistical plan, classification, rating schedule, minimum premium, policy fee, rating rule, rate-related underwriting rule, minimum rate, class rate, rating plan, manual or schedule of rates or premiums, rule or regulation that governs the setting or making of rates or premiums, and any other information, not otherwise inconsistent with the purposes of this title, that the Commissioner requires by regulation.

(f) "Working day" means a day when the Administration is open for business.

§11–201.

(a) The purposes of this subtitle are:

(1) to promote the public welfare by regulating insurance rates so that they are not excessive, inadequate, or unfairly discriminatory; and

(2) to authorize and regulate cooperative action among insurers in rate making and in other matters within the scope of this subtitle.

(b) This subtitle is not intended:

(1) to prohibit or discourage reasonable competition; or

(2) to prohibit or, except to the extent necessary to accomplish the purposes stated in subsection (a) of this section, to encourage uniformity in insurance rates, rating systems, rating plans, or rating practices.

(c) This subtitle shall be interpreted liberally to carry out the provisions of this section.

§11–202.

(a) (1) This subtitle applies to all types of insurers.

(2) Except as provided in subsection (b) of this section, this subtitle applies to:

(i) property insurance;

(ii) casualty insurance;

(iii) surety insurance;

(iv) marine insurance; and

(v) wet marine and transportation insurance.

(b) This subtitle does not apply to:

(1) reinsurance, except as provided in § 11–222 of this subtitle;

(2) insurance of vessels or craft or their cargoes, marine protection and indemnity insurance, or insurance of other risks commonly insured under policies of marine insurance, as distinguished from inland marine insurance;

(3) insurance against loss of or damage to aircraft including their accessories and equipment, or insurance against liability, other than workers'

compensation insurance or employer's liability insurance, arising out of the ownership, maintenance, or use of aircraft; or

(4) title insurance, except for §§ 11–218 through 11–227 of this subtitle.

(c) If a kind of insurance, subdivision or combination of kinds of insurance, or type of coverage is subject to this subtitle and is also subject to regulation by another rate regulatory provision of the statutes of the State, an insurer to which both provisions are otherwise applicable shall file with the Commissioner a designation as to which rate regulatory provision is applicable to it with respect to that kind of insurance, subdivision or combination of kinds of insurance, or type of coverage.

§11–205.

(a) All rates shall be made in accordance with the principles set forth in this section.

(b) Uniformity among insurers in matters within the scope of this subtitle is neither required nor prohibited.

(c) Due consideration shall be given to:

(1) past and prospective loss experience within and outside the State;

(2) conflagration and catastrophe hazards, if any;

(3) past and prospective expenses, both countrywide and those specially applicable to the State;

(4) underwriting profits;

(5) contingencies;

(6) investment income from unearned premium reserve and reserve for losses;

(7) dividends, savings, or unabsorbed premium deposits allowed or returned by insurers to policyholders; and

(8) all other relevant factors within and outside the State.

(d) Rates may not be excessive, inadequate, or unfairly discriminatory.

(e) The systems of expense provisions included in the rates for use by an insurer or group of insurers may differ from those of other insurers or groups of insurers to reflect the requirements of the operating methods of the insurer or group with respect to a kind of insurance, or with respect to a subdivision or combination of kinds of insurance for which separate expense provisions are applicable.

(f) (1) Risks may be grouped by classifications for the establishment of rates and minimum premiums.

(2) Classification rates may be modified to produce rates for individual risks in accordance with rating plans that establish standards for measuring variations in hazards or expense provisions, or both.

(3) The standards may measure any difference among risks that are demonstrated objectively to the Commissioner to have had a direct and substantial effect on losses or expenses.

(4) Notwithstanding any other provision of this subsection, a rate may not be based wholly or partly on geographic area itself, as opposed to underlying risk considerations, even though expressed in geographic terms.

(g) For fire insurance rates, consideration shall be given to experience during a period of not less than the most recent 5-year period for which experience is available.

§11–206.

(a) (1) Except as otherwise provided in this section, each insurer shall file with the Commissioner all rates, supplementary rate information, policy forms, and endorsements and all modifications of rates, supplementary rate information, policy forms, and endorsements that the insurer proposes to use.

(2) Each filing shall state its proposed effective date and shall indicate the character and extent of the coverage contemplated.

(b) (1) (i) If a filing is not accompanied by the information on which the insurer supports the filing and the Commissioner does not have sufficient information to determine whether the filing meets the requirements of this subtitle, the Commissioner shall require the insurer to provide supporting information for the filing within 60 days.

(ii) If the Commissioner requires the filer to provide supporting information, the waiting period under subsection (g) of this section begins on the date the supporting information is provided.

(2) The information provided in support of a filing may include:

(i) the judgment of the filer;

(ii) the filer's interpretation of any statistical data relied on;

(iii) the experience of other filers; and

(iv) any other relevant factors.

(c) Each filing shall include the experience of the filer.

(d) A filing and any supporting information shall be open to public inspection as soon as filed.

(e) An insurer may satisfy its obligation to make filings by:

(1) being a member of or subscriber to a licensed rating organization that makes filings; and

(2) authorizing the Commissioner to accept filings on its behalf from the rating organization.

(f) The Commissioner shall review each filing as soon as reasonably possible after it is made to determine whether it meets the requirements of this subtitle.

(g) (1) (i) Except as provided in subsections (h) and (i) of this section, a filing may not take effect until 30 working days after it is filed with the Commissioner.

(ii) By written notice to the filer during the initial 30–day waiting period that the Commissioner needs additional time for consideration of the filing, the Commissioner may extend the waiting period for an additional period not exceeding 30 working days.

(2) On written application by the filer, the Commissioner may authorize a filing that the Commissioner has reviewed to become effective before the expiration of the waiting period or any extension of the waiting period or at a later date.

(3) A filing is deemed approved unless disapproved by the Commissioner during the waiting period or any extension of the waiting period.

(4) A filing may be withdrawn or amended by the filer at any time before approval.

(5) After approval or disapproval of a filing, the withdrawal or amendment of the filing is subject to the approval of the Commissioner in accordance with this section.

(h) (1) Inland marine risks that by general custom of the business are not written according to manual rates or rating plans need not be filed.

(2) Notwithstanding paragraph (1) of this subsection, specific inland marine rates on risks specially rated by a rating organization shall be filed, become effective when filed, and remain effective until the Commissioner finds the filing does not meet the requirements of this subtitle.

(i) A special filing with respect to a surety or guarantee bond required by law, by court, by executive order, or by order, rule, or regulation of a public body, not covered by a previous filing shall become effective when filed and remain effective until the Commissioner finds that the filing does not meet the requirements of this subtitle.

(j) (1) In this subsection, "exempt commercial policyholder" means a person that:

(i) pays annual aggregate property and casualty premiums for commercial insurance policies issued in the State during the current or preceding calendar year of $25,000 or more; and

(ii) meets any two of the following criteria:

1. generates annual revenues or sales in excess of $5,000,000;

2. possesses a net worth in excess of $2,500,000;

3. employs at least 25 full–time employees;

4. is a nonprofit organization or public body with an annual budget of at least $5,000,000; or

5. is a municipal corporation with a population of at least 15,000.

(2) The filing requirements of this section do not apply to rates, supplementary rate information, policy forms, and endorsements and to modifications of rates, supplementary rate information, policy forms, and endorsements issued to an exempt commercial policyholder.

(3) (i) An exempt commercial policyholder must certify in writing, on a form approved by the Commissioner, to the insurer issuing coverage that it meets the criteria necessary for exemption from rate and form filing requirements.

(ii) The certification must include:

1. specific reference to the optional criteria that the insured has satisfied to qualify as an exempt commercial policyholder;

2. information required by the Commissioner for the purpose of determining the annual aggregate premiums of the insured for purposes of paragraph (1)(i) of this subsection; and

3. an acknowledgment by the insured that the rate, supplementary rate information, policy form, endorsement, or modification intended for use has not been filed with the Commissioner.

(4) This subsection does not apply to the filing of workers' compensation insurance rate and policy forms.

(5) The Commissioner may require, by regulation, that insurers provide information to the Administration on the number and types of policies written for exempt commercial policyholders under this subsection.

(6) On written request of the Commissioner, an insurer shall file with the Commissioner a form or endorsement issued to an exempt commercial policyholder.

(7) Except for the exemption from rate and form filing requirements under this section, a rate, supplementary rate information, form, or endorsement issued to an exempt commercial policyholder is subject to all applicable provisions of this article.

§11–207.

(a) (1) By written order, the Commissioner may suspend or modify the filing requirement for a kind of insurance, subdivision or combination of kinds of insurance, or for classes of risks, for which it is not practicable to file rates before they are used.

(2) The Commissioner shall adopt regulations for the suspension or modification of filing requirements.

(b) A regulation adopted or order issued under this section shall be made known to the insurers and rating organizations affected by the regulation or order.

(c) The Commissioner may make any examination that the Commissioner considers advisable to determine if the rates affected by an order issued under this section meet the standards set forth in § 11-205 of this subtitle.

§11–208.

(a) Unless the filer demonstrates that a proposed rate is not excessive, inadequate, or unfairly discriminatory, the Commissioner may disapprove the filing.

(b) (1) If, during the waiting period or any extension of the waiting period provided under § 11-206(g) of this subtitle, the Commissioner finds that a filing does not meet the requirements of this subtitle, the Commissioner shall send written notice of disapproval to the filer.

(2) The notice of disapproval shall specify the ways in which the filing fails to meet the requirements of this subtitle and shall state that the filing may not become effective.

(c) (1) If, within 30 days after a filing made under § 11-206(h) or (i) of this subtitle, the Commissioner finds that the filing does not meet the requirements of this subtitle, the Commissioner shall send written notice of disapproval to the filer.

(2) The notice of disapproval shall specify the ways in which the filing fails to meet the requirements of this subtitle and shall state when, within a reasonable period after the notice, the filing will no longer be effective.

(3) Disapproval under this subsection does not affect a contract made or issued before the expiration of the period set forth in the notice.

(d) (1) If, after the applicable review period under subsection (b) or (c) of this section, the Commissioner finds that a filing does not meet the requirements of this subtitle, the Commissioner shall issue to the filer an order that specifies the ways

in which the filing fails to meet the requirements of this subtitle and states when, within a reasonable period after the order, the filing will no longer be effective.

(2) (i) The Commissioner shall hold a hearing before issuing an order under paragraph (1) of this subsection.

(ii) The Commissioner shall give written notice of the hearing to the filer at least 10 days before the hearing.

(iii) The notice shall specify the matters to be considered at the hearing.

(3) An order issued under this subsection does not affect a contract or policy made or issued before the expiration of the period set forth in the order.

(e) (1) Except for the filer, any person aggrieved with respect to a filing that is in effect or that has been filed but is not yet effective may apply in writing to the Commissioner for a hearing on the filing.

(2) An application under this subsection shall specify the grounds on which the applicant will rely.

(3) If the Commissioner finds that the application is made in good faith, that the applicant would be aggrieved if the specified grounds are established, and that the grounds otherwise justify a hearing, the Commissioner shall hold a hearing within 30 days after receipt of the application.

(4) The Commissioner shall give written notice of the hearing to the applicant and each filer at least 10 days before the hearing.

(5) If, after the hearing, the Commissioner finds that the filing does not meet the requirements of this subtitle, the Commissioner shall issue to the filer an order that specifies the ways in which the filing fails to meet the requirements of this subtitle and states when, within a reasonable period after the order, the filing will no longer be effective.

(6) The Commissioner shall send a copy of an order issued under this subsection to the applicant.

(7) An order issued under this subsection does not affect a contract or policy made or issued before the expiration of the period set forth in the order.

§11–209.

(a) (1) Notwithstanding any other provision of this subtitle, an insurer may reduce its rates previously approved by the Commissioner by filing the reduced rates with the Commissioner within 30 days after the reduced rates become effective.

(2) An insurer that has reduced its rates in accordance with paragraph (1) of this subsection may withdraw the reduction wholly or partly by filing revised rates at a level not higher than the level approved by the Commissioner before the reduction within 30 days after they become effective.

(b) If, after notice and a hearing, the Commissioner finds that the rates produced are in violation of this subtitle, the Commissioner may revoke a reduction of rates made in accordance with this section.

§11–210.

On written application of the insured that states its reasons for requesting the rate, filed with and approved by the Commissioner, a rate in excess of that provided by a filing otherwise applicable may be used on a specific risk.

§11–211.

(a) Within a reasonable time after a filer receives a written request for information about a filing and on payment of a reasonable charge, the filer shall provide all pertinent information about the filing to an insured affected by the filing or the authorized representative of the insured.

(b) At the time of filing a proposed rate increase with the Commissioner, an insurer that provides professional liability insurance to a physician or other health care provider shall notify each policyholder in writing that:

(1) the insurer has filed a proposed rate increase with the Commissioner;

(2) a hearing may be requested with respect to the filing under § 11-208(e) of this subtitle; and

(3) an order, hearing, or refusal of a hearing by the Commissioner may be appealed under Subtitle 5 of this title.

§11–212.

(a) Each filer shall provide reasonable means within the State by which a person aggrieved by the application of its rating system may be heard in person or by an authorized representative on the person's written request to review the manner

in which the rating system has been applied in connection with the insurance afforded the aggrieved person.

(b) If the filer fails to grant or reject the aggrieved person's request within 30 days after it is made, the applicant may proceed as if the application had been rejected.

(c) Within 30 days after written notice of the action of a filer on a request for review, any person affected by the action may appeal to the Commissioner.

(d) (1) The Commissioner shall hold a hearing on the action of the filer.

(2) The Commissioner shall give written notice of the hearing to the appellant and filer at least 10 days before the hearing.

(3) After the hearing, the Commissioner may affirm or reverse the action.

§11–213.

(a) All homeowner's insurance rates shall be made in accordance with the principles set forth in this section.

(b) (1) An insurer under a homeowner's insurance policy may not classify or maintain an insured for a period longer than 3 years in a classification that entails a higher premium because of a specific claim.

(2) For the purpose of determining whether to classify an insured in a classification that entails a higher premium, an insurer may review only a period not greater than 3 years before:

(i) if the policy has not yet been issued:

1. the date of the application; or

2. the proposed effective date of the policy; or

(ii) on renewal of a policy, the effective date of the renewal.

(3) (i) The removal of, reduction of, or refusal to apply a discount is not a violation of this subsection if the claim resulting in the removal of, reduction of, or refusal to apply the discount was filed not more than 5 years before the removal, reduction, or refusal.

(ii) Subparagraph (i) of this paragraph may not be construed to prevent an insurer from granting a claim–free discount to an insured.

§11–214.

(a) Each insurer that provides a private passenger automobile insurance policy shall provide to the policyholder at the time of issuance or renewal of the policy a statement that:

(1) defines the policyholder's rate classifications; and

(2) if the insurer is an authorized insurer, includes a summary, in a form approved by the Commissioner, of the insurer's approved surcharge plan or driver record point plan for that policy.

(b) The statement must be sufficiently clear and specific so that an individual of average intelligence can identify the classifications without making further inquiry.

§11–215.

(a) All automobile insurance rates shall be made in accordance with the principles set forth in this section.

(b) (1) An insurer under an automobile liability insurance policy may not classify or maintain an insured for a period longer than 3 years in a classification that entails a higher premium:

(i) because of a specific claim; or

(ii) because of the insured's driving record.

(2) For the purpose of determining whether to classify an insured in a classification that entails a higher premium, an insurer may review only a period not greater than 3 years before:

(i) if the policy has not yet been issued:

1. the date of the application; or

2. the proposed effective date of the policy; or

(ii) on renewal of a policy, the effective date of the renewal.

(3) (i) The removal of a discount is not a violation of this subsection.

(ii) Subparagraph (i) of this paragraph may not be construed to prevent an insurer from granting a claim–free discount to an insured.

(c) An insurer's automobile and physical damage insurance premiums shall reflect the reduction in claims, if any, attributable to the requirement that drivers under the age of 18 years must acquire a provisional driver's license before acquiring a driver's license.

(d) For purposes of reclassifying an insured in a classification that entails a higher premium, an insurer under an automobile insurance policy may not consider accident reports and abstracts of court convictions that relate to driving an emergency vehicle and that are on record with the Motor Vehicle Administration, as provided in § 16–117(b) of the Transportation Article.

(e) For purposes of reclassifying an insured in a classification that entails a higher premium, an insurer under an automobile insurance policy may not consider a probation before judgment disposition of a motor vehicle law offense, a civil penalty imposed pursuant to § 21–202.1, § 21–809, § 21–810, § 21–810.1, or § 24–111.3 of the Transportation Article, or a first offense of driving with an alcohol concentration of 0.08 or more under § 16–205.1 of the Transportation Article on record with the Motor Vehicle Administration, as provided in § 16–117(b) of the Transportation Article.

(f) If the insured under an automobile insurance policy notifies the insurer of a change in circumstances that justifies reclassifying the insured in a different classification or territory, the insurer shall adjust the premium charged the insured from the date of notification.

(g) For motor vehicle personal injury and property damage coverage, an insurer may provide a reduction in rates based on actuarial justification to an insured who:

(1) is at least 55 years old; and

(2) within the last 2 years, has completed successfully a course in accident prevention:

(i) that is approved by the Motor Vehicle Administration;

(ii) that includes classroom instruction or practice driving of the number of hours that the Motor Vehicle Administration requires; and

(iii) for which the insured has received a certificate that certifies the completion of the course.

§11–216.

An insurer that uses territory as a factor in establishing automobile insurance rates shall submit a statement to the Commissioner certifying that:

(1) the territories used by the insurer have been reviewed within the previous 3 years; and

(2) use of the territories is actuarially justified.

§11–218.

(a) (1) Any person, whether located within or outside the State, may apply to the Commissioner for a license as a rating organization for a kind of insurance, subdivision of kinds of insurance, or class of risk or part or combination of kinds of insurance or classes of risk, as specified in its application.

(2) An applicant for a license as a rating organization shall file with its application:

(i) a copy of its constitution, articles of agreement or association, or certificate of incorporation and its bylaws, rules, and regulations that govern the conduct of its business;

(ii) a list of its members and subscribers;

(iii) the name and address of a resident of the State on whom may be served notices or orders of the Commissioner or process that affects the rating organization; and

(iv) a statement of its qualifications as a rating organization.

(3) Within 60 days after an application is filed, the Commissioner shall grant or deny the application wholly or partly.

(4) The Commissioner shall grant the application if the Commissioner finds that:

(i) the applicant is competent, trustworthy, and otherwise qualified to act as a rating organization; and

(ii) its constitution, articles of agreement or association, or certificate of incorporation, and its bylaws, rules, and regulations that govern the conduct of its business conform to the requirements of law.

(5) A license as a rating organization issued under this section expires 3 years after its effective date.

(6) The fee for a license as a rating organization is $25.

(7) If a rating organization ceases to meet the requirements of this subsection, the Commissioner, after notice and a hearing, may suspend or revoke its license.

(8) A rating organization shall notify the Commissioner promptly of any change in the information and documents provided to the Commissioner under paragraph (2) of this subsection.

(b) (1) Subject to rules adopted by the rating organization that the Commissioner has approved as reasonable, each rating organization shall allow an insurer that is not a member to be a subscriber to its rating services for a kind of insurance, subdivision of kinds of insurance, or class of risk or part or combination of kinds of insurance or classes of risk for which it is authorized to act as a rating organization.

(2) Each rating organization shall give notice to subscribers of proposed changes in its rules.

(3) Each rating organization shall provide its rating services without discrimination to its members and subscribers.

(4) (i) 1. At the request of a subscriber or an insurer that has been refused admission as a subscriber to a rating organization, the Commissioner shall review the reasonableness of the application of a rule to subscribers or the refusal of the rating organization to admit the insurer as a subscriber.

2. If a rating organization fails to grant or reject the application of an insurer for admission as a subscriber within 30 days after the application was made, the insurer may request a review of the action by the Commissioner as if the application had been rejected.

(ii) 1. The Commissioner shall review the challenged rule or action of the rating organization at a hearing.

2. The Commissioner shall give written notice of the hearing to the rating organization and subscriber or insurer at least 10 days before the hearing.

(iii) If the Commissioner finds that the challenged rule is unreasonable in its application to subscribers, the Commissioner shall issue an order that the rule is not applicable to subscribers.

(iv) 1. If the Commissioner finds that an insurer has been refused admission as a subscriber to the rating organization without justification, the Commissioner shall issue an order that requires the rating organization to admit the insurer as a subscriber.

2. If the Commissioner finds that the action of the rating organization in refusing admission as a subscriber was justified, the Commissioner shall issue an order that affirms the action of the rating organization.

(c) A rating organization may not adopt a rule the effect of which would be to prohibit or regulate the payment of dividends, savings, or unabsorbed premium deposits allowed or returned by insurers to their policyholders, members, or subscribers.

(d) (1) Cooperation among rating organizations or among rating organizations and insurers in rate making or in other matters within the scope of this subtitle is authorized, if the filings that result from the cooperation are subject to all provisions of this subtitle that are applicable to filings generally.

(2) (i) The Commissioner may review cooperative activities and practices among rating organizations and among rating organizations and insurers.

(ii) If, after a hearing, the Commissioner finds that an activity or practice is unfair, unreasonable, or otherwise inconsistent with this subtitle, the Commissioner may issue an order that requires that the activity or practice be discontinued.

(e) (1) A rating organization may provide for the examination of policies, daily reports, binders, renewal certificates, endorsements, or other evidence of insurance or the cancellation of insurance and may make reasonable rules that govern their submission.

(2) Rules adopted under this subsection shall require that:

(i) within 60 days after a rating organization has notified an insurer of an error or omission, the insurer shall provide to the rating organization satisfactory evidence of the correction of the error or omission; and

(ii) the rating organization shall notify the Commissioner if an insurer fails to provide satisfactory evidence of the correction of the error or omission.

(3) All information submitted for examination under this subsection is confidential.

(f) (1) A rating organization may subscribe to or purchase actuarial, technical, or other services.

(2) The services shall be available to all members and subscribers without discrimination.

(g) (1) An association or other entity that has been organized by regulation or law to provide insurance not available through the voluntary market shall apply to the Commissioner for permission to file rates to be used by the entity.

(2) If the Commissioner finds that allowing the entity to file rates will be in the public interest, then the Commissioner shall treat a filing made by the entity like a filing made by a rating organization.

§11–219.

(a) An insurer may deviate from the rates filed by a rating organization if:

(1) the insurer has filed the deviation to be applied with the rating organization and Commissioner;

(2) the deviation is uniform in its application to all risks in the State of the class of insurance to which the deviation is to apply; and

(3) the deviation is approved by the Commissioner.

(b) The Commissioner may approve or disapprove a deviation as if the deviation filing were a rate filing and specify the period of time during which an approval will be effective.

§11–220.

(a) (1) A member of or subscriber to a rating organization may appeal to the Commissioner from the action or decision of the rating organization in approving or rejecting a proposed change in or addition to the filings of the rating organization.

(2) The Commissioner:

(i) shall issue an order that approves the action or decision of the rating organization or directs it to give further consideration to the proposal; or

(ii) if the appeal is from the action or decision of the rating organization in rejecting a proposed addition to its filings and the Commissioner finds that the action or decision was unreasonable, may issue an order that directs the rating organization to make, within a reasonable time after issuance of the order, an addition to its filings on behalf of its members and subscribers in a manner consistent with the Commissioner's findings.

(3) The Commissioner shall hold a hearing before issuing an order under paragraph (2) of this subsection.

(4) The Commissioner shall give written notice of the hearing to the appellant and rating organization at least 10 days before the hearing.

(b) (1) If the appeal is based on the failure of a rating organization to make a filing on behalf of the member or subscriber that is based on a system of expense provisions that differs from the system of expense provisions included in a filing made by the rating organization, as authorized under § 11-205(e) of this subtitle, and the Commissioner grants the appeal, the Commissioner shall issue an order that requires the rating organization to make the requested filing for use by the appellant.

(2) In deciding the appeal, the Commissioner shall apply the standards set forth in this subtitle.

§11–221.

(a) Each advisory organization shall file with the Commissioner:

(1) a copy of its constitution, articles of agreement or association, or certificate of incorporation and its bylaws, rules, and regulations that govern its activities;

(2) a list of its members;

(3) the name and address of a resident of the State on whom may be served notices or orders of the Commissioner or process issued at the direction of the Commissioner; and

(4) an agreement that the Commissioner may examine the advisory organization in accordance with § 11-225 of this subtitle.

(b) If, after a hearing, the Commissioner finds that the provision of information or help by an advisory organization involves an act or practice that is unfair, unreasonable, or otherwise inconsistent with this subtitle, the Commissioner may issue a written order that specifies the ways in which the act or practice is unfair, unreasonable, or otherwise inconsistent with this subtitle and requires that the act or practice be discontinued.

(c) (1) An insurer that makes its own filings or a rating organization may not support its filings by statistics or adopt rate making recommendations provided to it by an advisory organization that has failed to comply with:

(i) this section; or

(ii) an order of the Commissioner issued under subsection (b) of this section that involves the statistics or recommendations.

(2) If the Commissioner finds that an insurer or rating organization has violated this subsection, the Commissioner may issue an order that requires that the violation be discontinued.

§11–222.

(a) Each group, association, or other organization of insurers that engages in joint underwriting or joint reinsurance is subject to this subtitle with respect to its joint underwriting or joint reinsurance activities.

(b) If, after a hearing, the Commissioner finds that an activity or practice of a group, association, or other organization that engages in joint underwriting or joint reinsurance is unfair, unreasonable, or otherwise inconsistent with this subtitle, the Commissioner may issue a written order that specifies the ways in which the activity or practice is unreasonable, unfair, or otherwise inconsistent with this subtitle and requires that the activity or practice be discontinued.

§11–225.

(a) (1) At least once every 5 years, the Commissioner shall make an examination of each rating organization licensed in the State.

(2) Whenever the Commissioner considers it expedient, the Commissioner may make an examination of each advisory organization and each group, association, or other organization that engages in joint underwriting or joint reinsurance.

(b) The entity examined shall pay the reasonable costs of an examination on presentation to it of a detailed account of the costs.

(c) The officers, manager, agents, and employees of the entity examined may be examined at any time under oath and shall exhibit all books, records, accounts, documents, or agreements that govern the entity's methods of operation.

(d) Instead of making an examination under this section, the Commissioner may accept the report of an examination made by the insurance supervisory official of another state under the laws of that state.

§11–226.

(a) (1) (i) So that the experience of all insurers may be made available at least annually in the form and detail necessary to help the Commissioner in determining whether rating systems comply with the standards set forth in this subtitle, the Commissioner shall adopt reasonable rules and statistical plans that are reasonably adapted to each of the rating systems on file with the Commissioner for the recording and reporting of loss and expense experience.

(ii) The Commissioner periodically may modify the rules and plans adopted under this subsection.

(iii) Each insurer shall use the rules and plans adopted by the Commissioner to record and report its loss and countrywide expense experience.

(2) The rules and plans adopted under this subsection may also provide for the recording and reporting of expense experience items that are specially applicable to the State and are not susceptible of determination by prorating countrywide expense experience.

(3) In adopting the rules and plans, the Commissioner shall give due consideration:

(i) to the rating systems on file with the Commissioner; and

(ii) to the rules and to the form of the plans used for the rating systems in other states, so that the rules and plans may be as uniform as is practicable among states.

(4) An insurer may not be required to record or report its loss experience on a classification basis that is inconsistent with the rating system filed by it.

(5) (i) The Commissioner may designate one or more rating organizations or other agencies to help in gathering and compiling experience information.

(ii) Subject to reasonable regulations adopted by the Commissioner, the compilations shall be made available to insurers and rating organizations.

(b) The Commissioner may adopt reasonable rules and plans for the interchange of data necessary for the application of rating plans.

(c) To further uniform administration of rate regulatory laws, the Commissioner and each insurer and rating organization may:

(1) exchange information and experience data with each other and with insurance supervisory officials, insurers, and rating organizations in other states; and

(2) consult with them about rate making and the application of rating systems.

§11–227.

The Commissioner may adopt reasonable rules and regulations necessary to carry out the purposes of this subtitle.

§11–230.

(a) An insurer or officer, insurance producer, or representative of an insurer may not knowingly issue or deliver or knowingly allow the issuance or delivery of a policy or endorsement, certificate, or addition to the policy, except in accordance with the filings that are in effect for the insurer as provided in this subtitle.

(b) An insurer may pay or allow a commission to a licensed insurance producer of the insurer as compensation for procuring business.

§11–231.

A person may not willfully withhold information from or knowingly give false or misleading information to the Commissioner, a statistical agency designated by the Commissioner, a rating organization, or an insurer if the information will affect the rates or premiums chargeable under this subtitle or the proper issuance of an insurance contract, policy, or guarantee of insurance.

§11–232.

(a) (1) If the Commissioner finds that a person has violated a provision of this subtitle, the Commissioner may impose a civil penalty not exceeding $250 for each violation.

(2) If the Commissioner finds a violation of this subtitle to be willful, the Commissioner may impose a civil penalty not exceeding $1,000 for the violation.

(3) A penalty imposed under this subsection is in addition to any other penalty provided by law.

(b) (1) The Commissioner may suspend the license of a rating organization or certificate of authority of an insurer that fails to comply with an order of the Commissioner within the time set by the order or any extension of that time granted by the Commissioner.

(2) The Commissioner may not suspend the license of a rating organization or certificate of authority of an insurer for failure to comply with an order:

(i) until the time set for an appeal from the order has expired; or

(ii) if an appeal has been taken, until the order has been affirmed.

(3) The Commissioner may determine when the suspension of a license or certificate of authority becomes effective.

(4) The suspension shall remain in effect for the period set by the Commissioner unless the Commissioner modifies or rescinds the suspension or until the order on which the suspension is based is modified, rescinded, or reversed.

(c) (1) Before the Commissioner imposes a penalty or suspends or revokes a license or certificate of authority under this subtitle, the Commissioner shall issue a written order that states the findings of the Commissioner.

(2) The Commissioner shall hold a hearing before issuing an order under paragraph (1) of this subsection.

(3) The Commissioner shall give written notice of the hearing at least 10 days before the hearing.

(4) The notice shall specify the alleged violation.

§11–301.

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

(b) "Competitive market" means any market except those which, by application of the standards in § 11-306 of this subtitle, have been determined to be noncompetitive under § 11-308(c) of this subtitle.

(c) "Market" means the interaction between buyers and sellers of a particular line of insurance in a geographical area consisting of not less than one entire county.

§11–302.

(a) The purposes of this subtitle are:

(1) to protect policyholders and the public against the adverse effect of excessive, inadequate, or unfairly discriminatory rates;

(2) as the most effective way to produce rates that conform to the standards of paragraph (1) of this subsection, to encourage independent action by insurers and reasonable price competition among insurers;

(3) to provide formal regulatory controls for use if price competition fails;

(4) to authorize cooperative action among insurers in the rate making process and to regulate that cooperation in order to prevent practices that tend to bring about monopoly or to lessen or destroy competition; and

(5) to provide rates that are responsive to competitive market conditions and to improve the availability of insurance in the State.

(b) This subtitle shall be construed liberally to achieve the purposes stated in subsection (a) of this section, which shall constitute an aid and guide to interpretation of this subtitle but not an independent source of power.

§11–303.

(a) Notwithstanding Subtitle 2 of this title, this subtitle applies to the establishment of rates for all types of insurance except:

(1) life insurance;

(2) annuities;

(3) health insurance;

(4) marine insurance described in § 11–202(b)(2) of this title;

(5) aircraft insurance described in § 11–202(b)(3) of this title;

(6) reinsurance;

(7) title insurance;

(8) medical malpractice insurance;

(9) any form or plan of insurance regulated under § 27–217 of this article; and

(10) surety insurance.

(b) If and to the extent that the Commissioner finds that the application of any or all of the provisions of this subtitle is unnecessary to achieve the purposes of this subtitle, the Commissioner by rule may exempt a person or class of persons or a line or lines of insurance from any or all of those provisions.

§11–306.

(a) The standards set forth in this section apply to the making and use of rates under this subtitle.

(b) (1) Rates may not be:

(i) excessive or inadequate, as defined under this subtitle; or

(ii) unfairly discriminatory.

(2) Except as provided in paragraph (4) of this subsection, a rate may not be held to be excessive unless:

(i) the rate is unreasonably high for the insurance provided; and

(ii) the Commissioner has issued a ruling under § 11-308(c) of this subtitle that a reasonable degree of competition does not exist in a market to which the rate is applicable.

(3) A rate may not be held to be inadequate unless:

(i) the rate is unreasonably low for the insurance provided and continued use of the rate would endanger the solvency of the insurer; or

(ii) the rate is unreasonably low for the insurance provided and the use of the rate by the insurer has had, or if continued will have, the effect of destroying competition or of creating monopoly.

(4) For personal lines property insurance and casualty insurance, the Commissioner may hold a statewide rate or a rate in a particular jurisdiction or geographic territory to be excessive without determining whether a reasonable degree of competition exists under § 11-308(c) of this subtitle if the Commissioner determines that the rate:

(i) is unreasonably high for the insurance provided; and

(ii) is not actuarially justified based on commonly accepted actuarial principles.

(5) If the Commissioner determines that a rate is excessive under paragraph (4) of this subsection and disapproves the rate, the disapproval is subject to § 11-308(c)(4), (d), and (e) of this subtitle.

(c) In determining whether rates comply with the standards set forth in subsection (b) of this section, due consideration shall be given to:

(1) past and prospective loss experience within and outside the State;

(2) conflagration or catastrophe hazards;

(3) a reasonable margin for underwriting profit and contingencies;

(4) dividends, savings, or unabsorbed premium deposits allowed or returned by insurers to their policyholders, members, or subscribers;

(5) past and prospective expenses, both countrywide and those specially applicable to the State;

(6) investment income earned or realized by insurers both from their unearned premium and from their loss reserve funds; and

(7) all relevant factors within and outside the State.

(d) The systems of expense provisions included in the rates for use by an insurer or group of insurers may differ from those of other insurers or groups of insurers to reflect the requirements of the operating methods of the insurer or group of insurers with respect to a kind of insurance, or with respect to a subdivision or combination of insurance for which separate expense provisions are applicable.

(e) (1) Risks may be grouped by classifications for the establishment of rates and minimum premiums.

(2) Classification rates may be modified to produce rates for individual risks in accordance with rating plans that establish standards for measuring variations in hazards or expense provisions, or both.

(3) The standards may measure any difference among risks that have had a direct and substantial effect on losses or expenses.

(4) Notwithstanding any other provision of this subsection, a rate may not be based wholly or partly on geographic area itself, as opposed to underlying risk considerations, even though expressed in geographic terms.

§11–307.

(a) (1) Except as otherwise provided in this subsection, each authorized insurer and each rating organization that has been designated by an insurer for the filing of rates under subsection (b) of this section shall file with the Commissioner all rates and supplementary rate information and all changes and amendments of rates and supplementary information made by it for use in the State on or before the date they become effective.

(2) Rates and supplementary rate information need not be filed for inland marine risks that by general custom are not written according to manual rules or rating plans.

(b) (1) An insurer may itself establish rates and supplementary rate information based on the factors in § 11–306 of this subtitle.

(2) Except for workers' compensation insurance rates, an insurer may use rates and supplementary rate information prepared and filed with the Commissioner by a rating organization of which it is a member or subscriber, with average loss factors or expense factors determined by the rating organization or with modification for its own expense and loss experience as the credibility of that experience allows.

(3) If an insurer uses rates and supplementary rate information prepared by a rating organization:

(i) the insurer shall notify the Commissioner that it uses rates and supplementary rate information prepared and filed with the Commissioner by a designated rating organization of which it is a member or subscriber and shall provide the Commissioner with information about modifications of those rates and supplementary rate information that is necessary to inform the Commissioner fully; and

(ii) subject to modifications filed by the insurer, the insurer's rates and supplementary rate information shall be those filed periodically by the rating organization, including any amendments to those filings.

(c) (1) In this subsection, "proprietary rate–related information":

(i) means a rating model; and

(ii) includes the formulas, algorithms, analyses, and specific weights given to variables used in the model.

(2) (i) Except as provided in paragraph (3) of this subsection, each filing and any supporting information filed under this subtitle shall be open to public inspection as soon as filed.

(ii) On request and payment of a reasonable charge, a person may obtain copies of a filing and any supporting information.

(3) (i) Information that an insurer files with the Commissioner and identifies as proprietary rate–related information:

1. constitutes a trade secret and confidential commercial information;

2. subject to subparagraph (ii) of this paragraph and except as provided in subparagraph (iii) of this paragraph, shall be kept confidential by the Commissioner; and

3. is not subject to subpoena served on the Commissioner or any recipient of proprietary rate–related information under subparagraph (iii) of this paragraph.

(ii) 1. Except as provided in subsubparagraph 2 of this subparagraph, if the Commissioner determines that some or all of the material that an insurer files and identifies as proprietary rate–related information does not constitute proprietary rate–related information as defined in paragraph (1) of this subsection, the Commissioner shall:

A. give the insurer written notice of that determination; and

B. make the material open to public inspection 10 business days after the date the Commissioner gives notice of the determination to the insurer.

2. The Commissioner may not disclose the material if:

A. the insurer has not put the rate filing into effect; and

B. within the time period described in subsubparagraph 1B of this subparagraph, the insurer withdraws the rate filing and notifies the Commissioner that the rate filing is withdrawn.

(iii) This paragraph does not prohibit the Commissioner from disclosing an insurer's proprietary rate–related information:

1. in furtherance of a regulatory or legal action that the Commissioner undertakes in performing the Commissioner's duties under this article;

2. if the recipient enters into a written agreement to maintain the confidentiality of the proprietary rate–related information, to:

A. an outside consultant that the Commissioner engages to assist the Commissioner in reviewing the insurer's rate filing;

B. another state's insurance regulatory agency;

C. the National Association of Insurance Commissioners; or

D. a state or federal law enforcement authority, including the United States Department of Justice and the Maryland Attorney General, if acting in a law enforcement capacity; or

3. if the proprietary rate–related information is part of a homeowner's insurance rate filing, to the People's Insurance Counsel Division acting under § 6–306 of the State Government Article.

(iv) 1. Except as provided in subsubparagraph 2 of this subparagraph, the People's Insurance Counsel Division shall maintain the confidentiality of proprietary rate–related information disclosed to the Division under subparagraph (iii)3 of this paragraph.

2. The People's Insurance Counsel Division may disclose proprietary rate–related information to an outside consultant that the Division engages to assist the Division in reviewing a homeowner's insurance rate filing, provided that the outside consultant enters into a written agreement to maintain the confidentiality of the proprietary rate–related information.

(v) The Commissioner shall notify the insurer in writing at least 10 business days before the Commissioner discloses any of the insurer's proprietary rate–related information under subparagraph (iii) of this paragraph.

(vi) In addition to any other rights an insurer may have under any other applicable law, the insurer may seek to have any disclosure of the insurer's proprietary rate–related information under subparagraph (iii)1 of this paragraph be made under seal or other protection of confidentiality.

(vii) There is no waiver of any applicable privilege or claim of confidentiality with regard to any proprietary rate–related information that is disclosed under subparagraph (iii) of this paragraph.

(4) This subsection may not be construed to:

(i) authorize an insurer to designate the rating factors used to calculate the premium as proprietary rate–related information; or

(ii) authorize the Commissioner to keep the rating factors confidential.

(d) (1) The Commissioner may investigate and determine whether or not rates in the State are excessive, inadequate, or unfairly discriminatory.

(2) In an investigation and determination under this subsection, the Commissioner shall give due consideration to the factors specified in § 11–306 of this subtitle.

§11–308.

(a) (1) If, after a hearing, the Commissioner finds that a rate is not in compliance with § 11-306 of this subtitle or that a rate was set in violation of § 11-342 of this subtitle, the Commissioner shall issue an order that requires that use of the rate be discontinued for each policy issued or renewed after a date specified in the order.

(2) The order may provide prospectively for premium adjustment of each policy then in force.

(3) Except as provided in subsection (b) of this section, the Commissioner shall issue the order within 30 days after the conclusion of the hearing or within a reasonable extension of that time set by the Commissioner.

(4) An order issued under this subsection expires 1 year after its effective date unless it is rescinded earlier by the Commissioner.

(b) (1) Pending a hearing, the Commissioner may issue an order that prospectively suspends a rate filed by an insurer and reimposes the last previous rate in effect if the Commissioner has reasonable cause to believe that:

(i) the rate is in violation of § 11-306 of this subtitle;

(ii) unless the order of suspension is issued, certain insureds will suffer irreparable harm;

(iii) the hardship that insureds will suffer in the absence of the order of suspension outweighs the hardship that the insurer would suffer if the order of suspension were issued; and

(iv) the order of suspension will not cause substantial harm to the public.

(2) Unless the insurer waives a hearing, the Commissioner:

(i) shall hold a hearing within 15 working days after issuing the order of suspension; and

(ii) within 15 working days after the conclusion of the hearing, shall make a determination and issue an order as to whether the rate should be disapproved.

(c) (1) (i) At a hearing to determine compliance with § 11-306(b)(2) of this subtitle, the Commissioner first shall determine whether a reasonable degree of competition exists within a market and shall issue a ruling to that effect.

(ii) All insurers that operate within a market that is subject to a determination by the Commissioner under this paragraph shall have the burden of establishing that a reasonable degree of competition exists within that market.

(iii) In determining the competitiveness of a market, the Commissioner shall consider all relevant factors including:

1. the number of insurers actively engaged in providing coverage in the market;

2. market shares;

3. changes in market shares; and

4. ease of entry.

(2) (i) If the Commissioner determines that a reasonable degree of competition does not exist in a market, each insurer designated by the Commissioner shall have the burden of justifying its rate in that market.

(ii) The Commissioner may require that an insurer file supporting data as provided under § 11-312 of this subtitle.

(3) The Commissioner shall make each determination on the basis of findings of fact and conclusions of law.

(4) If the Commissioner disapproves a rate:

(i) the disapproval may not take effect until at least 15 days after the date of the order of disapproval; and

(ii) unless the Commissioner approves a rate under subsection (d) or (e) of this section, the last previous rate in effect for the insurer shall be reimposed for a period of 1 year.

(d) During the 1-year period after the effective date of an order of disapproval, a rate adopted to replace a rate disapproved under the order may not be used until:

(1) the rate has been filed with the Commissioner; and

(2) the Commissioner has not disapproved the rate within 30 days after it was filed.

(e) (1) If an insurer does not have any legally effective rates as a result of the Commissioner's disapproval of rates or other act, the Commissioner:

(i) on request of the insurer, shall specify interim rates for the insurer that are high enough to protect the interests of all parties; and

(ii) may order that a specified part of the premiums be placed in a special reserve established by the insurer.

(2) (i) Except as provided in subparagraph (ii) of this paragraph, when new rates become legally effective, the Commissioner shall order the specially reserved funds or any overcharge in the interim rates to be distributed appropriately.

(ii) The Commissioner may not require refunds to policyholders if the refunds are minimal.

§11–309.

(a) If, after a hearing, the Commissioner finds that the protection of the interests of the insureds of a particular insurer and the public in the State requires closer supervision of the insurer's rates because of the insurer's financial condition or repetitive filing of rates that are not in compliance with § 11-306 of this subtitle, the Commissioner may issue an order that requires the insurer to file any or all of the insurer's rates and supplementary rate information 30 days before they become effective.

(b) By written notice to the insurer during the initial 30-day waiting period, the Commissioner may extend the waiting period for an additional period not exceeding 30 days.

(c) (1) The Commissioner shall approve or disapprove the filing during the waiting period or any extension of the waiting period.

(2) The filing is deemed approved unless disapproved by the Commissioner during the waiting period or any extension of the waiting period.

(d) An insurer affected by an action of the Commissioner under this section may not request a rehearing by the Commissioner until 12 months after the date of an order of the Commissioner under subsection (a) of this section.

§11–310.

(a) (1) The Commissioner may adopt a rule that requires that subsequent changes in the rates or supplementary rate information for a kind or line of insurance, subdivision of a kind or line of insurance, or rating class or rating territory be filed with the Commissioner at least 30 working days before they become effective if the Commissioner finds that with respect to that kind, line, subdivision, rating class, or rating territory:

(i) competition is not an effective regulator of the rates charged;

(ii) a substantial number of insurers are competing irresponsibly through the rates charged; or

(iii) there are widespread violations of this subtitle.

(2) By written notice to the filer during the initial 30-day waiting period, the Commissioner may extend the waiting period for an additional period not exceeding 30 working days.

(b) (1) A rule adopted under this section may not remain in effect for more than 1 year after it is adopted.

(2) The Commissioner may renew a rule adopted under this section after a hearing and appropriate findings under this section.

§11–311.

On written application of an insurer that states its reasons for requesting the rate, accompanied by the written consent of the insured or prospective insured, filed with and approved by the Commissioner, a rate in excess of that provided by a filing otherwise applicable may be used on a specific risk.

§11–312.

(a) (1) The Commissioner may require the filing of supporting data as to any or all kinds or lines of insurance or subdivisions of kinds or lines of insurance or classes of risks or combinations of classes of risks as the Commissioner considers necessary for the proper functioning of the rate monitoring and regulating process.

(2) The supporting data shall include:

(i) the experience and judgment of the filer and, to the extent the filer wishes or the Commissioner requires, the experience and judgment of other insurers or rating organizations;

(ii) the filer's interpretation of any statistical data relied on;

(iii) a description of the actuarial and statistical methods used in setting the rates; and

(iv) any other relevant matters required by the Commissioner.

(b) Whenever a filing is not accompanied by the information as required by the Commissioner under § 11-310(a) of this subtitle, the Commissioner may so inform the insurer and the filing will be deemed to be made when the information is provided.

§11–313.

For a kind or line of insurance as to which the Commissioner has issued an order in which the Commissioner finds that a reasonable degree of competition does not exist, the Commissioner may require the insurer at the time of filing a proposed rate increase with the Commissioner to notify each policyholder in writing that:

(1) the insurer has filed a proposed rate increase with the Commissioner;

(2) a hearing may be requested with respect to the filing; and

(3) an order, hearing, or refusal of a hearing by the Commissioner may be appealed under Subtitle 5 of this title.

§11–314.

(a) Each rating organization and each insurer subject to this subtitle that makes its own rates shall provide reasonable means within the State by which a person aggrieved by the application of its rating system may be heard in person or by

an authorized representative on the person's written request to review the manner in which the rating system has been applied in connection with the insurance afforded the aggrieved person.

(b) If the rating organization or insurer fails to grant or reject the aggrieved person's request within 30 days after it is made, the applicant may proceed as if the application had been rejected.

(c) (1) Within 30 days after written notice of the action of a rating organization or insurer on a request for review, any party affected by the action may apply, in writing, for an appeal to the Commissioner.

(2) An application under this subsection shall set forth the basis for the appeal and the grounds on which the applicant will rely.

(d) (1) The Commissioner shall review the application for appeal.

(2) If the Commissioner finds that the application is made in good faith and sets forth on its face grounds that reasonably justify a hearing, the Commissioner shall hold a hearing.

(3) The Commissioner shall give written notice of the hearing to the applicant and rating organization or insurer at least 10 days before the hearing.

(4) After the hearing, the Commissioner shall affirm or reverse the action.

§11–315.

(a) All homeowner's insurance rates shall be made in accordance with the principles set forth in this section.

(b) (1) An insurer under a homeowner's insurance policy may not classify or maintain an insured for a period longer than 3 years in a classification that entails a higher premium because of a specific claim.

(2) For the purpose of determining whether to classify an insured in a classification that entails a higher premium, an insurer may review only a period not greater than 3 years before:

(i) if the policy has not yet been issued:

1. the date of the application; or

2. the proposed effective date of the policy; or

(ii) on renewal of a policy, the effective date of the renewal.

(3) (i) The removal of, reduction of, or refusal to apply a discount is not a violation of this subsection if the claim resulting in the removal of, reduction of, or refusal to apply the discount was filed not more than 5 years before the removal, reduction, or refusal.

(ii) Subparagraph (i) of this paragraph may not be construed to prevent an insurer from granting a claim–free discount to an insured.

§11–317.

(a) In this section, "increase in a policy premium" includes an increase in premium due to:

(1) a surcharge;

(2) retiering or other reclassification of an insured; or

(3) removal or reduction of a discount.

(b) Each insurer that provides a private passenger automobile insurance policy shall provide to the policyholder at the time of issuance or renewal of the policy a statement that:

(1) defines the policyholder's rate classifications;

(2) if the insurer is an authorized insurer includes a summary, in a form approved by the Commissioner, of the insurer's approved surcharge plan or driver record point plan for that policy; and

(3) includes a section that provides a general description of the factors, including credit information if applicable, that may cause or contribute to an increase in a policy premium.

(c) The statement must be sufficiently clear and specific so that an individual of average intelligence can identify the classifications without making further inquiry.

(d) An insurer that markets private passenger automobile insurance through insurance producers shall make available to its producers a copy of the statement required under this section.

§11–318.

(a) All automobile insurance rates shall be made in accordance with the principles set forth in this section.

(b) (1) An insurer under an automobile liability insurance policy may not classify or maintain an insured for a period longer than 3 years in a classification that entails a higher premium:

(i) because of a specific claim; or

(ii) because of the insured's driving record.

(2) For the purpose of determining whether to classify an insured in a classification that entails a higher premium, an insurer may review only a period not greater than 3 years before:

(i) if the policy has not yet been issued:

1. the date of the application; or

2. the proposed effective date of the policy; or

(ii) on renewal of a policy, the effective date of the renewal.

(3) (i) The removal of a discount is not a violation of this subsection.

(ii) The application of a program that measures the operation of an insured vehicle during the current policy period is not a violation of this subsection.

(iii) Subparagraph (i) of this paragraph may not be construed to prevent an insurer from granting a claim–free discount to an insured.

(c) An insurer's automobile and physical damage insurance premiums shall reflect the reduction in claims, if any, attributable to the requirement that drivers under the age of 18 years must acquire a provisional driver's license before acquiring a driver's license.

(d) For purposes of reclassifying an insured in a classification that entails a higher premium, an insurer under an automobile insurance policy may not consider accident reports and abstracts of court convictions that relate to driving an emergency

vehicle and that are on record with the Motor Vehicle Administration, as provided in § 16–117(b) of the Transportation Article.

(e) For purposes of reclassifying an insured in a classification that entails a higher premium, an insurer under an automobile insurance policy may not consider a probation before judgment disposition of a motor vehicle law offense, a civil penalty imposed pursuant to § 21–202.1, § 21–809, § 21–810, § 21–810.1, or § 24–111.3 of the Transportation Article, or a first offense of driving with an alcohol concentration of 0.08 or more under § 16–205.1 of the Transportation Article on record with the Motor Vehicle Administration, as provided in § 16–117(b) of the Transportation Article.

(f) If the insured under an automobile insurance policy notifies the insurer of a change in circumstances that justifies reclassifying the insured in a different classification or territory, the insurer shall adjust the premium charged the insured from the date of notification.

(g) For motor vehicle personal injury and property damage coverage, an insurer may provide a reduction in rates based on actuarial justification to an insured who:

(1) is at least 55 years old; and

(2) within the last 2 years, has completed successfully a course in accident prevention:

(i) that is approved by the Motor Vehicle Administration;

(ii) that includes classroom instruction or practice driving of the number of hours that the Motor Vehicle Administration requires; and

(iii) for which the insured has received a certificate that certifies the completion of the course.

§11–319.

An insurer that uses territory as a factor in establishing automobile insurance rates shall submit a statement to the Commissioner certifying that:

(1) the territories used by the insurer have been reviewed within the previous 3 years; and

(2) use of the territories is actuarially justified.

§11–321.

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

(b) "Affiliate" has the meaning stated in § 7-101 of this article.

(c) "Major insurer" means an insurer or affiliate or subsidiary of that insurer that has written an amount of private passenger premium in the State that totals 1% or more of the total premium of private passenger premium written in the State by all insurers, including the Maryland Automobile Insurance Fund.

(d) "Private passenger premium" means the direct written premium derived from the sale of private passenger motor vehicle insurance policies in a calendar year.

(e) "Subsidiary" has the meaning stated in § 7-101 of this article.

§11–322.

(a) Part IV of this subtitle applies to each authorized insurer that writes private passenger motor vehicle insurance in the State.

(b) Except as expressly provided otherwise, Part IV of this subtitle does not apply to the Maryland Automobile Insurance Fund.

§11–323.

(a) On or before July 1 of each year, each insurer and the Maryland Automobile Insurance Fund shall file data about the geographic distribution of private passenger premium written by it in the State for the preceding calendar year.

(b) The data required under this section shall:

(1) be filed with the Commissioner in the form required by the Commissioner; and

(2) at a minimum, detail the amount of private passenger premium written by the insurer and the Maryland Automobile Insurance Fund in the preceding calendar year and the number of policies represented by that premium:

(i) in the State as a whole; and

(ii) in Baltimore City.

(c) The data shall be submitted by each rating territory or each zip code, or both.

(d) Failure by the insurer or the Maryland Automobile Insurance Fund to submit the data required under this section on a timely basis is grounds for the imposition of the penalties provided in §§ 4-113 and 4-114 of this article.

§11–324.

On or before August 15 of each year, the Commissioner shall:

(1) prepare a list of insurers that are major insurers;

(2) compute each insurer's market share in the State in the preceding calendar year;

(3) notify in writing each insurer that has been designated as a major insurer; and

(4) compute each insurer's market share in Baltimore City.

§11–325.

(a) On or before October 1 of each year, each insurer that has been designated a major insurer on or before August 15 of the same year shall file a marketing plan with the Commissioner.

(b) The goal of the marketing plan shall be to ensure that the insurer markets and otherwise makes available insurance to those persons who reside in Baltimore City in the same manner as to persons who reside in other jurisdictions in the State.

(c) (1) The Commissioner shall review the marketing plan to determine whether the plan will achieve the goal stated in subsection (b) of this section.

(2) A marketing plan is deemed approved unless disapproved by the Commissioner within 30 days after submission.

(3) (i) If the marketing plan does not contain sufficient information for the Commissioner to determine if the plan will achieve the goal stated in subsection (b) of this section, the Commissioner shall require the major insurer to provide the needed information within 30 days after the Commissioner requests the information.

(ii) If additional information is required by the Commissioner under this paragraph, the time period for approval, disapproval, or deemed approval begins on the date the additional information is submitted.

(4) If the Commissioner determines that the marketing plan will not achieve the goal stated in subsection (b) of this section, the Commissioner shall require the major insurer to file for review and approval a revised marketing plan for Baltimore City.

(d) (1) On or before September 1 of each year, a major insurer may file a written request with the Commissioner for a 1-year exemption from the requirements of this section.

(2) The Commissioner may grant an exemption under this subsection if the Commissioner determines that for calendar year 1994 the major insurer wrote a de minimus amount of total yearly private passenger motor vehicle insurance, as determined by the Commissioner, in the Baltimore standard metropolitan statistical area.

(3) On or before September 15 of each year in which a request is filed, the Commissioner shall determine whether the exemption should be granted.

(e) (1) Subject to paragraph (2) of this subsection, the Commissioner shall exempt from the requirements of this section an insurer that:

(i) on or after January 1, 1995, has limited the availability of its insurance to persons who are members of a club, group, or organization; and

(ii) uniformly requires eligibility for that club, group, or organization as a condition of providing insurance.

(2) On or before October 1 of each year, each major insurer exempted under this subsection shall file a marketing plan for Baltimore City.

(3) The goal of the marketing plan shall be to ensure that the insurer markets and otherwise makes available insurance to those persons who reside in Baltimore City and who otherwise satisfy the eligibility conditions of the insurer, in the same manner as to persons who reside in other jurisdictions in the State.

(f) Unless otherwise exempted from the requirements of this section, the failure of a major insurer to file or substantially implement a marketing plan for Baltimore City or to market and otherwise make available insurance to those persons who reside in Baltimore City in the same manner as to persons who reside in other jurisdictions in the State as required under this section is, after notice and

opportunity for a hearing, grounds for the imposition of the penalties provided under §§ 4-113 and 4-114 of this article.

(g) This section does not authorize the Commissioner to require that an insurer place an insurance producer in a particular location or jurisdiction.

(h) If the market share of private passenger premium written by a major insurer in Baltimore City equals or exceeds 75% of the market share of private passenger premium written by the major insurer in any year in the State, excluding Baltimore City, the major insurer is not required to file a marketing plan under this section for the following year.

§11–326.

(a) Notwithstanding any other provision of law, any data, documents, or other information filed with the Commissioner under Part IV of this subtitle about a particular insurer or that insurer's market share or plan:

(1) shall be considered confidential commercial information;

(2) shall be kept confidential by the Commissioner; and

(3) may not be made public or be subject to subpoena, other than by the Commissioner for the purpose of enforcement of Part IV of this subtitle by the Commissioner.

(b) The Commissioner:

(1) may release a list of the names of all insurers designated as major insurers; and

(2) may not release the particular market share of a major insurer in Baltimore City unless authorized by the insurer.

§11–329.

(a) Each workers' compensation insurer shall:

(1) be a member of a workers' compensation rating organization; and

(2) adhere to the policy forms filed by the rating organization.

(b) (1) Each workers' compensation insurer shall adhere to a uniform classification system and uniform experience rating plan filed with the Commissioner

by a rating organization designated by and subject to disapproval by the Commissioner.

(2) (i) An insurer may develop subclassifications of the uniform classification system on which a rate may be made.

(ii) Any subclassification developed under subparagraph (i) of this paragraph shall be filed with the Commissioner at least 30 days before its use.

(iii) If the insurer fails to demonstrate that the data produced under a subclassification can be reported in a manner consistent with the uniform classification system and uniform statistical plan, the Commissioner shall disapprove the subclassification.

(3) (i) An insurer may develop a tiered rating plan containing two or more risk tiers to be applied to the insurer's acceptance of risks under the uniform classification system on which a rate may be made.

(ii) A tiered rating plan under subparagraph (i) of this paragraph shall:

1. establish discrete tiers for the acceptance of risks based on defined risk attributes that:

A. are not arbitrary, capricious, or unfairly discriminatory; and

B. are reasonably related to the insurer's business and economic purposes; and

2. require that each insured be placed in the highest quality tier for which that insured qualifies.

(iii) An insurer shall file a tiered rating plan developed under subparagraph (i) of this paragraph with the Commissioner at least 30 days before the tiered rating plan's use.

(iv) If an insurer fails to demonstrate that the data produced under a tiered rating plan can be reported in a manner consistent with the uniform classification system and the uniform statistical plan, the Commissioner shall disapprove the tiered rating plan.

(c) Each workers' compensation insurer shall record and report its workers' compensation experience to a rating organization as set forth in the uniform statistical plan approved by the Commissioner.

(d) (1) Subject to the approval of the Commissioner, each rating organization shall develop and file rules reasonably related to the recording and reporting of data under the uniform classification system, uniform statistical plan, and uniform experience rating plan.

(2) In writing and reporting its business, each workers' compensation insurer shall adhere to the approved rules and experience rating plan.

(3) An insurer may not agree with another insurer or rating organization to adhere to rules that are not reasonably related to the recording and reporting of data under the uniform classification system or uniform statistical plan.

(e) The experience rating plan methodology required under § 11–330(d)(4) of this subtitle shall be based on:

(1) reasonable eligibility standards;

(2) adequate incentives for loss prevention; and

(3) sufficient premium differentials so as to encourage safety.

(f) (1) Except as provided in paragraphs (2), (3), and (4) of this subsection, the uniform experience rating plan shall be the exclusive means of providing prospective premium adjustment based on measurement of the loss–producing characteristics of an individual insured.

(2) In addition to any premium adjustment allowed under paragraph (1) of this subsection and pursuant to a filing made by a rating organization and approved by the Commissioner, an insurer may file a rating plan with the Commissioner that provides for prospective premium adjustments up to 25% based upon characteristics of a risk that are not reflected in the uniform experience rating plan.

(3) An insurer may file a rating plan with the Commissioner that provides for prospective premium adjustments based on merit for an insured that does not meet minimum premium requirements to qualify for a uniform experience rating plan.

(4) (i) Except as provided in subparagraph (ii) of this paragraph, in addition to any premium adjustment allowed under paragraphs (1), (2), and (3) of

this subsection and pursuant to a filing made by a rating organization and approved by the Commissioner, an insurer may file a rating plan with the Commissioner that provides for a premium discount for appropriate classifications or subclassifications of a risk of up to 4% to an insured that has an alcohol– and drug–free workplace policy that may include one or more of the following programs:

1. an alcohol and drug testing program;

2. an employee education program on alcohol and drug abuse;

3. a supervisor education program on alcohol and drug abuse;

4. an employee assistance program that includes referrals of employees for appropriate diagnosis, treatment, and assistance;

5. a program requiring an employee who has caused or contributed to an accident while at work to undergo alcohol or drug testing; and

6. any other program that the insurer deems effective to encourage an alcohol– and drug–free workplace.

(ii) An insurer is not required to provide a premium discount under this paragraph if the insured is required under federal or State law to test its employees for drugs or otherwise provide an alcohol– and a drug–free workplace.

(5) An insurer may file a rating plan that provides for retrospective premium adjustments based on an insured's past experience.

§11–330.

(a) In this section, "provision for claim payment" means an estimate, expressed on a per unit of exposure basis, of the monetary amount ultimately to be needed to pay workers' compensation insurance claims, excluding all loss adjustment or claim management expenses, other operating expenses, assessments, taxes, and profit or contingency allowances.

(b) Except as provided in subsection (e) of this section, the Commissioner shall review each workers' compensation insurance filing as soon as reasonably possible after it is made to determine whether it meets the requirements of this subtitle.

(c) (1) (i) Except as otherwise provided in this subsection, the effective date of a workers' compensation insurance filing is the date specified in the filing.

(ii) The effective date of a workers' compensation insurance filing may not be earlier than 30 days after:

1. the date on which the Commissioner receives the filing; or

2. the date on which the Commissioner receives information in support of the filing, if the Commissioner requires information to be provided in support of the filing.

(2) By written notice to the filer during the initial 30-day waiting period that the Commissioner needs additional time for consideration of the filing, the Commissioner may extend the waiting period for an additional period not exceeding 30 days.

(3) On written application by the filer, the Commissioner may authorize a filing that the Commissioner has reviewed to become effective before the expiration of the waiting period or any extension of the waiting period.

(4) A filing is deemed approved unless disapproved by the Commissioner during the waiting period or any extension of the waiting period.

(d) Subject to approval or disapproval under subsection (c) of this section, each workers' compensation rating organization shall file with the Commissioner:

(1) workers' compensation rates and rating plans that are limited to provision for claim payment;

(2) each workers' compensation policy form to be used by its members or subscribers;

(3) the uniform classification;

(4) the uniform experience rating plan and rules; and

(5) any other information that the Commissioner requests and is otherwise entitled to receive under this subtitle.

(e) Notwithstanding subsection (c) of this section, if each rate in a schedule of workers' compensation rates for specific classifications of risks filed by an insurer

is not lower than the provision for claim payment contained in the schedule of workers' compensation rates for those classifications filed by a rating organization under subsection (d) of this section and approved by the Commissioner, the schedule of rates filed by the insurer may become effective as soon as it is filed.

(f) Notwithstanding subsection (e) of this section, the Commissioner shall investigate and evaluate all workers' compensation filings to determine whether they meet the requirements of this subtitle.

(g) Notwithstanding § 11-307 of this subtitle, the Commissioner may require an insurer or rating organization to comply with the requirements of subsection (c) of this section if the Commissioner has good cause to believe that a reasonable degree of competition does not exist within a workers' compensation insurance market.

§11–332. NOT IN EFFECT

** TAKES EFFECT JANUARY 1, 2022 PER CHAPTER 36 OF 2015 **

The rating organization that the Commissioner designates under § 11–329 of this subtitle shall create and maintain an exception in its classification system to allow any authorized insurer in the State to use a single classification code for governmental occupations that are not included in police, firefighter, and clerical classifications.

§11–333.

(a) A rating organization may not provide a service that relates to the rates of insurance subject to this subtitle, and an insurer may not utilize the service of the rating organization for those purposes, unless the rating organization has obtained a license under § 11-218 of this title.

(b) A rating organization may not refuse to supply services for which it is licensed in the State to an authorized insurer that offers to pay the fair and usual compensation for the services.

(c) An advisory organization has the same authority and functions under this subtitle as under § 11-221 of this title.

§11–334.

(a) Cooperation among rating organizations or among rating organizations and insurers in rate making or in other matters within the scope of this subtitle is

authorized, if the filings that result from cooperation are subject to all provisions of this subtitle that are applicable to filings generally.

(b) (1) The Commissioner may review cooperative activities and practices among rating organizations and among rating organizations and insurers.

(2) If, after a hearing, the Commissioner finds that an activity or practice is unfair, unreasonable, or otherwise inconsistent with this subtitle, the Commissioner may issue a written order that specifies the ways in which the activity or practice is unfair, unreasonable, or otherwise inconsistent with this subtitle and requires that the activity or practice be discontinued.

§11–337.

(a) (1) Each insurer shall file with the Commissioner, and the Commissioner shall review, reasonable rules and plans for the recording and reporting of loss and expense experience in appropriate form and detail.

(2) An insurer may not be required to record or report its experience on a classification basis that is inconsistent with its own rating system.

(3) The Commissioner may designate one or more rating organizations to help in gathering and compiling experience information.

(b) The Commissioner and each insurer and rating organization may:

(1) exchange information and experience data with each other and with insurance supervisory officials, insurers, and rating organizations in other states; and

(2) consult with them about rate making and the application of rating systems.

(c) Rating organizations shall collect all relevant information from member insurers.

§11–341.

An insurer may not make or issue an insurance contract or policy of insurance of a kind to which this subtitle applies, except in accordance with the filings that are in effect for the insurer as provided in this subtitle.

§11–342.

(a) In this section, "insurer" includes two or more affiliated insurers under common management or under common controlling ownership or other common effective legal control and in fact engaged in joint or cooperative underwriting, investment management, marketing, servicing, or administration of their business and affairs as insurers.

(b) An insurer or rating organization may not:

(1) monopolize, attempt to monopolize, or combine or conspire with another person or persons to monopolize the business of a kind of insurance, subdivision, or class of insurance;

(2) agree with another insurer or rating organization to charge or adhere to a rate, although insurers and rating organizations may continue to exchange statistical information;

(3) make an agreement with another insurer, rating organization, or other person to unreasonably restrain trade;

(4) make an agreement with another insurer, rating organization, or other person if the effect of the agreement may be substantially to lessen competition in the business of a kind of insurance, subdivision, or class of insurance; or

(5) make an agreement with another insurer or rating organization to refuse to deal with a person in connection with the sale of insurance.

(c) An insurer may not acquire or retain the capital stock or assets of, or have any common management with, another insurer if the acquisition, retention, or common management substantially lessens competition in the business of a kind of insurance, subdivision, or class of insurance.

(d) A rating organization or member or subscriber of a rating organization may not interfere with the right of an insurer to make its rates independently of the rating organization or to charge different rates from the rates made by the rating organization.

(e) A rating organization may not adopt a rule, require an agreement, or formulate or engage in a program that would require a member, subscriber, or insurer to:

(1) use some or all of its services;

(2) adhere to its rates, rating plan, rating systems, underwriting rules, or policy forms; or

(3) prevent an insurer from acting independently.

(f) (1) The Commissioner shall disapprove a rate in violation of this section in accordance with the procedures required by § 11-308(a) of this subtitle.

(2) A person that violates this section is subject to the penalties provided in § 11-344 of this subtitle.

(g) The Commissioner may maintain an action to enjoin a violation of this section.

§11–343.

(a) A person may not willfully withhold information from or knowingly give false or misleading information to the Commissioner, a statistical agency designated by the Commissioner, a rating organization, or an insurer if the information will affect the rates or premiums chargeable under this subtitle.

(b) A person that violates this section:

(1) is subject to the penalties provided in § 11-344 of this subtitle; and

(2) if the violation is committed with intent to deceive, is guilty of perjury and subject to prosecution for perjury in a court of competent jurisdiction.

§11–344.

(a) If, after notice and a hearing, the Commissioner finds that a person has violated a provision of this subtitle or a regulation of the Commissioner adopted under this subtitle, the Commissioner may impose a monetary penalty as provided in § 4-113(d) of this article.

(b) (1) The Commissioner may suspend, revoke, or refuse to renew a license or certificate of authority for a violation of this subtitle.

(2) The Commissioner may determine when the suspension or revocation of a license or certificate of authority becomes effective.

(3) The suspension or revocation shall remain in effect for the period set by the Commissioner unless the Commissioner modifies or rescinds the suspension or revocation or until the order on which the suspension or revocation is based is modified or reversed as the result of an appeal.

(c) (1) Before the Commissioner imposes a penalty or suspends or revokes a license or certificate of authority under this section, the Commissioner shall issue a written order that states the findings of the Commissioner.

(2) The Commissioner shall hold a hearing before issuing an order under paragraph (1) of this subsection.

(3) The Commissioner shall give written notice of the hearing to the person at least 10 days before the hearing.

(4) The notice shall specify the alleged violation.

§11–401.

(a) This subtitle applies to all kinds and classes of insurance that:

(1) insure or guarantee titles to real or leasehold property or an estate in real or leasehold property;

(2) insure or guarantee against loss by reason of defects, encumbrances, liens, or charges on real or leasehold property or an estate in real or leasehold property;

(3) insure or guarantee the validity, priority, and status of liens on real or leasehold property or an estate in real or leasehold property; or

(4) insure or guarantee the correctness and sufficiency of searches for instruments, liens, charges, or other matters affecting the title to real or leasehold property or an estate in real or leasehold property.

(b) This subtitle applies to a person that makes guarantees or issues insurance described in subsection (a) of this section.

§11–402.

(a) All title insurance rates shall be made in accordance with this section.

(b) Rates shall be reasonable and adequate for the class of risks to which they apply.

(c) Rates may not discriminate unfairly between risks that involve essentially the same hazards and expense elements.

(d) Due consideration shall be given to:

(1) past and prospective loss experience within and outside the State;

(2) a reasonable margin for profit and contingencies;

(3) the cost of participating insurance;

(4) the percentage to be allocated to reserve;

(5) operating expenses; and

(6) all other relevant factors fairly attributable to the business of title insurance.

(e) (1) Guarantees may be grouped by classifications for the establishment of rates and minimum premiums.

(2) A special or unusual guarantee that is more hazardous to the title insurer than ordinary title guarantees because of an alleged irregularity or a difference in interpretation or application of law that might affect marketability of title, may be classified individually and separately according to the circumstances peculiar to each case.

§11–403.

(a) (1) Except as otherwise provided in this subsection, each title insurer shall file with the Commissioner all rates or premiums, supplementary rate information, forms of contracts, policies, or guarantees of insurance, and all modifications of contracts, policies, or guarantees of insurance that it proposes to use.

(2) A filing is not required for rates or premiums for a special or unusual guarantee as described in § 11–402(e)(2) of this subtitle.

(b) Each filing shall indicate the character or extent of coverage contemplated under the rates and premiums for which it is made.

(c) A title insurer may not make a change in rates or premiums or in the forms of contracts, policies, or guarantees of insurance unless a report that indicates the change has been filed with and approved by the Commissioner.

(d) A title insurer may satisfy its obligation to make filings by:

(1) being a member of or a subscriber to a licensed title rating organization that makes filings; and

(2) authorizing the Commissioner to accept filings on its behalf from the title rating organization.

§11–404.

(a) (1) Unless the Commissioner finds that a filing does not meet the requirements of this subtitle or is otherwise contrary to law, the Commissioner shall approve the filing.

(2) As soon as reasonably possible after a filing is made, the Commissioner shall approve or disapprove the filing in writing.

(3) If the Commissioner disapproves a filing, the Commissioner shall specify the ways that the Commissioner finds that the filing fails to meet the requirements of this subtitle or is otherwise contrary to law.

(b) (1) This subsection does not apply to filings by a rating organization on behalf of title insurers that are members or subscribers of the rating organization.

(2) If a filing is not disapproved by the Commissioner within 15 days after the date of filing, or within 30 days after the date of filing if the Commissioner extends the waiting period in writing during the initial 15–day period, the filing is deemed approved and the effective date of the filing is the end of the 15–day or 30–day waiting period.

(c) (1) The Commissioner shall hold a hearing to review the approval or disapproval of a filing under this section if:

(i) after approval of the filing, the Commissioner finds that the filing does not meet the requirements of this subtitle or is otherwise contrary to law;

(ii) a person with an interest in the filing makes a complaint to the Commissioner in writing that sets forth specific and reasonable causes for complaint; or

(iii) a title insurer or a rating organization on behalf of its members or subscribers, on notice of disapproval by the Commissioner under this section, requests a hearing.

(2) A hearing under this subsection shall be held within 30 days after the occurrence of an action specified in paragraph (1) of this subsection.

(3) The Commissioner shall give written notice of the hearing to all interested parties.

(4) The Commissioner may confirm, modify, change, or rescind any previous action, if warranted by the facts shown at the hearing.

§11–405.

(a) The Commissioner shall require that each title insurer subject to this subtitle provide to the Commissioner on a uniform basis financial data and any other information that the Commissioner requires in the regulation of rates.

(b) The financial data to be provided shall include:

(1) rates, taxes, general expenses, allocated and unallocated loss adjustment expenses, licenses, and fees; and

(2) all other expenses that relate to the procurement of business not specifically listed as commissions, including dividends, retainers, stock, office space, or any other valuable consideration.

(c) The information to be provided under this section shall be supplied on forms provided by the Commissioner.

§11–406.

To further more equitable establishment and adjustment of rates and premiums and forms of contracts, policies, or guarantees of insurance, the Commissioner and each title insurer may:

(1) exchange information and experience data with each other, with insurance supervisory officials and insurers in other states, and with national organizations and associations; and

(2) consult and cooperate with them about rate and premium making and forms of contracts, policies, and guarantees of insurance.

§11–407.

(a) A title insurer may not make or issue a contract, policy, or guarantee of insurance except in accordance with filings approved as provided in this subtitle, except for special or unusual risks for which a filing has not yet been provided.

(b) Each title insurer must hold to the rates or premiums as approved by the Commissioner and may not deviate from the rates or premiums or allow to or for the account of an insured a rebate or discount on the rates or premiums payable.

(c) A title insurer may pay or allow a commission to a licensed insurance producer of the title insurer as compensation for procuring business.

§11–408.

A person may not knowingly give false or misleading information to the Commissioner, an insurer, or another person if the information will affect the proper determination of rates or premiums or the proper issuance of a contract, policy, or guarantee of insurance.

§11–409.

(a) (1) If the Commissioner finds that a person has violated a provision of this subtitle, the Commissioner may impose a civil penalty not exceeding $250 for each violation.

(2) If the Commissioner finds a violation of this subtitle to be willful, the Commissioner may impose a civil penalty not exceeding $1,000 for each violation.

(3) A penalty imposed under this subsection is in addition to any other penalty provided by law.

(b) (1) The Commissioner may suspend the certificate of authority of a title insurer that fails to comply with an order of the Commissioner within the time set by the order or any extension of that time granted by the Commissioner.

(2) The Commissioner may not suspend the certificate of authority of a title insurer for failure to comply with an order:

(i) until the time set for an appeal from the order has expired; or

(ii) if an appeal has been taken, until the order has been affirmed.

(3) The Commissioner may determine when the suspension of a certificate of authority becomes effective.

(4) The suspension shall remain in effect for the period set by the Commissioner unless the Commissioner modifies or rescinds the suspension or until the order on which the suspension is based is modified, rescinded, or reversed.

(c) (1) Before the Commissioner imposes a penalty or suspends a certificate of authority under this section, the Commissioner shall issue a written order that states the findings of the Commissioner.

(2) The Commissioner shall hold a hearing before issuing an order under paragraph (1) of this subsection.

(3) The Commissioner shall give written notice of the hearing to the person at least 10 days before the hearing.

(4) The notice shall specify the alleged violation.

§11–501.

(a) (1) This subtitle governs hearings, orders, and appeals in matters arising under this title.

(2) Sections 2-210 through 2-215 of this article do not apply to rating and rating organizations.

(3) Each order, decision, ruling, or finding of the Commissioner under this title is subject to judicial review under this subtitle.

(b) Notwithstanding subsection (a) of this section, an order, decision, ruling, or finding of the Commissioner under § 11-344 of this title:

(1) is not subject to judicial review under this subtitle; and

(2) is subject to judicial review in accordance with § 2-215 of this article.

§11–502.

(a) Within 30 days after notice of an order or decision of the Commissioner under this title made without a hearing, an insurer or rating organization aggrieved by the order or decision may make a written request to the Commissioner for a hearing on the order or decision.

(b) (1) Within 20 days after receipt of a request for a hearing under subsection (a) of this section, the Commissioner shall hold a hearing on the challenged order or decision.

(2) The Commissioner shall give written notice of the time and place of the hearing at least 10 days before the hearing.

(c) (1) The hearing shall be concluded within 15 days after commencement of the hearing.

(2) Notwithstanding paragraph (1) of this subsection, on application with notice to the interested parties and for good cause shown, the Commissioner may grant up to an additional 15 days for a hearing to be concluded.

(d) (1) Within 20 days after the conclusion of a hearing under this section, the Commissioner shall:

(i) issue an order that affirms, reverses, or modifies the challenged order or decision; and

(ii) give a copy of the order to all interested parties.

(2) The order shall:

(i) state the Commissioner's reasons for affirming, reversing, or modifying the challenged order or decision; and

(ii) contain specific findings of fact by the Commissioner in relation to the matter, that are supported by a preponderance of the evidence on consideration of the record as a whole.

(3) (i) Any interested party may file proposed findings of fact with the Commissioner.

(ii) The Commissioner may accept or reject the proposed findings of fact.

(e) After a request for a hearing under this section, the Commissioner may suspend or postpone the effective date of the challenged order or decision until the hearing is concluded and the Commissioner issues an order.

(f) If the Commissioner fails to hold or conclude the hearing or issue an order within the time required under this section, the filing or application at issue is deemed to meet the requirements of this title and is deemed approved.

(g) This subtitle does not require the observance of formal rules of pleading or evidence at any hearing.

§11–503.

(a) An order or decision of the Commissioner under this title is subject to judicial review by appeal to the Circuit Court for Baltimore City.

(b) (1) Within 30 days after the issuance of an order or decision of the Commissioner, an appeal may be commenced by filing a notice of appeal with the Circuit Court for Baltimore City and a copy of the notice of appeal with the Commissioner.

(2) If an appeal is not commenced under paragraph (1) of this subsection, the right to appeal no longer exists.

(3) The Commissioner shall be made a party to each appeal under this section.

(c) (1) After a copy of the notice of appeal is filed with the Commissioner, the Commissioner shall prepare or cause to be prepared an official record.

(2) The official record:

(i) shall be certified by the Commissioner;

(ii) shall include a copy of:

1. all proceedings;

2. the findings and order of the Commissioner; and

3. a transcript of any testimony and exhibits or records; and

(iii) may be in typewritten form.

(3) If a hearing was not held by the Commissioner on the matter that is the subject of the appeal, the Commissioner shall prepare and certify a transcript of the files in the office of the Commissioner relating to the matter.

(4) Within 30 days after a copy of the notice of appeal is filed with the Commissioner, the Commissioner shall file the official record with the Circuit Court for Baltimore City.

(d) (1) Except as provided in paragraph (2) of this subsection, the filing of the notice of appeal acts as a stay of a ruling, order, or decision of the Commissioner pending the final determination of the issue if the ruling, order, or decision relates to an increase or decrease of premiums or rate or to a change in a rating system.

(2) Paragraph (1) does not apply if the ruling, order, or decision approves or allows a filing of an insurer or rating organization.

(e) (1) Within 60 days after the date of the filing of a notice of appeal, the Circuit Court for Baltimore City shall:

(i) hear and decide the appeal; and

(ii) affirm, reverse, or modify the order or decision of the Commissioner from which the appeal is taken.

(2) The Circuit Court for Baltimore City shall reverse or modify the order or decision of the Commissioner wholly or partly if the court finds that the order or decision:

(i) is not supported by the preponderance of the evidence on consideration of the record as a whole; or

(ii) is not in accordance with law.

(f) (1) An appeal to the Appellate Court of Maryland may be taken from the decision of the Circuit Court for Baltimore City as in other civil cases.

(2) The Commissioner shall be made a party to each appeal to the Appellate Court of Maryland under paragraph (1) of this subsection.

§11–601.

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

(b) "Carrier" means a person that:

(1) offers a health benefit plan in the State; and

(2) is:

(i) an insurer;

(ii) a nonprofit health service plan; or

(iii) a health maintenance organization.

(c) "Contract holder" means a person to which a carrier has issued a health benefit plan.

(d) (1) "Health benefit plan" means:

(i) a health insurance contract, a nonprofit health service plan contract, or a health maintenance organization contract that includes benefits for medical care; or

(ii) a certificate of health insurance issued or delivered to a Maryland resident under a contract issued to an association located in the State or any other state.

(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;

7. coverage for on–site medical clinics; and

8. other similar insurance coverage, as specified in federal regulations issued pursuant to P.L. 104–191, under which benefits for medical care are secondary or incidental to other insurance benefits;

(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 health benefit plan:

1. limited scope dental or vision benefits;

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

3. other similar limited benefits as specified in federal regulations issued pursuant to P.L. 104–191;

(iii) the following benefits if offered as independent, noncoordinated benefits:

1. coverage only for a specified disease or illness; and

2. hospital indemnity or other fixed indemnity insurance; or

(iv) the following benefits if offered as a separate policy, certificate, or contract of insurance:

1. Medicare supplemental health insurance, as defined in § 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.

(e) "Medical care" means:

(1) items or services for the diagnosis, cure, mitigation, treatment, or prevention of a disease, injury, or condition affecting any structure or function of the body; and

(2) transportation primarily for and essential to medical care described in item (1) of this subsection.

§11–602.

This subtitle applies to a carrier that issues or delivers a health benefit plan in the State.

§11–603.

(a) A carrier subject to this subtitle may not charge a premium to a contract holder or to an individual covered under a health benefit plan before the applicable premium rate is filed with and approved by the Commissioner.

(b) A carrier subject to this subtitle may not change the premium charged to a contract holder or to an individual covered under a health benefit plan until the applicable premium rate change has been filed with and approved by the Commissioner.

(c) (1) Any applicable premium rate or premium rate change of a carrier subject to this subtitle shall be filed with the Commissioner:

(i) for insurers, in accordance with § 12–203 of this article and regulations adopted under Title 31, Subtitle 10 of the Code of Maryland Regulations;

(ii) for nonprofit health service plans, in accordance with § 14–126 of this article; and

(iii) for health maintenance organizations, in accordance with § 19–713 of the Health – General Article and regulations adopted under Title 31, Subtitle 12 of the Code of Maryland Regulations.

(2) (i) The Commissioner shall disapprove or modify a proposed premium rate filing if the proposed premium rates appear, based on statistical analysis and reasonable assumptions, to be inadequate, unfairly discriminatory, or excessive in relation to benefits.

(ii) In determining whether to disapprove or modify a premium rate filing of a carrier, the Commissioner shall consider, to the extent appropriate:

1. past and prospective loss experience in and outside the State;

2. underwriting practice and judgment;

3. a reasonable margin for reserve needs;

4. past and prospective expenses, both countrywide and those specifically applicable to the State; and

5. any other relevant factors in and outside the State.

(3) (i) Each premium rate filing and any supporting information filed under this subtitle shall be open to public inspection as soon as filed.

(ii) A carrier may request a finding by the Commissioner that certain information filed with the Commissioner be considered confidential commercial information under § 4–335 of the General Provisions Article and not subject to public inspection.

(iii) On request and payment of a reasonable fee, a person may obtain copies of a premium rate filing and any supporting information.

(d) Notwithstanding the Commissioner's previous approval of a premium rate filing of a carrier subject to this section, the Commissioner, at any time, may require the carrier to demonstrate that, based on statistical analysis and reasonable assumptions and considering the factors listed in subsection (c)(2) of this section, its premium rates for a health benefit plan are not inadequate, unfairly discriminatory, or excessive in relation to benefits.

(e) (1) If, after the applicable review period, the Commissioner finds that the premium rates in a premium rate filing of a carrier subject to this section are inadequate, unfairly discriminatory, or excessive, as determined under subsection (c)(2) of this section, the Commissioner shall issue to the carrier an order that:

(i) specifies the reasons why the premium rate filing is inadequate, unfairly discriminatory, or excessive in relation to benefits under subsection (c)(2) of this section; and

(ii) states when, within a reasonable period after the order, the premium rate filing will no longer be effective.

(2) (i) The Commissioner shall hold a hearing before issuing an order under paragraph (1) of this subsection.

(ii) The Commissioner shall give written notice of the hearing to the carrier at least 10 days before the hearing.

(iii) The written notice shall specify the matters to be considered at the hearing.

(3) An order issued under paragraph (1) of this subsection does not affect a health benefit plan issued or delivered before the expiration of the period stated in the order.

(f) Each decision or finding of the Commissioner about premium rates made under this subtitle is subject to judicial review in accordance with Subtitle 5 of this title.

§11–604.

A carrier shall provide notice annually to its insureds and enrollees, and post a notice on the carrier's Web site, that an insured or enrollee may access information about proposed rate increases and submit comments regarding proposed rate increases on the Administration's Web site.

§11–701.

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

(b) "Carrier" means an insurer, a nonprofit health service plan, or a preferred provider organization that offers, issues, or delivers a policy, contract, or certificate of long–term care insurance in the State.

(c) "Certificate" has the meaning stated in § 18–101 of this article.

(d) "Long–term care insurance" has the meaning stated in § 18–101 of this article.

§11–702.

The Commissioner shall provide information on the Administration's Web site describing:

(1) the factors that carriers use to determine premium rates for policies or contracts of long–term care insurance; and

(2) the process and factors that the Administration uses in reviewing and approving premium rates for policies or contracts of long–term care insurance.

§11–703.

(a) A carrier may not charge a premium to an insured under a policy or contract of long–term care insurance before the applicable premium rate is filed with and approved by the Commissioner.

(b) A carrier may not change the premium charged to an insured under a policy or contract of long–term care insurance until the applicable premium rate change has been filed with and approved by the Commissioner.

(c) (1) Any applicable premium rate or premium rate change of a carrier shall be filed with the Commissioner in accordance with regulations adopted by the Commissioner.

(2) (i) The Commissioner shall disapprove or modify a proposed premium rate filing if the proposed premium rates appear, based on actuarial analysis and reasonable assumptions, to be inadequate, unfairly discriminatory, or excessive in relation to benefits.

(ii) In determining whether to disapprove or modify a premium rate filing of a carrier, the Commissioner shall consider, to the extent appropriate:

1. past and prospective loss experience in and outside the State;

2. underwriting practice and judgment;

3. a reasonable margin for reserve needs;

4. past and prospective expenses, both countrywide and those specifically applicable to the State; and

5. any other relevant factors in and outside the State.

(3) (i) Each premium rate filing and any supporting information filed under this subtitle shall be open to public inspection as soon as filed.

(ii) A carrier may request a finding by the Commissioner that certain information filed with the Commissioner be considered confidential commercial information under § 4–335 of the General Provisions Article and not subject to public inspection.

(iii) On request and payment of a reasonable fee, a person may obtain copies of a premium rate filing and any supporting information.

(d) (1) Except as provided in paragraph (2) of this subsection, at least quarterly, the Commissioner shall hold a public hearing to review long–term care insurance rate filings received by the Commissioner during the preceding 3–month period.

(2) A public hearing is not required if the Commissioner has not received a long–term care insurance rate filing during the preceding 3–month period.

(e) The Commissioner shall provide all individuals present at a public hearing held under this subtitle who wish to testify an opportunity to do so, but may limit repetitious testimony.

(f) Each decision or finding of the Commissioner about premium rates made under this subtitle is subject to judicial review in accordance with Subtitle 5 of this title.

§11–704.

(a) A carrier shall provide a one–time written notice to its insureds that an insured may access information about proposed rate increases on the Administration's Web site.

(b) (1) For a policy or contract issued or delivered on or after January 1, 2018, the one–time written notice shall be provided at the time the policy or contract is issued or delivered.

(2) For a policy or contract issued or delivered before January 1, 2018, the one–time written notice shall be provided no later than the next policy or contract anniversary date after January 1, 2018.

§11–801.

(a) In this section, "travel insurance" has the meaning stated in § 10–101 of this article.

(b) Notwithstanding any other provision of this article, travel insurance shall be classified and filed for purposes of rates and forms under an inland marine line of insurance.

(c) Travel insurance may be in the form of an individual, a group, or a blanket policy.

(d) Eligibility and underwriting standards for travel insurance may be developed and provided based on travel protection plans designed for individual or identified marketing or distribution channels if those standards also meet the State's underwriting standards for inland marine lines of insurance and applicable provisions of § 27–501 of this article.

§12–101.

This title does not apply to reinsurance and wet marine and transportation insurance.

§12–102.

(a) Except as provided in subsection (b)(1) of this section, an insurance contract or annuity contract shall contain the standard provisions required under this article.

(b) (1) The Commissioner may waive the required use of a provision in an insurance policy or contract form if the Commissioner:

(i) finds that the provision is unnecessary to protect the insured or is inconsistent with the purposes of the policy; and

(ii) approves the policy.

(2) A required standard provision may not be waived by agreement between an insurer and another person.

(c) (1) (i) In this subsection the following words have the meanings indicated.

(ii) "Carrier" means:

1. an insurer authorized to sell health insurance;

2. a nonprofit health service plan;

3. a health maintenance organization; or

4. any other entity providing a plan of health insurance, health benefits, or health services authorized under this article or the Affordable Care Act.

(iii) "Enrollee" means an individual entitled to benefits from a carrier's health benefit plan.

(iv) "Health benefit plan" has the meaning stated in § 15–1301 of this article.

(2) Each health benefit plan issued by a carrier shall include provisions that:

(i) permit enrollees a minimum of 1 year after the date of service to submit a claim for the service;

(ii) provide that:

1. an enrollee's legal incapacity shall suspend the time to submit a claim; and

2. the suspension period ends when legal capacity is regained; and

(iii) provide that the failure to submit a claim within 1 year after the date of service does not invalidate or reduce the amount of the claim if:

1. it was not reasonably possible to submit the claim within 1 year after the date of service; and

2. the claim is submitted within 2 years after the date of service.

(d) The Commissioner may approve a substitute provision in an insurance policy or annuity contract if the provision is not less favorable than the required provision to the insured, annuitant, or beneficiary.

(e) Instead of a provision required by this article, a foreign insurer or alien insurer may use a substantially similar provision required by the law of the foreign insurer's or alien insurer's domicile if the substantially similar provision does not conflict with the law of this State.

(f) A policy or contract may not contain a provision that is inconsistent with a standard provision used or required to be used.

§12–103.

An otherwise valid insurance policy, rider, or endorsement issued after December 31, 1963, with a condition or provision that does not comply with the requirements of this article is not invalid but is to be construed and applied in accordance with the condition or provision that would be applicable if the policy, rider, or endorsement were in full compliance with this article.

§12–104.

(a) A provision in an insurance contract or surety contract that sets a shorter time to bring an action under or on the insurance contract or surety contract than required by the law of the State when the insurance contract or surety contract is issued or delivered is against State public policy, illegal, and void.

(b) If an insurance contract or surety contract contains a provision that is illegal under this section:

(1) a State court may not give effect to the provision; and

(2) a defense to liability under the insurance contract or surety contract may not be based upon the shorter limitation period.

§12–105.

Without limitation of any right or defense of an insurer, the following acts by or on behalf of an insurer are not considered to be a waiver of a provision of a policy or of a defense of the insurer under the policy:

(1) acknowledging the receipt of notice of loss or claim under the policy;

(2) furnishing a form for:

(i) reporting a loss or claim;

(ii) giving information relating to a loss or claim; or

(iii) making proof of a loss;

(3) receiving or acknowledging receipt of a form or proof listed in item (2) of this section, completed or uncompleted;

(4) investigating a loss or claim under a policy; or

(5) engaging in negotiations toward settlement of a loss or claim.

§12–106.

(a) (1) In this section the following words have the meanings indicated.

(2) (i) "Material risk factor" means a risk factor that:

1. was incorrectly recorded or not disclosed by the insured in an application for insurance;

2. was in existence on the date of the application; and

3. modifies the premium charged on the policy or binder in accordance with the rates and supplementary rating information filed by the insurer under Title 11, Subtitle 3 of this article.

(ii) "Material risk factor" does not include:

1. information that constitutes a material misrepresentation; or

2. a change initiated by an insured, including any request by the insured that results in a change in coverage, change in deductible, or other change to a policy.

(3) "Personal insurance" means property insurance or casualty insurance issued to an individual, trust, estate, or similar entity that is intended to insure against loss arising principally from the personal, noncommercial activities of the insured.

(b) This section applies only to a binder or policy, other than a renewal policy, of personal insurance, commercial property insurance, and commercial liability insurance.

(c) A binder or policy is subject to a 45–day underwriting period beginning on the effective date of coverage.

(d) (1) An insurer may cancel a binder or policy during the underwriting period if the risk does not meet the underwriting standards of the insurer.

(2) If the insurer discovers a material risk factor during the underwriting period, the insurer shall recalculate the premium for the policy or binder based on the material risk factor as long as the risk continues to meet the underwriting standards of the insurer in accordance with the rates and supplementary rating information filed by the insurer under Title 11, Subtitle 3 of this article.

(3) An insurer that recalculates a premium under paragraph (2) of this subsection shall provide a written notice to the insured on a form approved by the Commissioner that states:

(i) the amount of the recalculated premium;

(ii) the reason for the increase or reduction in the premium; and

(iii) the insured's right to terminate the policy.

(e) If applicable, at the time of application or when a binder or policy is issued, an insurer shall provide written notice of its ability to cancel a binder or policy or recalculate the premium from the effective date of the policy during the underwriting period.

(f) (1) Except as provided in paragraph (2) of this subsection, a notice of cancellation under this section shall:

(i) be in writing;

(ii) have an effective date not less than 15 days after mailing;

(iii) state clearly and specifically the insurer's actual reason for the cancellation; and

(iv) be sent by a first–class mail tracking method to the named insured's last known address.

(2) A notice of cancellation under this section for nonpayment of premium shall:

(i) be in writing;

(ii) have an effective date of not less than 10 days after mailing;

(iii) state the insurer's intent to cancel for nonpayment of premium; and

(iv) be sent by a first–class mail tracking method to the named insured's last known address.

(3) With respect to a workers' compensation insurance policy or binder, the insurer shall file a copy of the notice of cancellation required under paragraph (1) or (2) of this subsection with the designee of the Workers' Compensation Commission.

(g) A binder or other contract for temporary insurance:

(1) may be made orally or in writing; and

(2) except as superseded by the clear and express terms of the binder, is considered to include:

(i) all the usual terms of the policy as to which the binder was given; and

(ii) the applicable endorsements designated in the binder.

(h) A binder is no longer valid after the policy as to which it was given is issued.

(i) (1) If a binder is given to a consumer borrower to satisfy a lender's requirement that the borrower obtain property insurance or credit loss insurance as a condition of making a loan secured by a first mortgage or first deed of trust on an interest in owner–occupied residential real property, the insurer or its insurance producer shall include in or with the binder:

(i) the name and address of the insured consumer borrower;

(ii) the name and address of the lender;

(iii) a description of the insured residential real property;

(iv) a provision that the binder may not be canceled within the term of the binder unless the lender and the insured borrower receive written notice at least 15 days before the cancellation;

(v) except in the case of the renewal of a policy after the closing of a loan, a paid receipt for the full amount of the applicable premium; and

(vi) the amount of coverage.

(2) With respect to a binder given under this subsection, an insurer:

(i) if the binder is to be canceled, shall give the lender and the insured consumer borrower at least 15 days' written notice before the cancellation; and

(ii) within 45 days after the date the binder was given, shall issue a policy of insurance or provide the required notice of cancellation of the binder.

(j) (1) Subject to paragraph (2) of this subsection, an insurer may rescind a policy or binder of personal automobile insurance if:

(i) the applicant's initial premium payment for the policy or binder is made by a check or other remittance that is not honored on presentation to the financial institution where the check or other remittance is drawn; and

(ii) the insurer has disclosed to the applicant at the time of application that no coverage will be in effect if the initial premium payment is not honored on presentation to the financial institution.

(2) An insurer shall continue or reinstate a policy or binder under paragraph (1) of this subsection without a lapse in coverage if:

(i) 1. the financial institution erroneously failed to honor the check or other remittance; and

2. the applicant:

A. promptly notifies the insurer of the error; and

B. provides documentation of the error to the insurer as it becomes available and on request of the insurer; or

(ii) the applicant or any secured creditor pays the insurer the amount of the initial premium within 5 business days after the insurer has sent notice, as provided in paragraph (3) of this subsection, to the applicant and any secured creditor that the check or other remittance for the initial premium payment was not honored.

(3) To rescind a policy or binder, an insurer shall send, immediately or the next business day after receipt of a notice that the check or other remittance for the initial premium payment was not honored on presentation to the financial institution, written notice to the applicant and any secured creditor, by a first–class mail tracking method and, if available, by electronic mail or other electronic means, to the applicant's and any secured creditor's last known address, stating that:

(i) 1. the policy or binder is rescinded as of its proposed effective date because the applicant's check or other remittance for the initial premium payment was not honored on presentation to the financial institution; and

2. no coverage is in effect under the policy or binder; but

(ii) the insurer shall continue or reinstate the policy or binder without a lapse in coverage if:

1. the financial institution erroneously failed to honor the check or other remittance and the applicant:

A. promptly notifies the insurer of the error; and

B. provides documentation of the financial institution's error to the insurer as it becomes available and on request of the insurer; or

2. the applicant or any secured creditor pays the insurer the amount of the initial premium within 5 business days after the insurer has sent notice to the applicant and any secured creditor that the check or other remittance for the initial premium payment was not honored.

§12–107.

(a) Notwithstanding any provision of this article or other law that specifies the content of policies, the Commissioner may approve and insurers may issue simplified policies of insurance that provide broad coverage of all or various combinations of risks.

(b) The Commissioner shall adopt regulations that:

(1) specify the standards that must be met by insurers for issuing simplified policies; and

(2) ensure protections to policyholders and claimants that are not less favorable than protections to which they would be entitled under a substantially similar policy that is not subject to this section.

§12–201.

(a) (1) An individual of competent legal capacity may procure or effect an insurance contract on the individual's own life or body for the benefit of any person.

(2) Except as provided in subsection (c) of this section, a person may not procure or cause to be procured an insurance contract on the life or body of another individual unless the benefits under the insurance contract are payable to:

(i) the individual insured;

(ii) the individual insured's personal representative; or

(iii) a person with an insurable interest in the individual insured at the time the insurance contract was made.

(b) (1) With reference to personal insurance, an insurable interest includes only the interests described in this subsection.

(2) (i) For individuals related closely by blood or law, a substantial interest engendered by love and affection is an insurable interest.

(ii) For the prospective parent of a prospective adoptive child, an insurable interest exists in the life of the child as of the date of the earlier of:

1. a placement for adoption, as defined in § 5-301 of the Family Law Article, provided that:

A. any consents required under Title 5, Subtitle 3 or Subtitle 3A of the Family Law Article have been given; or

B. a decree awarding guardianship has been granted under Title 5, Subtitle 3 or Subtitle 3A of the Family Law Article; or

2. an interlocutory or final decree of adoption.

(3) For persons other than individuals closely related by blood or law, a lawful and substantial economic interest in the continuation of the life, health, or bodily safety of the individual is an insurable interest but an interest that arises only by, or would be enhanced in value by, the death, disablement, or injury of the individual is not an insurable interest.

(4) (i) This paragraph applies only to employees with respect to whom the corporate employer or an employer sponsored trust for the benefits of employees is the beneficiary under an insurance contract, if the employer is:

1. a private corporation; or

2. a public corporation, the stock of which is traded on a recognized stock exchange or traded in accordance with the National Association of Securities Dealers Automated Quotation (NASDAQ) Systems.

(ii) A lawful and substantial economic interest exists in:

1. a key employee of a private corporation or a public corporation described in subparagraph (i) of this paragraph; and

2. a nonkey employee of a public corporation described in subparagraph (i) of this paragraph if:

A. the employee has been employed by the public corporation for at least 12 consecutive months and consents in writing to the insurance contract; and

B. the amount of insurance coverage on the nonkey employee does not exceed an amount commensurate with employer-provided benefits.

(5) (i) This paragraph applies only to a contract or option for the purchase or sale of:

1. an interest in a business partnership or firm; or

2. stock shares, or an interest in stock shares, of a close corporation.

(ii) An individual party to a contract or option described in subparagraph (i) of this paragraph has an insurable interest in the life of each individual party to the contract or option.

(iii) The insurable interest specified in subparagraph (ii) of this paragraph:

1. is only for the purposes of the contract or option; and

2. is in addition to any other insurable interest that may exist on the life of an individual party to the contract or option.

(6) The trustee of a trust has an insurable interest in the life of an individual insured under a life insurance policy owned by the trust or the trustee of a trust if, on the date on which the policy is issued:

(i) the insured is:

1. the grantor of the trust;

2. an individual related closely by blood or law to the grantor; or

3. an individual in whom the grantor otherwise has an insurable interest; and

(ii) the life insurance proceeds are primarily for the benefit of trust beneficiaries having an insurable interest in the life of the insured.

(7) A partnership, limited partnership, or limited liability company has an insurable interest in the life of an individual insured under a life insurance policy owned by the partnership, limited partnership, or limited liability company if, on the date on which the policy is issued, substantially all of the owners of the partnership, limited partnership, or limited liability company are:

(i) the insured;

(ii) individuals related closely by blood or law to the insured; or

(iii) persons having an insurable interest in the life of the insured.

(c) (1) This subsection applies only to a charitable, benevolent, educational, governmental, or religious institution that is described in § 170(b)(1)(A) or § 501(c)(3) of the Internal Revenue Code, or a trust for the benefit of that institution that is qualified as a pooled income fund under § 642(c)(5) or a charitable remainder trust under § 664 of the Internal Revenue Code.

(2) An institution or trust described in paragraph (1) of this subsection may procure or cause to be procured an insurance policy on the life of an individual if:

(i) the institution or trust is designated irrevocably as the beneficiary of the insurance policy; and

(ii) the application for the insurance policy is signed by the individual whose life is to be insured or the individual's legal guardian.

(3) This subsection does not prohibit the institution or individual from being the beneficiary or owner of the policy or paying the premiums for the policy.

(d) If a beneficiary, assignee, or other payee under an insurance contract made in violation of this section receives from the insurer benefits that accrue on the insured's death, disablement, or injury, the insured or the insured's executor or

administrator may bring an action to recover benefits from the payee that receives them.

(e) Notwithstanding subsection (b)(4) of this section, a corporate employer with an insurable interest in employees described in subsection (b)(3) or (4) of this section may not retaliate against an employee who refuses to consent to an insurance contract being purchased in the employee's name.

§12–202.

(a) (1) This subsection does not apply to a contract of group life insurance or group or blanket health insurance.

(2) Except as provided in subsection (b) of this section, a life insurance or health insurance contract may not be made or put into effect unless at the time of making the contract the individual to be insured:

(i) is of competent legal capacity to contract; and

(ii) applies for or consents in writing to the contract.

(b) (1) A spouse may put into effect life insurance or health insurance on the other spouse.

(2) A person with an insurable interest in the life of a minor, or a person on whom the minor is dependent for support and maintenance, may put into effect life insurance on or insurance relating to the minor.

(3) A family policy that insures two or more family members may be issued on an application signed by a parent, stepparent, husband, or wife.

(4) A person with an insurable interest in the life of a person who lacks the legal capacity to consent to life insurance may, on written application, put into effect life insurance on that person.

(c) (1) If an agreement in an application for a life insurance or health insurance contract authorizes the insurer to issue a policy other than that applied for or to amend the application, the agreement must contain substantially the following language: "Except that no change in amount, classification, plan of insurance, or benefits may take effect unless agreed to in writing by the applicant".

(2) Ratification of an amendment under paragraph (1) of this subsection is made by the applicant's acceptance of the amended contract.

§12–203.

(a) (1) This section applies to a form for a life insurance or health insurance policy, an annuity contract, an application for that policy or contract that is required to be written, a rider, or an endorsement that:

(i) is delivered or issued for delivery in the State; or

(ii) is used by domestic insurers for delivery in a jurisdiction outside the State, if:

1. the insurance supervisory official of the jurisdiction informs the Commissioner that the form is not subject to approval or disapproval by the official; and

2. the Commissioner requires the form to be submitted to the Commissioner for approval.

(2) This section does not apply to unique riders, endorsements, or forms that are:

(i) designed for and relate to the manner of distribution of benefits or to the reservation of rights and benefits under life insurance or health insurance policies or annuity contracts; and

(ii) used at the request of the individual policyholder, contract holder, or certificate holder.

(b) (1) A form subject to this section may not be delivered or issued for delivery in the State, unless the form has been filed with and approved by the Commissioner.

(2) An individual certificate may not be used in connection with a group or blanket insurance policy or group annuity contract unless the form for the certificate has been filed with and approved by the Commissioner.

(c) (1) The filing of a form with the Commissioner shall be made at least 60 days before delivery.

(2) Approval by the Commissioner of the form constitutes a waiver of any unexpired part of the filing period.

(3) The Commissioner may extend the initial filing period up to an additional 30 days if the Commissioner gives notice of the extension before the initial filing period ends.

(4) The form is deemed approved unless the Commissioner affirmatively approves or disapproves it before the end of the initial filing period or any extended period.

(5) At any time, the Commissioner may withdraw approval of a form, if the Commissioner:

(i) gives prior notice of the withdrawal;

(ii) shows cause for the withdrawal; and

(iii) states the effective date of the withdrawal in the notice.

(6) The withdrawal of approval shall take effect at least 20 days after the withdrawal notice is given.

(d) (1) The Commissioner may order an exemption from this section for as long as the Commissioner considers proper for an insurance document or form or type of insurance document or form if the Commissioner finds that:

(i) this section is not practicably applicable; or

(ii) the filing and approval of the document or form or type of document or form are not desirable or necessary to protect the public.

(2) (i) The Commissioner may adopt regulations to allow a type or kind of form to be effective upon receipt of the filing by the Commissioner.

(ii) If an insurer uses a form which becomes effective in accordance with the provisions of subparagraph (i) of this paragraph and the form would be subject to disapproval under § 12-205(b) of this subtitle, the Commissioner may:

1. subsequently disapprove the form; and

2. impose on the insurer a penalty under § 4-113 of this article.

(iii) If an insurer files a form with the Commissioner which becomes effective in accordance with the provisions of subparagraph (i) of this

paragraph, the insurer shall pay the applicable filing fee provided in § 2-112 of this article.

(e) (1) The Commissioner shall approve life insurance policies, health insurance policies, and annuity contracts in loose-leaf form and shall approve alternate pages submitted separately for use with the policies and contracts if their provisions comply with this article.

(2) Whenever alternate pages are filed after the initial policies or contracts are approved, the Commissioner may require that those policies or contracts also be submitted with an explanation of the intended usage of the alternate pages.

(3) A combination of approved pages may form a complete policy or contract if a schedule is filed with the Commissioner that shows the pages to be used to form each particular policy or contract.

(f) The applicable standards for forms used by domestic insurers for delivery in the State shall apply to forms used by domestic insurers for delivery outside the State.

(g) By regulation, the Commissioner shall adopt the language and format for standard provisions required under § 12-102(a) of this title for contracts and policies issued by insurers, nonprofit health service plans, and health maintenance organizations.

§12–204.

(a) The Commissioner may hold hearings to determine if accident, disability, and health insurance policies meet the requirements of § 12-205 of this subtitle, so that fraud and the issuance of insurance policies economically unsound to insureds may be prevented and to ensure that a minimum amount of benefits or coverage is made available to the policy or certificate holders.

(b) After evaluating the results of a hearing, the Commissioner shall, in compliance with § 12-205 of this subtitle, adopt reasonable regulations establishing minimum benefits or coverages necessary to meet the needs of insureds.

§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.

§12–206.

(a) (1) This subsection does not apply to industrial life insurance policies.

(2) Unless a complete copy of the application for the issuance of a life insurance or health insurance policy or annuity contract is attached to or otherwise made a part of the policy or contract when issued, the application is not admissible in evidence in a proceeding relating to the policy or contract.

(b) (1) If an insured, beneficiary, or assignee of a reinstated or renewed life insurance or health insurance policy that is delivered in the State makes a written request to the insurer for a copy of any application for reinstatement or renewal, the insurer shall deliver or mail the copy within 30 days after the request is received at the insurer's home office or branch office.

(2) If a requested copy is not delivered or mailed, the insurer may not introduce the application in evidence in any proceeding based on or involving the policy, its reinstatement, or its renewal.

(3) If the request is from a beneficiary, the time for the insurer to provide a copy does not begin to run until after the insurer receives evidence that satisfies the insurer of the beneficiary's vested interest in the policy or contract.

(c) (1) Except as provided in paragraph (2) of this subsection, an alteration of a written application for a life insurance or health insurance policy or annuity contract may not be made by a person other than the applicant without the applicant's written consent.

(2) An insurer may make an insertion for administrative purposes only in a way that indicates clearly that the insertion is not to be ascribed to the applicant.

§12–207.

(a) Each statement by or on behalf of the insured or annuitant in an application for the issuance, renewal, or reinstatement of a life insurance or health insurance policy or annuity contract is considered to be a representation and not a warranty.

(b) A misrepresentation, omission, concealment of facts, or incorrect statement does not prevent a recovery under the policy or contract unless:

(1) the misrepresentation, omission, concealment, or statement is fraudulent or material to the acceptance of the risk or to the hazard that the insurer assumes; or

(2) if the correct facts had been made known to the insurer, as required by the application for the policy or contract or otherwise, the insurer in good faith would not have:

(i) issued, reinstated, or renewed the policy or contract;

(ii) issued the policy or contract in as large an amount or at the same premium or rate; or

(iii) provided coverage with respect to the hazard resulting in the loss.

§12–208.

(a) Whenever the proceeds of or payments under a life insurance or health insurance policy or annuity contract become payable in accordance with the policy or contract or in accordance with the exercise of any right or privilege under the policy or contract, and the insurer makes payment in accordance with the policy or contract or in accordance with a written assignment of the policy or contract, the person then designated in the policy or contract or by the assignment as being entitled to the proceeds or payments is entitled to receive the proceeds or payments and to give a full release.

(b) Payment shall discharge the insurer fully from all claims under the policy or contract unless, before payment is made, the insurer has received at its home

office notice written by or on behalf of another person that the other person claims to be entitled to the payment or to some interest in the policy or contract.

§12–209.

A life insurance or health insurance policy or annuity contract may not be delivered or issued for delivery in the State if the policy or contract:

(1) states that the policy or contract is to be construed according to the laws of another state or country;

(2) states that the rights and obligations of the insured or of a person with a claim under the policy or contract are to be governed by laws other than the laws of this State;

(3) provides a period shorter than 3 years within which an action may be brought on the policy or contract;

(4) deprives the courts of the State of the jurisdiction of any action against the insurer;

(5) provides that the insurance producer who solicits the insurance or annuity is the agent of the insured; or

(6) makes the acts or representations of the insurance producer who solicits the insurance or annuity binding on the insured.

§12–210.

(a) On advance written notice to an insurer, the Commissioner may extend by a maximum of 60 days the grace period for making premium payments on life insurance, accident, and health insurance policies if:

(1) an emergency situation exists that would delay or prevent the prompt and orderly payment of the premiums due by all or a substantial number of the insureds of the insurer; and

(2) the emergency is not the fault of the insureds.

(b) For purposes of this section, an emergency situation includes a fire, earthquake, flood, postal strike, insurance producer strike, or other situation that is not under the control of insureds.

§12–211.

(a) In this section, "carrier" means:

(1) an insurer;

(2) a nonprofit health service plan; or

(3) a health maintenance organization.

(b) A health insurance policy, a life insurance policy, an annuity contract, a health maintenance organization contract, or a disability insurance policy may not be sold, delivered, or issued for delivery in the State by a carrier if the policy contains a clause that purports to reserve sole discretion to the carrier to interpret the terms of the policy or to provide standards of interpretation or review that are inconsistent with the laws of the State.

§12–301.

(a) In this section, "insurable interest" means an actual, lawful, and substantial economic interest in the safety or preservation of the subject of the insurance against loss, destruction, or pecuniary damage or impairment to the property.

(b) A contract of property insurance or a contract of insurance of an interest in or arising from property is enforceable only for the benefit of a person with an insurable interest in the property at the time of the loss.

(c) An insurable interest in property is measured by the extent of possible harm to the insured from loss, injury, or impairment of the property.

(d) (1) This subsection applies only to an automobile insurance policy that is procured by an independent insurance producer.

(2) Upon renewal of an existing automobile insurance policy, if the insured or a person holding an insurable interest in the subject of the policy requests proof of insurance, an authorized insurer shall provide:

(i) a copy of the automobile insurance policy declarations; or

(ii) written proof of the automobile insurance that consists of:

1. the name and address of the insured and insurer;

2. a description of the vehicle, including the vehicle identification number, that is the subject of the insurance policy;

3. a description and the amount, if applicable, of the insurance coverage including applicable deductibles;

4. the inception and expiration dates of coverage;

5. the name and address of the person with an insurable interest; and

6. the premium for the applicable coverage.

(e) An insurer may require written authorization from the insured before providing proof of insurance under this section to a person other than a financial institution.

§12–302.

(a) A guardian of a minor may insure for the minor property that the minor owns.

(b) A property insurance contract issued to a guardian under subsection (a) of this section has the same effect as if the minor were an adult and had made the property insurance contract.

§12–303.

A change of interest on the death of the insured does not void property insurance and the property insurance passes to the person taking the interest in the property.

§12–304.

(a) If an insurer issues and delivers a policy to a lender on property of a borrower that has been pledged, mortgaged, or is subject to a conditional contract of sale, the insurer must issue a certificate to the borrower or owner of the property in accordance with subsection (b) of this section.

(b) The certificate issued under this section shall set forth:

(1) the coverages provided in the policy;

(2) the amount of premium charged for the policy;

(3) the date the policy takes effect; and

(4) the date the policy expires.

§12–305.

(a) A claim for damage to property resulting from a motor vehicle accident may not be denied or payment of the claim delayed because the claimant, or another person, has a claim pending for bodily injury that may have arisen from the same or another accident.

(b) The amount payable for a claim for damage to property is due and owing immediately and shall be paid promptly by an insurer or by a self-insurer that is approved under § 17-103(a) of the Transportation Article if:

(1) the insurer or self-insurer has provided the coverage for the liable party; and

(2) there is no significant dispute about:

(i) the liability for the payment of the full property damages; or

(ii) the monetary amount of those damages, including:

1. if claimed, an amount for the loss of the use of the motor vehicle; and

2. the cost of obtaining an estimate of repairs.

§12–306.

A settlement made by an insurer or a self-insurer approved under § 17-103(a) of the Transportation Article under a motor vehicle liability insurance policy of a claim arising from an accident or other event for damage to or destruction of property owned by another person:

(1) may not be construed as an admission of liability by the insured or recognition of liability by the insurer or self-insurer with respect to another claim arising from the same accident or event; and

(2) does not preclude a claim for bodily injury or other claims outside the scope of the settlement.

§13–101.

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

(b) "Credit health insurance" means insurance on a debtor that provides indemnity for payments that are due on a specific loan or other credit transaction while the debtor is disabled as defined by the policy.

(c) "Credit involuntary unemployment benefit insurance" means insurance on a debtor that provides indemnity for payments that are due on a specific loan or other credit transaction while the debtor is involuntarily unemployed as defined by the policy.

(d) "Credit life insurance" means insurance on the life of a debtor in connection with a specific loan or other credit transaction.

(e) "Creditor" means:

(1) a lender of money or vendor or lessor of goods, services, or property rights or privileges for which payment is arranged through a credit transaction;

(2) a successor to the right, title, or interest of the lender, vendor, or lessor;

(3) an affiliate, associate, subsidiary, director, officer, or employee of the lender, vendor, or lessor; or

(4) any other person in any way associated with the lender, vendor, or lessor.

(f) (1) "Debtor" means a borrower of money or purchaser or lessee of goods, services, or property rights or privileges for which payment is arranged through a credit transaction.

(2) "Debtor" includes the husband or wife or both, as specified in the certificate of insurance, if the husband and wife are jointly liable under a contract of indebtedness.

(g) "Indebtedness" means the total amount payable by a debtor to a creditor in connection with a loan or other credit transaction.

§13–102.

(a) The purpose of this title is to promote the public welfare by regulating credit life insurance, credit health insurance, and credit involuntary unemployment benefit insurance.

(b) This title is not intended to prohibit or discourage reasonable competition.

(c) This title shall be construed liberally.

§13–103.

(a) Except as provided in subsection (b) of this section, all credit life insurance, all credit health insurance, and all credit involuntary unemployment benefit insurance are subject to this title.

(b) This title does not apply to insurance if:

(1) the insurance is in connection with a loan or other credit transaction for which premiums are payable for more than 10 years; or

(2) the issuance of the insurance is an isolated transaction by an insurer that is not related to an agreement or plan for insuring debtors of the creditor.

§13–104.

Each policy of credit life insurance, credit health insurance, or credit involuntary unemployment benefit insurance shall be:

(1) delivered or issued for delivery in the State only by an authorized insurer; and

(2) issued only through a holder of a license, certificate of authority, or certificate of qualification issued by the Commissioner.

§13–105.

Credit life insurance, credit health insurance, and credit involuntary unemployment benefit insurance shall be issued only in the following forms:

(1) an individual policy of life insurance issued to a debtor on a term plan;

(2) an individual policy of health insurance issued to a debtor on a term plan;

(3) a disability benefit provision in an individual policy of credit life insurance;

(4) an individual policy of involuntary unemployment benefit insurance issued to a debtor on a term plan;

(5) a group policy of life insurance issued to a creditor that provides insurance on the lives of debtors on the term plan;

(6) a group policy of health insurance issued to a creditor on a term plan that insures debtors;

(7) a disability benefit provision in a group policy of credit life insurance; or

(8) a group policy of involuntary unemployment benefit insurance issued to a creditor on a term plan that insures debtors.

§13–106.

(a) (1) The initial amount of credit life insurance may not exceed the total amount repayable under the contract of indebtedness.

(2) Notwithstanding any other provision of this title, insurance on an agricultural credit transaction commitment not exceeding a term of 1 year may be written up to the amount of the loan commitment on a nondecreasing or level term plan.

(3) Notwithstanding any other provision of the Code, insurance on an educational credit transaction commitment may be written for the amount of that part of the commitment that has not been advanced by the creditor.

(b) (1) The total amount of periodic indemnity payable by credit health insurance in the event of disability may not exceed the aggregate of the periodic scheduled unpaid installments of the indebtedness.

(2) The amount of each periodic indemnity payment under a policy of credit health insurance may not exceed the original indebtedness divided by the number of periodic installments.

§13–107.

(a) (1) Except as provided in paragraph (2) of this subsection, the term of credit life insurance, credit health insurance, or credit involuntary unemployment benefit insurance subject to acceptance by the insurer, begins on the date that the debtor becomes obligated to the creditor.

(2) If a group policy provides coverage for an existing obligation, the credit life insurance, credit health insurance, or credit involuntary unemployment benefit insurance begins on the effective date of the group policy.

(b) If an insurer requires evidence of insurability and the evidence is provided more than 30 days after the debtor becomes obligated to the creditor:

(1) the term of the credit life insurance, credit health insurance, or credit involuntary unemployment benefit insurance may begin on the date that the insurer determines that the evidence is satisfactory; and

(2) the insurer shall refund or adjust any charge to the debtor for insurance as appropriate.

(c) (1) The term of credit life insurance, credit health insurance, or credit involuntary unemployment benefit insurance may not extend more than 15 days after the scheduled maturity date of the indebtedness, unless the term is extended without additional cost to the debtor.

(2) If the indebtedness is discharged before its scheduled maturity date due to renewal or refinancing, the insurer shall terminate the credit life insurance, credit health insurance, or credit involuntary unemployment benefit insurance in force before issuance of any new credit life insurance, credit health insurance, or credit involuntary unemployment benefit insurance for the renewed or refinanced indebtedness.

(3) The insurer shall pay or credit a refund as provided in § 13-112 of this title in all cases of termination of the insurance before the scheduled maturity date of the indebtedness.

§13–108.

(a) Credit life insurance, credit health insurance, and credit involuntary unemployment benefit insurance shall be evidenced by an individual policy or, in the case of group insurance, a group certificate of insurance.

(b) In addition to other requirements of law, each individual policy or group certificate of credit life insurance, credit health insurance, or credit involuntary unemployment benefit insurance shall include:

(1) the name and home office address of the insurer;

(2) the name of the insured debtor under an individual policy, or the name or other identification of the insured debtor under a group certificate;

(3) the premium or amount of payment, if any, paid by the debtor shown separately for credit life insurance, credit health insurance, and credit involuntary unemployment benefit insurance;

(4) a description of the coverage, including the amount and term of the coverage and any exceptions, limitations, or restrictions; and

(5) a statement that the benefits shall be paid to the creditor to reduce or extinguish the unpaid indebtedness and, if the amount of credit life insurance, credit health insurance, or credit involuntary unemployment benefit insurance exceeds the unpaid indebtedness, the excess shall be payable to a beneficiary, other than the creditor, named by the debtor or to the estate of the debtor.

§13–109.

(a) Except as otherwise provided in this section, the individual policy or group certificate of credit life insurance, credit health insurance, or credit involuntary unemployment benefit insurance shall be delivered to the insured debtor when the indebtedness is incurred.

(b) (1) If the individual policy or group certificate is not delivered to the debtor when the indebtedness is incurred, a copy of the application for the policy or a notice of proposed insurance shall be delivered to the debtor when the indebtedness is incurred.

(2) The application for the policy or notice of proposed insurance shall:

(i) be signed by the debtor;

(ii) include:

1. the name and home office address of the insurer;

2. the name of the insured debtor;

3. the premium or amount of payment, if any, paid by the debtor shown separately for credit life insurance, credit health insurance, and credit involuntary unemployment benefit insurance;

4. a brief description of the coverage, including the amount and term of the coverage; and

5. a statement that the proposed insurance becomes effective under § 13-107 of this title on acceptance by the insurer;

(iii) refer exclusively to insurance coverage; and

(iv) be separate from the loan, sale, or other credit statement of account, instrument, or agreement, unless that document sets forth prominently the information required by this paragraph.

(3) If the insurer accepts the insurance, within 30 days after the date the indebtedness is incurred, the insurer shall cause the individual policy or group certificate to be delivered to the debtor.

(c) If the named insurer does not accept the risk:

(1) the debtor shall receive an individual policy or group certificate that sets forth the name and home office address of the substituted insurer, if any, and the amount of the premium to be charged; and

(2) an appropriate refund shall be made if the amount of the premium charged by the substituted insurer is less than the premium set forth in the notice of proposed insurance.

§13–110.

(a) Each form for a policy, certificate of insurance, notice of proposed insurance, application for insurance, endorsement, or rider delivered or issued for delivery in the State and each related schedule of premium rates shall be filed with the Commissioner for approval.

(b) (1) Within 60 days after a form or premium rate described in subsection (a) of this section is filed, the Commissioner shall disapprove the filing if:

(i) the table of premium rates appears by reasonable assumptions to be excessive in relation to benefits; or

(ii) the form contains provisions that:

1. are unjust, unfair, inequitable, misleading, or deceptive;

2. encourage misrepresentation of the coverage; or

3. are contrary to a provision of this article or a regulation adopted under this article.

(2) In making a determination under paragraph (1) of this subsection, the Commissioner shall consider:

(i) past and prospective loss experience within and outside the State;

(ii) underwriting practice and judgment to the extent appropriate;

(iii) a reasonable margin for underwriting profit and contingencies;

(iv) past and prospective expenses, whether countrywide or specially applicable to the State; and

(v) all other relevant factors within and outside the State.

(3) If the Commissioner disapproves a form or premium rate, the Commissioner shall:

(i) notify the insurer of the disapproval and specify in the notice the reason for disapproval; and

(ii) state that a hearing on the disapproval will be held within 20 days after receipt of a written request by the insurer.

(4) After notification of disapproval, an insurer may not issue or use the disapproved form or premium rate.

(c) An insurer may not issue or use a form or premium rate filed under this section until the end of the 60–day period unless the Commissioner approves the filing in writing before the end of the period.

(d) (1) The Commissioner may withdraw approval of a form or premium rate if the Commissioner:

(i) notifies the insurer in writing of the proposed withdrawal;

(ii) specifies in the notice the reason for withdrawal;

(iii) states that a hearing on the withdrawal will be held not less than 20 days after the date of the notice; and

(iv) bases the withdrawal of approval on a ground set forth in subsection (b)(1) of this section.

(2) An insurer may not issue or use a form or premium rate after the effective date of withdrawal of approval by the Commissioner.

(e) (1) If a group policy of credit life insurance, credit health insurance, or credit involuntary unemployment benefit insurance was delivered in the State before April 28, 1970, or is delivered in another state, the insurer shall file with the Commissioner only the group certificate and notice of proposed insurance that have been delivered or issued for delivery in this State.

(2) The Commissioner shall approve the group certificate and notice of proposed insurance if:

(i) the group certificate and notice conform with §§ 13-108(b) and 13-109(b) of this title; and

(ii) the schedule of premium rates for the group insurance does not exceed the schedule of premium rates that the insurer has filed with the Commissioner.

(f) (1) The purpose of this subsection is to ensure that the credit life insurance, credit health insurance, or credit involuntary unemployment benefit insurance operations of the insurer do not:

(i) result in rates that are excessive in relation to benefits;

(ii) endanger the solvency of the insurer so that its transaction of business is hazardous to its policyholders or the public; or

(iii) adversely affect another class of business of the insurer.

(2) To accomplish this purpose, the Commissioner may establish:

(i) the maximum rates of commission or other compensation that may be paid to insurance producers; and

(ii) standards for the maximum amounts of dividends, retrospective rate credits, and any other form of refund or benefit to policyholders.

(g) An order of the Commissioner under this section is subject to judicial review in accordance with § 2-215 of this article.

§13–111.

(a) (1) In this section the following words have the meanings indicated.

(2) "Account" means the coverage for a single plan of benefits under one premium payment method offered to a single class of business by one creditor written on a group or individual basis or both.

(3) "Case" means an account of an insurer or, at the option of the insurer, a combination of accounts of the insurer written under an identical plan of benefits for which the premiums for the account or combination of accounts exceed, or reasonably may be expected to exceed, $50,000 in a policy year.

(4) "Class of business" means:

(i) cash loans made by banks and not secured by real estate;

(ii) cash loans made by banks and secured by real estate;

(iii) cash loans made by credit unions;

(iv) cash loans made by creditors other than banks and credit unions and not secured by real estate;

(v) cash loans made by creditors other than banks and secured by real estate;

(vi) production credit association and other agricultural loans;

(vii) installment sales finance contracts; or

(viii) open end credit, including revolving charge agreements and credit card accounts.

(5) "Experience period" means 2 calendar years or, at the option of the insurer, 2 policy years under a group policy issued to one creditor.

(6) "Loss ratio" means the ratio of incurred claims to premiums earned.

(b) (1) An insurer may revise its schedules of premium rates from time to time.

(2) The insurer shall file any revised schedules with the Commissioner for approval.

(3) An insurer may not issue a policy of credit life insurance, credit health insurance, or credit involuntary unemployment benefit insurance if the premium rate exceeds the premium rate contained in the schedules of the insurer on file with the Commissioner.

(4) If the Commissioner approves the premium rate for a policy of credit life insurance, credit health insurance, or credit involuntary unemployment benefit insurance under § 13-110 of this title, the premium rate is presumed to be reasonable in relation to benefits.

(c) The amount charged to a debtor for credit life insurance, credit health insurance, or credit involuntary unemployment benefit insurance may not exceed the aggregate of the premiums to be charged by the insurer, as computed at the time the charge to the debtor is determined.

(d) (1) Within 120 days after the expiration of an experience period established for a case, the insurer shall file with the Commissioner an appropriate experience report that is signed by the actuary of the insurer certifying the loss ratio for the case.

(2) If the loss ratio certified for a case under paragraph (1) of this subsection satisfies the loss ratio guideline adopted by the Commissioner, the insurer may continue to charge the existing premium rate.

(3) If the loss ratio certified for a case under paragraph (1) of this subsection is less than the loss ratio guideline, the insurer shall:

(i) reduce the premium rate appropriately with an effective date within 45 days after the experience report was filed under paragraph (1) of this subsection; or

(ii) show cause to the Commissioner why the premium rate should not be reduced.

(4) (i) If the loss ratio certified for a case under paragraph (1) of this subsection is less than the loss ratio guideline, and the insurer refuses to reduce the premium rate, then after notice and an opportunity for a hearing, and within 60 days after the insurer filed the experience report, the Commissioner shall notify the insurer in writing of the premium rate authorized for use with the case.

(ii) The insurer shall implement the premium rate authorized by the Commissioner not later than 45 days after receipt of the notice from the Commissioner.

(e) (1) Every 2 years the Commissioner shall adopt a prima facie acceptable premium rate applicable to each specific plan of benefits for each class of business for:

(i) a new case;

(ii) a case that does not satisfy the experience period requirement; and

(iii) any business that is not a case because premiums do not exceed $50,000 in a policy year.

(2) The prima facie premium rates shall be adopted after notice and hearing.

(3) The prima facie premium rates shall be based on experience for each class of business reported by all insurers that write credit life insurance, credit health insurance, and credit involuntary unemployment benefit insurance in the State, excluding experience for which premium rates are established by case.

(4) The adoption of a prima facie rate by the Commissioner does not prohibit an insurer from filing another premium rate for use with a new case in accordance with § 13-110 of this title.

(f) This title does not authorize payments for insurance prohibited under a statute or regulation that governs credit transactions.

§13–112.

(a) (1) Subject to paragraph (3) of this subsection, each individual policy or group certificate shall provide that any refund of the amount paid by the debtor

for credit life insurance, credit health insurance, or credit involuntary unemployment benefit insurance will be paid or credited promptly to the person entitled to it if the insurance is terminated before the scheduled maturity date of the indebtedness.

(2) The formula to be used in computing a refund shall be filed with and approved by the Commissioner.

(3) The Commissioner shall establish a minimum refund, below which an insurer need not make a refund.

(b) If a creditor requires a debtor to make a payment for credit life insurance, credit health insurance, or credit involuntary unemployment benefit insurance and an individual policy or group certificate is not issued, the creditor immediately shall give written notice to the debtor and promptly shall make an appropriate credit to the debtor's account.

§13–113.

(a) (1) A claimant shall report a claim promptly to the insurer or its designated claim representative.

(2) The insurer shall maintain adequate claim files.

(3) The insurer shall settle a claim as soon as possible and in accordance with the terms of the insurance contract.

(b) The insurer shall pay a claim by a draft drawn on the insurer or by a check of the insurer to the order of:

(1) the claimant to whom payment of the claim is due under the policy; or

(2) a person to whom the claimant directs payment be made.

(c) (1) A plan or arrangement may not be used if it authorizes a person other than the insurer or its designated claim representative to settle or adjust claims.

(2) The creditor may not be designated as the claim representative of the insurer to adjust a claim.

(3) Notwithstanding paragraph (2) of this subsection, by arrangement with the group insurer, a group policyholder may draw a draft or check

in payment of a claim due to the group policyholder subject to audit and review by the group insurer.

§13–114.

(a) (1) If a creditor requires credit life insurance, credit health insurance, or credit involuntary unemployment benefit insurance as additional security for an indebtedness, the debtor may:

(i) provide the required coverage through existing policies that the debtor owns or controls; or

(ii) procure and provide the required coverage through any authorized insurer.

(2) At any time during the credit transaction by giving notice to the creditor, the debtor may choose to provide the required coverage.

(b) (1) On consummation of a credit transaction in which a creditor requires as additional security for an indebtedness, and a debtor agrees to buy, credit life insurance, credit health insurance, or credit involuntary unemployment benefit insurance, the creditor shall notify the debtor in writing of the option referred to in subsection (a) of this section.

(2) The debtor shall acknowledge in writing that the debtor has received notice under paragraph (1) of this subsection.

§13–115.

A creditor may not require that both a husband and wife be insured unless the debtor expressly authorizes that coverage in writing.

§13–116.

(a) An authorized insurer that issues coverage under this title may not engage in fronting agreements with unauthorized insurers with respect to any insurance written or issued in the State under which the authorized insurer by reinsurance or otherwise transfers to one or more unauthorized insurers:

(1) substantially the entire risk of loss under substantially all of the insurance written by the authorized insurer in the State;

(2) all of a kind, line, type, or class of insurance;

(3) all of the business produced through an insurance producer or agency;

(4) all of the business in a designated geographical area; or

(5) all of the business written on a policy form.

(b) (1) This section does not apply to an unauthorized insurer if the unauthorized insurer:

(i) files an annual statement with the Commissioner in accordance with § 4–116 of this article;

(ii) maintains reserves on its life insurance and health insurance business in accordance with § 5–203 and Title 5, Subtitle 3 of this article;

(iii) meets the requirements of Title 5, Subtitles 1 through 5 of this article with regard to the valuation of its assets and liabilities;

(iv) allows examination by the Commissioner in accordance with §§ 2–205 through 2–209 of this article; and

(v) has maintained on its behalf security on deposit with the Commissioner equal to the amount by which the capital and surplus required of an authorized insurer under §§ 4–104 and 4–105 of this article exceeds the actual capital and surplus of the unauthorized insurer.

(2) The security required under paragraph (1)(v) of this subsection may consist of:

(i) cash;

(ii) an irrevocable letter of credit issued by a bank domiciled in the State that may be terminated only after 30 days' written notice sent by certified mail or electronic means in accordance with § 2–116 of this article to the Commissioner;

(iii) obligations, valued at the lower of market value or par value, that are general obligations of, or obligations guaranteed by, the federal government, the State, or a political subdivision of the State; or

(iv) any other type of security that would be acceptable to the Commissioner if posted by a domestic insurer or foreign insurer.

§13–117.

(a) After notice and hearing, the Commissioner may adopt regulations to carry out this title.

(b) If the Commissioner finds that an insurer or other person authorized or licensed by the Commissioner has violated this title or a regulation adopted under this title, then after written notice and a hearing, the Commissioner shall:

(1) set forth the details of the findings; and

(2) issue an order for compliance by a specified date.

(c) An order issued under subsection (b) of this section binds the insurer or other person authorized or licensed by the Commissioner on the date specified unless:

(1) the Commissioner withdraws the order before the specified date; or

(2) a court of competent jurisdiction orders a stay of the order of the Commissioner.

(d) (1) A party to a proceeding under this title that is aggrieved by an order of the Commissioner is entitled to judicial review in accordance with § 2-215 of this article.

(2) The filing of an appeal from the withdrawal of approval of a form or rate previously in use operates as a stay, unless the court determines otherwise.

(e) In addition to any other penalty provided by law, on proof satisfactory to the court, the court may impose on an insurer or other person that violates a final order of the Commissioner while the order is in effect a civil penalty not exceeding $250, or if the violation is willful, a civil penalty not exceeding $1,000.

(f) (1) After notice and a hearing, the Commissioner may suspend or revoke the license, certificate of authority, or certificate of qualification of an insurer or other person that violates a final order of the Commissioner.

(2) The order for suspension or revocation is subject to judicial review in accordance with § 2-215 of this article.

§14–101.

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

(b) "Health care provider" means a chiropractor, dentist, hospital, optometrist, pharmacist, physician, podiatrist, or psychologist.

(c) "Health care services" means chiropractic, dental, hospital, medical, optometric, pharmaceutical, podiatric, or psychological services.

§14–102.

(a) The purpose of this subtitle is:

(1) to regulate the formation and operation of nonprofit health service plans in the State; and

(2) to promote the formation and existence of nonprofit health service plans in the State that:

(i) are committed to a nonprofit corporate structure;

(ii) seek to provide individuals, businesses, and other groups with affordable and accessible health insurance; and

(iii) recognize a responsibility to contribute to the improvement of the overall health status of the residents of the jurisdictions in which the nonprofit health service plans operate.

(b) A nonprofit health service plan that complies with the provisions of this subtitle is declared to be a public benefit corporation that is exempt from taxation as provided by law.

(c) The mission of a nonprofit health service plan shall be, in accordance with the charter of the nonprofit health service plan, to:

(1) provide affordable and accessible health insurance to the plan's insureds and those persons insured or issued health benefit plans by affiliates or subsidiaries of the plan;

(2) assist and support public and private health care initiatives for individuals without health insurance; and

(3) promote the integration of a health care system that meets the health care needs of all the residents of the jurisdictions in which the nonprofit health service plan operates.

(d) A nonprofit health service plan shall develop goals, objectives, and strategies for carrying out, in accordance with the charter of the nonprofit health service plan, its statutory mission.

(e) On or before May 31, 2015, and annually thereafter, the Commissioner shall report to the Governor and, in accordance with § 2–1257 of the State Government Article, the Senate Finance Committee and the House Health and Government Operations Committee on the compliance of a nonprofit health service plan subject to § 14–115(d) of this subtitle with the provisions of this subtitle.

(f) (1) Subject to paragraph (2) of this subsection, this section applies to:

(i) a nonprofit health service plan that is issued a certificate of authority in the State, whether or not organized under the laws of the State; and

(ii) an insurer or a health maintenance organization, whether or not organized as a nonprofit corporation, that is wholly owned or controlled by a nonprofit health service plan that:

1. is issued a certificate of authority in the State; and

2. does business in the State.

(2) To the extent that the legislatively enacted charter of an entity subject to this section, or the laws or administrative rules or regulations of the jurisdiction of domicile of an entity subject to this section, prohibit the entity from complying with a requirement of subsection (c) of this section, the legislatively enacted charter, laws, and administrative rules and regulations of the jurisdiction of domicile shall supersede and take precedence over the requirement of subsection (c) of this section.

(g) A corporation without capital stock organized for the purpose of establishing, maintaining, and operating a nonprofit health service plan through which health care providers provide health care services to subscribers to the plan under contracts that entitle each subscriber to certain health care services shall be governed and regulated by:

(1) this subtitle;

(2) Title 2, Subtitle 2 of this article and §§ 1–206, 3–127, and 12–210 of this article;

(3) Title 2, Subtitle 5 of this article;

(4) §§ 4–113, 4–114, and 4–503 of this article;

(5) Title 5, Subtitles 1, 2, 3, 4, and 5 of this article;

(6) Title 7 of this article, except for § 7–706 and Subtitle 2 of Title 7;

(7) Title 9, Subtitles 1, 2, and 4 of this article;

(8) Title 10, Subtitle 1 of this article;

(9) Title 27 of this article;

(10) Title 33 of this article; and

(11) any other provision of this article that:

(i) is expressly referred to in this subtitle;

(ii) expressly refers to this subtitle; or

(iii) expressly refers to nonprofit health service plans or persons subject to this subtitle.

(h) The provisions of subsections (d) and (e) of this section and §§ 14–106, 14–106.1, 14–115(d), (e), (f), and (g), and 14–139(d) and (e) of this subtitle do not apply to a nonprofit health service plan that insures between 1 and 10,000 covered lives in Maryland or issues contracts for only one of the following services:

(1) podiatric;

(2) chiropractic;

(3) pharmaceutical;

(4) dental;

(5) psychological; or

(6) optometric.

§14–103.

Each nonprofit health service plan shall disclose on each document, statement, announcement, and advertisement and in any representation it places before the public that the nonprofit health service plan is a private nonprofit corporation.

§14–104.

(a) Each nonprofit health service plan that provides hospital benefits shall furnish a statement of the plan's principal claims practices as part of the certificate form or booklet describing the coverage to be afforded.

(b) The statement shall include practices for payment for:

(1) surgical procedures performed by two or more surgeons;

(2) services provided in-area by nonparticipating providers; and

(3) services provided out-of-area by affiliated plans and affiliated providers.

§14–105.

(a) If a nonprofit health service plan is successful in an action against a person authorized to provide health care in the State, the nonprofit health service plan may recover the costs and expenses reasonably incurred by it in the action if it shows that:

(1) the person knowingly or willfully made or caused to be made:

(i) a false statement or representation of a material fact in an application for a benefit or payment from a nonprofit health service plan under this subtitle or Title 15 of this article;

(ii) a false statement or representation of a material fact for use in determining rights to those benefits or payments; or

(iii) a false statement or representation about a procedure, operation, or service alleged to have been performed; or

(2) the person:

(i) engaged in gross, willful, and continued overcharging for a procedure, operation, or service; or

(ii) filed false statements for collection of fees for services that were not rendered.

(b) If a nonprofit health service plan is denied relief in an action under this section, the person against whom the action was brought may recover the costs and expenses reasonably incurred by the person in defending the action.

(c) This section does not limit any additional rights or remedies that a nonprofit health service plan may have at law or in equity.

§14–106.

(a) It is the public policy of this State that the exemption from taxation for nonprofit health service plans under § 6–101(b)(1) of this article is granted so that funds which would otherwise be collected by the State and spent for a public purpose shall be used in a like manner and amount by the nonprofit health service plan.

(b) By March 1 of each year or a deadline otherwise imposed by the Commissioner for good cause, each nonprofit health service plan shall file with the Commissioner a premium tax exemption report that:

(1) is in a form approved by the Commissioner; and

(2) demonstrates that the plan has used funds equal to the value of the premium tax exemption provided to the plan under § 6–101(b) of this article, in a manner that serves the public interest in accordance with this section.

(c) A nonprofit health service plan may satisfy the public service requirement of this section by establishing that, to the extent the value of the nonprofit health service plan's premium tax exemption under § 6–101(b) of this article exceeds the subsidy required under the Senior Prescription Drug Assistance Program established under Title 15, Subtitle 10 of the Health – General Article, the plan has:

(1) increased access to, or the affordability of, one or more health care products or services by offering and selling health care products or services that are not required or provided for by law;

(2) provided financial or in–kind support for public health programs;

(3) employed underwriting standards in a manner that increases the availability of one or more health care services or products;

(4) employed pricing policies that enhance the affordability of health care services or products and result in a higher medical loss ratio than that established by a comparable for–profit health insurer; or

(5) served the public interest by any method or practice approved by the Commissioner.

(d) (1) Notwithstanding subsection (c) of this section, a nonprofit health service plan that is subject to this section and issues comprehensive health care benefits in the State shall:

(i) offer health care products in the individual market;

(ii) offer health care products in the small employer group market in accordance with Title 15, Subtitle 12 of this article;

(iii) subsidize the Senior Prescription Drug Assistance Program established under Title 15, Subtitle 10 of the Health – General Article;

(iv) subsidize the Kidney Disease Program under Title 13, Subtitle 3 of the Health – General Article;

(v) support the costs of the Community Health Resources Commission under Title 19, Subtitle 21 of the Health – General Article, including:

1. operating grants to community health resources;

2. funding for a unified data information system;

3. the documented direct costs of fulfilling the statutory and regulatory duties of the Commission; and

4. the administrative costs of the Commission; and

(vi) subsidize the provision of mental health services to the uninsured under Title 10, Subtitle 2 of the Health – General Article.

(2) (i) Except as provided in subparagraph (ii) of this paragraph, the support provided under paragraph (1)(iv), (v), and (vi) of this subsection to the Kidney Disease Program, the Community Health Resources Commission, and the Maryland Department of Health, respectively, shall be the value of the premium tax exemption less the subsidy required under this subsection for the Senior Prescription Drug Assistance Program.

(ii) The subsidy provided under this subsection to the Community Health Resources Commission may not be less than:

1. $3,000,000 for each of fiscal years 2012 and 2013; and

2. $8,000,000 for each of fiscal years 2014 through 2022.

(3) For any year, the subsidy and funding required under this subsection by a nonprofit health service plan subject to this section may not exceed the value of the nonprofit health service plan's premium tax exemption under § 6–101(b) of this article.

(e) The subsidy that a nonprofit health service plan is required to provide to the Senior Prescription Drug Assistance Program under subsection (d)(1)(iii) of this section:

(1) for the period of January 1, 2006 through June 30, 2006, may not exceed $8,000,000;

(2) for fiscal years 2008 through 2021, may not exceed $14,000,000;

(3) for fiscal year 2022, may not exceed $14,000,000; and

(4) for any year after fiscal year 2022, may not exceed the value of the nonprofit health service plan's premium tax exemption under § 6–101(b) of this article.

(f) (1) Subject to paragraph (2) of this subsection, each report filed with the Commissioner under subsection (b) of this section is a public record.

(2) In accordance with § 4–335 of the General Provisions Article, the Commissioner shall deny inspection of any part of a report filed under subsection (b) of this section that the Commissioner determines contains confidential commercial information or confidential financial information.

§14–106.1.

Beginning in fiscal year 2006, a nonprofit health service plan shall transfer funds in the amounts provided under § 14–106(d)(2) of this subtitle to:

(1) the Community Health Resources Commission Fund established under § 19–2201 of the Health – General Article to support the costs of the

Community Health Resources Commission as provided in § 14–106(d)(1)(v) of this subtitle;

(2) the Maryland Department of Health for the Kidney Disease Program under Title 13, Subtitle 3 of the Health – General Article; and

(3) the Maryland Department of Health for the provision of mental health services to the uninsured under Title 10, Subtitle 2 of the Health – General Article.

§14–107.

(a) By November 1 of each year, the Commissioner shall issue an order notifying each nonprofit health service plan that is required to file a report under § 14–106 of this subtitle of whether the plan has satisfied the requirements of § 14–106 of this subtitle.

(b) If the Commissioner determines that a nonprofit health service plan has not satisfied the requirements of § 14–106 of this subtitle, the Commissioner shall issue an order requiring the nonprofit health service plan to pay the premium tax under Title 6, Subtitle 1 of this article:

(1) for a period of time beginning with the date the plan was determined to be out of compliance with § 14–106 of this subtitle; and

(2) in an amount equal to the amount by which the value of the nonprofit health service plan's premium tax exemption under § 6–101(b) of this article exceeds the sum of:

(i) the subsidy required under the Senior Prescription Drug Assistance Program established under Title 15, Subtitle 10 of the Health – General Article; and

(ii) other funds used by the nonprofit health service plan to meet the public service requirement under § 14–106 of this subtitle.

(c) A nonprofit health service plan that fails to timely file the report required under § 14–106 of this subtitle shall pay the penalties under § 14–121 of this subtitle.

(d) A party aggrieved by an order of the Commissioner issued under this section has a right to a hearing in accordance with §§ 2–210 through 2–215 of this article.

(e) Premium tax revenue collected by the Administration as the result of an order issued under subsection (b) of this section shall be deposited into the Senior Prescription Drug Assistance Program Fund established under § 15–1004 of the Health – General Article.

§14–108.

A corporation subject to this subtitle may not issue contracts for the rendering of health care services to subscribers unless the Commissioner has issued a certificate of authority to the corporation authorizing it to do so.

§14–109.

An applicant for a certificate of authority shall:

(1) file with the Commissioner an application on the form that the Commissioner provides containing the information that the Commissioner considers necessary;

(2) pay to the Commissioner the applicable fee required by § 2-112 of this article; and

(3) file with the Commissioner copies of the following documents, certified by at least two of the executive officers of the corporation:

(i) articles of incorporation, including the applicant's corporate mission statement, with all amendments;

(ii) bylaws with all amendments;

(iii) each contract executed or proposed to be executed by the corporation and a health care provider, embodying the terms under which health care services are to be furnished to subscribers to the plan;

(iv) each form of contract issued or proposed to be issued to subscribers to the plan and a table of the rates charged or proposed to be charged to subscribers for each form of contract;

(v) a financial statement of the corporation, including the amount of each contribution paid or agreed to be paid to the corporation for working capital, the name of each contributor, and the terms of each contribution;

(vi) a list of the names and addresses of and biographical information about the members of the board of directors of the corporation;

(vii) a list of the total compensation paid or proposed to be paid to each officer and member of the board of directors of the corporation;

(viii) a list of the beginning and ending terms of membership for each member of the board of directors of the corporation; and

(ix) any other information or documents that the Commissioner considers necessary to ensure compliance with this subtitle.

§14–110.

(a) The Commissioner shall issue a certificate of authority to an applicant if:

(1) the applicant has paid the applicable fee required by § 2-112 of this article; and

(2) the Commissioner is satisfied:

(i) that the applicant has been organized in good faith for the purpose of establishing, maintaining, and operating a nonprofit health service plan that:

1. is committed to a nonprofit corporate structure;

2. in accordance with the charter of the nonprofit health service plan, seeks to provide affordable and accessible health insurance; and

3. in accordance with the charter of the nonprofit health service plan, recognizes a responsibility to contribute to the improvement of the overall health status of the residents of the jurisdictions in which it operates;

(ii) that:

1. each contract executed or proposed to be executed by the applicant and a health care provider to furnish health care services to subscribers to the nonprofit health service plan, obligates or, when executed, will obligate each health care provider party to the contract to render the health care services to which each subscriber is entitled under the terms and conditions of the various contracts issued or proposed to be issued by the applicant to subscribers to the plan; and

2. each subscriber is entitled to reimbursement for podiatric, chiropractic, psychological, or optometric services, regardless of whether

the service is performed by a licensed physician, licensed podiatrist, licensed chiropractor, licensed psychologist, or licensed optometrist;

(iii) that:

1. each contract issued or proposed to be issued to subscribers to the plan is in a form approved by the Commissioner; and

2. the rates charged or proposed to be charged for each form of each contract are fair and reasonable;

(iv) that the applicant has a surplus, as defined in § 14-117 of this subtitle, of the greater of:

1. $100,000; and

2. an amount equal to that required under § 14-117 of this subtitle; and

(v) that, except for a nonprofit health service plan that insures between 1 and 10,000 covered lives in the State, the nonprofit health service plan's corporate headquarters is located in the State.

(b) If the Commissioner determines that a nonprofit health service plan does not continue to satisfy the requirements of this subtitle, the Commissioner may disapprove the renewal of the certificate of authority of the nonprofit health service plan.

(c) The Commissioner shall consider an entity's inability to comply with the requirements of § 14-102(c) of this subtitle as a result of a conflict with the legislatively enacted charter of the entity or the laws or administrative rules or regulations of the jurisdiction of domicile of the entity in determining whether to issue or renew a certificate of authority under this section.

§14–111.

Subject to the authority of the Commissioner to regulate nonprofit health service plans under this article, a certificate of authority issued under this subtitle authorizes a corporation to:

(1) issue contracts in the form filed with the Commissioner to persons that become subscribers to the plan;

(2) finance capital improvement projects through the Maryland Health and Higher Educational Facilities Authority as provided under Title 10, Subtitle 3 of the Economic Development Article;

(3) finance capital improvement projects through the Maryland Economic Development Corporation as provided under Title 10, Subtitle 1 of the Economic Development Article; and

(4) partner with the State and other public or private entities to provide services or administer programs intended to address community health care needs.

§14–112.

The Commissioner may revoke a certificate of authority issued to a corporation subject to this subtitle, and at any time after revocation may institute proceedings under Title 9, Subtitle 2 of this article to rehabilitate or liquidate the corporation, if:

(1) grounds exist under § 4-113 of this article; or

(2) the Commissioner has reason to believe that the corporation:

(i) is being operated for profit;

(ii) is being fraudulently conducted;

(iii) is not complying with this subtitle or article;

(iv) knowingly is failing to comply with a rule, regulation, or order of the Commissioner; or

(v) has violated the provisions of Title 6.5 of the State Government Article.

§14–115.

(a) (1) In this section the following words have the meanings indicated.

(2) "Board" means the board of directors of a nonprofit health service plan.

(3) "Immediate family member" means a spouse, child, child's spouse, parent, spouse's parent, sibling, or sibling's spouse.

(b) This section applies to a nonprofit health service plan that is:

(1) issued a certificate of authority in the State; and

(2) organized under the laws of the State.

(c) (1) The business and affairs of a nonprofit health service plan shall be managed under the direction of a board of directors.

(2) (i) The board and its individual members are fiduciaries and shall act:

1. in good faith;

2. in a manner that is reasonably believed to be in the best interests of the corporation and its controlled affiliates or subsidiaries that offer health benefit plans;

3. in a manner that is reasonably believed to be in furtherance of the mission of the corporation as a nonprofit health service plan as required under § 14-102(c) of this subtitle; and

4. with the care that an ordinarily prudent person in a like position would use under similar circumstances.

(ii) The board and its individual members may not use board membership for personal or financial enrichment to the detriment of the nonprofit health service plan or the mission of the nonprofit health service plan.

(3) The principal functions of the board shall include:

(i) ensuring that the corporation effectively carries out the nonprofit mission established under § 14-102(c) of this subtitle;

(ii) selecting corporate management and evaluating its performance;

(iii) ensuring to the extent practicable that human resources and other resources are sufficient to meet corporate objectives;

(iv) subject to the provisions of subsection (d) of this section, nominating and selecting suitable candidates for the board;

(v) establishing a system of governance at the board level, including an annual evaluation of board performance; and

(vi) before considering any bid or offer to acquire the nonprofit health service plan and to convert to a for-profit entity under Title 6.5 of the State Government Article, ensuring that adequate consideration is given to an independent valuation of the nonprofit health service plan.

(4) Each member of the board shall demonstrate a commitment to the mission of the nonprofit health service plan as required by § 14-102(c) of this subtitle.

(5) An officer or employee of a nonprofit health service plan or any of its affiliates or subsidiaries may not be appointed or elected to the board.

(6) A nonprofit health service plan is subject to the provisions of § 2-419 of the Corporations and Associations Article.

(d) (1) This subsection applies to a corporation that is:

(i) issued a certificate of authority as a nonprofit health service plan; and

(ii) the sole member of a corporation issued a certificate of authority as a nonprofit health service plan.

(2) The board shall be composed of at least 11 members and no more than 23 members, including:

(i) one nonvoting member, who is not a member of the Maryland General Assembly, appointed by and serving at the pleasure of the President of the Senate of Maryland;

(ii) one nonvoting member, who is not a member of the Maryland General Assembly, appointed by and serving at the pleasure of the Speaker of the House of Delegates; and

(iii) no more than 21 voting members selected by the board, in accordance with the bylaws of the corporation, including three consumer members, who are covered by the nonprofit health service plan or its affiliates at the time of their initial election to the board and who satisfy the requirements of paragraphs (13), (14), and (15) of this subsection.

(3) No more than five members of the board may be:

(i) licensed health care professionals;

(ii) hospital administrators; or

(iii) employees of health care professionals or hospitals.

(4) To the extent possible, the board shall seek to include individuals with a diverse range of experience relevant to the mission of the corporation as a nonprofit health service plan as required under § 14–102 of this subtitle, including experience in data, consumer experience, government programs, population health, geriatrics, diversity, equity and inclusion, audit, human resources, benefit consulting, executive level, actuarial, accounting, information technology, finance, law, large and small businesses, nonprofit businesses, and organized labor.

(5) Except for nonvoting members under paragraph (2)(i) and (ii) of this subsection, the board shall be self–perpetuating.

(6) The board shall have the following standing committees whose duties shall include:

(i) an audit committee responsible for ensuring financial accountability;

(ii) a finance committee responsible for reviewing and making recommendations on the annual budget and for developing and recommending long–range financial objectives;

(iii) a compensation committee responsible for developing proposed compensation guidelines in accordance with § 14–139(d) of this subtitle;

(iv) a nominating committee responsible for identifying, evaluating, and recommending to the board individuals qualified to become board members, including individuals who represent a corporation for which the nonprofit health service plan is the sole member;

(v) a service and quality oversight committee responsible for ensuring that policies and processes are in effect to assess and improve the quality of health insurance products provided to subscribers and certificate holders;

(vi) a mission oversight committee responsible for ensuring that the officers of the corporation act in accordance with the mission of the nonprofit health service plan;

(vii) a strategic planning committee responsible for examining long–range planning objectives, assessing strategies that may be used to implement the planning objectives, and analyzing the nonprofit health service plan's role in the insurance marketplace; and

(viii) any other committee that the board determines is necessary to carry out its duties.

(7) Each standing committee shall have representation from:

(i) the voting members under paragraph (2) of this subsection; and

(ii) each corporation for which the nonprofit health service plan is the sole member.

(8) The compensation committee and the nominating committee shall each include either the appointee of the President of the Senate or the appointee of the Speaker of the House of Delegates.

(9) Each board member shall serve on at least one standing committee.

(10) The chairman of the board shall select a chairman for each board committee.

(11) (i) The board shall approve in advance any action by the nonprofit health service plan, a corporation for which the plan is the sole member, or any affiliate or subsidiary of the nonprofit health service plan to:

1. materially modify options available in benefit plans marketed in the State;

2. materially modify Maryland provider networks or Maryland provider reimbursement levels;

3. materially modify underwriting guidelines for products marketed in the State;

4. materially modify rates or rating plans that are required to be approved by the Commissioner;

5. add a product to or withdraw a product from the Maryland market, withdraw from a line or type of business in the State, or withdraw from a geographic region in the State;

6. materially modify marketing goals and objectives in the State; or

7. materially impact the availability or affordability of health care in the State.

(ii) The Commissioner shall adopt regulations that define "material" for purposes of subparagraph (i) of this paragraph.

(iii) A decision by the board to convert to a for–profit entity under Title 6.5 of the State Government Article may be rejected by any three members of the board.

(iv) The board may delegate approval for the actions listed in subparagraph (i) of this paragraph to a standing committee of the board.

(12) The board shall take and retain complete minutes of all board and committee meetings.

(13) The three consumer members shall be either subscribers or certificate holders of the nonprofit health service plan or its affiliates at the time of their initial election to the board.

(14) Each consumer member of the board:

(i) shall be a member of the general public;

(ii) may not be considered an agent or employee of the State for any purpose; and

(iii) is entitled to the same rights, powers, and privileges as the other members of the board.

(15) A consumer member of the board may not:

(i) be a licensee of or otherwise be subject to regulation by the Commissioner;

(ii) be employed by or have a financial interest in:

1. a nonprofit health service plan or its affiliates or subsidiaries; or

2. a person regulated under this article or the Health – General Article; or

(iii) within 3 years before appointment, have been employed by, had a financial interest in, or have received compensation from:

1. a nonprofit health service plan or its affiliates or subsidiaries; or

2. a person regulated under this article or the Health – General Article.

(e) (1) This subsection does not apply to a board that has fewer than three authorized members.

(2) The term of a member is 3 years.

(3) The terms of the members of a board shall be staggered over a 3–year period as required by the terms provided for members of the board in the bylaws filed and approved by the Commissioner on or after June 1, 2003.

(4) At the end of a term, a member continues to serve until a successor is appointed and qualifies.

(5) A member who is appointed after a term has begun serves only for the rest of the term and until a successor is appointed and qualifies.

(6) A member may not serve for more than:

(i) three full terms; or

(ii) a total of more than 9 years.

(7) A person may not be a member of the board if the person:

(i) has defaulted on the payment of a monetary obligation to the nonprofit health service plan;

(ii) has been convicted of a criminal offense involving dishonesty or breach of trust or a felony;

(iii) habitually has neglected to pay debts; or

(iv) has been prohibited under any federal securities law from acting as a director or officer of any corporation.

(8) A member shall meet any other qualifications set forth in the bylaws of the nonprofit health service plan.

(9) A member may not be an immediate family member of another board member or an officer or employee of the nonprofit health service plan.

(10) The board shall elect a chairman from among its members.

(11) (i) The composition of the board shall represent the racial and gender diversity of the State.

(ii) The board shall include representation from each geographic region of the State.

(f) The board shall notify the Commissioner of any member who attends less than 65% of the meetings of the board during a period of 12 consecutive months.

(g) (1) Board members may receive the following compensation:

(i) reimbursement for ordinary and necessary expenses; and

(ii) an amount of base compensation and compensation for attendance at meetings in accordance with § 14–139 of this subtitle.

(2) A board member may not receive more than the amount specified in paragraph (1) of this subsection for serving on more than one board of a corporation subject to this section.

(3) (i) This paragraph applies to a corporation that is:

1. issued a certificate of authority as a nonprofit health service plan; and

2. the sole member of a corporation issued a certificate of authority as a nonprofit health service plan.

(ii) On or before June 30 of each calendar year, a corporation subject to this paragraph shall report to the Commissioner on:

1. the total amount of base compensation, compensation for attendance at meetings, and reimbursement for ordinary and necessary expenses paid to each board member in the preceding calendar year; and

2. the proposed annual compensation, together with necessary supporting documentation, to be paid to board members for the next calendar year.

§14–115.1.

(a) In this section, "officer" means any officer that a Maryland corporation is required or permitted to have under § 2-412 of the Corporations and Associations Article.

(b) (1) An officer of a nonprofit health service plan shall act:

(i) in good faith;

(ii) in a manner that is reasonably believed to be in the best interests of the corporation and its controlled affiliates or subsidiaries that offer health benefit plans;

(iii) in a manner that is consistent with the mission of a nonprofit health service plan as required under § 14-102(c) of this subtitle; and

(iv) with the care that an ordinarily prudent person in a like position would use under similar circumstances.

(2) Except for the receipt of reasonable remuneration in conformity with § 14-139 of this subtitle, an officer of a nonprofit health service plan may not use the position of officer for personal or financial enrichment.

(3) A violation of this subsection shall be considered an unsound or unsafe business practice under § 14-116 of this subtitle.

§14–116.

(a) (1) In this section, "unsound or unsafe business practice" means a business practice that:

(i) is detrimental to the financial condition of a nonprofit health service plan and does not conform to sound industry practice;

(ii) impairs the ability of a nonprofit health service plan to pay subscriber benefits; or

(iii) violates § 14-102, § 14-115, § 14-115.1, or § 14-139(a), (b), or (c) of this subtitle.

(2) "Unsound or unsafe business practice" includes:

(i) failing to comply with the notice requirements of § 14-119 of this subtitle;

(ii) willfully hindering an examination of a nonprofit health service plan or its affiliates or subsidiaries; and

(iii) failure of a director to attend at least 65% of the meetings of the board during a period of 12 consecutive months.

(b) (1) If the Commissioner believes that an officer or director of a nonprofit health service plan has engaged in an unsound or unsafe business practice, the Commissioner shall send a warning to that individual.

(2) If the Commissioner believes that an officer or director of a nonprofit health service plan has failed to take appropriate action in response to a warning received under paragraph (1) of this subsection, the Commissioner may impose a civil penalty not exceeding $125,000 for each warning.

(3) The Commissioner shall send a copy of the warning or, if a civil penalty is imposed under paragraph (2) of this subsection, a copy of the order:

(i) by certified mail, return receipt requested, bearing a postmark from the United States Postal Service, to each director of the nonprofit health service plan; and

(ii) if the nonprofit health service plan is a corporation incorporated in a state other than this State, to the insurance commissioner of the state in which the corporation is incorporated.

(c) (1) If the nonprofit health service plan is incorporated in this State, the Commissioner may remove the officer or director if the Commissioner determines after a hearing that the unsound or unsafe business practice continued after the warning.

(2) A copy of the removal order shall be served on the individual removed and each director of the nonprofit health service plan.

(3) The individual removed is entitled to a hearing under Title 2 of this article.

(4) Any person aggrieved by a final decision of the Commissioner under this section may appeal the decision under § 2-215 of this article.

(d) A nonprofit health service plan formed or organized under the laws of this State may not:

(1) form or organize under the laws of another jurisdiction unless the Commissioner determines that it is in the public interest; or

(2) alter its structure, operations, or affiliations, if such alteration results in the for-profit activities of the plan becoming so substantial that the Insurance Commissioner determines that the purpose of the nonprofit health service plan may no longer be characterized as operating a nonprofit health service plan.

(e) The Commissioner may revoke a certificate of authority issued to a foreign corporation subject to this subtitle if:

(1) the foreign corporation operates a nonprofit health service plan that is affiliated with a nonprofit health service plan formed or organized under the laws of this State; and

(2) the affiliation between the foreign nonprofit health service plan and the nonprofit health service plan formed or organized under the laws of this State is terminated.

(f) (1) If the Attorney General has reason to believe that a nonprofit health service plan is engaging in an unsound or unsafe business practice, the Attorney General shall notify the Commissioner.

(2) If the Commissioner fails to take action under this section within 60 days after notification by the Attorney General, the Attorney General may:

(i) investigate the unsound or unsafe business practice; and

(ii) initiate an action in circuit court for appropriate relief to remedy the unsound or unsafe business practice, including the removal of an officer or director of the nonprofit health service plan.

(3) In the course of any investigation conducted by the Attorney General, the Attorney General may:

(i) subpoena witnesses;

(ii) administer oaths;

(iii) examine an individual under oath;

(iv) compel production of records, books, papers, contracts, and other documents; and

(v) obtain all necessary assistance from the Administration.

§14–117.

(a) (1) In this section the following words have the meanings indicated.

(2) (i) "Assets" means assets that are:

1. authorized under § 14-120 of this subtitle; and

2. determined by the Commissioner to be admitted assets under the guidelines issued by the National Association of Insurance Commissioners.

(ii) "Assets" does not include:

1. cash, notes, or receivables that result from the sale of an asset of a nonprofit health service plan or its affiliate or subsidiary if the purchaser may require the plan to repurchase the asset; or

2. stock of an affiliate or subsidiary of the plan if the stock has not been issued in accordance with a public offering or is not publicly traded on a recognized stock exchange.

(iii) Notwithstanding subparagraph (ii)2 of this paragraph, "assets" includes stock of an affiliate or subsidiary of a nonprofit health service plan to the extent that the Commissioner determines that the stock has a value that could be made available for the payment of claims and losses.

(3) "Earned premium" means earned premiums under:

(i) insurance contracts and policies; and

(ii) the insured part of other contracts.

(4) "Surplus" means the amount by which assets exceed liabilities described in § 5-103 of this article.

(b) Except as provided in subsection (d) of this section, a corporation authorized under this subtitle shall maintain a surplus in an amount equal to the greater of:

(1) $75,000; and

(2) 8% of the total earned premium received by the corporation in the immediately preceding calendar year.

(c) If the size and structure of the corporation requires, the Commissioner may require the differentiation of the corporation's activities into risk and nonrisk business for the purpose of determining the corporation's income that is derived from earned premium and other sources.

(d) If the Commissioner determines after a hearing that a larger surplus is necessary for the protection of subscribers to a nonprofit health service plan, the Commissioner may require a corporation authorized under this subtitle to maintain a surplus in an amount greater than the amount required by subsection (b) of this section.

(e) (1) The surplus of a corporation authorized under this subtitle may be considered to be excessive only if:

(i) the surplus is greater than the appropriate risk based capital requirements as determined by the Commissioner for the immediately preceding calendar year; and

(ii) after a hearing, the Commissioner determines that the surplus is unreasonably large.

(2) After the Commissioner has determined the surplus of a corporation authorized under this subtitle to be excessive, the Commissioner:

(i) may order the corporation to submit a plan for distribution of the excess in a fair and equitable manner; or

(ii) if the corporation fails to submit a plan of distribution within 60 days, may compile a plan and order the corporation to implement it.

(3) A distribution ordered under paragraph (2) of this subsection may be made only to subscribers who are covered by the corporation's nonprofit health service plan at the time the distribution is made.

(f) The Commissioner may not order a distribution or plan for distribution under subsection (e) of this section if the distribution would render the corporation impaired or insolvent under the laws of its domiciliary state or any other state in which the corporation is authorized to do business.

§14–118.

(a) If the minimum surplus of a corporation authorized under this subtitle required to be maintained by § 14-117 of this subtitle becomes impaired, the Commissioner immediately may determine the amount of deficiency and serve notice on the corporation and its board of directors to cure the deficiency within the time period specified by the Commissioner, which may not exceed 120 days after service of the notice.

(b) The corporation may cure the deficiency in cash or in assets eligible for the investment of the corporation's funds under § 14-120 of this subtitle.

(c) Except as provided in subsection (d) of this section, if a corporation that has been notified of a deficiency under subsection (a) of this section does not cure the deficiency and file proof that it has done so with the Commissioner within the time period specified by the Commissioner:

(1) the corporation may be considered insolvent; and

(2) the Commissioner may institute delinquency proceedings against the corporation under Title 9, Subtitle 2 of this article.

(d) (1) The corporation may apply for a single extension of not more than 60 days to cure a deficiency.

(2) The Commissioner may grant the extension if:

(i) the corporation shows good cause why the deficiency was not cured in the initial time period specified by the Commissioner; and

(ii) the deficiency exists because the Commissioner required an increased surplus, disallowed certain assets, or reduced the value of certain assets carried in the corporation's accounts.

§14–119.

(a) In addition to the requirements of § 9-231 of this article, if a chief executive officer, chief financial officer, treasurer, or director knows that a nonprofit health service plan or its affiliate or subsidiary is impaired, that individual immediately shall notify the Commissioner of the impairment, unless the Commissioner has already been notified of the impairment by the chief executive officer, chief financial officer, treasurer, or director.

(b) The provisions of § 9-231(d), (f), and (g) of this article apply to notice provided to the Commissioner under this section.

§14–120.

(a) In this section, "group health care" means a practice by which an affiliate or subsidiary of a nonprofit health service plan engages the services of health care specialists who provide health care at predetermined locations in accordance with a prepaid health plan.

(b) (1) Except as provided in paragraph (2) of this subsection, a corporation subject to this subtitle may invest its funds only in assets allowed for the investment of the funds of life insurers under §§ 5-101 and 5-102 and Title 5, Subtitle 5 of this article.

(2) If the Commissioner determines that a corporation subject to this subtitle is engaged principally in the business of group health care rather than the sale of an insurance product or plan described in § 14-102 of this subtitle, the Commissioner may allow the corporation to invest a sum not to exceed 50% of its assets in real estate for use as medical facilities and fixed medical equipment to be used solely for the purpose of engaging in group health care.

§14–121.

(a) (1) On or before March 1 of each year, unless the Commissioner extends the time for good cause, each nonprofit health service plan shall file with the Commissioner a complete statement of its financial condition, transactions, and affairs for the immediately preceding calendar year.

(2) The annual statement shall:

(i) be in the form and have the content approved for current use by the National Association of Insurance Commissioners or its successor organization; and

(ii) contain any additional information that the Commissioner requires.

(3) The applicable fee required by § 2–112 of this article shall be submitted at the same time as the statement.

(4) Unless the Commissioner extends the time for filing, a nonprofit health service plan that fails to file an annual statement on or before March 10 shall pay a penalty of:

(i) $100 for each day from March 1 to March 10, both inclusive; and

(ii) $150 for each day from March 11 to the day before the Commissioner receives the statement, both inclusive.

(b) At any time, the Commissioner may require a nonprofit health service plan doing business in the State to file an interim statement containing the information that the Commissioner considers necessary.

(c) (1) (i) Except as provided in paragraph (2) of this subsection, on or before June 1 of each year, a nonprofit health service plan shall file with the Commissioner an audited financial report for the immediately preceding calendar year.

(ii) The nonprofit health service plan shall have the audited financial report prepared by an independent certified public accountant.

(iii) The Commissioner may:

1. set requirements for the form and content of the audited financial report; and

2. for good cause, extend the time for filing the audited financial report.

(2) With 90 days' advance notice, the Commissioner may require a nonprofit health service plan to file an audited financial report earlier than the date specified in paragraph (1) of this subsection.

(3) (i) This paragraph does not apply to:

1. a health maintenance organization required to file an annual report under § 19–717 of the Health – General Article; or

2. an authorized insurer required to file an annual report under § 4–116 of this article.

(ii) On or before June 1 of each year, a nonprofit health service plan shall file with the Commissioner an audited financial report for each affiliate and subsidiary owned by or under the control of the nonprofit health service plan during the immediately preceding calendar year.

(iii) The Commissioner may, for good cause, extend the time for filing the audited financial reports.

(iv) The audited financial reports:

1. shall contain the information required by the Commissioner; and

2. be certified by an independent certified public accountant as to the financial condition, transactions, and affairs of each affiliate and subsidiary for the immediately preceding calendar year.

(d) As part of the audited financial reports required under subsection (c)(3) of this section, each nonprofit health service plan shall:

(1) file a consolidated financial statement that:

(i) covers the nonprofit health service plan and each of its affiliates and subsidiaries; and

(ii) consists of the financial statements of the nonprofit health service plan and each of its affiliates and subsidiaries, certified by an independent certified public accountant as to the financial condition, transactions, and affairs of the plan and its affiliates and subsidiaries for the immediately preceding calendar year;

(2) provide a list of:

(i) the names and addresses of and biographical information about the members of the board of directors of the nonprofit health service plan;

(ii) the total compensation, including all cash and deferred compensation in addition to salary, of:

1. each member of the board of directors of the nonprofit health service plan;

2. each officer of the nonprofit health service plan or any affiliate or subsidiary of the plan; and

3. any employee of the nonprofit health service plan or any affiliate or subsidiary of the plan designated by the Commissioner; and

(3) provide any other information or documents necessary for the Commissioner to ensure compliance with this subtitle.

(e) Unless the Commissioner extends the time for filing, a nonprofit health service plan that fails to file an audited financial report on or before June 10 shall pay a penalty of:

(1) $100 for each day from June 1 to June 10, both inclusive; and

(2) $150 for each day from June 11 to the day before the Commissioner receives the report, both inclusive.

(f) The statements and reports required under this section shall be in the form required by the Commissioner.

(g) Whenever a corporation authorized under this subtitle makes a change that would result in a change in any of the information required under subsection (d) of this section, the corporation shall notify the Commissioner within 30 days after the change becomes effective.

§14–124.

(a) (1) The Commissioner may conduct any investigation or hearing that the Commissioner considers necessary to enforce this subtitle.

(2) In conducting a hearing or investigation under this section, the Commissioner has the same powers with respect to nonprofit health service plans as are granted to the Commissioner under Titles 2 and 4 of this article with respect to any other activity regulated under this article.

(3) If another state enacts a law or takes a regulatory action that requires a nonprofit health service plan operating in this State to provide a program or benefits for the residents of the other state or to distribute or reduce its surplus on the grounds that the surplus is excessive in whole or in part, the Commissioner may hold a quasi–legislative hearing or a hearing under Title 2 of this article or conduct

an examination to review and evaluate the impact of the law or regulatory action on the nonprofit health service plan, including the impact on:

(i) surplus;

(ii) premium rates for policies issued or delivered in this State; and

(iii) solvency.

(4) Based on the review and evaluation under paragraph (3) of this subsection, the Commissioner shall determine whether the impact on the nonprofit health service plan is harmful to the interests of subscribers covered by policies issued or delivered in this State.

(5) (i) If the Commissioner determines the program or benefits for the residents of another state or the surplus distribution or reduction have an impact on the nonprofit health service plan that is harmful to the interests of subscribers covered by policies issued or delivered in this State, the Commissioner shall issue an appropriate order to protect the subscribers.

(ii) The order issued under subparagraph (i) of this paragraph may include:

1. a prohibition on the nonprofit health service plan subsidizing the program or benefits for the residents of another state through:

A. premiums charged to subscribers under policies issued or delivered in this State; or

B. use of any surplus earned through policies issued or delivered in this State;

2. a prohibition on the nonprofit health service plan distributing or reducing its surplus for the benefit of residents of another state; or

3. any other action the Commissioner considers necessary to protect the interests of the subscribers covered by policies issued or delivered in this State.

(6) A nonprofit health service plan may not distribute or reduce its surplus under a law or regulatory action the impact of which is subject to a hearing or an examination under paragraph (3) of this subsection, except with the approval of the Commissioner.

(b) The Commissioner may adopt regulations to carry out this subtitle.

(c) The Commissioner may commence a delinquency proceeding against a corporation operating under this subtitle for any of the reasons set forth in § 9–211(a) and (b) of this article.

§14–125.

(a) The Commissioner or an examiner of the Administration may inspect and examine the affairs of a corporation authorized under this subtitle and an affiliate or subsidiary of a corporation authorized under this subtitle.

(b) In conducting an inspection or examination under this section, the Commissioner or examiner:

(1) shall have free access to all of the books and documents of the corporation and its affiliates or subsidiaries; and

(2) may subpoena and examine under oath any person, including an officer, agent, or employee of the corporation or its affiliates and subsidiaries, in relation to the affairs, transactions, and condition of the corporation or its affiliates and subsidiaries.

(c) The Commissioner may delegate the authority provided under this section to a designee of the Commissioner.

(d) The corporation or its affiliate or subsidiary whose affairs are examined under this section shall pay the expenses of examination in accordance with § 2-208 of this article.

§14–126.

(a) (1) A corporation subject to this subtitle may not amend its certificate of incorporation, bylaws, or the terms and provisions of contracts issued or proposed to be issued to subscribers to the plan until the proposed amendments have been submitted to and approved by the Commissioner and the applicable fees required by § 2–112 of this article have been paid.

(2) (i) A corporation subject to this subtitle may not change the table of rates charged or proposed to be charged to subscribers for a form of contract issued or to be issued for health care services until the proposed change has been submitted to and approved by the Commissioner.

(ii) 1. A nonprofit health service plan that offers a health benefit plan, as defined in § 11–601 of this article, is subject to Title 11, Subtitle 6 of this article for the health benefit plan.

2. If the provisions of Title 11, Subtitle 6 of this article conflict with the provisions of this section, the provisions of Title 11, Subtitle 6 of this article shall prevail.

(3) The Commissioner shall approve an amendment to the articles of incorporation or bylaws under paragraph (1) of this subsection unless the Commissioner determines the amendment is contrary to the public interest.

(b) (1) (i) An amendment may not take effect until 60 days after it is filed with the Commissioner.

(ii) The Commissioner may extend the initial waiting period described in subparagraph (i) of this paragraph for up to an additional 30 days if the Commissioner gives to a corporation subject to this subtitle notice of the extension before the initial waiting period ends.

(iii) If an amendment is not accompanied by the information needed to support it and the Commissioner does not have sufficient information to determine whether the filing meets the requirements of this section, the Commissioner shall require the nonprofit health service plan to provide the needed information.

(iv) If the Commissioner requires additional information, the waiting period under this paragraph shall begin again on the date the needed information is provided.

(v) On written application by the nonprofit health service plan, the Commissioner may authorize an amendment that the Commissioner has reviewed to become effective before the expiration of the waiting period or any extension of the waiting period or at a later date.

(2) A filing is deemed approved unless disapproved by the Commissioner within the waiting period or any extension of the waiting period.

(3) (i) The Commissioner shall disapprove or modify the proposed change if:

1. the table of rates appears by statistical analysis and reasonable assumptions to be inadequate, unfairly discriminatory, or excessive in relation to benefits; or

2. the form contains provisions that are unjust, unfair, inequitable, inadequate, misleading, or deceptive or encourage misrepresentations of the coverage.

(ii) In determining whether to disapprove or modify the form or table of rates, the Commissioner shall consider, to the extent appropriate:

1. past and prospective loss experience within and outside the State;

2. underwriting practice and judgment;

3. a reasonable margin for reserve needs;

4. past and prospective expenses, both countrywide and those specifically applicable to the State; and

5. any other relevant factors within and outside the State.

(4) On the adoption of an amendment or change, after approval by the Commissioner, the corporation shall file with the Commissioner a copy of the amendment or change that has been certified by at least two executive officers of the corporation.

(c) At any time, the Commissioner may require a nonprofit health service plan in the State to demonstrate that its filings, including the terms and provisions of its contracts, its table of rates, and its method for setting rates, comply with subsections (a) and (b) of this section, notwithstanding that the Commissioner had previously approved the filings.

(d) (1) If, after the applicable review period established under subsection (b) of this section, the Commissioner finds that a filing does not meet the requirements of this section, the Commissioner shall issue to the filer an order that specifies the ways in which the filing fails to meet the requirements of this section and states when, within a reasonable period after the order, the filing will no longer be effective.

(2) (i) The Commissioner shall hold a hearing before issuing an order under paragraph (1) of this subsection.

(ii) The Commissioner shall give written notice of the hearing to the filer at least 10 days before the hearing.

(iii) The written notice shall specify the matters to be considered at the hearing.

(3) An order issued under paragraph (1) of this subsection does not:

(i) affect a contract or policy made or issued before the expiration of the period set forth in the order; or

(ii) directly affect an existing contract or policy between a nonprofit health service plan and a subscriber established in accordance with a collective bargaining agreement.

(e) (1) The Commissioner may adopt regulations to allow a type or kind of form to be effective upon receipt of the filing by the Commissioner.

(2) If a nonprofit health service plan uses a form which becomes effective in accordance with the provisions of subparagraph (i) of this paragraph and the form would be subject to disapproval under subsection (b)(3) of this section, the Commissioner may:

(i) subsequently disapprove the form; and

(ii) impose on the nonprofit service plan a penalty under § 4–113 of this article.

(3) If a nonprofit health service plan files a form with the Commissioner which becomes effective in accordance with paragraph (1) of this subsection, the nonprofit health service plan shall pay the applicable filing fee provided in § 2–112 of this article.

§14–127.

(a) Each decision or finding of the Commissioner about rates and forms made under § 14-126 of this subtitle is subject to judicial review in accordance with Title 11, Subtitle 5 of this article.

(b) All other decisions and findings of the Commissioner about a corporation subject to this subtitle are subject to judicial review in accordance with § 2-215 of this article.

§14–130.

In Part V of this subtitle, "health insurer" means an insurer authorized to write health insurance.

§14–133.

(a) (1) In this section the following words have the meanings indicated.

(2) "Affiliate" means a person that directly or indirectly, through one or more intermediaries, controls, is controlled by, or is under common control with a corporation subject to this subtitle.

(3) "Control" has the meaning stated in § 7–101(c) of this article.

(4) "Subsidiary" has the meaning stated in § 7–101(g) of this article.

(b) A nonprofit health service plan may not invest in or otherwise acquire an affiliate or subsidiary unless:

(1) the affiliate or subsidiary is licensed by the Commissioner; or

(2) (i) the affiliate or subsidiary is majority owned by the nonprofit health service plan; and

(ii) the business of the affiliate or subsidiary is directly related to the operation of the nonprofit health service plan or the administration of a health benefits program.

(c) (1) A nonprofit health service plan shall submit a statement of proposed action to the Commissioner before the plan may:

(i) create, acquire, or invest in an affiliate or subsidiary in order to control the affiliate or subsidiary;

(ii) alter the structure, organization, purpose, or ownership of the plan or an affiliate or subsidiary of the corporation;

(iii) make an investment exceeding $500,000; or

(iv) make an investment in an affiliate or subsidiary.

(2) The nonprofit health service plan shall file the statement of proposed action required under this subsection at least 60 days before the effective date of the proposed action.

(3) The nonprofit health service plan may not engage in a proposed action described under paragraph (1)(i) through (iii) of this subsection unless the Commissioner approves the action in writing.

(4) The Commissioner shall either approve or disapprove the proposed action within 60 days after the Commissioner receives the statement of proposed action.

(5) The Commissioner shall approve a statement of proposed action under this section unless the Commissioner determines the proposed action is contrary to the public interest.

(d) The Commissioner may authorize a corporation to comply with the law of its domiciliary jurisdiction if the corporation is domiciled in a jurisdiction that has adopted by statute or regulation provisions that limit the ownership and operation of an affiliate or subsidiary in substantially the same manner as provided in this section.

(e) (1) If an affiliate or subsidiary of a corporation regulated under this subtitle does not comply with this section, the Commissioner shall require the corporation to file a plan of divestiture or liquidation of the affiliate or subsidiary.

(2) The plan of divestiture or liquidation:

(i) shall state the reasons for noncompliance clearly;

(ii) shall provide the Commissioner with the information that the Commissioner considers necessary to approve the divestiture or liquidation; and

(iii) is proprietary and confidential commercial information under § 4–335 of the General Provisions Article.

(3) Before a divestiture or liquidation under this section, the plan of divestiture or liquidation must be approved by the Commissioner.

(4) Any action by the Commissioner under this section may be appealed in accordance with Title 2 of this article.

§14–136.

(a) Nonprofit health service plans are subject to Title 27 of this article.

(b) A corporation authorized under this subtitle that maintains or operates a nonprofit health service plan may not:

(1) deny a claim made under a contract, certificate, or policy of a nonprofit health service plan for an unfair or unfairly discriminatory reason;

(2) without just cause, require a person making a claim under a contract, certificate, or policy of a nonprofit health service plan to accept less than the amount due; or

(3) fail to notify in writing a subscriber or certificate holder of a nonprofit health service plan of a denial of a properly completed claim within 60 days after the plan receives the claim.

(c) If it appears to the Commissioner that an act or practice or proposed act or practice of a corporation authorized under this subtitle that maintains or operates a nonprofit health service plan is in violation of subsection (b) of this section or Title 27 of this article, the burden of persuasion is on the corporation to show that the act or practice or proposed act or practice is not in violation of subsection (b) of this section or Title 27 of this article.

§14–137.

A nonprofit health service plan may not issue, renew, or deliver an individual or group contract in the State that excludes coverage for hospital or medical expenses based on a violation of:

(1) a provision of Title 21 of the Transportation Article; or

(2) a provision of the Natural Resources Article.

§14–138.

(a) Except as provided in subsection (b), (c), or (d) of this section, a nonprofit health service plan or Blue Cross or Blue Shield plan may not disclose specific medical information contained in a subscriber's or certificate holder's medical or claims records.

(b) A nonprofit health service plan or Blue Cross or Blue Shield plan may disclose specific medical information or medical data contained in a subscriber's or certificate holder's medical or claims records:

(1) to the individual or individual's agent or representative; or

(2) if the individual authorizes the disclosure.

(c) A nonprofit health service plan or Blue Cross or Blue Shield plan may disclose specific medical information contained in a subscriber's or certificate holder's medical records without the authorization of the subscriber or certificate holder:

(1) to a medical review committee, accreditation board, or commission, if the information is requested by or is in furtherance of the purpose of the committee, board, or commission;

(2) in response to legal process;

(3) to another nonprofit health service plan, Blue Cross or Blue Shield plan, or insurer to coordinate benefit payments under multiple sickness and accident, dental, or hospital medical contracts;

(4) to a government agency performing its lawful duties as authorized by an act of the General Assembly or United States Congress;

(5) to a researcher, on request, for medical and health care research in accordance with a protocol approved by an institutional review board;

(6) in accordance with a cost containment contractual obligation to verify that benefits paid by the nonprofit health service plan were proper contractually;

(7) to a third party payor if:

(i) the third party payor does not further disclose the specific medical or claims information; and

(ii) the information is required for an audit of the billing made by the plan to the payor;

(8) to evaluate and adjust a claim for benefits under a policy or to evaluate and calculate provider fiscal incentives or other types of provider payments; or

(9) to the individual's treating providers for the sole purposes of enhancing or coordinating patient care or assisting the treating providers' clinical decision making, provided that:

(i) a disclosure under this item is subject to the additional limitations in § 4–307 of the Health – General Article on disclosure of a medical record developed primarily in connection with the provision of mental health services;

(ii) medical information or medical data contained in an insured's medical or claims records may be disclosed only in accordance with the federal Health Insurance Portability and Accountability Act of 1996, any regulations adopted under the Act, and any other applicable federal privacy laws, and disclosures under this item may not be made in violation of the prohibited uses or disclosures under the federal Health Insurance Portability and Accountability Act of 1996;

(iii) a nonprofit health service plan or Blue Cross or Blue Shield plan that discloses medical information or medical data contained in an insured's medical or claims records in accordance with this item shall provide a notice consistent with the requirements of 45 C.F.R. § 164.520 specifying the information to be shared, with whom it will be shared, and the specific types of uses and disclosures that the nonprofit health service plan or Blue Cross or Blue Shield plan may make in accordance with this item;

(iv) the notice required by item (iii) of this item shall include an opportunity for the individual to opt–out of the sharing of the individual's medical information or medical data contained in an individual's medical or claims records with the individual's treating providers for the purposes identified in this item; and

(v) if a nonprofit health service plan or Blue Cross or Blue Shield plan discloses medical information or medical data through an infrastructure that provides organizational and technical capabilities for the exchange of protected health information, as defined in § 4–301 of the Health – General Article, among entities not under common ownership, the nonprofit health service plan or Blue Cross or Blue Shield plan is subject to the requirements of §§ 4–302.2 and 4–302.3 of the Health – General Article.

(d) This section does not prohibit the use of medical records, data, or statistics if the use does not disclose the identity of a particular subscriber or certificate holder.

(e) A nonprofit health service plan that knowingly violates this section is liable to a plaintiff for any damages recoverable in a civil action, including reasonable attorney's fees.

§14–139.

(a) An officer, director, or employee of a corporation operating under this subtitle may not:

(1) willfully violate a provision of this article or a regulation adopted under this article;

(2) willfully misrepresent or conceal a material fact in a statement, report, record, or communication provided to the Commissioner;

(3) willfully misrepresent or conceal a material fact to the board of directors;

(4) misappropriate or fail to account properly for money that belongs to the corporation, an insurer, insurance producer, subscriber, or certificate holder;

(5) engage in fraudulent or dishonest practices in connection with the provision or administration of a health service plan;

(6) willfully fail to produce records or allow an examination under § 14-125 of this subtitle; or

(7) willfully fail to comply with a lawful order of the Commissioner.

(b) An officer, director, or trustee of a corporation operating under this subtitle may not receive any immediate or future remuneration as the result of an acquisition or proposed acquisition, as defined under § 6.5-101 of the State Government Article, except in the form of compensation paid for continued employment with the company or acquiring entity.

(c) A director, trustee, officer, executive, or employee of a corporation operating under this subtitle may only approve or receive from the assets of the corporation fair and reasonable compensation in the form of salary, bonuses, or perquisites for work actually performed for the benefit of the corporation.

(d) (1) The compensation committee of the board shall:

(i) identify nonprofit health service plans in the United States that are similar in size and scope to the nonprofit health service plan managed by the board; and

(ii) develop proposed guidelines, for approval by the board:

1. for compensation, including salary, bonuses, and perquisites, of all officers and executives that is reasonable in comparison to compensation for officers and executives of similar nonprofit health service plans; and

2. for compensation for board members that is reasonable in comparison to compensation for board members of similar nonprofit health service plans.

(2) The board shall review the proposed guidelines at least annually.

(3) The board shall:

(i) provide a copy of the approved guidelines:

1. to each officer and executive of the nonprofit health service plan;

2. to each candidate for an officer or executive position with the nonprofit health service plan;

3. to each board member of the nonprofit health service plan; and

4. on or before September 1, 2004, and annually thereafter, to the Commissioner; and

(ii) adhere to the approved guidelines in compensating the officers, executives, and board members of the nonprofit health service plan.

(4) On an annual basis, the Commissioner shall review:

(i) the compensation paid by the nonprofit health service plan to each officer and executive; and

(ii) the base compensation and compensation for attendance at meetings paid by the nonprofit health service plan to board members.

(5) If the Commissioner finds that the compensation exceeds the amount authorized under the approved guidelines, the Commissioner shall issue an order prohibiting payment of the excess amount.

(e) The approval or receipt of remuneration in violation of an order issued under subsection (d)(5) of this section is a violation of § 14-115(c) of this subtitle and shall be considered an unsound or unsafe business practice under § 14-116 of this subtitle.

(f) (1) Except for an employee under subsection (c) of this section, a person that violates subsection (a) or (c) of this section is subject to a civil penalty not exceeding $10,000 for each violation.

(2) Instead of or in addition to imposing a civil penalty, the Commissioner may require the violator to make restitution to any person that has suffered financial injury as a result of the violation.

(g) In determining the amount of financial penalty to be imposed, the Commissioner shall consider:

(1) the seriousness of the violation;

(2) the good faith of the violator;

(3) the violator's history of previous violations;

(4) the deleterious effect of the violation on the public and the nonprofit health service industry; and

(5) the assets of the violator.

(h) (1) Before assessing a civil penalty or restitution, the Commissioner shall serve by certified mail, return receipt requested, on the person to be charged a notice that contains:

(i) the specifications of the charge; and

(ii) the time and place of a hearing to be held on the charges.

(2) The Commissioner shall hold a hearing on the charges at least 20 days after the date of mailing the notice.

(3) The Commissioner or designee of the Commissioner shall conduct a hearing on the charges in accordance with Title 2, Subtitle 2 of this article.

(4) Subject to Title 2, Subtitle 2 of this article, an appeal may be taken from a final order of the Commissioner to the Circuit Court for Baltimore City.

(i) In addition to any other penalty or remedy under this section, a person that is found to have gained financially from a violation of a provision of this article or a regulation adopted by the Commissioner shall forfeit the gain.

(j) This section does not prevent a person damaged by a director, officer, manager, employee, or agent of a corporation subject to this subtitle from bringing a separate action in a court of competent jurisdiction.

§14–140.

(a) (1) A person may not engage in the business of operating a nonprofit health service plan unless the person has a certificate of authority issued by the Commissioner under this subtitle.

(2) A person that violates this subsection is guilty of a misdemeanor and on conviction is subject to a fine not exceeding $50,000 for each violation.

(b) (1) A person may not:

(i) violate a provision of this subtitle; or

(ii) make a willfully false statement in a written document required by this subtitle to be filed with the Commissioner.

(2) A person that violates this subsection is guilty of a misdemeanor and on conviction is subject to a fine not exceeding $5,000 for each violation or imprisonment not exceeding 1 year or both.

(c) A person that willfully makes a false statement while under an oath administered by the Commissioner or designee of the Commissioner at an investigation or hearing conducted by the Commissioner or designee of the Commissioner is guilty of perjury.

§14–201. IN EFFECT

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

(b) "Allowed amount" means the dollar amount that an insurer determines is the value of the health care service provided by a provider before any cost sharing amounts are applied.

(c) "Assignment of benefits" means the transfer of health care coverage reimbursement benefits or other rights under a preferred provider insurance policy by an insured.

(d) "Balance bill" means the difference between a nonpreferred provider's bill for a health care service and the insurer's allowed amount.

(e) "Cost sharing amounts" means the amounts that an insured is responsible for under a preferred provider insurance policy, including any deductibles, coinsurance, or copayments.

(f) "Covered service" means a health care service that is a covered benefit under a preferred provider insurance policy.

(g) "Health care services" has the meaning stated in § 19–701 of the Health – General Article.

(h) "Hospital–based physician" means:

(1) a physician licensed in the State who is under contract to provide health care services to patients at a hospital; or

(2) a group physician practice that includes physicians licensed in the State that is under contract to provide health care services to patients at a hospital.

(i) "Insured" means a person covered for benefits under a preferred provider insurance policy offered or administered by an insurer.

(j) "Medicare economic index" means the fixed–weight input price index that:

(1) measures the weighted average annual price change for various inputs needed to produce physician services; and

(2) is used by the Centers for Medicare and Medicaid Services in the calculation of reimbursement of physician services under Title XVIII of the federal Social Security Act.

(k) "Nonpreferred provider" means a provider that is eligible for payment under a preferred provider insurance policy, but that is not a preferred provider under the applicable provider service contract.

(l) "On–call physician" means a physician who:

(1) has privileges at a hospital;

(2) is required to respond within an agreed upon time period to provide health care services for unassigned patients at the request of a hospital or a hospital emergency department; and

(3) is not a hospital–based physician.

(m) "Preferential basis" means an arrangement under which the insured or subscriber under a preferred provider insurance policy is entitled to receive health

care services from preferred providers at no cost, at a reduced fee, or under more favorable terms than if the insured or subscriber received similar services from a nonpreferred provider.

(n) "Preferred provider" means a provider that has entered into a provider service contract.

(o) "Preferred provider insurance policy" means:

(1) a policy or insurance contract that is issued or delivered in the State by an insurer, under which health care services are to be provided to the insured by a preferred provider on a preferential basis; or

(2) another contract that is offered by an employer, third party administrator, or other entity, under which health care services are to be provided to the subscriber by a preferred provider on a preferential basis.

(p) "Provider" means a physician, hospital, or other person that is licensed or otherwise authorized to provide health care services.

(q) "Provider service contract" means a contract between a provider and an insurer, employer, third party administrator, or other entity, under which the provider agrees to provide health care services on a preferential basis under specific preferred provider insurance policies.

(r) "Similarly licensed provider" means:

(1) for a physician:

(i) a physician who is board certified or eligible in the same practice specialty; or

(ii) a group physician practice that contains board certified or eligible physicians in the same practice specialty; or

(2) for a health care provider who is not a physician, a health care provider who holds the same type of license or certification.

(s) "Subscriber" means a person covered for benefits under a preferred provider insurance policy issued by a person that is not an insurer.

§14–201. ** TAKES EFFECT JANUARY 1, 2027 PER CHAPTERS 736 AND 737 OF 2026 **

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

(b) "Allowed amount" means the dollar amount that an insurer determines is the value of the health care service provided by a provider before any cost sharing amounts are applied.

(c) "Assignment of benefits" means the transfer of health care coverage reimbursement benefits or other rights under a preferred provider insurance policy by an insured.

(d) "Balance bill" means the difference between a nonpreferred provider's bill for a health care service and the insurer's allowed amount.

(e) "Cost sharing amounts" means the amounts that an insured is responsible for under a preferred provider insurance policy, including any deductibles, coinsurance, or copayments.

(f) "Covered service" means a health care service that is a covered benefit under a preferred provider insurance policy.

(g) "Health care services" has the meaning stated in § 19–701 of the Health – General Article.

(h) "Hospital–based physician" means:

(1) a physician licensed in the State who is under contract to provide health care services to patients at a hospital; or

(2) a group physician practice that includes physicians licensed in the State that is under contract to provide health care services to patients at a hospital.

(i) "Insured" means a person covered for benefits under a preferred provider insurance policy offered or administered by an insurer.

(j) "Medicare economic index" means the fixed–weight input price index that:

(1) measures the weighted average annual price change for various inputs needed to produce physician services; and

(2) is used by the Centers for Medicare and Medicaid Services in the calculation of reimbursement of physician services under Title XVIII of the federal Social Security Act.

(k) "Nonpreferred provider" means a provider that is eligible for payment under a preferred provider insurance policy, but that is not a preferred provider under the applicable provider service contract.

(l) "On–call physician" means a physician who:

(1) has privileges at a hospital;

(2) is required to respond within an agreed upon time period to provide health care services for unassigned patients at the request of a hospital or a hospital emergency department; and

(3) is not a hospital–based physician.

(m) "Preferential basis" means an arrangement under which the insured or subscriber under a preferred provider insurance policy is entitled to receive health care services from preferred providers at no cost, at a reduced fee, or under more favorable terms than if the insured or subscriber received similar services from a nonpreferred provider.

(n) "Preferred provider" means a provider that has entered into a provider service contract.

(o) "Preferred provider insurance policy" means:

(1) a policy or insurance contract that is issued or delivered in the State by an insurer, under which health care services are to be provided to the insured by a preferred provider on a preferential basis; or

(2) another contract that is offered by an employer, third party administrator, or other entity, under which health care services are to be provided to the subscriber by a preferred provider on a preferential basis.

(p) "Provider" means a physician, dentist, hospital, or other person that is licensed or otherwise authorized to provide health care services.

(q) "Provider service contract" means a contract between a provider and an insurer, employer, third party administrator, or other entity, under which the provider agrees to provide health care services on a preferential basis under specific preferred provider insurance policies.

(r) "Similarly licensed provider" means:

(1) for a physician:

(i) a physician who is board certified or eligible in the same practice specialty; or

(ii) a group physician practice that contains board certified or eligible physicians in the same practice specialty;

(2) for a dentist:

(i) a dentist licensed to practice dentistry in the State under Title 4 of the Health Occupations Article who performs the same or similar dental services; or

(ii) a group dental practice that consists of dentists licensed in the State under Title 4 of the Health Occupations Article who perform the same or similar dental services; or

(3) for a health care provider who is not a physician or dentist, a health care provider who holds the same type of license or certification.

(s) "Subscriber" means a person covered for benefits under a preferred provider insurance policy issued by a person that is not an insurer.

§14–202.

(a) (1) This subtitle applies to insurers that issue or deliver individual or group health insurance policies in the State.

(2) The provisions of this subtitle that apply to insurers also apply to nonprofit health service plans that issue or deliver individual or group health insurance policies in the State.

(b) Except as otherwise provided in § 14-206 of this subtitle, this subtitle does not apply to an employee benefit plan to the extent that the plan is governed by the Employee Retirement Income Security Act of 1974 (ERISA).

§14–203.

The Commissioner may adopt regulations to enforce this subtitle.

§14–204.

Subject to the approval of the Commissioner, an insurer may:

(1) offer or administer a health benefit program under which the insurer offers preferred provider insurance policies that limit, through the use of provider service contracts, the numbers and types of providers of health care services eligible for payment as preferred providers; and

(2) establish terms and conditions that providers must meet to qualify for payment as preferred providers.

§14–205.

(a) If a preferred provider insurance policy offered by an insurer provides benefits for a service that is within the lawful scope of practice of a health care provider licensed under the Health Occupations Article, an insured covered by the preferred provider insurance policy is entitled to receive the benefits for that service either through direct payments to the health care provider or through reimbursement to the insured.

(b) (1) A preferred provider insurance policy offered by an insurer under this subtitle shall provide for payment of services rendered by nonpreferred providers as provided in this subsection.

(2) Unless the insurer demonstrates to the satisfaction of the Commissioner that an alternative level of payment is more appropriate, for each covered service under a preferred provider insurance policy, the difference between the coinsurance percentage applicable to nonpreferred providers and the coinsurance percentage applicable to preferred providers may not be greater than 20 percentage points.

(3) If the preferred provider insurance policy contains a provision for the insured to pay the balance bill, the provision may not apply to an on–call physician or a hospital–based physician who has accepted an assignment of benefits in accordance with § 14–205.2 of this subtitle.

(4) The insurer's allowed amount for a health care service covered under the preferred provider insurance policy provided by nonpreferred providers may not be less than the allowed amount paid to a similarly licensed provider who is a preferred provider for the same health care service in the same geographic region.

(c) (1) In this subsection, "unfair discrimination" means an act, method of competition, or practice engaged in by an insurer:

(i) that is prohibited by Title 27, Subtitle 2 of this article; or

(ii) that, although not specified in Title 27, Subtitle 2 of this article, the Commissioner believes is unfair or deceptive and that results in the institution of an action by the Commissioner under § 27–104 of this article.

(2) If the rates for each institutional provider under a preferred provider insurance policy offered by an insurer vary based on individual negotiations, geographic differences, or market conditions and are approved by the Health Services Cost Review Commission, the rates do not constitute unfair discrimination under this article.

§14–205.1.

(a) The Commissioner may authorize an insurer or nonprofit health service plan to offer a preferred provider insurance policy that conditions the payment of benefits on the use of preferred providers if the insurer or nonprofit health service plan does not restrict payment for covered services provided by nonpreferred providers:

(1) for emergency services, as defined in § 19–701 of the Health – General Article;

(2) for an unforeseen illness, injury, or condition requiring immediate care; or

(3) as required under § 15–830 of this article.

(b) (1) If an employer, association, or other private group arrangement offers health benefit plan coverage to employees or individuals only through preferred providers, then the insurer or nonprofit health service plan with which the employer, association, or other private group arrangement is contracting for the coverage shall offer an option to include preferred and nonpreferred providers as an additional benefit for an employee or individual, at the employee's or individual's option, to accept or reject.

(2) The insurer or nonprofit health service plan shall provide to each employer, association, or other private group arrangement a disclosure statement on the group application that an option to include preferred and nonpreferred providers is available for the individual or employee to accept or reject.

(c) An employer, association, or other private group arrangement may require an employee or individual that accepts the additional coverage for preferred and nonpreferred providers to pay a premium greater than the amount of the premium for the coverage offered for preferred providers only.

§14–205.2.

(a) Except as otherwise provided, this section applies to both on–call physicians and hospital–based physicians who:

(1) are nonpreferred providers;

(2) obtain an assignment of benefits from an insured; and

(3) notify the insurer of an insured in a manner specified by the Commissioner that the on–call physician or hospital–based physician has obtained and accepted the assignment of benefits from the insured.

(b) (1) Except as provided in paragraph (3) of this subsection, an insured may not be liable to an on–call physician or a hospital–based physician subject to this section for covered services rendered by the on–call physician or hospital–based physician.

(2) An on–call physician or hospital–based physician subject to this section or a representative of an on–call physician or hospital–based physician subject to this section may not:

(i) collect or attempt to collect from an insured of an insurer any money owed to the on–call physician or hospital–based physician by the insurer for covered services rendered to the insured by the on–call physician or hospital–based physician; or

(ii) maintain any action against an insured of an insurer to collect or attempt to collect any money owed to the on–call physician or hospital–based physician by the insurer for covered services rendered to the insured by the on–call physician or hospital–based physician.

(3) An on–call physician or hospital–based physician subject to this section or a representative of an on–call physician or hospital–based physician subject to this section may collect or attempt to collect from an insured of an insurer:

(i) any deductible, copayment, or coinsurance amount owed by the insured for covered services rendered to the insured by the on–call physician or hospital–based physician;

(ii) if Medicare is the primary insurer and the insurer is the secondary insurer, any amount up to the Medicare approved or limiting amount, as specified under the federal Social Security Act, that is not owed to the on–call physician or hospital–based physician by Medicare or the insurer after coordination

of benefits has been completed, for Medicare covered services rendered to the insured by the on–call physician or hospital–based physician; and

(iii) any payment or charges for services that are not covered services.

(c) (1) This subsection applies only to on–call physicians subject to this section.

(2) For a covered service rendered to an insured of an insurer by an on–call physician subject to this section, the insurer or its agent:

(i) shall pay the on–call physician within 30 days after the receipt of a claim in accordance with the applicable provisions of this title; and

(ii) shall pay a claim submitted by the on–call physician for a covered service rendered to an insured in a hospital, no less than the greater of:

1. 140% of the average rate the insurer paid for the 12–month period that ends on January 1 of the previous calendar year in the same geographic area, as defined by the Centers for Medicare and Medicaid Services, for the same covered service, to similarly licensed providers under written contract with the insurer; or

2. the average rate the insurer paid for the 12–month period that ended on January 1, 2010, in the same geographic area, as defined by the Centers for Medicare and Medicaid Services, for the same covered service to a similarly licensed provider not under written contract with the insurer, inflated by the change in the Medicare Economic Index from 2010 to the current year.

(d) (1) This subsection applies only to hospital–based physicians subject to this section.

(2) For a covered service rendered to an insured of an insurer by a hospital–based physician subject to this section, the insurer or its agent:

(i) shall pay the hospital–based physician within 30 days after the receipt of the claim in accordance with the applicable provisions of this title; and

(ii) shall pay a claim submitted by the hospital–based physician for a covered service rendered to an insured no less than the greater of:

1. 140% of the average rate the insurer paid for the 12–month period that ends on January 1 of the previous calendar year in the same

geographic area, as defined by the Centers for Medicare and Medicaid Services, for the same covered service, to similarly licensed providers, who are hospital–based physicians, under written contract with the insurer; or

2. the final allowed amount of the insurer for the same covered service for the 12–month period that ended on January 1, 2010, inflated by the change in the Medicare Economic Index to the current year, to the hospital–based physician billing under the same federal tax identification number the hospital–based physician used in calendar year 2009.

(e) (1) For the purposes of subsections (c)(2)(ii)1 and (d)(2)(ii)1 of this section, an insurer shall calculate the average rate paid to similarly licensed providers under written contract with the insurer for the same covered service by summing the contracted rate for all occurrences of the Current Procedural Terminology Code for that covered service and then dividing by the total number of occurrences of the Current Procedural Terminology Code.

(2) For the purposes of subsection (c)(2)(ii)2 of this section, an insurer shall calculate the average rate paid to similarly licensed providers not under written contract with the insurer for the same covered service by summing the rates paid to similarly licensed providers not under written contract with the insurer for all occurrences of the Current Procedural Terminology Code for that covered service and then dividing by the total number of occurrences of the Current Procedural Terminology Code.

(f) An insurer shall disclose, on request of an on–call physician or hospital–based physician subject to this section, the reimbursement rate required under subsection (c)(2)(ii) or (d)(2)(ii) of this section.

(g) (1) An insurer may seek reimbursement from an insured for any payment under subsection (c)(2)(ii) or (d)(2)(ii) of this section for a claim or portion of a claim submitted by an on–call physician or hospital–based physician subject to this section and paid by the insurer that the insurer determines is the responsibility of the insured based on the insurance contract.

(2) The insurer may request and the on–call physician or hospital–based physician shall provide adjunct claims documentation to assist in making the determination under paragraph (1) of this subsection or under subsection (c) of this section.

(h) (1) An on–call physician or hospital–based physician subject to this section may enforce the provisions of this section by filing a complaint against an insurer with the Administration or by filing a civil action in a court of competent jurisdiction under § 1–501 or § 4–201 of the Courts Article.

(2) The Administration or a court shall award reasonable attorney's fees if the Administration or court finds that:

(i) the insurer's conduct in maintaining or defending the proceeding was in bad faith; or

(ii) the insurer acted willfully in the absence of a bona fide dispute.

(i) The Administration may take any action authorized under this article, including conducting an examination under Title 2, Subtitle 2 of this article, to investigate and enforce a violation of the provisions of this section.

(j) In addition to any other penalties under this article, the Commissioner may impose a penalty not to exceed $5,000 on an insurer for each violation of this section.

(k) The Administration, in consultation with the Maryland Health Care Commission, shall adopt regulations to implement this section.

§14–205.3. IN EFFECT

(a) This section does not apply to on–call physicians or hospital–based physicians.

(b) An insurer may not:

(1) prohibit the assignment of benefits to a provider who is a physician by an insured; or

(2) refuse to directly reimburse a nonpreferred provider who is a physician under an assignment of benefits.

(c) If an insured has not provided an assignment of benefits, the insurer shall include the following information with the payment to the insured for health care services rendered by the nonpreferred provider who is a physician:

(1) the specific claim covered by the payment;

(2) the amount paid for the claim;

(3) the amount that is the insured's responsibility; and

(4) a statement instructing the insured to use the payment to pay the nonpreferred provider in the event the insured has not paid the nonpreferred provider in full for the health care services rendered by the nonpreferred provider.

(d) If a physician who is a nonpreferred provider seeks an assignment of benefits from an insured, the physician shall provide the following information to the insured, prior to performing a health care service:

(1) a statement informing the insured that the physician is a nonpreferred provider;

(2) a statement informing the insured that the physician may charge the insured for noncovered services;

(3) a statement informing the insured that the physician may charge the insured the balance bill for covered services;

(4) an estimate of the cost of services that the physician will provide to the insured;

(5) any terms of payment that may apply; and

(6) whether interest will apply and, if so, the amount of interest charged by the physician.

(e) A physician who is a nonpreferred provider shall submit the disclosure form developed by the Commissioner under subsection (f) of this section to document to the insurer the assignment of benefits by an insured.

(f) The Commissioner shall develop disclosure forms to implement the requirements under subsections (c) and (d) of this section.

(g) Notwithstanding the provisions of subsection (b) of this section, an insurer may refuse to directly reimburse a nonpreferred provider under an assignment of benefits if:

(1) the insurer receives notice of the assignment of benefits after the time the insurer has paid the benefits to the insured;

(2) the insurer, due to an inadvertent administrative error, has previously paid the insured;

(3) the insured withdraws the assignment of benefits before the insurer has paid the benefits to the nonpreferred provider; or

(4) the insured paid the nonpreferred provider the full amount due at the time of service.

§14–205.3. ** TAKES EFFECT JANUARY 1, 2027 PER CHAPTERS 736 AND 737 OF 2026 **

(a) This section does not apply to on–call physicians or hospital–based physicians.

(b) An insurer may not:

(1) prohibit the assignment of benefits to a provider who is a physician or dentist by an insured; or

(2) refuse to directly reimburse a nonpreferred provider who is a physician or dentist under an assignment of benefits.

(c) If an insured has not provided an assignment of benefits, the insurer shall include the following information with the payment to the insured for health care services rendered by the nonpreferred provider who is a physician or dentist:

(1) the specific claim covered by the payment;

(2) the amount paid for the claim;

(3) the amount that is the insured's responsibility; and

(4) a statement instructing the insured to use the payment to pay the nonpreferred provider in the event the insured has not paid the nonpreferred provider in full for the health care services rendered by the nonpreferred provider.

(d) If a physician or dentist who is a nonpreferred provider seeks an assignment of benefits from an insured, the physician or dentist shall provide the following information to the insured, prior to performing a health care service:

(1) a statement informing the insured that the physician or dentist is a nonpreferred provider;

(2) a statement informing the insured that the physician or dentist may charge the insured for noncovered services;

(3) a statement informing the insured that the physician or dentist may charge the insured the balance bill for covered services;

(4) an estimate of the cost of services that the physician or dentist will provide to the insured;

(5) any terms of payment that may apply; and

(6) whether interest will apply and, if so, the amount of interest charged by the physician or dentist.

(e) A physician or dentist who is a nonpreferred provider shall submit the disclosure form developed by the Commissioner under subsection (f) of this section to document to the insurer the assignment of benefits by an insured.

(f) The Commissioner shall develop disclosure forms to implement the requirements under subsections (c) and (d) of this section.

(g) Notwithstanding the provisions of subsection (b) of this section, an insurer may refuse to directly reimburse a nonpreferred provider under an assignment of benefits if:

(1) the insurer receives notice of the assignment of benefits after the time the insurer has paid the benefits to the insured;

(2) the insurer, due to an inadvertent administrative error, has previously paid the insured;

(3) the insured withdraws the assignment of benefits before the insurer has paid the benefits to the nonpreferred provider; or

(4) the insured paid the nonpreferred provider the full amount due at the time of service.

§14–206.

(a) This section applies to an employee benefit plan whose benefit provisions are governed by the Employee Retirement Income Security Act of 1974 (ERISA) or another federal law.

(b) On request of the Commissioner, each insurer, employer, third party administrator, or other entity that issues, delivers, administers, or offers a preferred provider insurance policy in the State shall file with the Commissioner:

(1) a written summary description and a prototype copy of:

(i) the preferred provider insurance policy;

(ii) all attendant provider service contracts;

(iii) any other related contracts; and

(iv) any amendments to the documents listed in items (i) through (iii) of this item; and

(2) any other related documents or information that the Commissioner requires.

(c) The Commissioner may impose a penalty not exceeding $1,000 for each failure to comply with this section.

§14–401.

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

(b) "Dental plan" means a contractual arrangement for dental services.

(c) "Dental plan organization" means a person that provides directly, arranges for, or administers a dental plan on a prepaid or postpaid individual or group capitation basis.

(d) "Dental service" means a service included in practicing dentistry as defined in § 4-101 of the Health Occupations Article.

(e) "Enrollee" means an individual or dependent of the individual who is enrolled in a dental plan.

(f) "Evidence of coverage" means a contract or certificate that is issued to an enrollee and that specifies the dental services to which the enrollee is entitled.

§14–402.

(a) This subtitle does not apply to:

(1) a dentist or professional dental corporation that accepts payment on a fee-for-service basis for providing specific dental services to individual patients for whom the services have been prediagnosed;

(2) an authorized insurer whose activities are authorized and regulated under other provisions of this article;

(3) a nonprofit health service plan that is subject to Subtitle 1 of this title;

(4) a health maintenance organization that is authorized by and subject to Title 19, Subtitle 7 of the Health - General Article; or

(5) a dental plan whose regulation by the State is preempted by federal law.

(b) In addition to the provisions of this subtitle, dental plan organizations are subject to the provisions of Title 2, Subtitle 5 of this article.

§14–403.

A person may not establish, operate, or administer a dental plan organization or sell, offer to sell, solicit offers to purchase, or receive advance or periodic consideration in conjunction with a dental plan, unless the person has a certificate of authority issued by the Commissioner under this subtitle.

§14–404.

(a) Except as provided in subsection (d) of this section, in accordance with this section, a dental plan organization shall have and maintain at all times a surplus equal to the greater of:

(1) $50,000; or

(2) 2% of the organizations' annual gross premium income, up to a maximum of the required capital and surplus of a stock insurer under § 4-103 of this article.

(b) (1) Except as provided in subsection (d) of this section, a dental plan organization shall deposit with the Commissioner or with any organization or trustee acceptable to the Commissioner through which a custodial or controlled account is used, cash, securities, or any combination of these or other measures that is acceptable to the Commissioner in an amount equal to $25,000 plus 25% of the surplus required in subsection (a) of this section, provided that the deposit shall not be required to exceed $100,000.

(2) The deposit shall be:

(i) an admitted asset of the dental plan organization in the determination of surplus;

(ii) used to protect the interests of the dental plan organization's enrollees;

(iii) used to assure continuation of limited health care services to enrollees of a dental plan organization that is in rehabilitation or conservation; and

(iv) if a dental plan organization is placed in receivership or liquidation, an asset subject to provisions of the Uniform Insurers Liquidation Act.

(3) All income from deposits shall be an asset of the dental plan organization.

(4) A dental plan organization may withdraw a deposit or any part thereof after making a substitute deposit of equal amount and value.

(5) A substitute deposit of any securities is subject to the approval of the Commissioner.

(c) Except as provided in subsection (d) of this section, the Commissioner may reduce or eliminate the deposit requirement if the dental plan organization has made an acceptable deposit with the State or jurisdiction of domicile for the protection of all enrollees, wherever located, and delivers to the Commissioner a certificate to such effect, duly authenticated by the appropriate State official holding the deposit.

(d) Subject to subsection (e) of this section, subsections (a), (b), and (c) of this section do not apply to a dental plan organization, so long as the dental plan organization:

(1) did not have any enrollees as of January 1, 2000;

(2) held a certificate of authority as of January 1, 2000;

(3) maintains a current certificate of authority; and

(4) complies with all applicable laws and regulations, as determined by the Commissioner.

(e) Subsection (d) of this section does not apply to a dental plan organization that has one or more enrollees on or after January 1, 2000.

§14–405.

(a) An applicant for a certificate of authority shall:

(1) file with the Commissioner an application, verified by an officer or authorized representative of the dental plan organization, on the form that the Commissioner provides; and

(2) pay to the Commissioner an application fee of $200.

(b) An application for a certificate of authority shall include:

(1) the basic organizational documents of the dental plan organization, including the articles of incorporation, articles of association, partnership agreement, trade name certificate, trust agreement, and shareholder agreement;

(2) all amendments to the organizational documents of the dental plan organization;

(3) the bylaws, rules and regulations, or similar documents that regulate the conduct or internal affairs of the dental plan organization;

(4) the names, addresses, and official positions of the individuals who are responsible for conducting the affairs of the dental plan organization, including:

(i) the members of the board of directors, board of trustees, executive committee, or other governing board or committee;

(ii) for a corporation, the principal officers; and

(iii) for a partnership or association, the partners or members;

(5) each contract made between a dentist and the dental plan organization;

(6) each contract made between a dentist and an individual listed in item (4) of this subsection, a consultant, or a business manager;

(7) a description of the dental plan organization and its dental plan or plans, facilities, and personnel;

(8) the form of evidence of coverage to be issued to enrollees;

(9) the form of each group contract that is issued to employers, unions, trustees, or others;

(10) a financial statement that details the assets, liabilities, and sources of financial support for the dental plan organization or, if the financial affairs are audited by an independent certified public accountant, a copy of the most recent regular certified financial statement, unless the Commissioner determines that additional or more recent financial information is required for the proper administration of this subtitle;

(11) the proposed method of marketing the dental plan, a financial plan with a 3-year projection of the initial operating results, and a statement of the sources of working capital and any other sources of funding;

(12) if a dental plan organization is not domiciled in the State, an executed power of attorney that appoints the Commissioner as attorney for service of process issued against the dental plan organization in the State;

(13) a description of the geographic area to be served by the dental plan organization; and

(14) any other information that the Commissioner requires.

§14–406.

Within 10 days after a significant modification of information submitted with the application for a certificate of authority, a dental plan organization shall file notice of the modification with the Commissioner.

§14–407.

(a) If the Commissioner is satisfied that the individuals who are responsible for conducting the affairs of the dental plan organization are trustworthy and capable of providing, arranging for, or administering the services offered by the dental plan, the Commissioner shall issue a certificate of authority.

(b) If the Commissioner disapproves an application for a certificate of authority, the Commissioner shall notify the dental plan organization in writing of the reasons for disapproval.

§14–408.

(a) A certificate of authority expires on the first June 30 after its effective date unless it is renewed as provided in this section.

(b) The Commissioner shall renew the certificate of authority of a dental plan organization if the dental plan organization remains in compliance with this subtitle and pays to the Commissioner a renewal fee of $100.

§14–409.

(a) The Commissioner may suspend or revoke a certificate of authority issued to a dental plan organization under this subtitle if the Commissioner finds that:

(1) the dental plan organization is operating in a manner significantly contrary to that described in §§ 14-403, 14-405, 14-407, and 14-408 of this subtitle;

(2) the dental plan organization issues evidence of coverage that does not comply with § 14-410 of this subtitle;

(3) the dental plan organization can no longer be expected to meet its obligations to enrollees;

(4) the agreements of the dental plan organization with dentists are not sufficient to provide the dental services covered by the dental plan;

(5) the dental plan organization, or authorized person acting on its behalf, has advertised or merchandised its services in an untrue or misleading manner;

(6) the conditions or methods of operation of the dental plan organization make continued operation hazardous to enrollees or the public; or

(7) the dental plan organization has failed to comply with this subtitle or any regulations adopted under this subtitle.

(b) If the Commissioner has cause to believe that grounds exist for the suspension or revocation of a certificate of authority, the Commissioner shall notify the dental plan organization of the suspension or revocation in writing and the grounds.

(c) If the Commissioner suspends the certificate of authority, the dental plan organization may not accept additional enrollees or engage in advertising or solicitation during the period of suspension.

(d) (1) If the Commissioner revokes the certificate of authority, the dental plan organization shall dissolve its structure immediately after the effective

date of the order of revocation and may not conduct further business, except as essential to the orderly conclusion of the affairs of the dental plan organization.

(2) By written order, the Commissioner may allow further operation of the dental plan organization if the Commissioner finds that it is in the best interest of enrollees and that enrollees will be afforded the greatest practical opportunity to obtain continuing dental plan coverage.

(e) Instead of or in addition to suspending or revoking a certificate of authority, the Commissioner may:

(1) impose on the holder a penalty of not less than $1,000 but not exceeding $50,000 for each violation of this subtitle; and

(2) require the holder to make restitution to any person who has suffered financial injury because of a violation of this subtitle.

(f) (1) Notwithstanding subsections (c), (d), and (e) of this section, a dental plan organization that has had its certificate of authority suspended or revoked, has been ordered to pay a penalty or make restitution, or has suffered an adverse decision by the Commissioner is entitled to a hearing under § 2-210 of this article.

(2) Hearings and appeals from orders of the Commissioner are governed by §§ 2-203 and 2-210 through 2-215 of this article.

§14–410.

(a) Each enrollee shall receive evidence of coverage that indicates specifically the nature and extent of coverage and the total amount or percentage of payment, if any, that the enrollee must pay for dental services.

(b) (1) Except as provided under paragraph (2) of this subsection, a dental plan organization shall issue evidence of coverage to each enrollee of the dental plan organization.

(2) If an individual enrollee obtains coverage through a policy or through a contract issued by a medical or dental service corporation, the insurer that issued the policy or the medical or dental service corporation shall issue evidence of coverage.

(c) The dental plan organization, insurer, or medical or dental service corporation may not issue or deliver evidence of coverage or an amendment to

evidence of coverage until a copy of the form of evidence of coverage or amendment is filed with and approved by the Commissioner.

(d) The evidence of coverage shall contain:

(1) a clear and complete statement if a contract, or a reasonably complete summary if a certificate, of:

(i) the dental services and the insurance or other benefits, if any, to which enrollees are entitled;

(ii) any limitations on the services or kind of benefits to be provided, including any charge, deductible, or copayment feature; and

(iii) where and in what manner information is available about how services may be obtained; and

(2) a clear and understandable description of the dental plan organization's method for resolving enrollee complaints.

(e) A dental plan organization, insurer, or medical or dental service corporation that makes a change in evidence of coverage or the amount or percentage of payment that the enrollee must pay, shall issue to the enrollee evidence of the change in a separate document.

§14–410.1. NOT IN EFFECT

** TAKES EFFECT JANUARY 1, 2027 PER CHAPTERS 736 AND 737 OF 2026 **

(a) In this section, "dentist" means an individual licensed under Title 4 of the Health Occupations Article.

(b) Except as provided in subsection (g) of this section, a dental plan organization may not:

(1) prohibit the assignment of benefits to a dentist by an enrollee; or

(2) refuse to directly reimburse a nonpreferred dentist under an assignment of benefits.

(c) If an enrollee has not provided an assignment of benefits, the dental plan organization shall include the following information with the payment to the enrollee for dental services rendered by the nonpreferred dentist:

(1) the specific claim covered by the payment;

(2) the amount paid for the claim;

(3) the amount that is the enrollee's responsibility; and

(4) a statement instructing the enrollee to use the payment to pay the nonpreferred dentist in the event that the enrollee has not paid the nonpreferred dentist in full for dental services rendered by the nonpreferred dentist.

(d) If a nonpreferred dentist seeks an assignment of benefits from an enrollee, the dentist shall provide the following information to the enrollee before performing a dental service:

(1) a statement informing the enrollee that the dentist is a nonpreferred dentist;

(2) a statement informing the enrollee that the dentist may charge the enrollee for noncovered services;

(3) a statement informing the enrollee that the dentist may charge the enrollee the balance bill for covered services;

(4) an estimate of the cost of services that the dentist will provide to the enrollee;

(5) any terms of payment that may apply; and

(6) whether interest will apply and, if so, the amount of interest charged by the dentist.

(e) A nonpreferred dentist shall submit the disclosure form developed by the Commissioner under subsection (f) of this section to document to the dental plan organization the assignment of benefits by the enrollee.

(f) The Commissioner shall develop the forms necessary to implement this section.

(g) A dental plan organization may refuse to directly reimburse a nonpreferred dentist under an assignment of benefits if:

(1) the dental plan organization receives notice of the assignment of benefits after the time the dental plan organization has paid the benefits to the enrollee;

(2) the enrollee withdraws the assignment of benefits before the dental plan organization has paid the benefits to the nonpreferred dentist; or

(3) the enrollee paid the nonpreferred dentist the full amount due at the time of service.

§14–411.

(a) The Commissioner may investigate the business and examine the books, accounts, records, and files of each dental plan organization and to do so shall have reasonably free access to those materials and to the offices and places of business of the dental plan organization.

(b) (1) A dental plan organization shall preserve its books, accounts, and records for at least 5 years.

(2) Preservation by photographic reproduction shall constitute compliance with this subtitle.

(c) At the discretion of the Commissioner, the Secretary of Health and the State Board of Dental Examiners may participate in investigations and examinations described in this section to verify the solvency of a dental plan organization.

(d) In an examination under this section, the person examined shall pay the expense incurred by the Commissioner, Secretary of Health, and State Board of Dental Examiners in accordance with § 2–208 of this article.

§14–412.

(a) (1) A dental plan organization shall establish and maintain a complaint system to provide reasonable procedures for the resolution of written complaints initiated by enrollees about services of the dental plan organization.

(2) The dental plan organization shall maintain records of all written complaints initiated by enrollees.

(b) (1) The Commissioner may examine the complaint system of a dental plan organization.

(2) If the Commissioner determines that the complaint system is inadequate, the Commissioner may require a revision of the complaint system.

§14–413.

(a) On or before March 1 of each year, each dental plan organization shall file with the Commissioner a complete statement of its financial condition, transactions, and affairs for the immediately preceding calendar year.

(b) The annual statement shall:

(1) be in the form and have the content approved for current use by the National Association of Insurance Commissioners or its successor organization; and

(2) contain any additional information that the Commissioner requires.

(c) Unless the Commissioner extends the time for filing, a dental plan organization that fails to file an annual statement on or before March 10 shall pay a penalty of:

(1) $100 for each day from March 1 to March 10, both inclusive; and

(2) $150 for each day from March 11 to the day before the Commissioner receives the report, both inclusive.

(d) At any time, the Commissioner may require a dental plan organization doing business in the State to file an interim statement containing the information that the Commissioner considers necessary.

(e) (1) Except as provided in paragraph (5) of this subsection, on or before June 1 of each year, each dental plan organization shall file with the Commissioner an audited financial report for the immediately preceding calendar year.

(2) The dental plan organization shall have the audited financial report prepared by an independent certified public accountant.

(3) The Commissioner may:

(i) set requirements for the form and content of the audited financial report; and

(ii) for good cause, extend the time for filing the audited financial report.

(4) Unless the Commissioner extends the time for filing, a dental plan organization that fails to file an audited financial report on or before June 10 shall pay a penalty of:

(i) $100 for each day from June 1 to June 10, both inclusive; and

(ii) $150 for each day from June 11 to the day before the Commissioner receives the report, both inclusive.

(5) With 90 days' advance notice, the Commissioner may require a dental plan organization to file an audited financial report earlier than the date specified in paragraph (1) of this subsection.

§14–414.

A dental plan organization may not use more than 50% of its gross contract and certificate income in any fiscal year for general operating expenses, acquisition expenses, and miscellaneous taxes, licenses, and fees.

§14–415.

(a) A dental plan organization or its representative may not cause or knowingly allow:

(1) advertising that is untrue or misleading;

(2) solicitation that is untrue or misleading; or

(3) any form of evidence of coverage that is deceptive.

(b) Unless a dental plan organization holds a certificate of authority as an insurer, the dental plan organization may not use in its name, evidence of coverage, or literature:

(1) the words "insurance", "assurance", "casualty", "surety", or "mutual"; or

(2) any other words descriptive of the insurance, casualty, or surety business or deceptively similar to the name or description of an insurer authorized to do business in the State.

(c) The Commissioner shall enforce this section.

(d) This subtitle does not limit the powers of the Attorney General and the procedures with respect to consumer fraud.

§14–416.

(a) The Commissioner may issue an order that directs a dental plan organization or its representative to cease and desist from engaging in an act or practice that violates this subtitle.

(b) (1) Within 20 days after service of the cease and desist order, the dental plan organization or its representative may request a hearing to determine whether a violation of this subtitle has occurred.

(2) A hearing under this subsection shall be conducted in accordance with § 2-213 of this article and is subject to judicial review in accordance with § 2-215 of this article.

§14–417.

(a) The Commissioner may bring an action in a court of competent jurisdiction of the State to enjoin a dental plan organization from transacting any further business, or from transferring or disposing of its property, if:

(1) the dental plan organization becomes insolvent or suspends its ordinary business for lack of funds; or

(2) the Commissioner finds, as a result of an examination authorized by this subtitle or in any other manner, that:

(i) the dental plan organization is exceeding its powers or is violating the law;

(ii) the condition or methods of business of the dental plan organization may render the continuance of its operations hazardous to enrollees or the public; or

(iii) the assets of the dental plan organization are less than its liabilities.

(b) The court may:

(1) proceed in the action in a summary manner or otherwise;

(2) grant injunctive relief and appoint a receiver, with power to:

(i) sue for, collect, receive, take into possession, sell, convey, and assign all the goods and chattels, rights and credits, money and effects, lands and tenement, books, papers, choses in action, bills, notes, and property of every description belonging to the dental plan organization;

(ii) authorize the purchase of continuing coverage for enrollees utilizing the remaining assets; and

(iii) hold and dispose of any proceeds under the direction of the court; and

(3) cause the receiver to continue the existing operations of the dental plan organization, under court supervision, until the next anniversary of the subscription certificates and contracts then in force.

(c) A dental plan organization is deemed insolvent whenever it is presently or prospectively unable to fulfill its outstanding contracts and maintain the surpluses required under this subtitle.

§14–418.

(a) Except for contracts referred to in § 14-405(b)(5) of this subtitle and complaints filed under § 14-412 of this subtitle, applications, filings, and reports required under this subtitle are public documents and may not be considered confidential.

(b) (1) Except as provided in paragraph (2) of this subsection, information obtained by a dental plan organization about the diagnosis, treatment, or health of an enrollee is confidential and may not be disclosed.

(2) A dental plan organization may disclose information described in paragraph (1) of this subsection:

(i) to the extent that disclosure may be necessary to carry out the purposes of this subtitle;

(ii) with the express consent of the enrollee;

(iii) under statute or court order for the production or discovery of evidence; or

(iv) if the information is pertinent to a claim or in litigation between the enrollee and dental plan organization.

(c) A dental plan organization may claim any statutory privileges against disclosure of information that the dentist who provides the information to the dental plan organization may claim.

§14–601.

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

(b) (1) "Discount drug plan" means a business arrangement or contract in which a person, in exchange for fees, dues, charges, or other financial consideration paid by or on behalf of a plan member, provides the right to receive discounts on specified pharmaceutical supplies, prescription drugs, or medical equipment and supplies from specified providers.

(2) "Discount drug plan" does not include:

(i) a business arrangement or contract in which the fees, dues, charges, and other financial consideration paid by or on behalf of a plan member consist only of:

1. a payment made directly to a provider as a dispensing or transactional fee in connection with the purchase of pharmaceutical supplies, prescription drugs, or medical equipment and supplies that are subject to a discount; or

2. an administrative or processing fee paid by anyone other than a plan member to a provider in connection with that provider's provision of discounts to plan members; or

(ii) a patient assistance program that:

1. is sponsored, offered, or provided for by a pharmaceutical manufacturer; and

2. is not provided in exchange for fees, dues, charges, or other financial consideration.

(c) "Discount drug plan organization" means an entity that:

(1) contracts directly or indirectly with providers or provider networks to provide pharmaceutical supplies, prescription drugs, or medical equipment and supplies at a discount to plan members; and

(2) determines the charge to plan members.

(d) "Discount medical plan" means a business arrangement or contract in which a person, in exchange for fees, dues, charges, or other financial consideration paid by or on behalf of a plan member, provides the right to receive discounts on specified medical services from specified providers.

(e) "Discount medical plan organization" means an entity that:

(1) contracts directly or indirectly with providers or provider networks to provide medical services at a discount to plan members; and

(2) determines the charge to plan members.

(f) "Hospital services" has the meaning stated in § 19–201 of the Health – General Article.

(g) "Medical services" means any care, service, or treatment of illness or dysfunction of, or injury to, the human body, including physician care, outpatient services, ambulance services, dental care services, vision care services, mental health services, substance abuse services, chiropractic services, podiatric care services, and laboratory services.

(h) "Medicare prescription drug plan" means a plan that provides a Medicare Part D prescription drug benefit in accordance with the requirements of the federal Medicare Modernization Act.

(i) "Plan member" means any individual who pays fees, dues, charges, or other financial consideration for the right to receive the benefits of a discount medical plan or a discount drug plan.

(j) "Provider" means:

(1) any person or institution which is contracted, directly or indirectly, with a discount medical plan organization to provide medical services to plan members; or

(2) any person or institution which is contracted, directly or indirectly, with a discount drug plan organization to provide pharmaceutical supplies, prescription drugs, or medical equipment and supplies to plan members.

(k) "State prescription drug plan" means any discount plan operated by a State agency.

§14–602.

(a) Except as provided in subsection (b) of this section, this subtitle does not apply to an insurer, nonprofit health service plan, health maintenance organization, or dental plan organization that holds a certificate of authority in this State.

(b) An insurer, nonprofit health service plan, health maintenance organization, or dental plan organization shall:

(1) comply with §§ 14–606 through 14–611 of this subtitle;

(2) notify the Commissioner in writing that it sells, markets, or solicits a discount medical plan or discount drug plan in the State; and

(3) (i) file annually with the Commissioner a current list of the persons, other than licensed insurance producers, who are authorized to sell, market, or solicit in the State a discount medical plan or discount drug plan established by the insurer, nonprofit health service plan, health maintenance organization, or dental plan organization; and

(ii) provide the Commissioner with an additional list on request.

(c) An insurer, nonprofit health service plan, health maintenance organization, or dental plan organization may file the list required under subsection (b)(3) of this section electronically, in a format prescribed by the Commissioner.

(d) This subtitle does not apply to Medicare prescription drug plans or to a State prescription drug plan.

§14–603.

(a) (1) An entity shall register with the Commissioner as a discount medical plan organization before a discount medical plan established by that entity is sold, marketed, or solicited in the State.

(2) A discount medical plan may not be sold, marketed, or solicited in the State unless the discount medical plan organization that established the discount medical plan is registered with the Commissioner.

(b) (1) An entity shall register with the Commissioner as a discount drug plan organization before a discount drug plan established by that entity is sold, marketed, or solicited in the State.

(2) A discount drug plan may not be sold, marketed, or solicited in the State unless the discount drug plan organization that established the discount drug plan is registered with the Commissioner.

(c) An applicant for registration shall:

(1) file with the Commissioner an application on the form that the Commissioner requires; and

(2) pay to the Commissioner an application fee of $250.

(d) An entity that is required to register with the Commissioner under both subsections (a) and (b) of this section may file one application with the Commissioner and pay one application fee.

(e) An applicant shall file with its application a list of the persons authorized to sell, market, or solicit a discount medical plan or discount drug plan established by the applicant.

§14–604.

(a) A registration expires on the second June 30 following the registration unless it is renewed as provided in this section.

(b) Before a registration expires, the registrant may renew it for an additional 2–year term, if the registrant:

(1) otherwise is entitled to be registered;

(2) files with the Commissioner a renewal application on the form that the Commissioner requires; and

(3) pays to the Commissioner a renewal fee of $150.

(c) An application for renewal of a registration shall be considered made in a timely manner if it is postmarked on or before June 30 of the year of renewal.

(d) Subject to the provisions of § 14–605 of this subtitle, the Commissioner shall renew the registration of each registrant that meets the requirements of this section.

(e) (1) A registrant shall file annually with the Commissioner a current list of the persons authorized to sell, market, or solicit in the State a discount medical plan or discount drug plan established by the registrant.

(2) A registrant shall provide the Commissioner an additional list on request.

(3) A registrant may file the list required under this subsection electronically, in a format prescribed by the Commissioner.

§14–605.

(a) Subject to the hearing provisions of Title 2 of this article, the Commissioner may deny a registration to an applicant or refuse to renew, suspend, or revoke the registration of a registrant if the applicant or registrant, or an officer, director, or employee of the applicant or registrant:

(1) makes a material misstatement or misrepresentation in an application for registration;

(2) fraudulently or deceptively obtains or attempts to obtain a registration for the applicant or registrant or for another;

(3) has been convicted of a felony or of a misdemeanor involving moral turpitude;

(4) in connection with the administration of a discount medical plan or discount drug plan, commits fraud or engages in illegal or dishonest activities;

(5) has violated any provision of this subtitle or a regulation adopted under it;

(6) provides a false, falsely disparaging, or misleading oral or written statement, visual description, or other representation of any kind that has the capacity, tendency, or effect of deceiving or misleading consumers;

(7) makes a representation that a discount medical plan or discount drug plan has a sponsorship, approval, characteristic, use, or benefit that it does not have;

(8) has violated § 13–301 of the Commercial Law Article; or

(9) fails to maintain on file with the Commissioner a current list of the persons authorized to sell, market, or solicit a discount medical plan or discount drug plan established by the applicant or the registrant.

(b) This section does not limit any regulatory power of the Commissioner under Title 2 of this article.

§14–606.

A discount medical plan organization and a discount drug plan organization may not:

(1) use in their advertisements, marketing material, brochures, and discount cards the term "insurance" except:

(i) in the name of an insurer, nonprofit health service plan, health maintenance organization, or dental plan organization whose corporate name includes the word "insurance";

(ii) when comparing the discount medical plan or discount drug plan to insurance or otherwise distinguishing the discount medical plan or discount drug plan from insurance; or

(iii) as otherwise provided in this subtitle;

(2) use in their advertisements, marketing material, brochures, and discount cards the terms "health plan", "coverage", "copay", "copayments", "preexisting conditions", "guaranteed issue", "premium", "ppo", "preferred provider organization", or other terms in a context that could reasonably mislead a person into believing the discount medical plan or discount drug plan was health insurance;

(3) have restrictions on access to discount medical plan or discount drug plan providers, including waiting periods and notification periods;

(4) pay providers any fees for medical services, pharmaceutical supplies, prescription drugs, or medical equipment and supplies, except that a discount medical plan organization or a discount drug plan organization that also has an active registration under Title 8, Subtitle 3 of this article may continue to pay fees to providers in its capacity as a third party administrator;

(5) refuse to modify the method of payment for membership in a discount medical plan or a discount drug plan on request, unless a specific method of payment is required as a term of the discount medical plan or the discount drug plan and was agreed to in writing in advance;

(6) if membership is billed on a monthly basis, refuse to permit membership to terminate without financial penalty on no more than 30 calendar days' written notice; or

(7) (i) continue electronic fund transfer as a method of payment more than 30 calendar days after a written request for termination of electronic fund transfer has been made; or

(ii) require the member to notify more than one entity that is either the discount medical plan organization or the discount drug plan organization or an entity identified by the discount medical plan organization or the discount drug plan organization that electronic fund transfer should be terminated.

§14–607.

(a) The following disclosures shall be made in writing printed in 12 point type to any prospective member of a discount medical plan organization and shall be included in any marketing materials or brochures relating to an application or contract for a discount medical plan:

(1) a statement that the discount medical plan is not insurance;

(2) a statement that membership in the discount medical plan entitles members to discounts for certain medical services offered by providers who have agreed to participate in the discount medical plan;

(3) a statement that the discount medical plan organization itself does not pay providers of medical services for services provided to plan members;

(4) a statement that the plan member is required to pay for any medical service provided, but is entitled to receive a discount on certain identified medical services from those providers who have contracted with the discount medical plan organization;

(5) a description of the medical services subject to discount, a description of the discounts that the plan member is entitled to receive, and the mechanism by which a current or prospective plan member can obtain the names of the providers that have contracted with the discount medical plan organization to offer discounts to plan members;

(6) the name, location, and contact information, including a telephone number, for the discount medical plan organization;

(7) all fees, dues, charges, or other financial consideration to be paid by the plan member with respect to the member's participation in the discount medical plan, including all fees or charges relating to the processing of discounts or billing;

(8) if the marketing materials or brochures refer to hospital services, a statement that the discount medical plan does not offer a discount on hospital services in Maryland; and

(9) if applicable, a statement that a nominal fee associated with enrollment costs will be retained by the discount medical plan organization, in accordance with § 14–608(a) of this subtitle, if membership is canceled within the first 30 calendar days after the effective date of enrollment.

(b) The following disclosures shall be made in writing printed in 12 point type to any prospective member of a discount drug plan organization and shall be included in any marketing materials or brochures relating to an application or contract for a discount drug plan:

(1) a statement that the discount drug plan is not:

(i) insurance; or

(ii) a Medicare prescription drug plan;

(2) a statement that membership in the discount drug plan entitles members to discounts for certain pharmaceutical supplies, prescription drugs, or medical equipment and supplies offered by providers who have agreed to participate in the discount drug plan;

(3) a statement that the discount drug plan organization itself does not pay providers of pharmaceutical supplies, prescription drugs, and medical equipment and supplies provided to plan members;

(4) a statement that the discount drug plan member is required to pay for all pharmaceutical supplies, prescription drugs, and medical equipment and supplies provided, but is entitled to receive a discount on certain identified pharmaceutical supplies, prescription drugs, or medical equipment and supplies from those providers who have contracted with the discount drug plan organization;

(5) a description of the discounts that the discount drug plan member is entitled to receive and the mechanism by which a current or prospective plan member can obtain:

(i) unless the discount drug plan offers an open formulary, a listing of the items, including prescription drugs, subject to discount; and

(ii) the names of the providers who have contracted to offer discounts to plan members;

(6) the name, location, and contact information, including a telephone number, for the discount drug plan organization;

(7) all fees, dues, charges, or other financial consideration to be paid by the plan member with respect to the member's participation in the discount drug plan, including all fees or charges relating to the processing of discounts or billing; and

(8) if applicable, a statement that a nominal fee associated with enrollment costs will be retained by the discount drug plan organization, in accordance with § 14–608(a) of this subtitle, if membership is canceled within the first 30 calendar days after the effective date of enrollment.

(c) If a discount medical plan or a discount drug plan is sold, marketed, or solicited by telephone, the disclosures required by subsections (a) and (b) of this section shall be:

(1) made orally; and

(2) included with the membership card when mailed to the prospective plan member.

(d) The following disclosures shall be made in writing in 12 point type in any advertisement to promote interest in or promote the desire to inquire further about a discount medical plan:

(1) a statement that the discount medical plan is not insurance;

(2) a statement that membership in the discount medical plan entitles members to discounts for certain medical services offered by providers who have agreed to participate in the discount medical plan;

(3) a statement that the plan member, and not the discount medical plan organization, is required to pay for all medical services provided;

(4) the name, location, and contact information, including a telephone number, for the discount medical plan organization;

(5) a statement of the mechanism by which a prospective plan member may obtain the names of the providers who have contracted to offer discounts to plan members; and

(6) if the advertisement refers to hospital services, a statement that the discount medical plan does not offer a discount on hospital services in Maryland.

(e) The following disclosures shall be made in writing in 12 point type in any advertisement to promote interest in or promote the desire to inquire further about a discount drug plan:

(1) a statement that the discount drug plan is not:

(i) insurance; or

(ii) a Medicare prescription drug plan;

(2) a statement that membership in the discount drug plan entitles members to discounts for certain pharmaceutical supplies, prescription drugs, or medical equipment and supplies offered by providers who have agreed to participate in the discount drug plan;

(3) a statement that the plan member, and not the discount drug plan organization, is required to pay for all pharmaceutical supplies, prescription drugs, or medical equipment and supplies provided;

(4) the name, location, and contact information, including a telephone number, for the discount drug plan organization; and

(5) a statement of the mechanism by which a prospective plan member may obtain the names of the providers who have contracted to offer discounts to plan members.

§14–608.

(a) (1) If membership in a discount medical plan or a discount drug plan is canceled within the first 30 calendar days after the effective date of enrollment, all fees, dues, charges, or other financial consideration, except a nominal fee, not to exceed any fees, dues, charges, or other financial consideration the member has already paid, associated with enrollment costs that were part of the cost of the discount medical plan card or the discount drug plan card, shall be refunded to the payor on return of the discount medical plan card to the discount medical plan organization or return of the discount drug plan card to the discount drug plan organization.

(2) The Commissioner, in consultation with the Attorney General, shall adopt regulations that establish standards for determining the nominal fee associated with enrollment costs that may be retained by a discount medical plan organization or a discount drug plan organization under this subsection.

(3) Subject to paragraph (1) of this subsection, any regulation adopted under this subsection shall include a cap on the nominal fee that may be retained.

(b) If a discount medical plan organization or a discount drug plan organization cancels a membership for any reason other than nonpayment, the discount medical plan organization or discount drug plan organization shall make a pro rata refund to the payor of all fees, dues, charges, or other financial consideration within 30 calendar days after the date of cancellation.

§14–609.

(a) Each discount medical plan organization and each discount drug plan organization shall provide to a plan member or to a plan member for the member's family a discount card that includes, at a minimum, the following data elements:

(1) a statement that the discount medical plan or discount drug plan is not insurance;

(2) (i) the name or identifying trademark of the discount medical plan organization or the discount drug plan organization; or

(ii) the name or identifying trademark of the provider networks that participate with the discount medical plan or discount drug plan; and

(3) the telephone number that the plan member may call for assistance.

(b) (1) If a change occurs in the data element required under subsection (a)(3) of this section, a discount medical plan organization or a discount drug plan organization shall reissue a discount card.

(2) A discount medical plan organization or a discount drug plan organization shall notify a plan member when there is a material change in plan benefits or in the data elements required under subsection (a)(1), (2), or (3) of this section.

§14–610.

(a) Whenever the Commissioner considers it advisable, the Commissioner may examine the affairs, transactions, accounts, records, and assets of a discount medical plan organization or discount drug plan organization.

(b) The examination shall be conducted in accordance with § 2–207 of this article.

(c) The expense of the examination shall be paid in accordance with § 2–208 of this article.

(d) The reports of the examination and investigation shall be issued in accordance with § 2–209 of this article.

§14–611.

(a) To enforce this subtitle and any regulation adopted under it, the Commissioner may issue an order:

(1) that requires the violator to cease and desist from the identified violation and further similar violations;

(2) that requires the violator to take specific affirmative action to correct the violation;

(3) that requires the violator to make restitution of money, property, or other assets to a person who has suffered financial injury because of the violation; or

(4) that requires a discount medical plan organization or a discount drug plan organization to make restitution of money, property, or other assets to a person who has suffered financial injury because of a violation by any person authorized to sell, market, solicit, or administer a discount medical plan or discount drug plan established by the discount medical plan organization or discount drug plan organization while the person is acting with the actual or apparent authority of the discount medical plan organization or discount drug plan organization.

(b) (1) An order of the Commissioner issued under this section may be served on a violator who is registered under this subtitle in the manner provided in Title 2 of this article.

(2) An order of the Commissioner issued under this section may be served on a violator that is not registered under this subtitle in the manner provided

for service on an unauthorized insurer that does an act of insurance business in Title 4 of this article.

(3) A request for a hearing on any order issued under this subsection does not stay that portion of the order that requires the violator to cease and desist from conduct identified in the order.

(4) The Commissioner may file a petition in the circuit court of any county to enforce an order issued under this section, whether or not a hearing has been requested or, if requested, whether or not a hearing has been held.

(5) If the Commissioner prevails in an action brought by the Commissioner under this section, the Commissioner may recover for the use of the State reasonable attorney's fees and the costs of the action.

(c) (1) In addition to any other enforcement action taken by the Commissioner under this section, the Commissioner may impose a civil penalty of not more than $10,000 for each violation of this subtitle.

(2) Notwithstanding paragraph (1) of this subsection, the Commissioner may impose a civil penalty of not more than $1,000 per day for each day that a person is in violation of § 14–603 of this subtitle.

(d) This section does not limit any regulatory power of the Commissioner under this article.

§14–612.

The Commissioner shall adopt regulations to carry out the provisions of this subtitle.

§15–101.

This title does not apply to:

(1) a policy of liability or workers' compensation and employer's liability insurance;

(2) a group or blanket policy, except as otherwise provided in this title;

(3) reinsurance; or

(4) a life insurance, endowment, or annuity contract, or contract supplemental to a life insurance, endowment, or annuity contract that contains only those provisions relating to health insurance that:

(i) provide additional benefits in case of dismemberment, loss of sight, or death by accident or accidental means;

(ii) provide additional benefits for long-term home health care and long-term care in a nursing home or other related institution; or

(iii) operate to safeguard the contract or supplemental contract against lapse or to provide a special surrender value, special benefit, or annuity in the event that the insured or annuitant becomes totally and permanently disabled, as defined by the contract or supplemental contract.

§15–102.

In this title, the word "insured" may not be construed to prevent a person other than the insured with a proper insurable interest from applying for and owning a policy covering the insured or from being entitled under that policy to any indemnities, benefits, and rights provided in the policy.

§15–103.

(a) An insurer or nonprofit health service plan may not issue or deliver in the State an individual health insurance policy, or group health insurance policy covering a group of 1,000 lives or less, unless the policy or certificate is:

(1) written in simplified language; and

(2) approved by the Commissioner as complying with the simplified language standards adopted under subsection (c) of this section.

(b) Subsection (a) of this section applies:

(1) on or after January 2, 1992; or

(2) on or after July 2, 1997, if the policy or certificate was approved by the Commissioner on or before January 1, 1992.

(c) To establish simplified language standards for individual and group health insurance policies and certificates subject to this section, the Commissioner shall adopt regulations that are consistent with the Life and Health Insurance Policy

Language Simplification Model Act adopted by the National Association of Insurance Commissioners.

§15–104.

(a) (1) In this section the following words have the meanings indicated.

(2) "Intensive care policy" means a health insurance policy that provides benefits only for treatment received in the specifically designated facility of a hospital that provides the highest level of care and is restricted to patients who are physically and critically ill or injured.

(3) "Specified disease policy" has the meaning stated in § 15-109 of this subtitle.

(b) In accordance with regulations that the Commissioner adopts, the Commissioner shall allow health insurance policies and policies of nonprofit health service plans to contain nonduplication provisions or provisions to coordinate coverage with:

(1) other health insurance policies, including commercial individual, group, and blanket policies and policies of nonprofit health service plans;

(2) subscriber contracts that are issued by health maintenance organizations; and

(3) other established programs under which the insured may make a claim.

(c) Notwithstanding subsection (b) of this section or any other provision of this article, an individual, group, or blanket health insurance policy, nonprofit health insurance policy, or nonprofit health service plan may not contain a nonduplication provision or provision to coordinate coverage with an individually underwritten and issued, guaranteed renewable, specified disease policy or intensive care policy, that does not provide benefits on an expense-incurred basis.

(d) Health insurance policies and policies of nonprofit health service plans may not contain a provision that requires personal injury protection benefits under a motor vehicle liability insurance policy to be paid before benefits under the policies.

§15–105.

(a) (1) In this section the following words have the meanings indicated.

(2) "Breast implant" means a pocket or envelope that is surgically inserted under the skin and contains soft silicone gel, saline solution, or a combination of soft silicone gel and saline solution.

(3) "Breast implant-related condition" means a condition that the federal Food and Drug Administration recognizes as possibly linked to breast implants.

(b) This section applies to:

(1) insurers and nonprofit health service plans that provide hospital, medical, or surgical benefits to individuals or groups on an expense-incurred basis under health insurance policies that are issued or delivered in the State; and

(2) health maintenance organizations that provide hospital, medical, or surgical benefits to individuals or groups under contracts that are issued or delivered in the State.

(c) An entity subject to this section shall provide information to the Commissioner about the entity's:

(1) coverage for breast implant removals and breast implant-related conditions; and

(2) preexisting condition provisions in policies for individuals with breast implants.

(d) (1) On request, the Commissioner shall make available to consumers and licensed physicians the information collected under subsection (c) of this section.

(2) When providing the information, the Commissioner may include a statement that the Commissioner does not guarantee the accuracy of the information.

(3) The Commissioner may set a fee to cover the cost of providing the information under paragraph (1) of this subsection.

(e) A licensed physician may make available to a patient the information obtained from the Commissioner under subsection (d) of this section.

(f) The Commissioner shall adopt regulations to carry out this section, including regulations that determine the extent and format of the information required under subsection (c) of this section.

§15–106.

(a) (1) An insurer under a contract that provides an individual with home medical equipment pursuant to an individual, group, or blanket health insurance policy or certificate that is delivered or issued for delivery in the State and that provides benefits on an expense-incurred basis:

(i) shall pay the home medical equipment provider directly if the insured has executed an assignment of benefits; and

(ii) subject to the copayment and deductible provisions in the insurance contract, may not require the home medical equipment provider to accept less than the agreed monthly rental amount for each month in which benefits are payable under the insurance contract.

(2) A nonprofit health service plan under a contract that provides a subscriber with home medical equipment pursuant to a health insurance policy or certificate that is delivered or issued for delivery in the State and that provides benefits on an expense-incurred basis:

(i) shall pay the home medical equipment provider directly if the contract, policy, or certificate of insurance provides for direct payment;

(ii) may pay the home medical equipment provider or the subscriber receiving the home medical equipment, if the contract, policy, or certificate of insurance does not require direct payment; and

(iii) may not require the home medical equipment provider to accept less than the agreed monthly rental amount for each month that use of the home medical equipment is authorized by the nonprofit health service plan.

(b) Authorization may not be terminated until both the provider and beneficiary of the home medical equipment have been notified that authorization is terminated.

(c) (1) Rented home medical equipment and services may be purchased with the consent of the provider and insurer if:

(i) on the insurer's request either before the initial election to rent the equipment or on the insurer's receipt of the initial claim from the provider, the purchase price and rental price of the equipment were disclosed to the insurer; and

(ii) there is no material change in the medical condition of the insured, as certified by the attending physician.

(2) Rented home medical equipment and services may be purchased with the consent of the provider and nonprofit health service plan in accordance with the benefits available under the applicable health insurance policy or certificate.

§15–107.

(a) This section applies to insurers and nonprofit health service plans that issue or deliver individual, group, or blanket health insurance policies in the State.

(b) At least 30 days before the change is effective, an entity subject to this section that provides pharmaceutical benefits shall notify in writing all pharmacies under contract with the entity of any of the following changes in the pharmaceutical benefit program rules or requirements:

(1) exclusion of coverage for classes of drugs as specified by the contract;

(2) changes in prior or preauthorization procedures; or

(3) selection of new prescription claims processors.

(c) An entity subject to this section that fails to provide advance notice under subsection (b) of this section shall honor and pay in full any claim under the program rules or requirements that existed before the change for 30 days after the postmarked date of the notice.

§15–108.

Each insurer that issues or delivers individual, group, or blanket health insurance policies in the State shall establish record keeping procedures that allow review for overutilization and abuse of the use of hospital, health, and medical services that may result from the actions or activities of the policyholders or certificate holders of the insurer or the providers of hospital, health, and medical services to the insured individuals.

§15–109.

(a) (1) In this section the following words have the meanings indicated.

(2) "Loss ratio" means the ratio of losses incurred to premiums earned on policies that are issued, delivered, or renewed in the State.

(3) "Specified disease policy" means a health insurance policy that provides:

(i) benefits only for a disease or diseases specified in the policy or for a treatment unique to a specified disease or diseases; or

(ii) additional benefits for a disease or diseases specified in the policy or for treatment unique to a specified disease or diseases.

(b) This section applies to each individual, group, or blanket health insurance policy or nonprofit health service plan that is issued or delivered in the State.

(c) To administer §§ 12-203, 12-204, and 12-205 of this article, the Commissioner shall establish a minimum loss ratio in accordance with generally accepted actuarial principles with respect to specified disease policies.

§15–110.

(a) (1) In this section the following words have the meanings indicated.

(2) "Health care practitioner" has the meaning stated in § 1–301 of the Health Occupations Article.

(3) "Health care service" has the meaning stated in § 1–301 of the Health Occupations Article.

(4) "Prohibited referral" means a referral prohibited by § 1–302 of the Health Occupations Article.

(b) This section applies to insurers and nonprofit health service plans that issue or deliver individual or group health insurance policies in the State.

(c) An entity subject to this section may seek repayment from a health care practitioner of any money paid for a claim, bill, or other demand or request for payment for health care services that the appropriate regulatory board determines were provided as a result of a prohibited referral.

(d) Each individual and group health insurance policy that is issued for delivery in the State by an entity subject to this section and that provides coverage for health care services shall include a provision that excludes payment of any claim, bill, or other demand or request for payment for health care services that the

appropriate regulatory board determines were provided as a result of a prohibited referral.

(e) An entity subject to this section shall report to the Commissioner and the appropriate regulatory board any pattern of claims, bills, or other demands or requests for payment submitted for health care services provided as a result of a prohibited referral within 30 days after the entity has knowledge of the pattern.

(f) (1) Notwithstanding any other provision of this section, an entity subject to this section that reimburses for health care services is not required to audit or investigate a claim, bill, or other demand or request for payment for health care services to determine whether those services were provided as a result of a prohibited referral.

(2) An audit or investigation of a claim, bill, or other demand or request for payment for health care services to determine whether those services were provided as a result of a prohibited referral is not grounds to delay payment or waive the provisions of §§ 15–1004 and 15–1005 of this title.

(g) In accordance with § 1–305 of the Health Occupations Article, an entity subject to this section may seek a refund of a payment made for a claim, bill, or other demand or request for payment that is subsequently determined to be for a health care service provided as a result of a prohibited referral.

§15–111.

(a) Each payor shall cooperate fully in submitting reports and claims data and providing any other information to the Maryland Health Care Commission in accordance with Title 19, Subtitle 1 of the Health - General Article.

(b) The Commissioner shall report to the Maryland Health Care Commission in a timely manner the name and address of each payor that is assessed a fee under § 19–111 of the Health – General Article.

§15–112. IN EFFECT

(a) (1) In this section the following words have the meanings indicated.

(2) "Accredited hospital" has the meaning stated in § 19–301 of the Health – General Article.

(3) "Ambulatory surgical facility" has the meaning stated in § 19–3B–01 of the Health – General Article.

(4) "Behavioral health care services" has the meaning stated in § 15–127 of this subtitle.

(5) (i) "Carrier" means:

1. an insurer;

2. a nonprofit health service plan;

3. a health maintenance organization;

4. a dental plan organization; or

5. any other person that provides health benefit plans subject to regulation by the State.

(ii) "Carrier" includes an entity that arranges a provider panel for a carrier.

(6) "Credentialing intermediary" means a person to whom a carrier has delegated credentialing or recredentialing authority and responsibility.

(7) "Enrollee" means a person entitled to health care benefits from a carrier.

(8) "Group model health maintenance organization" has the meaning stated in § 19–713.6(a) of the Health – General Article.

(9) "Health benefit plan":

(i) for a group or blanket plan in the large group market, has the meaning stated in § 15–1401 of this title;

(ii) for a group in the small group market, has the meaning stated in § 31–101 of this article; and

(iii) for an individual plan, has the meaning stated in § 15–1301 of this title.

(10) (i) "Health care facility" means a health care setting or institution providing physical, mental, or substance use disorder health care services.

(ii) "Health care facility" includes:

1. a hospital;

2. an ambulatory surgical or treatment center;

3. a skilled nursing facility;

4. a residential treatment center;

5. an urgent care center;

6. a diagnostic, laboratory, or imaging center;

7. a rehabilitation facility; and

8. any other therapeutic health care setting.

(11) "Hospital" has the meaning stated in § 19–301 of the Health – General Article.

(12) "Network" means a carrier's participating providers and the health care facilities with which a carrier contracts to provide health care services to the carrier's enrollees under the carrier's health benefit plan.

(13) "Online credentialing system" means the system through which a provider may access an online provider credentialing application that the Commissioner has designated as the uniform credentialing form under § 15–112.1(e) of this subtitle.

(14) "Participating provider" means a provider on a carrier's provider panel.

(15) "Provider" means a health care practitioner or group of health care practitioners licensed, certified, or otherwise authorized by law to provide health care services.

(16) "Provider directory" means a list of a carrier's participating providers and participating health care facilities.

(17) (i) "Provider panel" means the providers that contract either directly or through a subcontracting entity with a carrier to provide health care services to the carrier's enrollees under the carrier's health benefit plan.

(ii) "Provider panel" does not include an arrangement in which any provider may participate solely by contracting with the carrier to provide health care services at a discounted fee–for–service rate.

(b) (1) Subject to paragraph (3) of this subsection, a carrier that uses a provider panel shall:

(i) if the carrier is an insurer, nonprofit health service plan, health maintenance organization, or dental plan organization, maintain standards in accordance with regulations adopted by the Commissioner for availability of health care providers to meet the health care needs of enrollees; and

(ii) establish procedures to:

1. review applications for participation on the carrier's provider panel in accordance with this section;

2. notify an enrollee of:

A. the termination from the carrier's provider panel, including when the provider elects to terminate participation from the provider panel, of the primary care provider that was furnishing health care services to the enrollee and any provider of behavioral health care services for whom the carrier has received a claim for services performed on the enrollee within the 3 months immediately preceding the date of the termination; and

B. the right of the enrollee, on request, to continue to receive health care services from the providers described in item A of this item for up to 90 days after the date of the notice of termination of the provider from the carrier's provider panel, if the termination was for reasons unrelated to fraud, patient abuse, incompetency, or loss of licensure status;

3. notify primary care providers on the carrier's provider panel of the termination of a specialty referral services provider;

4. verify with each provider on the carrier's provider panel, at the time of credentialing and recredentialing, whether the provider is accepting new patients and update the information on participating providers that the carrier is required to provide under subsection (n) of this section; and

5. notify a provider at least 90 days before the date of the termination of the provider from the carrier's provider panel, if the termination is for reasons unrelated to fraud, patient abuse, incompetency, or loss of licensure status.

(2) The provisions of paragraph (1)(ii)4 of this subsection may not be construed to require a carrier to allow a provider to refuse to accept new patients covered by the carrier.

(3) For a carrier that is an insurer, a nonprofit health service plan, or a health maintenance organization, the standards required under paragraph (1)(i) of this subsection shall:

(i) ensure that all enrollees, including adults and children, have access to providers and covered services without unreasonable travel or delay;

(ii) 1. include standards that ensure access to providers, including essential community providers, that serve predominantly low–income and medically underserved individuals; or

2. for a carrier that provides a majority of covered professional services through physicians employed by a single contracted medical group and through health care providers employed by the carrier, include alternative standards for addressing the needs of low–income, medically underserved individuals; and

(iii) except for a carrier that is a group model health maintenance organization, ensure that all enrollees have access to local health departments and covered services provided through local health departments, including behavioral health care services, to the extent that local health departments are willing to participate on a carrier's provider panel.

(4) The notice required under paragraph (1)(ii)2 of this subsection shall include:

(i) contact information that the enrollee may use to direct comments or concerns to the carrier regarding the termination of the provider from the carrier's provider panel;

(ii) instructions on how the enrollee may notify the carrier of the need for transitional care as described in paragraph (1)(ii)2B of this subsection by submitting a uniform form developed by the Commissioner under subsection (y)(4) of this section; and

(iii) the telephone number and e–mail address for the office in the Administration that is responsible for receiving and responding to complaints.

(c) (1) This subsection applies to a carrier that:

(i) is an insurer, a nonprofit health service plan, or a health maintenance organization; and

(ii) uses a provider panel for a health benefit plan offered by the carrier.

(2) (i) On or before July 1, 2018, and annually thereafter, a carrier shall file with the Commissioner for review by the Commissioner an access plan that meets the requirements of subsection (b) of this section and any regulations adopted by the Commissioner under subsections (b) and (d) of this section.

(ii) If the termination of a provider or health care facility from the carrier's provider panel will result in a material change to the access plan, the carrier shall:

1. subject to subparagraph (iv) of this paragraph, notify the Commissioner of the impending termination at least 60 days before the anticipated date of termination;

2. have a continuing obligation to update and supplement the initial and subsequent notifications until the termination is effective or an agreement is reached with the provider or health care facility; and

3. subject to subparagraph (v) of this paragraph, within 5 business days after the effective date of the termination, file with the Commissioner an update to the existing access plan for review by the Commissioner.

(iii) The Commissioner may order corrective action if, after review, the access plan is determined not to meet the requirements of this subsection.

(iv) The notice required under subparagraph (ii)1 of this paragraph shall be provided if:

1. the provider or health care facility provides advance notice to the carrier of its intention to terminate participation in the carrier's provider panel;

2. the carrier provides advance notice to the provider or health care facility of the carrier's intention to terminate the provider or health care facility from the carrier's provider panel;

3. the current term of the existing network participation contract between the carrier and the provider or health care facility is

set to expire within 60 days and an agreement to extend or renew the contract has not been reached; or

4. the carrier possesses other information that it reasonably determines is an indication that termination of the provider or health care facility from the carrier's provider panel is likely in the next 60 days.

(v) The update to the existing access plan required to be filed under subparagraph (ii)3 of this paragraph is required to include only information related to:

1. the provider specialty types affected by the material change; and

2. unless the network as a whole experienced a 10% reduction, the geographic areas where enrollees were affected by the material change.

(vi) The Commissioner may impose a fine of $5,000 per day for each day past 5 business days that the carrier fails to file an update to the existing access plan as required by subparagraph (ii)3 of this paragraph.

(3) (i) In accordance with § 4–335 of the General Provisions Article, the Commissioner shall deny inspection of the parts of the access plan filed under this subsection that contain confidential commercial information or confidential financial information.

(ii) The regulations adopted by the Commissioner under subsection (d) of this section shall identify the parts of the access plan that may be considered confidential by the carrier.

(4) An access plan filed under this subsection shall include a description of:

(i) the carrier's network, including how telemedicine, telehealth, or other technology may be used to meet network access standards required under subsection (b) of this section;

(ii) the carrier's process for monitoring and ensuring, on an ongoing basis, the sufficiency of the network to meet the health care needs of enrollees;

(iii) the factors used by the carrier to build its provider network, including the criteria used to select providers for participation in the network and, if applicable, place providers in network tiers;

(iv) the carrier's efforts to address the needs of both adult and child enrollees, including adults and children with:

1. limited English proficiency or illiteracy;

2. diverse cultural or ethnic backgrounds;

3. physical or mental disabilities; and

4. serious, chronic, or complex health conditions;

(v) 1. the carrier's efforts to include providers, including essential community providers, in its network who serve predominantly low–income, medically underserved individuals; or

2. for a carrier that provides a majority of covered professional services through physicians employed by a single contracted medical group and through health care providers employed by the carrier, the carrier's efforts to address the needs of low–income, medically underserved individuals;

(vi) except for an access plan filed by a group model health maintenance organization, the carrier's efforts to include local health departments in its network; and

(vii) the carrier's methods for assessing the health care needs of enrollees and enrollee satisfaction with health care services provided to them.

(5) Each carrier shall monitor, on an ongoing basis, the clinical capacity of its participating providers to provide covered services to its enrollees.

(d) (1) On or before December 31, 2017, the Commissioner shall, in consultation with interested stakeholders, adopt regulations to establish quantitative and, if appropriate, nonquantitative criteria to evaluate the network sufficiency of health benefit plans subject to the requirements of subsection (c) of this section.

(2) In adopting the regulations, the Commissioner may take into consideration:

(i) geographic accessibility of primary care and specialty providers, including mental health and substance use disorder providers;

(ii) waiting times for an appointment with participating primary care and specialty providers, including mental health and substance use disorder providers;

(iii) primary care provider–to–enrollee ratios;

(iv) provider–to–enrollee ratios, by specialty;

(v) geographic variation and population dispersion;

(vi) hours of operation;

(vii) the ability of the network to meet the needs of enrollees, which may include:

1. low–income individuals;

2. adults and children with:

A. serious, chronic, or complex health conditions; or

B. physical or mental disabilities; and

3. individuals with limited English proficiency or illiteracy;

(viii) other health care service delivery system options, including telemedicine, telehealth, mobile clinics, and centers of excellence;

(ix) the volume of technological and specialty care services available to serve the needs of enrollees requiring technologically advanced or specialty care services;

(x) any standards adopted by the federal Centers for Medicare and Medicaid Services or used by the Federally Facilitated Marketplace; and

(xi) any standards adopted by another state.

(e) (1) On or before December 31, 2017, for a carrier that is a dental plan organization or an insurer or nonprofit health service plan that provides coverage for dental services, the Commissioner, in consultation with appropriate stakeholders, shall adopt regulations to specify the standards under subsection (b)(1)(i) of this section for dental services.

(2) The regulations shall:

(i) ensure that all enrollees, including adults and children, have access to providers and covered services without unreasonable delay and travel;

(ii) ensure access to providers, including essential community providers, that serve predominantly low–income, medically underserved individuals; and

(iii) require the carrier to specify how the carrier will monitor, on an ongoing basis, the ability of its participating providers to provide covered services to its enrollees.

(3) In establishing the standards for dental services, the Commissioner may consider the appropriateness of quantitative and nonquantitative criteria.

(f) A carrier that uses a provider panel:

(1) on request, shall provide an application and information that relates to consideration for participation on the carrier's provider panel to any provider seeking to apply for participation;

(2) shall make publicly available its application; and

(3) shall make efforts to increase the opportunity for a broad range of minority providers to participate on the carrier's provider panel.

(g) (1) A provider that seeks to participate on a provider panel of a carrier shall submit an application to the carrier.

(2) (i) Subject to subparagraph (ii) of this paragraph and paragraph (3) of this subsection, the carrier, after reviewing the application, shall accept or reject the provider for participation on the carrier's provider panel.

(ii) A carrier may not reject a provider who provides community–based health services for a program accredited under COMAR 10.63.02 for participation on the carrier's provider panel because the provider practices within the scope of the provider's license and is:

1. a licensed master social worker, as defined in § 19–101 of the Health Occupations Article;

2. a licensed graduate alcohol and drug counselor, a licensed graduate marriage and family therapist, a licensed graduate professional art therapist, or a licensed graduate professional counselor, as those terms are defined in § 17–101 of the Health Occupations Article; or

3. a registered psychology associate, as defined in § 18–101 of the Health Occupations Article.

(iii) If the carrier rejects the provider for participation on the carrier's provider panel, the carrier shall send to the provider at the address listed in the application written notice of the rejection.

(3) (i) Subject to paragraph (4) of this subsection, within 30 days after the date a carrier receives a completed application, the carrier shall send to the provider at the address listed in the application written notice of:

1. the carrier's intent to continue to process the provider's application to obtain necessary credentialing information; or

2. the carrier's rejection of the provider for participation on the carrier's provider panel.

(ii) The failure of a carrier to provide the notice required under subparagraph (i) of this paragraph is a violation of this article and the carrier is subject to the penalties provided by § 4–113(d) of this article.

(iii) Except as provided in subsection (v) of this section and subparagraph (iv) of this paragraph, if, under subparagraph (i)1 of this paragraph, a carrier provides notice to the provider of its intent to continue to process the provider's application to obtain necessary credentialing information, the carrier, within 120 days after the date the notice is provided, shall:

1. accept or reject the provider for participation on the carrier's provider panel; and

2. send written notice of the acceptance or rejection to the provider at the address listed in the application.

(iv) For a provider described in paragraph (2)(ii) of this subsection, if, under subparagraph (i)1 of this paragraph, a carrier provides notice to the provider of its intent to continue to process the provider's application to obtain necessary credentialing information, within 60 days after the date a carrier receives a completed application, the carrier shall:

1. accept or reject the provider for participation on the carrier's provider panel; and

2. send written notice of the acceptance or rejection to the provider at the address listed in the application.

(v) The failure of a carrier to provide the notice required under subparagraph (iii)2 or (iv) of this paragraph is a violation of this article and the carrier is subject to the provisions of and penalties provided by §§ 4–113 and 4–114 of this article.

(4) (i) 1. Except as provided in subsubparagraph 4 of this subparagraph, a carrier that receives a complete application shall notify the provider that the application is complete.

2. If a carrier does not accept applications through the online credentialing system, notice shall be given to the provider at the address listed in the application within 10 days after the date the application is received.

3. If a carrier accepts applications through the online credentialing system, the notice from the online credentialing system to the provider that the carrier has received the provider's application shall be considered notice that the application is complete.

4. This subparagraph does not apply to a carrier that arranges a dental provider panel until the Commissioner certifies that the online credentialing system is capable of accepting the uniform credentialing form designated by the Commissioner for dental provider panels.

(ii) 1. A carrier that receives an incomplete application shall return the application to the provider at the address listed in the application within 10 days after the date the application is received.

2. The carrier shall indicate to the provider what information is needed to make the application complete.

3. The provider may return the completed application to the carrier.

4. After the carrier receives the completed application, the carrier is subject to the time periods established in paragraph (3) of this subsection.

(5) A carrier may charge a reasonable fee for an application submitted to the carrier under this section.

(h) A carrier may not deny an application for participation or terminate participation on its provider panel on the basis of:

(1) sex, sexual orientation, gender identity, race, age, religion, national origin, or a protected category under the federal Americans with Disabilities Act;

(2) the type or number of appeals that the provider files under Subtitle 10B of this title;

(3) the number of grievances or complaints that the provider files on behalf of a patient under Subtitle 10A of this title; or

(4) the type or number of complaints or grievances that the provider files or requests for review under the carrier's internal review system established under subsection (l) of this section.

(i) (1) A carrier may not deny an application for participation or terminate participation on its provider panel solely on the basis of the license, certification, or other authorization of the provider to provide health care services if the carrier provides health care services within the provider's lawful scope of practice.

(2) Notwithstanding paragraph (1) of this subsection, a carrier may reject an application for participation or terminate participation on its provider panel based on the participation on the provider panel of a sufficient number of similarly qualified providers.

(3) A violation of this subsection does not create a new cause of action.

(j) (1) Subject to the provisions of this subsection, a carrier may not require a provider participating on its provider panel to be recredentialed based on:

(i) a change in the federal tax identification number of the provider;

(ii) a change in the federal tax identification number of a provider's employer; or

(iii) a change in the employer of a provider, if the new employer is:

1. a participating provider on the carrier's provider panel; or

2. the employer of providers that participate on the carrier's provider panel.

(2) A provider that participates on a carrier's provider panel or the provider's employer shall give written notice to the carrier of a change in the federal tax identification number of the provider or the provider's employer not less than 45 days before the effective date of the change.

(3) The notice required under paragraph (2) of this subsection shall include:

(i) a statement of the intention of the provider or the provider's employer to continue to provide health care services in the same field of specialization, if applicable;

(ii) the effective date of the change in the federal tax identification number of the provider or the provider's employer;

(iii) the new federal tax identification number of the provider or the provider's employer and a copy of U.S. Treasury Form W–9, or any successor or replacement form; and

(iv) the following information about a new employer of the provider:

1. the employer's name;

2. the name of the employer's contact person for carrier questions about the provider; and

3. the address, telephone number, facsimile transmission number, and electronic mail address of the contact person for the employer.

(4) If the new federal tax identification number or the form required to be included in the notice under paragraph (3)(iii) of this subsection is not available at the time the notice is given to a carrier, it shall be provided to the carrier promptly after it is received by the provider or the provider's employer.

(5) Within 30 business days after receipt of the notice required under paragraph (2) of this subsection, a carrier:

(i) shall acknowledge receipt of the notice to the provider or the provider's employer; and

(ii) if the carrier considers it necessary to issue a new provider number as a result of a change in the federal tax identification number of a provider or a provider's employer or a change in the employer of a provider, shall issue a new provider number, by mail, electronic mail, or facsimile transmission, to:

1. the provider or the provider's employer; or

2. the representative of the provider or the provider's employer designated in writing to the carrier.

(6) A carrier may not terminate its existing contract with a provider or a provider's employer based solely on a notice given to the carrier in accordance with this subsection.

(k) A carrier may not terminate participation on its provider panel or otherwise penalize a provider for:

(1) advocating the interests of a patient through the carrier's internal review system established under subsection (l) of this section;

(2) filing an appeal under Subtitle 10B of this title; or

(3) filing a grievance or complaint on behalf of a patient under Subtitle 10A of this title.

(l) Each carrier shall establish an internal review system to resolve grievances initiated by providers that participate on the carrier's provider panel, including grievances involving the termination of a provider from participation on the carrier's provider panel.

(m) (1) For at least 90 days after the date of the notice of termination of a primary care provider or a provider of a behavioral health care services from a carrier's provider panel for reasons unrelated to fraud, patient abuse, incompetency, or loss of licensure status, the provider shall furnish health care services to each enrollee:

(i) who was receiving health care services from the provider before the notice of termination; and

(ii) who, after receiving notice under subsection (b) of this section of the termination of the provider, requests to continue receiving health care services from the provider.

(2) A carrier shall reimburse a provider that furnishes health care services under this subsection in accordance with the provider's agreement with the carrier.

(3) A provider that furnishes health care services under this subsection in accordance with a provider's agreement with a carrier shall accept as payment in full for the services payment from the carrier and cost–sharing from the patient, as applicable.

(n) (1) A carrier shall make the carrier's provider directory available to prospective enrollees on the Internet and, on request of a prospective enrollee, in printed form.

(2) The carrier's provider directory on the Internet shall be available:

(i) through a clear link or tab; and

(ii) in a searchable format.

(3) The provider directory shall include:

(i) for each provider on the carrier's provider panel:

1. the name of the provider;

2. the specialty areas of the provider;

3. whether the provider currently is accepting new patients;

4. for each office of the provider where the provider participates on the provider panel:

A. its location, including its address; and

B. contact information for the provider;

5. the gender of the provider, if the provider notifies the carrier or the multi–carrier common online provider directory information system designated under § 15–112.3 of this subtitle of the information; and

6. any languages spoken by the provider other than English, if the provider notifies the carrier or the multi–carrier common online provider directory information system designated under § 15–112.3 of this subtitle of the information;

(ii) for each health care facility in the carrier's network:

1. the health care facility's name;

2. the health care facility's address;

3. the types of services provided by the health care facility; and

4. contact information for the health care facility; and

(iii) a statement that advises enrollees and prospective enrollees to contact a provider or a health care facility before seeking treatment or services, to confirm the provider's or health care facility's participation in the carrier's network and the enrollee's health benefit plan.

(o) (1) A carrier shall have a customer service telephone number, e–mail address link, or other electronic means by which enrollees and prospective enrollees may notify the carrier of inaccurate information in the carrier's network directory.

(2) If notified of a potential inaccuracy in a network directory by a person other than the provider, a carrier shall investigate the reported inaccuracy and take corrective action, if necessary, to update the network directory within 45 working days after receiving the notification.

(p) (1) A carrier shall notify each enrollee at the time of initial enrollment and renewal about how to access or obtain the information required under subsection (n) of this section.

(2) (i) 1. Information provided in printed form under subsection (n) of this section shall be accurate on the date of publication.

2. A carrier shall update the information provided in printed form at least once a year.

(ii) 1. Information provided on the Internet under subsection (n) of this section shall be accurate on the date of initial posting and any update.

2. In addition to the requirement to update its provider information under subsection (t)(1) of this section, a carrier shall update the information provided on the Internet at least once every 15 days.

(3) A carrier shall:

(i) 1. periodically review at least a reasonable sample size of its provider directory for accuracy; and

2. retain documentation of the review and make the review available to the Commissioner on request; or

(ii) contact providers listed in the carrier's provider directory who have not submitted a claim in the last 6 months to determine if the providers intend to remain in the carrier's provider network.

(4) A carrier shall demonstrate the accuracy of the information provided under paragraph (3) of this subsection on request of the Commissioner.

(5) A carrier shall include in a provider directory that is in printed form a statement notifying a reader that:

(i) the information contained in the provider directory is accurate as of the date of publication; and

(ii) to obtain the most current information, the individual should consult the provider directory on the Internet or contact the carrier directly.

(6) Before imposing a penalty against a carrier for inaccurate network directory information, the Commissioner shall take into account, in addition to any other factors required by law, whether:

(i) the carrier afforded a provider or other person identified in § 15–112.3(c) of this subtitle an opportunity to review and update the provider's network directory information:

1. through the multi–carrier common online provider directory information system designated under § 15–112.3 of this subtitle; or

2. directly with the carrier;

(ii) the carrier can demonstrate the efforts made, in writing, electronically, or by telephone, to obtain updated network directory information from a provider or other person identified in § 15–112.3(c) of this subtitle;

(iii) the carrier has contacted a provider listed in the carrier's network directory who has not submitted a claim in the last 6 months to determine if the provider intends to remain on the carrier's provider panel;

(iv) the carrier includes in its network directory the last date that a provider updated the provider's information;

(v) the carrier has implemented any other process or procedure to:

1. encourage providers to update their network directory information; or

2. increase the accuracy of its network directory; and

(vi) a provider or other person identified in § 15–112.3(c) of this subtitle has not updated the provider's network directory information, despite opportunities to do so.

(q) A policy, certificate, or other evidence of coverage shall:

(1) indicate clearly the office in the Administration that is responsible for receiving and responding to complaints from enrollees about carriers; and

(2) include the telephone number of the office and the procedure for filing a complaint.

(r) The Commissioner:

(1) shall adopt regulations that relate to the procedures that carriers must use to process applications for participation on a provider panel; and

(2) in consultation with the Secretary of Health, shall adopt strategies to assist carriers in maximizing the opportunity for a broad range of minority providers to participate in the delivery of health care services.

(s) A carrier may not include in a contract with a provider, ambulatory surgical facility, or hospital a term or condition that:

(1) prohibits the provider, ambulatory surgical facility, or hospital from offering to provide services to the enrollees of another carrier at a lower rate of reimbursement;

(2) requires the provider, ambulatory surgical facility, or hospital to provide the carrier with the same reimbursement arrangement that the provider, ambulatory surgical facility, or hospital has with another carrier if the reimbursement arrangement with the other carrier is for a lower rate of reimbursement; or

(3) requires the provider, ambulatory surgical facility, or hospital to certify to the carrier that the reimbursement rate being paid by the carrier to the provider, ambulatory surgical facility, or hospital is not higher than the reimbursement rate being received by the provider, ambulatory surgical facility, or hospital from another carrier.

(t) (1) (i) Subject to subparagraph (ii) of this paragraph, a carrier shall update the information that must be made available on the Internet under subsection (n) of this section within 2 working days after receipt of electronic notification or notification by first–class mail tracking method from the participating provider of a change in the applicable information.

(ii) A dental carrier shall update the information required by this subsection within 15 working days after receipt of the notification described in subparagraph (i) of this paragraph.

(2) Notification is presumed to have been received by a carrier:

(i) 3 working days after the date the participating provider placed the notification in the U.S. mail, if the participating provider maintains the stamped certificate of mailing for the notice; or

(ii) on the date recorded by the courier, if the notification was delivered by courier.

(u) (1) A carrier may not require a provider that provides health care services through a group practice or health care facility that participates on the carrier's provider panel under a contract with the carrier to be considered a participating provider or accept the reimbursement fee schedule applicable under the contract when:

(i) providing health care services to enrollees of the carrier through an individual or group practice or health care facility that does not have a contract with the carrier; and

(ii) billing for health care services provided to enrollees of the carrier using a different federal tax identification number than that used by the group practice or health care facility under a contract with the carrier.

(2) A nonparticipating provider shall notify an enrollee:

(i) that the provider does not participate on the provider panel of the enrollee's carrier; and

(ii) of the anticipated total charges for the health care services.

(v) The provisions of subsection (g)(3)(iii) of this section do not apply to a carrier that uses a credentialing intermediary that:

(1) is a hospital or academic medical center;

(2) is a participating provider on the carrier's provider panel; and

(3) acts as a credentialing intermediary for that carrier for health care practitioners that:

(i) participate on the carrier's provider panel; and

(ii) have privileges at the hospital or academic medical center.

(w) (1) Notwithstanding subsection (u)(1) of this section, a carrier shall reimburse a group practice on the carrier's provider panel at the participating provider rate for covered services provided by a provider who is not a participating provider if:

(i) the provider is employed by or a member of the group practice;

(ii) the provider has applied for acceptance on the carrier's provider panel and the carrier has notified the provider of the carrier's intent to continue to process the provider's application to obtain necessary credentialing information;

(iii) the provider has a valid license issued by a health occupations board to practice in the State; and

(iv) the provider:

1. is currently credentialed by an accredited hospital in the State; or

2. has professional liability insurance.

(2) A carrier shall reimburse a group practice on the carrier's provider panel in accordance with paragraph (1) of this subsection from the date the notice required under subsection (g)(3)(i)1 of this section is sent to the provider until the date the notice required under subsection (g)(3)(iii)2 of this section is sent to the provider.

(3) A carrier that sends written notice of rejection of a provider for credentialing under subsection (g)(3)(iii)2 of this section shall reimburse the provider as a nonparticipating provider for covered services provided on or after the date the notice is sent.

(4) A health maintenance organization may not deny payment to a provider under this subsection solely because the provider was not a participating provider at the time the services were provided to an enrollee.

(5) A provider who is not a participating provider of a carrier and whose group practice is eligible for reimbursement under paragraph (1) of this subsection may not hold an enrollee of the carrier liable for the cost of any covered services provided to the enrollee during the time period described in paragraph (2) of this subsection, except for any deductible, copayment, or coinsurance amount owed by the enrollee to the group practice or provider under the terms of the enrollee's contract or certificate.

(6) A group practice shall disclose in writing to an enrollee at the time services are provided that:

(i) the treating provider is not a participating provider;

(ii) the treating provider has applied to become a participating provider;

(iii) the carrier has not completed its assessment of the qualifications of the treating provider to provide services as a participating provider; and

(iv) any covered services received must be reimbursed by the carrier at the participating provider rate.

(x) A carrier may not impose a limit on the number of behavioral health providers at a health care facility that may be credentialed to participate on a provider panel.

(y) (1) In this subsection, "health system" means:

(i) a hospital and any entity affiliated with the hospital through ownership, governance, membership, or other means; or

(ii) a parent corporation of one or more hospitals and any entity affiliated with the parent corporation through ownership, governance, membership, or other means.

(2) A carrier and a health system shall provide to each other written notice of any intent to terminate a contract between the carrier and the health system:

(i) at least 90 days before the proposed date of the termination of the contract; or

(ii) in the case of nonrenewal, at least 90 days before the end of the contract period.

(3) (i) For each contract between a carrier and a health system that is entered into, renewed, amended, or continued on or after October 1, 2026, if the contract is not renewed or is terminated by the carrier or the health system, the carrier and the health system shall continue to adhere to the terms of the contract, including reimbursement terms and patient balance billing protections for all health care services provided under the contract, for a period of:

1. at least 90 days after the date of termination; or

2. in the case of a nonrenewal, at least 90 days after the end of the contract period.

(ii) Except as otherwise agreed to by a carrier and a health system, the reimbursement terms of a contract entered into by the carrier and the health system during the 90–day period shall be retroactive to:

1. the date of termination; or

2. in the case of a nonrenewal, the end date of the contract period.

(iii) This paragraph does not apply if the carrier and health system:

1. agree, in writing, to the termination or nonrenewal of the contract; and

2. provide the notices required under paragraph (2) of this subsection.

(4) The Commissioner shall develop a uniform form that carriers, providers, and health care systems shall use for requests to continue to receive health services in accordance with subsection (b) of this section or 42 U.S.C. § 300GG–113.

§15–112. ** TAKES EFFECT JANUARY 1, 2027 PER CHAPTERS 706 AND 707 OF 2026 **

(a) (1) In this section the following words have the meanings indicated.

(2) "Accredited hospital" has the meaning stated in § 19–301 of the Health – General Article.

(3) "Ambulatory surgical facility" has the meaning stated in § 19–3B–01 of the Health – General Article.

(4) "Behavioral health care services" has the meaning stated in § 15–127 of this subtitle.

(5) (i) "Carrier" means:

1. an insurer;

2. a nonprofit health service plan;

3. a health maintenance organization;

4. a dental plan organization; or

5. any other person that provides health benefit plans subject to regulation by the State.

(ii) "Carrier" includes an entity that arranges a provider panel for a carrier.

(6) "Credentialing intermediary" means a person to whom a carrier has delegated credentialing or recredentialing authority and responsibility.

(7) "Enrollee" means a person entitled to health care benefits from a carrier.

(8) "Group model health maintenance organization" has the meaning stated in § 19–713.6(a) of the Health – General Article.

(9) "Health benefit plan":

(i) for a group or blanket plan in the large group market, has the meaning stated in § 15–1401 of this title;

(ii) for a group in the small group market, has the meaning stated in § 31–101 of this article; and

(iii) for an individual plan, has the meaning stated in § 15–1301 of this title.

(10) (i) "Health care facility" means a health care setting or institution providing physical, mental, or substance use disorder health care services.

(ii) "Health care facility" includes:

1. a hospital;

2. an ambulatory surgical or treatment center;

3. a skilled nursing facility;

4. a residential treatment center;

5. an urgent care center;

6. a diagnostic, laboratory, or imaging center;

7. a rehabilitation facility; and

8. any other therapeutic health care setting.

(11) "Hospital" has the meaning stated in § 19–301 of the Health – General Article.

(12) "Network" means a carrier's participating providers and the health care facilities with which a carrier contracts to provide health care services to the carrier's enrollees under the carrier's health benefit plan.

(13) "Online credentialing system" means the system through which a provider may access and submit an online provider credentialing application that the Commissioner has designated as the uniform credentialing form under § 15–112.1(e) of this subtitle.

(14) "Participating provider" means a provider on a carrier's provider panel.

(15) "Provider" means a health care practitioner or group of health care practitioners licensed, certified, or otherwise authorized by law to provide health care services.

(16) "Provider directory" means a list of a carrier's participating providers and participating health care facilities.

(17) (i) "Provider panel" means the providers that contract either directly or through a subcontracting entity with a carrier to provide health care services to the carrier's enrollees under the carrier's health benefit plan.

(ii) "Provider panel" does not include an arrangement in which any provider may participate solely by contracting with the carrier to provide health care services at a discounted fee–for–service rate.

(b) (1) Subject to paragraph (3) of this subsection, a carrier that uses a provider panel shall:

(i) if the carrier is an insurer, nonprofit health service plan, health maintenance organization, or dental plan organization, maintain standards in accordance with regulations adopted by the Commissioner for availability of health care providers to meet the health care needs of enrollees; and

(ii) establish procedures to:

1. review applications for participation on the carrier's provider panel in accordance with this section;

2. notify an enrollee of:

A. the termination from the carrier's provider panel, including when the provider elects to terminate participation from the provider panel, of the primary care provider that was furnishing health care services to the enrollee and any provider of behavioral health care services for whom the carrier has received a claim for services performed on the enrollee within the 3 months immediately preceding the date of the termination; and

B. the right of the enrollee, on request, to continue to receive health care services from the providers described in item A of this item for up to 90 days after the date of the notice of termination of the provider from the carrier's provider panel, if the termination was for reasons unrelated to fraud, patient abuse, incompetency, or loss of licensure status;

3. notify primary care providers on the carrier's provider panel of the termination of a specialty referral services provider;

4. verify with each provider on the carrier's provider panel, at the time of credentialing and recredentialing, whether the provider is accepting new patients and update the information on participating providers that the carrier is required to provide under subsection (n) of this section; and

5. notify a provider at least 90 days before the date of the termination of the provider from the carrier's provider panel, if the termination is for reasons unrelated to fraud, patient abuse, incompetency, or loss of licensure status.

(2) The provisions of paragraph (1)(ii)4 of this subsection may not be construed to require a carrier to allow a provider to refuse to accept new patients covered by the carrier.

(3) For a carrier that is an insurer, a nonprofit health service plan, or a health maintenance organization, the standards required under paragraph (1)(i) of this subsection shall:

(i) ensure that all enrollees, including adults and children, have access to providers and covered services without unreasonable travel or delay;

(ii) 1. include standards that ensure access to providers, including essential community providers, that serve predominantly low–income and medically underserved individuals; or

2. for a carrier that provides a majority of covered professional services through physicians employed by a single contracted medical

group and through health care providers employed by the carrier, include alternative standards for addressing the needs of low–income, medically underserved individuals; and

(iii) except for a carrier that is a group model health maintenance organization, ensure that all enrollees have access to local health departments and covered services provided through local health departments, including behavioral health care services, to the extent that local health departments are willing to participate on a carrier's provider panel.

(4) The notice required under paragraph (1)(ii)2 of this subsection shall include:

(i) contact information that the enrollee may use to direct comments or concerns to the carrier regarding the termination of the provider from the carrier's provider panel;

(ii) instructions on how the enrollee may notify the carrier of the need for transitional care as described in paragraph (1)(ii)2B of this subsection by submitting a uniform form developed by the Commissioner under subsection (y)(4) of this section; and

(iii) the telephone number and e–mail address for the office in the Administration that is responsible for receiving and responding to complaints.

(c) (1) This subsection applies to a carrier that:

(i) is an insurer, a nonprofit health service plan, or a health maintenance organization; and

(ii) uses a provider panel for a health benefit plan offered by the carrier.

(2) (i) On or before July 1, 2018, and annually thereafter, a carrier shall file with the Commissioner for review by the Commissioner an access plan that meets the requirements of subsection (b) of this section and any regulations adopted by the Commissioner under subsections (b) and (d) of this section.

(ii) If the termination of a provider or health care facility from the carrier's provider panel will result in a material change to the access plan, the carrier shall:

1. subject to subparagraph (iv) of this paragraph, notify the Commissioner of the impending termination at least 60 days before the anticipated date of termination;

2. have a continuing obligation to update and supplement the initial and subsequent notifications until the termination is effective or an agreement is reached with the provider or health care facility; and

3. subject to subparagraph (v) of this paragraph, within 5 business days after the effective date of the termination, file with the Commissioner an update to the existing access plan for review by the Commissioner.

(iii) The Commissioner may order corrective action if, after review, the access plan is determined not to meet the requirements of this subsection.

(iv) The notice required under subparagraph (ii)1 of this paragraph shall be provided if:

1. the provider or health care facility provides advance notice to the carrier of its intention to terminate participation in the carrier's provider panel;

2. the carrier provides advance notice to the provider or health care facility of the carrier's intention to terminate the provider or health care facility from the carrier's provider panel;

3. the current term of the existing network participation contract between the carrier and the provider or health care facility is set to expire within 60 days and an agreement to extend or renew the contract has not been reached; or

4. the carrier possesses other information that it reasonably determines is an indication that termination of the provider or health care facility from the carrier's provider panel is likely in the next 60 days.

(iv) The notice required under subparagraph (ii)1 of this paragraph shall be provided if:

1. the provider or health care facility provides advance notice to the carrier of its intention to terminate participation in the carrier's provider panel;

2. the carrier provides advance notice to the provider or health care facility of the carrier's intention to terminate the provider or health care facility from the carrier's provider panel;

3. the current term of the existing network participation contract between the carrier and the provider or health care facility is set to expire within 60 days and an agreement to extend or renew the contract has not been reached; or

4. the carrier possesses other information that it reasonably determines is an indication that termination of the provider or health care facility from the carrier's provider panel is likely in the next 60 days.

(v) The update to the existing access plan required to be filed under subparagraph (ii)3 of this paragraph is required to include only information related to:

1. the provider specialty types affected by the material change; and

2. unless the network as a whole experienced a 10% reduction, the geographic areas where enrollees were affected by the material change.

(vi) The Commissioner may impose a fine of $5,000 per day for each day past 5 business days that the carrier fails to file an update to the existing access plan as required by subparagraph (ii)3 of this paragraph.

(3) (i) In accordance with § 4–335 of the General Provisions Article, the Commissioner shall deny inspection of the parts of the access plan filed under this subsection that contain confidential commercial information or confidential financial information.

(ii) The regulations adopted by the Commissioner under subsection (d) of this section shall identify the parts of the access plan that may be considered confidential by the carrier.

(4) An access plan filed under this subsection shall include a description of:

(i) the carrier's network, including how telemedicine, telehealth, or other technology may be used to meet network access standards required under subsection (b) of this section;

(ii) the carrier's process for monitoring and ensuring, on an ongoing basis, the sufficiency of the network to meet the health care needs of enrollees;

(iii) the factors used by the carrier to build its provider network, including the criteria used to select providers for participation in the network and, if applicable, place providers in network tiers;

(iv) the carrier's efforts to address the needs of both adult and child enrollees, including adults and children with:

1. limited English proficiency or illiteracy;

2. diverse cultural or ethnic backgrounds;

3. physical or mental disabilities; and

4. serious, chronic, or complex health conditions;

(v) 1. the carrier's efforts to include providers, including essential community providers, in its network who serve predominantly low–income, medically underserved individuals; or

2. for a carrier that provides a majority of covered professional services through physicians employed by a single contracted medical group and through health care providers employed by the carrier, the carrier's efforts to address the needs of low–income, medically underserved individuals;

(vi) except for an access plan filed by a group model health maintenance organization, the carrier's efforts to include local health departments in its network; and

(vii) the carrier's methods for assessing the health care needs of enrollees and enrollee satisfaction with health care services provided to them.

(5) Each carrier shall monitor, on an ongoing basis, the clinical capacity of its participating providers to provide covered services to its enrollees.

(d) (1) On or before December 31, 2017, the Commissioner shall, in consultation with interested stakeholders, adopt regulations to establish quantitative and, if appropriate, nonquantitative criteria to evaluate the network sufficiency of health benefit plans subject to the requirements of subsection (c) of this section.

(2) In adopting the regulations, the Commissioner may take into consideration:

(i) geographic accessibility of primary care and specialty providers, including mental health and substance use disorder providers;

(ii) waiting times for an appointment with participating primary care and specialty providers, including mental health and substance use disorder providers;

(iii) primary care provider–to–enrollee ratios;

(iv) provider–to–enrollee ratios, by specialty;

(v) geographic variation and population dispersion;

(vi) hours of operation;

(vii) the ability of the network to meet the needs of enrollees, which may include:

1. low–income individuals;

2. adults and children with:

A. serious, chronic, or complex health conditions; or

B. physical or mental disabilities; and

3. individuals with limited English proficiency or illiteracy;

(viii) other health care service delivery system options, including telemedicine, telehealth, mobile clinics, and centers of excellence;

(ix) the volume of technological and specialty care services available to serve the needs of enrollees requiring technologically advanced or specialty care services;

(x) any standards adopted by the federal Centers for Medicare and Medicaid Services or used by the Federally Facilitated Marketplace; and

(xi) any standards adopted by another state.

(e) (1) On or before December 31, 2017, for a carrier that is a dental plan organization or an insurer or nonprofit health service plan that provides coverage for dental services, the Commissioner, in consultation with appropriate stakeholders, shall adopt regulations to specify the standards under subsection (b)(1)(i) of this section for dental services.

(2) The regulations shall:

(i) ensure that all enrollees, including adults and children, have access to providers and covered services without unreasonable delay and travel;

(ii) ensure access to providers, including essential community providers, that serve predominantly low–income, medically underserved individuals; and

(iii) require the carrier to specify how the carrier will monitor, on an ongoing basis, the ability of its participating providers to provide covered services to its enrollees.

(3) In establishing the standards for dental services, the Commissioner may consider the appropriateness of quantitative and nonquantitative criteria.

(f) A carrier that uses a provider panel:

(1) on request, shall provide an application and information that relates to consideration for participation on the carrier's provider panel to any provider seeking to apply for participation;

(2) shall make publicly available its application; and

(3) shall make efforts to increase the opportunity for a broad range of minority providers to participate on the carrier's provider panel.

(g) (1) A provider that seeks to participate on a provider panel of a carrier shall submit an application to the carrier.

(2) (i) Subject to subparagraph (ii) of this paragraph and paragraph (3) of this subsection, the carrier, after reviewing the application, shall accept or reject the provider for participation on the carrier's provider panel.

(ii) A carrier may not reject a provider who provides community–based health services for a program accredited under COMAR 10.63.02

for participation on the carrier's provider panel because the provider practices within the scope of the provider's license and is:

1. a licensed master social worker, as defined in § 19–101 of the Health Occupations Article;

2. a licensed graduate alcohol and drug counselor, a licensed graduate marriage and family therapist, a licensed graduate professional art therapist, or a licensed graduate professional counselor, as those terms are defined in § 17–101 of the Health Occupations Article; or

3. a registered psychology associate, as defined in § 18–101 of the Health Occupations Article.

(iii) In accordance with paragraph (3) of this subsection, if the carrier rejects the provider for participation on the carrier's provider panel, the carrier shall send to the provider written notice of the rejection.

(3) (i) Subject to paragraph (4) of this subsection, within 15 days after the date a carrier receives a completed application, the carrier shall send to the provider at the e–mail address listed in the application or, if an e–mail address is not listed in the application, the mailing address listed in the application written notice of:

1. the carrier's intent to continue to process the provider's application to obtain necessary credentialing information; or

2. the carrier's rejection of the provider for participation on the carrier's provider panel.

(ii) The failure of a carrier to provide the notice required under subparagraph (i) of this paragraph is a violation of this article and the carrier is subject to the penalties provided by § 4–113(d) of this article.

(iii) Except as provided in subsection (v) of this section and subparagraph (iv) of this paragraph, if, under subparagraph (i)1 of this paragraph, a carrier provides notice to the provider of its intent to continue to process the provider's application to obtain necessary credentialing information, the carrier, within 60 days after the date the notice is provided, shall:

1. accept or reject the provider for participation on the carrier's provider panel; and

2. send written notice of the acceptance or rejection to the provider at the e–mail address listed in the application or, if an e–mail address is not listed in the application, the mailing address listed in the application.

(iv) For a provider described in paragraph (2)(ii) of this subsection, if, under subparagraph (i)1 of this paragraph, a carrier provides notice to the provider of its intent to continue to process the provider's application to obtain necessary credentialing information, within 30 days after the date a carrier receives a completed application, the carrier shall:

1. accept or reject the provider for participation on the carrier's provider panel; and

2. send written notice of the acceptance or rejection to the provider at the e–mail address listed in the application or, if an e–mail address is not listed in the application, the mailing address listed in the application.

(v) The failure of a carrier to provide the notice required under subparagraph (iii)2 or (iv) of this paragraph is a violation of this article and the carrier is subject to the provisions of and penalties provided by §§ 4–113 and 4–114 of this article.

(4) (i) A carrier that receives an incomplete application shall return the application to the provider at the e–mail address listed in the application or, if an e–mail address is not listed in the application, the mailing address listed in the application within 10 days after the date the application is received.

(ii) The carrier shall indicate to the provider what information is needed to make the application complete.

(iii) The provider may return the completed application to the carrier.

(iv) After the carrier receives the completed application, the carrier is subject to the time periods established in paragraph (3) of this subsection.

(5) (i) In this paragraph, "uniform credentialing form" means the form designated by the Commissioner under § 15–112.1(e) of this subtitle.

(ii) A carrier shall:

1. allow a provider to submit the uniform credentialing form using the online credentialing system;

2. establish a direct e–mail address for inquiries on the uniform credentialing form that is monitored by the carrier and is not the general customer service line;

3. establish a direct e–mail address for inquiries on the uniform credentialing form that is monitored by the carrier and is not the general customer service e–mail address; and

4. respond to voice messages received at the telephone number established under item 2 of this subparagraph and e–mails received at the e–mail address established under item 3 of this subparagraph within 2 business days after receipt of the voice message or e–mail.

(h) A carrier may not deny an application for participation or terminate participation on its provider panel on the basis of:

(1) sex, sexual orientation, gender identity, race, age, religion, national origin, or a protected category under the federal Americans with Disabilities Act;

(2) the type or number of appeals that the provider files under Subtitle 10B of this title;

(3) the number of grievances or complaints that the provider files on behalf of a patient under Subtitle 10A of this title; or

(4) the type or number of complaints or grievances that the provider files or requests for review under the carrier's internal review system established under subsection (l) of this section.

(i) (1) A carrier may not deny an application for participation or terminate participation on its provider panel solely on the basis of the license, certification, or other authorization of the provider to provide health care services if the carrier provides health care services within the provider's lawful scope of practice.

(2) Notwithstanding paragraph (1) of this subsection, a carrier may reject an application for participation or terminate participation on its provider panel based on the participation on the provider panel of a sufficient number of similarly qualified providers.

(3) A violation of this subsection does not create a new cause of action.

(j) (1) Subject to the provisions of this subsection, a carrier may not require a provider participating on its provider panel to be recredentialed based on:

(i) a change in the federal tax identification number of the provider;

(ii) a change in the federal tax identification number of a provider's employer; or

(iii) a change in the employer of a provider, if the new employer is:

1. a participating provider on the carrier's provider panel; or

2. the employer of providers that participate on the carrier's provider panel.

(2) A provider that participates on a carrier's provider panel or the provider's employer shall give written notice to the carrier of a change in the federal tax identification number of the provider or the provider's employer not less than 45 days before the effective date of the change.

(3) The notice required under paragraph (2) of this subsection shall include:

(i) a statement of the intention of the provider or the provider's employer to continue to provide health care services in the same field of specialization, if applicable;

(ii) the effective date of the change in the federal tax identification number of the provider or the provider's employer;

(iii) the new federal tax identification number of the provider or the provider's employer and a copy of U.S. Treasury Form W–9, or any successor or replacement form; and

(iv) the following information about a new employer of the provider:

1. the employer's name;

2. the name of the employer's contact person for carrier questions about the provider; and

3. the address, telephone number, facsimile transmission number, and electronic mail address of the contact person for the employer.

(4) If the new federal tax identification number or the form required to be included in the notice under paragraph (3)(iii) of this subsection is not available at the time the notice is given to a carrier, it shall be provided to the carrier promptly after it is received by the provider or the provider's employer.

(5) Within 30 business days after receipt of the notice required under paragraph (2) of this subsection, a carrier:

(i) shall acknowledge receipt of the notice to the provider or the provider's employer; and

(ii) if the carrier considers it necessary to issue a new provider number as a result of a change in the federal tax identification number of a provider or a provider's employer or a change in the employer of a provider, shall issue a new provider number, by mail, electronic mail, or facsimile transmission, to:

1. the provider or the provider's employer; or

2. the representative of the provider or the provider's employer designated in writing to the carrier.

(6) A carrier may not terminate its existing contract with a provider or a provider's employer based solely on a notice given to the carrier in accordance with this subsection.

(k) A carrier may not terminate participation on its provider panel or otherwise penalize a provider for:

(1) advocating the interests of a patient through the carrier's internal review system established under subsection (l) of this section;

(2) filing an appeal under Subtitle 10B of this title; or

(3) filing a grievance or complaint on behalf of a patient under Subtitle 10A of this title.

(l) Each carrier shall establish an internal review system to resolve grievances initiated by providers that participate on the carrier's provider panel,

including grievances involving the termination of a provider from participation on the carrier's provider panel.

(m) (1) For at least 90 days after the date of the notice of termination of a primary care provider or a provider of a behavioral health care services from a carrier's provider panel for reasons unrelated to fraud, patient abuse, incompetency, or loss of licensure status, the provider shall furnish health care services to each enrollee:

(i) who was receiving health care services from the provider before the notice of termination; and

(ii) who, after receiving notice under subsection (b) of this section of the termination of the provider, requests to continue receiving health care services from the provider.

(2) A carrier shall reimburse a provider that furnishes health care services under this subsection in accordance with the provider's agreement with the carrier.

(3) A provider that furnishes health care services under this subsection in accordance with a provider's agreement with a carrier shall accept as payment in full for the services payment from the carrier and cost–sharing from the patient, as applicable.

(n) (1) A carrier shall make the carrier's provider directory available to prospective enrollees on the Internet and, on request of a prospective enrollee, in printed form.

(2) The carrier's provider directory on the Internet shall be available:

(i) through a clear link or tab; and

(ii) in a searchable format.

(3) The provider directory shall include:

(i) for each provider on the carrier's provider panel:

1. the name of the provider;

2. the specialty areas of the provider;

3. whether the provider currently is accepting new patients;

4. for each office of the provider where the provider participates on the provider panel:

A. its location, including its address; and

B. contact information for the provider;

5. the gender of the provider, if the provider notifies the carrier or the multi–carrier common online provider directory information system designated under § 15–112.3 of this subtitle of the information; and

6. any languages spoken by the provider other than English, if the provider notifies the carrier or the multi–carrier common online provider directory information system designated under § 15–112.3 of this subtitle of the information;

(ii) for each health care facility in the carrier's network:

1. the health care facility's name;

2. the health care facility's address;

3. the types of services provided by the health care facility; and

4. contact information for the health care facility; and

(iii) a statement that advises enrollees and prospective enrollees to contact a provider or a health care facility before seeking treatment or services, to confirm the provider's or health care facility's participation in the carrier's network and the enrollee's health benefit plan.

(o) (1) A carrier shall have a customer service telephone number, e–mail address link, or other electronic means by which enrollees and prospective enrollees may notify the carrier of inaccurate information in the carrier's network directory.

(2) If notified of a potential inaccuracy in a network directory by a person other than the provider, a carrier shall investigate the reported inaccuracy and take corrective action, if necessary, to update the network directory within 45 working days after receiving the notification.

(p) (1) A carrier shall notify each enrollee at the time of initial enrollment and renewal about how to access or obtain the information required under subsection (n) of this section.

(2) (i) 1. Information provided in printed form under subsection (n) of this section shall be accurate on the date of publication.

2. A carrier shall update the information provided in printed form at least once a year.

(ii) 1. Information provided on the Internet under subsection (n) of this section shall be accurate on the date of initial posting and any update.

2. In addition to the requirement to update its provider information under subsection (t)(1) of this section, a carrier shall update the information provided on the Internet at least once every 15 days.

(3) (i) A carrier shall use the online credentialing system as the primary source of information to create and update the carrier's provider directory in accordance with regulations adopted by the Commissioner.

(ii) The Commissioner shall adopt regulations governing the use by a carrier of the online credentialing system to create and update the carrier's provider directory, including the required frequency of updates.

(4) In addition to updates required under paragraph (3) of this subsection, a carrier shall:

(i) 1. periodically review at least a reasonable sample size of its provider directory for accuracy; and

2. retain documentation of the review and make the review available to the Commissioner on request; or

(ii) contact providers listed in the carrier's provider directory who have not submitted a claim in the last 6 months to determine if the providers intend to remain in the carrier's provider network.

(5) A carrier shall demonstrate the accuracy of the information provided under paragraph (4) of this subsection on request of the Commissioner.

(6) A carrier shall include in a provider directory that is in printed form a statement notifying a reader that:

(i) the information contained in the provider directory is accurate as of the date of publication; and

(ii) to obtain the most current information, the individual should consult the provider directory on the Internet or contact the carrier directly.

(7) Before imposing a penalty against a carrier for inaccurate network directory information, the Commissioner shall take into account, in addition to any other factors required by law, whether:

(i) the carrier afforded a provider or other person identified in § 15–112.3(c) of this subtitle an opportunity to review and update the provider's network directory information:

1. through the multi–carrier common online provider directory information system designated under § 15–112.3 of this subtitle; or

2. directly with the carrier;

(ii) the carrier has contacted a provider listed in the carrier's network directory who has not submitted a claim in the last 6 months to determine if the provider intends to remain on the carrier's provider panel;

(iii) the carrier includes in its network directory the last date that a provider updated the provider's information;

(iv) the carrier has implemented any other process or procedure to:

1. inform providers that the online credentialing system is the primary source of information to create and update the carrier's provider directory;

2. encourage providers to update their network directory information; or

3. increase the accuracy of its network directory; and

(v) a provider or other person identified in § 15–112.3(c) of this subtitle has not updated the provider's network directory information, despite opportunities to do so.

(q) A policy, certificate, or other evidence of coverage shall:

(1) indicate clearly the office in the Administration that is responsible for receiving and responding to complaints from enrollees about carriers; and

(2) include the telephone number of the office and the procedure for filing a complaint.

(r) The Commissioner:

(1) shall adopt regulations that relate to the procedures that carriers must use to process applications for participation on a provider panel; and

(2) in consultation with the Secretary of Health, shall adopt strategies to assist carriers in maximizing the opportunity for a broad range of minority providers to participate in the delivery of health care services.

(s) A carrier may not include in a contract with a provider, ambulatory surgical facility, or hospital a term or condition that:

(1) prohibits the provider, ambulatory surgical facility, or hospital from offering to provide services to the enrollees of another carrier at a lower rate of reimbursement;

(2) requires the provider, ambulatory surgical facility, or hospital to provide the carrier with the same reimbursement arrangement that the provider, ambulatory surgical facility, or hospital has with another carrier if the reimbursement arrangement with the other carrier is for a lower rate of reimbursement; or

(3) requires the provider, ambulatory surgical facility, or hospital to certify to the carrier that the reimbursement rate being paid by the carrier to the provider, ambulatory surgical facility, or hospital is not higher than the reimbursement rate being received by the provider, ambulatory surgical facility, or hospital from another carrier.

(t) (1) A carrier shall update the information that must be made available on the Internet under subsection (n) of this section within 2 working days after receipt of electronic notification or notification by first–class mail tracking method from the participating provider of a change in the applicable information.

(2) Notification is presumed to have been received by a carrier:

(i) 3 working days after the date the participating provider placed the notification in the U.S. mail, if the participating provider maintains the stamped certificate of mailing for the notice; or

(ii) on the date recorded by the courier, if the notification was delivered by courier.

(u) (1) A carrier may not require a provider that provides health care services through a group practice or health care facility that participates on the carrier's provider panel under a contract with the carrier to be considered a participating provider or accept the reimbursement fee schedule applicable under the contract when:

(i) providing health care services to enrollees of the carrier through an individual or group practice or health care facility that does not have a contract with the carrier; and

(ii) billing for health care services provided to enrollees of the carrier using a different federal tax identification number than that used by the group practice or health care facility under a contract with the carrier.

(2) A nonparticipating provider shall notify an enrollee:

(i) that the provider does not participate on the provider panel of the enrollee's carrier; and

(ii) of the anticipated total charges for the health care services.

(v) The provisions of subsection (g)(3)(iii) of this section do not apply to a carrier that uses a credentialing intermediary that:

(1) is a hospital or academic medical center;

(2) is a participating provider on the carrier's provider panel; and

(3) acts as a credentialing intermediary for that carrier for health care practitioners that:

(i) participate on the carrier's provider panel; and

(ii) have privileges at the hospital or academic medical center.

(w) (1) Notwithstanding subsection (u)(1) of this section, a carrier shall reimburse a group practice on the carrier's provider panel at the participating

provider rate for covered services provided by a provider who is not a participating provider if:

(i) the provider is employed by or a member of the group practice;

(ii) the provider has applied for acceptance on the carrier's provider panel and the carrier has notified the provider of the carrier's intent to continue to process the provider's application to obtain necessary credentialing information;

(iii) the provider has a valid license issued by a health occupations board to practice in the State; and

(iv) the provider:

1. is currently credentialed by an accredited hospital in the State;

2. has professional liability insurance; or

3. has immunity under the Federal Tort Claims Act or the Maryland Tort Claims Act.

(2) A carrier shall reimburse a group practice on the carrier's provider panel in accordance with paragraph (1) of this subsection from the date the notice required under subsection (g)(3)(i)1 of this section is sent to the provider until the date the notice required under subsection (g)(3)(iii)2 of this section is sent to the provider.

(3) A carrier that sends written notice of rejection of a provider for credentialing under subsection (g)(3)(iii)2 of this section shall reimburse the provider as a nonparticipating provider for covered services provided on or after the date the notice is sent.

(4) A health maintenance organization may not deny payment to a provider under this subsection solely because the provider was not a participating provider at the time the services were provided to an enrollee.

(5) A provider who is not a participating provider of a carrier and whose group practice is eligible for reimbursement under paragraph (1) of this subsection may not hold an enrollee of the carrier liable for the cost of any covered services provided to the enrollee during the time period described in paragraph (2) of this subsection, except for any deductible, copayment, or coinsurance amount owed

by the enrollee to the group practice or provider under the terms of the enrollee's contract or certificate.

(6) A group practice shall disclose in writing to an enrollee at the time services are provided that:

(i) the treating provider is not a participating provider;

(ii) the treating provider has applied to become a participating provider;

(iii) the carrier has not completed its assessment of the qualifications of the treating provider to provide services as a participating provider; and

(iv) any covered services received must be reimbursed by the carrier at the participating provider rate.

(x) A carrier may not impose a limit on the number of behavioral health providers at a health care facility that may be credentialed to participate on a provider panel.

(y) (1) In this subsection, "health system" means:

(i) a hospital and any entity affiliated with the hospital through ownership, governance, membership, or other means; or

(ii) a parent corporation of one or more hospitals and any entity affiliated with the parent corporation through ownership, governance, membership, or other means.

(2) A carrier and a health system shall provide to each other written notice of any intent to terminate a contract between the carrier and the health system:

(i) at least 90 days before the proposed date of the termination of the contract; or

(ii) in the case of nonrenewal, at least 90 days before the end of the contract period.

(3) (i) For each contract between a carrier and a health system that is entered into, renewed, amended, or continued on or after October 1, 2026, if the contract is not renewed or is terminated by the carrier or the health system, the

carrier and the health system shall continue to adhere to the terms of the contract, including reimbursement terms and patient balance billing protections for all health care services provided under the contract, for a period of:

1. at least 90 days after the date of termination; or

2. in the case of a nonrenewal, at least 90 days after the end of the contract period.

(ii) Except as otherwise agreed to by a carrier and a health system, the reimbursement terms of a contract entered into by the carrier and the health system during the 90–day period shall be retroactive to:

1. the date of termination; or

2. in the case of a nonrenewal, the end date of the contract period.

(iii) This paragraph does not apply if the carrier and health system:

1. agree, in writing, to the termination or nonrenewal of the contract; and

2. provide the notices required under paragraph (2) of this subsection.

(4) The Commissioner shall develop a uniform form that carriers, providers, and health care systems shall use for requests to continue to receive health care services in accordance with subsection (b) of this section or 42 U.S.C. § 300GG–113.

§15–112.1. IN EFFECT

(a) (1) In this section the following words have the meanings indicated.

(2) (i) "Carrier" means:

1. an insurer;

2. a nonprofit health service plan;

3. a health maintenance organization;

4. a dental plan organization;

5. a managed care organization; or

6. any other person that provides health benefit plans subject to regulation by the State.

(ii) "Carrier" includes an entity that arranges a provider panel for a carrier.

(3) "Credentialing intermediary" means a person to whom a carrier has delegated credentialing or recredentialing authority and responsibility.

(4) "Health care provider" means an individual who is licensed, certified, or otherwise authorized under the Health Occupations Article to provide health care services.

(5) "Provider panel" means the providers that contract with a carrier to provide health care services to the enrollees under a health benefit plan of the carrier.

(6) "Uniform credentialing form" means the form designated by the Commissioner for use by a carrier or its credentialing intermediary for credentialing and recredentialing a health care provider for participation on a provider panel.

(b) (1) Except as provided in subsection (c) of this section, a carrier or its credentialing intermediary shall accept the uniform credentialing form as the sole application for a health care provider to become credentialed or recredentialed for a provider panel of the carrier.

(2) A carrier or its credentialing intermediary shall make the uniform credentialing form available to any health care provider that is to be credentialed or recredentialed by that carrier or credentialing intermediary.

(c) The requirements of subsection (b) of this section do not apply to a hospital or academic medical center that:

(1) is a participating provider on the carrier's provider panel; and

(2) acts as a credentialing intermediary for that carrier for health care practitioners that:

(i) participate on the carrier's provider panel; and

(ii) have privileges at the hospital or academic medical center.

(d) The Commissioner may impose a penalty not to exceed $500 against any carrier for each violation of this section by the carrier or its credentialing intermediary.

(e) (1) The Commissioner may adopt regulations to implement the provisions of this section.

(2) The Commissioner may designate a provider credentialing application developed by a nonprofit alliance of health plans and trade associations for an online credentialing system offered to carriers and providers as the uniform credentialing form if:

(i) the provider credentialing application is available to providers at no charge; and

(ii) use of the provider credentialing application is not conditioned on submitting the provider credentialing application to a carrier through the online credentialing system.

§15–112.1. ** TAKES EFFECT JANUARY 1, 2027 PER CHAPTERS 706 AND 707 OF 2026 **

(a) (1) In this section the following words have the meanings indicated.

(2) (i) "Carrier" means:

1. an insurer;

2. a nonprofit health service plan;

3. a health maintenance organization;

4. a dental plan organization;

5. a managed care organization; or

6. any other person that provides health benefit plans subject to regulation by the State.

(ii) "Carrier" includes an entity that arranges a provider panel for a carrier.

(3) "Credentialing intermediary" means a person to whom a carrier has delegated credentialing or recredentialing authority and responsibility.

(4) "Health care provider" means an individual who is licensed, certified, or otherwise authorized under the Health Occupations Article to provide health care services.

(5) "Provider panel" means the providers that contract with a carrier to provide health care services to the enrollees under a health benefit plan of the carrier.

(6) "Uniform credentialing form" means the form designated by the Commissioner for use by a carrier or its credentialing intermediary for credentialing and recredentialing a health care provider for participation on a provider panel.

(b) (1) Except as provided in subsection (c) of this section, a carrier or its credentialing intermediary shall accept the uniform credentialing form as the sole application for a health care provider to become credentialed or recredentialed for a provider panel of the carrier.

(2) A carrier or its credentialing intermediary shall make the uniform credentialing form available to any health care provider that is to be credentialed or recredentialed by that carrier or credentialing intermediary.

(c) The requirements of subsection (b) of this section do not apply to a hospital or academic medical center that:

(1) is a participating provider on the carrier's provider panel; and

(2) acts as a credentialing intermediary for that carrier for health care practitioners that:

(i) participate on the carrier's provider panel; and

(ii) have privileges at the hospital or academic medical center.

(d) The Commissioner may impose a penalty not to exceed $500 against any carrier for each violation of this section by the carrier or its credentialing intermediary.

(e) (1) The Commissioner may adopt regulations to implement the provisions of this section.

(2) The Commissioner may designate a provider credentialing application for an online credentialing system offered to carriers and providers as the uniform credentialing form if:

(i) the provider credentialing application is available to providers at no charge;

(ii) use of the provider credentialing application is not conditioned on submitting the provider credentialing application to a carrier through the online credentialing system;

(iii) the system allows providers to:

1. grant access to a designated person managing the credentialing process for the provider; and

2. access the system directly without the assistance of a third party; and

(iv) the vendor:

1. establishes and maintains a stakeholder workgroup to identify and address operational issues to ensure efficiency of the online credentialing system consisting of representatives of:

A. health and dental carriers;

B. managed care organizations;

C. community health centers, including federally qualified health centers;

D. behavioral health providers;

E. private practices of physicians, dentists, advance practice clinicians, and other clinicians; and

F. credentialing intermediaries;

2. submits a report to the Commissioner by September 1 each year on:

A. the findings of the workgroup established under item 1 of this item and improvements implemented as a result of the workgroup's findings; and

B. for each carrier, the calculation of the average number of days between the date the carrier receives a completed credentialing application and the date the carrier sends written notice to the provider of the acceptance or rejection of the application; and

3. meets all other requirements established by the Commissioner.

(3) On or before December 1 each year, beginning in 2027, the Commissioner shall report to the General Assembly, in accordance with § 2–1257 of the State Government Article, on:

(i) the findings of the workgroup established under paragraph (2)(iv)1 of this subsection;

(ii) improvements implemented as a result of the workgroup's findings;

(iii) any legislative recommendations; and

(iv) any other relevant information.

§15–112.2.

(a) (1) In this section the following words have the meanings indicated.

(2) "Capitated dental provider panel" means a provider panel for one or more dental plan organizations offering contracts only for dental services reimbursed on a capitated basis for certain services.

(3) "Carrier" means:

(i) an insurer;

(ii) a nonprofit health service plan;

(iii) a health maintenance organization; or

(iv) a dental plan organization.

(4) "Enrollee" means a person entitled to health care benefits from a carrier.

(5) "Fee–for–service dental provider panel" means a provider panel for one or more dental plan organizations, insurers, or nonprofit health service plans offering contracts only for dental services reimbursed on a full or discounted fee–for–service basis.

(6) "HMO provider panel" means a provider panel for one or more health maintenance organizations.

(7) "Managed care organization" has the meaning stated in § 15–101 of the Health – General Article.

(8) "Non–HMO provider panel" means a provider panel for one or more nonprofit health service plans or insurers.

(9) "Provider" has the meaning stated in § 19–701 of the Health – General Article.

(10) "Provider contract" means a contract:

(i) between a provider and a carrier, an affiliate of a carrier, or an entity that contracts with a provider to serve a carrier; and

(ii) under which the provider agrees to provide health care services to enrollees.

(11) "Provider panel" means the providers that contract either directly or through a subcontracting entity with a carrier to provide health care services to enrollees.

(b) (1) A provider contract may not contain a provision that requires a provider:

(i) as a condition of participating in a non–HMO provider panel, to participate in an HMO provider panel; or

(ii) as a condition of participating in a fee–for–service dental provider panel, to participate in a capitated dental provider panel.

(2) Notwithstanding paragraph (1) of this subsection, a provider contract may contain a provision that requires a provider, as a condition of

participating in a non–HMO provider panel, an HMO provider panel, or a dental provider panel, to participate in a managed care organization.

(c) (1) This subsection does not apply to a provider contract for a dental provider panel.

(2) Each provider contract shall disclose the carriers comprising each provider panel.

(d) (1) This subsection does not apply to a provider contract for a dental provider panel.

(2) If a provider contract includes more than one schedule of applicable fees, the provider contract may not contain a provision that requires a provider as a condition of participation to accept each schedule of applicable fees included in the provider contract.

(3) If a provider rejects a schedule of applicable fees, the provider contract may not require the provider to treat the enrollees of the carriers that reimburse the provider in accordance with any of the rejected schedules of applicable fees.

(4) Notwithstanding the provisions of paragraph (1) of this subsection, a provider contract may include a provision that requires a provider, as a condition of participation, to accept each schedule of applicable fees for a carrier that is not affiliated through common ownership with the entity arranging the provider panel.

(e) If a provider elects to terminate participation on a provider panel, the provider shall:

(1) notify the carrier at least 90 days before the date of termination; and

(2) for at least 90 days after the date of the notice of termination, continue to furnish health care services to an enrollee of the carrier for whom the provider was responsible for the delivery of health care services before the notice of termination.

(f) A provider contract may not contain a provision that requires a participating dental provider, as a condition of continued participation in a capitated dental provider panel or a fee–for–service dental provider panel, to accept an added, revised, or amended fee schedule that contains a lower fee.

(g) (1) In this subsection, "covered services" means health care services that are reimbursable under a policy or contract for dental services between an enrollee and a carrier, subject to any contractual limitations on benefits, including deductibles, copayments, or frequency limitations.

(2) A carrier may not include in a dental provider contract a provision that requires a dental provider to provide health care services that are not covered services at a fee set by the carrier.

(h) (1) In this subsection, "covered services" means health care services that are reimbursable under a policy or contract for vision services between an enrollee and a carrier, subject to any contractual limitations on benefits, including deductibles, copayments, or frequency limitations.

(2) A carrier may not include in a vision provider contract a provision that requires a vision provider:

(i) to provide health care services that are not covered services at a fee set by the carrier; or

(ii) to provide discounts on materials that are not covered benefits.

(3) (i) A carrier may not include in a vision provider contract a provision that requires a vision provider, as a condition of participation in a fee–for–service vision provider panel, to participate in a capitated vision provider panel.

(ii) Notwithstanding subparagraph (i) of this paragraph, a vision provider contract may contain a provision that requires a vision provider, as a condition of participating in a non–HMO vision provider panel or an HMO vision provider panel to participate in a managed care organization.

§15–112.3. IN EFFECT

(a) (1) In this section the following words have the meanings indicated.

(2) (i) "Carrier" has the meaning stated in § 15–112 of this subtitle.

(ii) "Carrier" does not include a managed care organization, as defined in Title 15, Subtitle 1 of the Health – General Article.

(3) "Multi–carrier common online provider directory information system" means the system designated by the Commissioner for use by providers to provide and update their provider directory information with carriers.

(b) The Commissioner may designate a multi–carrier common online provider directory information system developed by a nonprofit alliance of health plans and trade associations if:

(1) the system is available to providers nationally;

(2) the system is available to providers at no charge;

(3) the system allows providers to:

(i) attest online to the accuracy of their information; and

(ii) 1. correct any inaccurate information; and

2. attest to the correction; and

(4) the nonprofit alliance has a well–established mechanism for outreach to providers.

(c) A carrier shall accept new and updated provider directory information for a provider submitted:

(1) (i) through the multi–carrier common online provider directory information system; or

(ii) directly to the carrier; and

(2) from:

(i) the provider;

(ii) a hospital or academic medical center that:

1. is a participating provider on the carrier's provider panel; and

2. acts as a credentialing intermediary for the carrier for providers that:

A. participate on the carrier's provider panel; and

B. have privileges at the hospital or academic medical center; or

(iii) any other person that performs credentialing functions on behalf of a provider.

§15–112.3. ** TAKES EFFECT JANUARY 1, 2027 PER CHAPTERS 706 AND 707 OF 2026 **

(a) (1) In this section the following words have the meanings indicated.

(2) (i) "Carrier" has the meaning stated in § 15–112 of this subtitle.

(ii) "Carrier" does not include a managed care organization, as defined in Title 15, Subtitle 1 of the Health – General Article.

(3) "Multi–carrier common online provider directory information system" means the system designated by the Commissioner for use by providers to provide and update their provider directory information with carriers.

(b) The Commissioner may designate a multi–carrier common online provider directory information system if:

(1) the system allows providers to:

(i) attest online to the accuracy of their information; and

(ii) update the provider's information every 120 days or at a frequency established by the Commissioner; and

(2) the vendor has a well–established mechanism for outreach to providers.

(c) A carrier shall accept new and updated provider directory information for a provider submitted:

(1) (i) through the multi–carrier common online provider directory information system; or

(ii) directly to the carrier; and

(2) from:

(i) the provider;

(ii) a hospital or academic medical center that:

1. is a participating provider on the carrier's provider panel; and

2. acts as a credentialing intermediary for the carrier for providers that:

A. participate on the carrier's provider panel; and

B. have privileges at the hospital or academic medical center; or

(iii) any other person that performs credentialing functions on behalf of a provider.

§15–113.

(a) (1) In this section the following words have the meanings indicated.

(2) "Carrier" means:

(i) an insurer;

(ii) a nonprofit health service plan;

(iii) a health maintenance organization;

(iv) a dental plan organization; or

(v) any other person that provides health benefit plans subject to regulation by the State.

(3) "Eligible provider" means:

(i) a licensed physician, as defined in § 14–101 of the Health Occupations Article, who voluntarily participates in a two–sided incentive arrangement; or

(ii) a set of health care practitioners that voluntarily participate in a two–sided incentive arrangement.

(4) "Health care practitioner" means an individual who is licensed, certified, or otherwise authorized under the Health Occupations Article to provide health care services.

(5) "Set of health care practitioners" means:

(i) a group practice;

(ii) a clinically integrated organization established in accordance with Subtitle 19 of this title;

(iii) an accountable care organization established in accordance with 42 U.S.C. § 1395jjj and any applicable federal regulations; or

(iv) a clinically integrated network that is a provider entity that meets the criteria established in guidance issued by the Federal Trade Commission, including a network of behavioral health care programs licensed under § 7.5–401 of the Health – General Article.

(6) "Two–sided incentive arrangement" means an arrangement between an eligible provider and a carrier in which the eligible provider may earn an incentive and a carrier may recoup funds from the eligible provider in accordance with the terms of a contract entered into with the eligible provider that meets the requirements of this section.

(b) A carrier may not reimburse a health care practitioner in an amount less than the sum or rate negotiated in the carrier's provider contract with the health care practitioner.

(c) (1) This section does not prohibit a carrier from:

(i) providing bonuses or other incentive–based compensation to a health care practitioner or a set of health care practitioners; or

(ii) entering into a two–sided incentive arrangement with an eligible provider.

(2) A bonus or other incentive–based compensation program or two–sided incentive arrangement authorized under this section:

(i) may not create a disincentive to the provision of medically appropriate or medically necessary health care services; and

(ii) if the carrier is a health maintenance organization, shall comply with the provisions of § 19–705.1 of the Health – General Article.

(3) A bonus or other incentive–based compensation or two–sided incentive arrangement authorized under this section:

(i) if applicable, shall promote health equity, improvement of health care outcomes, and the provision of preventive health care services; or

(ii) may reward a health care practitioner, a set of health care practitioners, or an eligible provider, based on satisfaction of performance measures, if the following is agreed on in writing by the carrier and the health care practitioner, set of health care practitioners, or eligible provider:

1. the performance measures, including the source of the measures;

2. the method and the time period for calculating whether the performance measures have been satisfied;

3. the method by which the health care practitioner, set of health care practitioners, or eligible provider may request reconsideration of the calculations by the carrier; and

4. if applicable, the risk–adjustment method used.

(4) Acceptance of a bonus or other incentive–based compensation or two–sided incentive arrangement under this subsection shall be voluntary.

(5) A carrier may not reduce the fee schedule of a health care practitioner or a set of health care practitioners because the health care practitioner or set of health care practitioners does not participate in the carrier's bonus or other incentive–based compensation or two–sided incentive arrangement program.

(6) Participation in a two–sided incentive arrangement may not be the sole opportunity for a health care practitioner or a set of health care practitioners to be eligible to receive increases in reimbursement.

(7) A carrier may not require as a condition of participation in the carrier's provider network:

(i) a health care practitioner or set of health care practitioners to participate in the carrier's bonus or other incentive–based compensation program; or

(ii) an eligible provider to participate in the carrier's two–sided incentive arrangement program.

(8) A health care practitioner, a set of health care practitioners, an eligible provider, a health care practitioner's designee, a designee of a set of health care practitioners, or a designee of an eligible provider may file a complaint with the Administration regarding a violation of this subsection.

(d) (1) A carrier shall provide a health care practitioner, a set of health care practitioners, or an eligible provider with a copy of:

(i) a schedule of all applicable fees or the 50 most common services billed by a health care practitioner in that specialty, whichever is less;

(ii) a description of the coding guidelines used by the carrier that are applicable to the services billed by a health care practitioner in that specialty;

(iii) the information about the practitioner and the methodology that the carrier uses to determine whether to:

1. increase or reduce the practitioner's level of reimbursement;

2. provide a bonus or other incentive–based compensation to the practitioner; and

3. recoup compensation from an eligible provider under a two–sided incentive arrangement; and

(iv) a summary of the terms of a two–sided incentive arrangement program.

(2) Except as provided in paragraph (4) of this subsection, a carrier shall provide the information required under paragraph (1) of this subsection in the manner indicated in each of the following instances:

(i) in writing before a contract execution;

(ii) in writing or electronically 30 days before a change; and

(iii) in writing or electronically on request of the health care practitioner, set of health care practitioners, or eligible provider.

(3) Except as provided in paragraph (4) of this subsection, a carrier shall make the pharmaceutical formulary that the carrier uses available to a health care practitioner, a set of health care practitioners, or an eligible provider electronically.

(4) On written request of a health care practitioner, a set of health care practitioners, or an eligible provider, a carrier shall provide the information required under paragraphs (1) and (3) of this subsection in writing.

(5) The Administration may adopt regulations to carry out the provisions of this subsection.

(e) (1) A carrier that compensates health care practitioners or a set of health care practitioners wholly or partly on a capitated basis in accordance with § 15–2102 of this article may not retain any capitated fee attributable to an enrollee or covered person during an enrollee's or covered person's contract year.

(2) A carrier is in compliance with paragraph (1) of this subsection if, within 45 days after an enrollee or covered person chooses or obtains health care from a health care practitioner or a set of health care practitioners, the carrier pays to the health care practitioner or set of health care practitioners all accrued but unpaid capitated fees attributable to that enrollee or person that the health care practitioner or set of health care practitioners would have received had the enrollee or person chosen the health care practitioner or set of health care practitioners at the beginning of the enrollee's or covered person's contract year.

(3) Acceptance of a capitated payment shall be voluntary.

(f) (1) Under a two–sided incentive arrangement that complies with the requirements of this section, a carrier may recoup funds paid to an eligible provider based on the terms of a written contract between the carrier and the eligible provider that at a minimum:

(i) establish a target budget for:

1. the total cost of care of a population of patients adjusted for risk and population size; or

2. the cost of an episode of care;

(ii) limit recoupment to not more than 50% of the excess above the mutually agreed on target established in accordance with item (i) of this paragraph;

(iii) specify a mutually agreed on maximum liability for total recoupment that may not exceed 10% of the annual payments from the carrier to the eligible provider;

(iv) provide an opportunity for gains by an eligible provider that is greater than the opportunity for recoupment by the carrier;

(v) following good faith negotiations, provide an opportunity for an audit by an independent third party and an independent third–party dispute resolution process;

(vi) require the carrier and the eligible provider to negotiate in good faith adjustments to the target budget when:

1. certain circumstances beyond the control of the carrier or the eligible provider arise, including changes in hospital rates; and

2. material changes occur in health care economics, health care delivery, or regulations that impact the arrangement; and

(vii) require the carrier to pay any incentive to or request any recoupment from the eligible provider within 6 months after the end of the contract year, unless the carrier or eligible provider initiates a dispute relating to the recoupment or incentive amount.

(2) Unless mutually agreed to by an eligible provider and a carrier, an arrangement entered into under this subsection may not provide an opportunity for recoupment by the carrier based on the eligible provider's performance during the first 12 months of the arrangement.

(3) A carrier that enters into a two–sided incentive arrangement with an eligible provider in which the amount of any payment is determined, in whole or in part, on the total cost of care of a population of patients or an episode of care, shall, at least quarterly, disclose to the eligible provider the following information in a manner that meets federal and State data use and privacy standards:

(i) any amount paid to another health care provider that is included in the total cost of care of a patient in the population or episode of care; and

(ii) any copayment, coinsurance, or deductible that is included in the total cost of care of a patient in the population or episode of care.

(4) Unless mutually agreed to by the carrier and eligible provider, a two–sided incentive arrangement may not be amended during the term of the contract.

(5) The opportunity for independent third–party dispute resolution provided for in paragraph (1)(v) of this subsection may not be required to be exhausted before a member or member's representative is allowed to file an appeal of a coverage decision under § 15–10D–02 of this title.

(6) Nothing in this subsection may be construed to:

(i) alter any requirement for a carrier to pay a hospital or related institution the rate approved by the Health Services Cost Review Commission for hospital services; or

(ii) supersede the Health Services Cost Review Commission's jurisdiction or authority over rate review and approval for hospital services.

§15–114.

(a) (1) In this section the following words have the meanings indicated.

(2) "Carrier" means:

(i) an insurer;

(ii) a nonprofit health service plan;

(iii) a health maintenance organization;

(iv) a dental plan organization; or

(v) any other person that provides dental benefit plans subject to regulation by the State.

(3) "Dental point–of–service option" means a delivery system that allows an insured, enrollee, or other covered person under a dental benefit plan to receive dental services outside a provider panel.

(4) "Provider panel" means the providers that contract with a carrier to provide dental services to the carrier's insureds, enrollees, or other covered persons under the carrier's dental benefit plan.

(b) (1) If an employer, association, or other private group arrangement offers dental benefit plan coverage to employees or other individuals only through a carrier's provider panel, the carrier of the employer, association, or other private group arrangement shall offer, or contract with another carrier to offer, a dental point–of–service option to the employer, association, or other private group arrangement as an additional benefit for an employee or other individual, to accept or reject at the employee's or other individual's option.

(2) If a carrier's dental provider panel is the sole delivery system offered to employees by an employer, the carrier:

(i) shall offer the employer a dental point–of–service option for the individual employee to accept or reject;

(ii) may not impose a minimum participation level on the dental point–of–service option; and

(iii) as part of the group enrollment application, shall provide to each employer a disclosure statement for each dental point–of–service option offered that conforms to regulations, for the point–of–service option required under § 19–710.2 of the Health – General Article, adopted by:

1. the Maryland Health Care Commission for the small group market; and

2. the Administration for the non–small group market.

(c) (1) An employer, association, or other private group arrangement may require an employee or other individual who accepts the additional coverage under a dental point–of–service option under subsection (b) of this section to pay a premium over the amount of the premium for the dental benefit coverage offered by the carrier only through its provider panel.

(2) A carrier may impose different cost–sharing provisions for the dental point–of–service option based on whether the dental service is provided through the carrier's provider panel or outside the carrier's provider panel.

§15–115.

(a) (1) In this section, "carrier" means:

(i) an insurer;

(ii) a nonprofit health service plan;

(iii) a health maintenance organization;

(iv) a dental plan organization; or

(v) any other person that provides health benefit plans subject to regulation by the State.

(2) "Carrier" includes an entity that arranges a provider panel for a carrier.

(b) A carrier that operates a managed care organization under Title 15, Subtitle 1 of the Health - General Article may not deny, limit, or otherwise impair the participation of a provider under contract with the carrier for choosing not to participate or limiting participation in the carrier's managed care organization if the carrier is in violation of § 15-102.5 of the Health - General Article.

§15–116.

(a) (1) In this section the following words have the meanings indicated.

(2) "Carrier" means:

(i) an insurer;

(ii) a nonprofit health service plan;

(iii) a health maintenance organization;

(iv) a dental plan organization; or

(v) any other person that provides health benefit plans subject to regulation by the State.

(3) "Health care provider" means an individual who is licensed, certified, or otherwise authorized under the Health Occupations Article to provide health care services.

(b) A carrier, as a condition of a contract with a health care provider or in any other manner, may not prohibit a health care provider from discussing with or communicating to an enrollee, subscriber, public official, or other person information that is necessary or appropriate for the delivery of health care services, including:

(1) communications that relate to treatment alternatives;

(2) communications that are necessary or appropriate to maintain the provider-patient relationship while the patient is under the health care provider's care;

(3) communications that relate to an enrollee's or subscriber's right to appeal a coverage determination of a carrier with which the health care provider, enrollee, or subscriber does not agree; and

(4) opinions and the basis of an opinion about public policy issues.

(c) This section does not prohibit a carrier, as a condition of a contract between the carrier and a health care provider, from prohibiting tortious interference with a contract as recognized under State law.

§15–117.

(a) This section applies to insurers and nonprofit health service plans that issue or deliver individual hospital or major medical insurance policies or group or blanket health insurance policies in the State.

(b) An entity subject to this section, by contract or in any other manner, may not require a health care provider to indemnify the entity or hold the entity harmless from a coverage decision or negligent act of the entity.

§15–118.

(a) (1) In this section the following words have the meanings indicated.

(2) "Health care service" means a health or medical care procedure or service rendered by a provider that:

(i) provides testing, diagnosis, or treatment of human disease or dysfunction; or

(ii) dispenses drugs, medical devices, medical appliances, or medical goods for the treatment of human disease or dysfunction.

(3) "Provider" means a physician, hospital, or other person that is licensed or otherwise authorized to provide health care services.

(b) This section applies to:

(1) insurers and nonprofit health service plans that provide coverage for health care services to individuals or groups on an expense–incurred basis under health insurance policies or contracts that are issued or delivered in the State; and

(2) health maintenance organizations that provide coverage for health care services to individuals or groups under contracts that are issued or delivered in the State.

(c) If an entity subject to this section negotiates and enters into a contract with providers to render health care services to insureds, subscribers, or members at alternative rates of payment, and coinsurance payments are to be based on a percentage of the fee for health care services rendered by a provider, the entity shall calculate the amount of the coinsurance payment to be paid by the insured, subscriber, or member exclusively from the negotiated alternative rate for the health care service rendered.

(d) An entity subject to this section may not charge or collect from an insured, a subscriber, or a member a coinsurance payment amount that is greater than the amount calculated under subsection (c) of this section.

§15–118.1. NOT IN EFFECT

** TAKES EFFECT JANUARY 1, 2026 PER CHAPTER 692 OF 2025 **

// EFFECTIVE UNTIL JULY 1, 2029 PER CHAPTER 692 OF 2025 //

(a) (1) This section applies to:

(i) insurers and nonprofit health service plans that provide hospital, medical, or surgical benefits to individuals or groups on an expense–incurred basis under health insurance policies or contracts that are issued or delivered in the State; and

(ii) health maintenance organizations that provide hospital, medical, or surgical benefits to individuals or groups under contracts that are issued or delivered in the State.

(2) An insurer, a nonprofit health service plan, or a health maintenance organization that provides coverage for prescription drugs through a pharmacy benefits manager is subject to the requirements of this section.

(b) (1) Subject to paragraph (2) of this subsection, when calculating an insured's or enrollee's contribution to the insured's or enrollee's coinsurance, copayment, deductible, or out–of–pocket maximum under the insured's or enrollee's

health benefit plan, an entity subject to this section shall include any discount, financial assistance payment, product voucher, or other out–of–pocket expense made by or on behalf of the insured or enrollee for a prescription drug:

(i) that is covered under the insured's or enrollee's health benefit plan; and

(ii) 1. that does not have an AB–rated generic equivalent drug or an interchangeable biological product preferred under the health benefit plan's formulary; or

2. A. that has an AB–rated generic equivalent drug or an interchangeable biological product preferred under the health benefit plan's formulary; and

B. for which the insured or enrollee originally obtained coverage through prior authorization, a step therapy protocol, or the exception or appeal process of the entity subject to this section.

(2) If an insured or enrollee is covered under a high–deductible health plan, as defined in 26 U.S.C. § 223, this subsection does not apply to the deductible requirement of the high–deductible health plan.

(c) (1) Except as provided in paragraph (3) of this subsection, a person that provides a discount, financial assistance payment, product voucher, or other out–of–pocket expense made by or on behalf of the insured or enrollee that is used in the calculation of the insured's or enrollee's contribution to the insured's or enrollee's coinsurance, copayment, deductible, or out–of–pocket maximum shall, within 7 days after the acceptance of the discount, financial assistance payment, product voucher, or other out–of–pocket expense, notify the insured or enrollee of:

(i) the maximum dollar amount of the discount, financial assistance payment, product voucher, or other out–of–pocket expense; and

(ii) the expiration date for the discount, financial assistance payment, product voucher, or other out–of–pocket expense.

(2) A violation of paragraph (1) of this subsection is a violation of the Consumer Protection Act.

(3) This subsection does not apply to a charitable organization that provides a discount, financial assistance payment, product voucher, or other out–of–pocket expense to an insured or enrollee.

(d) (1) Subject to paragraph (2) of this subsection, an entity subject to this section may not directly or indirectly set, alter, implement, or condition the terms of health benefit plan coverage, including the benefit design, based in whole or in part on information about the availability or amount of financial or product assistance available for a prescription drug.

(2) Paragraph (1) of this subsection may not be construed to prohibit an entity subject to this section from using rebates in the design of prescription drug coverage or benefits.

§15–119.

(a) This section applies to insurers and nonprofit health service plans that issue or deliver individual, group, or blanket health insurance policies in the State.

(b) An entity subject to this section that requires insureds to have a written referral to receive consultation services shall use the uniform consultation referral form adopted by the Commissioner under § 15–120 of this subtitle as the sole instrument for referrals for consultation services.

(c) An entity subject to this section may not impose as a condition of coverage a requirement to:

(1) modify the uniform consultation referral form; or

(2) submit additional consultation referral forms.

(d) The uniform consultation referral form:

(1) shall be properly completed by the health care provider that refers the insured for consultation services; and

(2) may be transmitted electronically.

§15–120.

(a) Subject to subsection (b) of this section, the Commissioner shall adopt by regulation a uniform consultation referral form for use by insurers, nonprofit health service plans, and health maintenance organizations that require insureds or subscribers to have a written referral to receive consultation services.

(b) The Commissioner may waive the requirements of regulations adopted under subsection (a) of this section for the use of uniform consultation referral forms for an entity that uses the forms solely for internal purposes.

(c) The Commissioner, in consultation with the Maryland Health Care Commission, shall adopt by regulation standards for the electronic transmission of the data elements contained in the uniform consultation referral form.

§15–121.

(a) (1) In this section the following words have the meanings indicated.

(2) "Carrier" means:

(i) an insurer;

(ii) a nonprofit health service plan;

(iii) a health maintenance organization;

(iv) a dental plan organization;

(v) any person or entity acting as a third party administrator; or

(vi) except for a managed care organization as defined in Title 15, Subtitle 1 of the Health – General Article, any other person that provides health benefit plans subject to regulation by the State.

(3) "Contract" means any written agreement between a provider and a carrier for the provider to render health care services to enrollees of the carrier.

(4) "Enrollee" means any person or subscriber entitled to health care benefits from a carrier.

(5) "Health care services" means a health or medical care procedure or service rendered by a provider that:

(i) provides testing, diagnosis, or treatment of a human disease or dysfunction; or

(ii) dispenses drugs, medical devices, medical appliances, or medical goods for the treatment of a human disease or dysfunction.

(6) (i) "Provider" means a person or entity licensed, certified, or otherwise authorized under the Health Occupations Article or the Health – General Article to provide health care services.

(ii) "Provider" includes:

1. a health care facility;

2. a pharmacy;

3. a professional services corporation;

4. a partnership;

5. a limited liability company;

6. a professional office; and

7. any other entity licensed or authorized by law to provide or deliver professional health care services through or on behalf of a provider.

(b) This section applies to a carrier that provides health care services to enrollees, or otherwise makes health care services available to enrollees, through contracts with providers.

(c) (1) Each carrier shall identify and disclose in layman's terms in its enrollment sales materials the reimbursement methodology or methodologies the carrier uses to reimburse physicians for health care services rendered to enrollees, including capitation, case rates, discounted fee-for-service, and fee-for-service reimbursement methodologies.

(2) The Maryland Health Care Commission shall develop a uniform definition in layman's terms of each reimbursement methodology required to be disclosed and identified by carriers under paragraph (1) of this subsection, including a representative example of a typical capitation arrangement between a carrier and a physician.

(d) (1) In addition to the requirements of subsection (c)(1) of this section, each carrier shall disclose in its enrollment sales materials the distribution of each $100 it receives in premium dollars from enrollees for the preceding calendar year, for which data are available.

(2) The disclosure required under paragraph (1) of this subsection shall be in the form of a pie chart or bar graph with descriptive terms and in layman's terms that identifies consistent with the National Association of Insurance Commissioners' health maintenance organization annual statement ("orange form"):

(i) the proportion of every $100 in premium dollars that the carrier uses to pay providers for the direct provision of health care services to enrollees, including what proportion is for direct medical care expenses; and

(ii) the proportion of every $100 in premium dollars that the carrier uses to pay for plan administration.

§15–122.

(a) In this section, "carrier" means:

(1) an insurer;

(2) a nonprofit health service plan;

(3) a health maintenance organization;

(4) a dental plan organization; or

(5) any other person that provides health benefit plans subject to regulation by the State.

(b) Before renewing a health benefit plan, a carrier shall mail a notice of renewal to the group contract holder at least 45 days before the expiration of the health benefit plan.

(c) The notice of renewal shall include the dates of the renewal period, the health benefit plan rates, and the terms of coverage under the health benefit plan.

§15–122.1.

(a) (1) In this section the following words have the meanings indicated.

(2) "Advance directive" has the meaning stated in § 5–601 of the Health – General Article.

(3) (i) "Carrier" means:

1. an insurer;

2. a nonprofit health service plan;

3. a health maintenance organization; and

4. any other person that provides health benefit plans subject to regulation by the State.

(ii) "Carrier" does not include a managed care organization.

(b) A carrier shall provide the advance directive information sheet developed under § 5–615 of the Health – General Article:

(1) to all members or enrollees in initial enrollment materials distributed after initial purchase and upon renewal and in the carrier's member publications;

(2) if the carrier maintains a website, on the carrier's website; and

(3) at the request of a member.

(c) If a carrier maintains a website, after the tab on the State–designated health information exchange website required under § 19–145(b)(2)(iv) of the Health – General Article is developed, the carrier shall provide a link to the webpage that is accessed through the tab.

(d) This section may not be construed to require a carrier to:

(1) assist a member or enrollee in drafting an electronic advance care planning document;

(2) store electronic advance care planning documents; or

(3) access advance care planning documents.

§15–123.

(a) (1) In this section the following words have the meanings indicated.

(2) "Carrier" means:

(i) an insurer;

(ii) a nonprofit health service plan;

(iii) a health maintenance organization;

(iv) a dental plan organization;

(v) any person or entity acting as a third party administrator; or

(vi) except for a managed care organization as defined in Title 15, Subtitle 1 of the Health – General Article, any other person that provides health benefit plans subject to regulation by the State.

(3) "Contract" means any written agreement between a provider and a carrier for the provider to render health care services to enrollees of the carrier.

(4) "Diagnostic services" means any medical or surgical service or procedure that allows a provider to identify or diagnose a human disease or disorder.

(5) "Enrollee" means any person or subscriber entitled to health care benefits from a carrier.

(6) "Health care services" means a health or medical care procedure or service rendered by a provider that:

(i) provides testing, diagnosis, or treatment of a human disease or dysfunction; or

(ii) dispenses drugs, medical devices, medical appliances, or medical goods for the treatment of a human disease or dysfunction.

(7) (i) "Provider" means a person or entity licensed, certified, or otherwise authorized under the Health Occupations Article or the Health – General Article to provide health care services.

(ii) "Provider" includes:

1. a health care facility;

2. a pharmacy;

3. a professional services corporation;

4. a partnership;

5. a limited liability company;

6. a professional office; and

7. any other entity licensed or authorized by law to provide or deliver professional health care services through or on behalf of a provider.

(8) "Therapeutic services" means any medical or surgical service or procedure that a provider can use to treat a human disease or disorder.

(b) This section applies to any carrier that provides health care services to enrollees or otherwise makes health care services available to enrollees through contracts with providers.

(c) The section does not:

(1) apply to any cosmetic or medically unnecessary service or procedure that typically would be excluded from coverage by any carrier that issues or delivers contracts or policies of health insurance in the State; or

(2) affect the right of an enrollee to appeal any adverse decision by a carrier through the carrier's appeal process.

(d) (1) Each carrier shall disclose to providers and enrollees the carrier's definition of "experimental medical care".

(2) The carrier shall disclose the definition in:

(i) contracts offered to providers that may render direct health care services to the enrollees of the carrier; and

(ii) marketing materials and enrollment materials of the carrier that are provided to current enrollees and prospective enrollees, as appropriate.

(e) Each carrier shall establish or subscribe or contract to provide a systematic, scientific process to follow for evaluating emerging medical and surgical treatments to ensure that subscribers have access to the latest appropriate treatments.

(f) The process established or subscribed to or contracted for by a carrier under subsection (e) of this section shall include:

(1) a comprehensive review of medical literature and data evaluation; and

(2) input from physicians and other recognized experts:

(i) who are not employees of the carrier; and

(ii) who:

1. are currently treating patients for the disease or condition being evaluated;

2. are board certified in the pertinent specialty or subspecialty area of the disease or condition being evaluated;

3. are generally recognized by their peers to be authoritative resources in the clinical area being evaluated as evidenced by:

A. faculty appointments;

B. authorship of a significant body of peer–reviewed clinical literature in the pertinent specialty or subspecialty area; or

C. a demonstrated history of leadership in local, State, or national professional associations and nonprofit patient and community advocacy organizations that address the disease or condition and the specialty or subspecialty area in question; or

4. have a demonstrated history of substantial experience and practical knowledge in the specialty or subspecialty area in question.

(g) A carrier's decision to provide coverage for an emerging medical or surgical treatment shall result from the consensus of opinion from its own analysis and the knowledge provided to the carrier from the process identified by the carrier in subsection (f) of this section.

(h) Each carrier, in conjunction with the clinical experts identified by the carrier under subsection (f)(2) of this section, shall decide the patient selection criteria for an emerging medical or surgical treatment for which coverage by the carrier is to be provided.

(i) Each carrier shall provide a description of the process identified by the carrier under subsection (f) of this section to enrollees and contracting providers and all other providers on request.

(j) (1) A carrier's coverage decision on an emerging medical or surgical treatment shall be in compliance with § 15–10B–07 of this title, when being appealed by an enrollee.

(2) A carrier may reevaluate annually whether scientific advances warrant a change in the carrier's coverage and payment policy for an emerging medical or surgical treatment.

(k) After notifying a carrier and providing an opportunity for a hearing, the Commissioner may issue an order under § 4–113(d) of this article for a violation of this section.

(l) (1) The Commissioner may waive the application of subsection (f) of this section for a carrier that has in place a process for evaluating emerging medical and surgical treatments used for the purpose of making coverage decisions, if the Commissioner determines that the carrier's process is substantially equivalent to, or exceeds, the requirements of this section.

(2) A carrier receiving a waiver under paragraph (1) of this subsection shall report any change in its process for evaluating emerging medical and surgical treatments to the Commissioner.

(3) The Commissioner may withdraw a waiver granted under paragraph (1) of this subsection whenever the Commissioner determines that the carrier's process for evaluating emerging medical and surgical treatments is not substantially equivalent to the requirements of this section.

(m) The Commissioner may adopt regulations to carry out this section.

§15–124.

(a) In this section, "group health insurance" has the meaning stated in § 15–301 of this title.

(b) This section applies to insurers and nonprofit health service plans that issue or deliver group health insurance policies in the State.

(c) An entity subject to this section when issuing or renewing a group health insurance policy with an employer that does not include dependent coverage shall provide enrollment information to insured employees regarding the methods of enrolling any dependent of an insured employee in the Maryland Children's Health Program established under § 15-301 of the Health - General Article.

§15–125.

(a) (1) In this section the following words have the meanings indicated.

(2) (i) "Carrier" means:

1. an insurer;

2. a nonprofit health service plan;

3. a health maintenance organization;

4. a dental plan organization; or

5. any other person that provides health benefit plans subject to regulation by the State.

(ii) "Carrier" includes an entity that arranges a provider panel for a carrier.

(3) "Contract" means the implied or express agreement between a health care provider and carrier, including the rights, obligations, and fee schedule for the provision of health care services.

(4) "Health care provider" means an individual who is licensed, certified, or otherwise authorized under the Health Occupations Article to provide health care services.

(b) (1) A carrier may not in any manner assign, transfer, or subcontract a health care provider's contract, wholly or partly, to an insurer that offers personal injury protection coverage under § 19-505 of this article without first informing the health care provider and obtaining the health care provider's express written consent.

(2) A carrier may not terminate, limit, or otherwise impair the contract or employment of a health care provider with the carrier on the basis that the health care provider refused to agree to an assignment, transfer, or subcontract of all or part of the health care provider's contract to an insurer that offers personal injury protection coverage under § 19-505 of this article.

(c) (1) A carrier that uses a provider panel for health care services may not require a health care provider, as a condition of participation or continuation on the carrier's provider panel for health care services, to also serve on a provider panel for workers' compensation services.

(2) A carrier may not terminate, limit, or otherwise impair a contract or an agreement with a health care provider, or terminate or limit the employment of a health care provider, based on the health care provider's election not to serve on a provider panel for workers' compensation services.

(3) A carrier shall include in a contract or an agreement with a health care provider a disclosure that informs the health care provider of the right to elect not to serve on a provider panel for workers' compensation services.

§15–126.

(a) In this section, "emergency medical condition" means a medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a prudent layperson, who possesses an average knowledge of health and medicine, to result in:

(1) placing the patient's health in serious jeopardy;

(2) serious impairment to bodily functions; or

(3) serious dysfunction of any bodily organ or part.

(b) This section applies to:

(1) insurers and nonprofit health service plans that provide hospital, medical, or surgical benefits to individuals or groups under health insurance policies that are issued or delivered in the State; and

(2) health maintenance organizations that provide hospital, medical, or surgical benefits to individuals or groups under contracts that are issued or delivered in the State.

(c) (1) An entity subject to this section may not establish or promote an emergency medical response and transportation system that encourages or directs access by an insured or enrollee in competition with or in substitution of the Maryland Emergency Medical Services System (911) or other State, county, or local government emergency medical services system.

(2) Notwithstanding paragraph (1) of this subsection, an entity subject to this section may use transportation outside the 911 or other government emergency medical services system for services that are not in response to an emergency medical condition.

(d) An entity subject to this section may not require an insured or enrollee to obtain prior authorization before accessing the 911 system or other State, county, or local government emergency medical services system for an emergency medical condition.

(e) An entity subject to this section may not use false or misleading language in its enrollment sales materials or in any other materials provided to insureds or enrollees to discourage or prohibit insureds or enrollees from accessing the 911 system for an emergency medical condition.

§15–127.

(a) (1) In this section the following words have the meanings indicated.

(2) (i) "Behavioral health care administrative expenses" means any expenses that are for administrative functions including:

1. billing and collection expenses;

2. accounting and financial reporting expenses;

3. quality assurance and utilization management program or activity expenses;

4. promotion and marketing expenses;

5. taxes, fees, and assessments;

6. legal expenses;

7. salary expenses for employees that are not related to the delivery of behavioral health care services to patients;

8. computer expenses;

9. provider credentialing;

10. collection and administrative review of treatment plans;

11. auditing the financial report submitted to the Commissioner under this section;

12. debt payment and debt service; and

13. other general and administrative expenses.

(ii) "Behavioral health care administrative expenses" does not include expenses incurred for behavioral health care services.

(3) (i) "Behavioral health care services" means procedures or services rendered by a health care provider for the treatment of mental illness, emotional disorders, drug abuse, or alcohol abuse.

(ii) "Behavioral health care services" includes any quality assurance or utilization management activities or treatment plan reviews that are clinical in nature.

(iii) "Behavioral health care services" does not include administrative functions.

(4) "Carrier" means:

(i) a health insurer;

(ii) a nonprofit health service plan;

(iii) a health maintenance organization;

(iv) a preferred provider organization;

(v) a third party administrator; or

(vi) except for a managed care organization as defined in Title 15, Subtitle 1 of the Health – General Article, any other person that provides health benefit plans subject to regulation by the State.

(5) "Direct behavioral health care expenses" means any payment to a health care provider by a managed behavioral health care organization for the provision of behavioral health care services to a member.

(6) "Direct payments" means the money that a carrier disburses to a managed behavioral health care organization for the provision of behavioral health care services to a member.

(7) "Managed behavioral health care organization" means a company, organization, private review agent, or subsidiary that:

(i) contracts with a carrier to provide, undertake to arrange, or administer behavioral health care services to members; or

(ii) otherwise makes behavioral health care services available to members through contracts with health care providers.

(8) (i) "Member" means an individual entitled to behavioral health care services from a carrier or a managed behavioral health care organization under a policy or plan issued or delivered in the State.

(ii) "Member" includes a subscriber.

(9) "Provider" means a person licensed, certified, or otherwise authorized under the Health Occupations Article or the Health – General Article to provide health care services.

(b) This section does not apply to a person that, for an administrative fee only, solely arranges a provider panel for a carrier for the provision of behavioral health care services on a discounted fee–for–service basis.

(c) (1) A carrier that owns or contracts with a managed behavioral health care organization shall distribute to its members at the time of enrollment an explanation of:

(i) the specific behavioral health care services covered and the specific exclusions under the member's contract;

(ii) the member's responsibilities for obtaining behavioral health care services;

(iii) the reimbursement methodology that the carrier and managed behavioral health care organization use to reimburse providers for behavioral health care services; and

(iv) the procedure that a member must utilize when attempting to obtain behavioral health care services outside the network of providers used by the carrier or managed behavioral health care organization.

(2) The explanation that a carrier is required to distribute under paragraph (1)(iii) of this subsection shall be consistent with § 15–121(c) of this subtitle.

(3) A carrier that owns or contracts with a managed behavioral health care organization shall:

(i) include information on behavioral health care providers in the list of providers on the carrier's provider panel required under § 15–112(n) of this subtitle; and

(ii) provide the same information on behavioral health care providers that is required for other providers under § 15–112(n) of this subtitle.

(4) (i) A carrier that contracts with a managed behavioral health care organization shall require the managed behavioral health care organization to provide to the carrier on an annual basis a report on the direct behavioral health care expenses of the managed behavioral health care organization.

(ii) The report required under subparagraph (i) of this paragraph shall be made publicly available by the carrier.

(d) (1) Each carrier that provides behavioral health care services through a company owned wholly or in part by the carrier or through a contract with a managed behavioral health care organization shall complete and maintain a form developed by the Commissioner that includes the following information:

(i) the carrier's direct payments for the preceding calendar year;

(ii) the information required to be collected by a carrier under subsection (c)(4) of this section; and

(iii) reported separately from the information required under item (ii) of this paragraph, the carrier's total expenses for quality assurance and utilization management activities and treatment plan reviews that are clinical in nature.

(2) The Commissioner shall develop a form to implement the requirements of this subsection.

(e) (1) Each carrier required under subsection (d) of this section to complete and maintain the form developed by the Commissioner shall make copies of the form publicly available to an individual, enrollee, or member, upon request.

(2) A carrier that is required to make a form publicly available to an individual, enrollee, or member under paragraph (1) of this subsection may charge:

(i) a reasonable preparation fee not to exceed $15 for each form requested; and

(ii) the actual cost for any postage and handling required to provide copies of the requested forms.

(f) The Commissioner may adopt regulations to carry out the provisions of this section.

§15–129.

(a) (1) In this section the following words have the meanings indicated.

(2) "Aggregate attachment point" means the percentage of expected claims in a policy year above which the medical stop–loss insurer assumes all or part of the liability for losses incurred by the insured.

(3) "Carrier" means:

(i) an insurer; or

(ii) a nonprofit health service plan.

(4) "Expected claims" means the amount of claims that, in the absence of medical stop–loss insurance, are projected to be incurred by the insured using reasonable and accepted actuarial principles.

(5) "Medical stop–loss insurance" means insurance, other than reinsurance, that is purchased by a person, other than a carrier or a health care provider, to protect the person against catastrophic, excess, or unexpected losses incurred by that person's obligations to third parties under the terms of a health benefit plan.

(6) "Medical stop–loss insurer" means a carrier that is authorized to sell, issue, and deliver policies of medical stop–loss insurance in the State.

(7) "Small employer" has the meaning stated in § 31–101 of this article.

(8) "Specific attachment point" means the dollar amount in losses attributable to a single individual in a policy year beyond which the medical stop–loss insurer assumes all or part of the liability for losses incurred by the insured.

(b) Subject to subsection (d)(2) of this section, this section applies to each medical stop–loss insurer and each medical stop–loss insurance policy or contract that is delivered or issued for delivery in the State.

(c) Medical stop–loss insurance may only be sold, issued, or delivered in the State by a carrier that holds a certificate of authority issued by the Commissioner

that authorizes the carrier to engage in the business of health insurance or to act as a nonprofit health service plan.

(d) (1) Except as provided in paragraph (2) of this subsection, a medical stop–loss insurer may not issue, renew, deliver, or offer a policy or contract of medical stop–loss insurance, if the policy or contract has:

(i) a specific attachment point of less than $22,500; or

(ii) an aggregate attachment point of less than 120% of expected claims.

(2) This subsection does not apply to:

(i) a policy or contract of medical stop–loss insurance issued or delivered before June 1, 2015, if the policy or contract maintains:

1. a specific attachment point of no less than $10,000; and

2. an aggregate attachment point of no less than 115% of expected claims;

(ii) a renewal of a policy or contract described in item (i) of this paragraph; or

(iii) a policy or contract of medical stop–loss insurance issued or delivered on or after June 1, 2015, if the policy or contract:

1. is issued or delivered to an employer that on May 31, 2015, held a policy or contract of medical stop–loss insurance with:

A. a specific attachment point of not less than $10,000; and

B. an aggregate attachment point of not less than 115% of expected claims; and

2. maintains:

A. a specific attachment point of not less than $10,000; and

B. an aggregate attachment point of not less than 115% of expected claims.

(e) For a stop–loss insurance policy or contract issued to a small employer, a medical stop–loss insurer may not:

(1) (i) impose higher cost sharing for a specific individual within a small employer's health benefit plan than is required for other individuals within the small employer's health benefit plan; or

(ii) decrease or remove stop–loss coverage for a specific individual within a small employer's health benefit plan; or

(2) exclude any employee or dependent from a policy or contract on the basis of an actual or expected health status–related factor or condition, including:

(i) physical or behavioral health, including mental illness or substance use disorder;

(ii) claims experience;

(iii) medical history;

(iv) receipt of health care;

(v) genetic information;

(vi) disability;

(vii) evidence of insurability, including conditions arising out of acts of domestic violence against an employee or dependent; or

(viii) any other health status–related factor as determined by the Commissioner.

(f) For a stop–loss insurance policy or contract issued to a small employer, a medical stop–loss insurer shall:

(1) guarantee rates for at least 12 months, without adjustment, unless there is a change in:

(i) the benefits provided under the small employer's health benefit plan during the policy or contract period;

(ii) the ownership and control of the small employer; or

(iii) the number of covered lives by a significant percentage resulting from an event such as an acquisition or a divestiture;

(2) pay stop–loss claims incurred during the policy or contract period and submitted within 12 months after the expiration date of the policy or contract; and

(3) disclose to the small employer, in a form and manner approved by the Commissioner and before entering into a policy or contract for medical stop–loss insurance:

(i) the total costs of the policy or contract;

(ii) 1. the dates on which the policy or contract takes effect and terminates; and

2. provisions for renewing the policy or contract;

(iii) the aggregate attachment point and the specific attachment point for the policy or contract; and

(iv) any limitations on coverage.

(g) A medical stop–loss insurer who offers or issues a medical stop–loss insurance policy or contract that does not meet the requirements of this section shall be subject to the sanctions set forth in § 4–113 of this article for authorized insurers and § 4–212 of this article for unauthorized insurers.

(h) Nothing in this section shall be construed as:

(1) imposing any requirement or duty on any person other than a carrier; or

(2) treating any medical stop–loss insurance policy as a policy of individual, group, or blanket health insurance covering the participants in the underlying health benefit plan.

§15–130.

(a) (1) This section applies to:

(i) insurers and nonprofit health service plans that provide coverage for prescription drugs on an outpatient basis under health insurance policies or contracts that are issued or delivered in the State;

(ii) health maintenance organizations that provide coverage for prescription drugs on an outpatient basis under contracts that are issued or delivered in the State;

(iii) managed care organizations, as defined in § 15–101 of the Health – General Article, that provide coverage for prescription drugs on an outpatient basis under contracts that are issued or delivered in the State; and

(iv) to the extent consistent with State and federal law, third party administrators.

(2) This section does not apply to:

(i) short–term travel or accident–only policies;

(ii) short–term nonrenewable policies of not more than 3 months duration; or

(iii) any health maintenance organization that operates or maintains its own pharmacies and dispenses, on an annual basis, over 95% of prescription drugs on an outpatient basis to its enrollees at its own pharmacies.

(b) Each entity subject to this section shall provide to its insureds, subscribers, or enrollees a health insurance benefit card, prescription benefit card, or other technology that:

(1) (i) complies with the standards set forth in the National Council for Prescription Drug Programs Pharmacy ID Card Implementation Guide in effect at the time of issuance of the card or other technology; or

(ii) includes, at a minimum, the following data elements:

1. the name or identifying trademark of the entity subject to this section or, if another entity administers the prescription benefit, the name or identifying trademark of the benefit administrator;

2. the name and identification number of the insured, subscriber, or enrollee;

3. the telephone number that providers may call for pharmacy benefit assistance; and

4. all electronic transaction routing information and other numbers required by the entity subject to this section or benefit administrator to process a prescription claim electronically; and

(2) indicates which State agency regulates, in whole or in part, the policy or contract offered by the entity by:

(i) for an entity subject to the Administration, displaying "MIA" prominently; or

(ii) for an entity subject to the Maryland Department of Health, displaying "MDH" prominently.

(c) If an entity subject to this section contracts with or otherwise arranges for the prescription benefit to be administered by another subsidiary or entity, including a pharmacy benefit manager, the entity subject to this section shall require the benefit administrator to comply with this section.

(d) (1) The health insurance benefit card, prescription benefit card, or other technology shall be issued to each insured, subscriber, or enrollee by an entity subject to this section.

(2) If a change occurs in any of the data elements required under subsection (b)(1)(ii) of this section, an entity subject to this section shall:

(i) reissue a health insurance benefit card, prescription drug benefit card, or other technology; or

(ii) provide the insured, subscriber, or enrollee with the corrective information necessary to electronically process a prescription claim.

(e) An entity subject to this section may comply with this section by issuing to each insured, subscriber, or enrollee a health insurance benefit card that contains data elements related to both prescription and nonprescription health insurance benefits.

(f) The Maryland Department of Health shall adopt regulations to enable managed care organizations to comply with:

(1) the requirements of this section; and

(2) any unique requirements of the HealthChoice Program that relate to the electronic processing of claims.

§15–130.1.

(a) This section applies to:

(1) each health insurer;

(2) each nonprofit health service plan;

(3) each health maintenance organization; and

(4) each managed care organization, as defined in § 15–101 of the Health – General Article.

(b) Each entity subject to this section shall provide to each insured, subscriber, or enrollee of a policy or contract that meets the definition of minimum essential coverage, as described in 26 C.F.R. § 1.5000a–2, a health insurance benefit card, prescription benefit card, or other technology that indicates which State agency regulates, in whole or in part, the policy or contract offered by the entity by:

(1) for an entity subject to the Administration, displaying "MIA" prominently; or

(2) for an entity subject to the Maryland Department of Health, displaying "MDH" prominently.

(c) This section may not be construed to preclude an entity subject to this section from including:

(1) any other information required to be included under this article; or

(2) any information that is in addition to the information required under this section.

§15–131.

(a) This section applies to:

(1) insurers and nonprofit health service plans that provide, directly or through a pharmacy benefit manager, coverage for prescription drugs under health insurance policies or contracts that are issued or delivered in the State; and

(2) health maintenance organizations that provide, directly or through a pharmacy benefit manager, coverage for prescription drugs under contracts that are issued or delivered in the State.

(b) If an entity subject to this section requires a pharmacy to submit a request for payment electronically, then the pharmacy or designated agent may choose to be reimbursed electronically, and in that event the entity shall reimburse the pharmacy electronically, and shall provide the appropriate payment data electronically.

(c) An entity subject to this section may not impose a processing fee for the electronic reimbursement or for providing payment data electronically.

§15–132.

(a) In this section, "carrier" has the meaning stated in § 19–142 of the Health – General Article.

(b) A carrier shall provide incentives to health care providers in accordance with the requirements of Title 19, Subtitle 1, Part IV of the Health – General Article.

§15–133.

On or before December 1 of each year, the Commissioner shall report to the General Assembly, in accordance with § 2–1257 of the State Government Article, on the estimated number of insured and self–insured contracts for health benefit plans in the State and the number of insured and self–insured lives under the age of 65 enrolled in benefit plans in the State.

§15–134.

(a) In this section, "grandfathered health plan" has the meaning stated in the federal Patient Protection and Affordable Care Act, as amended by the federal Health Care and Education Reconciliation Act of 2010.

(b) Except as provided in subsection (c) of this section, a provision of this title or Title 14 of this article enacted after January 1, 2010, may not apply to a group health plan that is a grandfathered health plan or health insurance coverage that is a grandfathered health plan if the provision would prevent the group health plan or health insurance coverage from being considered a grandfathered health plan.

(c) Subsection (b) of this section does not apply to any provision of this title or Title 14 of this article enacted after January 1, 2010, to enforce a provision of federal law that was enacted on or before January 1, 2010.

§15–135.

(a) (1) In this section, "annual preventive care" means an annual preventive visit, screening, or examination that is a covered benefit under a policy or contract issued or delivered by an entity subject to this section.

(2) "Annual preventive care" includes, if the service is a covered benefit:

(i) an annual child wellness visit;

(ii) a routine gynecological visit;

(iii) a screening test or examination for colorectal cancer, chlamydia, human papillomavirus, prostate cancer, or breast cancer; and

(iv) an annual vision visit that includes a vision examination.

(b) This section applies to:

(1) insurers and nonprofit health service plans that provide hospital, medical, or surgical benefits to individuals or groups on an expense–incurred basis under health insurance policies or contracts that are issued or delivered in the State; and

(2) health maintenance organizations that provide hospital, medical, or surgical benefits to individuals or groups under contracts that are issued or delivered in the State.

(c) An entity subject to this section that provides covered benefits for annual preventive care shall provide coverage for the annual preventive care if:

(1) the annual preventive care is provided no more than once at any time during the plan year established in the policy or contract; and

(2) any other requirements for coverage of the annual preventive care are met.

(d) This section may not be construed to require coverage for a service not otherwise required by law.

§15–135.1.

(a) (1) In this section the following words have the meanings indicated.

(2) "Carrier" means an insurer, nonprofit health service plan, health maintenance organization, or dental plan organization that provides dental benefits on an expense–incurred basis under policies or contracts issued or delivered in the State.

(3) "Dental preventive care" means a preventive dental visit, screening, oral examination, teeth cleaning (prophylaxis), fluoride treatment, or routine preventive service that is a covered benefit under a policy or contract issued or delivered by a carrier.

(b) If benefits for dental preventive care are available and all other requirements for the coverage of dental preventive care are met, a carrier shall provide coverage for dental preventive care:

(1) at any time during the plan year for a policy or contract that provides coverage for dental preventive care once during the plan year; or

(2) subject to subsection (c) of this section, in accordance with any frequency limitation for a policy or contract that provides coverage for dental preventive care more than once during the plan year.

(c) A carrier may not impose a frequency limitation on dental preventive care that requires the dental preventive care to be provided at an interval greater than 120 days during a plan year.

(d) This section may not be construed to require coverage for a service not otherwise required by law.

§15–136.

(a) (1) In this section the following words have the meanings indicated.

(2) "Carrier" means:

(i) an insurer;

(ii) a nonprofit health service plan;

(iii) a health maintenance organization; or

(iv) any other person that provides health benefit plans subject to regulation by the State.

(3) "Group model health maintenance organization" has the meaning stated in § 19–713.6(a) of the Health – General Article.

(b) This section applies only to contracts or policies that:

(1) are issued or delivered by a carrier; and

(2) provide hospital, medical, or surgical benefits to individuals or groups on an expense–incurred basis.

(c) (1) Except as provided in subsection (d) of this section, each carrier shall pay a bonus to primary care providers for services provided in the office:

(i) after 6 p.m. and before 8 a.m.; or

(ii) on weekends and national holidays.

(2) A carrier shall provide for and describe the terms of the bonus payment required in paragraph (1) of this subsection in a separate clause in the carrier's contract with the primary care provider.

(d) A group model health maintenance organization is not required to make any bonus payments described in subsection (c) of this section to physicians that are employed by the physician group under contract with the group model health maintenance organization.

§15–138.

(a) (1) In this section the following words have the meanings indicated.

(2) "Ambulance" means any conveyance designed and constructed or modified and equipped to be used, maintained, or operated to transport individuals who are sick, injured, wounded, or otherwise incapacitated.

(3) "Ambulance service provider" means a provider of ambulance services that:

(i) is owned, operated, or under the jurisdiction of a political subdivision of the State or a volunteer fire company or volunteer rescue squad; or

(ii) has contracted to provide ambulance services for a political subdivision of the State.

(4) "Assignment of benefits" means the transfer by an insured, a subscriber, or an enrollee of health care coverage reimbursement benefits or other rights under a health insurance policy or contract.

(5) "Carrier" means:

(i) an insurer that provides benefits on an expense–incurred basis;

(ii) a nonprofit health service plan; or

(iii) a health maintenance organization.

(6) "Nonpreferred provider" has the meaning stated in § 14–201 of this article.

(7) "Preferred provider" has the meaning stated in § 14–201 of this article.

(8) "Preferred provider insurance policy" has the meaning stated in § 14–201 of this article.

(b) This section applies to individual or group policies or contracts issued or delivered in the State by a carrier.

(c) (1) Except for a health maintenance organization, a carrier shall reimburse directly an ambulance service provider that obtains an assignment of benefits from an insured, a subscriber, or an enrollee for covered services provided to the insured, subscriber, enrollee, or any other individual covered by a policy or contract issued by the carrier.

(2) A health maintenance organization shall reimburse an ambulance service provider directly for covered services provided to a subscriber, enrollee, or any other individual covered by a policy or contract issued by the health maintenance organization.

(d) (1) This subsection applies to an ambulance service provider that receives direct reimbursement under subsection (c) of this section.

(2) Except as provided in paragraph (4) of this subsection, an insured, a subscriber, or an enrollee may not be liable to an ambulance service provider for covered services.

(3) An ambulance service provider or a representative of the ambulance service provider may not:

(i) collect or attempt to collect from an insured, a subscriber, or an enrollee of a carrier any money owed to the ambulance service provider by the carrier for covered services rendered to the insured, subscriber, or enrollee by the ambulance service provider; or

(ii) maintain any action against an insured, a subscriber, or an enrollee of a carrier to collect or attempt to collect any money owed to the ambulance service provider by the carrier for covered services rendered to the insured, subscriber, or enrollee by the ambulance service provider.

(4) An ambulance service provider or a representative of the ambulance service provider may collect or attempt to collect from an insured, a subscriber, or an enrollee of a carrier:

(i) any copayment, deductible, or coinsurance amount owed by the insured, subscriber, or enrollee for covered services rendered to the insured, subscriber, or enrollee by the ambulance service provider;

(ii) if Medicare is the primary insurer and the carrier is the secondary insurer, any amount up to the Medicare–approved or limiting amount, as specified under the federal Social Security Act, that is not owed to the ambulance service provider by Medicare or the carrier after coordination of benefits has been completed, for Medicare covered services rendered to the insured, subscriber, or enrollee by the ambulance service provider; and

(iii) any payment or charge for services that are not covered services.

(e) (1) Notwithstanding § 19–710.1 of the Health – General Article, a health maintenance organization's allowed amount for a covered health care service provided by an ambulance service provider that is not under written contract with the health maintenance organization may not be less than the allowed amount paid to an ambulance service provider that is under written contract with the health maintenance organization for the same covered service in the same geographic region, as defined by the Centers for Medicare and Medicaid Services.

(2) An insurer's or nonprofit health service plan's allowed amount for a health care service covered under a preferred provider insurance policy and provided by an ambulance service provider that is a nonpreferred provider may not be less than the allowed amount paid to an ambulance service provider who is a preferred provider for the same health care service in the same geographic region, as defined by the Centers for Medicare and Medicaid Services.

(f) The Commissioner may adopt regulations to implement this section.

§15–139.

(a) (1) In this section, "telehealth" means, as it relates to the delivery of health care services, the use of interactive audio, video, or other telecommunications or electronic technology by a licensed health care provider to deliver a health care service within the scope of practice of the health care provider at a location other than the location of the patient.

(2) "Telehealth" includes 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.

(3) "Telehealth" does not include:

(i) except as provided in paragraph (2) of this subsection, an audio–only telephone conversation between a health care provider and a patient;

(ii) an electronic mail message between a health care provider and a patient; or

(iii) a facsimile transmission between a health care provider and a patient.

(b) This section applies to:

(1) insurers and nonprofit health service plans that provide hospital, medical, or surgical benefits to individuals or groups on an expense–incurred basis under health insurance policies or contracts that are issued or delivered in the State; and

(2) health maintenance organizations that provide hospital, medical, or surgical benefits to individuals or groups under contracts that are issued or delivered in the State.

(c) (1) An entity subject to this section:

(i) shall provide coverage under a health insurance policy or contract for health care services appropriately delivered through telehealth regardless of the location of the patient at the time the telehealth services are provided;

(ii) may not exclude from coverage a health care service solely because it is provided through telehealth and is not provided through an in–person consultation or contact between a health care provider and a patient; and

(iii) may not exclude from coverage or deny coverage 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.

(2) The health care services appropriately delivered through telehealth shall include counseling and treatment for substance use disorders and mental health conditions.

(d) (1) Subject to paragraph (2) of this subsection, an entity subject to this section:

(i) shall reimburse a health care provider for the diagnosis, consultation, and treatment of an insured patient for a health care service covered under a health insurance policy or contract that can be appropriately provided through telehealth;

(ii) is not required to:

1. reimburse a health care provider for a health care service delivered in person or through telehealth that is not a covered benefit under the health insurance policy or contract; or

2. reimburse a health care provider who is not a covered provider under the health insurance policy or contract; and

(iii) 1. may impose a deductible, copayment, or coinsurance amount on benefits for health care services that are delivered either through an in–person consultation or through telehealth;

2. may impose an annual dollar maximum as permitted by federal law; and

3. may not impose a lifetime dollar maximum.

(2) (i) When a health care service is appropriately provided through telehealth, an entity subject to this section shall provide reimbursement in accordance with paragraph (1)(i) of this subsection on the same basis and at the same rate as if the health care service were delivered by the health care provider in person.

(ii) The reimbursement required under subparagraph (i) of this paragraph does not include:

1. clinic facility fees unless the health care service is provided by a health care provider not authorized to bill a professional fee separately for the health care service; or

2. any room and board fees.

(iii) This paragraph may not be construed to supersede the authority of the Health Services Cost Review Commission to set the appropriate rates for hospitals, including setting the hospital facility fee for hospital–provided telehealth.

(e) Subject to subsection (d)(1)(ii) of this section, an entity subject to this section may not impose as a condition of reimbursement of a covered health care service delivered through telehealth that the health care service be provided by a third–party vendor designated by the entity.

(f) An entity subject to this section may undertake utilization review, including preauthorization, to determine the appropriateness of any health care service whether the service is delivered through an in–person consultation or through telehealth if the appropriateness of the health care service is determined in the same manner.

(g) A health insurance policy or contract may not distinguish between patients in rural or urban locations in providing coverage under the policy or contract for health care services delivered through telehealth.

(h) A decision by an entity subject to this section not to provide coverage for telehealth in accordance with this section constitutes an adverse decision, as defined in § 15–10A–01 of this title, if the decision is based on a finding that telehealth is not medically necessary, appropriate, or efficient.

§15–140.

(a) (1) In this section the following words have the meanings indicated.

(2) "Acute condition" means a medical or dental condition that:

(i) involves a sudden onset of symptoms due to an illness, an injury, or any other medical or dental problem that requires prompt medical attention; and

(ii) has a limited duration.

(3) "Carrier" means:

(i) an insurer authorized to sell health insurance;

(ii) a nonprofit health service plan;

(iii) a health maintenance organization;

(iv) a dental plan organization; or

(v) any other entity providing a plan of health insurance, health benefits, or health services authorized under this article or the Affordable Care Act.

(4) "Enrollee" means:

(i) a person entitled to health care benefits from a carrier; or

(ii) a Program recipient who is enrolled in a managed care organization.

(5) (i) "Health benefit plan" means a policy, a contract, a certificate, or an agreement offered, issued, or delivered by a carrier to an individual or a group in the State to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services.

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

1. coverage only for accident or disability insurance or any combination of accident and disability 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;

7. coverage for on–site medical clinics; or

8. other similar insurance coverage, specified in federal regulations issued pursuant to the federal Health Insurance Portability and Accountability Act, under which benefits for health care services are secondary or incidental to other insurance benefits.

(iii) "Health benefit plan" does not include the following benefits if they are provided under a separate policy, certificate, or contract of insurance, or are otherwise not an integral part of the plan:

1. limited scope vision benefits;

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

3. such other similar limited benefits as are specified in federal regulations issued pursuant to the federal Health Insurance Portability and Accountability Act.

(iv) "Health benefit plan" does not include the following benefits if the benefits are provided under a separate policy, certificate, or contract of insurance, there is no coordination between the provision of the benefits and any exclusion of benefits under any group health plan maintained by the same plan sponsor, and the benefits are paid with respect to an event without regard to whether the benefits are provided under any group health plan maintained by the same plan sponsor:

1. coverage only for a specified disease or illness; or

2. hospital indemnity or other fixed indemnity insurance.

(v) "Health benefit plan" does not include the following if offered as a separate policy, certificate, or contract of insurance:

1. Medicare Supplemental 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 (Civilian Health and Medical Program of the Uniformed Services (CHAMPUS)); or

3. similar supplemental coverage provided to coverage under a group health plan.

(6) (i) "Health care provider" means:

1. a health care practitioner or group of health care practitioners licensed, certified, or otherwise authorized to provide, in the ordinary course of business or practice of a profession, health care services covered in a health benefit plan, the Maryland Medical Assistance Program, or the Maryland Children's Health Program; or

2. a facility where health care is provided to patients or recipients including:

A. a hospital, as defined in § 19–301 of the Health – General Article;

B. a related institution as defined in § 19–301 of the Health – General Article;

C. a freestanding ambulatory care facility as defined in § 19–3B–01 of the Health – General Article;

D. a facility that is organized primarily to help in the rehabilitation of persons with disabilities;

E. a home health agency as defined in § 19–901 of the Health – General Article;

F. a hospice as defined in § 19–901 of the Health – General Article;

G. a facility that provides radiological or other diagnostic imagery services;

H. a medical laboratory as defined in § 17–201 of the Health – General Article;

I. an alcohol abuse and drug abuse treatment program as defined in § 8–403 of the Health – General Article; and

J. a Federally Qualified Health Center.

(ii) "Health care provider" includes the agents, employees, officers, and directors of a health care provider described in subparagraph (i) of this paragraph.

(7) "Managed care organization" means:

(i) a certified health maintenance organization that is authorized to receive medical assistance prepaid capitation payments;

(ii) a corporation that:

1. is a managed care system that is authorized to receive medical assistance prepaid capitation payments;

2. enrolls only Program recipients or individuals or families served under the Maryland Children's Health Program; and

3. is subject to the requirements of § 15–102.4 of the Health – General Article; or

(iii) a prepaid dental plan that receives fees to manage dental services.

(8) "Nonparticipating provider" means a health care provider who is not on the provider panel of a carrier or managed care organization.

(9) "Participating provider" means a health care provider who is on the provider panel of a carrier or managed care organization.

(10) "Prior authorization" means a utilization management technique that:

(i) is used by carriers and managed care organizations;

(ii) requires prior approval for a procedure, treatment, medication, or service before an enrollee is eligible for full payment of the benefit; and

(iii) is used to determine whether the procedure, treatment, medication, or service is medically necessary.

(11) "Program recipient" means an individual who receives benefits under the Maryland Medical Assistance Program.

(12) (i) "Provider panel" means the health care providers that contract either directly or through a subcontracting entity with a carrier or managed care organization to provide health care services to the enrollees of the carrier or managed care organization.

(ii) "Provider panel" does not include an arrangement in which any health care provider may participate solely by contracting with the carrier or managed care organization to provide health care services at a discounted fee–for–service rate.

(13) "Receiving carrier or managed care organization" means:

(i) the carrier that issues the new health benefit plan when an enrollee transitions from another carrier or a managed care organization; or

(ii) the managed care organization that accepts the enrollee when the enrollee transitions from another managed care organization or a carrier.

(14) "Relinquishing carrier or managed care organization" means:

(i) the carrier that issued the prior health benefit plan when an enrollee transitions to a new carrier or a managed care organization; or

(ii) the managed care organization in which an enrollee had been enrolled prior to the enrollee's transition to a new managed care organization or a carrier.

(15) "Serious chronic condition" means a medical or dental condition due to a disease, an illness, or any other medical or dental problem that:

(i) is serious in nature;

(ii) persists without full cure or worsens over an extended period of time; and

(iii) is actively managed or supervised by a health care provider to maintain remission or prevent deterioration.

(16) "Third–party administrator" means an organization under contract with the Maryland Medical Assistance Program to administer certain benefits and services provided by the Maryland Medical Assistance Program.

(b) (1) The purpose of this section is to advance the State's progress in:

(i) protecting Marylanders from harmful disruptions in health care services; and

(ii) promoting reasonable continuity of health care for Marylanders when transitioning:

1. from one carrier to another carrier; and

2. between a carrier and the Maryland Medical Assistance Program or the Maryland Children's Health Program.

(2) This section:

(i) with respect to any benefit or service that is provided through the Maryland Medical Assistance fee–for–service program:

1. shall not apply when the enrollee is transitioning from a carrier to the Maryland Medical Assistance Program; and

2. except as provided in subsection (c) of this section, shall apply when the enrollee is transitioning from the Maryland Medical Assistance Program to a carrier;

(ii) shall apply to contracts issued or renewed on or after January 1, 2015; and

(iii) subject to subparagraph (i) of this paragraph, with respect to dental benefits, shall apply to covered services for which a coordinated treatment plan is in progress.

(c) (1) With respect to any benefit or service provided through the Maryland Medical Assistance fee–for–service program, this subsection shall apply:

(i) only to enrollees transitioning from the Maryland Medical Assistance Program to a carrier; and

(ii) only to behavioral health and dental benefits, to the extent they are authorized by a third–party administrator.

(2) Subject to paragraph (3) of this subsection, at the request of an enrollee or an enrollee's parent, guardian, designee, or health care provider, a receiving carrier or managed care organization shall accept a preauthorization from a relinquishing carrier, managed care organization, or third–party administrator for:

(i) the procedures, treatments, medications, or services covered by the benefits offered by the receiving carrier or managed care organization; and

(ii) the following time periods:

1. the lesser of the course of treatment or 90 days; and

2. the duration of the three trimesters of a pregnancy and the initial postpartum visit.

(3) Subject to applicable laws relating to the confidentiality of medical records, including 42 C.F.R. Part 2, at the request and with the consent of an enrollee or an enrollee's parent, guardian, or designee, a relinquishing carrier, managed care organization, or third–party administrator, shall provide a copy of a preauthorization to the enrollee's receiving carrier or managed care organization within 10 days after receipt of the request.

(4) After the time periods under paragraph (2)(ii) have lapsed, the receiving carrier or managed care organization may elect to perform its own utilization review in order to:

(i) reassess and make its own determination regarding the need for continued treatment; and

(ii) authorize any continued procedure, treatment, medication, or service determined to be medically necessary.

(d) (1) Subject to paragraphs (2) through (5) of this subsection, at the request of an enrollee or an enrollee's parent, guardian, designee, or health care provider, a receiving carrier or managed care organization shall allow a new enrollee to continue to receive health care services being rendered by a nonparticipating provider at the time of the enrollee's transition to the receiving health benefit plan or managed care organization.

(2) (i) The services an enrollee shall be allowed to continue to receive are services for:

1. the following conditions:

A. acute conditions;

B. serious chronic conditions;

C. pregnancy; and

D. mental health conditions and substance use disorders; and

2. any other condition on which the nonparticipating provider and the receiving carrier or managed care organization reach agreement.

(ii) Examples of conditions set forth in subparagraph (i)1A and B of this paragraph may include:

1. bone fractures;

2. joint replacements;

3. heart attacks;

4. cancer;

5. HIV/AIDS; and

6. organ transplants.

(iii) An enrollee shall be allowed to continue to receive services for the conditions under this paragraph for the time periods under subsection (c)(2)(ii) of this section.

(3) (i) This paragraph does not apply to compensation rates or methods of payment established under § 14–205.2 of this article or § 19–710.1 of the Health – General Article.

(ii) Subject to paragraphs (4) and (5) of this subsection, the receiving carrier or managed care organization, with respect to the provision of the covered services, shall pay the nonparticipating provider the rate and method of payment the receiving carrier or managed care organization normally would pay and use for participating providers who provide similar services in the same or similar geographic area.

(iii) The nonparticipating provider may decline to accept the rate or method of payment under subparagraph (ii) of this paragraph by giving 10 days' prior notice to the enrollee and receiving carrier.

(iv) Subject to paragraphs (4) and (5) of this subsection, if the nonparticipating provider does not accept the rate or method of payment under subparagraph (ii) of this paragraph, the nonparticipating provider and the receiving carrier or managed care organization may reach agreement on an alternative rate or method of payment for the provision of covered services.

(4) The rates and methods of payment under paragraph (3)(ii) and (iv) of this subsection shall:

(i) be subject to any State or federal requirements applicable to reimbursement for health care provider services, including:

1. § 1302(g) of the Affordable Care Act, which applies to reimbursement rates for Federally Qualified Health Centers; and

2. Title 19, Subtitle 2 of the Health – General Article, under which the Health Services Cost Review Commission establishes provider rates; and

(ii) ensure that:

1. an enrollee is not subject to balance billing; and

2. the copayments, deductibles, and any coinsurance required of an enrollee for the services rendered in accordance with this section are the same as those that would be required if the enrollee were receiving the services from a participating provider of the receiving carrier or managed care organization.

(5) If the nonparticipating provider does not accept the rate and method of compensation under paragraph (3)(ii) of this subsection, and the carrier or managed care organization does not reach an agreement with the nonparticipating provider for an alternative rate and method of payment under paragraph (3)(iv) of this subsection:

(i) the nonparticipating provider is not required to continue to provide the services;

(ii) § 14–205.3 of this article, under which an enrollee may assign benefits to a nonpreferred provider and the provider may balance bill the enrollee, shall apply to the extent it would apply absent this section; and

(iii) unless the enrollee has assigned benefits to a nonpreferred provider under § 14–205.3 of this article, the carrier or managed care organization shall facilitate transition of the enrollee to a provider on the provider panel of the carrier or managed care organization.

(e) (1) This section does not:

(i) require a carrier or managed care organization to cover services or provide benefits that are not otherwise covered under the terms and conditions of a health benefit plan, the Maryland Medical Assistance Program, or the Maryland Children's Health Program; or

(ii) preclude a carrier or managed care organization from providing continuity of care beyond the requirements of this section within the parameters of the approved rates of the carrier or managed care organization.

(2) (i) To ensure continuity of treatment in progress for dental services provided to an enrollee, a relinquishing carrier may elect to allow an enrollee to continue to receive dental services being provided by a participating provider of the relinquishing carrier through an arrangement in which the relinquishing carrier pays the participating provider according to the rate and method of payment the relinquishing carrier normally would pay and use for the participating provider.

(ii) The rate and method of payment under subparagraph (i) of this paragraph shall comply with:

1. the prohibition on balance billing under subsection (d)(4)(ii) of this section; and

2. any copayments, deductibles, and coinsurance requirements in the enrollee's health benefit plan under the relinquishing carrier.

(f) (1) A receiving carrier or managed care organization shall provide notice to a new enrollee of the enrollee's options and responsibilities under this section in a manner prescribed by the Commissioner.

(2) The requirements of this section are:

(i) in addition to any other legal, professional, or ethical obligations of a carrier or managed care organization to provide continuity of care; and

(ii) not intended to limit or make more restrictive any other continuity of care requirements in State or federal law, regulations, or professional codes of conduct.

(g) The Commissioner and the Secretary of Health each may adopt regulations to enforce the requirements of this section.

(h) (1) The Commissioner, the Maryland Health Benefit Exchange, and the Secretary of Health shall collaborate to determine the data, to the extent its collection is feasible and permitted by law, that is necessary to:

(i) assess the implementation and efficacy of the requirements of this section; and

(ii) develop a process to evaluate and monitor continuity of care, with particular focus on newly eligible populations, any disparate or discriminatory impact on specific populations, and trends in health disparities.

(2) On request of the Commissioner, the Maryland Health Benefit Exchange, or the Secretary of Health carriers, managed care organizations, and health care providers shall provide the requisite data.

§15–141.

(a) (1) In this section the following words have the meanings indicated.

(2) "Carrier" means:

(i) an insurer;

(ii) a nonprofit health service plan;

(iii) a health maintenance organization;

(iv) a dental plan organization; or

(v) any other person that provides health benefit plans subject to regulation by the State.

(3) "Enrollee" means a person entitled to health care benefits from a carrier.

(b) The Commissioner shall develop and make available a standardized form for an enrollee to use to request confidential communications from a carrier in accordance with 45 C.F.R. § 164.522(b).

(c) A carrier that requires an enrollee to make a request for confidential communications in writing in accordance with 45 C.F.R. § 164.522(b) shall accept the standardized form developed by the Commissioner under this section for that purpose.

(d) This section may not be construed to limit acceptance by a carrier of any other form of written request from an enrollee for confidential communications from a carrier under 45 C.F.R. § 164.522(b).

§15–142.

(a) (1) In this section the following words have the meanings indicated.

(2) "Step therapy drug" means a prescription drug or sequence of prescription drugs required to be used under a step therapy or fail–first protocol.

(3) "Step therapy exception request" means a request to override a step therapy or fail–first protocol.

(4) (i) "Step therapy or fail–first protocol" means a protocol established by an insurer, a nonprofit health service plan, or a health maintenance organization that requires a prescription drug or sequence of prescription drugs to be used by an insured or an enrollee before a prescription drug ordered by a prescriber for the insured or the enrollee is covered.

(ii) "Step therapy or fail–first protocol" includes a protocol that meets the definition under subparagraph (i) of this paragraph regardless of the name, label, or terminology used by the insurer, nonprofit health service plan, or health maintenance organization to identify the protocol.

(5) "Supporting medical information" means:

(i) a paid claim from an entity subject to this section for an insured or an enrollee;

(ii) a pharmacy record that documents that a prescription has been filled and delivered to an insured or an enrollee, or a representative of an insured or an enrollee; or

(iii) other information mutually agreed on by an entity subject to this section and the prescriber of an insured or an enrollee.

(b) (1) This section applies to:

(i) insurers and nonprofit health service plans that provide hospital, medical, or surgical benefits to individuals or groups on an expense–incurred basis under health insurance policies or contracts that are issued or delivered in the State; and

(ii) health maintenance organizations that provide hospital, medical, or surgical benefits to individuals or groups under contracts that are issued or delivered in the State.

(2) An insurer, a nonprofit health service plan, or a health maintenance organization that provides coverage for prescription drugs through a pharmacy benefits manager is subject to the requirements of this section.

(c) An entity subject to this section may not impose a step therapy or fail–first protocol on an insured or an enrollee if:

(1) the step therapy drug has not been approved by the U.S. Food and Drug Administration for the medical condition being treated; or

(2) a prescriber provides supporting medical information to the entity that a prescription drug covered by the entity:

(i) was ordered by a prescriber for the insured or enrollee within the past 180 days; and

(ii) based on the professional judgment of the prescriber, was effective in treating the insured's or enrollee's disease or medical condition.

(d) Subsection (c) of this section may not be construed to require coverage for a prescription drug that is not:

(1) covered by the policy or contract of an entity subject to this section; or

(2) otherwise required by law to be covered.

(e) An entity subject to this section may not impose a step therapy or fail–first protocol on an insured or an enrollee for a prescription drug approved by the U.S. Food and Drug Administration if:

(1) (i) the prescription drug is used to treat the insured's or enrollee's stage four advanced metastatic cancer; and

(ii) use of the prescription drug is:

1. consistent with the U.S. Food and Drug Administration–approved indication or the National Comprehensive Cancer Network Drugs & Biologics Compendium indication for the treatment of stage four advanced metastatic cancer; and

2. supported by peer–reviewed medical literature;

(2) the prescription drug is insulin or an insulin analog used to treat the insured's or enrollee's type 1, type 2, or gestational diabetes; or

(3) (i) the prescription drug is prescribed by a treating physician to treat a symptom of or a side effect from treatment of the insured's or enrollee's stage four advanced metastatic cancer;

(ii) use of the prescription drug is:

1. consistent with best practices for the treatment of stage four advanced metastatic cancer, a condition associated with stage four advanced metastatic cancer, or a side effect associated with stage four advanced metastatic cancer treatment; and

2. supported by peer–reviewed medical literature; and

(iii) the prescription drug is covered under the terms of the policy or contract of the insured or enrollee.

(f) (1) An entity subject to this section shall establish a process for requesting an exception to a step therapy or fail–first protocol that is:

(i) clearly described, including the specific information and documentation, if needed, that must be submitted by the prescriber to be considered a complete step therapy exception request;

(ii) easily accessible to the prescriber; and

(iii) posted on the entity's website.

(2) A step therapy exception request shall be granted if, based on the professional judgment of the prescriber and any information and documentation required under paragraph (1)(i) of this subsection:

(i) the step therapy drug is contraindicated or will likely cause an adverse reaction to the insured or enrollee;

(ii) the step therapy drug is expected to be ineffective based on the known clinical characteristics of the insured or enrollee and the known characteristics of the prescription drug regimen;

(iii) the insured or enrollee is stable on a prescription drug prescribed for the medical condition under consideration while covered under the policy or contract of the entity or under a previous source of coverage; or

(iv) while covered under the policy or contract of the entity or a previous source of coverage, the insured or enrollee has tried a prescription drug that:

1. is in the same pharmacologic class or has the same mechanism of action as the step therapy drug; and

2. was discontinued by the prescriber due to lack of efficacy or effectiveness, diminished effect, or an adverse event.

(3) On granting a step therapy exception request, an entity subject to this section shall authorize coverage for the prescription drug ordered by the prescriber for an insured or enrollee.

(4) An enrollee or insured may appeal a step therapy exception request denial in accordance with Subtitle 10A or Subtitle 10B of this title.

(5) This subsection may not be construed to:

(i) prevent:

1. an entity subject to this section from requiring an insured or enrollee to try an AB–rated generic equivalent or interchangeable biological product before providing coverage for the equivalent branded prescription drug; or

2. a health care provider from prescribing a prescription drug that is determined to be medically appropriate; or

(ii) require an entity subject to this section to provide coverage for a prescription drug that is not covered by a policy or contract of the entity.

(6) An entity subject to this section may use an existing step therapy exception process that satisfies the requirements under this subsection.

§15–143.

(a) In this section, "participation agreement" means a contract that:

(1) is executed by a payor or program administrator and other participating entities; and

(2) describes the requirements for participation in a payment model subject to this section.

(b) This section applies only to a payment model described in § 1–302(d)(12) of the Health Occupations Article:

(1) that applies to individuals covered under health insurance; and

(2) under which there is cash compensation.

(c) (1) Except as provided in paragraph (2) of this subsection, at least 60 days before an exemption provided under § 1–302(d)(12) of the Health Occupations Article for a payment model subject to this section is implemented, the participation agreement and other documents relevant to the payment model under which a compensation arrangement between a health care practitioner and a health care entity is funded or paid shall be filed with the Commissioner.

(2) The filing under paragraph (1) of this subsection is not required if the compensation arrangement is funded fully by or paid fully under the Medicare or Medicaid program.

(d) Within 60 days after the documents required under subsection (c)(1) of this section are filed, the Commissioner shall determine if any compensation arrangement between a health care practitioner and a health care entity funded by or paid under the payment model:

(1) is insurance business; and

(2) violates this article or a regulation adopted under this article.

(e) (1) If the Commissioner determines that a compensation arrangement is insurance business and violates this article or a regulation adopted under this article, the Commissioner shall issue an order to the filer that specifies the ways in which the compensation arrangement violates this article or a regulation adopted under this article.

(2) (i) The Commissioner shall hold a hearing before issuing an order under paragraph (1) of this subsection.

(ii) The Commissioner shall give written notice of the hearing to the filer at least 10 days before the hearing.

(iii) The notice shall specify the matters to be considered at the hearing.

(3) If the compensation arrangement between a health care practitioner and a health care entity changes during its term:

(i) the filer shall submit a revised filing to the Commissioner for review of the changes; and

(ii) the Commissioner shall make a new determination, as provided under subsection (d) of this section.

(f) A filing under subsection (c) of this section is subject to the fee required under § 2–112(a)(13) of this article.

§15–144.

(a) (1) In this section the following words have the meanings indicated.

(2) "Carrier" means:

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

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

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

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

(3) "Core treatment" means a standard treatment or course of treatment, therapy, service, or intervention indicated by generally recognized independent standards of current medical practice.

(4) "Health benefit plan" means:

(i) for a large group or blanket plan, a health benefit plan as defined in § 15–1401 of this title;

(ii) for a small group plan, a health benefit plan as defined in § 15–1201 of this title;

(iii) for an individual plan:

1. a health benefit plan as defined in § 15–1301(l) of this title; or

2. an individual health benefit plan as defined in § 15–1301(o) of this title;

(iv) short–term limited duration insurance as defined in § 15–1301(s) of this title; or

(v) a student health plan as defined in § 15–1318(a) of this title.

(5) "Medical/surgical benefits" has the meaning stated in 45 C.F.R. § 146.136(a) and 29 C.F.R. § 2590.712(a).

(6) (i) "Mental health benefits" means benefits with respect to items or services for mental health conditions that are defined under the terms of a health benefit plan and in accordance with applicable federal and State law, including requirements that:

1. any condition defined under the terms of the health benefit plan as being or as not being a mental health condition be defined consistent with generally recognized independent standards of current medical practice and include all conditions, except for substance use disorders, covered under the health benefit plan that:

A. fall under any of the diagnostic categories listed in the mental, behavioral, and neurodevelopmental disorders chapter, or equivalent chapter, of the most recent version of the World Health Organization's International

Classification of Diseases adopted by the federal Department of Health and Human Services; or

B. are listed in the most recent version of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders; and

2. to the extent generally recognized independent standards of current medical practice do not address whether a condition is a mental health condition, the condition be defined in accordance with applicable federal and State law.

(ii) "Mental health benefits" does not include medical/surgical benefits or substance use disorder benefits.

(7) "Nonquantitative treatment limitation" means treatment limitations as defined in 45 C.F.R. § 146.136(a) and 29 C.F.R. § 2590.712(a).

(8) (i) "Parity Act" means the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, as amended.

(ii) "Parity Act" includes 45 C.F.R. § 146.136, 29 C.F.R. § 2590.712, and any other related federal regulations found in the Code of Federal Regulations to implement or enforce the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008.

(9) "Parity Act classification" means:

(i) inpatient in–network benefits;

(ii) inpatient out–of–network benefits;

(iii) outpatient in–network benefits;

(iv) outpatient out–of–network benefits;

(v) prescription drug benefits; and

(vi) emergency care benefits.

(10) "Product" has the meaning stated in § 15–1309(a)(3) of this title.

(11) (i) "Substance use disorder benefits" means benefits with respect to items or services for substance use disorders that are defined under the

terms of a health benefit plan and in accordance with applicable federal and State law, including requirements that:

1. any disorder defined under the terms of the health benefit plan as being or as not being a substance use disorder be defined consistent with generally recognized independent standards of current medical practice and include all disorders covered under the health benefit plan that:

A. fall under any of the diagnostic categories listed as a mental or behavioral disorder due to psychoactive substance use, or equivalent category, in the mental, behavioral, and neurodevelopmental disorders chapter, or equivalent chapter, of the most recent version of the World Health Organization's International Classification of Diseases adopted by the federal Department of Health and Human Services; or

B. are listed as a substance–related and addictive disorder, or equivalent category, in the most recent version of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders; and

2. to the extent generally recognized independent standards of current medical practice do not address whether a disorder is a substance use disorder, the disorder shall be defined under the terms of the health benefit plan in accordance with applicable federal and State law.

(ii) "Substance use disorder benefits" does not include medical/surgical benefits or mental health benefits.

(b) This section applies to a carrier that delivers or issues for delivery a health benefit plan in the State.

(c) (1) Each carrier subject to this section shall:

(i) for each Parity Act classification, identify all nonquantitative treatment limitations that are applied to mental health benefits, substance use disorder benefits, and medical/surgical benefits;

(ii) in accordance with the Parity Act and any State regulations adopted under subsection (o) of this section, perform and document comparative analyses of the design and application of all nonquantitative treatment limitations imposed on mental health benefits and substance use disorder benefits;

(iii) 1. collect and evaluate relevant data in a manner reasonably designed to assess the impact of each nonquantitative treatment

limitation on relevant outcomes related to access to mental health and substance use disorder benefits and medical/surgical benefits; and

2. with respect to nonquantitative treatment limitations related to network composition, collect and evaluate relevant data in a manner reasonably designed to assess the aggregate impact of all the nonquantitative treatment limitations on access to mental health and substance use disorder benefits and medical/surgical benefits;

(iv) provide the comparative analysis, including the evaluation of relevant data, for each nonquantitative treatment limitation requested by the Commissioner within:

1. 15 working days after a written request; or

2. if adopted by the federal government, less than 15 working days to align with the federal rule or regulation;

(v) within 30 days after a written request, provide the comparative analysis for each nonquantitative treatment limitation and related in operation data analysis, if available and requested by a member in accordance with the Parity Act disclosure requirements or, for members with individual plans, in accordance with subsection (e)(8) of this section; and

(vi) submit the reports required under paragraph (2) of this subsection.

(2) On or before July 1, 2024, and every 2 years thereafter, each carrier subject to this section shall submit a report to the Commissioner on each product offered by the carrier in the individual, small, and large group markets to demonstrate the carrier's compliance with the Parity Act.

(3) The report submitted under paragraph (2) of this subsection shall include the following information:

(i) all nonquantitative treatment limitation information required under the Parity Act, subsection (d) of this section, and any State regulations for the products identified under paragraph (2) of this subsection;

(ii) the results of a comparative analysis, including the evaluation of relevant data, conducted by the carrier on not fewer than five nonquantitative treatment limitations selected by the Commissioner in accordance with paragraph (5) of this subsection; and

(iii) subject to paragraph (4) of this subsection, a statement, signed by a corporate officer, attesting that, for each product identified under paragraph (2) of this subsection, the selected nonquantitative treatment limitations and the processes, strategies, evidentiary standards, or other factors used in designing and applying the selected nonquantitative treatment limitations to mental health benefits, substance use disorder benefits, and medical/surgical benefits are the same for all plans within the product, as written and in operation.

(4) If, for any plan within a product identified under paragraph (2) of this subsection, the processes, strategies, evidentiary standards, or other factors used in designing and applying the selected nonquantitative treatment limitations to mental health benefits, substance use disorder benefits, or medical/surgical benefits are different, as written or in operation, from the other plans within the product:

(i) the statement required under paragraph (3)(iii) of this subsection shall note the exception and identify the plan; and

(ii) the carrier shall submit a separate comparative analysis for the selected nonquantitative treatment limitations for the plan.

(5) (i) In selecting the nonquantitative treatment limitations required to be included for each reporting period, the Commissioner:

1. shall prioritize the nonquantitative treatment limitations identified by the Commissioner as having the greatest impact on member access to care;

2. shall review the same subset of nonquantitative treatment limitations for each carrier report; and

3. may take into consideration other factors determined relevant by the Commissioner, including complaint trends, federal Parity Act guidance, and whether the nonquantitative treatment limitation was selected for a previous reporting year.

(ii) Of the five selected nonquantitative treatment limitations:

1. not more than two may be for utilization review; and

2. at least one must be for network composition, including reimbursement rate setting.

(6) A finding of noncompliance for a product shall apply to all plans within the product.

(7) If the relevant data evaluated under paragraph (1)(iii) of this subsection indicate that the nonquantitative treatment limitation contributes to material differences in access to mental health and substance use disorder benefits as compared to medical/surgical benefits in a Parity Act classification:

(i) the differences shall be considered a strong indicator of noncompliance with the Parity Act and may subject the carrier to the provisions of subsection (k) of this section; and

(ii) the carrier shall submit to the Commissioner documentation of reasonable actions that have been or are being taken to address the material differences to ensure compliance, in operation, with the Parity Act within 15 working days of a request from the Commissioner for the documentation in accordance with this section.

(d) (1) A carrier subject to this section shall conduct a comparative analysis for the nonquantitative treatment limitations selected under subsection (c)(5) of this section as nonquantitative treatment limitations are:

(i) written; and

(ii) in operation.

(2) The comparative analysis of the nonquantitative treatment limitations selected under subsection (c)(5) of this section shall:

(i) demonstrate that the processes, strategies, evidentiary standards, or other factors used in designing and applying each selected nonquantitative treatment limitation to mental health benefits and substance use disorder benefits in each Parity Act classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in designing and applying each selected nonquantitative treatment limitation to medical/surgical benefits within the same Parity Act classification;

(ii) demonstrate that none of the information, evidence, sources, or standards on which a factor or evidentiary standard is based are biased or not objective in a manner that discriminates against mental health or substance use disorder benefits as compared to medical/surgical benefits;

(iii) in accordance with the provisions of paragraph (3) of this subsection, demonstrate that the health benefit plan provides meaningful benefits for each covered mental health condition and substance use disorder in every Parity Act classification in which medical/surgical benefits are provided; and

(iv) include all information required under the Parity Act and any State regulations adopted under subsection (o) of this section.

(3) (i) The benefits provided for the mental health condition or substance use disorder shall be compared to the benefits provided for medical conditions and surgical procedures in each Parity Act classification to determine whether benefits are meaningful.

(ii) Except as provided under subparagraph (iii) of this paragraph, benefits are not meaningful unless coverage is provided for a core treatment for the mental health condition or substance use disorder in each classification in which coverage is provided for a core treatment for one or more medical conditions or surgical procedures.

(iii) If there is no core treatment for a covered mental health condition or substance use disorder with respect to a Parity Act classification, the health benefit plan:

1. is not required to provide benefits for a core treatment for the covered mental health condition or substance use disorder in that Parity Act classification; and

2. is required to provide benefits for the covered mental health condition or substance use disorder in every Parity Act classification in which medical/surgical benefits are provided.

(4) Regardless of whether it was used before the Parity Act was enacted and as requested by the Commissioner, a carrier shall perform and provide a comparative analysis for each process, strategy, evidentiary standard, or other factor used in designing and applying a selected nonquantitative treatment limitation used during a reporting period.

(e) In providing the analysis required under subsection (d) of this section, a carrier shall:

(1) identify the factors used to determine that a nonquantitative treatment limitation will apply to a benefit, including:

(i) the sources for the factors; and

(ii) if a factor was given more weight than another, the reason for the difference in weighting;

(2) identify and define the specific evidentiary standards used to define the factors and any other evidence relied on in designing each nonquantitative treatment limitation;

(3) include the results of the audits, reviews, and analyses performed on the nonquantitative treatment limitations identified under subsection (c)(5) of this section to conduct the analysis required under subsection (d)(2) of this section for the plans and products as written;

(4) include the relevant data evaluated under subsection (c)(1)(iii) of this section and the results of the audits, reviews, and analyses performed on the nonquantitative treatment limitations identified under subsection (c)(5) of this section to conduct the analysis required under subsection (d)(2) of this section for the plans and products as in operation;

(5) if the relevant data evaluated under subsection (c)(1)(iii) of this section indicate that the nonquantitative treatment limitation contributes to material differences in access to mental health and substance use disorder benefits as compared to medical/surgical benefits in a Parity Act classification, include an explanation of the differences and a discussion of the actions that have been or are being taken by the carrier to address the differences;

(6) identify the measures used to ensure comparable design and application of nonquantitative treatment limitations that are implemented by the carrier and any entity delegated by the carrier to manage mental health benefits, substance use disorder benefits, or medical/surgical benefits on behalf of the carrier;

(7) disclose the specific findings and conclusions reached by the carrier that indicate that the health benefit plan is in compliance with this section and the Parity Act; and

(8) identify the process used to comply with the Parity Act disclosure requirements for mental health benefits, substance use disorder benefits, and medical/surgical benefits, including:

(i) the criteria for a medical necessity determination;

(ii) reasons for a denial of benefits; and

(iii) in connection with a member's request for individual or group plan information and for purposes of filing an internal coverage or grievance matter and appeals, plan documents that contain information about processes, strategies, evidentiary standards, and any other factors used to apply a nonquantitative treatment limitation.

(f) The Commissioner shall:

(1) develop additional standardized data templates:

(i) to evaluate the comparative analysis of nonquantitative treatment limitations in operation; and

(ii) that meet or exceed any minimum requirements for data reporting specified in federal regulations;

(2) require each carrier subject to this section to submit:

(i) for each product identified under subsection (c)(2) of this section, the data templates described in item (1) of this subsection for the nonquantitative treatment limitations selected by the Commissioner for the reporting year in accordance with subsection (c)(5) of this section; and

(ii) a separate data template for any plans described in subsection (c)(4) of this section; and

(3) post the data templates on the Administration's website for a comment period of not less than 30 days before adoption.

(g) The reports required under this section shall:

(1) be submitted on a standard form developed by the Commissioner that meets or exceeds any minimum requirements specified in the federal regulations and sub–regulatory guidance on nonquantitative treatment limitations reporting;

(2) be submitted by the carrier that issues or delivers the product;

(3) be prepared in coordination with any entity the carrier contracts with to provide mental health benefits and substance use disorder benefits;

(4) contain a statement, signed by a corporate officer, attesting to the accuracy of the information contained in the report;

(5) be available to plan members and the public on the carrier's website in a summary form that removes confidential or proprietary information and is developed by the Commissioner in accordance with subsection (n)(2) of this section; and

(6) exclude any identifying information of any plan member.

(h) (1) A carrier submitting a report under this section may submit a written request to the Commissioner that disclosure of specific information included in the report be denied under the Public Information Act and, if submitting a request, shall:

(i) identify the particular information the disclosure of which the carrier requests be denied; and

(ii) cite the statutory authority under the Public Information Act that authorizes denial of access to the information.

(2) The Commissioner may review a request submitted under paragraph (1) of this subsection on receipt of a request for access to the information under the Public Information Act.

(3) The Commissioner may notify the carrier that submitted the request under paragraph (1) of this subsection before granting access to information that was the subject of the request.

(4) A carrier shall disclose to a member on request any plan information contained in a report that is required to be disclosed to that member under federal or State law.

(i) (1) The Commissioner shall:

(i) review each report submitted in accordance with subsections (c), (d), and (f) of this section to assess each carrier's compliance with the Parity Act and any State regulations adopted under subsection (o) of this section for each Parity Act classification;

(ii) notify a carrier in writing of any noncompliance with the Parity Act or any State regulations adopted under subsection (o) of this section before issuing an administrative order; and

(iii) within 90 days after the notice of noncompliance is issued, allow the carrier to:

1. submit a compliance plan to the Administration to comply with the Parity Act and any State regulations adopted under subsection (o) of this section; and

2. reprocess any claims that were improperly denied, in whole or in part, because of the noncompliance.

(2) The Commissioner may require carriers to complete data templates for a nonquantitative treatment limitation more frequently than every 2 years.

(j) (1) If the Commissioner finds that the carrier failed to submit a complete report required under this section, the Commissioner may:

(i) take action authorized under paragraph (2) of this subsection;

(ii) in accordance with § 2–208 of this article, charge the carrier for any additional expenses incurred by the Commissioner to review additional reports;

(iii) impose a penalty for each day that the carrier fails to submit information required by the Commissioner to evaluate compliance; or

(iv) impose any penalty or take any action as authorized:

1. for an insurer, nonprofit health service plan, or any other person subject to this section, under this article; or

2. for a health maintenance organization, under this article or the Health – General Article.

(2) If the Commissioner cannot make a determination that a specific conduct or practice is compliant with the Parity Act because the carrier failed to provide a sufficient comparative analysis for a nonquantitative treatment limitation, the Commissioner may:

(i) issue an administrative order requiring the carrier or an entity delegated by the carrier to take the following action until the Commissioner can make a determination of compliance with the Parity Act:

1. modify the conduct or practice as specified by the Commissioner;

2. cease the conduct or practice; or

3. submit periodic data related to the conduct or practice; or

(ii) subject to paragraph (3) of this subsection, require the carrier to perform a new comparative analysis.

(3) The Commissioner may require the carrier to establish specific quantitative thresholds for evidentiary standards and conduct a new comparative analysis for a nonquantitative treatment limitation if the Commissioner determines a carrier failed to provide a sufficient comparative analysis because the carrier did not:

(i) use applicable quantitative thresholds for the evidentiary standard; or

(ii) provide a specific, detailed, and reasoned explanation of how the carrier ensures that the factors for the nonquantitative treatment limitation are being applied comparably and no more stringently to mental health and substance use disorder services.

(4) Subsection (i)(1)(iii) of this section does not apply to the failure of a carrier to submit a complete report.

(k) If, as a result of the review required under subsection (i)(1)(i) of this section, the Commissioner finds that the carrier failed to comply with the Parity Act or any State regulations adopted under subsection (o) of this section, and did not submit a compliance plan to adequately correct the noncompliance, the Commissioner may:

(1) issue an administrative order that requires:

(i) the carrier or an entity delegated by the carrier to cease the noncompliant conduct or practice; or

(ii) the carrier to provide a payment that has been denied improperly because of the noncompliance; or

(2) impose any other penalty or take any action as authorized:

(i) for an insurer, nonprofit health service plan, or any other person subject to this section, under this article; or

(ii) for a health maintenance organization, under this article or the Health – General Article.

(l) (1) A carrier shall have the burden of persuasion in demonstrating that its design and application of a nonquantitative treatment limitation complies

with the Parity Act and any State regulations adopted under subsection (o) of this section:

(i) in any review conducted by the Commissioner under this section; or

(ii) in any complaint investigation or market conduct action undertaken by the Commissioner that involves the application of the Parity Act.

(2) (i) A failure of a carrier to submit complete Parity Act compliance information required under this section or in connection with an investigation or examination by the Commissioner shall constitute noncompliance with the Parity Act.

(ii) Subsection (i)(1)(iii) of this section does not apply to a carrier that fails to submit complete Parity Act compliance information.

(m) In determining an appropriate penalty under subsection (j) or (k) of this section, the Commissioner shall consider the late filing of a report required under subsection (c) or (f) of this section and any parity violation to be a serious violation with a significantly deleterious effect on the public.

(n) The Commissioner shall create:

(1) a standard form for entities to submit the reports in accordance with subsection (g)(1) of this section; and

(2) a summary form for entities to post to their websites in accordance with subsection (g)(5) of this section.

(o) The Commissioner shall, in consultation with interested stakeholders, adopt regulations to implement this section, including to ensure uniform definitions and methodology for the reporting requirements established under this section.

§15–145.

(a) (1) In this section the following words having the meanings indicated.

(2) "Health savings account" has the meaning stated in § 223 of the Internal Revenue Code.

(3) "High deductible health plan" has the meaning stated in § 223 of the Internal Revenue Code.

(b) A health savings account is established on the first day that an individual becomes covered by a high deductible health plan.

(c) The health savings account shall be opened with a trustee or custodian within the time period prescribed by law, without extensions, for filing a federal income tax return for the year in which the health savings account is established.

(d) A health savings account is established regardless of a transfer of cash or other property to the account and, unless required by the trustee or custodian, it is not necessary for any party to sign a health savings account trust or custodial agreement regarding the health savings account.

§15–146.

(a) (1) In this section the following words have the meanings indicated.

(2) "Blanket health insurance" means the form of health insurance described in § 15–305 of this title.

(3) "Health benefit plan" means:

(i) an individual health benefit plan as defined in § 15–1301(o) of this title;

(ii) a health benefit plan as defined in § 15–1201 of this title; or

(iii) a health benefit plan as defined in § 15–1401 of this title.

(4) "Short–term limited duration insurance" has the meaning stated in § 15–1301(s) of this title.

(b) The provisions of the federal No Surprises Act and Division BB, Title II, § 201 of the federal Consolidated Appropriations Act, 2021, apply to all insurers, nonprofit health service plans, and health maintenance organizations that deliver or issue for delivery in the State policies or contracts for a health benefit plan or blanket health insurance.

(c) The provisions of Division BB, Title II, §§ 202 and 203 of the federal Consolidated Appropriations Act, 2021, apply to all insurers, nonprofit health service plans, and health maintenance organizations that deliver or issue for delivery in the State policies or contracts for a health benefit plan, blanket health insurance, or short–term limited duration insurance.

(d) The Commissioner may enforce this section under any applicable provisions of this article.

§15–148.

(a) This section applies to:

(1) insurers and nonprofit health service plans that provide hospital, medical, or surgical benefits to individuals or groups on an expense–incurred basis under health insurance policies or contracts that are issued or delivered in the State; and

(2) health maintenance organizations that provide hospital, medical, or surgical benefits to individuals or groups under contracts that are issued or delivered in the State.

(b) The Administration shall order the transfer of funds from each entity maintaining a segregated account in accordance with § 1303(b)(2)(B) and (C) of the federal Patient Protection and Affordable Care Act to the Dedicated Purpose Account for the purposes of health care access grants as follows:

(1) on or before July 1, 2026, 90% of the amount of the ending balance of the segregated account that exceeds disbursements for each of the plan years 2014 through 2024; and

(2) on or before July 1, 2027, and each July 1 thereafter, 90% of the amount of the ending balance of a segregated account that exceeds disbursements after the 15–month period following the end of a plan year.

§15–1A–01.

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

(b) "Carrier" means:

(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.

(c) "Child" means:

(1) a natural child, a stepchild, a foster child, or an adopted child of the insured; or

(2) a child placed with the insured for legal adoption.

(d) "Essential health benefit" means a health benefit that:

(1) meets the criteria established under § 1302(b) of the Affordable Care Act; or

(2) if the Commissioner adopts regulations as described in § 15–1A–04 of this subtitle, meets the criteria established by the adopted regulations.

(e) "Grandfathered plan" means a health benefit plan that:

(1) meets the criteria established under 45 C.F.R. § 147.140 and any corresponding federal rules and guidance as those provisions were in effect December 31, 2024; or

(2) if the Commissioner adopts regulations as described in § 15–1A–03 of this subtitle, meets the criteria established by the adopted regulations.

(f) "Group plan" means a small group plan or a large group plan.

(g) "Health benefit plan" means an individual plan, a small group plan, or a large group plan.

(h) "Individual plan" means an individual health benefit plan as defined in § 15–1301(o) of this title.

(i) "Insured individual" means:

(1) an insured, an enrollee, a subscriber, a participant, a member, or a beneficiary of a health benefit plan; or

(2) any covered dependent of a health benefit plan.

(j) "Large group plan" means a health benefit plan as defined in § 15–1401 of this title.

(k) "Small group plan" means a health benefit plan as defined in § 15–1201 of this title.

§15–1A–02.

(a) The Commissioner may enforce:

(1) the provisions of this subtitle; and

(2) notwithstanding any other provisions of law, the following provisions of Title 1, Subtitles A, C, and D of the Affordable Care Act as they apply to individual health insurance coverage and health insurance coverage offered in the small group and large group markets as those terms are defined in the federal Public Health Service Act, issued or delivered in the State by an authorized insurer, nonprofit health service plan, or health maintenance organization:

(i) coverage of children up to the age of 26 years;

(ii) preexisting condition exclusions;

(iii) policy rescissions;

(iv) bona fide wellness programs;

(v) lifetime limits;

(vi) annual limits for essential benefits;

(vii) waiting periods;

(viii) designation of primary care providers;

(ix) access to obstetrical and gynecological services;

(x) emergency services;

(xi) summary of benefits and coverage explanation;

(xii) minimum loss ratio requirements and premium rebates;

(xiii) disclosure of information;

(xiv) annual limitations on cost–sharing;

(xv) child–only plan offerings in the individual market;

(xvi) minimum benefit requirements for catastrophic plans;

(xvii) health insurance premium rates;

(xviii) coverage for individuals participating in approved clinical trials;

(xix) contract requirements for stand–alone dental plans sold on the Maryland Health Benefit Exchange;

(xx) guaranteed availability of coverage;

(xxi) prescription drug benefit requirements; and

(xxii) preventive and wellness services and chronic disease management.

(b) The Commissioner may enforce the provisions identified under subsection (a) of this section under any applicable powers granted to the Commissioner under this article.

§15–1A–03.

(a) For purposes of this subtitle, to the extent necessary, the Commissioner shall adopt regulations that:

(1) establish criteria that a health benefit plan must meet to be considered a grandfathered plan; and

(2) are consistent with 45 C.F.R. § 147.140 and any corresponding federal rules and guidance as those provisions were in effect December 31, 2024.

(b) Except as otherwise provided in this subtitle and subject to subsection (c) of this section, this subtitle applies to any health benefit plan that is offered by a carrier in the State within the scope of:

(1) Subtitle 12 of this title;

(2) Subtitle 13 of this title; or

(3) Subtitle 14 of this title.

(c) (1) Except as provided in paragraph (2) of this subsection, the provisions of this subtitle do not apply to a grandfathered plan.

(2) (i) The following provisions apply to all grandfathered plans:

1. the provisions of § 15–1A–08 of this subtitle related to health benefit plans that provide dependent coverage of a child;

2. the provisions of § 15–1A–11 of this subtitle related to the prohibition on establishing lifetime limits on the dollar value of benefits;

3. the provisions of § 15–1A–12 of this subtitle related to waiting periods;

4. the provisions of § 15–1A–13 of this subtitle related to choice of provider;

5. the provisions of § 15–1A–14 of this subtitle related to coverage of emergency services;

6. the provisions of § 15–1A–15 of this subtitle related to summary of benefits and coverage requirements;

7. the provisions of § 15–1A–16 of this subtitle related to medical loss ratio and corresponding reporting and rebate requirements; and

8. the provisions of § 15–1A–21 of this subtitle related to rescission of a health benefit plan.

(ii) The following provisions apply to all grandfathered plans except grandfathered plans that are individual plans:

1. the provisions of § 15–1A–05 of this subtitle related to preexisting condition exclusions; and

2. the provisions of § 15–1A–11 of this subtitle related to the prohibition on establishing annual limits on the dollar value of benefits.

§15–1A–04.

For purposes of this subtitle, to the extent necessary, the Commissioner shall adopt regulations that:

(1) establish criteria that a health benefit plan must meet to be considered a health benefit plan that covers essential health benefits; and

(2) are consistent with 45 C.F.R. Part 156 Subpart B and any corresponding federal rules and guidance as those provisions were in effect December 31, 2024.

§15–1A–05.

(a) This section applies to all grandfathered plans except grandfathered plans that are individual plans and to every health benefit plan that is not a grandfathered plan.

(b) A carrier may not:

(1) exclude or limit benefits because a health condition was present before the effective date of coverage; or

(2) deny coverage because a health condition was present before or on the date of denial.

(c) The prohibition in subsection (b) of this section applies whether or not:

(1) any medical advice, diagnosis, care, or treatment was recommended or received for the condition; or

(2) the health condition was identified as a result of:

(i) a pre–enrollment questionnaire or physical examination given to an individual; or

(ii) a review of records relating to the pre–enrollment period.

§15–1A–06.

(a) A carrier may not establish rules for eligibility, including continued eligibility, for enrollment of an individual into a health benefit plan based on health status–related factors, including:

(1) health condition;

(2) claims experience;

(3) receipt of health care;

(4) medical history;

(5) genetic information;

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

(7) disability.

(b) A carrier may not require an individual, as a condition of enrollment or continued enrollment in a health benefit plan, to pay a premium or contribution that is greater than the premium or contribution for a similarly situated individual enrolled in the health benefit plan on the basis of any health status–related factor in relation to the individual or to an individual enrolled under the health benefit plan as a dependent of the individual.

§15–1A–07.

(a) (1) This section may not be construed to limit the authority of the Commissioner to conduct a health benefit plan premium rate review under Title 11, Subtitle 6 of this article.

(2) This section applies only to a carrier offering an individual plan and, subject to § 15–1205 of this title, a carrier offering a small group plan.

(b) A carrier may determine a premium rate based on:

(1) subject to subsection (c) of this section, age;

(2) geography based on the following contiguous areas of the State:

(i) the Baltimore metropolitan area;

(ii) the District of Columbia metropolitan area;

(iii) Western Maryland; and

(iv) Eastern Maryland and Southern Maryland;

(3) subject to subsection (d) of this section, whether the plan covers an individual or a family; and

(4) subject to subsection (e) of this section, tobacco use.

(c) (1) In this subsection, "age" means an individual's age as of the date of issuance or renewal of a health benefit plan.

(2) For individuals who are 21 years of age or older, a premium rate based on age:

(i) may not vary by more than a ratio of 3 to 1 for adults;

(ii) shall provide for 1–year age bands for individuals at least 21 years old and under the age of 64 years; and

(iii) shall provide for a single age band for individuals at least 64 years old.

(3) For individuals who are under the age of 21 years, a premium rate based on age shall:

(i) be actuarially justified and consistent with the uniform age rating curve established in accordance with paragraph (4) of this subsection;

(ii) provide for a single age band for individuals under the age of 15 years; and

(iii) provide for 1–year age bands for individuals at least 15 years old and under the age of 20 years.

(4) The uniform age rating curve required under paragraph (3)(i) of this subsection may be established by the Commissioner in the individual market, small group market, or both markets.

(d) (1) A rating variation for a health benefit plan that provides coverage for a family shall be applied based on the portion of the premium attributable to each family member covered.

(2) (i) Subject to subparagraph (ii) of this paragraph, a premium for a health benefit plan that provides coverage for a family shall be determined by summing the premiums for each individual family member.

(ii) For a health benefit plan that provides family coverage for individuals under the age of 21 years, the sum shall include not more than the premiums for the three oldest individuals under the age of 21 years.

(e) A premium rate based on tobacco use may not vary by more than a ratio of 1.5 to 1.

§15–1A–08.

(a) A carrier that offers a health benefit plan, including a grandfathered plan, that provides for dependent coverage of a child shall continue to make the coverage available for the child until the child is 26 years old.

(b) A carrier may not establish rules for eligibility, including continued eligibility, for coverage of a child under the age of 26 years based on any factor other than the relationship between the child and the insured.

§15–1A–09.

(a) Except as provided in subsections (b) through (d) of this section, a carrier shall accept every employer and individual in the State that applies for a health benefit plan, subject to the following provisions of this article:

(1) Subtitle 4 of this title;

(2) §§ 15–1206(c), 15–1208.1, 15–1208.2, 15–1209, and 15–1210 of this title;

(3) §§ 15–1316 and 15–1318 of this title; and

(4) §§ 15–1406 and 15–1406.1 of this title.

(b) (1) Except as provided in paragraph (2) of this subsection, a carrier may restrict enrollment to open or special enrollment periods.

(2) A carrier that offers a large group plan shall allow an employer eligible to purchase a large group plan to purchase a large group plan at any time during the year.

(c) If a carrier uses a network for a health benefit plan under which the financing and delivery of medical care are provided, in whole or in part, through a defined set of providers under contract with the carrier, the carrier:

(1) (i) may limit the employers that may apply for coverage to employers of eligible individuals who live, work, or reside in the service area for the network; and

(ii) if the carrier is a health maintenance organization, may limit the individuals who may apply for coverage in the individual market to those who live or reside in the service area for the network; or

(2) may deny coverage within a service area if the carrier:

(i) demonstrates to the Commissioner that:

1. the carrier does not have the capacity to deliver adequate services to additional enrollees of groups or additional individuals because of its obligations to existing group contract holders and enrollees; and

2. the carrier applies the denial of coverage uniformly to all employers and individuals without regard to the claims experience or any health status–related factor; and

(ii) does not offer coverage within the service area for at least 180 days after the date the carrier denied coverage in the service area.

(d) A carrier may deny coverage if the carrier:

(1) demonstrates to the Commissioner that:

(i) the carrier does not have the financial reserves necessary to underwrite additional coverage; and

(ii) the carrier applies the denial of coverage uniformly to all employers and individuals without regard to the claims experience or any health status–related factor; and

(2) unless a later date is otherwise authorized by the Commissioner, does not offer the denied coverage for at least 180 days after the date the carrier denied the coverage.

§15–1A–10.

(a) Subject to subsection (e) of this section and except as provided in subsections (b), (c), and (d) of this section, a carrier shall provide coverage for and may not impose any cost–sharing requirements, including copayments, coinsurance, or deductibles for:

(1) evidence–based items or services that have in effect a rating of A or B in the recommendations of the United States Preventive Services Task Force with respect to the individual involved;

(2) immunizations for routine use in children, adolescents, and adults 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, if the recommendation:

(i) has been adopted by the Director of the Centers for Disease Control and Prevention; or

(ii) is listed on the Immunization Schedules of the Centers for Disease Control and Prevention for routine use;

(3) with respect to infants, children, and adolescents, evidence–informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration; and

(4) with respect to women:

(i) to the extent not provided in item (ii) of this item, preventive care and screenings as provided for in comprehensive guidelines supported by the Health Resources and Services Administration for purposes of § 2713(a)(4) of the federal Public Health Service Act; and

(ii) subject to § 15–826(c) of this title, contraceptive coverage as provided for in comprehensive guidelines supported by the Health Resources and Services Administration for purposes of § 2713(a)(4) of the federal Public Health Service Act.

(b) To the extent that cost–sharing is otherwise allowed under federal or State law, a health benefit plan that uses a network of providers may impose cost–sharing requirements on the coverage described in subsection (a) of this section for items or services delivered by an out–of–network provider.

(c) (1) In this subsection, "high deductible health plan" has the meaning stated in 26 U.S.C. § 223(c)(2).

(2) If an insured or enrollee is covered under a high deductible health plan, a carrier may apply the deductible requirement of the high deductible health plan to the coverage required under subsection (a) of this section, unless the

Commissioner determines that the coverage is included in the safe harbor provisions for preventive care under 26 U.S.C. § 223(c)(2)(c).

(d) This section may not be construed to prohibit a carrier from providing coverage for services in addition to those recommended by the United States Preventive Services Task Force or to deny coverage for services that are not recommended by the Task Force.

(e) Subject to § 15–826(c) of this title, the Commissioner shall enforce this section consistent with the recommendations and guidelines in effect on December 31, 2024, set by the United States Preventive Services Task Force, the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention, or the Health Resources and Services Administration, and related federal rules or guidance, as updated by recommendations issued by the Secretary of Health in accordance with § 18–112 of the Health – General Article.

(f) A carrier shall provide the coverage described in subsection (a) of this section for plan years that begin on or after the date that is 1 year after the date the recommendations described in subsection (e) of this section are issued.

§15–1A–11.

(a) Except as provided in subsections (b) and (c) of this section, a carrier that offers a health benefit plan, including a grandfathered plan, may not establish lifetime limits or annual limits on the dollar value of benefits for any insured individual.

(b) To the extent that limits are otherwise authorized under federal or State law, a carrier may establish annual limits on the dollar value of benefits for an insured individual for a grandfathered plan that is an individual plan.

(c) This section may not be construed to prohibit a carrier from placing annual or lifetime per beneficiary limits on specific covered benefits that are not essential health benefits.

§15–1A–12.

A carrier offering a group plan, including a grandfathered plan, may not apply a waiting period of more than 90 days that must pass before coverage becomes effective for an individual who is otherwise eligible for the group plan.

§15–1A–13.

(a) If a carrier requires or provides for the designation of a participating primary care provider for an insured individual, the carrier shall allow each insured individual to designate any participating primary care provider if the provider is available to accept the insured individual.

(b) (1) (i) This subsection applies only to an individual who has a child who is an insured individual under the individual's health benefit plan.

(ii) This subsection may not be construed to waive any exclusions of coverage under the terms and conditions of a health benefit plan with respect to coverage of pediatric care.

(2) If a carrier requires or provides for the designation of a participating primary care provider for a child, the carrier shall allow the individual to designate any participating physician who specializes in pediatrics as the child's primary care provider if the provider is available to accept the child.

(c) (1) (i) This subsection applies only to a carrier that:

1. provides coverage for obstetrical or gynecological care; and

2. requires the designation by an insured individual of a participating primary care provider.

(ii) This subsection may not be construed to:

1. waive any exclusions of coverage under the terms and conditions of a health benefit plan with respect to coverage of obstetrical or gynecological care; or

2. prohibit a carrier from requiring that the obstetrical or gynecological provider notify the primary care provider or carrier for an insured individual of treatment decisions.

(2) A carrier shall treat the provision of obstetrical and gynecological care and the ordering of related obstetrical and gynecological items and services by a participating health care provider that specializes in obstetrics or gynecology as care authorized by the primary care provider for the insured individual.

(3) A carrier may not require authorization or referral by any person, including the primary care provider for the insured individual, for an insured individual who seeks coverage for obstetrical or gynecological care provided by a participating health care provider who specializes in obstetrics or gynecology.

(4) A health care provider that provides obstetrical or gynecological care shall comply with a carrier's policies and procedures.

§15–1A–14.

(a) (1) In this section the following words have the meanings indicated.

(2) "Emergency medical condition" means a medical condition, including a mental health condition or substance use disorder, that manifests itself by acute symptoms of such severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a prudent layperson, who possesses an average knowledge of health and medicine, to result in a condition described in § 1867(e)(1) of the Social Security Act.

(3) (i) "Emergency services" means, with respect to an emergency medical condition:

1. a medical screening examination that is within the capability of the emergency department of a hospital or freestanding medical facility, including ancillary services routinely available to the emergency department to evaluate an emergency medical condition;

2. any other examination or treatment within the capabilities of the staff and facilities available at the hospital or freestanding medical facility that is necessary to stabilize the patient, regardless of the department of the hospital in which the examination or treatment is furnished; or

3. except as provided in subparagraph (iii) of this paragraph, additional covered items and services furnished by a health care provider of emergency services that does not have a contractual relationship with the carrier after the patient is stabilized and as part of outpatient observation or an inpatient or outpatient stay with respect to the visit in which the services described in items 1 and 2 of this subparagraph are furnished.

(ii) "Emergency services" includes services described in subparagraph (i) of this paragraph that are provided in specialized facilities that are staffed by behavioral health providers trained to provide crisis services.

(iii) Subject to § 14–205.2 of this article and § 19–710(p) of the Health – General Article, "emergency services" does not include items and services described in subparagraph (i)3 of this paragraph if all of the conditions in 45 C.F.R. § 149.410(b) are met.

(b) If a carrier provides or covers any benefits for emergency services in an emergency department of a hospital or freestanding medical facility, the carrier:

(1) may not require prior authorization for the emergency services;

(2) shall provide coverage for the emergency services regardless of whether the health care provider providing the emergency services has a contractual relationship with the carrier to furnish emergency services;

(3) may not limit what constitutes an emergency medical condition solely on the basis of diagnosis codes; and

(4) may not impose any other term or condition on the coverage for emergency services, except for:

(i) the exclusion or coordination of benefits;

(ii) a waiting period; and

(iii) applicable cost–sharing.

(c) If a health care provider of emergency services does not have a contractual relationship with the carrier to provide emergency services, the carrier:

(1) may not impose any administrative requirement or limitation on coverage that would be more restrictive than administrative requirements or limitations imposed on coverage for emergency services furnished by a health care provider with a contractual relationship with the carrier;

(2) subject to § 14–205.2 of this article and § 19–710.1 of the Health – General Article, may not impose any cost–sharing amount greater than the amount imposed for emergency services furnished by a health care provider with a contractual relationship with the carrier;

(3) shall calculate and apply the cost–sharing amounts in accordance with the requirements of 45 C.F.R. § 149.110(b)(3)(iii) and (v); and

(4) except as provided in § 14–205.2 of this article and § 19–710.1 of the Health – General Article, shall reimburse the health care provider in accordance with the requirements of 45 C.F.R. § 149.110(b)(3)(iv).

§15–1A–15.

(a) This section applies to all grandfathered plans and to every health benefit plan that is not a grandfathered plan.

(b) (1) A carrier shall compile and provide to consumers a summary of benefits and coverage explanation that:

(i) accurately describes the benefits and coverage under the applicable health benefit plan; and

(ii) except as provided in paragraph (2) of this subsection, complies with the standards under 45 C.F.R. § 147.200.

(2) If the Commissioner adopts regulations as described in subsection (c) of this section, a summary of benefits and coverage explanation shall comply with the standards in the adopted regulations.

(c) To the extent necessary, the Commissioner, in consultation with the Maryland Health Benefit Exchange, shall adopt regulations that:

(1) establish standards for the summary of benefits and coverage; and

(2) are consistent with 45 C.F.R. § 147.200 and any corresponding federal rules and guidance in effect December 31, 2024.

(d) The summary of benefits and coverage shall be presented:

(1) in a uniform format that does not exceed four pages in length and does not include print smaller than 12 point type; and

(2) in a culturally and linguistically appropriate manner that uses terminology understandable by the average insured individual.

(e) The standards developed under subsection (c) of this section shall include:

(1) uniform definitions of standard insurance–related terms and medical terms so consumers may compare health benefit plans and understand the terms of and exceptions to coverage, including:

(i) premium;

(ii) deductible;

(iii) coinsurance;

(iv) copayment;

(v) out–of–pocket limit;

(vi) preferred provider;

(vii) nonpreferred provider;

(viii) out–of–network copayments;

(ix) usual, customary, and reasonable fees;

(x) excluded services;

(xi) grievance and appeals;

(xii) hospitalization;

(xiii) hospital outpatient care;

(xiv) emergency room care;

(xv) physician services;

(xvi) prescription drug coverage;

(xvii) durable medical equipment;

(xviii) home health care;

(xix) skilled nursing care;

(xx) rehabilitation services;

(xxi) hospice services;

(xxii) emergency medical transportation; and

(xxiii) any other terms the Commissioner determines are important to define so a consumer may compare the medical benefits offered by health benefit plans and understand the extent of and exceptions to those medical benefits;

(2) a description of the coverage of a health benefit plan, including cost–sharing for:

(i) each of the categories of the essential health benefits in the State benchmark plan selected in accordance with § 31–116 of this article; and

(ii) other benefits, as identified by the Commissioner;

(3) the exceptions, reductions, and limitations on coverage;

(4) the renewability and continuation of coverage provisions;

(5) a coverage facts label that includes examples to illustrate common benefits scenarios based on recognized clinical practice guidelines, including pregnancy and serious or chronic medical conditions and related cost–sharing requirements;

(6) a statement of whether the health benefit plan ensures that the plan or coverage share of the total allowed costs of benefits provided under the plan or coverage is not less than 60% of the costs;

(7) a statement that:

(i) the summary of benefits is an outline of the health benefit plan; and

(ii) the language of the health benefit plan should be consulted to determine the governing contractual provisions; and

(8) a contact number for the consumer to call with additional questions and a website where a copy of the actual health benefit plan can be reviewed and obtained.

(f) As appropriate, the Commissioner, in consultation with the Maryland Health Benefit Exchange, shall periodically review and update the standards developed under subsection (c) of this section.

(g) (1) Each carrier shall provide a summary of benefits and coverage explanation that complies with the standards developed under subsection (c) of this section by the Commissioner to:

(i) an applicant at the time of application; and

(ii) an insured individual before the time of enrollment or reenrollment, as applicable.

(2) A carrier may provide a summary of benefits and coverage explanation as required under paragraph (1) of this subsection in paper or electronic form.

(h) Except as otherwise provided in this article, if a carrier makes any material modification in any of the terms of the plan or coverage involved that is not reflected in the most recently provided summary of benefits and coverage explanation, the carrier shall provide notice of the modification to insured individuals not later than 60 days before the effective date of the modification.

(i) (1) The Maryland Insurance Administration shall levy a fine of not more than $1,000 against a carrier that willfully fails to provide the information required under this section.

(2) A failure with respect to each insured individual shall constitute a separate offense for purposes of this subsection.

§15–1A–16.

(a) (1) For purposes of this section, "medical loss ratio":

(i) has the meaning established in 45 C.F.R. § 158.221; or

(ii) if the Commissioner adopts regulations as described in paragraph (2) of this subsection, has the meaning established by the adopted regulations.

(2) To the extent necessary, the Commissioner shall adopt regulations that:

(i) establish a definition for "medical loss ratio"; and

(ii) are consistent with 45 C.F.R. § 158.221 and any corresponding federal rules and guidance as those provisions were in effect December 31, 2024.

(b) This section applies to all grandfathered plans and to every health benefit plan that is not a grandfathered plan.

(c) The minimum acceptable medical loss ratio is:

(1) for the large group market, 85% or a higher percentage as determined by the Commissioner in regulations; and

(2) for the small group market and individual market, 80% or a higher percentage as determined by the Commissioner in regulations.

(d) (1) Except as provided in paragraph (2) of this subsection, each carrier shall comply with the requirements for calculating medical loss ratios and related reporting and rebate requirements established in 45 C.F.R. Part 158 and any corresponding federal rules and guidance.

(2) If the Commissioner adopts regulations as described in subsection (e) of this section, each carrier shall comply with the requirements in the adopted regulations.

(e) To the extent necessary, the Commissioner shall adopt regulations that:

(1) establish requirements for calculating medical loss ratios and related reporting and rebate requirements; and

(2) are consistent with 45 C.F.R. Part 158 and any corresponding federal rules and guidance as those provisions were in effect December 31, 2024.

§15–1A–17.

(a) (1) This section may not be construed to require a carrier to disclose information that is proprietary and trade secret information under applicable law.

(2) This section applies only to carriers offering an individual plan or a small group plan.

(b) A carrier shall disclose to an individual or employer, as applicable, the following information:

(1) the carrier's right to change premium rates and the factors that may affect changes in premium rates; and

(2) the benefits and premiums available under all health benefit plans for which the employer or individual is qualified.

(c) The carrier shall make the disclosure required under subsection (b) of this section:

(1) as part of its solicitation and sales material; or

(2) if the information is requested by the individual or employer.

(d) Information disclosed in accordance with subsection (b) of this section shall be:

(1) provided in a manner determined to be understandable by the average employer or individual; and

(2) sufficient to reasonably inform the employer or individual of the employer's or individual's rights and obligations under the health benefit plan.

§15–1A–18.

(a) A carrier may offer a catastrophic plan in the individual market in accordance with the requirements of this section.

(b) A catastrophic plan may be offered only to individuals who:

(1) are under the age of 30 years before the beginning of the plan year; or

(2) hold certification for a hardship exemption or an affordability exemption as required in subsection (c) of this section.

(c) (1) Except as provided in paragraph (2) of this subsection, to be offered a catastrophic plan, an individual shall hold certification for a hardship exemption or an affordability exemption under 42 U.S.C. § 5000A.

(2) If the Maryland Health Benefit Exchange adopts regulations as described under subsection (d) of this section, an individual shall hold certification for a hardship exemption or an affordability exemption under the regulations adopted by the Exchange.

(d) To the extent necessary, the Maryland Health Benefit Exchange shall adopt regulations that:

(1) establish a process for issuing hardship exemptions and affordability exemptions; and

(2) are consistent with 42 U.S.C. § 5000A and any corresponding federal rules and guidance as those provisions were in effect December 31, 2024.

(e) (1) Subject to paragraph (2) of this subsection, a catastrophic plan shall provide coverage for essential health benefits.

(2) A catastrophic plan shall require a deductible that:

(i) is equal to the annual limit on cost–sharing described in § 15–1A–19 of this subtitle;

(ii) applies to essential health benefits;

(iii) does not apply to at least three primary care visits each plan year; and

(iv) does not apply to any covered benefits for which a deductible is prohibited under this title.

§15–1A–19.

(a) (1) In this section, "cost–sharing" means any expenditure required by or on behalf of an insured individual with respect to essential health benefits.

(2) "Cost–sharing" includes:

(i) deductibles, coinsurance, copayments, or similar charges; and

(ii) any other expenditure required of an insured individual that is a qualified medical expense, as defined in 26 U.S.C. § 223(d)(2), with respect to essential health benefits covered under the plan.

(3) "Cost–sharing" does not include premiums, balance billing amounts for nonnetwork providers, or spending for noncovered services.

(b) (1) Except as provided in paragraph (2) of this subsection, each carrier shall comply with annual limitations on cost–sharing for essential health benefits covered under health benefit plans as established by 45 C.F.R. § 156.130.

(2) If the Commissioner adopts regulations as described in subsection (c) of this section, each carrier shall comply with the adopted regulations.

(c) To the extent necessary, the Commissioner shall adopt regulations that:

(1) establish annual limitations on cost–sharing; and

(2) are consistent with 45 C.F.R. § 156.130 and any corresponding federal rules and guidance as those provisions were in effect December 31, 2024.

§15–1A–20.

(a) (1) This section applies only to individual plans and small group plans.

(2) The requirements in this section are in addition to and not in substitution of any other requirements of law related to prescription drug benefits.

(b) (1) Except as provided in paragraph (2) of this subsection, an individual plan or a small group plan shall be considered to provide prescription drug essential health benefits only if the individual plan or small group plan complies with 45 C.F.R. § 156.122.

(2) If the Commissioner adopts regulations as described in subsection (c) of this section, an individual plan or a small group plan shall be considered to provide prescription drug essential health benefits only if the individual plan or small group plan complies with the regulations adopted by the Commissioner.

(c) To the extent necessary, the Commissioner shall adopt regulations that:

(1) establish criteria to determine whether an individual plan or a small group plan provides prescription drug essential health benefit coverage; and

(2) are consistent with 45 C.F.R. § 156.122 and any corresponding federal rules and guidance as those provisions were in effect December 31, 2024.

§15–1A–21.

(a) This section applies to all grandfathered plans and to every health benefit plan that is not a grandfathered plan.

(b) (1) Subject to § 15–1106 of this title, a carrier may not rescind the coverage under a health benefit plan unless:

(i) the insured individual performs an act, a practice, or an omission that constitutes fraud or makes a misrepresentation of material fact as prohibited by the health benefit plan; and

(ii) except as provided in paragraph (2) of this subsection, the carrier complies with 45 C.F.R. § 147.128.

(2) If the Commissioner adopts regulations as described in subsection (c) of this section, a carrier that rescinds the coverage under a health benefit plan in accordance with subsection (b) of this section shall comply with the adopted regulations.

(c) To the extent necessary, the Commissioner shall adopt regulations that:

(1) establish requirements that a carrier shall comply with to rescind coverage under subsection (b) of this section; and

(2) are consistent with 45 C.F.R. § 147.128 and any federal rules and guidance as those provisions were in effect December 31, 2024.

§15–1A–22.

(a) (1) In this section the following words have the meanings indicated.

(2) "Gender identity" has the meaning stated in § 20–101 of the State Government Article.

(3) "Sexual orientation" has the meaning stated in § 20–101 of the State Government Article.

(b) This section does not prohibit a carrier from refusing, withholding, or denying coverage under a health benefit plan to any individual for failure to conform to the usual and regular requirements, standards, and regulations of the carrier, unless the denial is based on discrimination on the grounds of race, sex, color, creed, national origin, marital status, sexual orientation, age, gender identity, or disability.

(c) This section does not apply to limitations or restrictions related to age or marital status that are specifically authorized or required under this article to limit or restrict eligibility for insurance coverage or benefits.

(d) A carrier may not refuse, withhold, or deny any individual coverage under a health benefit plan offered by the carrier or otherwise discriminate against any individual because of the individual's race, sex, creed, color, national origin, marital status, sexual orientation, age, gender identity, or disability.

(e) The Commissioner and the Commission on Civil Rights shall enforce the provisions of this section as provided for in § 2–202 of this article.

(f) The Commissioner may adopt regulations necessary to carry out this section consistent with federal statutes, rules, and guidance in effect on December 31, 2024.

§15–201.

(a) A policy of health insurance may not be delivered or issued for delivery in the State unless the policy complies with the provisions of this section and other sections of this article.

(b) Each policy of health insurance shall state explicitly:

(1) any consideration, including the entire amount of money, given for the policy; and

(2) the time when the health insurance takes effect and terminates.

(c) (1) Except as provided in paragraph (2) of this subsection, each policy of health insurance shall purport to insure only one individual.

(2) On application by an adult member of a family, a policy of health insurance may insure, originally or by subsequent amendment:

(i) the applicant, who is deemed the policyholder; and

(ii) two or more eligible members of the policyholder's family, including a spouse, dependent child, any other child under a specified age not exceeding 18 years, and any other individual dependent on the policyholder or any other individual related to and resident in the household of the policyholder.

(d) (1) In this subsection, "text" includes all printed matter of a policy except the name and address of the insurer, name or title of the policy, any brief description, captions, and subcaptions.

(2) The style, arrangement, and overall appearance of a policy may not give undue prominence to any part of the text.

(3) Each printed part of the text and of any endorsements or attached papers shall be printed plainly in lightfaced type:

(i) of a style in general use; and

(ii) in a size that is uniform and not less than 10 point with a lower case unspaced alphabet length not less than 120 point.

(e) (1) The exceptions and reductions of indemnity shall be set forth in the policy.

(2) Other than those contained in §§ 15-207 through 15-226 of this subtitle, and except as provided in paragraph (3) of this subsection, the exceptions and reductions shall be printed at the insurer's option:

(i) with the benefit provisions to which they apply; or

(ii) under an appropriate caption such as "Exceptions" or "Exceptions and Reductions".

(3) If an exception or reduction specifically applies only to a particular benefit of the policy, a statement of the exception or reduction shall be included with the benefit provision to which it applies.

(f) Each form of a policy, including riders and endorsements, shall be identified by a form number in the lower left-hand corner of the first page.

(g) (1) Except as provided in paragraph (2) of this subsection, a policy may not contain a provision that purports to incorporate in the policy a part of the charter, rules, constitution, or bylaws of the insurer unless the part is set forth in full in the policy.

(2) A statement of rates, classification of risks, or short-rate table that is filed with the Commissioner may be referred to or incorporated in the policy without being set forth in full.

(h) (1) Subject to paragraph (2) of this subsection, a notice shall be prominently printed on or attached to the face of the policy that states that:

(i) the policy may be surrendered to the insurer for cancellation within 10 days after the date the policy is delivered to the insured; and

(ii) if a policy is canceled during the 10-day period, a pro rata premium for the unexpired term of the policy shall be returned to the insured.

(2) The insured shall notify the insurer of the cancellation in writing.

(3) The insurer may print or attach the notice required under paragraph (1) of this subsection or a notice of equal prominence that, in the opinion of the Commissioner, is not less favorable to the policyholder.

(i) A policy that is subject to renewal at the option of the insurer shall contain a notice of this provision prominently printed on the first page of the policy.

§15–202.

(a) Except as otherwise provided in this section, each policy of health insurance that is delivered or issued for delivery in the State:

(1) shall contain the exact language of each provision that is required under §§ 15-207 through 15-218 of this subtitle and any optional provision in §§ 15-207 through 15-226 of this subtitle that is used; and

(2) shall contain each mandatory provision and any optional provision that is used:

(i) in the order in which those provisions appear in this subtitle; or

(ii) as individual items in any part of the policy with other provisions to which they may be logically related, if the resulting policy is not wholly or partly unintelligible, uncertain, or likely to mislead a person to whom the policy is offered, delivered, or issued.

(b) The insurer may substitute a corresponding provision with different wording for a provision set forth in this subtitle if the corresponding provision is approved by the Commissioner and is not less favorable in any respect to the insured or beneficiary.

(c) If a provision specified in §§ 15-207 through 15-218 of this subtitle is wholly or partly inapplicable to or inconsistent with the coverage provided by a particular form of policy, the insurer, with the approval of the Commissioner, shall:

(1) omit from the policy the inapplicable provision or part of the provision; or

(2) modify the inconsistent provision or part of the provision to make it consistent with the coverage provided by the policy.

(d) Each provision shall be preceded individually by the applicable caption shown or, at the option of the insurer, by an appropriate individual or group caption or subcaption that the Commissioner approves.

§15–203.

Other than a policy of accident only insurance, each policy of health insurance in which the insurer reserves the right to refuse renewal on an individual basis shall contain a provision, endorsement, or rider that provides in substance:

(1) that, subject to the right to terminate the policy on nonpayment of premium when due, the right to refuse renewal may not be exercised so as to take effect before the renewal date occurring on, or after and nearest, each anniversary of the policy;

(2) that a refusal to renew shall be without prejudice to any claim that originates while the policy is in effect;

(3) that a renewal may not be refused solely because of a change in the health or physical or mental condition of the insured; and

(4) unless omitted at the insurer's option, that the right to refuse renewal of a policy of health insurance that was reinstated after lapse may not be exercised so as to take effect before the renewal date occurring on, or after and nearest, each anniversary of the last reinstatement.

§15–204.

(a) If a policy of health insurance establishes, as an age limit or otherwise, a date after which the coverage provided by the policy will not be effective, and the date falls within a period for which the insurer accepts a premium for the policy, or if the insurer accepts a premium for the policy after that date, the coverage provided by the policy continues in effect until the end of the period for which the insurer has accepted the premium.

(b) If the age of the insured is misstated and, according to the correct age of the insured, the coverage provided by the policy would not have become effective or would have ceased before the acceptance of a premium for the policy, the liability of the insurer is limited to the refund, on request, of the premiums paid for the period not covered by the policy.

§15–205.

(a) A policy of a foreign insurer or alien insurer that is delivered or issued for delivery in the State may contain a provision that:

(1) is not less favorable to the insured or beneficiary than the provisions of this subtitle; and

(2) is required by the law of the state or country under which the foreign insurer or alien insurer is organized.

(b) A policy of a domestic insurer that is issued for delivery in another state or country may contain a provision that is allowed or required by the laws of the other state or country.

§15–206.

(a) A policy provision that is not subject to this subtitle may not make the policy or any part of the policy less favorable in any respect to the insured or beneficiary than the provisions of the policy that are subject to this subtitle.

(b) A policy that is delivered or issued for delivery in the State in violation of this subtitle is valid but shall be construed as provided in this subtitle.

(c) Whenever a policy provision that is subject to this subtitle conflicts with a provision of this subtitle, the rights, duties, and obligations of the insurer, insured, and beneficiary shall be governed by this subtitle.

§15–207.

Each policy of health insurance shall contain the following provision:

"Entire contract; changes: This policy, including the endorsements and the attached papers, if any, constitutes the entire contract of insurance. No change in this policy shall be valid until approved by an executive officer of the insurer and unless such approval be endorsed hereon or attached hereto. No insurance producer has authority to change this policy or to waive any of its provisions."

§15–208.

(a) Except as provided in subsection (c) of this section, each policy of health insurance shall contain the following provision:

"Time limit on certain defenses: (1) After two years from the date of issue of this policy no misstatements, except fraudulent misstatements, made by the applicant in the application for such policy shall be used to void the policy or to deny a claim for loss incurred or disability (as defined in the policy) commencing after the expiration of such two-year period."

(2) "No claim for loss incurred or disability (as defined in the policy) commencing after two years from the date of issue of this policy shall be reduced or denied on the ground that a disease or physical condition not excluded from coverage by name or specific description effective on the date of loss had existed prior to the effective date of coverage of this policy."

(b) The first provision set forth in subsection (a) of this section does not:

(1) affect a legal requirement for avoidance of a policy or denial of a claim during the initial two-year period after the issuance of the policy; or

(2) limit the application of §§ 15-219 through 15-223 of this subtitle if there is a misstatement with respect to age, occupation, or other insurance.

(c) (1) This subsection applies only to a policy that the insured may continue in effect subject to its terms by the timely payment of premiums:

(i) until the insured is at least 50 years old; or

(ii) if the policy is issued after the insured is 44 years old, for at least 5 years after its date of issue.

(2) A policy subject to this subsection may omit the first provision set forth in subsection (a) of this section and substitute the following provision under the caption "incontestable":

"After this policy has been in force for a period of two years during the lifetime of the insured (excluding any period during which the insured is disabled), it shall become incontestable as to the statements contained in the application."

(3) In the provision set forth in paragraph (2) of this subsection, an insurer may omit the clause "excluding any period during which the insured is disabled".

§15–209.

(a) (1) Subject to subsection (b) of this section, each policy of health insurance shall contain the following provision:

"Grace period: A grace period of ..... (insert a number not less than '7' days for weekly premium policies, '10' days for monthly premium policies and '31' days for all other policies) days will be granted for the payment of each premium falling due after the first premium, during which grace period this policy shall continue in force."

(2) A policy shall provide a grace period of 31 days if the policy:

(i) allows the policyholder to choose any one of two or more modes of premium payment by remitting an amount stated in the policy for that particular mode of payment; and

(ii) does not require a formal request by the policyholder to change the mode of premium payment.

(b) A policy in which the insurer reserves the right to refuse renewal shall state the following provision at the beginning of the provision set forth in subsection (a)(1) of this section:

"Unless not less than thirty days prior to the premium due date the insurer has delivered to the insured or has mailed to his last address as shown by the records of the insurer written notice of its intention not to renew this policy beyond the period for which the premium has been accepted."

§15–210.

(a) Each policy of health insurance shall contain the following provision:

"Reinstatement: If any renewal premium be not paid within the time granted the insured for payment, a subsequent acceptance of premium by the insurer or by any insurance producer duly authorized by the insurer to accept such premium, without requiring in connection therewith an application for reinstatement, shall reinstate the policy; provided, however, that if the insurer or such insurance producer requires an application for reinstatement and issues a conditional receipt for the premium tendered, the policy will be reinstated upon approval of such application by the insurer or, lacking such approval, upon the forty-fifth (45th) day following the date of such conditional receipt unless the insurer has previously notified the insured in writing of its disapproval of such application. The reinstated policy shall cover only loss resulting from such accidental injury as may be sustained after the date of reinstatement and loss due to such sickness as may begin more than ten days after such date. In all other respects the insured and insurer shall have the same rights thereunder as they had under the policy immediately before the due date of the defaulted premium, subject to any provisions endorsed hereon or attached hereto in connection with the reinstatement. Any premium accepted in connection with a reinstatement shall be applied to a period for which premium has not been previously paid, but not to any period more than sixty (60) days prior to the date of reinstatement."

(b) The last sentence of the provision set forth in subsection (a) of this section may be omitted from a policy that the insured may continue in effect subject to its terms by the timely payment of premiums:

(1) until the insured is at least 50 years old; or

(2) if the policy is issued after the insured is 44 years old, for at least 5 years after its date of issue.

§15–211.

(a) Each policy of health insurance shall contain the following provision:

"Notice of claim: Written notice of claim must be given to the insurer within twenty (20) days after the occurrence or commencement of any loss covered by the policy, or as soon thereafter as is reasonably possible. Notice given by or on behalf of the insured or the beneficiary to the insurer at ..... (insert the location of such office as the insurer may designate for the purpose), or to any authorized insurance producer of the insurer, with information sufficient to identify the insured, shall be deemed notice to the insurer."

(b) In a policy that provides a loss-of-time benefit that may be payable for at least 2 years, an insurer may insert the following provision between the first and second sentences of the provision set forth in subsection (a) of this section:

"Subject to the qualifications set forth below, if the insured suffers loss of time on account of disability for which indemnity may be payable for at least two years, he shall, at least once in every six (6) months after having given notice of the claim, give to the insurer notice of continuance of the disability, except in the event of legal incapacity. The period of six (6) months following any filing of proof by the insured or any payment by the insurer on account of such claim or any denial of liability in whole or in part by the insurer shall be excluded in applying this provision. Delay in the giving of such notice shall not impair the insured's right to any indemnity which would otherwise have accrued during the period of six (6) months preceding the date on which such notice is actually given."

§15–212.

Each policy of health insurance shall contain the following provision:

"Claim forms: The insurer, upon receipt of a notice of claim, will furnish to the claimant such forms as are usually furnished by it for filing proofs of loss. If such forms are not furnished within fifteen days after the giving of such notice the claimant shall be deemed to have complied with the requirements of this policy as to proof of loss upon submitting, within the time fixed in the policy for filing proofs of loss, written proof covering the occurrence, the character and the extent of the loss for which claim is made."

§15–213.

Except as provided in § 12–102(c) of this article, each policy of health insurance shall contain the following provision:

"Proofs of loss: Written proof of loss must be furnished to the insurer at its said office in case of claim for loss for which this policy provides any periodic payment contingent upon continuing loss within ninety (90) days after the termination of the period for which the insurer is liable and in case of claim for any other loss within ninety (90) days after the date of such loss. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity, later than one (1) year from the time proof is otherwise required."

§15–214.

(a) Each policy of health insurance shall contain the following provision:

"Time of payment of claims: Indemnities payable under this policy for any loss other than loss for which this policy provides any periodic payment, will be paid immediately upon receipt of due written proof of such loss. Subject to due written proof of loss, all accrued indemnities for loss for which this policy provides periodic payment will be paid ..... (insert period for payment which must not be less frequently than monthly) and any balance remaining unpaid upon the termination of liability will be paid immediately upon receipt of due written proof."

(b) A policy is considered to provide for periodic payment for loss only if the policy contains a specific statement to that effect.

§15–215.

(a) Each policy of health insurance shall contain the following provision:

"Payment of claims: Indemnity for loss of life will be payable in accordance with the beneficiary designation and the provisions respecting such payment which may be prescribed herein and effective at the time of payment. If no such designation or provision is then effective, such indemnity shall be payable to the estate of the insured. Any other accrued indemnities unpaid at the insured's death may, at the option of the insurer, be paid either to such beneficiary or to such estate. All other indemnities will be payable to the insured."

(b) (1) At the option of the insurer, a policy may include either or both of the provisions set forth in paragraphs (2) and (3) of this subsection with the provision set forth in subsection (a) of this section.

(2) "If any indemnity of this policy shall be payable to the estate of the insured, or to an insured or beneficiary who is under eighteen years of age or

otherwise not competent to give a valid release, the insurer may pay such indemnity, up to an amount not exceeding $ ..... (insert an amount which shall not exceed $1,000), to any relative by blood or connection by marriage of the insured or beneficiary who is deemed by the insurer to be equitably entitled thereto. Any payment made by the insurer in good faith pursuant to this provision shall fully discharge the insurer to the extent of such payment."

(3) "Subject to any written direction of the insured in the application or otherwise all or a portion of any indemnities provided by this policy on account of hospital, nursing, medical or surgical services may, at the insurer's option and unless the insured requests otherwise in writing not later than the time of filing proof of such loss, be paid directly to the hospital or person rendering such services; but it is not required that the service be rendered by a particular hospital or person."

§15–216.

Each policy of health insurance shall contain the following provision:

"Physical examinations and autopsy: The insurer at its own expense shall have the right and opportunity to examine the person of the insured when and as often as it may reasonably require during the pendency of a claim hereunder and to make an autopsy in case of death where it is not forbidden by law."

§15–217.

Each policy of health insurance shall contain the following provision:

"Legal actions: No action at law or in equity shall be brought to recover on this policy prior to the expiration of sixty days after written proof of loss has been furnished in accordance with the requirements of this policy. No such action shall be brought after the expiration of three (3) years after the written proof of loss is required to be furnished."

§15–218.

(a) Subject to subsection (b) of this section, each policy of health insurance shall contain the following provision:

"Change of beneficiary: Unless the insured makes an irrevocable designation of beneficiary, the right to change a beneficiary is reserved to the insured and the consent of the beneficiary or beneficiaries shall not be requisite to surrender or assignment of this policy or to any change of beneficiary or beneficiaries, or to any other changes in this policy."

(b) An insurer may choose to omit from the provision set forth in subsection (a) of this section the clause:

"Unless the insured makes an irrevocable designation of beneficiary".

§15–219.

A policy of health insurance may contain the following provision:

"Change of occupation: If the insured be injured or contract sickness after having changed his occupation to one classified by the insurer as more hazardous than that stated in this policy or while doing for compensation anything pertaining to an occupation so classified, the insurer will pay only such portion of the indemnities provided in this policy as the premium paid would have purchased at the rates and within the limits fixed by the insurer for such more hazardous occupation. If the insured changes his occupation to one classified by the insurer as less hazardous than that stated in this policy, the insurer, upon receipt of proof of such change of occupation, will reduce the premium rate accordingly, and will return the excess pro rata unearned premium from the date of change of occupation or from the policy anniversary date immediately preceding receipt of such proof, whichever is the more recent. In applying this provision, the classification of occupational risk and the premium rates shall be such as have been last filed by the insurer prior to the occurrence or the loss for which the insurer is liable or prior to date of proof of change in occupation with the state official having supervision of insurance in the state where the insured resided at the time this policy was issued; but if such filing was not required, then the classification of occupational risk and the premium rates shall be those last made effective by the insurer in such state prior to the occurrence of the loss or prior to the date of proof of change in occupation."

§15–220.

A policy of health insurance may contain the following provision:

"Misstatement of age: If the age of the insured has been misstated, all amounts payable under this policy shall be such as the premium paid would have purchased at the correct age."

§15–221.

(a) A policy of health insurance may contain the following provision:

"Other insurance in this insurer: If an accident or sickness or accident and sickness policy or policies previously issued by the insurer to the insured be in force concurrently herewith, making the aggregate indemnity for ..... (insert type of

coverage or coverages) in excess of $ ..... (insert maximum limit of indemnity or indemnities) the excess insurance shall be void and all premiums paid for such excess shall be returned to the insured or to his estate."

(b) A policy of health insurance may substitute the following provision for the provision set forth in subsection (a) of this section:

"Insurance effective at any one time on the insured under a like policy or policies in this insurer is limited to the one such policy elected by the insured, his beneficiary or his estate, as the case may be, and the insurer will return all premiums paid for all other such policies."

§15–222.

(a) A policy of health insurance may contain the following provision:

"Insurance with other insurers: If there be other valid coverage, not with this insurer, providing benefits for the same loss on a provision of service basis or on an expense incurred basis and of which this insurer has not been given written notice prior to the occurrence or commencement of loss, the only liability under any expense incurred coverage of this policy shall be for such proportion of the loss as the amount which would otherwise have been payable hereunder plus the total of the like amounts under all such other valid coverages for the same loss of which this insurer had notice bears to the total like amounts under all valid coverages for such loss, and for the return of such portion of the premiums paid as shall exceed the pro rata portion for the amount so determined. For the purpose of applying this provision when other coverage is on a provision of service basis, the 'like amount' of such other coverage shall be taken as the amount which the services rendered would have cost in the absence of such coverage."

(b) The phrase "-- Expense incurred benefits" shall be added to the caption of the provision set forth in subsection (a) of this section if the provision is included in a policy that contains the policy provision set forth in § 15-223 of this subtitle.

(c) (1) A benefit provided for the insured under a compulsory benefit statute, including a workers' compensation or employer's liability statute, whether provided by a governmental unit or otherwise, shall be considered "other valid coverage" of which the insurer has had notice.

(2) The insurer may include in the provision set forth in subsection (a) of this section a definition of "other valid coverage" if the definition:

(i) is approved as to form by the Commissioner; and

(ii) is limited to:

1. coverage provided by organizations subject to regulation by insurance law or insurance authorities of this State, another state, or a province of Canada;

2. coverage provided by hospital or medical service organizations; and

3. any other coverage that the Commissioner may approve for inclusion.

(3) Unless defined otherwise, "other valid coverage" does not include:

(i) group insurance or automobile medical payments insurance;

(ii) coverage provided by hospital or medical service organizations; or

(iii) coverage provided by union welfare plans or by employer or employee benefit organizations.

(4) "Other valid coverage" may not include third party liability coverage.

§15–223.

(a) A policy of health insurance may contain the following provision:

"Insurance with other insurers: If there be other valid coverage, not with this insurer, providing benefits for the same loss on other than an expense incurred basis and of which this insurer has not been given written notice prior to the occurrence or commencement of loss, the only liability for such benefits under this policy shall be for such proportion of the indemnities otherwise provided hereunder for such loss as the like indemnities of which the insurer had notice (including the indemnities under this policy) bear to the total amount of all like indemnities for such loss, and for the return of such portion of the premium paid as shall exceed the pro rata portion for the indemnities thus determined."

(b) The phrase "-- Other benefits" shall be added to the caption of the provision set forth in subsection (a) of this section if the provision is included in a policy that contains the policy provision set out in § 15-222 of this subtitle.

(c) (1) A benefit provided for the insured under a compulsory benefit statute, including a workers' compensation or employer's liability statute, whether provided by a governmental unit or otherwise, shall be considered "other valid coverage" of which the insurer has had notice.

(2) The insurer may include in the provision set forth in subsection (a) of this section a definition of "other valid coverage" if the definition:

(i) is approved as to form by the Commissioner; and

(ii) is limited to:

1. coverage provided by organizations subject to regulation by insurance law or insurance authorities of this State, another state, or a province of Canada; and

2. any other coverage the Commissioner may approve for inclusion.

(3) Unless defined otherwise, "other valid coverage" does not include:

(i) group insurance; or

(ii) coverage provided by union welfare plans or by employer or employee benefit organizations.

(4) "Other valid coverage" may not include third party liability coverage.

§15–224.

(a) A policy of health insurance may contain the following provision:

"Relation of earnings to insurance: If the total monthly amount of loss-of-time benefits promised for the same loss under all valid loss-of-time coverage upon the insured, whether payable on a weekly or monthly basis, shall exceed the monthly earnings of the insured at the time disability commenced or his average monthly earnings for the period of two years immediately preceding a disability for which claim is made, whichever is the greater, the insurer will be liable only for such proportionate amount of such benefits under this policy as the amount of such monthly earnings or such average monthly earnings of the insured bears to the total amount of monthly benefits for the same loss under all such coverage upon the insured at the time such disability commences and for the return of such part of the premiums paid during such two years as shall exceed the pro rata amount of the

premiums for the benefits actually paid hereunder; but this shall not operate to reduce the total monthly amount of benefits payable under all such coverage upon the insured below the sum of $200 or the sum of the monthly benefits specified in such coverages, whichever is the lesser, nor shall it operate to reduce benefits other than those payable for loss of time."

(b) The policy provision set forth in subsection (a) of this section may be inserted only in a policy that the insured may continue in effect subject to its terms by the timely payment of premiums:

(1) until the insured is at least 50 years old; or

(2) if the policy is issued after the insured is 44 years old, for at least 5 years after its date of issue.

(c) (1) The insurer may include in the provision set forth in subsection (a) of this section a definition of "valid loss-of-time coverage" if the definition:

(i) is approved as to form by the Commissioner;

(ii) is limited to:

1. coverage provided by governmental units or organizations subject to regulation by insurance law or insurance authorities of this State, another state, or a province of Canada;

2. any other coverage that the Commissioner may approve for inclusion; or

3. a combination of these coverages.

(2) Unless defined otherwise, "valid loss-of-time coverage" does not include:

(i) coverage provided for the insured under a compulsory benefit statute, including a workers' compensation or employer's liability statute; or

(ii) coverage provided by union welfare plans or by employer or employee benefit organizations.

§15–225.

A policy of health insurance may contain the following provision:

"Unpaid premiums: Upon the payment of a claim under this policy, any premium then due and unpaid or covered by any note or written order may be deducted therefrom."

§15–226.

A policy of health insurance may contain the following provision:

"Conformity with state statutes: Any provision of this policy which, on its effective date is in conflict with the statutes of the state in which the insured resides on such date is hereby amended to conform to the minimum requirements of such statutes."

§15–301.

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

(b) "Blanket health insurance" means the form of health insurance described in § 15-305 of this subtitle.

(c) "Group health insurance" means the form of health insurance described in § 15-302 of this subtitle.

§15–302.

(a) Group health insurance is health insurance issued to persons specified in this section to cover the groups of individuals described in this section, with or without their dependents or family members, or to cover their dependents or family members.

(b) (1) (i) In this subsection, "employee" may include:

1. an officer or manager of the employer;

2. a sole proprietor if the employer is a sole proprietorship;

3. a partner if the employer is a partnership;

4. an officer, manager, or employee of a corporation that is an affiliate or subsidiary of the employer;

5. a sole proprietor, partner, or employee of a sole proprietorship or partnership if the businesses of the employer and sole

proprietorship or partnership are under common control through stock ownership, contract, or otherwise;

6. a retired employee;

7. an elected or appointed official of a public body, but only if the policy is issued to insure employees of the public body; and

8. a trustee of the fund, employee of the trustee, or both if the duties of the trustee or employee are connected principally with the trusteeship.

(ii) "Employee" does not include a director of a corporate employer unless the director is otherwise eligible as an employee of the corporation by performing services other than the usual duties of a director.

(2) A policy of group health insurance may be issued to an employer or the trustees of a fund established by an employer to cover employees of the employer for the benefit of persons other than the employer.

(3) The employer or trustees to which the policy is issued are deemed the policyholder.

(c) (1) In this subsection, "employee" may include a retired employee.

(2) A policy of group health insurance may be issued to an association, including a labor union, that has a constitution and bylaws and that is organized and maintained in good faith for purposes other than that of obtaining insurance, to cover members, employees, or employees of members of the association for the benefit of persons other than the association or its officers or trustees.

(d) (1) In this subsection, "employee" may include:

(i) an officer or manager of the employer;

(ii) a sole proprietor if the employer is a sole proprietorship;

(iii) a partner if the employer is a partnership;

(iv) a retired employee; and

(v) a trustee of the fund, employee of the trustee, or both if the duties of the trustee or employee are connected principally with the trusteeship.

(2) A policy of group health insurance may be issued to the trustees of a fund established by two or more employers in the same or related industry, by one or more labor unions, by one or more employers and one or more labor unions, or by an association described in subsection (b) of this section, to cover employees of the employers, members of the unions, members of the association, or employees of members of the association, for the benefit of persons other than the employers, unions, or association.

(3) The trustees to which the policy is issued are deemed the policyholder.

(e) A policy of group health insurance may be issued to a person to which a policy of group life insurance may be issued or delivered in the State, to cover a class or classes of individuals eligible for insurance under the group life policy.

(f) A policy of group health insurance may be issued to cover any other substantially similar group that, in the discretion of the Commissioner, may be eligible for group health insurance.

§15–304.

(a) Except as provided in §§ 14–205.2 and 14–205.3 of this article, and subject to subsection (b) of this section, on request of the policyholder, a policy of group health insurance may contain a provision that all or part of the benefits provided by the policy for hospital, nursing, medical, or surgical services, at the insurer's option, may be paid directly to the hospital or person that provides the services.

(b) A policy of group health insurance may not require that hospital, nursing, medical, or surgical services be provided by a particular hospital or person.

(c) A direct payment made under subsection (a) of this section discharges the insurer's obligation with respect to the amount paid.

§15–305.

(a) (1) Blanket health insurance is health insurance issued to or in the name of persons specified in this section to cover the groups of individuals described in this section.

(2) The person to which or in the name of which a policy or contract is issued is deemed the policyholder.

(b) A policy or contract of blanket health insurance may be issued to a common carrier or an operator, owner, or lessee of a means of transportation, to cover all individuals or all individuals of a class who may become passengers on the common carrier or means of transportation.

(c) A policy or contract of blanket health insurance may be issued to an employer, to cover all employees, dependents, or guests who are defined by reference to specific hazards that are incident to the activities or operations of the employer or a class of employees, dependents, or guests similarly defined.

(d) A policy or contract of blanket health insurance may be issued to a school or other institution of learning, a camp or its sponsor, or the head or principal of a school, other institution of learning, or camp, to cover students, campers, supervisors, or employees.

(e) A policy or contract of blanket health insurance may be issued in the name of a religious, charitable, recreational, educational, or civic organization, to cover participants in activities sponsored by the organization.

(f) A policy or contract of blanket health insurance may be issued to a sports team or its sponsors, to cover members, officials, and supervisors.

(g) A policy or contract of blanket health insurance may be issued in the name of a volunteer fire department, first aid group, other similar volunteer group, or agency with jurisdiction over a volunteer fire department, first aid group, or other similar volunteer group, to cover all members of the volunteer fire department or similar volunteer group.

(h) A policy or contract of blanket health insurance may be issued to cover any other risk, class of risks, or both that, in the discretion of the Commissioner, may be eligible for blanket health insurance.

§15–306.

(a) An insurer that is authorized to issue policies of health insurance in the State may issue blanket health insurance.

(b) A policy of blanket health insurance may not be issued or delivered in the State unless a copy of the form for the policy is filed with the Commissioner in accordance with § 12-203 of this article.

§15–308.

(a) An individual who is covered under a policy or contract of blanket health insurance may not be required to complete an individual application.

(b) An insurer need not provide a certificate to each individual covered under a policy of blanket health insurance.

§15–309.

(a) Except as provided in subsections (b) through (d) of this section, benefits under a policy of blanket health insurance are payable to the insured, beneficiaries designated by the insured, or estate of the insured.

(b) If the insured is under the age of 18 years or is mentally incompetent, benefits under a policy of blanket health insurance may be made payable to the insured's parents, guardian, or other person who supports the insured.

(c) If the employer has paid the entire cost of a policy of blanket health insurance, benefits under the policy may be made payable to the employer.

(d) (1) Subject to paragraph (2) of this subsection, a policy of blanket health insurance may contain a provision that all or part of the benefits provided by the policy for hospital, nursing, medical, or surgical services, at the insurer's option, may be paid directly to the hospital or person that provides the services.

(2) A policy of blanket health insurance may not require that hospital, nursing, medical, or surgical services be provided by a particular hospital or person.

(3) A direct payment made under paragraph (1) of this subsection discharges the insurer's obligation with respect to the amount paid.

§15–310.

A person may not solicit coverage in the State under a policy of group health insurance or blanket health insurance issued in another jurisdiction without the prior written approval of the Commissioner, unless the type of group to be covered conforms substantially to one of the groups described in § 15-302 or § 15-305 of this subtitle.

§15–401.

(a) In this section, "date of adoption" means the earlier of:

(1) a judicial decree of adoption; or

(2) the assumption of custody, pending adoption, of a prospective adoptive child by a prospective adoptive parent.

(b) (1) This subsection applies to:

(i) each individual health insurance policy that:

1. is delivered, issued for delivery, or renewed in the State;

2. provides coverage on an expense–incurred basis; and

3. provides coverage for a family member of the insured;

(ii) each group health insurance policy, including a contract issued by a nonprofit health service plan, that:

1. is delivered, issued for delivery, or renewed in the State;

2. provides coverage on an expense–incurred basis for employees of an employer or employers or members of a union or unions; and

3. provides coverage for a family member of a covered employee or member;

(iii) each individual service or indemnity contract that:

1. is delivered, issued for delivery, or renewed in the State by a nonprofit health service plan; and

2. provides coverage for a family member of the subscriber;

(iv) each individual contract that:

1. is delivered, issued for delivery, or renewed in the State by a health maintenance organization; and

2. provides coverage for a family member of the subscriber; and

(v) each group contract that:

1. is delivered, issued for delivery, or renewed in the State by a health maintenance organization;

2. provides coverage for employees of an employer or employers or members of a union or unions; and

3. provides coverage for a family member of the covered employee or member.

(2) Each policy or contract subject to this subsection shall provide that the health insurance benefits applicable:

(i) for children or grandchildren shall be payable for a newly born or newly adopted dependent child or grandchild from the moment of birth or date of adoption of the child or grandchild; and

(ii) for a minor for whom guardianship is granted by court or testamentary appointment shall be payable from the date of appointment.

(c) On request, an insurer or nonprofit health service plan that issues an individual or group health insurance policy that provides coverage on an expense–incurred basis, or a health maintenance organization that issues an individual or group contract, shall offer family members' coverage to an insured, subscriber, or member regardless of the marital status of the insured, subscriber, or member.

(d) Each insurer, nonprofit health service plan, or health maintenance organization that issues a policy or contract that does not provide family members' coverage shall:

(1) provide notice to the policyholder or contract holder that coverage for a newly born or newly adopted child or grandchild or a minor for whom guardianship is granted by court or testamentary appointment is not provided under the policy or contract; and

(2) inform the insured, subscriber, or member of the right and conditions to purchase family members' coverage under this section.

(e) To be eligible for coverage under this section:

(1) a grandchild must be a dependent, and in the court–ordered custody, of the insured, subscriber, or member; and

(2) a minor must be a dependent and in the custody of the insured, subscriber, or member as a result of a guardianship, other than a temporary guardianship of less than 12 months duration, granted by court or testamentary appointment.

(f) Coverage for a newly born or newly adopted child or grandchild or a minor for whom guardianship is granted by court or testamentary appointment shall consist of coverage for injury or sickness, including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities.

(g) If payment of a specific premium or subscription fee is required to provide coverage for a child or grandchild or a minor for whom guardianship is granted by court or testamentary appointment, the policy or contract may require notification of a birth, adoption, or appointment and payment of the required premium or fee to the insurer, nonprofit health service plan, or health maintenance organization within 31 days after the date of birth, date of adoption, or date of court or testamentary appointment in order to continue coverage beyond the 31–day period.

(h) (1) An insurer, nonprofit health service plan, or health maintenance organization may require proof that the insured, subscriber, or member is the parent or grandparent of a newly born or newly adopted child or grandchild or guardian of a minor under court or testamentary appointment.

(2) If the insurer, nonprofit health service plan, or health maintenance organization requires proof under this subsection, the insurer, nonprofit health service plan, or health maintenance organization shall pay the cost of the proof.

§15–402.

(a) This section applies to:

(1) each individual or group health insurance policy that is issued in the State; and

(2) each contract that is issued in the State by a nonprofit health service plan or a health maintenance organization.

(b) (1) Notwithstanding any limiting age stated in a policy or contract subject to this section, a child, grandchild, or individual for whom guardianship is granted by court or testamentary appointment shall continue to be covered under the policy or contract as a dependent of an employee, member, or other covered individual if the child, grandchild, or individual under guardianship:

(i) is unmarried;

(ii) is chiefly dependent for support on the employee, member, or other covered individual; and

(iii) at the time of reaching the limiting age, is incapable of self–support because of mental or physical incapacity that started before the child, grandchild, or individual under guardianship attained the limiting age.

(2) A child, grandchild, or individual under guardianship who is covered under this section shall continue to be covered while remaining unmarried, dependent, and mentally or physically incapacitated until the coverage on the employee, member, or other covered individual on whom the child, grandchild, or individual under guardianship is dependent terminates.

(c) To be eligible for coverage under this section:

(1) a grandchild must be a dependent, and in the court–ordered custody, of the employee, member, or other covered individual; and

(2) an individual must be a dependent and in the custody of the employee, member, or other covered individual as a result of a guardianship, other than a temporary guardianship of less than 12 months duration, granted by court or testamentary appointment.

§15–403.

(a) This section applies to:

(1) each individual health insurance policy that:

(i) provides coverage on an expense–incurred basis; and

(ii) provides coverage for a family member of the insured;

(2) each group health insurance policy that:

(i) provides coverage on an expense–incurred basis for employees of an employer or employers or members of a union or unions; and

(ii) provides coverage for a family member of a covered employee or member;

(3) each individual service or indemnity contract that:

(i) is issued by a nonprofit health service plan; and

(ii) provides coverage for a family member of the subscriber;

(4) each individual contract that:

(i) is issued by a health maintenance organization; and

(ii) provides coverage for a family member of the subscriber; and

(5) each group contract that:

(i) is issued by a health maintenance organization;

(ii) provides coverage for employees of an employer or employers or members of a union or unions; and

(iii) provides coverage for a family member of the covered employee or member.

(b) Each policy or contract subject to this section shall provide that the same health insurance benefits and eligibility guidelines that apply to any covered dependent are available, on request of the insured, subscriber, employee, or member, to a grandchild who:

(1) is unmarried;

(2) is in the court–ordered custody of the insured, subscriber, employee, or member;

(3) resides with the insured, subscriber, employee, or member;

(4) is the dependent of the insured, subscriber, employee, or member; and

(5) has not attained the limiting age under the terms of the policy or contract.

(c) On request, an insurer that issues an individual or group health insurance policy that provides coverage on an expense–incurred basis, a nonprofit health service plan, or a health maintenance organization shall offer family members'

coverage to an insured or subscriber regardless of the marital status of the insured or subscriber.

(d) (1) An insurer, nonprofit health service plan, or health maintenance organization may require proof that the insured or subscriber is the grandparent of the grandchild.

(2) If the insurer, nonprofit health service plan, or health maintenance organization requires proof under this subsection, the insurer, nonprofit health service plan, or health maintenance organization shall pay the cost of the proof.

§15–403.1.

(a) This section applies to:

(1) each individual health insurance policy that:

(i) provides coverage on an expense–incurred basis; and

(ii) provides coverage for a family member of the insured;

(2) each group health insurance policy that:

(i) provides coverage on an expense–incurred basis for employees of an employer or employers or members of a union or unions; and

(ii) provides coverage for a family member of a covered employee or member;

(3) each individual service or indemnity contract that:

(i) is issued by a nonprofit health service plan; and

(ii) provides coverage for a family member of the subscriber;

(4) each individual contract that:

(i) is issued by a health maintenance organization; and

(ii) provides coverage for a family member of the subscriber; and

(5) each group contract that:

(i) is issued by a health maintenance organization;

(ii) provides coverage for employees of an employer or employers or members of a union or unions; and

(iii) provides coverage for a family member of the covered employee or member.

(b) Each policy or contract subject to this section shall provide that the same health insurance benefits and eligibility guidelines that apply to any covered dependent are available, on request of the insured, subscriber, employee, or member, to an individual who:

(1) is unmarried;

(2) is under testamentary or court appointed guardianship, other than temporary guardianship of less than 12 months duration, of the insured, subscriber, employee, or member;

(3) resides with the insured, subscriber, employee, or member;

(4) is the dependent of the insured, subscriber, employee, or member; and

(5) has not attained the limiting age under the terms of the policy or contract.

(c) On request, an insurer that issues an individual or group health insurance policy that provides coverage on an expense–incurred basis, a nonprofit health service plan, or a health maintenance organization shall offer family members' coverage to an insured or subscriber regardless of the marital status of the insured or subscriber.

(d) (1) An insurer, nonprofit health service plan, or health maintenance organization may require proof that the insured or subscriber is a guardian under court or testamentary appointment.

(2) If the insurer, nonprofit health service plan, or health maintenance organization requires proof under this subsection, the insurer, nonprofit health service plan, or health maintenance organization shall pay the cost of the proof.

§15–403.2.

(a) In this section, "child dependent of the domestic partner" means an individual who:

(1) is:

(i) the natural child, stepchild, adopted child, or grandchild of the domestic partner of an insured;

(ii) a child placed with the domestic partner of an insured for legal adoption; or

(iii) a child who is under testamentary or court appointed guardianship, other than temporary guardianship of less than 12 months' duration, of the domestic partner of an insured;

(2) is a dependent, as that term is used in 26 U.S.C. §§ 104, 105, and 106, and any regulations adopted under those sections, of the domestic partner of an insured;

(3) resides with the insured;

(4) is unmarried; and

(5) is under the age of 25 years.

(b) This section applies to each individual or group policy or contract that:

(1) allows family coverage; and

(2) is issued by:

(i) an insurer or nonprofit health service plan that provides inpatient hospital, medical, or surgical benefits to individuals or groups on an expense–incurred basis under health insurance policies or contracts that are issued or delivered in the State; or

(ii) a health maintenance organization that provides inpatient hospital, medical, or surgical benefits to individuals or groups under contracts that are issued or delivered in the State.

(c) Each policy or contract subject to this section shall provide that the same health insurance benefits and eligibility guidelines that apply to any covered

dependent are available to a domestic partner of an insured or a child dependent of the domestic partner of an insured at the request of:

(1) an insured under an individual policy or contract that is subject to this section; or

(2) the group policyholder of a group policy or contract that is subject to this section.

(d) An insurer, nonprofit health service plan, or health maintenance organization may require a group policyholder that requests coverage for a domestic partner or child dependent of the domestic partner of an insured under subsection (c)(2) of this section to provide proof of the eligibility of the domestic partner or child dependent of the domestic partner for coverage under this section.

(e) The Commissioner shall adopt regulations to implement this section.

§15–404.

(a) This section applies to:

(1) each group or blanket health insurance policy that is issued or delivered in the State and provides coverage on an expense-incurred basis; and

(2) each group medical or major medical contract or certificate that is issued or delivered in the State by a nonprofit health service plan.

(b) Each policy, contract, or certificate subject to this section shall provide a benefit that allows the addition of a certificate holder's or subscriber's dependent children to the certificate holder's or subscriber's policy or contract at any time and without evidence of insurability if:

(1) the dependent children previously were covered under the policy or contract of the certificate holder's or subscriber's spouse; and

(2) the certificate holder's or subscriber's spouse has died.

(c) This section applies regardless of whether a certificate holder's or subscriber's dependent children are eligible for any continuation or conversion privileges under the policy or contract of the certificate holder's or subscriber's spouse.

(d) Within 6 months after the death of the spouse, the certificate holder or subscriber must exercise the benefit provided under this section.

§15–405.

(a) (1) In this section the following words have the meanings indicated.

(2) "Carrier" means:

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

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

(iii) a nonprofit health service plan that is licensed to operate in the State.

(3) "Health insurance coverage" means health care coverage under which medical care services can be provided to a child.

(4) "Insuring parent" means a parent who:

(i) is required under a court or administrative order to provide health insurance coverage for a child; or

(ii) otherwise provides health insurance coverage for a child.

(5) "Medical support notice" means a notice that is:

(i) in a format prescribed by federal law; and

(ii) issued by a child support agency to enforce the health insurance coverage provisions of a child support order.

(6) "Order" means a ruling that:

(i) is issued by a court of this State or another state or an administrative agency of another state; and

(ii) 1. creates or recognizes the right of a child to receive benefits under a parent's health insurance coverage; or

2. establishes a parent's obligation to pay child support and provide health insurance coverage for a child.

(7) "Qualified medical support order" means a medical child support order issued under State law that complies with § 609(a) of the Employee Retirement Income Security Act of 1974 (ERISA).

(b) This section applies to:

(1) insurers, nonprofit health service plans, and health maintenance organizations that operate in the State under a certificate of authority;

(2) group health plans, as defined in § 607(1) of the Employee Retirement Income Security Act of 1974 (ERISA); and

(3) persons that offer a service benefit plan, as defined in federal law.

(c) If a parent eligible for family members' coverage is required under an order to provide health insurance coverage for a child, an entity subject to this section:

(1) shall allow the insuring parent to enroll in family members' coverage and include the child in that coverage regardless of enrollment period restrictions;

(2) if the insuring parent is enrolled in health insurance coverage but does not include the child in the enrollment, shall:

(i) allow the noninsuring parent, child support enforcement agency, or Maryland Department of Health to apply for enrollment on behalf of the child; and

(ii) include the child in the coverage regardless of enrollment period restrictions; and

(3) may not terminate health insurance coverage for the child unless written evidence is provided to the entity that:

(i) the order is no longer in effect;

(ii) the child has been or will be enrolled under other reasonable health insurance coverage that will take effect on or before the effective date of the termination;

(iii) the employer has eliminated family members' coverage for all of its employees; or

(iv) the employer no longer employs the insuring parent, except that if the parent elects to exercise the provisions of the federal Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), coverage shall be provided for the child consistent with the employer's plan for postemployment health insurance coverage for dependents.

(d) Notwithstanding any other provision of this article, an entity subject to this section may not deny enrollment of a child under the health insurance coverage of an insuring parent because the child:

(1) was born out of wedlock;

(2) is not claimed as a dependent on the insuring parent's federal income tax return;

(3) does not reside with the insuring parent or in the service area of the entity; or

(4) is receiving benefits or is eligible to receive benefits under the Maryland Medical Assistance Program.

(e) If a child has health insurance coverage through an insuring parent, an entity subject to this section shall:

(1) provide to the noninsuring parent membership cards, claims forms, and any other information necessary for the child to obtain benefits through the health insurance coverage; and

(2) process the claims forms and make appropriate payment to the noninsuring parent, health care provider, or Maryland Department of Health if the noninsuring parent incurs expenses for health care provided to the child.

(f) Within 20 business days after receipt of a medical support notice from an employer, the carrier:

(1) shall determine whether the medical support notice contains:

(i) the employee's name and mailing address; and

(ii) the child's name and the child's mailing address or the address of a substituted official;

(2) if the medical support notice does not contain the information described in paragraph (1) of this subsection, shall complete and forward the

appropriate part of the medical support notice to the issuing child support enforcement agency advising that the medical support notice does not constitute a qualified medical child support order; and

(3) if the medical support notice contains the information described in paragraph (1) of this subsection, shall comply with the following requirements:

(i) determine the child's eligibility for enrollment;

(ii) complete and send the appropriate part of the medical support notice to the employer and the Child Support Administration;

(iii) enroll the child if the child is eligible for enrollment, subject to subsection (g) of this section;

(iv) send to the employee, child, and custodial parent of the child a written notice that explains that the coverage of the child is or will become available to the child; and

(v) send to the custodial parent of the child a written description of:

1. the health insurance coverage;

2. the effective date of coverage;

3. the employee's cost for the health insurance coverage; and

4. if not already provided:

A. a summary plan description;

B. any forms, documents, or information necessary to effectuate coverage; and

C. any information necessary to submit claims for benefits.

(g) If the employee's eligibility for health insurance coverage is subject to a waiting period that has not been completed, the carrier:

(1) shall complete and send the appropriate part of the medical support notice to the employer and the issuing child support agency within 20 business days after receipt of the medical support notice from the employer; and

(2) on the employee's satisfaction of the waiting period, shall complete enrollment of the child in accordance with this section and send the notice and information required under subsection (f)(3) of this section.

(h) If the employee's health insurance plan requires that the employee be enrolled in order for the child to be enrolled and the employee is not currently enrolled, the carrier shall enroll both the employee and the child, without regard to enrollment period restrictions, within the time period specified in subsection (f) of this section.

(i) If a child is eligible for enrollment, the carrier shall complete the enrollment without regard to enrollment period restrictions, within the time periods specified in subsections (f) and (g) of this section.

(j) The requirement for notification of the child under subsection (f)(3)(iv) of this section may be satisfied by notifying the custodial parent if the child and the custodial parent live at the same address.

§15–406.

(a) In this section, "health insurance coverage" means health care coverage under which medical care services can be provided to a child.

(b) This section applies to:

(1) commercial insurers, nonprofit health service plans, and health maintenance organizations that operate in the State under a certificate of authority;

(2) group health plans, as defined in § 607(1) of the Employee Retirement Income Security Act of 1974 (ERISA); and

(3) persons that offer a service benefit plan, as defined in federal law.

(c) An entity subject to this section may not consider whether an individual is eligible for or receives medical assistance from this State or another state under 42 U.S.C. § 1396a when:

(1) determining the eligibility of the individual for enrollment in health insurance coverage; or

(2) calculating any payments for benefits for which the individual is eligible under the health insurance coverage.

(d) On presentation of a claim, an entity subject to this section shall reimburse the State to the extent that:

(1) the State has paid for expenses for health care services that are provided to an eligible individual and covered under the Maryland Medical Assistance Program; and

(2) those health care services are included under the individual's health insurance coverage provided by the entity.

(e) If a State agency has been assigned the rights of an individual who is eligible for medical assistance and who has health insurance coverage provided by an entity subject to this section, the entity may not impose on the State agency requirements that are different from the requirements that apply to an insurance producer, assignee, or any other individual who has health insurance coverage provided by the entity.

§15–407.

(a) (1) In this section the following words have the meanings indicated.

(2) "Dependent child" means a child of the insured who:

(i) was covered under a group contract as a qualified or eligible dependent of the insured immediately before the death of the insured; or

(ii) was born to a qualified secondary beneficiary defined in paragraph (5)(i) of this subsection after the death of the insured.

(3) "Group contract" means:

(i) an insurance contract or policy that is issued or delivered in the State to the employer of the insured by an insurer or nonprofit health service plan and that provides group hospital, medical, or surgical benefits to the employees of the employer on an expense–incurred basis; or

(ii) a contract between the employer of the insured and a health maintenance organization certified under Title 19, Subtitle 7 of the Health – General Article that provides hospital, medical, or surgical benefits to the employees of the employer.

(4) "Insured" means an employee who is a resident of the State and covered under a current or predecessor group contract with the same employer for at least 3 months before death.

(5) "Qualified secondary beneficiary" means an individual who is:

(i) a beneficiary under the group contract as the spouse of the insured for at least 30 days immediately preceding the death of the insured; or

(ii) a dependent child of the insured.

(b) (1) Each group contract in force on the date of the death of the insured shall provide continuation coverage in accordance with this section.

(2) Subject to subsection (c) of this section, if continuation coverage is elected by or on behalf of a qualified secondary beneficiary, the group contract shall provide continuation coverage to the qualified secondary beneficiary after the death of the insured.

(c) Continuation coverage that is elected by or on behalf of a qualified secondary beneficiary under the group contract shall begin on the date of the death of the insured and end on the earliest of the following:

(1) 18 months after the date of the death of the insured;

(2) the date on which the qualified secondary beneficiary fails to make timely payment of an amount required under subsection (d)(2) of this section;

(3) the date on which the qualified secondary beneficiary becomes eligible for hospital, medical, or surgical benefits under an insured or self–insured group health benefit program or plan, other than the group contract, that is written on an expense–incurred basis or is with a health maintenance organization;

(4) the date on which the qualified secondary beneficiary becomes entitled to benefits under Title XVIII of the Social Security Act;

(5) the date on which the qualified secondary beneficiary accepts hospital, medical, or surgical coverage under a nongroup contract or policy that is written on an expense–incurred basis or is with a health maintenance organization;

(6) the date on which the qualified secondary beneficiary elects to terminate coverage under the group contract;

(7) the date on which the employer ceases to provide benefits to its employees under a group contract; or

(8) for an individual who is a qualified secondary beneficiary by reason of having been a dependent child, the date on which the individual would no longer be covered under the group contract if the insured had not died.

(d) Continuation coverage under this section shall:

(1) be provided without evidence of insurability or additional waiting periods;

(2) require the qualified secondary beneficiary to pay to the employer an amount that does not exceed:

(i) the sum of the employer contribution and any contribution that the insured would have been required to pay if the insured had not died; and

(ii) a reasonable administrative fee that is subject to review and approval by the Commissioner;

(3) allow the payment of the amount specified in paragraph (2) of this subsection in monthly installments if the qualified secondary beneficiary elects to do so; and

(4) be identical to the coverage offered under the group contract to similarly situated individuals for whom there has not been a death of the insured.

(e) (1) To elect continuation coverage provided under this section, a qualified secondary beneficiary or authorized representative shall submit a signed election notification form to the insured's employer during the election period.

(2) The election period for continuation coverage under this section begins on the date of the death of the insured and ends at least 45 days after that date.

(3) Within 14 days after receipt of a request for an election notification form, the employer shall deliver or send by first–class mail the election notification form to the qualified secondary beneficiary or authorized representative.

(f) Each certificate issued to an insured under a group contract shall include a statement, in a manner and form approved by the Commissioner, that advises the insured of the following:

(1) the availability of continuation coverage under this section;

(2) a summary of the eligibility for and duration of the continuation coverage; and

(3) the procedure for making an election to receive continuation coverage if the insured dies.

(g) The Commissioner shall:

(1) publish at least annually in the Maryland Register and in a newspaper of general circulation in each county notice that describes the continuation coverage required under this section;

(2) prescribe by regulation the form and content of the election notification form; and

(3) make election notification forms available to each employer whose employees are covered by a group contract.

(h) Notice of the availability of continuation coverage under this section shall be provided by:

(1) the Secretary of Health as specified in § 4–217 of the Health – General Article; and

(2) licensed funeral directors as specified in § 7–407 of the Health Occupations Article.

(i) An employer that fails to provide notice or an election notification form under this section is not liable to a qualified secondary beneficiary or the insured for benefits that otherwise would have been payable or for other damages that result from the failure to provide the notice or form.

(j) An employer that terminates continuation coverage after notice or nonpayment of an amount required under subsection (d)(2) of this section by a qualified secondary beneficiary, or an insurer that terminates continuation coverage after notice by the employer, is not liable to a qualified secondary beneficiary for benefits that otherwise would have been payable under this section if the termination:

(1) is made in good faith;

(2) is reasonable under the circumstances; and

(3) is not the result of a mutual or material mistake of fact.

(k) This section does not affect or limit the right of a qualified secondary beneficiary to conversion privileges under a group contract.

§15–408.

(a) (1) In this section the following words have the meanings indicated.

(2) "Change in status" means the divorce of the insured and the insured's spouse.

(3) "Dependent child" means a child of the insured who:

(i) was covered under a group contract as a qualified or eligible dependent of the insured immediately before the change in status; or

(ii) was born to a qualified secondary beneficiary defined in paragraph (6)(i) of this subsection after the change in status.

(4) "Group contract" means:

(i) an insurance contract or policy that is issued or delivered in the State to the employer of the insured by an insurer or nonprofit health service plan and that provides group hospital, medical, or surgical benefits to the insured on an expense-incurred basis; or

(ii) a contract between the employer of the insured and a health maintenance organization certified under Title 19, Subtitle 7 of the Health - General Article that provides group hospital, medical, or surgical benefits offered to the insured.

(5) "Insured" means an employee who is a resident of the State and covered under a group contract.

(6) "Qualified secondary beneficiary" means an individual who is:

(i) a beneficiary under the group contract as the spouse of the insured for at least 30 days immediately preceding the change in status; or

(ii) a dependent child of the insured.

(7) "Termination statement" means written notice of an event specified in subsection (c) of this section that is:

(i) provided to the employer on a form that the Commissioner prescribes; and

(ii) 1. signed by the insured and a qualified secondary beneficiary defined in paragraph (6)(i) of this subsection; or

2. accompanied by the insured's signed and sworn affidavit that verifies all facts in the termination statement.

(b) (1) Each group contract in force on the date of the change in status shall provide continuation coverage in accordance with this section.

(2) Subject to subsection (c) of this section, a qualified secondary beneficiary is entitled to continuation coverage under a group contract after a change in status.

(3) Paragraph (2) of this subsection does not apply while the insured is not covered by a group contract.

(c) Continuation coverage under this section shall begin on the date of the change in status and end on the earliest of the following:

(1) the date on which the qualified secondary beneficiary becomes eligible for hospital, medical, or surgical benefits under an insured or self-insured group health benefit program or plan, other than the group contract, that is written on an expense-incurred basis or is with a health maintenance organization;

(2) the date on which the qualified secondary beneficiary becomes entitled to benefits under Title XVIII of the Social Security Act;

(3) the date on which the qualified secondary beneficiary accepts hospital, medical, or surgical coverage under a nongroup contract or policy that is written on an expense-incurred basis or is with a health maintenance organization;

(4) the date on which the qualified secondary beneficiary elects to terminate coverage under the group contract;

(5) for an individual who is a qualified secondary beneficiary by reason of having been a dependent child, the date on which the individual would no longer be covered under the group contract if there had not been a change in status; or

(6) for an individual who is a qualified secondary beneficiary by reason of having been the insured's spouse, the date on which the individual remarries.

(d) Continuation coverage under this section shall be identical to the coverage offered under the group contract to similarly situated beneficiaries for whom there has not been a change in status.

(e) (1) From the date of the change in status until the date on which a termination statement is received by the employer, the insured shall pay to the employer, through payroll deduction or otherwise as determined by the employer, the sum of the employer's contribution for a qualified secondary beneficiary defined in subsection (a)(6)(i) of this section and the amount of contribution that would have been paid by the insured if there had not been a change in status.

(2) The additional costs payable by the insured under paragraph (1) of this subsection may be allocated between the insured and a qualified secondary beneficiary who was the insured's spouse or may be reimbursed in full to the insured by the qualified secondary beneficiary by agreement between the parties or, as equity may require, by court order under Title 10, Title 11, or Title 12 of the Family Law Article at the time of the change in status or after the change in status.

(f) Each certificate issued to an insured under a group contract shall include a statement, in a manner and form approved by the Commissioner, that advises the insured of the following:

(1) the availability of continuation coverage under this section; and

(2) a summary of the eligibility for and duration of the continuation coverage.

(g) The Commissioner shall:

(1) publish at least annually in the Maryland Register and in a newspaper of general circulation in each county notice that describes the continuation coverage required under this section;

(2) prescribe by regulation the form and content of the termination statement; and

(3) make termination statement forms available to each employer whose employees are covered by a group contract.

(h) (1) On request of a qualified secondary beneficiary, from the date of the change in status until the date on which a termination statement is received by the employer, the employer shall make available to the qualified secondary beneficiary forms for submitting claims to the group contract insurer.

(2) On presentation of a divorce decree by a qualified secondary beneficiary, the group contract insurer may reimburse the qualified secondary beneficiary directly for hospital, medical, or surgical expenses that the qualified secondary beneficiary has paid.

(3) A group contract insurer that reimburses a qualified secondary beneficiary in accordance with this subsection is not liable to any other party for payment for the same services.

(4) If the insured receives reimbursement from the group contract insurer for hospital, medical, or surgical expenses that a qualified secondary beneficiary has paid, the insured immediately shall pay the reimbursement to the qualified secondary beneficiary unless a written agreement or court order provides otherwise.

(i) (1) An employer that terminates continuation coverage after notice by the insured or qualified secondary beneficiary, or an insurer that terminates continuation coverage after notice by the employer, is not liable to the insured or qualified secondary beneficiary for benefits that otherwise would have been payable under this section if the termination:

(i) is made in good faith;

(ii) is reasonable under the circumstances; and

(iii) is not the result of a mutual or material mistake of fact.

(2) Notwithstanding paragraph (1) of this subsection, receipt by the employer of a termination statement is conclusive evidence of termination, and neither the employer nor the insurer is liable to the qualified secondary beneficiary or insured for benefits that otherwise would have been payable under this section.

(j) This section does not affect or limit the right of a qualified secondary beneficiary to conversion privileges under a group contract.

§15–409.

(a) (1) In this section the following words have the meanings indicated.

(2) (i) "Change in status" means the termination of the insured's employment other than for cause.

(ii) "Change in status" includes:

1. involuntary termination of the insured's employment other than for cause; and

2. voluntary termination of the insured's employment by the insured employee.

(3) "Group contract" means:

(i) an insurance contract or policy that is issued or delivered in the State to the employer of the insured by an insurer or nonprofit health service plan and that provides group hospital, medical, or surgical benefits to the employees of the employer on an expense–incurred basis; or

(ii) a contract between the employer of an insured and a health maintenance organization certified under Title 19, Subtitle 7 of the Health – General Article that provides group hospital, medical, or surgical benefits to the employees of the employer.

(4) "Insured" means an employee who is a resident of the State and covered under a current or predecessor group contract with the same employer for at least 3 months before the change in status.

(b) (1) Each group contract in force on the date of the change in status shall provide continuation coverage in accordance with this section.

(2) Subject to subsection (c) of this section, if continuation coverage is elected by or on behalf of an insured, the group contract shall provide continuation coverage to the insured after a change in status.

(c) Continuation coverage that is elected by or on behalf of the insured under the group contract shall begin on the date of the change in status and end on the earliest of the following:

(1) 18 months after the date of the change in status;

(2) the date on which the insured fails to make timely payment of an amount required under subsection (d)(2) of this section;

(3) the date on which the insured becomes eligible for hospital, medical, or surgical benefits under an insured or self–insured group health benefit program or plan, other than the group contract, that is written on an expense–incurred basis or is with a health maintenance organization;

(4) the date on which the insured becomes entitled to benefits under Title XVIII of the Social Security Act;

(5) the date on which the insured accepts hospital, medical, or surgical coverage under a nongroup contract or policy that is written on an expense–incurred basis or is with a health maintenance organization;

(6) the date on which the insured elects to terminate coverage under the group contract; or

(7) the date on which the employer ceases to provide benefits to its employees under a group contract.

(d) Continuation coverage under this section shall:

(1) be provided without evidence of insurability or additional waiting periods;

(2) require the insured to pay to the employer an amount that does not exceed:

(i) the sum of the employer contribution and any contribution that the insured would have been required to pay if there had not been a change in status; and

(ii) a reasonable administrative fee that is subject to review and approval by the Commissioner;

(3) allow the payment of the amount specified in item (2) of this subsection in monthly installments if the insured elects to do so;

(4) be identical to the coverage offered under the group contract to similarly situated individuals for whom there has not been a change in status; and

(5) be available to the spouse and dependent children of the insured if:

(i) the group contract provides benefits for spouses and dependent children; and

(ii) the insured's spouse and dependent children were covered under the group contract before the change in status.

(e) (1) To elect continuation coverage provided under this section, an insured or authorized representative shall submit a signed election notification form to the insured's employer during the election period.

(2) The election period for continuation coverage under this section begins on the date of the change in status and ends at least 45 days after that date.

(3) Within 14 days after receipt of a request for an election notification form, the employer shall deliver or send by first–class mail the election notification form to the insured or authorized representative.

(f) Each certificate issued to an insured under a group contract shall include a statement, in a manner and form approved by the Commissioner, that advises the insured of the following:

(1) the availability of continuation coverage under this section;

(2) a summary of the eligibility for and duration of the continuation coverage; and

(3) the procedure for making an election to receive continuation coverage if a change in status occurs.

(g) The Commissioner shall:

(1) publish at least annually in the Maryland Register and in a newspaper of general circulation in each county notice that describes the continuation coverage required under this section;

(2) prescribe by regulation the form and content of the election notification form; and

(3) make election notification forms available to each employer whose employees are covered by a group contract.

(h) Notice of the availability of continuation coverage under this section shall be provided by:

(1) the employer; and

(2) the Secretary of Labor as specified in § 8–805(c) of the Labor and Employment Article.

(i) An employer that fails to provide notice or an election notification form under this section is not liable to the insured or any other covered individual for benefits that otherwise would have been payable or for other damages that result from the failure to provide the notice or form.

(j) An employer that terminates continuation coverage after notice or nonpayment of an amount required under subsection (d)(2) of this section by the insured or other covered individual, or an insurer that terminates continuation coverage after notice by the employer, is not liable to the insured or other covered individual for benefits that otherwise would have been payable under this section if the termination:

(1) is made in good faith;

(2) is reasonable under the circumstances; and

(3) is not the result of a mutual or material mistake of fact.

(k) This section does not affect or limit the right of an insured to conversion privileges under a group contract.

§15–409.1.

(a) (1) In this section the following words have the meanings indicated.

(2) "Act" means the federal American Recovery and Reinvestment Act of 2009 (P.L. 111–5).

(3) "Carrier" means:

(i) an insurer;

(ii) a nonprofit health service plan; or

(iii) a health maintenance organization.

(4) "Small employer" has the meaning stated in § 15–1201 of this title.

(b) This section applies to a carrier that issues health benefit plans to small employers in accordance with Subtitle 12 of this title.

(c) A carrier shall allow an extended election period for continuation coverage under § 15–409 of this subtitle if the individual:

(1) was involuntarily terminated from employment by a small employer between September 1, 2008, and February 16, 2009, inclusive, as described in § 3001(a)(3)(C) of the Act;

(2) is an assistance eligible individual, as defined in § 3001(a)(3) of the Act, or would be an assistance eligible individual if an election of continuation coverage under § 15–409 of this subtitle was in effect on the date of enactment of the Act; and

(3) was eligible for continuation coverage under § 15–409 of this subtitle at the time of the individual's termination of employment.

(d) The extended election period provided under this section shall continue until 60 days after provision of the notification required by § 3001(a)(7)(C) of the Act if the notification describes the extended election period required under this section.

(e) Any continuation coverage elected by an individual during an extended election period under this section:

(1) shall begin during the first period of coverage beginning on or after the individual's election of continuation coverage; and

(2) may not extend beyond the period of continuation coverage that would have been required under § 15–409 of this subtitle if the coverage had been elected as required under that section.

§15–411.

(a) Each group health insurance contract or policy that is issued by an insurer or nonprofit health service plan shall provide continuous open enrollment for the purpose of allowing a married employee who is enrolled under the contract or policy to alter the terms of the employee's coverage to include the employee's spouse or children if the employee's spouse loses coverage under another group health insurance contract or policy because of the involuntary termination of the spouse's employment other than for cause.

(b) A group health insurance contract or policy may not require evidence of insurability for a spouse who qualifies for group health insurance coverage under this section.

(c) A married employee who wishes to alter the terms of the employee's coverage under this section shall notify the employer within 6 months after the date on which the coverage of the employee's spouse under another group health insurance contract or policy terminates.

§15–413.

(a) (1) Except as provided in paragraph (2) of this subsection, this section applies to each group health insurance policy that:

(i) 1. is issued or delivered in the State;

2. is issued to a policyholder that is incorporated or has a main office in the State; or

3. covers individuals who reside or work in the State; and

(ii) provides benefits in the event of the disability of an individual covered under the policy.

(2) This section does not apply to:

(i) a policy issued under Title 13 of this article if the insurance under the policy is terminated because of the prepayment or refinancing, wholly or partly, with the same creditor of a prior debt; or

(ii) except as the Commissioner provides by regulation, a group policy issued to an employer to cover its employees.

(b) Each group policy subject to this section shall provide that a covered individual whose coverage under the group policy is terminated for any reason other than failure of the covered individual to pay a required premium or contribution is entitled, without evidence of insurability, to an individual policy of disability income insurance.

(c) By regulation the Commissioner may exempt from the requirements of this section certain types of group policies that the Commissioner considers appropriate.

(d) (1) An individual policy issued under this section shall take effect immediately after the termination of coverage under the group policy if the covered individual:

(i) makes a timely written request for an individual policy; and

(ii) pays the first premium for the individual policy.

(2) By regulation the Commissioner shall establish rules to determine when a written request and payment of the required premium are timely.

(e) An individual policy issued under this section shall be guaranteed renewable for the term or to the limiting age for which benefits would have been provided if coverage under the group policy had not terminated.

(f) The level of benefits under an individual policy issued under this section shall equal approximately the disability benefits that would have been provided if coverage under the group policy had not terminated.

(g) (1) The premium for an individual policy issued under this section shall be determined in accordance with the insurer's table of premium rates that is applicable to the attained age and class of risk of the covered individual for the type and amount of insurance provided.

(2) The insurer shall reserve the right to change the premium on any policy anniversary subject to approval by the Commissioner.

(h) The Commissioner may establish requirements that govern notification by the insurer or group policyholder to the individual whose coverage under the group policy is being terminated of the right of conversion to an individual policy.

(i) The insurer may limit the right of conversion to individuals who have been covered under the group policy for at least 1 year.

(j) Each group health insurance policy that was issued before January 1, 1984, shall be amended to comply with the requirements of this section on the first policy renewal anniversary date on or after January 1, 1984.

§15–416.

(a) This section applies to insurers, nonprofit health service plans, and health maintenance organizations that deliver or issue for delivery in the State individual, group, or blanket health insurance policies and contracts.

(b) At least 60 days before a child who is covered under a parent's individual, group, or blanket health insurance policy or contract reaches the limiting age under the policy or contract, an entity subject to this section shall:

(1) notify the parent of criteria under which a child may remain eligible for coverage as a dependent under the policy or contract; and

(2) provide information regarding:

(i) any other policies that may be available to the child from the entity; and

(ii) the availability of additional information from the Administration regarding individual policies in the State.

(c) The Commissioner shall establish and publish by bulletin the notice to be given under this section.

§15–417.

(a) This section applies to:

(1) insurers and nonprofit health service plans that provide hospital, medical, or surgical benefits to individuals or groups on an expense-incurred basis under health insurance policies or contracts that are issued or delivered in the State; and

(2) health maintenance organizations that provide hospital, medical, or surgical benefits to individuals or groups under contracts that are issued or delivered in the State.

(b) An entity subject to this section that provides health benefits to full-time students over the age of 18 may not exclude health benefits for a student over the age of 18 who:

(1) is enrolled less than full time as a result of a documented disability that prevents the student from maintaining a full-time course load; and

(2) is maintaining a course load of at least 7 credit hours per semester.

(c) An entity subject to this section may require the insured, subscriber, or enrollee to provide verification of the disability from a disability services professional employed by the institution of higher education that the student attends or a health care provider with special expertise in and knowledge of the disability.

§15–418.

(a) (1) In this section the following words have the meanings indicated.

(2) "Carrier" means:

(i) an insurer;

(ii) a nonprofit health service plan; or

(iii) a health maintenance organization.

(3) "Child dependent" means an individual who:

(i) is:

1. the grandchild of the insured; or

2. a child who is entitled to dependent coverage under § 15–403.1 of this subtitle;

(ii) is unmarried; and

(iii) is under the age of 25 years.

(b) (1) This section applies to:

(i) each policy of individual or group health insurance that is issued in the State;

(ii) each contract that is issued in the State by a nonprofit health service plan; and

(iii) each contract that is issued in the State by a health maintenance organization.

(2) Notwithstanding paragraph (1) of this subsection, this section does not apply to:

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

1. coverage only for loss caused by an accident;

2. disability coverage;

3. credit–only insurance; or

4. long–term care coverage; or

(ii) the following benefits if they are provided under a separate contract:

1. dental coverage;

2. vision coverage;

3. Medicare supplement insurance;

4. coverage limited to benefits for a specified disease or diseases;

5. travel accident or sickness coverage; and

6. fixed indemnity limited benefit insurance that does not provide benefits on an expense incurred basis.

(c) Each policy or contract subject to this section that provides coverage for dependents shall:

(1) include coverage for a child dependent;

(2) provide the same health insurance benefits to a child dependent that are available to any other covered dependent; and

(3) provide health insurance benefits to a child dependent at the same rate or premium applicable to any other covered dependent.

(d) This section does not limit or alter any right to dependent coverage or to the continuation of coverage that is otherwise provided for in this article.

§15–501.

An individual, group, or blanket health insurance contract may not contain a provision that reduces payments to an individual entitled to receive disability payments under the contract because the individual receives an increase in Social Security payments.

§15–502.

(a) This section applies to each individual or group policy or certificate of health insurance or automobile insurance that is:

(1) delivered or issued for delivery in the State by an insurer or nonprofit health service plan; and

(2) issued, renewed, amended, or reissued on or after July 1, 1978.

(b) A policy or certificate subject to this section that provides or pays for health care benefits may not contain a provision that denies or reduces benefits because services are rendered to a policyholder, certificate holder, or beneficiary who is eligible for or receives medical assistance under § 15-103 of the Health - General Article.

§15–503.

An insurer or nonprofit health service plan may not deny, cancel, or refuse to renew an individual, group, or blanket health insurance policy solely because the insured has been exposed to diethylstilbestrol, commonly known as DES.

§15–505.

(a) This section applies to each individual, group, or blanket health insurance policy or certificate that is issued by an insurer or nonprofit health service plan on or after July 2, 1970, covering a person in the State.

(b) (1) A policy or certificate subject to this section that provides coverage for disability or sickness while an individual is confined at home may not exclude payments or benefits because the individual leaves home for medical treatment.

(2) Coverage extends to individuals confined at home, who are otherwise eligible, regardless of the place of medical treatment.

§15–506.

(a) Each insurer and nonprofit health service plan that provides maternity benefits in a policy form customarily issued on an individual or family basis shall offer the benefits to individuals regardless of marital status.

(b) (1) This subsection applies to each group or blanket health insurance policy that is delivered or issued for delivery in the State by an insurer or nonprofit health service plan.

(2) Each policy subject to this subsection that provides maternity benefits for pregnancy and childbirth of employees or members or of covered dependents of employees or members, whether the benefits are in the form of disability, hospital, medical, or surgical benefits, shall provide identical benefits regardless of marital status to:

(i) all covered employees or members; or

(ii) all covered employees or members and all covered dependents of employees or members.

§15–508.1.

(a) (1) In this section the following words have the meanings indicated.

(2) "Carrier" means an insurer or a nonprofit health service plan.

(3) "Exclusionary rider" means an endorsement to an individual health benefit plan that excludes benefits for one or more named conditions that are discovered by a carrier during the underwriting process.

(4) "Health benefit plan" has the meaning stated in § 15–1301 of this title.

(5) "Individual health benefit plan" means a health benefit plan issued by a carrier that insures:

(i) only one individual; or

(ii) one individual and one or more family members of the individual.

(b) This section applies to individual health benefit plans that are issued or delivered in the State before March 23, 2010.

(c) A carrier may not attach an exclusionary rider to an individual health benefit plan unless the carrier obtains the prior written consent of the policyholder.

(d) A carrier may impose a preexisting condition exclusion or limitation on an individual for a condition that was not discovered during the underwriting process for an individual health benefit plan only if the exclusion or limitation:

(1) relates to a condition of the individual, regardless of its cause, for which medical advice, diagnosis, care, or treatment was recommended or received within the 12–month period immediately preceding the effective date of the individual's coverage; and

(2) extends for a period of not more than 12 months after the effective date of the individual's coverage.

§15–509.

(a) (1) In this section the following words have the meanings indicated.

(2) "Activity–only wellness program" means a type of health–contingent wellness program in which an individual is required to perform or complete an activity related to a health factor in order to obtain a reward, but which does not require the individual to attain or maintain a specific health outcome.

(3) "Carrier" means:

(i) an insurer;

(ii) a nonprofit health service plan; or

(iii) a health maintenance organization.

(4) "Grandfathered health benefit plan" has the meaning stated in § 1251 of the Affordable Care Act.

(5) "Health benefit plan" has the meaning stated in § 15–1301 of this title.

(6) (i) "Health–contingent wellness program" means a program that requires an individual to satisfy a standard related to a health factor to obtain a reward.

(ii) "Health–contingent wellness program" includes:

1. an activity–only wellness program; and

2. an outcome–based wellness program.

(7) "Health factor" means, in relation to an individual, any of the following health status–related factors:

(i) health status;

(ii) medical condition;

(iii) claims experience;

(iv) receipt of health care;

(v) medical history;

(vi) genetic information;

(vii) evidence of insurability;

(viii) disability; or

(ix) any other health status–related factor determined appropriate by the U.S. Secretary of Health and Human Services.

(8) "Incentive" means:

(i) a discount of a premium or contribution;

(ii) a waiver of all or part of a cost–sharing mechanism, such as deductibles, copayments, or coinsurance;

(iii) the absence of a surcharge;

(iv) the value of a benefit that otherwise would not be provided under the policy or contract; or

(v) a rebate as permitted under § 27–210 of this article.

(9) "Outcome–based wellness program" means a type of health–contingent wellness program in which an individual must attain or maintain a specific health outcome in order to obtain a reward.

(10) "Participatory wellness program" means a program that does not:

(i) provide a reward; or

(ii) include any conditions for obtaining a reward that are based on an individual satisfying a standard that is related to a health factor.

(11) "Reward" means:

(i) obtaining an incentive; or

(ii) avoiding a penalty.

(b) This section applies to grandfathered and nongrandfathered individual and group health benefit plans.

(c) (1) A carrier may include a participatory wellness program as part of an individual or group health benefit plan.

(2) A participatory wellness program shall be made available to all similarly situated individuals regardless of health status.

(d) A carrier may condition a reward for an activity–only wellness program in a group health benefit plan if:

(1) the activity–only wellness program provides individuals with an opportunity to qualify for the reward at least once a year;

(2) the reward for the activity–only wellness program, together with the reward for other health–contingent wellness programs with respect to the health benefit plan, does not exceed:

(i) 30% of the total cost of employee–only coverage under the health benefit plan, except that the applicable percentage is increased by an additional 20 percentage points to the extent that the additional percentage is in connection with a program designed to prevent or reduce tobacco use; or

(ii) when the plan provides coverage for family members, and when family members are permitted to participate in the activity–only wellness program, 30% of the cost of the coverage in which the family members are enrolled, except that the applicable percentage is increased by an additional 20 percentage points to the extent that the additional percentage is in connection with a program designed to prevent or reduce tobacco use;

(3) the activity–only wellness program is reasonably designed to promote health or prevent disease;

(4) the full reward under the activity–only wellness program is available to all similarly situated individuals; and

(5) the carrier discloses the availability of a reasonable alternative standard to qualify for the reward in all plan materials describing the terms of an activity–only wellness program.

(e) An activity–only wellness program shall be construed to be reasonably designed to promote health or prevent disease if the activity–only wellness program:

(1) has a reasonable chance of improving the health of or preventing disease in participating individuals;

(2) is not overly burdensome;

(3) is not a subterfuge for discriminating based on a health factor;

(4) is not highly suspect in the method chosen to promote health or prevent disease; and

(5) provides a reasonable alternative standard to qualify for the reward for all individuals who do not meet the initial standard that is related to a health factor.

(f) (1) For an activity–only wellness program, a carrier shall provide a reasonable alternative standard for obtaining the reward for any individual who requests an alternative standard and for whom it is:

(i) unreasonably difficult due to a medical condition to satisfy the otherwise applicable standard; or

(ii) medically inadvisable to attempt to satisfy the otherwise applicable standard.

(2) A carrier may seek verification, such as a statement from an individual's health care provider, that a health factor makes it unreasonably difficult or medically inadvisable for the individual to satisfy or attempt to satisfy the otherwise applicable standard, if reasonable under the circumstances.

(g) (1) A carrier may condition the reward for an outcome–based wellness program in a group health benefit plan if:

(i) the outcome–based wellness program meets the requirements under subsections (d) and (e) of this section;

(ii) the full reward is available to all similarly situated individuals; and

(iii) an individual, on request, is provided with a reasonable alternative standard, provided that the individual does not meet the initial standard because of a medical condition or other health factor.

(2) If the reasonable alternative standard is an educational program, the carrier:

(i) shall make the educational program available or assist the individual in finding a program; and

(ii) may not require an individual to pay for the cost of the educational program.

(3) The time commitment required for the alternative standard shall be reasonable.

(4) If the reasonable alternative is a diet program, the carrier is not required to pay for the cost of food, but is required to pay any membership or participation fee.

(5) If the reasonable alternative standard is an activity–only wellness program, the reasonable alternative standard must comply with the requirements for activity–only wellness programs as if it were an initial program standard.

(6) If the reasonable alternative standard is an outcome–based wellness program, the reasonable alternative standard must comply with the requirements for outcome–based wellness programs.

(7) The reasonable alternative may not be a requirement to meet a different level of the same standard without additional time to comply that takes into account the individual's circumstances.

(8) An individual shall be given the opportunity to comply with the recommendations of the individual's personal physician as a second reasonable alternative standard to meeting the reasonable alternative standard defined by the carrier, but only if the physician joins in the request.

(h) A reward under an outcome–based wellness program is not available to all similarly situated individuals as required by subsection (g)(1)(ii) of this section unless the outcome–based wellness program allows a reasonable alternative standard, or waiver of the otherwise applicable standard, for obtaining the reward

for any individual who does not meet the initial standard based on the measurement, test, or screening required by the outcome–based wellness program.

(i) (1) In determining if a carrier's health–contingent wellness program meets the requirements of this section, the Commissioner may request a review of the health–contingent wellness program by an independent review organization selected from the list compiled under § 15–10A–05(b) of this title.

(2) The expense of the review of the health–contingent wellness program by an independent review organization shall be paid by the carrier in the manner provided under § 15–10A–05(h) of this title.

§15–510.

No individual, group, or blanket insurance policy or contract issued or delivered in the State by an insurer, a nonprofit health service plan, or a health maintenance organization may deny a covered medically necessary behavioral health care service provided by a participating provider to a member who is a student solely on the basis that the service is provided at a public school or through a school–based health center under § 7–440 of the Education Article.

§15–601.

(a) This section applies to insurers and nonprofit health service plans that provide hospital benefits in the State under individual, group, or blanket health insurance policies.

(b) Each entity subject to this section that offers benefits to an insured or beneficiary who uses designated low-cost hospitals, that are different from the benefits offered when other hospitals are used, shall base its designation of a low-cost hospital on information that:

(1) excludes the reasonable cost of medical education and of uncompensated care as determined by the Health Services Cost Review Commission;

(2) excludes the cost associated with a shock trauma facility as determined by the Health Services Cost Review Commission;

(3) excludes the amount in rates approved by the Health Services Cost Review Commission for undergraduate nursing education;

(4) excludes from consideration each hospital that is determined by the Maryland Health Care Commission to be a sole community provider; and

(5) compares hospitals on a regional basis, unless the entity demonstrates to the satisfaction of the Commissioner that a statewide comparison is more appropriate.

(c) An entity subject to this section that provides hospital benefits under subsection (b) of this section may not subsidize those benefits from premiums earned by other benefit plans, programs, or policies.

§15–602.

(a) This section applies to each individual, group, or blanket health insurance policy or certificate that is delivered or issued for delivery in the State by an insurer or nonprofit health service plan on or after July 2, 1969.

(b) A policy or certificate subject to this section may not exclude payments or benefits for the treatment of tuberculosis, mental illness, or another illness covered under the policy or certificate because treatment is received in a hospital or other institution of the State or of a county or municipal corporation of the State, whether or not the hospital or other institution is deemed charitable.

§15–603.

(a) If the Maryland Department of Health notifies an insurer or nonprofit health service plan that the Department has paid for or provided services to an individual who is covered under an individual, group, or blanket health insurance policy or contract that the insurer or nonprofit health service plan issued, delivered, or renewed in the State, the insurer or nonprofit health service plan shall reimburse the Department for the cost of the services, regardless of any provision in the health insurance policy or contract that requires payment to the policyholder, subscriber, or another payee.

(b) (1) The benefits payable to the Maryland Department of Health under this section are limited to those benefits available under the terms and conditions of the health insurance policy or contract for the services paid for or provided by the Department.

(2) An insurer or nonprofit health service plan is not required to make payment to the Department under this section if, before receiving notice from the Department under subsection (a) of this section, the insurer or nonprofit health service plan has paid the benefits available under the health insurance policy or contract in good faith and in accordance with the terms and conditions of the policy or contract.

(c) Notwithstanding any other provision of a health insurance policy, contract, or certificate, an insurer or nonprofit health service plan may not refuse to reimburse the Maryland Department of Health because of the manner, form, or date of a claim for reimbursement if, within 2 years after the date of the service for which reimbursement is sought, the Department provides to the insurer or nonprofit health service plan sufficient information to determine the liability of the insurer or nonprofit health service plan.

§15–604.

Each authorized insurer, nonprofit health service plan, and fraternal benefit society, and each managed care organization that is authorized to receive Medicaid prepaid capitation payments under Title 15, Subtitle 1 of the Health – General Article, shall:

(1) pay hospitals for hospital services rendered on the basis of the rate approved by the Health Services Cost Review Commission; and

(2) comply with the applicable terms and conditions of the all–payer model contract, as defined in § 19–201 of the Health – General Article.

§15–605.

(a) (1) On or before March 1 of each year, an annual report that meets the specifications of paragraph (2) of this subsection shall be submitted to the Commissioner by, as applicable in accordance with regulations adopted by the Commissioner, each managed care organization that is authorized to receive Medicaid prepaid capitation payments under Title 15, Subtitle 1 of the Health – General Article.

(2) The annual report required under this subsection shall:

(i) be submitted in a form required by the Commissioner; and

(ii) include for the preceding calendar year the following data for all health benefit plans specific to the State:

1. premiums written;

2. premiums earned;

3. total amount of incurred claims including reserves for claims incurred but not reported at the end of the previous year;

4. total amount of incurred expenses, including commissions, acquisition costs, general expenses, taxes, licenses, and fees, estimated if necessary;

5. loss ratio; and

6. expense ratio.

(3) The data required under paragraph (2) of this subsection shall be reported in the aggregate.

(4) The Commissioner, in consultation with the Secretary of Health, shall establish and adopt by regulation a methodology to be used in the annual report that ensures a clear separation of all medical and administrative expenses whether incurred directly or through a subcontractor.

(5) The Commissioner may conduct an examination to ensure that an annual report submitted under this subsection is accurate.

(b) (1) Before a managed care organization may enroll a medical assistance program recipient, the managed care organization shall provide a business plan to the Commissioner.

(2) As part of the annual report required under subsection (a) of this section, a managed care organization shall:

(i) provide a list of the total compensation from the managed care organization, including all cash and deferred compensation, stock, and stock options in addition to salary, of each member of the board of directors of the managed care organization, and each senior officer of the managed care organization or any subsidiary of the managed care organization as designated by the Commissioner; and

(ii) provide any other information or documents necessary for the Commissioner to ensure compliance with this subsection and subsections (a)(3)(iii) and (c)(5), (6), and (7) of this section and for the Secretary of Health to carry out Title 15, Subtitle 1 of the Health – General Article.

(c) (1) (i) Individual health insurance coverage and health insurance coverage offered in the small group and large group markets, as those terms are defined in the federal Public Health Service Act, issued or delivered in the State by an authorized insurer, nonprofit health service plan, or health maintenance organization shall comply with the loss ratio requirements of sections 1001(5) and 10101(f) of the Affordable Care Act, which amend section 2718 of the Public Health Service Act.

(ii) The provisions of subparagraph (i) of this paragraph do not apply to coverage for excepted benefits, as defined in 45 C.F.R. § 146.145(c).

(iii) The Commissioner may require an insurer, a nonprofit health service plan, or a health maintenance organization to file new rates if the loss ratio reported in the manner required under 45 C.F.R. § 158 is less than that required under subparagraph (i) of this paragraph.

(2) The authority of the Commissioner under paragraph (1) of this subsection to require an insurer, nonprofit health service plan, or health maintenance organization to file new rates based on loss ratio:

(i) is in addition to any other authority of the Commissioner under this article to require that rates not be excessive, inadequate, or unfairly discriminatory; and

(ii) does not limit any existing authority of the Commissioner to determine whether a rate is excessive.

(3) (i) In determining whether to require an insurer to file new rates under this subsection, the Commissioner may consider the amount of health insurance premiums earned in the State on individual policies in proportion to the total health insurance premiums earned in the State for the insurer.

(ii) The insurer shall provide to the Commissioner the information necessary to determine the proportion of individual health insurance premiums to total health insurance premiums as provided under this paragraph.

(4) The Secretary of Health, in consultation with the Commissioner and in accordance with their memorandum of understanding, may adjust capitation payments for a managed care organization or for the Maryland Medical Assistance Program of a managed care organization that is a certified health maintenance organization if the loss ratio is less than 85%.

(5) A loss ratio reported under paragraph (4) of this subsection shall be calculated separately and may not be part of another loss ratio reported under this section.

(6) Any rebate received by a managed care organization may not be considered part of the loss ratio of the managed care organization.

(7) If the Secretary of Health adjusts capitation payments for a managed care organization or a certified health maintenance organization under

paragraph (4) of this subsection, the managed care organization or certified health maintenance organization may:

(i) appeal the decision of the Secretary to the Board of Review established under Title 2, Subtitle 2 of the Health – General Article; and

(ii) take any further appeal allowed by the Administrative Procedure Act under Title 10, Subtitle 2 of the State Government Article.

(8) The Secretary of Health shall publish in a conspicuous manner on the Web site of the Maryland Department of Health:

(i) the loss ratio, as determined by the Maryland Department of Health for each managed care organization participating in the medical assistance program, for each year during the most recent 3–year period;

(ii) for each year during the 3–year period, the amount to be returned to the medical assistance program, if any, from a managed care organization for failing to meet the loss ratio requirement under paragraph (4) of this subsection; and

(iii) any amount due to or received by the Maryland Department of Health from a managed care organization for each year during the 3–year period.

(d) Each insurer, nonprofit health service plan, and health maintenance organization shall provide annually to each contract holder a written statement of the loss ratio for a health benefit plan as submitted to the Commissioner under this section.

(e) (1) (i) On or before March 1 of each year, unless, for good cause shown, the Commissioner extends the time for a reasonable period, each managed care organization shall file with the Commissioner a report that shows the financial condition of the managed care organization on the last day of the preceding calendar year and any other information that the Commissioner requires by bulletin or regulation.

(ii) At any time, the Commissioner may require a managed care organization to file an interim statement containing the information that the Commissioner considers necessary.

(iii) The annual and interim reports shall be filed in a form required by the Commissioner.

(2) (i) Except as provided in paragraph (3) of this subsection on or before June 1 of each year, each managed care organization shall file with the Commissioner an audited financial report for the preceding calendar year.

(ii) The audited financial report shall:

1. be filed in a form required by the Commissioner; and

2. be certified by an audit of an independent certified public accountant.

(3) With 90 days' advance notice, the Commissioner may require a managed care organization to file an audited financial report earlier than the date specified in paragraph (2) of this subsection.

(f) Each financial report filed under this section is a public record.

§15–701.

(a) (1) This subsection applies to each individual or group health insurance policy, contract, or certificate that is:

(i) delivered or issued for delivery in the State by an insurer or nonprofit health service plan; and

(ii) issued, renewed, amended, or reissued on or after July 1, 1984.

(2) Notwithstanding any other provision of a policy, contract, or certificate subject to this subsection, if the policy, contract, or certificate provides for reimbursement for a service that is within the lawful scope of practice of a health care provider licensed under the Health Occupations Article, the insured or any other person covered by or entitled to reimbursement under the policy, contract, or certificate is entitled to reimbursement for the service.

(b) An individual or group disability insurance policy or contract that is delivered or issued for delivery in the State may not contain a provision that precludes a licensed health care provider from attesting to the rendition of service that is within the lawful scope of practice of the attesting provider.

§15–702.

(a) This section applies to each self-funded group insurance plan that:

(1) (i) is formed by an order, society, or association that is incorporated or has a main office in the State; or

(ii) covers individuals who reside or work in the State; and

(2) is issued, renewed, amended, or reissued on or after July 1, 1972.

(b) Notwithstanding any other provision of a self-funded group insurance plan subject to this section, if the plan provides for reimbursement for a service that is within the lawful scope of practice of a physician, dentist, or podiatrist, the plan may not prohibit a person covered by the plan from being reimbursed for the service regardless of whether the service is performed by a physician, dentist, or podiatrist.

§15–703.

(a) In this section, "certified nurse practitioner" means a licensed registered nurse who has:

(1) completed a nurse practitioner program approved by the State Board of Nursing; and

(2) passed an examination approved by the State Board of Nursing.

(b) Each insurer that proposes to issue, renew, amend, or reissue an individual, group, or blanket health insurance policy in the State that is written on an expense-incurred basis shall offer the option of providing benefits for expenses that arise from services rendered by a certified nurse practitioner.

(c) Each nonprofit health service plan that proposes to issue, renew, amend, or reissue a health insurance policy in the State shall offer the option of providing benefits for expenses that arise from services rendered by a certified nurse practitioner.

(d) The insurer or nonprofit health service plan may limit the coverage offered under this section for services provided by a certified nurse practitioner while working under the direct supervision of a physician.

(e) The utilization of health insurance benefits provided under this section for services rendered by a certified nurse practitioner is subject to review by a peer review committee appointed by the State Board of Nursing.

§15–704. IN EFFECT

(a) This section applies to each individual, group, or blanket health insurance policy, contract, or certificate of an insurer or nonprofit health service plan that:

(1) (i) is delivered or issued for delivery in the State;

(ii) is issued to a group that is incorporated or has a main office in the State; or

(iii) covers individuals who reside or work in the State; and

(2) is issued, renewed, amended, or reissued on or after October 1, 2003.

(b) If a policy, contract, or certificate subject to this section provides for reimbursement for a service that is within the lawful scope of practice of a licensed clinical professional counselor, a licensed clinical marriage and family therapist, a licensed clinical alcohol and drug counselor, or a licensed clinical professional art therapist, the insured or any other person covered by the policy or certificate is entitled to reimbursement for the service.

§15–704. ** TAKES EFFECT JANUARY 1, 2027 PER CHAPTERS 43 AND 44 OF 2026 **

(a) This section applies to each individual, group, or blanket health insurance policy, contract, or certificate of an insurer or nonprofit health service plan that:

(1) (i) is delivered or issued for delivery in the State;

(ii) is issued to a group that is incorporated or has a main office in the State; or

(iii) covers individuals who reside or work in the State; and

(2) is issued, renewed, amended, or reissued on or after October 1, 2003.

(b) If a policy, contract, or certificate subject to this section provides for reimbursement for a service that is within the lawful scope of practice of a licensed clinical professional counselor, a licensed clinical marriage and family therapist, a licensed clinical alcohol and drug counselor, or a licensed clinical professional art therapist, the insured or any other person covered by the policy or certificate is entitled to reimbursement for the service.

(c) (1) Subject to paragraph (2) of this subsection, if a policy, contract, or certificate subject to this section provides for reimbursement of a service that is within the lawful scope of practice of a licensed graduate professional counselor, the insured or any other person covered by the policy, contract, or certificate is entitled to reimbursement for the service provided by a graduate–level counseling clinical intern.

(2) The services provided under this subsection shall be reimbursable if the services are:

(i) provided at an outpatient health care facility;

(ii) provided by a counseling clinical intern who is:

1. enrolled in a counseling graduate program; and

2. providing the services under direct supervision as supervised by a Board–approved supervisor, as defined under COMAR 10.58.12.02, who meets the qualification under COMAR 10.58.12.08; and

(iii) billed by the Board–approved supervisor of the counseling clinical intern who provides supervision in accordance with item (ii)2 of this paragraph.

§15–705.

For the purposes of a policy of health insurance or other insurance, a chiropractor is entitled to compensation for those services that the chiropractor is licensed to perform under the Health Occupations Article and that the chiropractor has rendered to an insured.

§15–706.

(a) (1) Subject to subsection (c) of this section, a policy, contract, or certificate described in § 15–701(a) of this subtitle may provide for reimbursement under § 15–701(a) of this subtitle for usual, customary, and reasonable charges for services rendered by a dietitian or nutritionist licensed under the Health Occupations Article if a licensed physician determines that the services are medically necessary for the treatment of cardiovascular disease, diabetes, prediabetes, obesity, malnutrition, cancer, cerebral vascular disease, or kidney disease.

(2) Application of this subsection is limited to six visits with a dietitian or nutritionist during a 12–month period for each condition described in

paragraph (1) of this subsection and to services for the treatment of obesity only if provided in conjunction with the treatment of a condition described in paragraph (1) of this subsection.

(b) This section does not require a policy, contract, or certificate described in § 15–701(a) of this subtitle to provide coverage for services rendered by a nutritionist or dietitian.

(c) If a service covered under a policy, contract, or certificate described in § 15–701(a) of this subtitle is provided to a hospital patient by a dietitian or nutritionist:

(1) the usual, customary, and reasonable charges of the dietitian or nutritionist shall be included in the patient's hospital charges; and

(2) the dietitian or nutritionist may not bill the patient separately for the service.

§15–707. IN EFFECT

(a) This section applies to each individual, group, or blanket health insurance policy of an insurer or nonprofit health service plan that:

(1) (i) is delivered or issued for delivery in the State;

(ii) is issued to a group that is incorporated or has a main office in the State; or

(iii) covers individuals who reside or work in the State; and

(2) is issued, renewed, amended, or reissued on or after January 1, 1978.

(b) If a policy or certificate subject to this section provides for reimbursement for a service that is within the lawful scope of practice of a licensed certified social worker, the insured or any other person covered by the policy or certificate is entitled to reimbursement for the service regardless of whether the service is performed by a physician or licensed certified social worker–clinical.

§15–707. ** TAKES EFFECT JANUARY 1, 2027 PER CHAPTERS 43 AND 44 OF 2026 **

(a) This section applies to each individual, group, or blanket health insurance policy of an insurer or nonprofit health service plan that:

(1) (i) is delivered or issued for delivery in the State;

(ii) is issued to a group that is incorporated or has a main office in the State; or

(iii) covers individuals who reside or work in the State; and

(2) is issued, renewed, amended, or reissued on or after January 1, 1978.

(b) If a policy or certificate subject to this section provides for reimbursement for a service that is within the lawful scope of practice of a licensed certified social worker, the insured or any other person covered by the policy or certificate is entitled to reimbursement for the service regardless of whether the service is performed by a physician or licensed certified social worker–clinical.

(c) (1) Subject to paragraph (2) of this subsection, if a policy or certificate subject to this section provides for reimbursement of a service that is within the lawful scope of practice of a licensed master social worker, the insured or any other person covered by the policy, contract, or certificate is entitled to reimbursement for the service provided by a graduate–level social work clinical intern.

(2) The services provided under this subsection shall be reimbursable if the services are:

(i) provided at an outpatient health care facility;

(ii) provided by a social work clinical intern who is:

1. enrolled in a social work graduate program; and

2. providing the services under the direct supervision of a licensed certified social worker–clinical; and

(iii) billed by the supervising licensed certified social worker–clinical.

§15–708.

(a) In this section, "nurse anesthetist" means a registered nurse who is certified as a nurse anesthetist by:

(1) the Council on Certification of Nurse Anesthetists; or

(2) the Council on Recertification of Nurse Anesthetists.

(b) This section applies to each individual, group, or blanket health insurance policy, contract, or certificate of an insurer or nonprofit health service plan that:

(1) (i) is issued or delivered in the State;

(ii) is issued to a group that is incorporated or has a main office in the State; or

(iii) covers individuals who reside or work in the State;

(2) is issued, renewed, amended, or reissued on or after July 1, 1984; and

(3) if issued by an insurer, is written on an expense-incurred basis.

(c) Notwithstanding any other provision of a policy, contract, or certificate subject to this section, if the policy, contract, or certificate provides for reimbursement for a service that is within the lawful scope of practice of a nurse anesthetist, the insured or any other person covered by the policy, contract, or certificate is entitled to reimbursement for the service regardless of whether the service is performed by a physician or nurse anesthetist.

(d) A policy that provides benefits under this section for services rendered by a nurse anesthetist may not require, as a condition for the payment of benefits, that the nurse anesthetist be employed by a physician.

(e) The utilization of health insurance benefits provided under this section for services rendered by a nurse anesthetist is subject to review by a peer review committee appointed by the State Board of Nursing.

§15–709.

(a) In this section, "nurse midwife" means a licensed registered nurse who is certified as a nurse midwife by the American College of Nurse-Midwives.

(b) Each insurer that proposes to issue, renew, amend, or reissue an individual, group, or blanket health insurance policy in the State that is written on an expense-incurred basis shall offer the option of providing benefits for expenses that arise from services rendered by a nurse midwife.

(c) Each nonprofit health service plan that proposes to issue, renew, amend, or reissue a health insurance policy in the State shall offer the option of providing benefits for expenses that arise from services rendered by a nurse midwife.

(d) (1) This subsection applies to each individual, group, or blanket health insurance policy, contract, or certificate of an insurer or nonprofit health service plan that:

(i) 1. is issued or delivered in the State;

2. is issued to a group that is incorporated or has a main office in the State; or

3. covers individuals who reside or work in the State;

(ii) is issued, renewed, amended, or reissued on or after July 1, 1979; and

(iii) if issued by an insurer, is written on an expense-incurred basis.

(2) Notwithstanding any other provision of a policy, contract, or certificate subject to this subsection, if the policy, contract, or certificate provides for reimbursement for a service that is within the lawful scope of practice of a nurse midwife, the insured or any other person covered by the policy, contract, or certificate is entitled to reimbursement for the service regardless of whether the service is performed by a physician or nurse midwife.

(e) A policy that provides benefits under this section for services rendered by a nurse midwife may not require, as a condition for the payment of benefits, that the nurse midwife be employed by a physician or act under a physician's orders.

(f) The utilization of health insurance benefits provided under this section for services rendered by a nurse midwife is subject to review by a peer review committee appointed by the State Board of Nursing.

§15–710.

(a) This section applies to each individual or group health insurance policy or certificate of an insurer that:

(1) is issued or delivered in the State;

(2) is issued to a group that is incorporated or has a main office in the State; or

(3) covers individuals who reside or work in the State.

(b) Each policy or certificate subject to this section that provides for reimbursement for a service that is within the lawful scope of practice of an optometrist licensed under the Health Occupations Article shall require the insurer to reimburse the insured or any other person covered by the policy or certificate for the service performed by the optometrist in accordance with the other provisions of the policy or certificate.

§15–711.

(a) This section applies to each individual or group health insurance policy or contract that is:

(1) delivered or issued for delivery in the State by an insurer or nonprofit health service plan; and

(2) issued, renewed, amended, or reissued on or after October 1, 1993.

(b) An insurer or nonprofit health service plan may not impose a time limit on the receipt of services covered under a policy or contract subject to this section that are provided during the policy or contract period by a physical therapist licensed under the Health Occupations Article.

(c) This section does not prohibit an insurer or nonprofit health service plan from imposing a limit on the number of visits with a licensed physical therapist that are allowed under a policy or contract.

§15–712.

Notwithstanding § 15-701(a) of this subtitle, unless a policy, contract, or certificate described in § 15-701(a) of this subtitle expressly provides for reimbursement for a service that is within the lawful scope of practice of a physician assistant certified under the Health Occupations Article, the provisions of the Health Occupations Article that govern the certification and regulation of physician assistants may not be construed to entitle the insured or any other person covered by the policy, contract, or certificate to reimbursement for the service.

§15–713.

(a) This section applies to individual, group, or blanket health insurance policies and contracts delivered or issued for delivery in the State by insurers, nonprofit health service plans, and health maintenance organizations.

(b) Notwithstanding any other provision of an individual, group, or blanket health insurance policy or contract subject to this section, if the policy or contract provides for reimbursement for a service that is within the lawful scope of practice of a licensed podiatrist, the insured or any other person covered by or entitled to reimbursement under the policy or contract is entitled to the same amount of reimbursement for the service regardless of whether the service is performed by a physician or licensed podiatrist.

(c) This section does not prohibit, and may not be construed as prohibiting, the determination of reimbursement based on the geographic location of the delivery of service, the preeminent qualifications of a physician or podiatrist, or the need to provide services in an underserved area of the State.

§15–714. IN EFFECT

(a) This section applies to each individual or group health insurance policy, contract, or certificate that:

(1) (i) is issued or delivered in the State;

(ii) is issued to a group that is incorporated or has a main office in the State; or

(iii) covers individuals who reside or work in the State; and

(2) is issued, renewed, amended, or reissued on or after July 1, 1972.

(b) Notwithstanding any other provision of a policy, contract, or certificate subject to this section, if the policy, contract, or certificate provides for reimbursement for a service that is within the lawful scope of practice of a licensed psychologist, the insured or any other person covered by the policy, contract, or certificate is entitled to reimbursement for the service regardless of whether the service is performed by a physician or licensed psychologist.

§15–714. ** TAKES EFFECT JANUARY 1, 2027 PER CHAPTERS 43 AND 44 OF 2026 **

(a) This section applies to each individual or group health insurance policy, contract, or certificate that:

(1) (i) is issued or delivered in the State;

(ii) is issued to a group that is incorporated or has a main office in the State; or

(iii) covers individuals who reside or work in the State; and

(2) is issued, renewed, amended, or reissued on or after July 1, 1972.

(b) Notwithstanding any other provision of a policy, contract, or certificate subject to this section, if the policy, contract, or certificate provides for reimbursement for a service that is within the lawful scope of practice of a licensed psychologist, the insured or any other person covered by the policy, contract, or certificate is entitled to reimbursement for the service regardless of whether the service is performed by a physician or licensed psychologist.

(c) (1) Subject to paragraph (2) of this subsection, if a policy, contract, or certificate subject to this section provides for reimbursement of a service that is within the lawful scope of practice of a licensed psychologist, the insured or any other person covered by the policy, contract, or certificate is entitled to reimbursement for the service provided by a graduate–level psychology clinical intern.

(2) The services provided under this subsection shall be reimbursable if the services are:

(i) provided at an outpatient health care facility;

(ii) provided by a psychology clinical intern who is:

1. enrolled in a psychology graduate program; and

2. providing the services under the direct supervision of a licensed psychologist; and

(iii) billed by the supervising licensed psychologist.

§15–715.

(a) This section applies to each individual or group health insurance policy or contract that is issued or delivered in the State by an insurer, nonprofit health service plan, or health maintenance organization.

(b) To the extent required under federal law, an insurer, nonprofit health service plan, or health maintenance organization shall reimburse a community

health resource, as defined in § 19-2101 of the Health - General Article, for covered services provided to the insured or any other person covered by the policy or contract.

§15–716.

(a) This section applies to individual, group, or blanket health insurance policies and contracts delivered or issued for delivery in the State by insurers, nonprofit health service plans, and health maintenance organizations that provide coverage for services that are within the lawful scope of practice of a licensed pharmacist.

(b) An entity subject to this section shall provide coverage for services rendered by a licensed pharmacist acting within the pharmacist's lawful scope of practice to an individual who is covered under a policy or contract issued or delivered by the entity, to the same extent as services rendered by any other licensed health care practitioner.

(c) Reimbursement for services provided under this section may not be conditioned on whether the licensed pharmacist is:

(1) employed by a physician, pharmacy, or facility; or

(2) acting under a physician's orders.

§15–801.

(a) This section applies to:

(1) insurers that propose to issue or deliver in the State group or blanket health insurance policies that are written on an expense-incurred basis; and

(2) nonprofit health service plans that propose to issue or deliver in the State group medical or major medical contracts that are written on an expense-incurred basis.

(b) An entity subject to this section shall offer the policyholder the option of providing benefits for expenses arising from the care, including nursing home care and intermediate or custodial nursing care, of individuals who have Alzheimer's disease.

(c) An entity subject to this section shall offer the policyholder the option of providing benefits for expenses arising from the care of elderly individuals, including nursing home care and intermediate or custodial nursing care of elderly individuals

who have any disease, other than Alzheimer's disease, that is designated in regulations adopted by the Commissioner.

(d) An entity subject to this section may establish reasonable limits on the benefits offered under this section, including copayment and deductible provisions and maximum annual and lifetime dollar limits.

§15–802.

(a) (1) In this section the following words have the meanings indicated.

(2) "Alcohol misuse" has the meaning stated in § 8–101 of the Health – General Article.

(3) "ASAM criteria" means the most recent edition of the American Society of Addiction Medicine treatment criteria for addictive, substance–related, and co–occurring conditions that establishes guidelines for placement, continued stay and transfer or discharge of patients with addiction and co–occurring conditions.

(4) "Drug misuse" has the meaning stated in § 8–101 of the Health – General Article.

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

(6) "Health benefit plan" means:

(i) for a group or blanket plan, a health benefit plan as defined in § 15–1401 of this title;

(ii) for an individual plan, a health benefit plan as defined in § 15–1301(l) of this title; or

(iii) short–term limited duration insurance as defined in § 15–1301(s) of this title.

(7) "Managed care system" means a system of cost containment methods that a carrier uses to review and preauthorize a treatment plan developed by a health care provider for a covered individual in order to control utilization, quality, and claims.

(8) "Partial hospitalization" means the provision of medically directed intensive or intermediate short–term treatment:

(i) to an insured, subscriber, or member;

(ii) in a licensed or certified facility or program;

(iii) for mental illness, emotional disorders, drug misuse, or alcohol misuse; and

(iv) for a period of less than 24 hours but more than 4 hours in a day.

(9) "Small employer" has the meaning stated in § 31–101 of this article.

(b) With the exception of small employer grandfathered health plan coverage, this section applies to each individual, group, and blanket health benefit plan that is delivered or issued for delivery in the State by an insurer, a nonprofit health service plan, or a health maintenance organization.

(c) A health benefit plan subject to this section shall provide at least the following benefits for the diagnosis and treatment of a mental illness, emotional disorder, drug use disorder, or alcohol use disorder:

(1) inpatient benefits for services provided in a licensed or certified facility, including hospital inpatient and residential treatment center benefits;

(2) partial hospitalization benefits; and

(3) outpatient and intensive outpatient benefits, including all office visits, diagnostic evaluation, opioid treatment services, medication evaluation and management, and psychological and neuropsychological testing for diagnostic purposes.

(d) (1) The benefits under this section are required only for expenses arising from the treatment of mental illnesses, emotional disorders, drug misuse, or alcohol misuse if, in the professional judgment of health care providers:

(i) the mental illness, emotional disorder, drug misuse, or alcohol misuse is treatable; and

(ii) the treatment is medically necessary.

(2) The benefits required under this section:

(i) shall be provided as one set of benefits covering mental illnesses, emotional disorders, drug misuse, and alcohol misuse;

(ii) shall comply with 45 C.F.R. § 146.136(a) through (d) and 29 C.F.R. § 2590.712(a) through (d);

(iii) subject to paragraph (3) of this subsection, may be delivered under a managed care system; and

(iv) for partial hospitalization under subsection (c)(2) of this section, may not be less than 60 days.

(3) The benefits required under this section may be delivered under a managed care system only if the benefits for physical illnesses covered under the health benefit plan are delivered under a managed care system.

(4) The processes, strategies, evidentiary standards, or other factors used to manage the benefits required under this section 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 health benefit plan.

(5) An insurer, nonprofit health service plan, or health maintenance organization shall use the ASAM criteria for all medical necessity and utilization management determinations for substance use disorder benefits.

(e) An entity that issues or delivers a health benefit plan subject to this section shall provide on its website and annually in print to its insureds or members:

(1) notice about the benefits required under this section and the federal Mental Health Parity and Addiction Equity Act; and

(2) notice that the insured or member may contact the Administration for further information about the benefits.

(f) An entity that issues or delivers a health benefit plan subject to this section shall:

(1) post a release of information authorization form on its website; and

(2) provide a release of information authorization form by standard mail within 10 business days after a request for the form is received.

§15–803.

(a) An insurer or nonprofit health service plan that issues or delivers an individual, group, or blanket health insurance policy or contract in the State, or a health maintenance organization that issues or delivers an individual or group contract in the State, may not exclude payments for blood products, both derivatives and components, that otherwise would be covered under the health insurance contract.

(b) This section does not apply to whole blood or concentrated red blood cells.

§15–804.

(a) (1) In this section the following words have the meanings indicated.

(2) "Medical literature" means scientific studies published in a peer–reviewed national professional medical journal.

(3) "Off–label use" means the prescription of a drug for a treatment other than those treatments stated in the labeling approved by the federal Food and Drug Administration.

(4) "Standard reference compendia" means any authoritative compendia as recognized periodically by the federal Secretary of Health and Human Services or the Commissioner.

(b) This section does not:

(1) alter any law that limits the coverage of drugs that have not been approved by the federal Food and Drug Administration;

(2) require coverage of a drug if the federal Food and Drug Administration has determined use of the drug to be contraindicated; or

(3) require coverage of experimental drugs not approved for any indication by the federal Food and Drug Administration.

(c) (1) This subsection applies to each health insurance policy or contract that is delivered or issued for delivery in the State to an employer or individual on a group or individual basis, including a contract issued by a health maintenance organization.

(2) A policy or contract subject to this subsection that provides coverage for drugs may not exclude coverage of a drug for an off–label use of the drug if the drug is recognized for treatment in any of the standard reference compendia or in the medical literature.

(3) Coverage of a drug required by this subsection also includes medically necessary services associated with the administration of the drug.

(d) The Commissioner may direct a person, including a health maintenance organization, that issues a health insurance policy or contract to make payments required by this section.

§15–805.

(a) (1) In this section the following words have the meanings indicated.

(2) "Authorized prescriber" means a licensed dentist, licensed physician, or licensed podiatrist who is authorized under the Health Occupations Article to prescribe a pharmaceutical product.

(3) "Pharmaceutical product" means a drug or medicine that may be prescribed by an authorized prescriber.

(b) This section does not apply to a policy or contract that is issued to an employer under a collective bargaining agreement.

(c) (1) This subsection applies to each policy or contract that is issued or delivered in the State to an employer or individual by an insurer or nonprofit health service plan and that provides group or individual hospital, medical, or surgical benefits.

(2) A policy or contract subject to this subsection that provides reimbursement for a pharmaceutical product prescribed by an authorized prescriber may not establish the amount of reimbursement to the insured or the insured's beneficiary, including copayments and deductibles, based on the identity, practicing specialty, or occupation of the authorized prescriber.

(d) (1) This subsection applies to each individual or group policy or contract that is issued or delivered in the State to an employer or individual by an insurer or nonprofit health service plan and that provides benefits for pharmaceutical products.

(2) A policy or contract subject to this subsection may not impose a copayment, deductible, or other condition on an insured or certificate holder who uses

the services of a community pharmacy that is not imposed when the insured or certificate holder uses the services of a mail order pharmacy, if the benefits are provided under the same program, policy, or contract.

§15–806.

A nonprofit health service plan that provides pharmaceutical services shall allow a subscriber, member, or beneficiary to fill prescriptions at the pharmacy of the subscriber's, member's, or beneficiary's choice.

§15–807.

(a) (1) In this section the following words have the meanings indicated.

(2) (i) "Inherited metabolic disease" means a disease caused by an inherited abnormality of body chemistry.

(ii) "Inherited metabolic disease" includes a disease for which the State screens newborn babies.

(3) (i) "Low protein modified food product" means a food product that is:

1. specially formulated to have less than 1 gram of protein per serving; and

2. intended to be used under the direction of a physician for the dietary treatment of an inherited metabolic disease.

(ii) "Low protein modified food product" does not include a natural food that is naturally low in protein.

(4) "Medical food" means a food that is:

(i) intended for the dietary treatment of a disease or condition for which nutritional requirements are established by medical evaluation; and

(ii) formulated to be consumed or administered enterally under the direction of a physician.

(b) This section applies to each individual hospital or major medical insurance policy, group or blanket health insurance policy, and nonprofit health service plan that:

(1) is delivered or issued for delivery in the State;

(2) is written on an expense-incurred basis; and

(3) provides coverage for a family member of the insured.

(c) A policy or plan subject to this section shall include under the family member coverage, coverage for medical foods and low protein modified food products for the treatment of inherited metabolic diseases if the medical foods or low protein modified food products are:

(1) prescribed as medically necessary for the therapeutic treatment of inherited metabolic diseases; and

(2) administered under the direction of a physician.

§15–808.

(a) In this section, "home health care" means the continued care and treatment of a covered individual if:

(1) institutionalization of the individual would have been required if home health care was not provided; and

(2) the individual's physician establishes and approves in writing the plan of treatment covering the home health care service.

(b) This section applies to each individual, group, or blanket health insurance policy that is issued or delivered in the State by an insurer or nonprofit health service plan.

(c) A policy subject to this section that provides coverage for inpatient hospital care on an expense-incurred basis shall provide benefits for the expenses of home health care that is provided by a person licensed under the Health Occupations Article.

(d) Home health care shall be provided by:

(1) a hospital that has a valid operating certificate and is certified to provide home health care services; or

(2) a public or private health service or agency that is licensed as a home health agency under Title 19, Subtitle 4 of the Health - General Article to provide coordinated home health care.

(e) (1) A contract may limit the number of home health care visits, but not to fewer than 40 visits in a calendar year or in a continuous 12-month period for each individual covered under the contract.

(2) In determining the benefits for home health care available to a covered individual:

(i) each visit by a member of a home health care team is considered one home health care visit; and

(ii) up to 4 hours of home health care service is considered one home health care visit.

§15–809.

(a) (1) Each insurer that issues or delivers individual health insurance policies in the State that are written on an expense-incurred basis shall offer benefits for hospice care services to its insureds.

(2) Each insurer that issues or delivers group or blanket health insurance policies or contracts in the State that are written on an expense-incurred basis shall offer benefits for hospice care services to its policyholders or beneficiaries.

(b) Each nonprofit health service plan shall offer benefits for hospice care services to its subscribers.

§15–810.

(a) This section applies to:

(1) insurers and nonprofit health service plans that provide hospital, medical, or surgical benefits to individuals or groups on an expense–incurred basis under health insurance policies that are issued or delivered in the State; and

(2) health maintenance organizations that provide hospital, medical, or surgical benefits to individuals or groups under contracts that are issued or delivered in the State.

(b) An entity subject to this section that provides coverage for infertility benefits other than in vitro fertilization may not require as a condition of that coverage, for a patient who is married to an individual of the same sex:

(1) that the patient's spouse's sperm be used in the covered treatments or procedures; or

(2) that the patient demonstrate infertility exclusively by means of a history of unsuccessful heterosexual intercourse.

(c) (1) This subsection does not apply to insurers, nonprofit health service plans, and health maintenance organizations that provide hospital, medical, or surgical benefits under health insurance policies or contracts:

(i) that are issued or delivered to a small employer in the State; and

(ii) for which the Administration has determined that in vitro fertilization procedures are not essential health benefits, as determined under § 31–116 of this article.

(2) An entity subject to this section that provides pregnancy–related benefits may not exclude benefits for all outpatient expenses arising from in vitro fertilization procedures performed on a policyholder or subscriber or on the dependent spouse of a policyholder or subscriber.

(3) The benefits under this subsection shall be provided:

(i) for insurers and nonprofit health service plans, to the same extent as the benefits provided for other pregnancy–related procedures; and

(ii) for health maintenance organizations, to the same extent as the benefits provided for other infertility services.

(d) Subsection (c) of this section applies if:

(1) the patient is the policyholder or subscriber or a covered dependent of the policyholder or subscriber;

(2) for a married patient whose spouse is of the opposite sex, the patient's oocytes are fertilized with the patient's spouse's sperm, unless:

(i) the patient's spouse is unable to produce and deliver functional sperm; and

(ii) the inability to produce and deliver functional sperm does not result from:

1. a vasectomy; or

2. another method of voluntary sterilization;

(3) (i) for a married patient, the patient and the patient's spouse have a history of involuntary infertility, which may be demonstrated by a history of:

1. if the patient and the patient's spouse are of opposite sexes, intercourse of at least 1 year's duration failing to result in pregnancy; or

2. if the patient and the patient's spouse are of the same sex, three attempts of artificial insemination over the course of 1 year failing to result in pregnancy; or

(ii) the infertility of the patient or the patient's spouse is associated with any of the following medical conditions:

1. endometriosis;

2. exposure in utero to diethylstilbestrol, commonly known as DES;

3. blockage of, or surgical removal of, one or both fallopian tubes (lateral or bilateral salpingectomy); or

4. abnormal male factors, including oligospermia, contributing to the infertility;

(4) for an unmarried patient:

(i) the patient has had three attempts of artificial insemination over the course of 1 year failing to result in pregnancy; or

(ii) the infertility is associated with any of the following medical conditions of the patient:

1. endometriosis;

2. exposure in utero to diethylstilbestrol, commonly known as DES;

3. blockage of, or surgical removal of, one or both fallopian tubes (lateral or bilateral salpingectomy); or

4. abnormal male factors, including oligospermia, contributing to the infertility;

(5) the patient has been unable to attain a successful pregnancy through a less costly infertility treatment for which coverage is available under the policy or contract; and

(6) the in vitro fertilization procedures are performed at medical facilities that conform to applicable guidelines or minimum standards issued by the American College of Obstetricians and Gynecologists or the American Society for Reproductive Medicine.

(e) An entity subject to this section may limit coverage of the benefits for in vitro fertilization required under this section to three in vitro fertilization attempts per live birth, not to exceed a maximum lifetime benefit of $100,000.

(f) An entity subject to this section is not responsible for any costs incurred by a policyholder or subscriber or a dependent of a policyholder or subscriber in obtaining donor sperm.

(g) A denial of coverage for in vitro fertilization benefits required under this section by an entity subject to this section constitutes an adverse decision under Subtitle 10A of this title.

(h) This section may not be construed to require an entity subject to this section to provide coverage for a treatment or a procedure that would not treat a diagnosed medical condition of a patient.

(i) Notwithstanding any other provision of this section, if the coverage required under this section conflicts with the bona fide religious beliefs and practices of a religious organization, on request of the religious organization, an entity subject to this section shall exclude the coverage otherwise required under this section in a policy or contract with the religious organization.

§15–810.1.

(a) (1) In this section the following words have the meanings indicated.

(2) "Iatrogenic infertility" means an impairment of fertility caused directly or indirectly by surgery, chemotherapy, radiation, or other medical treatment affecting the reproductive organs or processes.

(3) "Medical treatment that may directly or indirectly cause iatrogenic infertility" means medical treatment with a likely side effect of infertility

as established by the American Society for Reproductive Medicine, the American College of Obstetricians and Gynecologists, or the American Society of Clinical Oncology.

(4) (i) "Standard fertility preservation procedures" means procedures to preserve fertility that are consistent with established medical practices and professional guidelines published by the American Society for Reproductive Medicine, the American College of Obstetricians and Gynecologists, or the American Society of Clinical Oncology.

(ii) "Standard fertility preservation procedures" includes sperm and oocyte cryopreservation and evaluations, laboratory assessments, medications, and treatments associated with sperm and oocyte cryopreservation.

(iii) "Standard fertility preservation procedures" does not include the storage of sperm or oocytes.

(b) This section applies to:

(1) insurers and nonprofit health service plans that provide hospital, medical, or surgical benefits to individuals or groups on an expense–incurred basis under health insurance policies that are issued or delivered in the State; and

(2) health maintenance organizations that provide hospital, medical, or surgical benefits to individuals or groups under contracts that are issued or delivered in the State.

(c) Except as provided in subsection (d) of this section, an entity subject to this section shall provide coverage for standard fertility preservation procedures:

(1) performed on a policyholder or subscriber or on the covered dependent of a policyholder or subscriber; and

(2) that are medically necessary to preserve fertility for a policyholder or subscriber or for the covered dependent of a policyholder or subscriber due to a need for medical treatment that may directly or indirectly cause iatrogenic infertility.

(d) An entity subject to this section may not be required to provide coverage under subsection (c) of this section to a religious organization that requests and receives an exclusion from in vitro fertilization coverage under § 15–810(i) of this subtitle.

§15–811.

(a) Each insurer and nonprofit health service plan that issues or delivers an individual, group, or blanket health insurance policy in the State that provides hospitalization benefits for normal pregnancy shall provide hospitalization benefits for childbirth to the same extent as the hospitalization benefits provided in the policy for any covered illness.

(b) (1) In addition to the provisions of subsection (a) of this section and § 15-812 of this subtitle, whenever a mother is required to remain hospitalized after childbirth for medical reasons and the mother requests that the newborn remain in the hospital, the insurer or nonprofit health service plan shall pay the cost of additional hospitalization for the newborn for up to 4 days.

(2) The attending physician or certified nurse midwife of the mother, or designee of the attending physician or certified nurse midwife, shall provide notice to the mother of the provisions of paragraph (1) of this subsection.

§15–812.

(a) (1) In this section the following words have the meanings indicated.

(2) "Attending provider" means an obstetrician, pediatrician, other physician, certified nurse midwife, or pediatric nurse practitioner attending a mother or newborn child.

(3) "High-deductible health plan" means a health benefit plan that meets the federal requirements established by § 1201 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003.

(b) This section applies to:

(1) insurers and nonprofit health service plans that provide inpatient hospitalization coverage to individuals or groups on an expense-incurred basis under health insurance policies or contracts that are issued or delivered in the State; and

(2) health maintenance organizations that provide inpatient hospitalization coverage to individuals or groups under contracts that are issued or delivered in the State.

(c) An entity subject to this section shall provide coverage for the cost of inpatient hospitalization services for a mother and newborn child for a minimum of:

(1) 48 hours of inpatient hospitalization care after an uncomplicated vaginal delivery; and

(2) 96 hours of inpatient hospitalization care after an uncomplicated cesarean section.

(d) A mother may request a shorter length of stay than that provided in subsection (c) of this section if the mother decides, in consultation with the mother's attending provider, that less time is needed for recovery.

(e) (1) For a mother and newborn child who have a shorter hospital stay than that provided under subsection (c) of this section, an entity subject to this section shall provide coverage for:

(i) one home visit scheduled to occur within 24 hours after hospital discharge; and

(ii) an additional home visit if prescribed by the attending provider.

(2) For a mother and newborn child who remain in the hospital for at least the length of time provided under subsection (c) of this section, an entity subject to this section shall provide coverage for a home visit if prescribed by the attending provider.

(3) A home visit under paragraph (1) or (2) of this subsection shall:

(i) be provided in accordance with generally accepted standards of nursing practice for home care of a mother and newborn child;

(ii) be provided by a registered nurse with at least 1 year of experience in maternal and child health nursing or community health nursing with an emphasis on maternal and child health; and

(iii) include any services required by the attending provider.

(f) An entity subject to this section may not deny, limit, or otherwise impair the participation of an attending provider under contract with the entity in providing health care services to enrollees or insureds for:

(1) advocating the interest of a mother and newborn child through the entity's utilization review or appeals system;

(2) advocating more than 48 hours of inpatient hospital care after a complicated vaginal delivery or more than 96 hours of inpatient hospital care after a complicated cesarean section; or

(3) prescribing a home visit under subsection (e)(1)(ii) or (2) of this section.

(g) (1) Except as provided in paragraph (2) of this subsection, an entity subject to this section may not impose a copayment or coinsurance requirement or deductible for coverage required under subsection (e)(1) or (2) of this section or refuse reimbursement under subsection (e)(1) of this section if the services do not occur within the time specified.

(2) If an insured or enrollee is covered under a high-deductible health plan, an entity subject to this section may require that the coverage required under subsection (e)(1) and (2) of this section be subject to the deductible of the high-deductible health plan.

(h) An entity subject to this section shall provide notice annually to insureds and enrollees about the coverage provided by this section.

§15–813.

(a) This section applies to each group or blanket health insurance policy that:

(1) is issued or delivered in the State;

(2) is issued or delivered to an entity that is incorporated or has a main office in the State; or

(3) covers individuals who reside or work in the State.

(b) Each insurer that proposes to issue a policy subject to this section that provides benefits for temporary disability shall offer the policyholder the option of providing benefits for temporary disability caused or contributed to by pregnancy or childbirth.

(c) The benefits under this section shall be provided to the same extent and on the same terms as the benefits provided for any other covered disability.

§15–814.

(a) In this section, "digital tomosynthesis" means a radiologic procedure that involves the acquisition of projection images over the stationary breast to produce cross–sectional digital three–dimensional images of the breast.

(b) This section applies to:

(1) insurers and nonprofit health service plans that provide hospital, medical, or surgical benefits to individuals or groups on an expense–incurred basis under health insurance policies or contracts that are issued or delivered in the State; and

(2) health maintenance organizations that provide hospital, medical, or surgical benefits to individuals or groups under contracts that are issued or delivered in the State.

(c) (1) Subject to paragraph (2) of this subsection, an entity subject to this section shall provide coverage for breast cancer screening in accordance with the latest screening guidelines issued by the American Cancer Society.

(2) The coverage required under this section shall include coverage for digital tomosynthesis that, under accepted standards in the practice of medicine, the treating physician determines is medically appropriate and necessary for an enrollee or insured.

(d) An entity subject to this section is not required to cover breast cancer screenings used to identify breast cancer in asymptomatic women that are provided by a facility that is not accredited by the American College of Radiology or certified or licensed under a program established by the State.

(e) (1) An entity subject to this section may not impose a deductible on the coverage required under this section.

(2) Each health insurance policy and certificate issued by an entity subject to this section shall contain a notice of the prohibition established by paragraph (1) of this subsection in a form approved by the Commissioner.

(3) An entity subject to this section may not impose a copayment or coinsurance requirement for digital tomosynthesis that is greater than a copayment or coinsurance requirement for other breast cancer screenings for which coverage is required under this section.

§15–814.1.

(a) (1) In this section the following words have the meanings indicated.

(2) (i) "Diagnostic breast examination" means a medically necessary and appropriate examination of the breast that is used to evaluate an abnormality that is:

1. seen or suspected from a prior screening examination for breast cancer; or

2. detected by another means of prior examination.

(ii) "Diagnostic breast examination" includes an examination using diagnostic mammography, breast magnetic resonance imaging, or breast ultrasound.

(3) (i) "Supplemental breast examination" means a medically necessary examination of the breast that is used to screen for breast cancer when:

1. there is no abnormality seen or suspected from a prior examination; and

2. there is a personal or family medical history or additional factors that may increase an individual's risk of breast cancer.

(ii) "Supplemental breast examination" includes an examination using breast magnetic resonance imaging, breast ultrasound, or image–guided breast biopsy.

(b) This section applies to:

(1) insurers and nonprofit health service plans that provide coverage for diagnostic breast examinations or supplemental breast examinations under individual, group, or blanket health insurance policies or contracts that are issued or delivered in the State; and

(2) health maintenance organizations that provide coverage for diagnostic breast examinations or supplemental breast examinations under individual or group contracts that are issued or delivered in the State.

(c) (1) Except as provided in paragraph (2) of this subsection, an entity subject to this section may not impose a copayment, coinsurance, or deductible requirement on coverage for diagnostic breast examinations or supplemental breast examinations.

(2) If an insured or enrollee is covered under a high–deductible health plan, as defined in 26 U.S.C. § 223, an entity subject to this section may subject diagnostic breast examinations or supplemental breast examinations to the deductible requirement of the high–deductible health plan.

§15–815.

(a) (1) In this section the following words have the meanings indicated.

(2) "Mastectomy" means the surgical removal of all or part of a breast.

(3) (i) "Reconstructive breast surgery" means surgery performed as a result of a mastectomy to reestablish symmetry between the two breasts.

(ii) "Reconstructive breast surgery" includes augmentation mammoplasty, reduction mammoplasty, and mastopexy.

(b) This section applies to contracts issued by:

(1) insurers and nonprofit health service plans that provide medical and surgical benefits to individuals or groups on an expense–incurred basis under health insurance contracts that are issued or delivered in the State; and

(2) health maintenance organizations that provide medical and surgical benefits to individuals or groups under contracts that are issued or delivered in the State.

(c) A contract subject to this section shall provide coverage for:

(1) reconstructive breast surgery, including coverage for all stages of reconstructive breast surgery performed on a nondiseased breast to establish symmetry with the diseased breast when reconstructive breast surgery is performed on the diseased breast; and

(2) physical complications of all stages of mastectomy, including lymphedemas, in a manner determined in consultation with the attending physician and the patient.

§15–816.

(a) This section applies to:

(1) insurers and nonprofit health service plans that provide hospital, medical, or surgical benefits to individuals or groups on an expense-incurred basis under health insurance policies that are issued or delivered in the State; and

(2) health maintenance organizations that provide hospital, medical, or surgical benefits to individuals or groups under contracts that are issued or delivered in the State.

(b) An entity subject to this section:

(1) shall classify an obstetrician/gynecologist as a primary care provider; or

(2) if the obstetrician/gynecologist chooses not to be a primary care provider, shall allow a woman to receive routine gynecological care from an in-network obstetrician/gynecologist without requiring the woman to visit a primary care provider first, if:

(i) the care is medically necessary, including care that is routine;

(ii) after each visit for gynecological care, the obstetrician/gynecologist communicates with the woman's primary care provider about any diagnosis or treatment rendered; and

(iii) the obstetrician/gynecologist confers with the primary care provider before performing any diagnostic procedure that is not routine gynecological care rendered during an annual visit.

(c) If an entity subject to this section classifies an obstetrician/gynecologist as a primary care provider as provided in subsection (b) of this section, and a woman does not choose an obstetrician/gynecologist as the woman's primary care provider, the entity shall allow the woman an annual visit to an in-network obstetrician/gynecologist for routine gynecological care without requiring the woman to visit the woman's primary care provider first, whether or not the primary care provider is qualified to and regularly does provide routine gynecological care.

(d) (1) An entity subject to this section shall allow a woman to receive medically necessary, routine obstetric and gynecological care from an in-network, certified nurse midwife or any other in-network provider authorized under the Health Occupations Article to provide obstetric and gynecological services without first requiring the woman to visit a primary care provider.

(2) A certified nurse midwife or other nonphysician provider authorized under the Health Occupations Article to provide obstetric and gynecological services shall consult with an obstetrician/gynecologist with whom the certified nurse midwife or other provider has a collaborative agreement, in

accordance with the collaborative agreement, regarding any care rendered under this subsection.

§15–817.

(a) In this section, "child wellness services" means preventive activities designed to protect children from morbidity and mortality and promote child development.

(b) This section applies to each individual hospital or major medical insurance policy, group or blanket health insurance policy, and nonprofit health service plan that:

(1) is delivered or issued for delivery in the State;

(2) is written on an expense–incurred basis; and

(3) provides coverage for a family member of the insured.

(c) (1) A policy or plan subject to this section shall include under the family member coverage a minimum package of child wellness services that are consistent with:

(i) public health policy;

(ii) professional standards; and

(iii) scientific evidence of effectiveness.

(2) The minimum package of child wellness services shall cover at least:

(i) all visits for and costs of childhood and adolescent immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention as of December 31, 2024, as updated by recommendations issued by the Secretary of Health in accordance with § 18–112 of the Health – General Article;

(ii) visits for the collection of adequate samples, the first of which is to be collected before 2 weeks of age, for hereditary and metabolic newborn screening and follow–up between birth and 4 weeks of age;

(iii) universal hearing screening of newborns provided by a hospital before discharge;

(iv) all visits for and costs of age–appropriate screening tests for tuberculosis, anemia, lead toxicity, hearing, and vision as determined by the American Academy of Pediatrics;

(v) all visits for obesity evaluation and management;

(vi) all visits for and costs of developmental screening as recommended by the American Academy of Pediatrics;

(vii) a physical examination, developmental assessment, and parental anticipatory guidance services at each of the visits required under items (i), (ii), (iv), (v), and (vi) of this paragraph; and

(viii) any laboratory tests considered necessary by the physician as indicated by the services provided under items (i), (ii), (iv), (v), (vi), or (vii) of this paragraph.

(d) Except as provided in subsection (e) of this section, an insurer or nonprofit health service plan that issues a policy or plan subject to this section, on notification of the pregnancy of the insured and before the delivery date, shall:

(1) encourage and help the insured to choose and contact a primary care provider for the expected newborn before delivery; and

(2) provide the insured with information on postpartum home visits for the mother and the expected newborn, including the names of health care providers that are available for postpartum home visits.

(e) An insurer or nonprofit health service plan that does not require or encourage the insured to use a particular health care provider or group of health care providers that has contracted with the insurer or nonprofit health service plan to provide services to the insurer's or nonprofit health service plan's insureds need not comply with subsection (d) of this section.

(f) (1) A policy or plan subject to this section may not impose a deductible on the coverage required under this section.

(2) Each health insurance policy and certificate shall contain a notice of the prohibition established by paragraph (1) of this subsection in a form approved by the Commissioner.

(g) The Commissioner may adopt regulations necessary to carry out subsection (c)(2)(i) of this section consistent with federal statutes, rules, and guidance

in effect on December 31, 2024, as updated by recommendations issued by the Secretary of Health in accordance with § 18–112 of the Health – General Article.

§15–818.

(a) This section applies to:

(1) each individual or group hospital or major medical insurance policy or certificate that is delivered or issued for delivery in the State by an insurer and is written on an expense–incurred basis;

(2) each individual or group medical or major medical contract, policy, or certificate that is delivered or issued for delivery in the State by a nonprofit health service plan; and

(3) each contract that provides hospital, medical, or surgical benefits to individuals or groups and is issued or delivered in the State by a health maintenance organization.

(b) A policy, contract, or certificate subject to this section shall include benefits for inpatient or outpatient expenses arising from orthodontics, oral surgery, and otologic, audiological, and speech/language treatment involved in the management of the birth defect known as cleft lip or cleft palate or both.

§15–819.

(a) This section applies to:

(1) each individual, group, or blanket health insurance policy that is issued or delivered in the State by an insurer; and

(2) each contract or certificate that is issued or delivered in the State by a nonprofit health service plan.

(b) A policy, contract, or certificate subject to this section that provides coverage for an inpatient service in an acute general hospital shall provide coverage for:

(1) a corresponding outpatient service that is provided to the insured instead of the inpatient service because of the denial, after review under a utilization review program, of a request by the attending physician for an inpatient admission; and

(2) an objective second opinion given to the insured when required by a utilization review program under § 19-319 of the Health - General Article.

§15–820. IN EFFECT

(a) In this section, "orthopedic brace" means a rigid or semi–rigid device that is used to:

(1) support a weak or deformed body member; or

(2) restrict or eliminate motion in a diseased or injured part of the body.

(b) Each health insurance contract that is delivered or issued for delivery in the State by a nonprofit health service plan and that provides hospital benefits shall provide benefits for orthopedic braces.

§15–820. ** TAKES EFFECT JANUARY 1, 2027 PER CHAPTERS 628 AND 629 OF 2026 **

(a) (1) In this section, "orthosis" means a rigid or semi–rigid device that is used to:

(i) support a weak or misaligned body member; or

(ii) restrict or eliminate motion, improve function, or relieve symptoms of a disease, an injury, or a post–operative condition in a part of the body.

(2) "Orthosis" includes a custom–designed, custom–fabricated, custom–molded, custom–fitted, or modified device to treat a neuromuscular, musculoskeletal, acquired, or congenital condition.

(b) This section applies to:

(1) insurers and nonprofit health service plans that provide hospital, medical, or surgical benefits to individuals or groups on an expense–incurred basis under health insurance policies or contracts that are issued or delivered in the State; and

(2) health maintenance organizations that provide hospital, medical, or surgical benefits to individuals or groups under contracts that are issued or delivered in the State.

(c) An entity subject to this section shall provide once annually coverage for:

(1) orthoses;

(2) components of orthoses;

(3) repairs to orthoses; and

(4) subject to subsection (d) of this section, replacements of orthoses or orthosis components.

(d) (1) An entity subject to this section shall provide coverage for replacements of orthoses without regard to continuous use or useful lifetime restrictions if an ordering health care provider determines that the provision of a replacement orthosis or a replacement component of the orthosis is necessary:

(i) because of a change in the physiological condition of the patient; or

(ii) unless necessitated by misuse, because of an irreparable change in the condition of the orthosis or a component of the orthosis.

(2) An entity subject to this section may require an ordering health care provider to confirm that the orthosis or component of the orthosis being replaced meets the requirements of paragraph (1) of this subsection if the orthosis or component of the orthosis is less than 1 year old.

(e) The covered benefits under this section may not be subject to a higher copayment or coinsurance requirement than the copayment or coinsurance for other similar medical and surgical benefits covered under the policy or contract of the insured or enrollee.

(f) An entity subject to this section may not impose an annual or lifetime dollar maximum on coverage required under this section separate from any annual or lifetime dollar maximum that applies in the aggregate to all covered benefits under the policy or contract of the insured or enrollee.

(g) (1) An entity subject to this section may not establish requirements for medical necessity or appropriateness for the coverage required under this section that are more restrictive than the indications and limitations of coverage and medical necessity established under the Medicare Coverage Database.

(2) The covered benefits under this section include all orthoses determined by a treating health care provider to be medically necessary for:

(i) completing activities of daily living;

(ii) essential job–related activities; or

(iii) performing physical activities including running, biking, swimming, strength training, and other activities to maximize the whole–body health and lower or upper limb function of the insured or enrollee.

(h) An entity subject to this section that uses a provider panel for a policy or contract described in subsection (b) of this section and the provision of covered benefits under this section shall comply with § 15–112(b)(3) of this title.

§15–821.

(a) This section applies to each policy or contract that is issued or delivered in the State to an employer or individual by an insurer or nonprofit health service plan.

(b) (1) A policy or contract subject to this section that provides coverage on a group or individual basis for a diagnostic or surgical procedure involving a bone or joint of the skeletal structure may not exclude or deny coverage for the same diagnostic or surgical procedure involving a bone or joint of the face, neck, or head if, under the accepted standards of the profession of the health care provider rendering the service, the procedure is medically necessary to treat a condition caused by a congenital deformity, disease, or injury.

(2) This subsection does not apply to intraoral prosthetic devices.

(c) (1) This section does not affect any other coverage required under this article or restrict the scope of coverage under a policy or contract subject to this section.

(2) This section is not intended to encourage surgical procedures over appropriate nonsurgical procedures, or to prohibit the continued coverage of nonsurgical procedures in the treatment of a bone or joint of the face, neck, or head.

§15–822.

(a) This section applies to:

(1) insurers and nonprofit health service plans that provide hospital, medical, or surgical benefits to individuals or groups on an expense–incurred basis under health insurance policies that are issued or delivered in the State; and

(2) health maintenance organizations that provide hospital, medical, or surgical benefits to individuals or groups under contracts that are issued or delivered in the State.

(b) An entity subject to this section shall provide coverage for all medically appropriate and necessary diabetes equipment, diabetes supplies, and diabetes outpatient self–management training and educational services, including medical nutrition therapy, that the insured's or enrollee's treating physician or other appropriately licensed health care provider, or a physician who specializes in the treatment of diabetes, certifies are necessary for the treatment of:

(1) insulin–using diabetes;

(2) noninsulin–using diabetes;

(3) elevated or impaired blood glucose levels induced by pregnancy; or

(4) consistent with the American Diabetes Association's standards, elevated or impaired blood glucose levels induced by prediabetes.

(c) If certified as necessary under subsection (b) of this section, the diabetes outpatient self–management training and educational services, including medical nutrition therapy, to be provided to the insured or enrollee shall be provided through a program supervised by an appropriately licensed, registered, or certified health care provider whose scope of practice includes diabetes education or management.

(d) (1) Subject to paragraph (2) of this subsection, and except as provided in paragraph (3) of this subsection, the coverage required under this section may be subject to the annual deductibles or coinsurance requirements imposed by an entity subject to this section for similar coverages under the same health insurance policy or contract.

(2) Except as provided in paragraph (3) of this subsection, the annual deductibles or coinsurance requirements imposed under paragraph (1) of this subsection for the coverage required under this section may not be greater than the annual deductibles or coinsurance requirements imposed by the entity for similar coverages.

(3) (i) Except as provided in subparagraph (ii) of this paragraph, an entity subject to this section may not impose a deductible, copayment, or coinsurance requirement on diabetes test strips.

(ii) If an insured or enrollee is covered under a high–deductible health plan, as defined in 26 U.S.C. § 223, an entity subject to this section may subject diabetes test strips to the deductible requirement of the high–deductible health plan.

(e) An entity subject to this section may not reduce or eliminate coverages in its health insurance policies or contracts due to the requirements of this section.

§15–822.1.

(a) (1) This section applies to:

(i) insurers and nonprofit health service plans that provide coverage for prescription drugs and devices to individuals or groups under health insurance policies or contracts that are delivered in the State; and

(ii) health maintenance organizations that provide coverage for prescription drugs and devices to individuals or groups under contracts that are issued or delivered in the State.

(2) An insurer, a nonprofit health service plan, or a health maintenance organization that provides coverage for prescription drugs and devices through a pharmacy benefits manager is subject to the requirements of this section.

(b) An entity subject to this section shall limit the amount a covered individual is required to pay in copayments or coinsurance for a covered prescription insulin drug to not more than $30 for a 30–day supply, regardless of the amount or type of insulin needed to fill the covered individual's prescription.

(c) An entity subject to this section may set the amount a covered individual is required to pay to an amount that is less than the payment amount limit under subsection (b) of this section.

(d) A contract between an entity subject to this section, or a pharmacy benefits manager through which the entity provides coverage for prescription drugs and devices, and a pharmacy or the pharmacy's contracting agent, may not:

(1) authorize a party to the contract to charge a covered individual an amount that is more than the payment amount limit under subsection (b) of this section;

(2) require a pharmacy to collect from a covered individual an amount that is more than the payment amount limit under subsection (b) of this section; or

(3) require a covered individual to pay an amount that is more than the payment amount limit under subsection (b) of this section.

§15–823.

(a) (1) In this section the following words have the meanings indicated.

(2) "Bone mass measurement" means a radiologic or radioisotopic procedure or other scientifically proven technology performed on a qualified individual for the purpose of identifying bone mass or detecting bone loss.

(3) "Qualified individual" means:

(i) an estrogen deficient individual at clinical risk for osteoporosis;

(ii) an individual with a specific sign suggestive of spinal osteoporosis, including roentgenographic osteopenia or roentgenographic evidence suggestive of collapse, wedging, or ballooning of one or more thoracic or lumbar vertebral bodies, who is a candidate for therapeutic intervention or for an extensive diagnostic evaluation for metabolic bone disease;

(iii) an individual receiving long–term glucocorticoid (steroid) therapy;

(iv) an individual with primary hyperparathyroidism; or

(v) an individual being monitored to assess the response to or efficacy of an approved osteoporosis drug therapy.

(b) This section applies to:

(1) each individual hospital or major medical insurance policy of an insurer that is delivered or issued for delivery in the State and is written on an expense–incurred basis;

(2) each group or blanket health insurance policy of an insurer that is issued or delivered in the State and is written on an expense–incurred basis;

(3) each individual or group medical or major medical contract or certificate of a nonprofit health service plan that is issued or delivered in the State and is written on an expense–incurred basis; and

(4) each individual or group contract of a health maintenance organization that is issued or delivered in the State.

(c) A policy, contract, or certificate subject to this section shall include coverage for qualified individuals for reimbursement for bone mass measurement for the prevention, diagnosis, and treatment of osteoporosis when the bone mass measurement is requested by a health care provider for the qualified individual.

§15–824.

(a) (1) In this section the following words have the meanings indicated.

(2) "Authorized prescriber" has the meaning stated in § 12-101 of the Health Occupations Article.

(3) "Maintenance drug" means a drug anticipated to be required for 6 months or more to treat a chronic condition.

(b) This section applies to:

(1) insurers and nonprofit health service plans that provide coverage for drugs under health insurance policies or contracts that are delivered or issued for delivery in the State to employers or individuals on a group or individual basis; and

(2) health maintenance organizations that provide coverage for drugs under contracts that are delivered or issued for delivery in the State to employers or individuals on a group or individual basis.

(c) This section does not apply to an insured or enrollee who is a resident of a nursing home.

(d) (1) An entity subject to this section shall allow an insured or enrollee, if authorized by an authorized prescriber, to receive up to a 90-day supply of a maintenance drug in a single dispensing of the prescription.

(2) The provisions of paragraph (1) of this subsection do not apply to the first prescription or change in a prescription for a maintenance drug that the authorized prescriber prescribes for the insured or enrollee.

(e) Whenever an entity subject to this section increases the co-payment for a single dispensing of a prescription in a supply in excess of 30 days, the entity shall also proportionately increase the dispensing fee to the pharmacist for the prescription.

§15–825.

(a) This section applies to:

(1) insurers and nonprofit health service plans that provide inpatient hospital, medical, or surgical benefits to individuals or groups on an expense–incurred basis under health insurance policies or contracts that are issued or delivered in the State; and

(2) health maintenance organizations that provide inpatient hospital, medical, or surgical benefits to individuals or groups under contracts that are issued or delivered in the State.

(b) An entity subject to this section shall provide coverage for the expenses incurred in conducting a medically recognized diagnostic examination which shall include a digital rectal exam and a blood test called the prostate–specific antigen (PSA) test:

(1) for men who are between 40 and 75 years of age;

(2) when used for the purpose of guiding patient management in monitoring the response to prostate cancer treatment;

(3) when used for staging in determining the need for a bone scan in patients with prostate cancer; or

(4) when used for male patients who are at high risk for prostate cancer.

(c) Subject to federal guidance on the preventive care safe harbor for the absence of a preventive care deductible provided for under 26 U.S.C. § 223(c)(2)(C), an entity subject to this section may not apply a deductible, a copayment, or coinsurance to coverage for preventive care screening services for prostate cancer**,** which shall include a digital rectal exam and a blood test called the prostate–specific antigen (PSA) test in accordance with subsection (b) of this section.

§15–826.

(a) This section applies to:

(1) insurers and nonprofit health service plans that provide coverage for prescription drugs under health insurance policies or contracts that are issued or delivered in the State; and

(2) health maintenance organizations that provide coverage for prescription drugs under contracts that are issued or delivered in the State.

(b) An entity subject to this section:

(1) shall provide coverage for any contraceptive drug or device that is approved by the United States Food and Drug Administration for use as a contraceptive and that is obtained under a prescription written by an authorized prescriber as defined in § 12-101 of the Health Occupations Article;

(2) shall provide coverage for the insertion or removal, and any medically necessary examination associated with the use, of such contraceptive drug or device; and

(3) may not impose a different copayment or coinsurance for a contraceptive drug or device than is imposed for any other prescription.

(c) (1) A religious organization may request and an entity subject to this section shall grant the request for an exclusion from coverage under the policy, plan, or contract for the coverage required under subsection (b) of this section if the required coverage conflicts with the religious organization's bona fide religious beliefs and practices.

(2) A religious organization that obtains an exclusion under paragraph (1) of this subsection shall provide its employees reasonable and timely notice of the exclusion.

§15–826.1.

(a) In this section, "authorized prescriber" has the meaning stated in § 12–101 of the Health Occupations Article.

(b) This section applies to:

(1) insurers and nonprofit health service plans that provide coverage for contraceptive drugs and devices under individual, group, or blanket health insurance policies or contracts that are issued or delivered in the State; and

(2) health maintenance organizations that provide coverage for contraceptive drugs and devices under individual or group contracts that are issued or delivered in the State.

(c) (1) This subsection does not apply to a health benefit plan that is a grandfathered health plan, as defined in § 1251 of the Affordable Care Act.

(2) An entity subject to this section:

(i) except for a drug or device for which the U.S. Food and Drug Administration has issued a black box warning, may not apply a prior authorization requirement for a contraceptive drug or device that is:

1. A. an intrauterine device; or

B. an implantable rod;

2. approved by the U.S. Food and Drug Administration; and

3. obtained under a prescription written by an authorized prescriber; and

(ii) except as provided in paragraph (3) of this subsection, may not apply a copayment or coinsurance requirement for a contraceptive drug or device that is:

1. approved by the U.S. Food and Drug Administration; and

2. obtained under a prescription written by an authorized prescriber.

(3) An entity subject to this section may apply a copayment or coinsurance requirement for a contraceptive drug or device that, according to the U.S. Food and Drug Administration, is therapeutically equivalent to another contraceptive drug or device that is available under the same policy or contract without a copayment or coinsurance requirement.

(d) (1) An entity subject to this section shall provide coverage for a single dispensing to an insured or an enrollee of a supply of prescription contraceptives for up to a 12–month period.

(2) Whenever an entity subject to this section increases the copayment for a single dispensing of a supply of prescription contraceptives for up to a 12–month period, the entity shall also increase proportionately the dispensing fee paid to the pharmacist.

(3) This subsection may not be construed to require a provider to prescribe, furnish, or dispense 12 months of contraceptives at one time.

(e) (1) Subject to paragraph (2) of this subsection, an entity subject to this section:

(i) shall provide coverage without a prescription for all contraceptive drugs approved by the U.S. Food and Drug Administration and available by prescription and over the counter; and

(ii) may not apply a copayment or coinsurance requirement for a contraceptive drug dispensed without a prescription under item (i) of this paragraph that exceeds the copayment or coinsurance requirement for the contraceptive drug dispensed under a prescription.

(2) An entity subject to this section:

(i) may only be required to provide point–of–sale coverage under paragraph (1)(i) of this subsection at in–network pharmacies; and

(ii) may limit the frequency with which the coverage required under paragraph (1)(i) of this subsection is provided.

§15–826.2.

(a) (1) In this subsection, "group" means a group that is not a group covered under a health insurance policy or contract or under a health maintenance organization contract issued or delivered to a small employer, as defined in § 31–101 of this article.

(2) This subsection applies to:

(i) insurers and nonprofit health service plans that provide hospital, medical, or surgical benefits to groups on an expense–incurred basis under health insurance policies or contracts that are issued or delivered in the State; and

(ii) health maintenance organizations that provide hospital, medical, or surgical benefits to groups under contracts that are issued or delivered in the State.

(3) This subsection does not apply to an organization that requests and receives an exclusion from coverage under § 15–826(c) of this subtitle.

(4) An entity subject to this subsection shall provide coverage for male sterilization.

(b) (1) This subsection applies to:

(i) insurers and nonprofit health service plans that provide coverage for male sterilization under individual, group, or blanket health insurance policies or contracts that are issued or delivered in the State; and

(ii) health maintenance organizations that provide coverage for male sterilization under individual or group contracts that are issued or delivered in the State.

(2) Except as provided in paragraph (3) of this subsection and except with respect to a health benefit plan that is a grandfathered health plan, as defined in § 1251 of the Affordable Care Act, an entity subject to this subsection may not apply a copayment, coinsurance requirement, or deductible to coverage for male sterilization.

(3) If an insured or enrollee is covered under a high–deductible health plan, as defined in 26 U.S.C. § 223, an entity subject to this subsection may subject male sterilization to the deductible requirement of the high–deductible health plan.

§15–826.2. ** CONTINGENCY – NOT IN EFFECT – CHAPTERS 64 AND 65 OF 2018 **

(a) (1) In this subsection, "group" means a group that is not a group covered under a health insurance policy or contract or under a health maintenance organization contract issued or delivered to a small employer, as defined in § 31–101 of this article.

(2) This subsection applies to:

(i) insurers and nonprofit health service plans that provide hospital, medical, or surgical benefits to groups on an expense–incurred basis under health insurance policies or contracts that are issued or delivered in the State; and

(ii) health maintenance organizations that provide hospital, medical, or surgical benefits to groups under contracts that are issued or delivered in the State.

(3) This subsection does not apply to an organization that requests and receives an exclusion from coverage under § 15–826(c) of this subtitle.

(4) An entity subject to this subsection shall provide coverage for male sterilization.

(b) (1) This subsection applies to:

(i) insurers and nonprofit health service plans that provide coverage for male sterilization under individual, group, or blanket health insurance policies or contracts that are issued or delivered in the State; and

(ii) health maintenance organizations that provide coverage for male sterilization under individual or group contracts that are issued or delivered in the State.

(2) Except with respect to a health benefit plan that is a grandfathered health plan, as defined in § 1251 of the Affordable Care Act, an entity subject to this subsection may not apply a copayment, coinsurance requirement, or deductible to coverage for male sterilization.

§15–826.3.

(a) In this section, "fertility awareness–based methods" means methods of identifying times of fertility and infertility by an individual to avoid pregnancy, including:

(1) cervical mucus methods;

(2) sympto–thermal or sympto–hormonal methods;

(3) the standard days method; and

(4) the lactational amenorrhea method.

(b) This section applies to:

(1) insurers and nonprofit health service plans that provide hospital, medical, or surgical benefits to individuals or groups on an expense–incurred basis

under health insurance policies or contracts that are issued or delivered in the State; and

(2) health maintenance organizations that provide hospital, medical, or surgical benefits to individuals or groups under contracts that are issued or delivered in the State.

(c) An entity subject to this section shall provide coverage for instruction by a licensed health care provider on fertility awareness–based methods.

(d) Except with respect to a health benefit plan that is a grandfathered health plan, as defined in § 1251 of the Affordable Care Act, an entity subject to this section may not apply a copayment, coinsurance requirement, or deductible to the coverage required under this section.

§15–827.

(a) (1) In this section the following words have the meanings indicated.

(2) (i) "Cooperative group" means a formal network of facilities that collaborate on research projects and have an established NIH-approved Peer Review Program operating within the group.

(ii) "Cooperative group" includes:

1. the National Cancer Institute Clinical Cooperative Group;

2. the National Cancer Institute Community Clinical Oncology Program;

3. the AIDS Clinical Trials Group; and

4. the Community Programs for Clinical Research in AIDS.

(3) "FDA" means the federal Food and Drug Administration.

(4) "Member" means a policyholder, subscriber, insured, or certificate holder or a covered dependent of a policyholder, subscriber, insured, or certificate holder.

(5) "Multiple project assurance contract" means a contract between an institution and the federal Department of Health and Human Services that

defines the relationship of the institution to the federal Department of Health and Human Services and sets out the responsibilities of the institution and the procedures that will be used by the institution to protect human subjects.

(6) "NIH" means the National Institutes of Health.

(7) (i) "Patient cost" means the cost of a medically necessary health care service that is incurred as a result of the treatment being provided to the member for purposes of the clinical trial.

(ii) "Patient cost" does not include:

1. the cost of an investigational drug or device;

2. the cost of nonhealth care services that a patient may be required to receive as a result of the treatment being provided for purposes of the clinical trial;

3. costs associated with managing the research associated with the clinical trial; or

4. costs that would not be covered under the patient's policy, plan, or contract for noninvestigational treatments.

(b) This section applies to:

(1) insurers and nonprofit health service plans that provide hospital, medical, surgical, or pharmaceutical benefits to individuals or groups on an expense-incurred basis under a health insurance policy or contract issued or delivered in the State; and

(2) health maintenance organizations that provide hospital, medical, surgical, or pharmaceutical benefits to individuals or groups under contracts that are issued or delivered in the State.

(c) This section does not apply to a policy, plan, or contract paid for under Title XVIII or Title XIX of the Social Security Act.

(d) A policy, plan, or contract subject to this section shall provide coverage for patient cost to a member in a clinical trial, as a result of:

(1) treatment provided for a life-threatening condition; or

(2) prevention, early detection, and treatment studies on cancer.

(e) The coverage under subsection (d) of this section shall be required if:

(1) (i) the treatment is being provided or the studies are being conducted in a Phase I, Phase II, Phase III, or Phase IV clinical trial for cancer; or

(ii) the treatment is being provided in a Phase I, Phase II, Phase III, or Phase IV clinical trial for any other life-threatening condition;

(2) the treatment is being provided in a clinical trial approved by:

(i) one of the National Institutes of Health;

(ii) an NIH cooperative group or an NIH center;

(iii) the FDA in the form of an investigational new drug application;

(iv) the federal Department of Veterans Affairs; or

(v) an institutional review board of an institution in the State which has a multiple project assurance contract approved by the Office of Protection from Research Risks of the National Institutes of Health;

(3) the facility and personnel providing the treatment are capable of doing so by virtue of their experience, training, and volume of patients treated to maintain expertise;

(4) there is no clearly superior, noninvestigational treatment alternative; and

(5) the available clinical or preclinical data provide a reasonable expectation that the treatment will be at least as effective as the noninvestigational alternative.

(f) In conjunction with the provisions of subsection (d) of this section, a policy, plan, or contract shall provide coverage for patient cost incurred for drugs and devices that have been approved for sale by the FDA whether or not the FDA has approved the drug or device for use in treating the patient's particular condition, to the extent that the drugs or devices are not paid for by the manufacturer, distributor, or provider of that drug or device.

(g) (1) An entity seeking coverage for treatment in a clinical trial approved by an institutional review board under subsection (e)(2)(v) of this section

shall post electronically and keep up-to-date a list of the clinical trials meeting the requirements of subsections (d) and (e) of this section.

(2) The list shall include, for each clinical trial:

(i) the phase for which the trial is approved;

(ii) the entity approving the trial;

(iii) whether the trial is for treatment of cancer or another life-threatening disease and, if not cancer, the particular disease; and

(iv) the estimated number of participants in the trial.

(h) This section may not be construed to affect compliance with § 15-804 of this subtitle regarding coverage for off-label use of drugs.

§15–828.

(a) This section applies to:

(1) insurers and nonprofit health service plans that provide hospital, medical, or surgical benefits to individuals or groups on an expense-incurred basis under health insurance policies that are issued or delivered in the State; and

(2) health maintenance organizations that provide hospital, medical, or surgical benefits to individuals or groups under contracts that are issued or delivered in the State.

(b) An entity subject to this section shall provide coverage for general anesthesia and associated hospital or ambulatory facility charges in conjunction with dental care provided to an enrollee or insured if the enrollee or insured:

(1) (i) is 7 years of age or younger or is developmentally disabled;

(ii) is an individual for whom a successful result cannot be expected from dental care provided under local anesthesia because of a physical, intellectual, or other medically compromising condition of the enrollee or insured; and

(iii) is an individual for whom a superior result can be expected from dental care provided under general anesthesia; or

(2) (i) is an extremely uncooperative, fearful, or uncommunicative child who is 17 years of age or younger with dental needs of such magnitude that treatment should not be delayed or deferred; and

(ii) is an individual for whom lack of treatment can be expected to result in oral pain, infection, loss of teeth, or other increased oral or dental morbidity.

(c) An entity subject to this section may require prior authorization for general anesthesia and associated hospital or ambulatory facility charges for dental care in the same manner that prior authorization is required for these benefits in connection with other covered medical care.

(d) An entity subject to this section may restrict coverage for general anesthesia and associated hospital or ambulatory facility charges to dental care that is provided by:

(1) a fully accredited specialist in pediatric dentistry;

(2) a fully accredited specialist in oral and maxillofacial surgery; and

(3) a dentist to whom hospital privileges have been granted.

(e) The provisions of this section may not be construed to require coverage for the dental care for which the general anesthesia is provided.

(f) The provisions of this section do not apply to dental care rendered for temporal mandibular joint disorders.

§15–829.

(a) (1) In this section the following words have the meanings indicated.

(2) "Chlamydia screening test" means any laboratory test that:

(i) specifically detects for infection by one or more agents of chlamydia trachomatis; and

(ii) is approved for this purpose by the federal Food and Drug Administration.

(3) "Human papillomavirus screening test" means any laboratory test that:

(i) specifically detects for infection by one or more agents of the human papillomavirus; and

(ii) is approved for this purpose by the federal Food and Drug Administration.

(4) "Multiple risk factors" means having a prior history of a sexually transmitted disease, new or multiple sex partners, inconsistent use of barrier contraceptives, or cervical ectopy.

(b) This section applies to:

(1) insurers and nonprofit health service plans that provide hospital, medical, or surgical benefits to individuals or groups on an expense-incurred basis under health insurance policies or contracts that are issued or delivered in the State; and

(2) health maintenance organizations that provide hospital, medical, or surgical benefits to individuals or groups under contracts that are issued or delivered in the State.

(c) An entity subject to this section shall:

(1) provide coverage for an annual routine chlamydia screening test for:

(i) women who are:

1. under the age of 20 years if they are sexually active; and

2. at least 20 years old if they have multiple risk factors; and

(ii) men who have multiple risk factors; and

(2) provide coverage for a human papillomavirus screening at the testing intervals outlined in the recommendations for cervical cytology screening developed by the American College of Obstetricians and Gynecologists.

(d) (1) Subject to paragraph (2) of this subsection, the coverage required under this section may be subject to a copayment or coinsurance requirement or deductible that an entity subject to this section imposes for similar coverages under the same policy or contract.

(2) The copayment or coinsurance requirement or deductible imposed under paragraph (1) of this subsection may not be greater than the copayment or coinsurance requirement or deductible imposed by the entity for similar coverages.

(e) Nothing in this section may be construed to prohibit an entity subject to this section from providing coverages that are greater than or more favorable to an insured or enrollee than the coverage required under this section.

§15–830. IN EFFECT

(a) (1) In this section the following words have the meanings indicated.

(2) "Carrier" means:

(i) an insurer that offers health insurance other than long–term care insurance or disability insurance;

(ii) a nonprofit health service plan;

(iii) a health maintenance organization;

(iv) a dental plan organization; or

(v) except for a managed care organization as defined in Title 15, Subtitle 1 of the Health – General Article, any other person that provides health benefit plans subject to State regulation.

(3) (i) "Member" means an individual entitled to health care benefits under a policy or plan issued or delivered in the State by a carrier.

(ii) "Member" includes a subscriber.

(4) "Nonphysician specialist" means a health care provider:

(i) 1. who is not a physician;

2. who is licensed or certified under the Health Occupations Article; and

3. who is certified or trained to treat or provide health care services for a specified condition or disease in a manner that is within the scope of the license or certification of the health care provider; or

(ii) that is licensed as a behavioral health program under § 7.5–401 of the Health – General Article.

(5) (i) "Provider panel" means the providers that contract with a carrier either directly or through a subcontracting entity to provide health care services to enrollees of the carrier.

(ii) "Provider panel" does not include an arrangement in which any provider may participate solely by contracting with the carrier to provide health care services at a discounted fee–for–service rate.

(6) "Specialist" means a physician who is certified or trained to practice in a specified field of medicine and who is not designated as a primary care provider by the carrier.

(b) (1) Each carrier that does not allow direct access to specialists shall establish and implement a procedure by which a member may receive a standing referral to a specialist in accordance with this subsection.

(2) The procedure shall provide for a standing referral to a specialist if:

(i) the primary care physician of the member determines, in consultation with the specialist, that the member needs continuing care from the specialist;

(ii) the member has a condition or disease that:

1. is life threatening, degenerative, chronic, or disabling; and

2. requires specialized medical care; and

(iii) the specialist:

1. has expertise in treating the life–threatening, degenerative, chronic, or disabling disease or condition; and

2. is part of the carrier's provider panel.

(3) Except as provided in subsection (c) of this section, a standing referral shall be made in accordance with a written treatment plan for a covered service developed by:

(i) the primary care physician;

(ii) the specialist; and

(iii) the member.

(4) A treatment plan may:

(i) limit the number of visits to the specialist;

(ii) limit the period of time in which visits to the specialist are authorized; and

(iii) require the specialist to communicate regularly with the primary care physician regarding the treatment and health status of the member.

(5) The procedure by which a member may receive a standing referral to a specialist may not include a requirement that a member see a provider in addition to the primary care physician before the standing referral is granted.

(c) (1) Notwithstanding any other provision of this section, a member who is pregnant shall receive a standing referral to an obstetrician in accordance with this subsection.

(2) After the member who is pregnant receives a standing referral to an obstetrician, the obstetrician is responsible for the primary management of the member's pregnancy, including the issuance of referrals in accordance with the carrier's policies and procedures, through the postpartum period.

(3) A written treatment plan may not be required when a standing referral is to an obstetrician under this subsection.

(d) (1) Each carrier shall establish and implement a procedure by which a member may request a referral to a specialist or nonphysician specialist who is not part of the carrier's provider panel in accordance with this subsection.

(2) The procedure shall provide for a referral to a specialist or nonphysician specialist who is not part of the carrier's provider panel if:

(i) 1. the member is diagnosed with a condition or disease that requires specialized health care services or medical care; and

2. A. the carrier does not have in its provider panel a specialist or nonphysician specialist with the professional training and expertise to treat or provide health care services for the condition or disease; or

B. the carrier cannot provide reasonable access to a specialist or nonphysician specialist with the professional training and expertise to treat or provide health care services for the condition or disease without unreasonable delay or travel, including within the reasonable appointment waiting time and travel distance standards established in regulation for mental health and substance use disorder services; or

(ii) 1. the member is seeking mental health or substance use disorder care; and

2. the carrier cannot provide reasonable access to a specialist or nonphysician specialist within the reasonable appointment waiting time and travel distance standards established in regulation for mental health and substance use disorder services.

(3) The procedure shall ensure that a request to obtain a referral to a specialist or nonphysician specialist who is not part of the carrier's provider panel is addressed in a timely manner that is:

(i) appropriate for the member's condition; and

(ii) in accordance with the timeliness requirements for determinations made by private review agents under § 15–10B–06 of this title.

(4) If a member cannot access mental health or substance use disorder services through the referral requirements under paragraphs (2) and (3) of this subsection, the procedure shall require the carrier to provide additional assistance to the member in identifying and arranging coverage of mental health or substance use disorder services by a specialist or nonphysician specialist who is not part of the carrier's provider panel.

(5) If a carrier approves a member's request for a referral made in accordance with this subsection, the carrier may not require utilization review other than what would be required if the covered benefit were provided by a provider on the carrier's provider panel.

(6) The procedure may not be used by a carrier as a substitute for establishing and maintaining a sufficient provider network in accordance with § 15–112 of this title.

(7) Each carrier shall:

(i) have a system in place that documents all requests to obtain a referral to receive a covered service from a specialist or nonphysician specialist who is not part of the carrier's provider panel;

(ii) inform members of the procedure to request a referral under paragraph (1) of this subsection; and

(iii) provide the information documented under item (i) of this paragraph to the Commissioner on request.

(e) (1) Except as provided in paragraph (2) of this subsection, for purposes of calculating any deductible, copayment amount, or coinsurance payable by the member, a carrier shall treat services received in accordance with subsection (d) of this section as if the service was provided by a provider on the carrier's provider panel.

(2) A carrier shall ensure that services received in accordance with subsection (d) of this section for mental health or substance use disorders are provided for the duration of the treatment plan at no greater cost to the covered individual than if the covered benefit were provided by a provider on the carrier's provider panel.

(f) A decision by a carrier not to provide access to or coverage of treatment or health care services by a specialist or nonphysician specialist in accordance with this section constitutes an adverse decision as defined under Subtitle 10A of this title if the decision is based on a finding that the proposed service is not medically necessary, appropriate, or efficient.

(g) (1) Each carrier shall file with the Commissioner a copy of each of the procedures required under this section, including:

(i) steps the carrier requires of a member to request a referral;

(ii) the carrier's timeline for decisions; and

(iii) the carrier's grievance procedures for denials.

(2) Each carrier shall make a copy of each of the procedures filed under paragraph (1) of this subsection available to its members:

(i) in the carrier's online provider directory required under § 15–112(n)(1) of this title; and

(ii) on request.

(h) The Consumer Education and Advocacy Program, established under Title 2, Subtitle 3 of this article, in collaboration with the Health Education and Advocacy Unit of the Office of the Attorney General, shall provide public education to inform consumers of their procedures to request a referral to a specialist or nonphysician specialist as provided for in this section.

(i) This section may not be construed to limit the provisions in § 19–710(p) of the Health – General Article.

§15–830. ** TAKES EFFECT JANUARY 1, 2027 PER CHAPTERS 636 AND 637 OF 2026 **

(a) (1) In this section the following words have the meanings indicated.

(2) "Carrier" means:

(i) an insurer that offers health insurance other than long–term care insurance or disability insurance;

(ii) a nonprofit health service plan;

(iii) a health maintenance organization;

(iv) a dental plan organization; or

(v) except for a managed care organization as defined in Title 15, Subtitle 1 of the Health – General Article, any other person that provides health benefit plans subject to State regulation.

(3) (i) "Member" means an individual entitled to health care benefits under a policy or plan issued or delivered in the State by a carrier.

(ii) "Member" includes a subscriber.

(4) "Nonphysician specialist" means a health care provider:

(i) 1. who is not a physician;

2. who is licensed or certified under the Health Occupations Article; and

3. who is certified or trained to treat or provide health care services for a specified condition or disease in a manner that is within the scope of the license or certification of the health care provider; or

(ii) that is licensed as a behavioral health program under § 7.5–401 of the Health – General Article.

(5) (i) "Perinatal behavioral health condition" means a behavioral health condition occurring during pregnancy or within 1 year after the conclusion of a pregnancy, including a pregnancy that does not result in a live birth.

(ii) "Perinatal behavioral health condition" includes postpartum depression.

(6) (i) "Provider panel" means the providers that contract with a carrier either directly or through a subcontracting entity to provide health care services to enrollees of the carrier.

(ii) "Provider panel" does not include an arrangement in which any provider may participate solely by contracting with the carrier to provide health care services at a discounted fee–for–service rate.

(7) "Specialist" means a physician who is certified or trained to practice in a specified field of medicine and who is not designated as a primary care provider by the carrier.

(b) (1) Each carrier that does not allow direct access to specialists shall establish and implement a procedure by which a member may receive a standing referral to a specialist in accordance with this subsection.

(2) The procedure shall provide for a standing referral to a specialist if:

(i) the primary care physician of the member determines, in consultation with the specialist, that the member needs continuing care from the specialist;

(ii) the member has a condition or disease that:

1. is life threatening, degenerative, chronic, or disabling; and

2. requires specialized medical care; and

(iii) the specialist:

1. has expertise in treating the life–threatening, degenerative, chronic, or disabling disease or condition; and

2. is part of the carrier's provider panel.

(3) Except as provided in subsection (c) of this section, a standing referral shall be made in accordance with a written treatment plan for a covered service developed by:

(i) the primary care physician;

(ii) the specialist; and

(iii) the member.

(4) A treatment plan may:

(i) limit the number of visits to the specialist;

(ii) limit the period of time in which visits to the specialist are authorized; and

(iii) require the specialist to communicate regularly with the primary care physician regarding the treatment and health status of the member.

(5) The procedure by which a member may receive a standing referral to a specialist may not include a requirement that a member see a provider in addition to the primary care physician before the standing referral is granted.

(c) (1) (i) Notwithstanding any other provision of this section, a member who is pregnant shall receive a standing referral to an obstetrician, in accordance with this subsection.

(ii) After the member who is pregnant receives a standing referral to an obstetrician, the obstetrician is responsible for the primary management of the member's pregnancy, including the issuance of referrals in accordance with the carrier's policies and procedures, through the postpartum period.

(2) Notwithstanding any other provision of this section, a member shall receive a standing referral, in accordance with this subsection, to a behavioral health care provider acting within the scope of the provider's license, including a

psychiatrist, psychologist, licensed social worker–clinical, or licensed professional counselor for:

(i) the behavioral health services recognized by the United States Preventive Services Task Force as preventive benefits; and

(ii) the duration of the member's pregnancy and 1 year after the conclusion of the pregnancy.

(3) A written treatment plan may not be required when a standing referral is to an obstetrician or behavioral health care provider under this subsection.

(d) (1) Each carrier shall establish and implement a procedure by which a member may request a referral to a specialist or nonphysician specialist who is not part of the carrier's provider panel in accordance with this subsection.

(2) The procedure shall provide for a referral to a specialist or nonphysician specialist who is not part of the carrier's provider panel if:

(i) 1. the member is diagnosed with a condition or disease that requires specialized health care services or medical care; and

2. A. the carrier does not have in its provider panel a specialist or nonphysician specialist with the professional training and expertise to treat or provide health care services for the condition or disease; or

B. the carrier cannot provide reasonable access to a specialist or nonphysician specialist with the professional training and expertise to treat or provide health care services for the condition or disease without unreasonable delay or travel, including within the reasonable appointment waiting time and travel distance standards established in regulation for mental health and substance use disorder services; or

(ii) 1. the member is seeking mental health or substance use disorder care; and

2. the carrier cannot provide reasonable access to a specialist or nonphysician specialist within the reasonable appointment waiting time and travel distance standards established in regulation for mental health and substance use disorder services.

(3) The procedure shall ensure that a request to obtain a referral to a specialist or nonphysician specialist who is not part of the carrier's provider panel is addressed in a timely manner that is:

(i) appropriate for the member's condition; and

(ii) in accordance with the timeliness requirements for determinations made by private review agents under § 15–10B–06 of this title.

(4) If a member cannot access mental health or substance use disorder services through the referral requirements under paragraphs (2) and (3) of this subsection, the procedure shall require the carrier to provide additional assistance to the member in identifying and arranging coverage of mental health or substance use disorder services by a specialist or nonphysician specialist who is not part of the carrier's provider panel.

(5) If a carrier approves a member's request for a referral made in accordance with this subsection, the carrier may not require utilization review other than what would be required if the covered benefit were provided by a provider on the carrier's provider panel.

(6) The procedure may not be used by a carrier as a substitute for establishing and maintaining a sufficient provider network in accordance with § 15–112 of this title.

(7) Each carrier shall:

(i) have a system in place that documents all requests to obtain a referral to receive a covered service from a specialist or nonphysician specialist who is not part of the carrier's provider panel;

(ii) inform members of the procedure to request a referral under paragraph (1) of this subsection; and

(iii) provide the information documented under item (i) of this paragraph to the Commissioner on request.

(e) (1) Except as provided in paragraph (2) of this subsection, for purposes of calculating any deductible, copayment amount, or coinsurance payable by the member, a carrier shall treat services received in accordance with subsection (d) of this section as if the service was provided by a provider on the carrier's provider panel.

(2) A carrier shall ensure that services received in accordance with subsection (d) of this section for mental health or substance use disorders are provided for the duration of the treatment plan at no greater cost to the covered

individual than if the covered benefit were provided by a provider on the carrier's provider panel.

(f) A decision by a carrier not to provide access to or coverage of treatment or health care services by a specialist or nonphysician specialist in accordance with this section constitutes an adverse decision as defined under Subtitle 10A of this title if the decision is based on a finding that the proposed service is not medically necessary, appropriate, or efficient.

(g) (1) Each carrier shall file with the Commissioner a copy of each of the procedures required under this section, including:

(i) steps the carrier requires of a member to request a referral;

(ii) the carrier's timeline for decisions; and

(iii) the carrier's grievance procedures for denials.

(2) Each carrier shall make a copy of each of the procedures filed under paragraph (1) of this subsection available to its members:

(i) in the carrier's online provider directory required under § 15–112(n)(1) of this title; and

(ii) on request.

(h) The Consumer Education and Advocacy Program, established under Title 2, Subtitle 3 of this article, in collaboration with the Health Education and Advocacy Unit of the Office of the Attorney General, shall provide public education to inform consumers of their procedures to request a referral to a specialist or nonphysician specialist as provided for in this section.

(i) This section may not be construed to limit the provisions in § 19–710(p) of the Health – General Article.

§15–831.

(a) (1) In this section the following words have the meanings indicated.

(2) "Authorized prescriber" has the meaning stated in § 12–101 of the Health Occupations Article.

(3) "Formulary" means a list of prescription drugs or devices that are covered by an entity subject to this section.

(4) (i) "Member" means an individual entitled to health care benefits for prescription drugs or devices under a policy issued or delivered in the State by an entity subject to this section.

(ii) "Member" includes a subscriber.

(b) (1) This section applies to:

(i) insurers and nonprofit health service plans that provide coverage for prescription drugs and devices under individual, group, or blanket health insurance policies or contracts that are issued or delivered in the State; and

(ii) health maintenance organizations that provide coverage for prescription drugs and devices under individual or group contracts that are issued or delivered in the State.

(2) An insurer, nonprofit health service plan, or health maintenance organization that provides coverage for prescription drugs and devices through a pharmacy benefits manager is subject to the requirements of this section.

(3) This section does not apply to a managed care organization as defined in § 15–101 of the Health – General Article.

(c) Each entity subject to this section that limits its coverage of prescription drugs or devices to those in a formulary shall establish and implement a procedure by which a member may:

(1) receive a prescription drug or device that is not in the entity's formulary or has been removed from the entity's formulary in accordance with this section; or

(2) continue the same cost sharing requirements if the entity has moved the prescription drug or device to a higher deductible, copayment, or coinsurance tier.

(d) The procedure shall provide for coverage for a prescription drug or device in accordance with subsection (c) of this section if, in the judgment of the authorized prescriber:

(1) there is no equivalent prescription drug or device in the entity's formulary in a lower tier;

(2) an equivalent prescription drug or device in the entity's formulary in a lower tier:

(i) has been ineffective in treating the disease or condition of the member; or

(ii) has caused or is likely to cause an adverse reaction or other harm to the member; or

(3) for a contraceptive prescription drug or device, the prescription drug or device that is not on the formulary is medically necessary for the member to adhere to the appropriate use of the prescription drug or device.

(e) A decision by an entity subject to this section not to provide access to or coverage of a prescription drug or device in accordance with this section constitutes an adverse decision as defined under Subtitle 10A of this title if the decision is based on a finding that the proposed drug or device is not medically necessary, appropriate, or efficient.

(f) An entity subject to this section that removes a drug from its formulary or moves a prescription drug or device to a benefit tier that requires a member to pay a higher deductible, copayment, or coinsurance amount for the prescription drug or device shall provide a member who is currently on the prescription drug or device and the member's health care provider with:

(1) notice of the change at least 30 days before the change is implemented; and

(2) in the notice required under item (1) of this subsection, the process for requesting an exemption through the procedure adopted in accordance with this section.

§15–832.

(a) This section applies to:

(1) insurers and nonprofit health service plans that provide inpatient hospital, medical, or surgical benefits to individuals or groups on an expense–incurred basis under health insurance policies or contracts that are issued or delivered in the State; and

(2) health maintenance organizations that provide inpatient hospital, medical, or surgical benefits to individuals or groups under contracts that are issued or delivered in the State.

(b) For a patient who receives less than 48 hours of inpatient hospitalization following the surgical removal of a testicle, or who undergoes the surgical removal of a testicle on an outpatient basis, an entity subject to this section shall provide coverage for:

(1) one home visit scheduled to occur within 24 hours after discharge from the hospital or outpatient health care facility; and

(2) an additional home visit if prescribed by the patient's attending physician.

(c) Each entity subject to this section shall provide notice annually to its enrollees and insureds about the coverage required under this section.

§15–832.1.

(a) In this section, "mastectomy" means the surgical removal of all or part of a breast as a result of breast cancer.

(b) This section applies to:

(1) insurers and nonprofit health service plans that provide inpatient hospital, medical, or surgical benefits to individuals or groups on an expense–incurred basis under health insurance policies or contracts that are issued or delivered in the State; and

(2) health maintenance organizations that provide inpatient hospital, medical, or surgical benefits to individuals or groups under contracts that are issued or delivered in the State.

(c) An entity subject to this section shall provide coverage for the cost of inpatient hospitalization services for a patient for a minimum of 48 hours following a mastectomy.

(d) A patient may request a shorter length of stay than that provided in subsection (c) of this section if the patient decides, in consultation with the patient's attending physician, that less time is needed for recovery.

(e) (1) For a patient who receives less than 48 hours of inpatient hospitalization following a mastectomy or who undergoes a mastectomy on an outpatient basis, an entity subject to this section shall provide coverage for:

(i) one home visit scheduled to occur within 24 hours after discharge from the hospital or outpatient health care facility; and

(ii) an additional home visit if prescribed by the patient's attending physician.

(2) For a patient who remains in the hospital for at least the length of time provided under subsection (c) of this section, an entity subject to this section shall provide coverage for a home visit if prescribed by the attending physician.

(f) An entity subject to this section may not deny, limit, or otherwise impair the participation of an attending physician under contract with the entity in providing health care services to enrollees or insureds for:

(1) advocating the interest of a mastectomy patient through the entity's utilization review or appeals system;

(2) advocating more than 48 hours of inpatient hospital care for a patient with complications related to a mastectomy; or

(3) prescribing a home visit under subsection (e)(1)(ii) or (2) of this section.

(g) An entity subject to this section may not refuse reimbursement under subsection (e)(1) of this section if the services do not occur within the time specified.

(h) An entity subject to this section shall provide notice annually to insureds and enrollees about the coverage provided by this section.

§15–833.

(a) A policy will be considered to provide benefits on an expense-incurred basis if benefits payable under the policy are based on both medical expenses incurred and flat fees regardless of actual expenses incurred.

(b) This section applies to health benefit plans issued under Subtitle 12 of this title.

(c) This section does not apply if:

(1) coverage is terminated because an individual fails to pay a required premium;

(2) coverage is terminated for fraud or material misrepresentation by the individual; or

(3) any coverage provided by a succeeding health benefit plan:

(i) is provided at a cost to the individual that is less than or equal to the cost to the individual of the extended benefit required under this section; and

(ii) does not result in an interruption of benefits.

(d) During an extension period required under this section a premium may not be charged.

(e) (1) This subsection applies to:

(i) insurers and nonprofit health service plans that provide hospital, medical, or surgical benefits on an expense-incurred basis under group or blanket health insurance policies that are issued or delivered in the State; and

(ii) health maintenance organizations that provide hospital, medical, or surgical benefits under contracts that are issued or delivered in the State.

(2) If an individual is totally disabled when the individual's coverage terminates, an entity subject to this subsection shall continue to pay covered benefits, in accordance with the policy in effect at the time the individual's coverage terminates, for expenses incurred by the individual for the condition causing the disability until the earlier of:

(i) the date the individual ceases to be totally disabled; or

(ii) 12 months after the date coverage terminates.

(3) An entity subject to this subsection may at any time require the individual to provide proof of total disability.

(f) (1) This subsection applies to:

(i) insurers and nonprofit health service plans that provide hospital, medical, or surgical benefits on an expense-incurred basis under individual health insurance policies that are issued or delivered in the State; and

(ii) health maintenance organizations that provide hospital, medical, or surgical benefits under individual contracts that are issued or delivered in the State.

(2) If an individual has a claim in progress when the individual's coverage terminates, an entity subject to this subsection shall continue to pay covered benefits, in accordance with the policy in effect at the time the individual's coverage terminates, related to the claim until the earlier of:

(i) the date the individual is released from the care of a physician for the condition that is the basis of the claim; or

(ii) 12 months after the date coverage terminates.

(g) (1) This subsection applies to:

(i) group, blanket, and individual policies that limit coverage to hospital or surgical benefits on an expense-incurred basis; and

(ii) group, blanket, and individual hospital indemnity policies.

(2) If an individual is confined in a hospital on the date coverage terminates, a policy subject to this subsection shall continue to pay covered benefits, in accordance with the policy in effect at the time the individual's coverage terminates, for the confinement until the earlier of:

(i) the date the individual is discharged from the hospital; or

(ii) 12 months after the date coverage terminates.

(h) (1) This subsection applies to insurers, nonprofit health service plans, and health maintenance organizations that provide group, blanket, or individual vision benefits.

(2) If an individual has ordered glasses or contact lenses before the date coverage terminates, an entity subject to this subsection that provides coverage for glasses or contact lenses shall continue to provide covered benefits, in accordance with the policy in effect at the time the individual's coverage terminates, for the glasses or contact lenses if the individual receives the glasses or contact lenses within 30 days after the date of the order.

(i) (1) This subsection applies to insurers that provide group, blanket, or individual accidental death or dismemberment benefits.

(2) An insurer subject to this subsection shall provide covered benefits, in accordance with the policy in effect at the time the individual's coverage terminates, for a covered loss that occurs after the date coverage terminates if:

(i) an accident occurs while the individual is covered; and

(ii) the loss occurs within 90 days after the accident.

(j) (1) This subsection applies to insurers, nonprofit health service plans, health maintenance organizations, and dental plan organizations that provide group, blanket, or individual dental benefits.

(2) Except as provided in paragraph (3) of this subsection, an entity subject to this subsection shall provide covered benefits, in accordance with the policy in effect at the time the individual's coverage terminates, for a course of treatment for at least 90 days after the date coverage terminates if the treatment:

(i) begins before the date coverage terminates; and

(ii) requires two or more visits on separate days to a dentist's office.

(3) An entity subject to this subsection that provides coverage for orthodontics shall provide covered benefits, in accordance with the policy in effect at the time the individual's coverage terminates, for orthodontics:

(i) for 60 days after the date coverage terminates if the orthodontist has agreed to or is receiving monthly payments; or

(ii) until the later of 60 days after the date coverage terminates or the end of the quarter in progress, if the orthodontist has agreed to accept or is receiving payments on a quarterly basis.

§15–834.

(a) This section applies to:

(1) insurers and nonprofit health service plans that provide hospital, medical, or surgical benefits to individuals or groups on an expense-incurred basis under health insurance policies or contracts that are issued or delivered in the State; and

(2) health maintenance organizations that provide hospital, medical, or surgical benefits to individuals or groups under contracts that are issued or delivered in the State.

(b) An entity subject to this section shall provide coverage for a prosthesis that has been prescribed by a physician for an enrollee or insured who has undergone a mastectomy and has not had breast reconstruction.

§15–835.

(a) (1) In this section the following words have the meanings indicated.

(2) "Habilitative services" means services and devices, including occupational therapy, physical therapy, and speech therapy, that help a child keep, learn, or improve skills and functioning for daily living.

(3) "Managed care system" means a method that an insurer, a nonprofit health service plan, or a health maintenance organization uses to review and preauthorize a treatment plan that a health care practitioner develops for a covered person using a variety of cost containment methods to control utilization, quality, and claims.

(b) This section applies to:

(1) insurers and nonprofit health service plans that provide hospital, medical, or surgical benefits to individuals or groups on an expense–incurred basis under health insurance policies or contracts that are issued or delivered in the State; and

(2) health maintenance organizations that provide hospital, medical, or surgical benefits to individuals or groups under contracts that are issued or delivered in the State.

(c) (1) An entity subject to this section:

(i) shall provide coverage of habilitative services for insureds and enrollees who are children until at least the end of the month in which the insured or enrollee turns 19 years old; and

(ii) may do so through a managed care system.

(2) An entity subject to this section is not required to provide reimbursement for habilitative services delivered through early intervention or school services.

(d) An entity subject to this section shall provide notice annually to its insureds and enrollees about the coverage required under this section:

(1) in print; and

(2) on its Web site.

(e) Beginning November 1, 2013, a determination by an entity subject to this section of whether habilitative services covered under this section are medically necessary and appropriate to treat autism and autism spectrum disorders shall be made in accordance with regulations adopted by the Commissioner.

§15–836.

(a) This section applies to:

(1) insurers and nonprofit health service plans that provide inpatient hospital, medical, or surgical benefits to individuals or groups on an expense-incurred basis under health insurance policies or contracts that are issued or delivered in the State; and

(2) health maintenance organizations that provide inpatient hospital, medical, or surgical benefits to individuals or groups under contracts that are issued or delivered in the State.

(b) (1) Subject to paragraph (2) of this subsection, an entity subject to this section shall provide, for an enrollee or insured whose hair loss results from chemotherapy or radiation treatment for cancer, coverage for one hair prosthesis.

(2) The cost of a hair prosthesis required under paragraph (1) of this subsection may not exceed $350.

(c) To be covered under this section, a hair prosthesis must be prescribed by the oncologist in attendance.

§15–837.

(a) This section applies to:

(1) insurers and nonprofit health service plans that provide hospital, medical, or surgical benefits to individuals or groups on an expense-incurred basis under health insurance policies or contracts that are issued or delivered in the State; and

(2) health maintenance organizations that provide hospital, medical, or surgical benefits to individuals or groups under contracts that are issued or delivered in the State.

(b) An entity subject to this section shall provide coverage for colorectal cancer screening in accordance with the latest screening guidelines issued by the American Cancer Society.

(c) (1) Subject to paragraph (2) of this subsection, the coverage required under this section may be subject to a copayment or coinsurance requirement or deductible that an entity subject to this section imposes for similar coverages under the same policy or contract.

(2) The copayment or coinsurance requirement or deductible imposed under paragraph (1) of this subsection may not be greater than the copayment or coinsurance requirement or deductible imposed by the entity for similar coverages.

(d) Nothing in this section may be construed to prohibit an entity subject to this section from providing coverages that are greater than or more favorable to an insured or enrollee than the coverage required under this section.

§15–838.

(a) This section applies to:

(1) insurers and nonprofit health service plans that provide hospital, medical, or surgical benefits to individuals or groups on an expense–incurred basis under health insurance policies or contracts that are issued or delivered in the State; and

(2) health maintenance organizations that provide hospital, medical, or surgical benefits to individuals or groups under contracts that are issued or delivered in the State.

(b) (1) In this subsection, "hearing aid" means a device that:

(i) is of a design and circuitry to optimize audibility and listening skills in the environment commonly experienced by children; and

(ii) is nondisposable.

(2) An entity subject to this section shall provide coverage for hearing aids for a minor child who is covered under a policy or contract if the hearing aids are prescribed, fitted, and dispensed by a licensed audiologist.

(3) (i) An entity subject to this section may limit the benefit payable under paragraph (2) of this subsection to $1,400 per hearing aid for each hearing–impaired ear every 36 months.

(ii) An insured or enrolled individual may choose a hearing aid that is priced higher than the benefit payable under this subsection and may pay the difference between the price of the hearing aid and the benefit payable under this subsection, without financial or contractual penalty to the provider of the hearing aid.

(c) This section does not prohibit an entity subject to this section from providing coverage that is greater or more favorable to an insured or enrolled individual than the coverage required under this section.

§15–838.1.

(a) In this section, "hearing aid" means a device that:

(1) is of a design and circuitry to optimize audibility and listening skills in the environment commonly experienced by adults; and

(2) is nondisposable.

(b) This section applies to:

(1) insurers and nonprofit health service plans that provide hospital, medical, or surgical benefits to individuals or groups on an expense–incurred basis under health insurance policies or contracts that are issued or delivered in the State; and

(2) health maintenance organizations that provide hospital, medical, or surgical benefits to individuals or groups under contracts that are issued or delivered in the State.

(c) An entity subject to this section shall provide coverage for all medically appropriate and necessary hearing aids for an adult who is covered under a policy or contract if the hearing aids are:

(1) prescribed, fitted, and dispensed by a licensed audiologist; or

(2) ordered, fitted, and dispensed by a licensed hearing aid dispenser.

(d) (1) An entity subject to this section may limit the benefit payable under subsection (c) of this section to $1,400 per hearing aid for each hearing–impaired ear every 36 months.

(2) An insured or enrollee may choose a hearing aid that is priced higher than the benefit payable under this subsection and may pay the difference between the price of the hearing aid and the benefit payable under this subsection, without financial or contractual penalty to the provider of the hearing aid.

(e) This section does not prohibit an entity subject to this section from providing coverage that is greater or more favorable to an insured or enrollee than the coverage required under this section.

§15–839.

(a) (1) In this section the following words have the meanings indicated.

(2) "Body mass index" means a practical marker that is used to assess the degree of obesity and is calculated by dividing the weight in kilograms by the height in meters squared.

(3) "Morbid obesity" means a body mass index that is:

(i) greater than 40 kilograms per meter squared; or

(ii) equal to or greater than 35 kilograms per meter squared with a comorbid medical condition, including hypertension, a cardiopulmonary condition, sleep apnea, or diabetes.

(b) This section applies to:

(1) insurers and nonprofit health service plans that provide hospital, medical, or surgical benefits to individuals or groups on an expense-incurred basis under health insurance policies or contracts that are issued or delivered in the State;

(2) health maintenance organizations that provide hospital, medical, or surgical benefits to individuals or groups under contracts that are issued or delivered in the State; and

(3) managed care organizations, as defined in § 15-101 of the Health - General Article.

(c) An entity subject to this section shall provide coverage for the surgical treatment of morbid obesity that is:

(1) recognized by the National Institutes of Health as effective for the long-term reversal of morbid obesity; and

(2) consistent with guidelines approved by the National Institutes of Health.

(d) An entity subject to this section shall provide the benefits required under this section to the same extent as for other medically necessary surgical procedures under the enrollee's or insured's contract or policy with the entity.

§15–840.

(a) In this section, "residential crisis services" means intensive mental health and support services that are:

(1) provided to a child or an adult with a mental illness who is experiencing or is at risk of a psychiatric crisis that would impair the individual's ability to function in the community;

(2) designed to prevent a psychiatric inpatient admission, provide an alternative to psychiatric inpatient admission, or shorten the length of inpatient stay;

(3) provided out of the individual's residence on a short–term basis in a community–based residential setting; and

(4) provided by entities that are licensed by the Maryland Department of Health to provide residential crisis services.

(b) This section applies to:

(1) insurers and nonprofit health service plans that provide hospital, medical, or surgical benefits to individuals or groups on an expense–incurred basis under health insurance policies or contracts that are issued or delivered in the State; and

(2) health maintenance organizations that provide hospital, medical, or surgical benefits to individuals or groups under contracts that are issued or delivered in the State.

(c) (1) An entity subject to this section shall provide coverage for medically necessary residential crisis services.

(2) The services required under this section may be delivered under a managed care system.

§15–841.

(a) (1) In this section the following words have the meanings indicated.

(2) "Authorized prescriber" has the meaning stated in § 12-101 of the Health Occupations Article.

(3) (i) "Nicotine replacement therapy" means a product that:

1. is used to deliver nicotine to an individual attempting to cease the use of tobacco products; and

2. is obtained under a prescription written by an authorized prescriber.

(ii) "Nicotine replacement therapy" does not include any over-the-counter product that may be obtained without a prescription.

(4) "Tobacco product" has the meaning stated in § 10-101 of the Criminal Law Article.

(b) (1) This subsection applies to:

(i) insurers and nonprofit health service plans that provide coverage for prescription drugs to individuals or groups under health insurance policies or contracts that are issued or delivered in the State; and

(ii) health maintenance organizations that provide coverage for prescription drugs to individuals or groups under contracts that are issued or delivered in the State.

(2) An entity subject to this subsection shall provide coverage for:

(i) except for a drug that may be obtained over-the-counter without a prescription, any drug that:

1. is approved by the United States Food and Drug Administration as an aid for the cessation of the use of tobacco products; and

2. is obtained under a prescription written by an authorized prescriber; and

(ii) two 90-day courses of nicotine replacement therapy during each policy year.

(3) An entity subject to this subsection may not impose a different copayment or coinsurance requirement for a drug or nicotine replacement therapy provided under paragraph (2) of this subsection than is imposed for any other comparable prescription.

§15–842.

(a) (1) This section applies to:

(i) insurers and nonprofit health service plans that provide coverage for prescription drugs and devices under health insurance policies or contracts that are issued or delivered in the State; and

(ii) health maintenance organizations that provide coverage for prescription drugs and devices under contracts that are issued or delivered in the State.

(2) An insurer, nonprofit health service plan, or health maintenance organization that provides coverage for prescription drugs and devices through a pharmacy benefits manager is subject to the requirements of this section.

(b) An entity subject to this section may not impose a copayment or coinsurance requirement for a covered prescription drug or device that exceeds the retail price of the prescription drug or device.

§15–843.

(a) This section applies to:

(1) insurers and nonprofit health service plans that provide hospital, medical, or surgical benefits to individuals or groups on an expense–incurred basis under health insurance policies that are issued or delivered in the State; and

(2) health maintenance organizations that provide hospital, medical, and surgical benefits to individuals or groups under contracts that are issued or delivered in the State.

(b) (1) Subject to paragraph (2) of this subsection, a policy or plan subject to this section shall include, under the family member coverage, coverage for amino acid–based elemental formula, regardless of delivery method, for the diagnosis and treatment of:

(i) Immunoglobulin E and non–Immunoglobulin E mediated allergies to multiple food proteins;

(ii) severe food protein induced enterocolitis syndrome;

(iii) eosinophilic disorders, as evidenced by the results of a biopsy; and

(iv) impaired absorption of nutrients caused by disorders affecting the absorptive surface, functional length, and motility of the gastrointestinal tract.

(2) Subject to paragraph (3) of this subsection, the coverage required under paragraph (1) of this subsection is required if the ordering physician has issued a written order stating that the amino acid–based elemental formula is medically necessary for the treatment of a disease or disorder listed in paragraph (1) of this subsection.

(3) In accordance with Subtitle 10A of this title, a private review agent, acting on behalf of an insurer, nonprofit health service plan, or health maintenance organization, may review the ordering physician's determination of the medical necessity of the amino acid–based elemental formula for the treatment of a disease or disorder listed in paragraph (1) of this subsection.

§15–844. IN EFFECT

(a) (1) In this section, "prosthesis" means an artificial device to replace, in whole or in part, a leg, an arm, or an eye.

(2) "Prosthesis" includes a custom–designed, –fabricated, –fitted, or –modified device to treat partial or total limb loss for purposes of restoring physiological function.

(b) This section applies to:

(1) insurers and nonprofit health service plans that provide hospital, medical, or surgical benefits to individuals or groups on an expense–incurred basis under health insurance policies or contracts that are issued or delivered in the State; and

(2) health maintenance organizations that provide hospital, medical, or surgical benefits to individuals or groups under contracts that are issued or delivered in the State.

(c) An entity subject to this section shall provide once annually coverage for:

(1) prostheses;

(2) components of prostheses;

(3) repairs to prostheses; and

(4) subject to subsection (d) of this section, replacements of prostheses or prosthesis components.

(d) (1) An entity subject to this section shall provide coverage for replacements of prostheses if an ordering health care provider determines that the provision of a replacement prosthesis or a component of the prosthesis is necessary:

(i) because of a change in the physiological condition of the patient;

(ii) unless necessitated by misuse, because of an irreparable change in the condition of the prosthesis or a component of the prosthesis; or

(iii) unless necessitated by misuse, because the condition of the prosthesis or the component of the prosthesis requires repairs and the cost of the repairs would be more than 60% of the cost of replacing the prosthesis or the component of the prosthesis.

(2) An entity subject to this section may require an ordering health care provider to confirm that the prosthesis or component of the prosthesis being replaced meets the requirements of paragraph (1) of this subsection if the prosthesis or component is less than 3 years old.

(e) The covered benefits under this section may not be subject to a higher copayment or coinsurance requirement than the copayment or coinsurance for other similar medical and surgical benefits covered under the policy or contract of the insured or enrollee.

(f) An entity subject to this section may not impose an annual or lifetime dollar maximum on coverage required under this section separate from any annual

or lifetime dollar maximum that applies in the aggregate to all covered benefits under the policy or contract of the insured or enrollee.

(g) (1) An entity subject to this section may not establish requirements for medical necessity or appropriateness for the coverage required under this section that are more restrictive than the indications and limitations of coverage and medical necessity established under the Medicare Coverage Database.

(2) The covered benefits under this section include prostheses determined by a treating health care provider to be medically necessary for:

(i) completing activities of daily living;

(ii) essential job–related activities; or

(iii) performing physical activities, including running, biking, swimming, strength training, and other activities to maximize the whole–body health and lower or upper limb function of the insured or enrollee.

(h) An entity subject to this section that uses a provider panel for a policy or contract described in subsection (b) of this section and the provision of covered benefits under this section shall comply with § 15–112(b)(3) of this title.

§15–844. ** TAKES EFFECT JANUARY 1, 2027 PER CHAPTERS 628 AND 629 OF 2026 **

(a) (1) In this section, "prosthesis" means an artificial device to replace, in whole or in part, a leg, an arm, or an eye.

(2) "Prosthesis" includes a custom–designed, –fabricated, –fitted, or –modified device to treat partial or total limb loss for purposes of restoring physiological function.

(b) This section applies to:

(1) insurers and nonprofit health service plans that provide hospital, medical, or surgical benefits to individuals or groups on an expense–incurred basis under health insurance policies or contracts that are issued or delivered in the State; and

(2) health maintenance organizations that provide hospital, medical, or surgical benefits to individuals or groups under contracts that are issued or delivered in the State.

(c) An entity subject to this section shall provide once annually coverage for:

(1) prostheses;

(2) components of prostheses;

(3) repairs to prostheses; and

(4) subject to subsection (d) of this section, replacements of prostheses or prosthesis components.

(d) (1) An entity subject to this section shall provide coverage for replacements of prostheses if an ordering health care provider determines that the provision of a replacement prosthesis or a component of the prosthesis is necessary:

(i) because of a change in the physiological condition of the patient;

(ii) unless necessitated by misuse, because of an irreparable change in the condition of the prosthesis or a component of the prosthesis; or

(iii) unless necessitated by misuse, because the condition of the prosthesis or the component of the prosthesis requires repairs and the cost of the repairs would be more than 60% of the cost of replacing the prosthesis or the component of the prosthesis.

(2) An entity subject to this section may require an ordering health care provider to confirm that the prosthesis or component of the prosthesis being replaced meets the requirements of paragraph (1) of this subsection if the prosthesis or component is less than 3 years old.

(e) The covered benefits under this section may not be subject to a higher copayment or coinsurance requirement than the copayment or coinsurance for other similar medical and surgical benefits covered under the policy or contract of the insured or enrollee.

(f) An entity subject to this section may not impose an annual or lifetime dollar maximum on coverage required under this section separate from any annual or lifetime dollar maximum that applies in the aggregate to all covered benefits under the policy or contract of the insured or enrollee.

(g) (1) An entity subject to this section may not establish requirements for medical necessity or appropriateness for the coverage required under this section

that are more restrictive than the indications and limitations of coverage and medical necessity established under the Medicare Coverage Database.

(2) The covered benefits under this section include all prostheses determined by a treating health care provider to be medically necessary for:

(i) completing activities of daily living;

(ii) essential job–related activities; or

(iii) performing physical activities, including running, biking, swimming, strength training, and other activities to maximize the whole–body health and lower or upper limb function of the insured or enrollee.

(h) An entity subject to this section that uses a provider panel for a policy or contract described in subsection (b) of this section and the provision of covered benefits under this section shall comply with § 15–112(b)(3) of this title.

§15–845.

(a) This section applies to:

(1) insurers and nonprofit health service plans that provide coverage for prescription eye drops under health insurance policies or contracts that are issued or delivered in the State; and

(2) health maintenance organizations that provide coverage for prescription eye drops under contracts that are issued or delivered in the State.

(b) An entity subject to this section shall provide coverage for a refill of prescription eye drops:

(1) in accordance with guidance for early refills of topical ophthalmic products provided to Medicare Part D plan sponsors by the Centers for Medicare and Medicaid Services; and

(2) if:

(i) the prescribing health care practitioner indicates on the original prescription that additional quantities of the prescription eye drops are needed;

(ii) the refill requested by the insured does not exceed the number of additional quantities indicated on the original prescription by the prescribing health care practitioner; and

(iii) the prescription eye drops prescribed by the health care practitioner are a covered benefit under the policy or contract of the insured.

§15–846.

(a) In this section, "cancer chemotherapy" means medication that is prescribed by a licensed physician to kill or slow the growth of cancer cells.

(b) This section applies to:

(1) insurers and nonprofit health service plans that provide coverage for both orally administered cancer chemotherapy and cancer chemotherapy that is administered intravenously or by injection under health insurance policies or contracts that are issued or delivered in the State; and

(2) health maintenance organizations that provide coverage for both orally administered cancer chemotherapy and cancer chemotherapy that is administered intravenously or by injection under contracts that are issued or delivered in the State.

(c) An entity subject to this section may not impose dollar limits, copayments, deductibles, or coinsurance requirements on coverage for orally administered cancer chemotherapy that are less favorable to an insured or enrollee than the dollar limits, copayments, deductibles, or coinsurance requirements that apply to coverage for cancer chemotherapy that is administered intravenously or by injection.

(d) An entity subject to this section may not reclassify cancer chemotherapy or increase a copayment, deductible, coinsurance requirement, or other out–of–pocket expense imposed on cancer chemotherapy to achieve compliance with this section.

§15–847.

(a) (1) In this section the following words have the meanings indicated.

(2) (i) "Complex or chronic medical condition" means a physical, behavioral, or developmental condition that:

1. may have no known cure;

2. is progressive; or

3. can be debilitating or fatal if left untreated or undertreated.

(ii) "Complex or chronic medical condition" includes:

1. multiple sclerosis;

2. hepatitis C; and

3. rheumatoid arthritis.

(3) "Managed care system" means a system of cost containment methods that an insurer, a nonprofit health service plan, or a health maintenance organization uses to review and preauthorize drugs prescribed by a health care provider for a covered individual to control utilization, quality, and claims.

(4) (i) "Rare medical condition" means a disease or condition that affects fewer than:

1. 200,000 individuals in the United States; or

2. approximately 1 in 1,500 individuals worldwide.

(ii) "Rare medical condition" includes:

1. cystic fibrosis;

2. hemophilia; and

3. multiple myeloma.

(5) (i) "Specialty drug" means a prescription drug that:

1. is prescribed for an individual with a complex or chronic medical condition or a rare medical condition;

2. costs $600 or more for up to a 30–day supply;

3. is not typically stocked at retail pharmacies; and

4. A. requires a difficult or unusual process of delivery to the patient in the preparation, handling, storage, inventory, or distribution of the drug; or

B. requires enhanced patient education, management, or support, beyond those required for traditional dispensing, before or after administration of the drug.

(ii) "Specialty drug" does not include a prescription drug prescribed to treat diabetes, HIV, or AIDS.

(b) This section applies to:

(1) insurers and nonprofit health service plans that provide coverage for prescription drugs under individual, group, or blanket health insurance policies or contracts that are issued or delivered in the State; and

(2) health maintenance organizations that provide coverage for prescription drugs under individual or group contracts that are issued or delivered in the State.

(c) (1) Subject to paragraph (2) of this subsection, an entity subject to this section may not impose a copayment or coinsurance requirement on a covered specialty drug that exceeds $150 for up to a 30–day supply of the specialty drug.

(2) On July 1 of each year, the limit on the copayment or coinsurance requirement on a covered specialty drug shall increase by a percentage equal to the percentage change from the preceding year in the medical care component of the March Consumer Price Index for All Urban Consumers, Washington Metropolitan Area, from the U.S. Department of Labor, Bureau of Labor Statistics.

(d) Subject to subsection (h) of this section and § 15–805 of this subtitle, notwithstanding § 15–806 of this subtitle, and except as provided in § 15–847.2 of this subtitle, this article or regulations adopted under this article do not preclude an entity subject to this section from requiring a covered specialty drug to be obtained through:

(1) a designated pharmacy or other source authorized under the Health Occupations Article to dispense or administer prescription drugs; or

(2) a pharmacy participating in the entity's provider network, if the entity determines that the pharmacy:

(i) meets the entity's performance standards; and

(ii) accepts the entity's network reimbursement rates.

(e) (1) A pharmacy registered under § 340B of the federal Public Health Services Act may apply to an entity subject to this section to be a designated pharmacy under subsection (d)(1) of this section for the purpose of enabling the pharmacy's patients with hepatitis C to receive the copayment or coinsurance maximum provided for in subsection (c) of this section if:

(i) the pharmacy is owned by a federally qualified health center, as defined in 42 U.S.C. § 254B;

(ii) the federally qualified health center provides integrated and coordinated medical and pharmaceutical services to hepatitis C patients; and

(iii) the prescription drugs are covered specialty drugs for the treatment of hepatitis C.

(2) An entity subject to this section may not unreasonably withhold approval of a pharmacy's application under paragraph (1) of this subsection.

(f) An entity subject to this section may provide coverage for specialty drugs through a managed care system.

(g) (1) A determination by an entity subject to this section that a prescription drug is not a specialty drug is considered a coverage decision under § 15–10D–01 of this title.

(2) For complaints filed with the Commissioner under this subsection, if the entity made its determination that a prescription drug is not a specialty drug on the basis that the prescription drug did not meet the criteria listed in subsection (a)(5)(i) of this section:

(i) the Commissioner may seek advice from an independent review organization or medical expert on the list compiled under § 15–10A–05(b) of this title; and

(ii) the expenses for any advice provided by an independent review organization or medical expert shall be paid for as provided under § 15–10A–05(h) of this title.

(h) This section may not be construed to supersede the authority of the Health Services Cost Review Commission to set rates for specialty drugs

administered to patients in a setting regulated by the Health Services Cost Review Commission.

§15–847.1.

(a) This section applies to:

(1) insurers and nonprofit health service plans that provide coverage for prescription drugs under individual, group, or blanket health insurance policies or contracts that are issued or delivered in the State; and

(2) health maintenance organizations that provide coverage for prescription drugs under individual group contracts that are issued or delivered in the State.

(b) (1) Subject to paragraph (2) of this subsection and § 15–822.1 of this subtitle, an entity subject to this section may not impose a copayment or coinsurance requirement on a prescription drug prescribed to treat diabetes, HIV, or AIDS that exceeds $150 for up to a 30–day supply of the drug.

(2) On July 1 each year, the limit on the copayment or coinsurance requirement on a prescription drug prescribed to treat diabetes, HIV, or AIDS shall increase by a percentage equal to the percentage change from the preceding year in the medical care component of the March Consumer Price Index for All Urban Consumers, Washington Metropolitan Area, from the U.S. Department of Labor, Bureau of Labor Statistics.

§15–847.2.

(a) In this section, "specialty drug" has the meaning stated in § 15–847 of this subtitle.

(b) (1) This section applies to:

(i) insurers and nonprofit health service plans that provide coverage for prescription drugs under individual, group, or blanket health insurance policies or contracts that are issued or delivered in the State; and

(ii) health maintenance organizations that provide coverage for prescription drugs under individual or group contracts that are issued or delivered in the State.

(2) An insurer, a nonprofit health service plan, or a health maintenance organization that provides coverage for prescription drugs through a pharmacy benefits manager is subject to the requirements of this section.

(c) An entity subject to this section may not exclude coverage for a covered specialty drug administered or dispensed by a provider under § 12–102 of the Health Occupations Article if the entity determines that:

(1) the provider that administers or dispenses the covered specialty drug:

(i) is an in–network provider of covered oncology services; and

(ii) complies with State regulations for the administering and dispensing of specialty drugs; and

(2) the covered specialty drug is:

(i) auto–injected or an oral targeted immune modulator; or

(ii) an oral medication that:

1. requires complex dosing based on clinical presentation; or

2. is used concomitantly with other infusion or radiation therapies.

(d) (1) Subject to subsection (f) of this section, the reimbursement rate for specialty drugs covered under this section shall be:

(i) agreed to by the covered, in–network provider and the entity subject to this section; and

(ii) billed at a nonhospital level of care or place of service.

(2) Unless otherwise agreed to by the covered, in–network provider and the entity subject to this section, the reimbursement rate for specialty drugs covered under this section may not exceed the rate applicable to a designated specialty pharmacy for dispensing the covered specialty drugs.

(e) This section does not prohibit an entity subject to this section from refusing to authorize or approve or from denying coverage for a covered specialty drug

administered or dispensed by a provider if administering or dispensing the drug fails to satisfy medical necessity criteria.

(f) This section may not be construed to supersede the authority of the Health Services Cost Review Commission to set rates for specialty drugs administered to patients in a setting regulated by the Health Services Cost Review Commission.

§15–848.

(a) This section applies to:

(1) insurers and nonprofit health service plans that provide hospital, medical, or surgical benefits to individuals or groups on an expense–incurred basis under health insurance policies or contracts that are issued or delivered in the State; and

(2) health maintenance organizations that provide hospital, medical, or surgical benefits to individuals or groups under contracts that are issued or delivered in the State.

(b) This section does not apply to a policy or contract issued or delivered by an entity subject to this section that provides the essential health benefits required under § 1302(a) of the Affordable Care Act.

(c) An entity subject to this section shall provide coverage for all medically appropriate and necessary equipment and supplies used for the treatment of ostomies, including flanges, collection bags, clamps, irrigation devices, sanitizing products, ostomy rings, ostomy belts, and catheters used for drainage of urostomies.

(d) (1) Subject to paragraph (2) of this subsection, the coverage required under this section may be subject to the annual deductibles or coinsurance requirements imposed by an entity subject to this section for similar coverages under the same health insurance policy or contract.

(2) The annual deductibles or coinsurance requirements imposed under paragraph (1) of this subsection for the coverage required under this section may not be greater than the annual deductibles or coinsurance requirements imposed by the entity for similar coverages.

§15–849.

(a) (1) In this section the following words have the meanings indicated.

(2) "Abuse–deterrent opioid analgesic drug product" means a brand name or generic opioid analgesic drug product approved by the U.S. Food and Drug Administration with abuse–deterrent labeling that indicates the drug product is expected to result in a meaningful reduction in abuse.

(3) "Opioid analgesic drug product" means a drug product that contains an opioid agonist and is indicated by the U.S. Food and Drug Administration for the treatment of pain, regardless of whether the drug product:

(i) is in immediate release or extended release form; or

(ii) contains other drug substances.

(b) (1) This section applies to:

(i) insurers and nonprofit health service plans that provide coverage for prescription drugs under individual, group, or blanket health insurance policies or contracts that are issued or delivered in the State; and

(ii) health maintenance organizations that provide coverage for prescription drugs under individual or group contracts that are issued or delivered in the State.

(2) An insurer, a nonprofit health service plan, or a health maintenance organization that provides coverage for prescription drugs through a pharmacy benefits manager is subject to the requirements of this section.

(c) (1) An entity subject to this section shall provide coverage for:

(i) at least two brand name abuse–deterrent opioid analgesic drug products, each containing different analgesic ingredients, on the lowest cost tier for brand name prescription drugs on the entity's formulary for prescription drug coverage; and

(ii) if available, at least two generic abuse–deterrent opioid analgesic drug products, each containing different analgesic ingredients, on the lowest cost tier for generic drugs on the entity's formulary for prescription drug coverage.

(2) An entity subject to this section may not require an insured or an enrollee to first use an opioid analgesic drug product without abuse–deterrent labeling before providing coverage for an abuse–deterrent opioid analgesic drug product covered on the entity's formulary for prescription drug coverage.

(d) Notwithstanding subsection (c)(2) of this section, an entity subject to this section may undertake utilization review, including preauthorization, for an abuse–deterrent opioid analgesic drug product covered by the entity, if the same utilization review requirements are applied to non–abuse–deterrent opioid analgesic drug products covered by the entity in the same formulary tier as the abuse–deterrent opioid analgesic product.

§15–850.

(a) In this section, "opioid antagonist" means:

(1) naloxone hydrochloride; or

(2) any other similarly acting and equally safe drug approved by the federal Food and Drug Administration for the treatment of a drug overdose.

(b) (1) This section applies to:

(i) insurers and nonprofit health service plans that provide coverage for prescription drugs under individual, group, or blanket health insurance policies or contracts that are issued or delivered in the State; and

(ii) health maintenance organizations that provide coverage for prescription drugs under individual or group contracts that are issued or delivered in the State.

(2) An insurer, a nonprofit health service plan, or a health maintenance organization that provides coverage for prescription drugs through a pharmacy benefits manager is subject to the requirements of this section.

(c) An entity subject to this section that includes on its formulary an opioid antagonist may apply a prior authorization requirement for an opioid antagonist only if the entity provides coverage for at least one formulation of the opioid antagonist without a prior authorization requirement.

§15–851.

(a) (1) This section applies to:

(i) insurers and nonprofit health service plans that provide coverage for substance use disorder benefits or prescription drugs under individual, group, or blanket health insurance policies or contracts that are issued or delivered in the State; and

(ii) health maintenance organizations that provide coverage for substance use disorder benefits or prescription drugs under individual or group contracts that are issued or delivered in the State.

(2) An insurer, a nonprofit health service plan, or a health maintenance organization that provides coverage for substance use disorder benefits under the medical benefit or for prescription drugs through a pharmacy benefits manager is subject to the requirements of this section.

(b) An entity subject to this section may not apply a prior authorization requirement for a prescription drug:

(1) when used for treatment of an opioid use disorder; and

(2) that contains methadone, buprenorphine, or naltrexone.

§15–852.

(a) (1) In this section the following words have the meanings indicated.

(2) "In–network pharmacy" means a pharmacy that is among the participating providers with which an entity subject to this section contracts to provide health care services to members.

(3) "Member" means an individual entitled to health care benefits for prescription drugs or devices under a policy issued or delivered in the State by an entity subject to this section.

(b) (1) This section applies to:

(i) insurers and nonprofit health service plans that provide coverage for prescription drugs and devices under health insurance policies or contracts that are issued or delivered in the State; and

(ii) health maintenance organizations that provide coverage for prescription drugs and devices under contracts that are issued or delivered in the State.

(2) An insurer, a nonprofit health service plan, or a health maintenance organization that provides coverage for prescription drugs and devices through a pharmacy benefits manager is subject to the requirements of this section.

(c) An entity subject to this section shall allow and apply a prorated daily copayment or coinsurance amount for a partial supply of a prescription drug dispensed by an in–network pharmacy if:

(1) the prescriber or the pharmacist determines dispensing a partial supply of a prescription drug to be in the best interest of the member;

(2) the prescription drug is anticipated to be required for more than 3 months;

(3) the member requests or agrees to a partial supply for the purpose of synchronizing the dispensing of the member's prescription drugs;

(4) the prescription drug is not a Schedule II controlled dangerous substance; and

(5) the supply and dispensing of the prescription drug meets all prior authorization and utilization management requirements specific to the prescription drug at the time of the synchronized dispensing.

(d) Subject to subsection (c) of this section, an entity subject to this section:

(1) may not deny payment of benefits to an in–network pharmacy for a covered prescription drug solely on the basis that only a partial supply of the prescription drug was dispensed; and

(2) shall allow an in–network pharmacy to override any denial codes indicating that a prescription is being refilled too soon.

(e) Subject to subsection (c) of this section, an entity subject to this section:

(1) may not use a payment structure that incorporates prorated dispensing fees for dispensing a partial supply of a prescription drug; and

(2) shall pay an in–network pharmacy a full dispensing fee for dispensing a partial supply of a prescription drug under this section, regardless of:

(i) any prorated copayment or coinsurance amount charged to a member; or

(ii) any fee paid to the pharmacy for synchronizing a member's prescriptions.

§15–853.

(a) (1) In this section, "gradient compression garment" means a garment that:

(i) is used for the treatment of lymphedema;

(ii) requires a prescription; and

(iii) is custom fit for the individual for whom the garment is prescribed.

(2) "Gradient compression garment" does not include disposable medical supplies, including over–the–counter compression or elastic knee–high or other stocking products.

(b) This section applies to:

(1) insurers and nonprofit health service plans that provide hospital, medical, or surgical benefits to individuals or groups on an expense–incurred basis under health insurance policies or contracts that are issued or delivered in the State; and

(2) health maintenance organizations that provide hospital, medical, or surgical benefits to individuals or groups under contracts that are issued or delivered in the State.

(c) An entity subject to this section shall provide coverage for the medically necessary diagnosis, evaluation, and treatment of lymphedema, including equipment, supplies, complex decongestive therapy, gradient compression garments, and self–management training and education.

(d) (1) Subject to paragraph (2) of this subsection, the coverage required under this section may be subject to the annual deductibles, copayments, or coinsurance requirements imposed by an entity subject to this section for similar coverages under the same health insurance policy or contract.

(2) The annual deductibles, copayments, or coinsurance requirements imposed under paragraph (1) of this subsection for the coverage required under this section may not be greater than the annual deductibles, copayments, or coinsurance requirements imposed by the entity for similar coverages.

§15–854.

(a) (1) This section applies to:

(i) insurers and nonprofit health service plans that provide coverage for prescription drugs through a pharmacy benefit under individual, group, or blanket health insurance policies or contracts that are issued or delivered in the State; and

(ii) health maintenance organizations that provide coverage for prescription drugs through a pharmacy benefit under individual or group contracts that are issued or delivered in the State.

(2) An insurer, a nonprofit health service plan, or a health maintenance organization that provides coverage for prescription drugs through a pharmacy benefits manager or that contracts with a private review agent under Subtitle 10B of this title is subject to the requirements of this section.

(3) This section does not apply to a managed care organization as defined in § 15–101 of the Health – General Article.

(b) (1) (i) If an entity subject to this section requires a prior authorization for a prescription drug, the prior authorization request shall allow a health care provider to indicate whether a prescription drug is to be used to treat a chronic condition.

(ii) If a health care provider indicates that the prescription drug is to treat a chronic condition, an entity subject to this section may not request a reauthorization for a repeat prescription for the prescription drug for 1 year or for the standard course of treatment for the chronic condition being treated, whichever is less.

(2) For a prior authorization that is filed electronically, the entity shall maintain a database that will prepopulate prior authorization requests with an insured's available insurance and demographic information.

(c) (1) On receipt of information documenting a prior authorization from the insured or from the insured's health care provider, an entity subject to this section shall honor a prior authorization granted to an insured from a previous entity for at least the lesser of 90 days or the length of the course of treatment.

(2) During the time period described in paragraph (1) of this subsection, an entity may perform its own review to grant a prior authorization for the prescription drug.

(d) (1) An entity subject to this section shall honor a prior authorization issued by the entity for a prescription drug and may not require a health care provider to submit a request for another prior authorization for the prescription drug:

(i) if the insured changes health benefit plans that are both covered by the same entity and the prescription drug is a covered benefit under the current health benefit plan; or

(ii) except as provided in paragraph (2) of this subsection, when the dosage for the approved prescription drug changes and the change is consistent with federal Food and Drug Administration labeled dosages.

(2) Except as provided in § 15–851 of this subtitle, an entity may require a prior authorization for a change in dosage for an opioid under this subsection.

(e) (1) If an entity under this section implements a new prior authorization requirement for a prescription drug, the entity shall provide notice of the new requirement at least 60 days before the implementation of a new prior authorization requirement:

(i) in writing to any insured who is prescribed the prescription drug; and

(ii) either in writing or electronically to all contracted health care providers.

(2) The notice required under paragraph (1) of this subsection shall indicate that the insured may remain on the prescription drug at the time of reauthorization in accordance with subsection (g) of this section.

(f) (1) Except as provided in paragraph (2) of this subsection, an entity subject to this section may not require more than one prior authorization if two or more tablets of different dosage strengths of the same prescription drug are:

(i) prescribed at the same time as part of an insured's treatment plan; and

(ii) manufactured by the same manufacturer.

(2) This subsection does not prohibit an entity from requiring more than one prior authorization if the prescription is for two or more tablets of different dosage strengths of an opioid that is not an opioid partial agonist.

(g) (1) An entity subject to this section may not issue an adverse decision on a reauthorization for the same prescription drug or request additional documentation from the prescriber for the reauthorization request if:

(i) the prescription drug is:

1. an immune globulin (human) as defined in 21 C.F.R. § 640.100; or

2. used for the treatment of a mental disorder listed in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association;

(ii) the entity previously approved a prior authorization for the prescription drug for the insured;

(iii) the insured has been treated with the prescription drug without interruption since the initial approval of the prior authorization; and

(iv) the prescriber attests that, based on the prescriber's professional judgment, the prescription drug continues to be necessary to effectively treat the insured's condition.

(2) If the prescription drug that is being requested has been removed from the formulary or has been moved to a higher deductible, copayment, or coinsurance tier, the entity shall provide the insured and insured's health care provider the information required under § 15–831 of this subtitle.

§15–854.1.

(a) (1) In this section the following words have the meanings indicated.

(2) "Active course of treatment" means a course of treatment for which an insured is actively seeing a health care provider and following the course of treatment.

(3) "Course of treatment" means treatment that:

(i) is prescribed to treat or ordered for the treatment of an insured with a specific condition;

(ii) is outlined and agreed to by the insured and the health care provider before the treatment begins; and

(iii) may be part of a treatment plan.

(b) (1) This section applies to:

(i) insurers and nonprofit health service plans that provide hospital, medical, or surgical benefits to individuals or groups on an expense–incurred basis under health insurance policies or contracts that are issued or delivered in the State; and

(ii) health maintenance organizations that provide hospital, medical, or surgical benefits to individuals or groups under contracts that are issued or delivered in the State.

(2) An insurer, a nonprofit health service plan, or a health maintenance organization that contracts with a private review agent under Subtitle 10B of this title is subject to the requirements of this section.

(3) An insurer, a nonprofit health service plan, or a health maintenance organization that contracts with a third party to dispense medical devices, medical appliances, or medical goods for the treatment of a human disease or dysfunction is subject to the requirements of this section.

(c) (1) Notwithstanding § 15–854 of this subtitle as it applies to coverage for prescription drugs, an entity subject to this section shall approve a request for the prior authorization of a course of treatment, including for chronic conditions, rehabilitative services, substance use disorders, and mental health conditions, that is:

(i) for a period of time that is as long as necessary to avoid disruptions in care; and

(ii) determined in accordance with applicable coverage criteria, the insured's medical history, and the health care provider's recommendation.

(2) For new enrollees, an entity subject to this section may not disrupt or require reauthorization for an active course of treatment for covered services for at least 90 days after the date of enrollment.

§15–855.

(a) This section applies to:

(1) insurers and nonprofit health service plans that provide hospital, medical, or surgical benefits to individuals or groups on an expense–incurred basis under health insurance policies or contracts that are issued or delivered in the State; and

(2) health maintenance organizations that provide hospital, medical, or surgical benefits to individuals or groups under contracts that are issued or delivered in the State.

(b) An entity subject to this section shall provide coverage for medically necessary diagnosis, evaluation, and treatment of pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections and pediatric acute onset neuropsychiatric syndrome, including the use of intravenous immunoglobulin therapy.

(c) (1) Subject to paragraph (2) of this subsection, the coverage required under this section may be subject to the annual deductibles, copayments, or coinsurance requirements imposed by an entity subject to this section for similar coverages under the same health insurance policy or contract.

(2) The annual deductibles, copayments, or coinsurance requirements imposed under paragraph (1) of this subsection for the coverage required under this section may not be greater than the annual deductibles, copayments, or coinsurance requirements imposed by the entity for similar coverages.

(d) (1) Except as provided for in paragraph (2) of this subsection, pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections and pediatric acute onset neuropsychiatric syndrome shall be coded as autoimmune encephalitis for billing and diagnosis purposes.

(2) If the American Medical Association and the Centers for Medicare and Medicaid Services create and assign a specific code for pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections or pediatric acute onset neuropsychiatric syndrome for billing and diagnosis purposes, pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections and pediatric acute onset neuropsychiatric syndrome may be coded as:

(i) autoimmune encephalitis;

(ii) pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections; or

(iii) pediatric acute onset neuropsychiatric syndrome.

§15–856. IN EFFECT

// EFFECTIVE UNTIL DECEMBER 31, 2022 PER CHAPTERS 29 AND 31 OF 2021 SPECIAL SESSION //

(a) (1) In this section the following words have the meanings indicated.

(2) "COVID–19" means, interchangeably and collectively, the coronavirus known as COVID–19 or 2019–nCoV and the SARS–CoV–2 virus.

(3) (i) "COVID–19 test" means an in vitro diagnostic test for the detection of SARS–CoV–2 or the diagnosis of the virus that causes COVID–19, as described in § 3201 of the federal Coronavirus Aid, Relief, and Economic Security (CARES) Act.

(ii) "COVID–19 test" includes a federal Food and Drug Administration–approved, cleared, or authorized rapid point–of–care test and an at–home collection test for the detection or diagnosis of COVID–19.

(4) "Health benefit plan":

(i) for a small employer plan, has the meaning stated in § 15–1201 of this title; and

(ii) for an individual plan, has the meaning stated in § 15–1301 of this title.

(5) (i) "Member" means an individual entitled to health care benefits under a policy issued or delivered in the State by an entity subject to this section.

(ii) "Member" includes a subscriber.

(b) (1) This section applies to:

(i) insurers and nonprofit health service plans that provide hospital, medical, or surgical benefits to individuals or groups on an expense–incurred basis under health insurance policies or contracts that are issued or delivered in the State; and

(ii) health maintenance organizations that provide hospital, medical, or surgical benefits to individuals or groups under contracts that are issued or delivered in the State.

(2) This section applies to each individual and small employer health benefit plan that is issued or delivered in the State by an insurer, a nonprofit health service plan, or a health maintenance organization, irrespective of §§ 15–1207(d) and 31–116 of this article.

(c) An entity subject to this section shall provide coverage for COVID–19 tests and related items and services for the administration of COVID–19 tests, including facility fees, health care practitioner fees, and evaluation of the member for purposes of determining the need for the COVID–19 test, as required by the Families First Coronavirus Response Act, the Coronavirus Aid, Relief, and Economic Security (CARES) Act, and any applicable federal regulations or guidance.

(d) An entity subject to this section may not apply a copayment, coinsurance requirement, or deductible to coverage for COVID–19 tests and related items and services for the administration of COVID–19 tests.

§15–857.

(a) (1) This section applies to:

(i) insurers and nonprofit health service plans that provide labor and delivery coverage to individuals or groups on an expense–incurred basis under health insurance policies or contracts that are issued or delivered in the State; and

(ii) health maintenance organizations that provide labor and delivery coverage to individuals or groups under contracts that are issued or delivered in the State.

(2) This section does not apply to a multistate plan that does not provide coverage for abortions in accordance with 42 U.S.C. § 18054(a)(6).

(3) An organization that is eligible to obtain an exclusion from the coverage requirements under § 15–826 of this subtitle may obtain from an entity subject to this section an exclusion from the coverage and notice requirements of this section if the requirements conflict with the organization's bona fide religious beliefs and practices.

(b) Except as provided in subsection (c) or (d) of this section and notwithstanding § 31–116(a) of this article, an entity subject to this section shall:

(1) cover abortion care services without:

(i) a deductible, coinsurance, copayment, or any other cost–sharing requirement; and

(ii) restrictions that are inconsistent with the protected rights under Title 20, Subtitle 2 of the Health – General Article; and

(2) provide information to consumers about abortion care coverage using the terminology "abortion care" to describe coverage.

(c) If the Commissioner determines that enforcement of this section may adversely affect the allocation of federal funds to the State, the Commissioner may grant an exemption to the requirements of this section to the minimum extent necessary to ensure the continued receipt of federal funds.

(d) A high–deductible plan, as defined in 26 U.S.C. § 223(c)(2)(C) of the Internal Revenue Code, is exempt from the requirements of this section if the Commissioner determines that abortion care services are excluded from the safe harbor provisions for preventive care under § 223(c)(2)(C) of the Internal Revenue Code.

§15–858.

(a) (1) This section applies to:

(i) insurers and nonprofit health service plans that provide coverage for prescription drugs under individual, group, or blanket health insurance policies or contracts that are issued or delivered in the State; and

(ii) health maintenance organizations that provide coverage for prescription drugs under individual or group contracts that are issued or delivered in the State.

(2) An insurer, a nonprofit health service plan, or a health maintenance organization that provides coverage for prescription drugs through a pharmacy benefits manager is subject to the requirements of this section.

(b) An entity subject to this section may not apply a prior authorization requirement for a prescription drug used as postexposure prophylaxis for the prevention of HIV if the prescription drug is prescribed for use in accordance with Centers for Disease Control and Prevention guidelines.

§15–859.

(a) (1) In this section the following words have the meanings indicated.

(2) (i) "Biomarker" means a characteristic that is objectively measured and evaluated as an indicator of normal biological processes, pathogenic processes, or pharmacologic responses to a specific therapeutic intervention, including known gene–drug interactions for medications being considered for use or already being administered.

(ii) "Biomarker" includes gene mutations, characteristics of genes, or protein expression.

(3) (i) "Biomarker testing" is the analysis of a patient's tissue, blood, or other biospecimen for the presence of a biomarker, the results of which:

1. provide information that may be used in the formulation of a treatment or monitoring strategy that informs a patient's outcome and impacts the clinical decision; and

2. include both information that is actionable and some information that cannot be immediately used in the formulation of a clinical decision.

(ii) "Biomarker testing" includes single–analyte tests, multi–plex panel tests, protein expression, and whole exome, whole genome, and whole transcriptome sequencing.

(b) This section applies to:

(1) insurers and nonprofit health service plans that provide hospital, medical, or surgical benefits to individuals or groups on an expense–incurred basis under health insurance policies or contracts that are issued or delivered in the State; and

(2) health maintenance organizations that provide hospital, medical, or surgical benefits to individuals or groups under contracts that are issued or delivered in the State.

(c) An entity subject to this section shall provide coverage for biomarker testing for the purpose of diagnosis, treatment, appropriate management, or ongoing monitoring of a disease or condition that is supported by medical and scientific evidence, including testing:

(1) cleared or approved by the U.S. Food and Drug Administration;

(2) required or recommended for a drug approved by the U.S. Food and Drug Administration to ensure an insured or enrollee is a good candidate for the drug treatment;

(3) required or recommended through a warning or precaution for a drug approved by the U.S. Food and Drug Administration to identify whether an insured or enrollee will have an adverse reaction to the drug treatment or dosage;

(4) covered under a Centers for Medicare and Medicaid Services National Coverage Determination or Medicare Administrative Contractor Local Coverage Determination; or

(5) supported by nationally recognized clinical practice guidelines that are:

(i) developed by independent organizations or medical professional societies using a transparent methodology and reporting structure and that have a conflict of interest policy; and

(ii) established standards of care informed by a systematic review of evidence and an assessment of the benefits and risks of alternative care options and include recommendations intended to optimize patient care.

(d) An entity subject to this section shall ensure that the coverage required under subsection (c) of this section is provided in a manner that limits disruptions in care including the need for multiple biopsies or biospecimen samples.

(e) (1) Subject to paragraph (2) of this subsection, the coverage required under this section may be subject to the annual deductibles, copayments, or coinsurance requirements imposed by an entity subject to this section for similar coverages under the same health insurance policy or contract.

(2) The annual deductibles, copayments, or coinsurance requirements imposed under paragraph (1) of this subsection for the coverage required under this section may not be greater than the annual deductibles, copayments, or coinsurance requirements imposed by the entity for similar coverages.

§15–860.

(a) This section applies to:

(1) insurers and nonprofit health service plans that provide hospital, medical, or surgical benefits to individuals or groups on an expense–incurred basis

under health insurance policies or contracts that are issued or delivered in the State; and

(2) health maintenance organizations that provide hospital, medical, or surgical benefits to individuals or groups under contracts that are issued or delivered in the State.

(b) (1) An entity subject to this section shall provide coverage for recommended lung cancer screening or follow–up diagnostic imaging to assist in the diagnosis of lung cancer for individuals for which lung cancer screening or follow–up diagnostic imaging is recommended by the U.S. Preventative Services Task Force.

(2) The coverage required under paragraph (1) of this subsection:

(i) shall include diagnostic ultrasound, magnetic resonance imaging, computed tomography, and image–guided biopsy; and

(ii) may not be subject to a prior authorization requirement.

(c) (1) Except as provided in paragraph (2) of this subsection, an entity subject to this section may not impose a copayment, coinsurance, or deductible requirement on coverage for lung cancer screening or follow–up diagnostic imaging that is greater than the copay, coinsurance, or deductible requirement for breast cancer screening or diagnosis.

(2) If an insured or enrollee is covered under a high–deductible health plan, as defined in 26 U.S.C. § 223, an entity subject to this section may subject follow–up diagnostic lung imaging to the deductible requirement of the high–deductible health plan.

§15–861.

(a) In this section, "special pediatric hospital" has the meaning stated in § 15–101 of the Health – General Article.

(b) This section applies to:

(1) insurers and nonprofit health service plans that provide hospital, medical, or surgical benefits to individuals or groups on an expense–incurred basis under health insurance policies or contracts that are issued or delivered in the State; and

(2) health maintenance organizations that provide hospital, medical, or surgical benefits to individuals or groups under contracts that are issued or delivered in the State.

(c) An entity subject to this section may not require prior authorization for a transfer to a special pediatric hospital.

§15–862.

(a) This section applies to:

(1) insurers and nonprofit health service plans that provide hospital, medical, or surgical benefits to individuals or groups on an expense–incurred basis under health insurance policies or contracts that are issued or delivered in the State; and

(2) health maintenance organizations that provide hospital, medical, or surgical benefits to individuals or groups under contracts that are issued or delivered in the State.

(b) An entity subject to this section that covers the delivery of anesthesia for a procedure for which a licensed medical professional issues an order:

(1) shall provide coverage for:

(i) the delivery of anesthesia for the entire duration of the procedure; and

(ii) medical care related to the delivery of anesthesia for the procedure that is provided immediately before and after the procedure; and

(2) may not establish, implement, or enforce a policy, practice, or procedure that places time limitations on the delivery of anesthesia.

§15–863.

(a) This section applies to:

(1) insurers and nonprofit health service plans that provide hospital, medical, or surgical benefits to individuals or groups on an expense–incurred basis under health insurance policies or contracts that are issued or delivered in the State; and

(2) health maintenance organizations that provide hospital, medical, or surgical benefits to individuals or groups under contracts that are issued or delivered in the State.

(b) An entity subject to this section shall provide coverage for calcium score testing in accordance with the most recent guidelines issued by the American College of Cardiology that expand the scope of preventive care services for the benefit of consumers.

§15–864. NOT IN EFFECT

** TAKES EFFECT JANUARY 1, 2027 PER CHAPTERS 51 AND 52 OF 2026**

(a) In this section, "scalp cooling system" means a device used to cool the human scalp to prevent or reduce hair loss in connection with chemotherapy to treat cancer that is:

(1) designed and intended for repeated use; and

(2) primarily and customarily used to serve a medical purpose.

(b) This section applies to:

(1) insurers and nonprofit health service plans that provide hospital, medical, or surgical benefits to individuals or groups on an expense–incurred basis under health insurance policies or contracts that are issued or delivered in the State; and

(2) health maintenance organizations that provide hospital, medical, or surgical benefits to individuals or groups under contracts that are issued or delivered in the State.

(c) An entity subject to this section that provides coverage for chemotherapy to treat cancer shall provide coverage for scalp cooling systems used for the preservation of hair in connection with the chemotherapy treatment.

§15–865. NOT IN EFFECT

** TAKES EFFECT JANUARY 1, 2027 PER CHAPTERS 605 AND 606 OF 2026 **

(a) This section applies to:

(1) insurers and nonprofit health service plans that provide hospital, medical, or surgical benefits to individuals or groups on an expense–incurred basis under health insurance policies or contracts that are issued or delivered in the State; and

(2) health maintenance organizations that provide hospital, medical, or surgical benefits to individuals or groups under contracts that are issued or delivered in the State.

(b) An entity subject to this section shall provide coverage for the evaluation and management of menopause and menopause–associated symptoms as determined by the treating health care provider.

§15–866. NOT IN EFFECT

** TAKES EFFECT JANUARY 1, 2027 PER CHAPTERS 614 AND 615 OF 2026 **

(a) In this section, "Collaborative Care Model" has the meaning stated in § 15–141.1 of the Health – General Article.

(b) This section applies to:

(1) insurers and nonprofit health service plans that provide hospital, medical, or surgical benefits to individuals or groups on an expense–incurred basis under health insurance policies or contracts that are issued or delivered in the State; and

(2) health maintenance organizations that provide hospital, medical, or surgical benefits to individuals or groups under contracts that are issued or delivered in the State.

(c) An entity subject to this section shall provide coverage for services provided in accordance with the Collaborative Care Model.

§15–867. NOT IN EFFECT

** TAKES EFFECT JANUARY 1, 2027 PER CHAPTERS 636 AND 637 OF 2026 **

(a) In this section, "perinatal behavioral health condition" has the meaning stated in § 15–830 of this subtitle.

(b) This section applies to:

(1) insurers and nonprofit health service plans that provide hospital, medical, or surgical benefits to individuals or groups on an expense–incurred basis under health insurance policies or contracts that are issued or delivered in the State; and

(2) health maintenance organizations that provide hospital, medical, or surgical benefits to individuals or groups under contracts that are issued or delivered in the State.

(c) An entity subject to this section shall provide coverage for screening for perinatal behavioral health conditions at well child visits within the first year of the child's life, as determined appropriate by the treating health care provider.

§15–901.

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

(b) "Applicant" means:

(1) for an individual Medicare supplement policy or subscriber contract, the individual who seeks to contract for insurance benefits; or

(2) for a group Medicare supplement policy or subscriber contract, the proposed certificate holder.

(c) "Carrier" means an insurer, nonprofit health service plan, or fraternal benefit society that is authorized to issue health insurance policies under this article.

(d) "Certificate" means a certificate that is delivered or issued for delivery in the State under a group Medicare supplement policy.

(e) "Certificate form" means the form on which the certificate is delivered or issued for delivery in the State by the carrier.

(f) "CMS" means the Centers for Medicare and Medicaid Services of the United States Department of Health and Human Services.

(g) "Medicaid" means the Health Insurance for the Aged Act, Title XIX of the Social Security Amendments of 1965, as amended.

(h) "Medicare" means the Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965, as amended.

(i) "Medicare benefit period" means the unit of time used in the Medicare Program to measure use of services and availability of benefits under Medicare Part A.

(j) "Medicare eligible expense" means a health care expense of the kind covered by Medicare to the extent the service for which the expense was incurred is considered reasonable under Medicare rules and regulations.

(k) (1) "Medicare supplement policy" or "Medigap policy" means an individual or group policy of health insurance or subscriber contract that is advertised, marketed, or designed primarily as a supplement to reimbursements under Medicare for the hospital, medical, or surgical expenses of individuals eligible for Medicare.

(2) "Medicare supplement policy" or "Medigap policy" does not include:

(i) a policy that is issued pursuant to a contract under § 1876 of the federal Social Security Act, 42 U.S.C. § 1395mm; or

(ii) a policy that is issued under a demonstration project authorized pursuant to amendments to the federal Social Security Act.

(l) "Policy" includes:

(1) a policy that is issued to an individual;

(2) a certificate, as that term is used in Title 14, Subtitle 1 of this article, that is issued to an individual subscriber;

(3) a certificate, as that term is used in Title 8, Subtitle 4 of this article, that is issued to a member of a fraternal benefit society; and

(4) a group policy authorized to be issued under this article.

(m) "Policy form" means the form on which the policy is delivered or issued for delivery in the State by the carrier.

§15–902.

This subtitle is not intended to prohibit or apply to policies, including group conversion policies, provided to Medicare eligible individuals, if the policies are not marketed or held to be Medicare supplement policies.

§15–903.

(a) Notwithstanding any other provision to the contrary, this subtitle applies to:

(1) Medicare supplement policies and subscriber contracts that are delivered or issued for delivery in the State after July 1, 1992;

(2) certificates that are issued under group Medicare supplement policies or subscriber contracts, which certificates have been delivered or issued for delivery in the State;

(3) individual or group Medicare supplement policies and certificates that are issued by nonprofit health service plans under Title 14, Subtitle 1 of this article;

(4) Medicare supplement policies and certificates that are issued by fraternal benefit societies under Title 8, Subtitle 4 of this article; and

(5) Medicare supplement group or blanket policies and certificates that are issued by insurers subject to Subtitle 3 of this title.

(b) This subtitle does not apply to a policy of:

(1) one or more employers or labor organizations; or

(2) the trustees of a fund established by one or more employers or labor organizations for employees, members, former employees, or former members.

(c) A health maintenance organization that enrolls members eligible for Medicare benefits under Title XVIII of the Social Security Act is subject to the requirements of this subtitle to the extent any of the provisions of this subtitle apply to the Medicare eligible members.

§15–904.

(a) A carrier may not issue, deliver, or renew a Medicare supplement policy in the State unless the Medicare supplement policy complies with this subtitle.

(b) (1) Notwithstanding any other provision of this subtitle, an insurer or a nonprofit health service plan that is authorized to issue Medicare supplement policies under this article may issue Medicare supplement policies under the Medicare Select Program.

(2) The requirements for a Medicare supplement policy issued under the Medicare Select Program shall be consistent with requirements set forth in the federal Omnibus Budget Reconciliation Act of 1990 and any subsequent relevant federal law and regulations.

(3) The Maryland Department of Health shall determine the adequacy of the network established by an insurer or a nonprofit health service plan under the Medicare Select Program, as to the number of providers, geographic location, hours of operation, promptness of service, and range of services, in the same manner as determined for a health maintenance organization under §§ 19–705.1 and 19–705.2 of the Health – General Article.

(c) The Commissioner may adopt regulations, in consultation with the Secretary of Health, to establish the requirements of the Medicare Select Program.

§15–905.

A carrier shall restore any benefit that was eliminated from a Medicare supplement policy because of the federal Medicare Catastrophic Coverage Act of 1988.

§15–906.

(a) A Medicare supplement policy shall provide the minimum benefits required by federal law.

(b) (1) For benefits designed to cover deductibles or coinsurance amounts under Medicare, a Medicare supplement policy shall provide for an automatic change in those benefits to coincide with changes in applicable Medicare deductible and copayment provisions.

(2) Subject to approval by the Commissioner, a carrier may reserve the right in a Medicare supplement policy to change premiums to correspond with changes in benefits under paragraph (1) of this subsection.

(c) Payment of a benefit for a Medicare eligible expense under a Medicare supplement policy may be conditioned on the same or less restrictive payment conditions that apply to a Medicare claim, including the determination of medical necessity.

(d) (1) Unless otherwise expressly authorized under this article or a regulation adopted by the Commissioner under this article, coverage under a Medicare supplement policy may not be subject to any exclusion, limitation, or

reduction that is inconsistent with the exclusions, limitations, or reductions under Medicare.

(2) To the extent a benefit is available to the insured under Medicare, a Medicare supplement policy shall provide that coverage for the benefit is not duplicated.

(e) If the insured is receiving medical assistance under Medicaid, a Medicare supplement policy shall provide for the suspension of policy benefits and premiums for a maximum of 24 months.

(f) (1) A Medicare supplement policy, contract, or certificate in force in the State may not provide benefits that duplicate benefits provided by Medicare.

(2) Unless approved by the Commissioner, a Medicare supplement policy may not be offered at an introductory premium rate.

§15–907.

(a) In this section, "low-dose mammography" means an x-ray examination of the breast using dedicated equipment, including an x-ray tube, filter, compression device, screens, films, and cassettes, specifically for mammography that delivers an average radiation exposure of less than one rad mid-breast with two views for each breast.

(b) If the federal standard under § 1882(p) of the federal Social Security Act is amended to authorize the inclusion of an annual mammography screening benefit in the core group of basic benefits for Medicare supplement policies, a Medicare supplement policy shall provide for coverage for an annual screening by low-dose mammography for the presence of occult breast cancer.

§15–908.

The Commissioner shall approve Medicare supplement policies that include benefits in addition to the minimum benefits listed in § 15-906(a) of this subtitle if the Medicare supplement policies and benefits:

(1) conform with the federal Omnibus Budget Reconciliation Act of 1990 and the Medicare Supplement Insurance Minimum Standards Model Act and any regulations under the Model Act adopted by the National Association of Insurance Commissioners; and

(2) comply with the applicable provisions of this article.

§15–909.

(a) This section does not extend the number of days of hospitalization offered under § 15–906(a) of this subtitle to the extent those days of hospitalization have been used under the original Medicare supplement policy.

(b) (1) If an application for a Medicare supplement policy or certificate is submitted during the 6–month period beginning with the first month in which an individual who is at least 65 years old first enrolls for benefits under Medicare Part B, a carrier:

(i) may not deny or condition the issuance or effectiveness of the Medicare supplement policy or certificate or discriminate in the pricing of the Medicare supplement policy or certificate because of the health status, claims experience, receipt of health care, or medical condition of the applicant; or

(ii) may not deny, reduce, or condition coverage or apply an increased premium rating to an applicant for a Medicare supplement policy because of the health status, claims experience, or medical condition of the applicant or the use of medical care by the applicant.

(2) Notwithstanding paragraph (1)(ii) or (8)(iii)2 of this subsection, a carrier may include in a Medicare supplement policy a provision that complies with subsection (d) of this section.

(3) A carrier that issues Medicare supplement policies in the State shall issue any Medicare supplement policy the carrier sells to an individual eligible for Medicare if the individual:

(i) was enrolled in Medicare Part B while enrolled in the Maryland Medical Assistance Program;

(ii) was not disenrolled or terminated from the Maryland Medical Assistance Program until at least 6 months following the effective date of enrollment in Medicare Part B;

(iii) applies for the Medicare supplement policy during the 63–day period following the later of notice of termination or disenrollment or the date of termination from the Maryland Medical Assistance Program; and

(iv) submits evidence of the date of termination or disenrollment from the Maryland Medical Assistance Program with the application for a Medicare supplement policy.

(4) A carrier that issues Medicare supplement policies in the State shall issue any Medicare supplement policy currently open to new enrollees to an individual eligible for Medicare if the individual:

(i) became eligible for Medicare before January 1, 2020;

(ii) qualifies under any federal special enrollment period guaranteed issue right, including for plans issued on or after January 1, 2020;

(iii) applies for the Medicare supplement policy during the 63–day period following the qualifying event for the federal special enrollment period guaranteed issue right; and

(iv) submits evidence of the date of the qualifying event for the federal special enrollment period guaranteed issue right with the application for a Medicare supplement policy.

(5) (i) A carrier shall make available Medicare supplement policy plans A and D to an individual who is under the age of 65 years but is eligible for Medicare due to a disability, if an application for a Medicare supplement policy or certificate is submitted:

1. during the 6–month period following the applicant's enrollment in Part B of Medicare; or

2. if the applicant is notified by Medicare of the applicant's retroactive enrollment in Medicare, during the 6–month period following notification of enrollment in Medicare.

(ii) For a Medicare supplement policy plan A or D required to be made available under subparagraph (i) of this paragraph, a carrier:

1. may not deny or condition the issuance or effectiveness of a Medicare supplement policy plan A or D because of the health status, claims experience, receipt of health care, or medical condition of the applicant; or

2. may not deny, reduce, or condition coverage to the applicant for a Medicare supplement policy plan A or D because of the health status, claims experience, or medical condition of the applicant or the use of medical care by the applicant.

(iii) For a Medicare supplement policy plan A required to be made available under subparagraph (i) of this paragraph, a carrier may not charge

individuals who are under the age of 65 years, but are eligible for Medicare due to a disability, a rate higher than the average of the premiums paid by all policyholders age 65 and older in the State who are covered under that plan A policy form.

(6) A carrier may elect to offer Medicare supplement policy plans to individuals who are under the age of 65 years, but eligible for Medicare due to a disability, in addition to the Medicare supplement policy plans A and D that are required to be offered under paragraph (5)(i) of this subsection.

(7) Paragraph (5) of this subsection may not be construed to require a carrier to offer a Medicare supplement policy plan to individuals who are under the age of 65 years, but are eligible for Medicare due to a disability, if the plan is not offered to individuals who are eligible for Medicare due to age.

(8) (i) This paragraph applies only on and after July 1, 2023.

(ii) During the 30 days following the birthday of an individual enrolled in a Medicare supplement policy, a carrier shall make available to the individual different Medicare supplement policies with benefits that are equal to or less than the benefits of the individual's existing coverage.

(iii) 1. For purposes of this paragraph, a Medicare supplement policy has equal or lesser benefits unless:

A. it contains one or more significant benefits not included in the Medicare supplement policy being replaced; or

B. it contains the same significant benefits included in the Medicare supplement policy being replaced but it reduces the cost–sharing responsibilities of the enrollee for the benefits.

2. The Commissioner shall adopt regulations establishing a matrix for identifying which Medicare supplement policies have equal or lesser benefits.

(iv) For a Medicare supplement policy required to be made available under subparagraph (ii) of this paragraph, a carrier may not:

1. deny or condition the issuance or effectiveness of a Medicare supplement policy, or discriminate in the pricing of the policy, because of the health status, claims experience, or medical condition of the individual or the receipt of health care by the individual; or

2. deny, reduce, or condition coverage to the individual for a Medicare supplement policy because of the health status, claims experience, or medical condition of the individual or the use of medical care by the individual.

(v) A carrier that offers Medicare supplement policies shall notify an insured of the insured's rights under this paragraph at least 30 days, but not more than 60 days, before the insured's birthday.

(c) Regardless of the applicant's age, each Medicare supplement policy or applicable certificate that a carrier currently has available shall be made available to each applicant who qualifies under subsection (b) of this section.

(d) (1) Notwithstanding any other provision of law, a Medicare supplement policy or certificate may not exclude or limit benefits for losses incurred more than 6 months after the effective date of coverage because the losses involved a preexisting condition.

(2) A Medicare supplement policy or certificate may not define a preexisting condition more restrictively than a condition for which a physician gave medical advice or recommended or gave treatment within 6 months before the effective date of coverage.

(e) If a Medicare supplement policy or certificate replaces another Medicare supplement policy or certificate, the succeeding carrier shall waive the time periods applicable to preexisting conditions, waiting periods, elimination periods, and probationary periods in the new Medicare supplement policy or certificate for similar benefits to the extent the time was spent under the original Medicare supplement policy or certificate.

(f) A carrier may not cancel or nonrenew a Medicare supplement policy or certificate for any reason other than for nonpayment of premium or material misrepresentation.

(g) (1) (i) If the group policyholder terminates a group Medicare supplement policy without replacing the group Medicare supplement policy under paragraph (3) of this subsection, the carrier shall offer each certificate holder an individual Medicare supplement policy.

(ii) The carrier shall offer the certificate holder at least the following:

1. an individual Medicare supplement policy that provides for continuation of the benefits contained in the group policy; or

2. an individual Medicare supplement policy that provides only the benefits that are required under § 15–906(a) of this subtitle.

(2) If membership in a group is terminated, the carrier:

(i) shall offer the certificate holder the conversion options under paragraph (1) of this subsection; or

(ii) at the option of the group policyholder, shall offer the certificate holder a continuation of coverage under the group Medicare supplement policy.

(3) (i) If a group Medicare supplement policy is replaced by another group Medicare supplement policy purchased by the same policyholder, the succeeding carrier shall offer coverage to each individual who was covered under the old group Medicare supplement policy on its date of termination.

(ii) Under the new group Medicare supplement policy, coverage may not be excluded for a preexisting condition that would have been covered under the group Medicare supplement policy being replaced.

§15–910.

(a) Each Medicare supplement policy or certificate shall have prominently printed on the first page of the policy or certificate or attached to it, a notice that states that the applicant may:

(1) return the Medicare supplement policy or certificate within 30 days after its delivery; and

(2) receive a refund of the premium if after examination of the Medicare supplement policy or certificate, the applicant is not satisfied for any reason.

(b) The carrier shall pay a refund made under this section directly to the applicant in a timely manner.

§15–911.

(a) In this section, "loss ratio" means the ratio of losses incurred to premiums earned on policies that are issued, delivered, or renewed in the State.

(b) Medicare supplement policies shall return aggregate benefits that are reasonable in relation to the premium charged.

(c) (1) For purposes of administering this subtitle and §§ 12-203 through 12-205 of this article, the Commissioner shall adopt reasonable regulations to establish minimum standards for loss ratios of Medicare supplement policies.

(2) The minimum standards for loss ratios shall be based on incurred claims experience and earned premiums in accordance with accepted actuarial principles and practices and the principles and standards of the National Association of Insurance Commissioners.

(d) The minimum acceptable loss ratios for Medicare supplement policies are:

(1) for group Medicare supplement policies, at least 75% of the aggregate amount of premiums earned; and

(2) for individual Medicare supplement policies or subscriber contracts that are issued or renewed on a policy anniversary after July 1, 1991, at least 65% of the aggregate amount of premiums earned.

(e) (1) To demonstrate compliance with the applicable minimum loss ratio standards established in the State for Medicare supplement policies, each carrier that provides Medicare supplement policies or certificates in the State shall file annually with the Commissioner the carrier's rates, rating schedule, and supporting documentation.

(2) Each filing of rates and rating schedules shall demonstrate that the actual and expected losses in relation to premiums comply with the requirements of this subtitle.

(f) The Commissioner may require a carrier to adjust rates or give credits or refunds to policyholders of Medicare supplement policies that in practice do not meet the minimum loss ratio standards required under this section.

§15–912.

(a) The Commissioner shall adopt reasonable regulations to establish specific standards for policy provisions of Medicare supplement policies and certificates.

(b) (1) The standards adopted by the Commissioner are in addition to and shall be in accordance with applicable laws of the State, including this title and Title 14, Subtitle 1 of this article.

(2) No requirement of this article that relates to minimum required policy benefits, other than the minimum standards contained in this subtitle, shall apply to Medicare supplement policies and certificates.

(c) The standards may cover, but are not limited to:

(1) terms of renewability;

(2) initial and subsequent conditions of eligibility;

(3) nonduplication of coverage;

(4) probationary periods;

(5) benefit limitations, exceptions, and reductions;

(6) elimination periods;

(7) replacement requirements;

(8) recurrent conditions;

(9) definitions of terms; and

(10) any other provisions required under federal Medicare law or CMS regulations.

§15–913.

The Commissioner shall adopt reasonable regulations that specify prohibited policy provisions, not otherwise specifically authorized by statute, that in the opinion of the Commissioner are unjust, unfair, or unfairly discriminatory to any individual insured or proposed to be insured under a Medicare supplement policy or certificate.

§15–914.

The Commissioner shall adopt reasonable regulations to establish minimum standards for benefits, claim payments, marketing practices, and compensation arrangements and reporting practices for Medicare supplement policies and certificates.

§15–915.

(a) The Commissioner shall adopt reasonable regulations as necessary to conform Medicare supplement policies and certificates to the requirements of federal law and regulations.

(b) The regulations may include, but are not limited to, provisions that:

(1) require rate adjustments, credits, or refunds if the Medicare supplement policies or certificates do not meet loss ratio requirements;

(2) establish a uniform methodology for calculating and reporting loss ratios;

(3) ensure public access to policies, premiums, and loss ratio information of carriers of Medicare supplement insurance;

(4) establish a process for approving or disapproving policy forms and certificate forms; and

(5) establish a policy for holding public hearings before approval of premium increases and a process for approving or disapproving proposed schedules of premium changes.

§15–916.

(a) The Commissioner shall prepare in clear, plain English the text of a Medicare supplement buyer's guide that carriers must provide to prospective buyers of Medicare supplement policies under this section.

(b) The buyer's guide shall:

(1) contain an outline of Medicare coverage; and

(2) include advice and other information about purchasing Medicare supplement policies, including a reference to the right of the buyer to cancel a Medicare supplement policy during the first 30 days after it is delivered, as provided in § 15-910 of this subtitle.

(c) The Commissioner shall submit the text of the buyer's guide for publication in the Maryland Register and at the same time send a copy of the text to the Department of Aging.

(d) The carrier or insurance producer of the carrier shall deliver to the prospective buyer a Medicare supplement buyer's guide that is printed in at least 12-point type:

(1) before accepting an application;

(2) when an existing policy is converted to a Medicare supplement policy; and

(3) at any other time required by the Commissioner by regulation.

(e) A carrier shall provide:

(1) a copy of the Medicare supplement buyer's guide to an individual covered under a group health insurance policy when the individual becomes eligible for Medicare by reason of age; and

(2) any information required under § 15-919 of this subtitle that is applicable to the continuing coverage under the group health insurance policy of the individual eligible for Medicare.

(f) (1) The text of the Medicare supplement buyer's guide shall be as the Commissioner submits for publication under subsection (c) of this section.

(2) The form of the Medicare supplement buyer's guide shall be as required by the Commissioner by regulation.

§15–917.

(a) In order to provide for full and fair disclosure in the sale of Medicare supplement policies, a Medicare supplement policy or certificate may not be delivered in the State unless an outline of coverage is provided to the applicant at the time the application is delivered.

(b) (1) In this subsection, "format" means style, arrangements, and overall appearance, including the size, color, and prominence of type and arrangement of text and captions.

(2) The Commissioner shall prescribe the format and content of the outline of coverage required by this section.

(3) The outline of coverage shall include:

(i) a description of the principal benefits and coverage provided in the Medicare supplement policy;

(ii) a statement of the exceptions, reductions, and limitations contained in the Medicare supplement policy;

(iii) a statement of the renewal provisions, including any reservation by the carrier of a right to change premiums;

(iv) disclosure of the existence of any automatic renewal premium increases based on the policyholder's age; and

(v) a statement that the outline of coverage is a summary of the Medicare supplement policy that is issued or applied for and that the Medicare supplement policy should be consulted to determine governing contractual provisions.

§15–918.

(a) The Commissioner may prescribe by regulation a standard form and the contents of an informational brochure for individuals eligible for Medicare by reason of age, which is intended to improve the buyer's ability to choose the most appropriate coverage and to improve the buyer's understanding of Medicare.

(b) Except for direct response insurance policies, the Commissioner may require by regulation that the informational brochure be provided to each prospective insured eligible for Medicare at the time of delivery of the outline of coverage.

(c) For direct response insurance policies, the Commissioner may require by regulation that the informational brochure be provided on request to a prospective insured eligible for Medicare by reason of age, but not later than the time of delivery of the policy.

§15–919.

(a) (1) Under any circumstance stated in this section, a carrier or insurance producer of a carrier shall give to a prospective buyer eligible for Medicare by reason of age a written statement as required, for each circumstance, by this section.

(2) The written statement shall be given before the carrier or insurance producer accepts an application.

(b) If the proposed policy excludes or limits benefits for preexisting conditions, a statement shall be given that describes in plain language the limitations or exclusions.

(c) If the proposed policy provides coverage for care in a Medicare–approved skilled nursing facility, but the policy does not provide coverage for care in other nursing home facilities or for custodial or rest home care, a statement shall be given that describes clearly those expenses that the policy does not cover.

(d) (1) If the proposed policy does not comply with the requirements of §§ 15–904, 15–906, 15–907, and 15–908 of this subtitle for a Medicare supplement policy, a statement printed in 12–point type shall be given that:

"This policy (or certificate) is not a Medicare supplement policy (or certificate). It is not designed to fill the 'gaps' of Medicare. If you are eligible for Medicare, review the Medicare supplement buyer's guide available from the company".

(2) The statement required by paragraph (1) of this subsection shall be printed on or attached to the first page of:

(i) the policy form or certificate; or

(ii) an outline of coverage delivered to the individual covered under the policy or certificate.

(3) A carrier or insurance producer of a carrier need not provide the statement required under paragraph (1) of this subsection for:

(i) a policy or certificate that is issued in accordance with a contract under § 1876 of the federal Social Security Act, 42 U.S.C. § 1395mm;

(ii) a disability income policy; or

(iii) a policy or contract of one or more employers or labor organizations or the trustees of a fund established by one or more employers or labor organizations or a combination of employers or labor organizations, for employees, former employees, a combination of employees or former employees, members, former members, or a combination of members or former members of the labor organization.

(4) Notwithstanding paragraph (1) of this subsection, the Commissioner shall adopt regulations necessary to conform this subsection to the requirements of applicable federal law.

(e) If the proposed policy provides accident–only benefits, a statement printed in 12–point type shall be given that contains the language in subsection (d) of this section and the following:

"This is an accident only policy. It does not pay benefits for loss due to sickness".

§15–920.

The Commissioner may adopt regulations for captions or notice requirements, determined to be in the public interest and designed to inform prospective insureds that particular insurance coverages are not Medicare supplement coverages, for all health insurance policies sold to individuals eligible for Medicare, other than Medicare supplement policies or disability income policies.

§15–921.

The Commissioner may adopt reasonable regulations to govern the full and fair disclosure of the information in connection with the replacement of health insurance policies, subscriber contracts, or certificates by individuals eligible for Medicare.

§15–922.

(a) (1) In this section, "compensation" means any pecuniary or nonpecuniary remuneration related to the sale or renewal of a Medicare supplement policy or certificate.

(2) "Compensation" includes bonuses, gifts, and finders' fees.

(3) "Compensation" does not include noncash prizes or awards.

(b) A carrier or other entity may provide a commission or other compensation to an insurance producer or other representative for the sale of a Medicare supplement policy or certificate only if the first year commission or other first year compensation is not more than 200% of the commission or other compensation paid for selling or servicing the Medicare supplement policy or certificate in the second year or period.

(c) A carrier or other entity must provide the same commission or other compensation in subsequent renewal years as the commission or other compensation provided in the second year or period and for no fewer than 5 renewal years.

(d) If an existing Medicare supplement policy or certificate is replaced, the carrier or other entity may not provide to its insurance producers or other producers, and an insurance producer or other producer may not receive, compensation greater than the renewal compensation payable by the succeeding carrier on renewal Medicare supplement policies or certificates.

§15–922.1.

(a) This section applies to a Medicare supplement policy issued:

(1) under § 15–909(b)(6) of this subtitle; or

(2) to an individual at least 65 years old.

(b) A carrier shall pay the same commission rates to an insurance producer for the sale of a Medicare supplement policy without regard to whether the policy is sold during an open enrollment period, as an underwritten policy, or under § 15–909(b)(6) of this subtitle.

§15–923.

Each carrier that offers a Medicare supplement policy in the State shall provide a copy of any Medicare supplement advertisement that the carrier intends to use in the State whether through a written, radio, or television medium to the Commissioner for review at least 5 business days before the carrier uses the advertisement.

§15–924.

(a) Solicitation of the sale of a health insurance policy proposed to be issued to an individual eligible for Medicare may be made only in accordance with this section and § 15-925 of this subtitle.

(b) (1) When soliciting the sale of a health insurance policy to an individual eligible for Medicare, a carrier or insurance producer shall ask the individual whether the individual:

(i) is already covered by an existing Medicare supplement policy; and

(ii) is entitled to Medicaid benefits.

(2) The carrier or insurance producer shall obtain a written statement from the individual that verifies the individual's information provided under paragraph (1) of this subsection.

(c) When soliciting or advertising the sale of a health insurance policy to an individual eligible for Medicare, a carrier or insurance producer may not:

(1) represent or imply that the carrier or insurance producer represents, works for, or is compensated by a federal, State, or local government agency;

(2) falsely represent or imply that the carrier or insurance producer is offering insurance to supplement Medicare that is approved or recommended by a federal, State, or local government agency;

(3) use terms such as "Medicare consultant", "Medicare advisor", "Medicare bureau", or "disability insurance consultant" when describing the carrier or insurance producer in a letter, envelope, reply card, or any other writing or advertisement or in any oral representation; or

(4) knowingly make a misrepresentation or incomplete or fraudulent comparison by commission or omission of a policy or carrier to induce or attempt to induce the individual to:

(i) purchase, amend, lapse, surrender, forfeit, change, duplicate, or not renew coverage already in force;

(ii) replace a policy that is only technically at variance with the policy being offered by the carrier or insurance producer; or

(iii) take out a policy with another carrier.

§15–925.

(a) When soliciting the sale of a health insurance policy, a carrier or insurance producer may not knowingly offer a Medicare supplement policy to an individual not eligible for Medicare.

(b) A carrier or insurance producer may only sell or offer to sell a Medicare supplement policy to an individual eligible for Medicaid benefits in accordance with the provisions of 42 U.S.C. § 1395ss and this subtitle.

(c) A carrier or insurance producer may not negligently or knowingly sell or offer to sell to an individual a Medicare supplement policy that duplicates to any extent an existing Medicare supplement policy that covers that individual.

(d) A carrier or insurance producer may not use the terms "Medicare supplement", "Medigap", or other words of similar meaning in advertising or otherwise in soliciting the sale of a health insurance policy or other policy, unless the policy conforms to §§ 15-904, 15-906, 15-907, and 15-908 of this subtitle.

§15–926.

(a) Each carrier that issues Medicare supplement policies shall provide to CMS any data, statistics, or other information that CMS requests about the carrier's Medicare supplement policies.

(b) On request from CMS, the Commissioner may provide to CMS any information about Medicare supplement policies that are issued in the State.

§15–927.

In addition to any other applicable penalties for violations of this article, the Commissioner may require a carrier that violates this subtitle or a regulation adopted under this subtitle to cease marketing any Medicare supplement policy or certificate in the State that is related directly or indirectly to the violation, or may require the carrier to take actions necessary to comply with this subtitle, or both.

§15–928.

This subtitle is the Medicare Supplement Act.

§15–1001.

(a) This section applies to entities that propose to issue or deliver individual, group, or blanket health insurance policies or contracts in the State or to administer health benefit programs that provide for the coverage of health care services and the utilization review of those services, including:

(1) an authorized insurer that provides health insurance in the State;

(2) a nonprofit health service plan;

(3) a health maintenance organization;

(4) a dental plan organization; or

(5) except for a managed care organization as defined in Title 15, Subtitle 1 of the Health - General Article, any other person that provides health benefit plans subject to regulation by the State.

(b) (1) Subject to paragraph (2) of this subsection, each entity subject to this section shall:

(i) 1. have a certificate issued under Subtitle 10B of this title; or

2. contract with a private review agent that has a certificate issued under Subtitle 10B of this title; and

(ii) when conducting utilization review for mental health and substance use benefits, ensure that the criteria and standards used are in compliance with the federal Mental Health Parity and Addiction Equity Act.

(2) For hospital services, each entity subject to this section may contract with or delegate utilization review to a hospital utilization review program approved under § 19–319(d) of the Health – General Article.

(c) Notwithstanding any other provision of this article, if the medical necessity of providing a covered benefit is disputed, an entity subject to this section that does not meet the requirements of subsection (b) of this section shall pay any person entitled to reimbursement under the policy or contract in accordance with the determination of medical necessity by:

(1) the treating provider; or

(2) when hospital services are provided, the hospital utilization review program approved under § 19-319(d) of the Health - General Article.

(d) An entity subject to this section may not:

(1) act as a private review agent without holding a certificate issued under Subtitle 10B of this title; or

(2) use a private review agent that does not hold a certificate issued under Subtitle 10B of this title.

(e) An entity that violates any provision of this section is subject to the penalties provided under § 15-10B-12 of this title.

§15–1002.

To provide a standard system of payment for medical services, each claim form for use under an individual or group health insurance policy that is issued or delivered in the State shall conform to a form or regulations that the Commissioner adopts.

§15–1003.

(a) (1) In this section the following words have the meanings indicated.

(2) (i) "Health care practitioner" means a person that is licensed or certified under the Health Occupations Article and reimbursed by a third party payor.

(ii) "Health care practitioner" does not include a physician or other person licensed or certified under this article when the physician or other person is rendering care to a member or subscriber of a health maintenance organization and is compensated by the health maintenance organization for that care on a salaried or capitated basis.

(3) "Hospital" has the meaning stated in § 19-301 of the Health - General Article.

(b) The Commissioner shall adopt by regulation as the uniform claims form for reimbursement of hospital services in the State the uniform claims form adopted by the National Uniform Billing Committee and approved by the Centers for Medicare and Medicaid Services for Hospital Payments under Title XVIII of the Social Security Act.

(c) The Commissioner shall adopt by regulation a uniform claims form for reimbursement of health care practitioners' services.

(d) (1) The Commissioner shall adopt by regulation:

(i) a definition of a clean claim, including:

1. the essential data elements that must be completed on the uniform claims form; and

2. uniform standards for attachments to the uniform claims form;

(ii) permissible categories of disputed claims for which additional information may be requested under §§ 15-1004(c) and 15-1005(c) of this subtitle; and

(iii) standards for determining when a claim is considered received for reimbursement.

(2) In adopting the regulations required under paragraph (1)(i) of this subsection, the Commissioner shall consider:

(i) standards for attachments required by the federal Centers for Medicare and Medicaid Services for the Medicare Program;

(ii) standards used by insurance carriers, nonprofit health service plans, and health maintenance organizations in the State; and

(iii) federal regulations adopted under the Health Insurance Portability and Accountability Act.

§15–1004.

(a) For services rendered by a person entitled to reimbursement under § 15–701(a) of this title or by a hospital, as defined in § 19–301 of the Health – General Article, an insurer, nonprofit health service plan, or health maintenance organization:

(1) shall accept the uniform claims form and any attachments approved or adopted by the Commissioner under § 15–1003 of this subtitle:

(i) as a properly filed claim with all necessary documentation; and

(ii) as the sole instrument for reimbursement; and

(2) may not impose as a condition of reimbursement a requirement to:

(i) modify the uniform claims form or its content; or

(ii) submit additional claims forms.

(b) (1) A uniform claims form submitted under this section shall be completed properly and may be submitted by electronic transfer.

(2) If the health care practitioner rendering the service is a certified registered nurse anesthetist or certified nurse midwife, the uniform claims form shall include identification modifiers for the certified registered nurse anesthetist or certified nurse midwife that indicate whether the service is provided with or without medical direction by a physician.

(c) In accordance with §§ 15–1003(d)(1)(ii) and 15–1005(c) of this subtitle, if the legitimacy or appropriateness of a health care service is disputed, an insurer, nonprofit health service plan, or health maintenance organization may request

additional medical information that describes and summarizes the diagnosis, treatment, and services rendered to the insured.

(d) (1) Insurers, nonprofit health service plans, and health maintenance organizations shall provide and update, as appropriate, all contracting providers and any other provider on request, with a manual or other document that sets forth the claims filing procedures, including:

(i) the address where the claims should be sent for processing;

(ii) the telephone number at which providers' questions and concerns regarding claims may be addressed;

(iii) the name, address, and telephone number of any entity to which the insurer, nonprofit health service plan, or health maintenance organization has delegated the claims payment function, if applicable; and

(iv) the address and telephone number of any separate claims processing center for specific types of applicable services.

(2) If an insurer, nonprofit health service plan, or health maintenance organization has delegated its claims processing function to a third party, the delegation agreement:

(i) shall require the claims processing entity to comply with the requirements of this subtitle; and

(ii) may not be construed to limit the responsibility of the insurer, nonprofit health service plan, or health maintenance organization to comply with the requirements of this subtitle.

(e) (1) If necessary to determine eligibility for benefits or to determine coverage, an insurer, nonprofit health service plan, or health maintenance organization may obtain additional information from its insured, member, or subscriber, the employer of the insured, member or subscriber, or any other nonprovider third party.

(2) If obtaining additional information results in a delay in paying a claim, the insurer, nonprofit health service plan, or health maintenance organization shall pay interest in accordance with the provisions of § 15–1005(g) of this subtitle.

(f) The Commissioner may impose a penalty not exceeding $5,000 on an insurer, nonprofit health service plan, or health maintenance organization that violates this section.

§15–1005.

(a) In this section, "clean claim" means a claim for reimbursement, as defined in regulations adopted by the Commissioner under § 15–1003 of this subtitle.

(b) To the extent consistent with the Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. 1001 et seq., this section applies to an insurer, nonprofit health service plan, or health maintenance organization that acts as a third party administrator.

(c) Except as provided in § 15–1315 of this title and subsection (i) of this section, within 30 days after receipt of a claim for reimbursement from a person entitled to reimbursement under § 15–701(a) of this title or from a hospital or related institution, as those terms are defined in § 19–301 of the Health – General Article, an insurer, nonprofit health service plan, or health maintenance organization shall:

(1) mail or otherwise transmit payment for the claim in accordance with this section; or

(2) send a notice of receipt and status of the claim that states:

(i) that the insurer, nonprofit health service plan, or health maintenance organization refuses to reimburse all or part of the claim and the reason for the refusal;

(ii) that, in accordance with § 15–1003(d)(1)(ii) of this subtitle, the legitimacy of the claim or the appropriate amount of reimbursement is in dispute and additional information is necessary to determine if all or part of the claim will be reimbursed and what specific additional information is necessary; or

(iii) that the claim is not clean and the specific additional information necessary for the claim to be considered a clean claim.

(d) (1) (i) In this subsection, "credit card" means a credit, debit, prepaid, or stored–value card used to make a payment through a private card network.

(ii) "Credit card" includes a method of payment to a provider where no physical card is presented.

(2) An insurer, a nonprofit health service plan, or a health maintenance organization may pay a claim under subsection (c) of this section, or a portion of a claim under subsection (f) of this section, using a credit card or an

electronic funds transfer payment method that imposes on the provider a fee or similar charge to process the payment if:

(i) the insurer, nonprofit health service plan, or health maintenance organization notifies the provider in advance of the payment that:

1. a fee or similar charge associated with the use of the credit card or electronic funds transfer payment method will apply; and

2. the provider will need to consult the provider's merchant processor or financial institution for the specific rates;

(ii) the insurer, nonprofit health service plan, or health maintenance organization offers the provider an alternative payment method that does not impose a fee or similar charge on the provider; and

(iii) the provider or the provider's designee elects to accept payment of the claim or a portion of the claim using the credit card or electronic funds transfer payment method.

(3) If a provider participates on a provider panel of an insurer, a nonprofit health service plan, or a health maintenance organization, the acceptance by the provider or the provider's designee of a payment method offered under paragraph (2)(ii) of this subsection or elected under paragraph (2)(iii) of this subsection shall apply to all claims paid for by the insurer, nonprofit health service plan, or health maintenance organization unless otherwise notified by the provider or the provider's designee.

(e) (1) An insurer, nonprofit health service plan, or health maintenance organization shall permit a provider a minimum of 180 days from the date a covered service is rendered to submit a claim for reimbursement for the service.

(2) If an insurer, nonprofit health service plan, or health maintenance organization wholly or partially denies a claim for reimbursement, the insurer, nonprofit health service plan, or health maintenance organization shall permit a provider a minimum of 90 working days after the date of denial of the claim to appeal the denial.

(3) If an insurer, nonprofit health service plan, or health maintenance organization erroneously denies a provider's claim for reimbursement submitted within the time period specified in paragraph (1) of this subsection because of a claims processing error, and the provider notifies the insurer, nonprofit health service plan, or health maintenance organization of the potential error within 1 year of the claim denial, the insurer, nonprofit health service plan, or health maintenance

organization, on discovery of the error, shall reprocess the provider's claim without the necessity for the provider to resubmit the claim, and without regard to timely submission deadlines.

(f) (1) If an insurer, nonprofit health service plan, or health maintenance organization provides notice under subsection (c)(2)(i) of this section, the insurer, nonprofit health service plan, or health maintenance organization shall mail or otherwise transmit payment for any undisputed portion of the claim within 30 days of receipt of the claim, in accordance with this section.

(2) If an insurer, nonprofit health service plan, or health maintenance organization provides notice under subsection (c)(2)(ii) of this section, the insurer, nonprofit health service plan, or health maintenance organization shall:

(i) mail or otherwise transmit payment for any undisputed portion of the claim in accordance with this section; and

(ii) comply with subsection (c)(1) or (2)(i) of this section within 30 days after receipt of the requested additional information.

(3) If an insurer, nonprofit health service plan, or health maintenance organization provides notice under subsection (c)(2)(iii) of this section, the insurer, nonprofit health service plan, or health maintenance organization shall comply with subsection (c)(1) or (2)(i) of this section within 30 days after receipt of the requested additional information.

(g) (1) If an insurer, nonprofit health service plan, or health maintenance organization fails to pay a clean claim for reimbursement or otherwise violates any provision of this section, the insurer, nonprofit health service plan, or health maintenance organization shall pay interest on the amount of the claim that remains unpaid 30 days after receipt of the initial clean claim for reimbursement at the monthly rate of:

(i) 1.5% from the 31st day through the 60th day;

(ii) 2% from the 61st day through the 120th day; and

(iii) 2.5% after the 120th day.

(2) The interest paid under this subsection shall be included in any late reimbursement without the necessity for the person that filed the original claim to make an additional claim for that interest.

(h) An insurer, nonprofit health service plan, or health maintenance organization that violates a provision of this section is subject to:

(1) a fine not exceeding $500 for each violation that is arbitrary and capricious, based on all available information; and

(2) the penalties prescribed under § 4–113(d) of this article for violations committed with a frequency that indicates a general business practice.

(i) (1) An insurer, a nonprofit health service plan, or a health maintenance organization may suspend review of a claim for reimbursement for a preauthorized or approved health care service if the insurer, nonprofit health service plan, or health maintenance organization sends written notice within 30 days after receipt of the claim that informs the person filing the claim, that:

(i) review of the claim is suspended during the second or third month of a grace period under 45 C.F.R. § 156.270(d); and

(ii) on receipt of the payment of premium, the insurer, nonprofit health service plan, or health maintenance organization is required to comply with paragraph (2) of this subsection.

(2) Within 30 days after receipt of the payment of premium, an insurer, a nonprofit health service plan, or a health maintenance organization shall comply with subsection (c)(1) or (2) of this section.

§15–1006.

(a) On written request of the claimant, an insurer that denies a claim made on an individual health insurance policy shall give written notice to the claimant that states fully the reason for the denial.

(b) The reason given by an insurer for denial of a claim shall not act as an estoppel or limit the insurer from offering an additional reason for the denial.

(c) The notice given by an insurer under this section is subject to 45 C.F.R. § 164.522(b).

§15–1007.

(a) This section applies to insurers and nonprofit health service plans that propose to issue or deliver individual, group, or blanket health insurance policies or contracts or to administer health benefit programs that provide hospital, medical, or surgical benefits on an expense–incurred basis.

(b) Each entity subject to this section shall provide to an insured individual who has filed a claim described in subsection (c) of this section an annual summary explanation of benefits that covers the preceding 12–month period.

(c) The summary explanation of benefits required under subsection (b) of this section shall provide a summary of:

(1) all claims filed by health care providers for services rendered to the insured individual or covered dependent of the insured individual during an inpatient hospitalization or an outpatient surgical procedure;

(2) the amount paid by the entity for each claim filed; and

(3) the balance owed by the insured individual for each claim filed.

(d) The explanation of benefits required under this section is subject to 45 C.F.R. § 164.522(b).

§15–1008.

(a) (1) In this section the following words have the meanings indicated.

(2) "Carrier" means:

(i) an insurer;

(ii) a nonprofit health service plan;

(iii) a health maintenance organization;

(iv) a dental plan organization;

(v) a managed care organization, as defined in § 15–101 of the Health – General Article; or

(vi) any other person that provides health benefit plans subject to regulation by the State.

(3) "Code" means:

(i) the applicable current procedural terminology (CPT) code, as adopted by the American Medical Association;

(ii) if for a dental service, the applicable code adopted by the American Dental Association; or

(iii) another applicable code under an appropriate uniform coding scheme used by a carrier in accordance with this section.

(4) "Coding guidelines" means those standards or procedures used or applied by a payor to determine the most accurate and appropriate code or codes for payment by the payor for a service or services.

(5) "Health care provider" means a person or entity licensed, certified or otherwise authorized under the Health Occupations Article or the Health – General Article to provide health care services.

(6) "Reimbursement" means payments made to a health care provider by a carrier on either a fee–for–service, capitated, or premium basis.

(b) This section does not apply to an adjustment to reimbursement:

(1) made as part of an annual contracted reconciliation of a risk sharing arrangement under an administrative service provider contract; or

(2) made as part of a two–sided incentive arrangement that complies with § 15–113 of this title.

(c) (1) If a carrier retroactively denies reimbursement to a health care provider, the carrier:

(i) may only retroactively deny reimbursement for services subject to coordination of benefits with another carrier, the Maryland Medical Assistance Program, or the Medicare Program during the 18–month period after the date that the carrier paid the health care provider; and

(ii) except as provided in item (i) of this paragraph, may only retroactively deny reimbursement during the 6–month period after the date that the carrier paid the health care provider.

(2) (i) A carrier that retroactively denies reimbursement to a health care provider under paragraph (1) of this subsection shall provide the health care provider with a written statement specifying the basis for the retroactive denial.

(ii) If the retroactive denial of reimbursement results from coordination of benefits by a carrier that is not a managed care organization, the

written statement shall provide the name and address of the entity acknowledging responsibility for payment of the denied claim.

(d) Except as provided in subsection (e) of this section, a carrier that does not comply with the provisions of subsection (c) of this section may not retroactively deny reimbursement or attempt in any manner to retroactively collect reimbursement already paid to a health care provider.

(e) (1) The provisions of subsection (c)(1) of this section do not apply if a carrier retroactively denies reimbursement to a health care provider because:

(i) the information submitted to the carrier was fraudulent;

(ii) the information submitted to the carrier was improperly coded and the carrier has provided to the health care provider sufficient information regarding the coding guidelines used by the carrier at least 30 days prior to the date the services subject to the retroactive denial were rendered;

(iii) the claim submitted to the carrier was a duplicate claim; or

(iv) for a claim submitted to a managed care organization, the claim was for services provided to a Maryland Medical Assistance Program recipient during a time period for which the Program has permanently retracted the capitation payment for the Program recipient from the managed care organization.

(2) Information submitted to the carrier may be considered to be improperly coded under paragraph (1) of this subsection if the information submitted to the carrier by the health care provider:

(i) uses codes that do not conform with the coding guidelines used by the carrier applicable as of the date the service or services were rendered; or

(ii) does not otherwise conform with the contractual obligations of the health care provider to the carrier applicable as of the date the service or services were rendered.

(f) If a carrier retroactively denies reimbursement for services as a result of coordination of benefits under provisions of subsection (c)(1)(i) of this section, the health care provider shall have 6 months from the date of denial, unless a carrier permits a longer time period, to submit a claim for reimbursement for the service to the carrier, Maryland Medical Assistance Program, or Medicare Program responsible for payment.

§15–1009.

(a) In this section, "carrier" means:

(1) an insurer;

(2) a nonprofit health service plan;

(3) a health maintenance organization;

(4) a dental plan organization; or

(5) any other person that provides health benefit plans subject to regulation by the State.

(b) If a health care service for a patient has been preauthorized or approved by a carrier or the carrier's private review agent, the carrier may not deny reimbursement to a health care provider for the preauthorized or approved service delivered to that patient unless:

(1) the information submitted to the carrier regarding the service to be delivered to the patient was fraudulent or intentionally misrepresentative;

(2) critical information requested by the carrier regarding the service to be delivered to the patient was omitted such that the carrier's determination would have been different had it known the critical information;

(3) a planned course of treatment for the patient that was approved by the carrier was not substantially followed by the health care provider; or

(4) on the date the preauthorized or approved service was delivered:

(i) the patient was not covered by the carrier;

(ii) the carrier maintained an automated eligibility verification system that was available to the contracting provider by telephone or via the Internet; and

(iii) according to the verification system, the patient was not covered by the carrier.

(c) Notwithstanding subsection (b) of this section, a carrier may suspend review of a claim for reimbursement of a preauthorized or approved health care service if:

(1) the patient is in the second or third month of a grace period under 45 C.F.R. § 156.270(d);

(2) the carrier maintains an automated eligibility verification system that was available to the health care provider by telephone or via the Internet at the time the health care service was provided;

(3) according to the verification system, the provider is informed that:

(i) the patient is in the second or third month of a grace period and review of a claim for reimbursement may be suspended; and

(ii) a carrier is not prohibited from denying a claim for reimbursement of a suspended claim; and

(4) the carrier complies with the notice and claim payment requirements under § 15–1005 of this subtitle.

(d) A carrier shall pay a claim for a preauthorized or approved covered health care service in accordance with §§ 15–1005 and 15–1008 of this subtitle.

§15–1010.

(a) (1) In this section the following words have the meanings indicated.

(2) "Adverse benefit determination" means:

(i) a denial, reduction, or termination of a disability benefit;

(ii) a failure to provide or make payment, in whole or in part, for a disability benefit; or

(iii) any denial, reduction, termination, or failure to provide or make payment that is based on a determination of an individual's eligibility for coverage of a disability benefit.

(3) (i) "Disability benefit" means a benefit that is payable based on the disability of a covered individual.

(ii) "Disability benefit" does not include:

1. long–term care insurance;

2. a benefit that is payable based solely on a dismemberment of a covered individual;

3. benefits in a life insurance policy that operate to safeguard the contract from lapse or to provide a special surrender value, special benefit, or annuity in the event of total and permanent disability; or

4. benefits in a health insurance policy that operate to safeguard the contract from lapse due to disability.

(b) (1) The Commissioner shall adopt regulations that establish standards governing the processing of claims by an insurer that:

(i) issues or delivers individual policies in the State that include a disability benefit; or

(ii) issues or delivers group policies in the State that include a disability benefit.

(2) The regulations adopted under this subsection shall establish and maintain reasonable claims procedures governing the filing of disability benefit claims, including:

(i) notification of an adverse benefit determination; and

(ii) an appeal by an insured or the insured's authorized representative of an insurer's adverse benefit determination.

(3) The claims procedures established for both individual and group policies under this subsection shall be consistent with the provisions of the Department of Labor's regulation entitled "Employee Retirement Income Security Act of 1974, Rules and Regulations for Administration and Enforcement; Claims Procedure; Final Rule" (29 C.F.R. 2560).

§15–1011.

(a) (1) This section applies to:

(i) insurers and nonprofit health service plans that provide hospital, medical, or surgical benefits to individuals or groups on an expense–incurred basis under health insurance policies or contracts that are issued or delivered in the State; and

(ii) health maintenance organizations that provide hospital, medical, or surgical benefits to individuals or groups under contracts that are issued or delivered in the State.

(2) This section does not apply to claims for reimbursement:

(i) for services received under Medicare supplemental policies or contracts; or

(ii) for pharmaceutical or vision services.

(b) An entity subject to this section shall permit an insured, a subscriber, or a member seeking reimbursement for expenses incurred by the insured, subscriber, or member, in connection with a covered service provided in the United States, to submit a claim for reimbursement:

(1) by first–class mail; and

(2) at the election of the entity:

(i) by facsimile transmission; or

(ii) through a Web site that allows for the secure transmission of information.

(c) An entity subject to this section annually shall provide:

(1) a notice that a claims form may be submitted:

(i) by first–class mail; and

(ii) at the election of the entity:

1. by facsimile transmission; or

2. through a Web site that allows for the secure transmission of information; and

(2) instructions on how to submit a claim by facsimile transmission or through a secure Web site.

§15–10A–01.

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

(b) (1) "Adverse decision" means:

(i) a utilization review determination by a private review agent, a carrier, or a health care provider acting on behalf of a carrier that:

1. a proposed or delivered health care service covered under the member's contract is or was not medically necessary, appropriate, or efficient; and

2. may result in noncoverage of the health care service; or

(ii) a denial by a carrier of a request by a member for an alternative standard or a waiver of a standard to satisfy the requirements of a wellness program under § 15–509 of this title.

(2) "Adverse decision" includes a utilization review determination based on a prior authorization or step therapy requirement.

(3) "Adverse decision" does not include a decision concerning a subscriber's status as a member.

(c) "Carrier" means a person that offers a health benefit plan and is:

(1) an authorized insurer that provides health insurance in the State;

(2) a nonprofit health service plan;

(3) a health maintenance organization;

(4) a dental plan organization;

(5) a self–funded student health plan operated by an independent institution of higher education, as defined in § 10–101 of the Education Article, that provides health care to its students and their dependents; or

(6) except for a managed care organization as defined in Title 15, Subtitle 1 of the Health – General Article, any other person that provides health benefit plans subject to regulation by the State.

(d) "Complaint" means a protest filed with the Commissioner involving an adverse decision or grievance decision concerning the member.

(e) "Designee of the Commissioner" means any person to whom the Commissioner has delegated the authority to review and decide complaints filed under this subtitle, including an administrative law judge to whom the authority to conduct a hearing has been delegated for recommended or final decision.

(f) "Grievance" means a protest filed by a member, a member's representative, or a health care provider on behalf of a member with a carrier through the carrier's internal grievance process regarding an adverse decision concerning the member.

(g) "Grievance decision" means a final determination by a carrier that arises from a grievance filed with the carrier under its internal grievance process regarding an adverse decision concerning a member.

(h) "Health Advocacy Unit" means the Health Education and Advocacy Unit in the Division of Consumer Protection of the Office of the Attorney General established under Title 13, Subtitle 4A of the Commercial Law Article.

(i) "Health benefit plan" has the meaning stated in § 2–112.2(a) of this article.

(j) "Health care provider" means:

(1) an individual who is licensed under the Health Occupations Article to provide health care services in the ordinary course of business or practice of a profession and is a treating provider of the member; or

(2) a hospital, as defined in § 19–301 of the Health – General Article.

(k) "Health care service" means a health or medical care procedure or service rendered by a health care provider that:

(1) provides testing, diagnosis, or treatment of a human disease or dysfunction;

(2) dispenses drugs, medical devices, medical appliances, or medical goods for the treatment of a human disease or dysfunction; or

(3) provides any other care, service, or treatment of disease or injury, the correction of defects, or the maintenance of physical or mental well–being of individuals.

(l) (1) "Member" means a person entitled to health care benefits under a policy, plan, or certificate issued or delivered in the State by a carrier.

(2) "Member" includes:

(i) a subscriber; and

(ii) unless preempted by federal law, a Medicare recipient.

(3) "Member" does not include a Medicaid recipient.

(m) "Member's representative" means an individual who has been authorized by the member to file a grievance or a complaint on the member's behalf.

(n) "Private review agent" has the meaning stated in § 15–10B–01 of this title.

§15–10A–01.1.

This subtitle applies to a health benefit plan that:

(1) is delivered or issued in the State; or

(2) covers individuals who reside or work in the State if the health benefit plan is delivered or issued in a state that the Commissioner determines does not have an external complaint process for adverse decisions or grievances comparable to the complaint process established in this subtitle.

§15–10A–02.

(a) Each carrier shall establish an internal grievance process for its members.

(b) (1) An internal grievance process shall meet the same requirements established under Subtitle 10B of this title.

(2) In addition to the requirements of Subtitle 10B of this title, an internal grievance process established by a carrier under this section shall:

(i) include an expedited procedure for use in an emergency case for purposes of rendering a grievance decision within 24 hours of the date a grievance is filed with the carrier;

(ii) provide that a carrier render a final decision in writing on a grievance within 30 working days after the date on which the grievance is filed unless:

1. the grievance involves an emergency case under item (i) of this paragraph;

2. the member, the member's representative, or a health care provider filing a grievance on behalf of a member agrees in writing to an extension for a period of no longer than 30 working days; or

3. the grievance involves a retrospective denial under item (iv) of this paragraph;

(iii) allow a grievance to be filed on behalf of a member by a health care provider or the member's representative;

(iv) provide that a carrier render a final decision in writing on a grievance within 45 working days after the date on which the grievance is filed when the grievance involves a retrospective denial; and

(v) for a retrospective denial, allow a member, the member's representative, or a health care provider on behalf of a member to file a grievance for at least 180 days after the member receives an adverse decision.

(3) For purposes of using the expedited procedure for an emergency case that a carrier is required to include under paragraph (2)(i) of this subsection, the carrier shall initiate the expedited procedure for an emergency case if the member or the member's representative requests the expedited review or the health care provider or the member or the member's representative attests that:

(i) the adverse decision was rendered for health care services that are proposed but have not been provided; and

(ii) the services are necessary to treat a condition or illness that, without immediate medical attention, would:

1. seriously jeopardize the life or health of the member or the member's ability to regain maximum functions;

2. cause the member to be in danger to self or others; or

3. cause the member to continue using intoxicating substances in an imminently dangerous manner.

(c) Except as provided in subsection (d) of this section, the carrier's internal grievance process shall be exhausted prior to filing a complaint with the Commissioner under this subtitle.

(d) (1) (i) A member, the member's representative, or a health care provider filing a complaint on behalf of a member may file a complaint with the Commissioner without first filing a grievance with a carrier and receiving a final decision on the grievance if:

1. the carrier waives the requirement that the carrier's internal grievance process be exhausted before filing a complaint with the Commissioner;

2. the carrier has failed to comply with any of the requirements of the internal grievance process as described in this section; or

3. the member, the member's representative, or the health care provider provides sufficient information and supporting documentation in the complaint that demonstrates a compelling reason to do so.

(ii) The Commissioner shall define by regulation the standards that the Commissioner shall use to decide what demonstrates a compelling reason under subparagraph (i) of this paragraph.

(2) Subject to subsections (b)(2)(ii) and (h) of this section, a member, a member's representative, or a health care provider may file a complaint with the Commissioner if the member, the member's representative, or the health care provider does not receive a grievance decision from the carrier on or before the 30th working day on which the grievance is filed.

(3) Whenever the Commissioner receives a complaint under paragraph (1) or (2) of this subsection, the Commissioner shall notify the carrier that is the subject of the complaint within 5 working days after the date the complaint is filed with the Commissioner.

(e) Each carrier shall:

(1) file for review with the Commissioner and submit to the Health Advocacy Unit a copy of its internal grievance process established under this subtitle; and

(2) file any revision to the internal grievance process with the Commissioner and the Health Advocacy Unit at least 30 days before its intended use.

(f) (1) For nonemergency cases, when a carrier renders an adverse decision, the carrier shall:

(i) inform the member, the member's representative, or the health care provider acting on behalf of the member of the adverse decision:

1. orally by telephone; or

2. with the affirmative consent of the member, the member's representative, or the health care provider acting on behalf of the member, by text, facsimile, e–mail, an online portal, or other expedited means; and

(ii) send, within 5 working days after the adverse decision has been made, a written notice to the member, the member's representative, and a health care provider acting on behalf of the member that:

1. states at the top in prominent bold print:

A. that the notice is a denial of a requested health care service;

B. that the member may file an appeal;

C. the telephone number and e–mail address required to be available under § 15–10B–05(e) of this title; and

D. that the notice includes additional information on how to file and receive assistance for filing a complaint;

2. states in detail in clear, understandable language the specific factual bases for the carrier's decision and the reasoning used to determine that the health care service is not medically necessary and did not meet the carrier's criteria and standards used in conducting the utilization review;

3. provides the specific reference, language, or requirements from the criteria and standards, including any interpretive guidelines, on which the decision was based, and may not solely use:

A. generalized terms such as "experimental procedure not covered", "cosmetic procedure not covered", "service included under another procedure", or "not medically necessary"; or

B. language directing the member to review the additional coverage criteria in the member's policy or plan documents;

4. includes a unique identifier for and the business address and business telephone number of:

A. if the carrier is a health maintenance organization, the medical director or associate medical director, as appropriate, who made the decision; or

B. if the carrier is not a health maintenance organization, the designated employee or representative of the carrier who has responsibility for the carrier's internal grievance process and the physician who is required to make all adverse decisions as required in § 15–10B–07(a) of this title;

5. gives written details of the carrier's internal grievance process and procedures under this subtitle; and

6. includes the following information:

A. that the member, the member's representative, or a health care provider on behalf of the member has a right to file a complaint with the Commissioner within 4 months after receipt of a carrier's grievance decision;

B. that a complaint may be filed without first filing a grievance if the member, the member's representative, or a health care provider filing a grievance on behalf of the member can demonstrate a compelling reason to do so as determined by the Commissioner;

C. the Commissioner's address, telephone number, and facsimile number;

D. a statement that the Health Advocacy Unit is available to assist the member or the member's representative in both mediating and filing a grievance under the carrier's internal grievance process; and

E. the address, telephone number, facsimile number, and electronic mail address of the Health Advocacy Unit.

(2) The business telephone number included in the notice as required under paragraph (1)(ii)4 of this subsection must be a dedicated number for adverse decisions and may not be the general customer call number for the carrier.

(g) If within 5 working days after a member, the member's representative, or a health care provider, who has filed a grievance on behalf of a member, files a

grievance with the carrier, and if the carrier does not have sufficient information to complete its internal grievance process, the carrier shall:

(1) after confirming through a complete review of any information already submitted by the health care provider:

(i) notify the member, the member's representative, or the health care provider that it cannot proceed with reviewing the grievance unless additional information is provided;

(ii) request the specific information, including any lab or diagnostic test or other medical information that must be submitted to complete the internal grievance process; and

(iii) provide the specific reference, language, or requirements from the criteria and standards used by the carrier to support the need for the additional information; and

(2) assist the member, the member's representative, or the health care provider in gathering the necessary information without further delay.

(h) A carrier may extend the 30–day or 45–day period required for making a final grievance decision under subsection (b)(2)(ii) of this section with the written consent of the member, the member's representative, or the health care provider who filed the grievance on behalf of the member.

(i) (1) For nonemergency cases, when a carrier renders a grievance decision, the carrier shall:

(i) document the grievance decision in writing after the carrier has provided oral communication of the decision to the member, the member's representative, or the health care provider acting on behalf of the member; and

(ii) send, within 5 working days after the grievance decision has been made, a written notice to the member, the member's representative, and a health care provider acting on behalf of the member that:

1. states at the top in prominent bold print:

A. that the notice is a denial of a requested health care service;

B. that the member may file a complaint with the Commissioner;

C. the telephone number and e–mail address required to be available under § 15–10B–05(e) of this title; and

D. that the notice includes additional information on how to file and receive assistance for an appeal;

2. states in detail in clear, understandable language the specific factual bases for the carrier's decision and the reasoning used to determine that the health care service is not medically necessary and did not meet the carrier's criteria and standards used in conducting utilization review;

3. provides the specific reference, language, or requirements from the criteria and standards, including any interpretive guidelines used by the carrier, on which the grievance decision was based;

4. includes a unique identifier for and the business address and business telephone number of:

A. if the carrier is a health maintenance organization, the medical director or associate medical director, as appropriate, who made the grievance decision; or

B. if the carrier is not a health maintenance organization, the designated employee or representative of the carrier who has responsibility for the carrier's internal grievance process and the designated employee or representative's title and clinical specialty; and

5. includes the following information:

A. that the member or the member's representative has a right to file a complaint with the Commissioner within 4 months after receipt of a carrier's grievance decision;

B. the Commissioner's address, telephone number, and facsimile number;

C. a statement that the Health Advocacy Unit is available to assist the member or the member's representative in filing a complaint with the Commissioner; and

D. the address, telephone number, facsimile number, and electronic mail address of the Health Advocacy Unit.

(2) The business telephone number included in the notice as required under paragraph (1)(ii)4 of this subsection must be a dedicated number for grievance decisions and may not be the general customer call number for the carrier.

(3) To satisfy the requirements of this subsection, a carrier may not use solely in the written notice sent under paragraph (1) of this subsection:

(i) generalized terms such as "experimental procedure not covered", "cosmetic procedure not covered", "service included under another procedure", or "not medically necessary"; or

(ii) language directing the member to review the additional coverage criteria in the member's policy or plan documents.

(j) (1) For an emergency case under subsection (b)(2)(i) of this section, within 1 day after a decision has been orally communicated to the member, the member's representative, or the health care provider, the carrier shall send notice in writing of any adverse decision or grievance decision to:

(i) the member and the member's representative, if any; and

(ii) if the grievance was filed on behalf of the member under subsection (b)(2)(iii) of this section, the health care provider.

(2) A notice required to be sent under paragraph (1) of this subsection shall include the following:

(i) for an adverse decision, the information required under subsection (f) of this section; and

(ii) for a grievance decision, the information required under subsection (i) of this section.

(k) (1) Each carrier shall include the information required by subsection (f)(1)(ii)3, 4, and 5 of this section in the policy, plan, certificate, enrollment materials, or other evidence of coverage that the carrier provides to a member at the time of the member's initial coverage or renewal of coverage.

(2) Each carrier shall include as part of the information required by paragraph (1) of this subsection a statement indicating that, when filing a complaint with the Commissioner, the member or the member's representative will be required to authorize the release of any medical records of the member that may be required to be reviewed for the purpose of reaching a decision on the complaint.

(l) (1) Nothing in this subtitle prohibits a carrier from delegating its internal grievance process to a private review agent that has a certificate issued under Subtitle 10B of this title and is acting on behalf of the carrier.

(2) If a carrier delegates its internal grievance process to a private review agent, the carrier shall be:

(i) bound by the grievance decision made by the private review agent acting on behalf of the carrier; and

(ii) responsible for a violation of any provision of this subtitle regardless of the delegation made by the carrier under paragraph (1) of this subsection.

§15–10A–03.

(a) (1) Within 4 months after the date of receipt of an adverse decision or a grievance decision, a member, a member's representative, or a health care provider, who filed the grievance on behalf of the member under § 15–10A–02(b)(2)(iii) of this subtitle, may file a complaint with the Commissioner.

(2) Whenever the Commissioner receives a complaint under this subsection, the Commissioner shall notify the carrier that is the subject of the complaint within 5 working days after the date the complaint is filed with the Commissioner.

(3) Except for an emergency case under subsection (b)(1)(ii) of this section, the carrier that is the subject of a complaint filed under paragraph (1) of this subsection shall provide to the Commissioner any information requested by the Commissioner no later than 7 working days from the date the carrier receives the request for information.

(b) (1) In developing procedures to be used in reviewing and deciding complaints, the Commissioner shall:

(i) allow a health care provider to file a complaint on behalf of a member; and

(ii) establish an expedited procedure for use in an emergency case for the purpose of making a final decision on a complaint within 24 hours after the complaint is filed with the Commissioner.

(2) For purposes of using the expedited procedure for an emergency case under paragraph (1)(ii) of this subsection, the Commissioner shall define by regulation the standards required for a grievance to be considered an emergency case.

(c) (1) Except as provided in paragraph (2) of this subsection and except for an emergency case under subsection (b)(1)(ii) of this section, the Commissioner shall make a final decision on a complaint:

(i) within 45 days after a complaint regarding a pending health care service is filed; and

(ii) within 45 days after a complaint is filed regarding a retrospective denial of services already provided.

(2) The Commissioner may extend the period within which a final decision is to be made under paragraph (1) of this subsection for up to an additional 30 working days if:

(i) the Commissioner has not yet received information requested by the Commissioner; and

(ii) the information requested is necessary for the Commissioner to render a final decision on the complaint.

(d) The Commissioner shall seek advice from an independent review organization or medical expert, as provided in § 15–10A–05 of this subtitle, for complaints filed with the Commissioner under this subtitle that involve a question of whether a health care service provided or to be provided to a member is medically necessary.

(e) (1) A carrier shall have the burden of persuasion that its adverse decision or grievance decision, as applicable, is correct:

(i) during the review of a complaint by the Commissioner or a designee of the Commissioner; and

(ii) in any hearing held in accordance with § 2–210 of this article.

(2) As part of the review of a complaint, the Commissioner or a designee of the Commissioner may consider all of the facts of the case and any other evidence that the Commissioner or designee of the Commissioner considers appropriate.

(3) As required under § 15–10A–02(i) of this subtitle, the carrier's adverse decision or grievance decision shall state in detail in clear, understandable language the factual bases for the decision and reference the specific criteria and standards, including interpretive guidelines on which the decision was based.

(4) (i) Except as provided in subparagraph (ii) of this paragraph, in responding to a complaint, a carrier may not rely on any basis not stated in its adverse decision or grievance decision.

(ii) The Commissioner may allow a carrier, a member, a member's representative, or a health care provider filing a complaint on behalf of a member to provide additional information as may be relevant for the Commissioner to make a final decision on the complaint.

(iii) The Commissioner shall allow the member, the member's representative, or the health care provider filing a complaint on behalf of the member at least 5 working days to provide the additional information described in subparagraph (ii) of this paragraph.

(iv) The Commissioner's use of additional information may not delay the Commissioner's decision on the complaint by more than 5 working days.

(f) The Commissioner may request the member that filed the complaint or a legally authorized designee of the member to sign a consent form authorizing the release of the member's medical records to the Commissioner or the Commissioner's designee that are needed in order for the Commissioner to make a final decision on the complaint.

§15–10A–04.

(a) The Commissioner shall:

(1) notwithstanding the provisions of § 15–10A–03(c)(1)(ii) of this subtitle, for the purpose of making final decisions on complaints, prioritize complaints regarding pending health care services over complaints regarding health care services already delivered;

(2) make and issue in writing a final decision on all complaints filed with the Commissioner under this subtitle that are within the Commissioner's jurisdiction; and

(3) provide notice in writing to all parties to a complaint of the available remedy to the party described under subsection (e) of this section and the time period for requesting the remedy.

(b) (1) For emergency cases, the Commissioner shall send written notification of the Commissioner's final decision within 1 working day after the Commissioner or the Commissioner's designee has informed the member or a health care provider who filed the complaint on behalf of the member of the final decision through an oral communication.

(2) The Commissioner shall include in the notice the information required under subsection (a)(3) of this section.

(c) (1) It is a violation of this subtitle for a carrier to fail to fulfill the carrier's obligations to provide or reimburse for health care services specified in the carrier's policies or contracts with members.

(2) If, in rendering an adverse decision or grievance decision, a carrier fails to fulfill the carrier's obligations to provide or reimburse for health care services specified in the carrier's policies or contracts with members, the Commissioner may:

(i) issue an administrative order that requires the carrier to:

1. cease inappropriate conduct or practices by the carrier or any of the personnel employed or associated with the carrier;

2. fulfill the carrier's contractual obligations;

3. provide a health care service or payment that has been denied improperly; or

4. take appropriate steps to restore the carrier's ability to provide a health care service or payment that is provided under a contract; or

(ii) impose any penalty or fine or take any action as authorized:

1. for an insurer, nonprofit health service plan, or dental plan organization, under this article; or

2. for a health maintenance organization, under the Health – General Article or under this article.

(3) In addition to paragraph (1) of this subsection, it is a violation of this subtitle, if the Commissioner, in consultation with an independent review organization, medical expert, the Department, or other appropriate entity, determines that the criteria and standards used by a health maintenance

organization to conduct utilization review are not in accordance with § 15–10B–05 of this title.

(d) The Commissioner may refer complaints not within the Commissioner's jurisdiction to the Health Advocacy Unit or any other appropriate federal or State government agency or unit for disposition or resolution.

(e) (1) A final decision of the Commissioner made on a complaint under this subtitle:

(i) is not subject to a request for a hearing under this subtitle for a carrier; and

(ii) is subject to a right to file a petition for judicial review under § 2–215 of this article for a carrier or a member.

(2) Unless prohibited under federal law, a member may request a hearing to be held in accordance with § 2–210 of this article of a final decision of the Commissioner made on a complaint under this subtitle.

§15–10A–05.

(a) For a complaint filed with the Commissioner under this subtitle that involves a question of whether the health care service provided or to be provided to a member is medically necessary, the Commissioner:

(1) shall select an independent review organization or medical expert to advise on the complaint; and

(2) may accept and base the final decision on the complaint on the professional judgment of an independent review organization or medical expert.

(b) To ensure access to advice when needed, the Commissioner, in consultation with the Secretary of Health and carriers, shall compile a list of independent review organizations and medical experts.

(c) Any expert reviewer assigned by an independent review organization or medical expert shall be a physician or other appropriate health care provider who meets the following minimum requirements:

(1) be an expert in the treatment of the member's medical condition, and knowledgeable about the recommended health care service or treatment through actual clinical experience;

(2) hold:

(i) a nonrestricted license in a state of the United States; and

(ii) in addition, for physicians, a current certification by a recognized American medical specialty board in the area or areas appropriate to the subject of review; and

(3) have no history of disciplinary actions or sanctions, including loss of staff privileges or participation restrictions that have been taken or are pending by any hospital, governmental agency or unit, or regulatory body that the Commissioner, in accordance with regulations adopted by the Commissioner, considers relevant in meeting the requirements of this subsection.

(d) An independent review organization may not be a subsidiary of, or in any way owned or controlled by, a health benefit plan, or a trade association of health benefit plans, or a trade association of health care providers.

(e) In addition to subsection (d) of this section, to be included on the list compiled under subsection (b) of this section, an independent review organization shall submit to the Commissioner the following information:

(1) if the independent review organization is a publicly held organization, the names of all stockholders and owners of more than 5% of any stock or options of the independent review organization;

(2) the names of all holders of bonds or notes in excess of $100,000, if any;

(3) the names of all corporations and organizations that the independent review organization controls or is affiliated with, and the nature and extent of any ownership or control, including the affiliated organization's type of business;

(4) the names of all directors, officers, and executives of the independent review organization as well as a statement regarding any relationships the directors, officers, and executives may have with any carrier or health care provider group; and

(5) evidence, in the form required by the Commissioner, that the independent review organization is accredited by a nationally recognized private accrediting organization.

(f) An expert reviewer assigned by an independent review organization or the independent review organization or medical expert selected by the Commissioner under this section may not have a material professional, familial, or financial conflict of interest with any of the following:

(1) the carrier that is the subject of the complaint;

(2) any officer, director, or management employee of the carrier that is the subject of the complaint;

(3) the health care provider, the health care provider's medical group, or the independent practice association that rendered or is proposing to render the health care service that is under review;

(4) the health care facility at which the health care service was provided or will be provided; or

(5) the developer or manufacturer of the principal drug, device, procedure, or other therapy that is being proposed for the member.

(g) For any independent review organization selected by the Commissioner under subsection (a) of this section, the independent review organization shall have a quality assurance mechanism in place that ensures:

(1) the timeliness and quality of the reviews;

(2) the qualifications and independence of the expert reviewers; and

(3) the confidentiality of medical records and review materials.

(h) (1) The carrier that is the subject of the complaint shall be responsible for paying the reasonable expenses of the independent review organization or medical expert selected by the Commissioner in accordance with subsection (a) of this section.

(2) The independent review organization or medical expert shall:

(i) present to the carrier for payment a detailed account of the expenses incurred by the independent review organization or medical expert; and

(ii) provide a copy of the detailed account of expenses to the Commissioner.

(3) The carrier that is the subject of the complaint may not pay and an independent review organization or medical expert may not accept any compensation in addition to the payment for reasonable expenses under paragraph (1) of this subsection.

§15–10A–06.

(a) (1) On a quarterly basis, each carrier shall submit to the Commissioner, on the form the Commissioner requires, a report that describes the following information aggregated by zip code as required by the Commissioner:

(i) the number of members entitled to health care benefits under a policy, plan, or certificate issued or delivered in the State by the carrier;

(ii) the number of clean claims for reimbursement processed by the carrier;

(iii) the activities of the carrier under this subtitle, including:

1. the outcome of each grievance filed with the carrier;

2. the number and outcomes of cases that were considered emergency cases under § 15–10A–02(b)(2)(i) of this subtitle;

3. the time within which the carrier made a grievance decision on each emergency case;

4. the time within which the carrier made a grievance decision on all other cases that were not considered emergency cases;

5. the number of grievances filed with the carrier that resulted from an adverse decision involving length of stay for inpatient hospitalization as related to the medical procedure involved;

6. the number of adverse decisions issued by the carrier under § 15–10A–02(f) of this subtitle, whether the adverse decision involved a prior authorization or step therapy protocol, the type of service at issue in the adverse decisions, and whether an artificial intelligence, algorithm, or other software tool was used in making the adverse decision;

7. the number of adverse decisions overturned after a reconsideration request under § 15–10B–06 of this title; and

8. the number of requests made and granted under § 15–831(c)(1) and (2) of this title; and

(iv) the number and outcome of all other cases that are not subject to activities of the carrier under this subtitle that resulted from an adverse decision involving the length of stay for inpatient hospitalization as related to the medical procedure involved.

(2) If the number of adverse decisions issued by a carrier for a type of service has grown by 10% or more in the immediately preceding calendar year or 25% or more in the immediately preceding 3 calendar years, the carrier shall submit in the report required under paragraph (1) of this subsection:

(i) a description of any changes in medical management contributing to the rise in adverse decisions for the type of service;

(ii) any other known reasons for the increase; and

(iii) a description of the carrier's efforts and actions taken to determine the reason for the increase.

(b) The Commissioner shall:

(1) compile an annual summary report based on the information provided:

(i) under subsection (a) of this section; and

(ii) by the Secretary under § 19–705.2(e) of the Health – General Article;

(2) include in the summary report data on adverse decisions and grievances related to post–acute services, including adverse decisions and grievances relating to admissions to skilled nursing facilities and inpatient rehabilitation facilities;

(3) report any violations or actions taken under § 15–10B–11 of this title; and

(4) provide copies of the summary report to the Governor and, subject to § 2–1257 of the State Government Article, to the General Assembly.

(c) The Commissioner may use information provided under subsection (a) of this section as the basis for an examination under Title 2, Subtitle 2 of this article.

§15–10A–07.

On a quarterly basis, the Health Advocacy Unit shall submit a report to the Commissioner that:

(1) describes activities it performed on behalf of members that have participated in an internal grievance process of a carrier established under this subtitle;

(2) describes its efforts to mediate cases that involve an adverse decision;

(3) names each carrier involved in the cases described in the report;

(4) states the number and outcome of each grievance considered an emergency case under § 15-10A-02(b)(2)(i) of this subtitle described in the report, including the time within which the carrier made a grievance decision on each emergency case; and

(5) states the number and outcome of each case described in the report that was not considered an emergency case, including the time within which the carrier made a grievance decision on the case.

§15–10A–08.

(a) On or before November 1, 1999, and each November 1 thereafter, the Health Advocacy Unit shall publish an annual summary report and provide copies of the report to the Governor and, subject to § 2–1257 of the State Government Article, the General Assembly.

(b) (1) The annual summary report required under subsection (a) of this section shall be on the grievances and complaints filed with or referred to a carrier, the Commissioner, the Health Advocacy Unit, or any other federal or State government agency or unit under this subtitle during the previous fiscal year.

(2) In consultation with the Commissioner and any affected State government agency or unit, the Health Advocacy Unit shall:

(i) evaluate the effectiveness of the internal grievance process and complaint process available to members; and

(ii) include in the annual summary report the results of the evaluation and any proposed changes to the law that it considers necessary to ensure compliance with the purposes of the law.

§15–10A–09.

(a) The Commissioner shall adopt regulations to carry out this subtitle.

(b) In addition to the requirements of subsection (a) of this section, the Commissioner shall adopt by regulation a requirement that each carrier provide a mechanism in a form and manner that the Commissioner may require to enable a member to:

(1) be informed of the member's right to challenge a decision made by a carrier that resulted in the nonpayment of a health care service; and

(2) access the Consumer Education and Advocacy Program in the Administration.

§15–10A–10.

A carrier shall provide the notices required to be provided to members under this subtitle in a culturally and linguistically appropriate manner as described in the Affordable Care Act.

§15–10B–01.

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

(b) (1) "Adverse decision" means a utilization review determination made by a private review agent that a proposed or delivered health care service:

(i) is or was not medically necessary, appropriate, or efficient; and

(ii) may result in noncoverage of the health care service.

(2) "Adverse decision" includes a utilization review determination based on a prior authorization or step therapy requirement.

(3) "Adverse decision" does not include a decision concerning a subscriber's status as a member.

(c) "Certificate" means a certificate of registration granted by the Commissioner to a private review agent.

(d) (1) "Employee assistance program" means a health care service plan that, in accordance with a contract with an employer or labor union:

(i) consults with employees or members of an employee's family or both to:

1. identify the employee's or the employee's family member's mental health, alcohol, or substance abuse problems; and

2. refer the employee or the employee's family member to health care providers or other community resources for counseling, therapy, or treatment; and

(ii) performs utilization review for the purpose of making claims or payment decisions on behalf of the employer's or labor union's health insurance or health benefit plan.

(2) "Employee assistance program" does not include a health care service plan operated by a hospital solely for employees, or members of an employee's family, of that hospital.

(e) (1) "Grievance" means a protest filed by a patient or a health care provider on behalf of a patient with a private review agent through the private review agent's internal grievance process regarding an adverse decision concerning a patient.

(2) "Grievance" does not include a verbal request for reconsideration of a utilization review determination.

(f) "Grievance decision" means a final determination by a private review agent that arises from a grievance filed with the private review agent under its internal grievance process regarding an adverse decision concerning a patient.

(g) "Health care facility" means:

(1) a hospital as defined in § 19–301 of the Health – General Article;

(2) a related institution as defined in § 19–301 of the Health – General Article;

(3) an ambulatory surgical facility or center which is any entity or part thereof that operates primarily for the purpose of providing surgical services to patients not requiring hospitalization and seeks reimbursement from third party payors as an ambulatory surgical facility or center;

(4) a facility that is organized primarily to help in the rehabilitation of disabled individuals;

(5) a home health agency as defined in § 19–401 of the Health – General Article;

(6) a hospice as defined in § 19–901 of the Health – General Article;

(7) a facility that provides radiological or other diagnostic imagery services;

(8) a medical laboratory as defined in § 17–201 of the Health – General Article; or

(9) an alcohol abuse and drug abuse treatment program as defined in § 8–403 of the Health – General Article.

(h) "Health care provider" means:

(1) an individual who:

(i) is licensed or otherwise authorized to provide health care services in the ordinary course of business or practice of a profession; and

(ii) is a treating provider of a patient; or

(2) a hospital, as defined in § 19–301 of the Health – General Article.

(i) "Health care service" means a health or medical care procedure or service rendered by a health care provider licensed or authorized to provide health care services that:

(1) provides testing, diagnosis, or treatment of a human disease or dysfunction;

(2) dispenses drugs, medical devices, medical appliances, or medical goods for the treatment of a human disease or dysfunction; or

(3) provides any other care, service, or treatment of disease or injury, the correction of defects, or the maintenance of the physical and mental well–being of human beings.

(j) "Health care service reviewer" means an individual who is licensed or otherwise authorized to provide health care services in the ordinary course of business or practice of a profession.

(k) "Private review agent" means:

(1) a nonhospital–affiliated person or entity performing utilization review that is either affiliated with, under contract with, or acting on behalf of:

(i) a Maryland business entity; or

(ii) a third party that pays for, provides, or administers health care services to citizens of this State; or

(2) any person or entity including a hospital–affiliated person performing utilization review for the purpose of making claims or payment decisions for health care services on behalf of the employer's or labor union's health insurance plan under an employee assistance program for employees other than the employees employed by:

(i) the hospital; or

(ii) a business wholly owned by the hospital.

(l) "Significant beneficial interest" means the ownership of any financial interest that is greater than the lesser of:

(1) 5 percent of the whole; or

(2) $5,000.

(m) "Utilization review" means a system for reviewing the appropriate and efficient allocation of health care resources and services given or proposed to be given to a patient or group of patients.

(n) "Utilization review plan" means a description of the standards governing utilization review activities performed by a private review agent.

§15–10B–02.

The purpose of this subtitle is to:

(1) promote the delivery of quality health care in a cost effective manner that ensures timely access to health care services;

(2) foster greater coordination, communication, and transparency between payors, patients, and providers conducting utilization review activities;

(3) protect patients, business, and providers by ensuring that private review agents are qualified to perform utilization review activities and to make informed decisions on the appropriateness of medical care; and

(4) ensure that private review agents maintain the confidentiality of medical records in accordance with applicable State and federal laws.

§15–10B–03.

(a) A private review agent may not conduct utilization review in this State unless the Commissioner has granted the private review agent a certificate.

(b) The Commissioner shall issue a certificate to an applicant that has met all the requirements of this subtitle and all applicable regulations of the Commissioner.

(c) A certificate issued under this subtitle is not transferable.

(d) The Commissioner may consider an applicant as having met a particular certification requirement under this subtitle if:

(1) the applicant has obtained utilization management accreditation from an approved accrediting organization as determined by the Commissioner;

(2) the approved accrediting organization has requirements that meet or exceed the particular requirement in this subtitle; and

(3) the applicant demonstrates that the applicant meets or exceeds the particular requirement under this subtitle.

(e) The Commissioner may adopt regulations to implement the provisions of this section.

(f) The Commissioner may not issue a certificate to an applicant with utilization management accreditation by an approved accrediting organization unless

the applicant meets all the requirements of this subtitle and all applicable regulations of the Commissioner.

(g) A report of an approved accrediting organization used by the Commissioner as evidence that the applicant has met a particular requirement for a private review agent certificate shall be made available by the Commissioner to the public on request.

(h) (1) The Commissioner, after consultation with payors, including the Health Insurance Association of America, the League of Life and Health Insurers of Maryland, and the Maryland Association of Health Plans, and providers of health care, including the MHA: the Association of Maryland Hospitals and Health Systems, CareFirst BlueCross BlueShield, the Medical and Chirurgical Faculty of Maryland, and licensed or certified providers of treatment for a mental illness, emotional disorder, or a drug abuse or alcohol abuse disorder, shall adopt regulations to implement the provisions of this subtitle.

(2) (i) Subject to the provisions of subparagraph (iii) of this paragraph, the regulations adopted by the Commissioner shall include a uniform treatment plan form for utilization review of services for the treatment of a mental illness, emotional disorder, or a substance abuse disorder.

(ii) The uniform treatment plan form adopted by the Commissioner:

1. shall adequately protect the confidentiality of the patient; and

2. may only request the patient's membership number, policy number, or other similar unique patient identifier and first name for patient identification.

(iii) The Commissioner may waive the requirements of regulations adopted under subparagraph (i) of this paragraph for the use of a uniform treatment plan form for any entity that would be using the form solely for internal purposes.

§15–10B–04.

(a) An applicant for a certificate shall:

(1) submit an application to the Commissioner; and

(2) pay to the Commissioner the application fee established by the Commissioner through regulation.

(b) The application shall:

(1) be on a form and accompanied by any supporting documentation that the Commissioner requires; and

(2) be signed and verified by the applicant.

(c) The fees required under subsection (a)(2) of this section or § 15-10B-10(b)(2) of this subtitle shall be sufficient to pay for the administrative costs of the certificate program and any other costs associated with carrying out the provisions of this subtitle.

§15–10B–05.

(a) In conjunction with the application, the private review agent shall submit information that the Commissioner requires including:

(1) a utilization review plan that includes:

(i) the specific criteria and standards to be used in conducting utilization review of proposed or delivered health care services;

(ii) those circumstances, if any, under which utilization review may be delegated to a hospital utilization review program; and

(iii) if applicable, any provisions by which patients or physicians, hospitals, or other health care providers may seek reconsideration;

(2) the type and qualifications of the personnel either employed or under contract to perform the utilization review;

(3) a copy of the private review agent's internal grievance process if a carrier delegates its internal grievance process to the private review agent in accordance with § 15–10A–02(l) of this title;

(4) the procedures and policies to ensure that a representative of the private review agent is reasonably accessible to patients and health care providers 7 days a week, 24 hours a day in this State including having a direct telephone number and monitored e–mail address as required in subsection (e) of this section;

(5) if applicable, the procedures and policies to ensure that a representative of the private review agent is accessible to health care providers to make all determinations on whether to authorize or certify an emergency inpatient admission, or an admission for residential crisis services as defined in § 15–840 of this title, for the treatment of a mental, emotional, or substance abuse disorder within 2 hours after receipt of the information necessary to make the determination;

(6) the policies and procedures to ensure that all applicable State and federal laws to protect the confidentiality of individual medical records are followed;

(7) a copy of the materials designed to inform applicable patients and providers of the requirements of the utilization review plan;

(8) a list of the third party payors for which the private review agent is performing utilization review in this State;

(9) the policies and procedures to ensure that the private review agent has a formal program for the orientation and training of the personnel either employed or under contract to perform the utilization review;

(10) a list of the persons involved in establishing the specific criteria and standards to be used in conducting utilization review, including each person's board certification or practice specialty, licensure category, and title within the person's organization; and

(11) certification by the private review agent that the criteria and standards to be used in conducting utilization review are generally recognized by health care providers practicing in the relevant clinical specialties and are:

(i) objective;

(ii) clinically valid;

(iii) reflected in published peer–reviewed scientific studies and medical literature;

(iv) developed by:

1. a nonprofit health care provider professional medical or clinical specialty society, including through the use of patient placement criteria and clinical practice guidelines; or

2. for criteria not within the scope of a nonprofit health care provider professional medical or clinical specialty society, an organization that

works directly with health care providers in the same specialty for the designated criteria who are employed or engaged within the organization or outside the organization to develop the clinical criteria, if the organization:

A. does not receive direct payments based on the outcome of the utilization review; and

B. demonstrates that its clinical criteria are consistent with criteria and standards generally recognized by health care providers practicing in the relevant clinical specialties;

(v) recommended by federal agencies;

(vi) approved by the federal Food and Drug Administration as part of drug labeling;

(vii) taking into account the needs of atypical patient populations and diagnoses, including the unique needs of children and adolescents;

(viii) sufficiently flexible to allow deviations from norms when justified on a case–by–case basis, including the need to use an off–label prescription drug;

(ix) ensuring quality of care of health care services;

(x) reviewed, evaluated, and updated at least annually and as necessary to reflect any changes; and

(xi) in compliance with any other criteria and standards required for coverage under this title, including compliance with § 15–802(d) of this title for the treatment of substance use disorders.

(b) The private review agent shall:

(1) post on the member's and provider's pages of its website or the carrier's website the specific criteria and standards to be used in conducting utilization review of proposed or delivered services and any subsequent revisions, modifications, or additions to the specific criteria and standards to be used in conducting utilization review of proposed or delivered services; and

(2) on the request of a person, including a health care facility, provide a copy of the information specified under item (1) of this subsection to the person making the request.

(c) The private review agent may charge a reasonable fee for a hard copy of the specific criteria and standards or any subsequent revisions, modifications, or additions to the specific criteria to any person or health care facility requesting a copy under subsection (b)(2) of this section.

(d) A private review agent shall advise the Commissioner, in writing, of a change in:

(1) ownership, medical director, or chief executive officer within 30 days of the date of the change;

(2) the name, address, or telephone number of the private review agent within 30 days of the date of the change; or

(3) the private review agent's scope of responsibility under a contract.

(e) (1) A private review agent shall:

(i) have available the following dedicated to utilization review:

1. a direct telephone number that is not the general customer call number; and

2. a monitored e–mail address; and

(ii) except where a shorter time period is otherwise required under this title, respond to voicemails or e–mails within 2 business days after receipt of the voicemail or e–mail.

(2) The telephone number and e–mail address shall be prominently displayed on the notices required under § 15–10A–02(f) and (i) of this title.

§15–10B–05.1.

(a) (1) In this section the following words have the meanings indicated.

(2) "Artificial intelligence" means an engineered or machine–based system that varies in its level of autonomy and that can, for explicit or implicit objectives, infer from the input it receives how to generate outputs that can influence physical or virtual environments.

(3) "Carrier" means:

(i) an insurer;

(ii) a nonprofit health service plan;

(iii) a health maintenance organization;

(iv) a dental plan organization; or

(v) any other person that provides health benefit plans subject to regulation by the State.

(b) This section applies to:

(1) a carrier that:

(i) uses an artificial intelligence, algorithm, or other software tool for the purpose of utilization review; or

(ii) contracts with or otherwise works through an entity that uses an artificial intelligence, algorithm, or other software tool for the purpose of utilization review; and

(2) a pharmacy benefits manager or private review agent that:

(i) contracts with a carrier to provide utilization review on behalf of the carrier; and

(ii) uses an artificial intelligence, algorithm, or other software tool for the purpose of conducting utilization review on behalf of the carrier.

(c) Subject to subsection (d) of this section, an entity subject to this section shall ensure that:

(1) an artificial intelligence, algorithm, or other software tool bases its determinations on:

(i) an enrollee's medical or other clinical history;

(ii) individual clinical circumstances as presented by a requesting provider; or

(iii) other relevant clinical information contained in the enrollee's medical or other clinical record;

(2) an artificial intelligence, algorithm, or other software tool does not base its determinations solely on a group dataset;

(3) the criteria and guidelines for using an artificial intelligence, algorithm, or other software tool for making determinations comply with the requirements of this title;

(4) an artificial intelligence, algorithm, or other software tool does not replace the role of a health care provider in the determination process under § 15–10B–07 of this subtitle;

(5) the use of an artificial intelligence, algorithm, or other software tool does not result in unfair discrimination;

(6) an artificial intelligence, algorithm, or other software tool is fairly and equitably applied, including in accordance with any applicable regulations and guidance issued by the federal Department of Health and Human Services;

(7) an artificial intelligence, algorithm, or other software tool is open to inspection for audit or compliance reviews by the Commissioner;

(8) written policies and procedures are included in the utilization plan submitted under § 15–10B–05 of this subtitle, including how an artificial intelligence, algorithm, or other software tool will be used and what oversight will be provided;

(9) the performance, use, and outcomes of an artificial intelligence, algorithm, or other software tool are reviewed and revised, if necessary and at least on a quarterly basis, to maximize accuracy and reliability;

(10) patient data is not used beyond its intended and stated purpose, consistent with the federal Health Insurance Portability and Accountability Act of 1996, as applicable; and

(11) an artificial intelligence, algorithm, or other software tool does not directly or indirectly cause harm to an enrollee.

(d) An artificial intelligence, algorithm, or other software tool may not deny, delay, or modify health care services.

§15–10B–06.

(a) (1) Except as otherwise provided in this subsection, a private review agent shall:

(i) make all initial determinations on whether to authorize or certify a nonemergency course of treatment or health care service, including pharmaceutical services not submitted electronically, for a patient within 2 working days after receipt of the information necessary to make the determination;

(ii) make all determinations on whether to authorize or certify an extended stay in a health care facility or additional health care services within 1 working day after receipt of the information necessary to make the determination;

(iii) make all determinations to authorize or certify a request for additional visits or days of care submitted as part of an existing course of treatment or treatment plan within 1 working day after receipt of the information necessary to make the determination; and

(iv) promptly notify the health care provider of the determination.

(2) After receipt of the initial request for health care services and confirming through a complete review of information already submitted by the health care provider, if the private review agent determines that the private review agent does not have sufficient information to make a determination, the private review agent shall promptly, but not later than 3 calendar days after receipt of the initial request, inform the health care provider that additional information must be provided by specifying:

(i) the information, including any lab or diagnostic test or other medical information, that must be submitted to complete the request; and

(ii) the criteria and standards to support the need for additional information.

(b) If a private review agent requires prior authorization for an emergency inpatient admission, or an admission for residential crisis services as defined in § 15–840 of this title, for the treatment of a mental, emotional, or substance abuse disorder, the private review agent shall:

(1) make all determinations on whether to authorize or certify an inpatient admission, or an admission for residential crisis services as defined in § 15–840 of this title, within 2 hours after receipt of the information necessary to make the determination;

(2) if additional information is needed, promptly request the specific information needed, including any lab or diagnostic test or other medical information; and

(3) promptly notify the health care provider of the determination.

(c) (1) For a step therapy exception request submitted electronically in accordance with a process established under § 15–142(f) of this title or a prior authorization request submitted electronically for pharmaceutical services, a private review agent shall make a determination:

(i) in real time if:

1. no additional information is needed by the private review agent to process the request; and

2. the request meets the private review agent's criteria for approval; or

(ii) if a request is not approved in real time under item (i) of this paragraph, within 1 working day after the private review agent receives all of the information necessary to make the determination.

(2) If additional information is needed to make a determination after confirming through a complete review of the information already submitted by the health care provider, the private review agent shall request the information promptly, but not later than 3 calendar days after receipt of the initial request, by specifying:

(i) the information, including any lab or diagnostic test or other medical information, that must be submitted to complete the request; and

(ii) the criteria and standards to support the need for the additional information.

(d) (1) (i) Except as provided in subsections (g) and (h) of this section, a private review agent shall make initial determinations on whether to authorize or certify an emergency course of treatment or health care service for a member within 24 hours after the initial request after receipt of the information necessary to make the determination.

(ii) If the private review agent determines that additional information is needed after confirming through a complete review of the information already submitted by the health care provider, the private review agent shall:

1. promptly request the specific information needed, including any lab or diagnostic test or other medical information; and

2. promptly, but not later than 2 hours after receipt of the information, notify the health care provider of an authorization or certification determination when made by the private review agent.

(2) A private review agent shall initiate the expedited procedure for an emergency case if the patient or the patient's representative requests or if the health care provider attests that the services are necessary to treat a condition or illness that, without immediate medical attention, would:

(i) seriously jeopardize the life or health of the member or the member's ability to regain maximum functions;

(ii) cause the member to be in danger to self or others; or

(iii) cause the member to continue using intoxicating substances in an imminently dangerous manner.

(e) If a private review agent fails to make a determination within the time limits required under this section, the request shall be deemed approved.

(f) (1) If an initial determination is made by a private review agent not to authorize or certify a health care service and the health care provider believes the determination warrants an immediate reconsideration, a private review agent shall provide the health care provider the opportunity to speak with the physician that rendered the determination, by telephone on an expedited basis, within a period of time not to exceed 24 hours of the health care provider seeking the reconsideration.

(2) If the physician is unable to immediately speak with the health care provider seeking the reconsideration, the physician shall provide the health care provider with the following contact information for the health care provider to use to contact the physician:

(i) a direct telephone number that is not the general customer call number; or

(ii) a monitored e–mail address that is dedicated to communication related to utilization review.

(g) For emergency inpatient admissions, a private review agent may not render an adverse decision solely because the hospital did not notify the private

review agent of the emergency admission within 24 hours or other prescribed period of time after that admission if the patient's medical condition prevented the hospital from determining:

(1) the patient's insurance status; and

(2) if applicable, the private review agent's emergency admission notification requirements.

(h) (1) Subject to paragraph (2) of this subsection, a private review agent may not render an adverse decision as to an admission of a patient during the first 24 hours after admission when:

(i) the admission is based on a determination that the patient is in imminent danger to self or others;

(ii) the determination has been made by the patient's physician or psychologist in conjunction with a member of the medical staff of the facility who has privileges to make the admission; and

(iii) the hospital immediately notifies the private review agent of:

1. the admission of the patient; and

2. the reasons for the admission.

(2) A private review agent may not render an adverse decision as to an admission of a patient to a hospital for up to 72 hours, as determined to be medically necessary by the patient's treating physician, when:

(i) the admission is an involuntary admission under §§ 10–615 and 10–617(a) of the Health – General Article; and

(ii) the hospital immediately notifies the private review agent of:

1. the admission of the patient; and

2. the reasons for the admission.

(i) (1) A private review agent that requires a health care provider to submit a treatment plan in order for the private review agent to conduct utilization

review of proposed or delivered services for the treatment of a mental illness, emotional disorder, or a substance abuse disorder:

(i) shall accept:

1. the uniform treatment plan form adopted by the Commissioner under § 15–10B–03(d) of this subtitle as a properly submitted treatment plan form; or

2. if a service was provided in another state, a treatment plan form mandated by the state in which the service was provided; and

(ii) may not impose any requirement to:

1. modify the uniform treatment plan form or its content; or

2. submit additional treatment plan forms.

(2) A uniform treatment plan form submitted under the provisions of this subsection:

(i) shall be properly completed by the health care provider; and

(ii) may be submitted by electronic transfer.

§15–10B–07.

(a) (1) Except as provided in paragraphs (2) and (3) of this subsection, all adverse decisions shall be made by a licensed physician, or a panel of other appropriate health care service reviewers with at least one physician on the panel, who is:

(i) board certified or eligible in the same specialty as the treatment under review; and

(ii) knowledgeable about the requested health care service or treatment through actual clinical experience.

(2) When the health care service under review is a mental health or substance abuse service, the adverse decision shall be made by a licensed physician, or a panel of other appropriate health care service reviewers with at least one licensed physician, selected by the private review agent who:

(i) is board certified or eligible in the same specialty as the treatment under review; or

(ii) is actively practicing or has demonstrated expertise in the substance abuse or mental health service or treatment under review.

(3) When the health care service under review is a dental service, the adverse decision shall be made by a licensed dentist, or a panel of other appropriate health care service reviewers with at least one licensed dentist on the panel who is knowledgeable about the requested health care service or treatment through actual clinical experience.

(b) All adverse decisions shall be made by a physician or a panel of other appropriate health care service reviewers who are not compensated by the private review agent in a manner that violates § 19–705.1 of the Health – General Article or that deters the delivery of medically appropriate care.

(c) Except as provided in subsection (d) of this section, if a course of treatment has been preauthorized or approved for a patient, a private review agent may not retrospectively render an adverse decision regarding the preauthorized or approved services delivered to that patient.

(d) A private review agent may retrospectively render an adverse decision regarding preauthorized or approved services delivered to a patient if:

(1) the information submitted to the private review agent regarding the services to be delivered to the patient was fraudulent or intentionally misrepresentative;

(2) critical information requested by the private review agent regarding services to be delivered to the patient was omitted such that the private review agent's determination would have been different had the agent known the critical information; or

(3) the planned course of treatment for the patient that was approved by the private review agent was not substantially followed by the provider.

(e) If a course of treatment has been preauthorized or approved for a patient, a private review agent may not revise or modify the specific criteria or standards used for the utilization review to make an adverse decision regarding the services delivered to that patient.

§15–10B–08.

(a) If a carrier delegates its internal grievance process to a private review agent, the private review agent shall establish an internal grievance process for its patients and health care providers acting on behalf of a patient.

(b) A private review agent's internal grievance process shall meet the same requirements established under §§ 15-10A-02 through 15-10A-05 of this title.

(c) A private review agent may not charge a fee to a patient or health care provider for filing a grievance.

§15–10B–09.

(a) In this section, "attending provider" means an obstetrician, pediatrician, or other physician or certified nurse midwife or pediatric nurse practitioner attending the mother or newborn child.

(b) Except as provided in subsections (c) and (d) of this section, the criteria and standards used by a private review agent or health maintenance organization in performing utilization review of hospital services related to maternity and newborn care, including length of stay, shall be in accordance with the medical criteria outlined in the most current version of the "Guidelines for Perinatal Care" prepared by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists.

(c) Subject to the provisions of subsection (d) of this section, a private review agent or health maintenance organization performing utilization review of hospital services related to maternity and newborn care shall authorize a minimum coverage of:

(1) 48 hours of inpatient hospitalization care following an uncomplicated vaginal delivery; and

(2) 96 hours of inpatient hospitalization care following an uncomplicated cesarean section.

(d) (1) The private review agent or health maintenance organization may authorize a shorter length of stay than that provided in subsection (c) of this section if the mother, in consultation with her attending provider, decides that less time is needed for recovery.

(2) For a mother and newborn child who have a hospital stay shorter in length than that provided under subsection (c) of this section, the private review

agent or health maintenance organization performing utilization review shall authorize:

(i) one home visit scheduled to occur within 24 hours after hospital discharge; and

(ii) an additional home visit as may be prescribed by the attending provider.

(3) For a mother and newborn child who remain in the hospital for at least the period of time provided under subsection (c) of this section, the private review agent or health maintenance organization performing utilization review shall authorize a home visit as may be prescribed by the attending provider.

(4) A home visit under paragraph (2) or (3) of this subsection shall:

(i) be provided in accordance with generally accepted standards of nursing practice for home care of a mother and newborn child;

(ii) be provided by a registered nurse with at least 1 year of experience in maternal and child health nursing or in community health nursing with an emphasis on maternal and child health; and

(iii) include any services required by the attending provider.

(e) (1) The private review agent or health maintenance organization may not require additional documentation from, require additional utilization review of, or otherwise provide financial disincentives for an attending provider who orders care for which coverage is required to be provided under this section, § 19-703 of the Health - General Article, or § 15-811 of this title.

(2) The private review agent, hospital, or health maintenance organization may not deny, limit, or otherwise impair the participation of an attending provider under a contract or any privilege granted an attending provider who advocates more than 48 hours of inpatient hospital care following a complicated vaginal delivery or more than 96 hours of inpatient hospital care following a complicated cesarean section.

§15–10B–09.1.

A grievance decision shall be made based on the professional judgment of:

(1) (i) a licensed physician who is board certified or eligible in the same specialty as the treatment under review and knowledgeable about the requested health care service or treatment through actual clinical experience; or

(ii) a panel of other appropriate health care service reviewers with at least one licensed physician on the panel who is board certified or eligible in the same specialty as the treatment under review and knowledgeable about the requested health care service or treatment through actual clinical experience;

(2) when the grievance decision involves a dental service, a licensed dentist, or a panel of appropriate health care service reviewers with at least one dentist on the panel who is a licensed dentist, who shall consult with a dentist who is board certified or eligible in the same specialty as the service under review and knowledgeable about the requested health care service or treatment through actual clinical experience; or

(3) when the grievance decision involves a mental health or substance abuse service:

(i) a licensed physician who:

1. is board certified or eligible in the same specialty as the treatment under review; or

2. is actively practicing or has demonstrated expertise in the substance abuse or mental health service or treatment under review; or

(ii) a panel of other appropriate health care service reviewers with at least one licensed physician, selected by the private review agent who:

1. is board certified or eligible in the same specialty as the treatment under review; or

2. is actively practicing or has demonstrated expertise in the substance abuse or mental health service or treatment under review.

§15–10B–10.

(a) A certificate expires on the second anniversary of its effective date unless the certificate is renewed for a 2-year term as provided in this section.

(b) Before the certificate expires, a certificate may be renewed for an additional 2-year term if the applicant:

(1) otherwise is entitled to the certificate;

(2) pays to the Commissioner the renewal fee set by the Commissioner through regulation; and

(3) submits to the Commissioner:

(i) a renewal application on the form that the Commissioner requires; and

(ii) satisfactory evidence of compliance with any requirement under this subtitle for certificate renewal.

(c) If the requirements of this section are met, the Commissioner shall renew a certificate.

§15–10B–11.

A private review agent may not:

(1) violate any provision of this subtitle or any rule or regulation adopted under this subtitle;

(2) fail to meet the requirements for certification under this subtitle;

(3) obtain or attempt to obtain certification based on inaccurate information;

(4) fraudulently or deceptively obtain or use a certificate;

(5) fail to make available the services of sufficient numbers of registered nurses, medical records technicians, or similarly qualified persons supported and supervised by appropriate physicians to carry out its utilization review activities;

(6) fail to meet any applicable regulations the Commissioner adopts under this subtitle relating to the qualifications of private review agents or the performance of utilization review;

(7) fail to protect the confidentiality of medical records in accordance with applicable State and federal laws;

(8) use criteria and standards to conduct utilization review unless the criteria and standards used by the private review agent are:

(i) objective;

(ii) clinically valid;

(iii) compatible with established principles of health care; or

(iv) flexible enough to allow deviations from norms when justified on a case-by-case basis; or

(9) act as a private review agent without holding a certificate issued under this subtitle.

§15–10B–12.

(a) (1) A person who violates any provision of § 15-10B-11 of this subtitle is guilty of a misdemeanor and on conviction is subject to a penalty not exceeding $1,000.

(2) Each day a violation is continued after the first conviction is a separate offense.

(b) In addition to the provisions of subsection (a) of this section, if any person violates any provision of § 15-10B-11 of this subtitle, the Commissioner may:

(1) deny, suspend, or revoke the certificate to do business as a private review agent;

(2) issue an order to cease and desist from acting as a private review agent without holding a certificate issued under this subtitle;

(3) require a private review agent to make restitution to a patient who has suffered actual economic damage because of the violation; and

(4) impose an administrative penalty of up to $5,000 for each violation of any provision of this subtitle.

§15–10B–13.

Any person aggrieved by an order of the Commissioner under this subtitle has the right to a hearing and the right to appeal from the action of the Commissioner in accordance with §§ 2-210 through 2-215 of this article.

§15–10B–14.

The Commissioner may waive the requirements of this subtitle for a private review agent that operates solely under contract with the federal government for utilization review of patients eligible for hospital services under Title XVIII of the Social Security Act.

§15–10B–15.

The Commissioner shall periodically provide a list of private review agents issued certificates and the renewal date for those certificates to any person on request.

§15–10B–16.

The Commissioner may establish reporting requirements to:

(1) evaluate the effectiveness of private review agents; and

(2) determine if the utilization review programs are in compliance with the provisions of this section and applicable regulations.

§15–10B–17.

(a) (1) Except as provided in paragraph (2) of this subsection, this section does not apply to:

(i) a private review agent referring an individual to a health care provider or facility that participates in a health maintenance organization;

(ii) a preferred provider organization network of participating health care providers or facilities to which the individual would otherwise be referred as part of the individual's membership or insurance contract; or

(iii) an employee assistance program referring an individual to a network of participating health care providers or facilities in accordance with a contract with the individual's employer or labor union to provide comprehensive mental health and substance abuse services.

(2) A private review agent or any other individual who is either affiliated with, under contract with, or acting on behalf of a private review agent may not approve or fail to approve a course of treatment based on whether the treatment is delivered by a provider who is a participating or nonparticipating provider in the preferred provider organization or employee assistance program network.

(b) A private review agent or any individual who is either affiliated with, under contract with, or acting on behalf of a private review agent may not:

(1) refer a patient who has undergone utilization review by the private review agent to:

(i) a health care facility in which the private review agent owns a significant beneficial interest; or

(ii) the private review agent's own health care practice;

(2) pay or agree to pay any sum to, or accept or agree to accept any sum from, any person for bringing or referring a patient to the private review agent; or

(3) provide for different insurance coverage or benefits based on receiving the service from a health care facility or health care provider in which the private review agent owns a significant beneficial interest.

(c) A private review agent or any individual who is either affiliated with, under contract with, or acting on behalf of a private review agent may refer a patient who has undergone utilization review by the private review agent to another health care provider regulated under the Health Occupations Article if:

(1) (i) the patient or provider requests the private review agent to provide the patient with the name of a health care provider appropriate to meet the health care needs of the patient; or

(ii) the patient has no attending physician; and

(2) the private review agent provides the patient with the names of at least two health care providers appropriate to meet the health care needs of the patient.

§15–10B–18.

(a) A private review agent shall advise the Commissioner, in writing, of its intention to withdraw its certificate within 60 days of intention to cease operations as a private review agent.

(b) A private review agent shall submit its certificate to the administration within 30 days after the date that the private review agent ceased operations.

§15–10B–19.

(a) Whenever the Commissioner considers it advisable, the Commissioner shall examine the affairs, transactions, accounts, records, and assets of each private review agent at least once every 5 years.

(b) The Commissioner shall examine the affairs, transactions, accounts, records, and assets of each private review agent that applies for a certificate of registration under § 15-10B-03 of this subtitle.

(c) The examination shall be conducted in accordance with § 2-207 of this article.

(d) The expense of the examination shall be paid in accordance with § 2-208 of this article.

(e) The reports of the examination and investigation shall be issued in accordance with § 2-209 of this article.

§15–10B–20.

(a) In addition to the requirements under § 15-10B-19 of this subtitle, the Commissioner shall conduct an examination of any pharmacy benefit manager registered as a private review agent to determine whether the pharmacy benefit manager is acting in compliance with this subtitle.

(b) The examination shall be conducted:

(1) in accordance with § 2-207 of this article; and

(2) at least once every 3 years.

(c) The expense of the examination shall be paid in accordance with § 2-208 of this article.

(d) The reports of the examination shall be issued in accordance with § 2-209 of this article.

(e) Within 30 days after the completion of a final report of an examination under this section, the Commissioner shall submit a copy of the report to the Senate Finance Committee and the House Health and Government Operations Committee in accordance with § 2–1257 of the State Government Article.

§15–10B–21.

(a) The Commissioner may conduct an examination of a carrier that has issued a pattern of adverse decisions or grievance decisions for a claim or authorization request for services in, or related to services in, an emergency department.

(b) A carrier examined under subsection (a) of this section shall produce all documents related to an adverse decision or grievance decision described under subsection (a) of this section, including documents or electronic documents in the possession of a private review agent acting on behalf of the carrier.

(c) (1) The Commissioner may have an adverse decision or grievance decision described under subsection (a) of this section reviewed by an independent review organization.

(2) The costs of a review conducted under paragraph (1) of this subsection shall be paid by the carrier.

§15–10C–01.

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

(b) "Board" means the State Board of Physicians established under Title 14 of the Health Occupations Article.

(c) "Certificate" means a certificate issued by the Commissioner under this subtitle to act as a medical director.

(d) "Department" means the Maryland Department of Health.

(e) "Health maintenance organization" has the meaning stated in § 19–701 of the Health – General Article.

(f) (1) "Medical director" means a physician employed by or under contract with a health maintenance organization who is responsible for:

(i) the establishment or maintenance of the policies and procedures at the health maintenance organization for:

1. quality assurance; and

2. utilization management;

(ii) compliance with the quality assurance and utilization management policies and procedures of the health maintenance organization; and

(iii) oversight of utilization review decisions of private review agents employed by or under contract with the health maintenance organization.

(2) "Medical director" includes an associate medical director or an assistant medical director, as defined by the Commissioner by regulation.

§15–10C–02.

The Commissioner, in consultation with the Department and the Board, shall establish and adopt by regulation standards for:

(1) the certification of medical directors;

(2) the renewal, suspension, and revocation of a certificate; and

(3) the issuance of a temporary certificate.

§15–10C–03.

(a) To be certified as a medical director under this subtitle, an applicant shall:

(1) submit an application to the Commissioner on the form required by the Commissioner; and

(2) pay to the Commissioner an application fee of no more than $100 established by the Commissioner by regulation.

(b) The application shall include:

(1) a description of the applicant's professional qualifications, including medical education information and, if appropriate, board certifications and licensure status;

(2) the utilization management procedures and policies to be used by the health maintenance organization; and

(3) certification by the medical director that the utilization management procedures and policies are:

(i) objective;

(ii) clinically valid;

(iii) compatible with established principles of health care; and

(iv) flexible enough to allow deviations from the norms when justified on a case by case basis.

(c) The delegation by a medical director of any of the medical director's responsibilities under this subtitle to an associate medical director or an assistant medical director does not prevent the medical director, regardless of the delegation, from being held responsible for any violation of this subtitle.

§15–10C–04.

(a) Subject to the hearing procedures in §§ 2-210 through 2-214 of this article, the Commissioner may suspend, revoke, or refuse to renew a certificate of a medical director if the Commissioner finds a pattern that the utilization management procedures and policies used by the medical director in making utilization review decisions or used by a private review agent employed by or under contract with the health maintenance organization over whose utilization review decisions the medical director has responsibility are not:

(1) objective;

(2) clinically valid;

(3) compatible with established principles of health care; or

(4) flexible enough to allow deviations from the norms when justified on a case by case basis.

(b) The Commissioner may consult with an independent review organization or medical expert that meets the requirements of § 15-10A-05 of this title, the Department, the Board, or any other appropriate entity for purposes of taking an action described under subsection (a) of this section.

§15–10D–01.

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

(b) "Appeal" means a protest filed by a member, a member's representative, or a health care provider with a carrier under its internal appeal process regarding a coverage decision concerning a member.

(c) "Appeal decision" means a final determination by a carrier that arises from an appeal filed with the carrier under its appeal process regarding a coverage decision concerning a member.

(d) "Carrier" means a person that offers a health benefit plan and is:

(1) an authorized insurer that provides health insurance in the State;

(2) a nonprofit health service plan;

(3) a health maintenance organization;

(4) a dental plan organization;

(5) a self–funded student health plan operated by an independent institution of higher education, as defined in § 10–101 of the Education Article, that provides health care to its students and their dependents; or

(6) except for a managed care organization, as defined in Title 15, Subtitle 1 of the Health – General Article, any other person that offers a health benefit plan subject to regulation by the State.

(e) "Complaint" means a protest filed with the Commissioner involving a coverage decision other than that which is covered by Subtitle 10A of this title.

(f) (1) "Coverage decision" means:

(i) an initial determination by a carrier or a representative of the carrier that results in noncoverage of a health care service;

(ii) a determination by a carrier that an individual is not eligible for coverage under the carrier's health benefit plan; or

(iii) any determination by a carrier that results in the rescission of an individual's coverage under a health benefit plan.

(2) "Coverage decision" includes nonpayment of all or any part of a claim.

(3) "Coverage decision" does not include:

(i) an adverse decision as defined in § 15–10A–01(b) of this title; or

(ii) a pharmacy inquiry.

(g) "Designee of the Commissioner" means any person to whom the Commissioner has delegated the authority to review and decide complaints filed under this subtitle, including an administrative law judge to whom the authority to conduct a hearing has been delegated for recommended or final decision.

(h) (1) "Health benefit plan" means:

(i) a hospital or medical policy or contract, including a policy or contract issued under a multiple employer trust or association;

(ii) a hospital or medical policy or contract issued by a nonprofit health service plan;

(iii) a health maintenance organization contract; or

(iv) a dental plan organization contract.

(2) "Health benefit plan" does not include one or more, or any combination of the following:

(i) long–term care insurance;

(ii) disability insurance;

(iii) accidental travel and accidental death and dismemberment insurance;

(iv) credit health insurance;

(v) a health benefit plan issued by a managed care organization, as defined in Title 15, Subtitle 1 of the Health – General Article;

(vi) disease–specific insurance; or

(vii) fixed indemnity insurance.

(i) "Health care provider" means:

(1) an individual who is licensed under the Health Occupations Article to provide health care services in the ordinary course of business or practice of a profession and is a treating provider of the member; or

(2) a hospital, as defined in § 19–301 of the Health – General Article.

(j) "Health care service" means a health or medical care procedure or service rendered by a health care provider that:

(1) provides testing, diagnosis, or treatment of a human disease or dysfunction; or

(2) dispenses drugs, medical devices, medical appliances, or medical goods for the treatment of a human disease or dysfunction.

(k) (1) "Member" means:

(i) a person entitled to health care services under a policy, plan, or contract issued or delivered in the State by a carrier; or

(ii) with regard to an individual who is determined by a carrier not to be eligible for a health benefit plan, an individual who has applied for coverage under a health benefit plan.

(2) "Member" includes:

(i) a subscriber; and

(ii) unless preempted by federal law, a Medicare recipient.

(3) "Member" does not include a Medicaid recipient.

(l) "Member's representative" means an individual who has been authorized by the member to file an appeal or a complaint on behalf of the member.

(m) "Pharmacy benefits manager" has the meaning stated in § 15–1601 of this title.

(n) "Pharmacy inquiry" means an inquiry submitted by a pharmacist or pharmacy on behalf of a member to a carrier or a pharmacy benefits manager at the point of sale about the scope of pharmacy coverage, pharmacy benefit design, or formulary under a health benefit plan.

§15–10D–02.

(a) (1) Each carrier shall establish an internal appeal process for use by its members, its members' representatives, and health care providers to dispute coverage decisions made by the carrier.

(2) The carrier may use the internal grievance process established under Subtitle 10A of this title to comply with the requirement of paragraph (1) of this subsection.

(b) A carrier under this section shall render a final decision in writing to a member, a member's representative, and a health care provider acting on behalf of the member within 60 working days after the date on which the appeal is filed.

(c) Except as provided in subsection (d) of this section, the carrier's internal appeal process shall be exhausted prior to filing a complaint with the Commissioner under this subtitle.

(d) A member, a member's representative, or a health care provider filing a complaint on behalf of a member may file a complaint with the Commissioner without first filing an appeal with a carrier only if the coverage decision involves an urgent medical condition, as defined by regulation adopted by the Commissioner, for which care has not been rendered.

(e) (1) Within 30 calendar days after a coverage decision has been made, a carrier shall send a written notice of the coverage decision to the member and the member's representative, if any, and, in the case of a health maintenance organization, the treating health care provider.

(2) Notice of the coverage decision required to be sent under paragraph (1) of this subsection shall:

(i) state in detail in clear, understandable language, the specific factual bases for the carrier's decision; and

(ii) include the following information:

1. that the member, the member's representative, or a health care provider acting on behalf of the member has a right to file an appeal with the carrier;

2. that the member, the member's representative, or a health care provider acting on behalf of the member may file a complaint with the Commissioner without first filing an appeal, if the coverage decision involves an urgent medical condition for which care has not been rendered;

3. the Commissioner's address, telephone number, and facsimile number;

4. that the Health Advocacy Unit is available to assist the member or the member's representative in both mediating and filing an appeal under the carrier's internal appeal process; and

5. the address, telephone number, facsimile number, and electronic mail address of the Health Advocacy Unit.

(f) (1) Within 30 calendar days after the appeal decision has been made, each carrier shall send to the member, the member's representative, and the health care provider acting on behalf of the member a written notice of the appeal decision.

(2) Notice of the appeal decision required to be sent under paragraph (1) of this subsection shall:

(i) state in detail in clear, understandable language the specific factual bases for the carrier's decision; and

(ii) include the following information:

1. that the member, the member's representative, or a health care provider acting on behalf of the member has a right to file a complaint with the Commissioner within 4 months after receipt of a carrier's appeal decision;

2. the Commissioner's address, telephone number, and facsimile number;

3. a statement that the Health Advocacy Unit is available to assist the member in filing a complaint with the Commissioner; and

4. the address, telephone number, facsimile number, and electronic mail address of the Health Advocacy Unit.

(g) The Commissioner may request the member that filed the complaint or a legally authorized designee of the member to sign a consent form authorizing the release of the member's medical records to the Commissioner or the Commissioner's designee that are needed in order for the Commissioner to make a final decision on the complaint.

(h) (1) A carrier shall have the burden of persuasion that its coverage decision or appeal decision, as applicable, is correct:

(i) during the review of a complaint by the Commissioner or a designee of the Commissioner; and

(ii) in any hearing held in accordance with Title 10, Subtitle 2 of the State Government Article to contest a final decision of the Commissioner made and issued under this subtitle.

(2) As part of the review of a complaint, the Commissioner or a designee of the Commissioner may consider all of the facts of the case and any other evidence that the Commissioner or designee of the Commissioner considers appropriate.

(i) The Commissioner shall:

(1) make and issue in writing a final decision on all complaints filed with the Commissioner under this subtitle that are within the Commissioner's jurisdiction; and

(2) provide notice in writing to all parties to a complaint of the opportunity and time period for requesting a hearing to be held in accordance with Title 10, Subtitle 2 of the State Government Article to contest a final decision of the Commissioner made and issued under this subtitle.

§15–10D–03.

(a) It is a violation of this subtitle for a carrier to fail to fulfill the carrier's obligations to provide or reimburse for health care services specified in the carrier's policies or contracts with members.

(b) If, in rendering a coverage decision or appeal decision, a carrier fails to fulfill the carrier's policies or contracts with members, the Commissioner may:

(1) issue an administrative order that requires the carrier to:

(i) cease inappropriate conduct or practices by the carrier or any of the personnel employed or associated with the carrier;

(ii) fulfill the carrier's contractual obligations;

(iii) provide a health care service or payment that has been denied improperly; or

(iv) take appropriate steps to restore the carrier's ability to provide a health care service or payment that is provided under a contract; or

(2) impose any penalty or fine or take any action as authorized:

(i) for an insurer, nonprofit health service plan, or dental plan organization, under this article; or

(ii) for a health maintenance organization, under the Health - General Article or under this article.

§15–10D–04.

The Commissioner may adopt any necessary regulations to carry out the provisions of this subtitle.

§15–10D–05.

A carrier shall provide the notices required to be provided to members under this subtitle in a culturally and linguistically appropriate manner as described in the Affordable Care Act.

§15–1102.

(a) In this section, "employee" includes:

(1) an officer, manager, or retired employee of an employer;

(2) a sole proprietor if the employer is a sole proprietorship; and

(3) a partner if the employer is a partnership.

(b) Health insurance on a franchise plan is the form of health insurance:

(1) that is issued to:

(i) three or more employees of a corporation, partnership, sole proprietorship, or governmental corporation, agency, or department; or

(ii) ten or more members, employees, or employees of members of a labor union, or trade, professional, or other association, that is organized in good faith for purposes other than obtaining insurance, has a constitution or bylaws, and has had an active existence for at least 2 years;

(2) under which the individuals insured, with or without their dependents, are issued the same form of an individual policy that varies only as to amounts and kinds of coverage applied for; and

(3) under which the premiums on the individual policies may be paid to the insurer periodically by:

(i) the employer, with or without payroll deductions;

(ii) the labor union or association for its members; or

(iii) a designated person acting on behalf of the employer, labor union, or association.

§15–1103.

(a) In this section, "transportation ticket policy" means a ticket policy of health insurance that:

(1) has as its dominant feature the protection of the insured from a transportation hazard; and

(2) is sold at transportation stations, ticket offices, or travel bureaus by:

(i) vending machines;

(ii) employees of railroads, steam lines, airlines, or other organizations engaged in transporting individuals on common carriers;

(iii) individuals or employees of persons engaged in selling transportation on common carriers; or

(iv) other qualified agents.

(b) A transportation ticket policy may not be issued or delivered in the State unless it conforms to the requirements and provisions of §§ 15-102, 15-201, 15-202, 15-203, 15-205, and 15-207 through 15-226 of this title, subject to § 15-202(c) of this title that relates to inapplicable or inconsistent provisions.

§15–1104.

(a) (1) In this section the following words have the meanings indicated.

(2) "Employer sponsored health benefit plan" means any plan, fund, or program that:

(i) is established or maintained by an employer under the Employee Retirement Income Security Act of 1974;

(ii) offers coverage for health benefits; and

(iii) is treated by the employer or any eligible employee or dependent as part of a plan, fund, or program under the United States Internal Revenue Code, 26 U.S.C. § 106, § 125, or § 162.

(3) "Group health insurance" has the meaning stated in § 15–302 of this title.

(4) "Limited benefit group health insurance contract" means a group health insurance contract that provides health insurance benefits, but is not required to provide all the benefits required under Subtitles 7 and 8 of this title.

(5) "Special eligible employee" means an employee who:

(i) is eligible for health coverage under the terms of an employer sponsored health benefit plan;

(ii) works:

1. on a temporary or substitute basis; or

2. less than 30 hours in a normal workweek; and

(iii) is not eligible for coverage under any group health insurance contract, nonprofit health service plan contract, or health maintenance organization contract issued to the employee's employer because the employee meets the criteria of item (ii) of this paragraph.

(b) A limited benefit group health insurance contract may be issued only by an insurer or nonprofit health service plan to an employer if the limited group health insurance contract is issued to provide health coverage only for:

(1) special eligible employees; or

(2) special eligible employees and their dependents.

(c) An insurer or nonprofit health service plan that sells a limited benefit group health insurance contract, as a condition of sale, may require the employer to:

(1) collect payment for premiums due under the limited benefit group health insurance contract through payroll deduction;

(2) contribute to the premium payments applicable to the coverage of a special eligible employee; and

(3) offer coverage to any dependent of a special eligible employee.

(d) A limited benefit group health insurance contract shall comply with:

(1) this title, except Subtitles 7 and 8 of this title; and

(2) notwithstanding item (1) of this subsection, §§ 15–802, 15–812, 15–815, 15–830, 15–831, 15–832, and 15–833 of this title.

(e) An insurer or nonprofit health service plan shall disclose in the group certificate and in enrollment material provided to each special eligible employee that the limited benefit group health insurance contract does not provide comprehensive health coverage.

§15–1106.

(a) (1) In this section the following words have the meanings indicated.

(2) "Carrier" means:

(i) an insurer;

(ii) a nonprofit health service plan; or

(iii) a health maintenance organization.

(3) "Evidence of individual insurability" has the meaning stated in § 15–1105 of this subtitle.

(4) "Health benefit plan" has the meaning stated in § 15–1301 of this title.

(b) If a carrier conditions coverage for a health benefit plan on evidence of individual insurability, the carrier may not rescind a contract or a certificate on the basis of written information submitted on or with, or omitted from, an application for the health benefit plan unless the carrier completed medical underwriting and resolved all reasonable medical questions related to the written information

submitted on or with, or omitted from, the application before issuing the health benefit plan.

(c) The carrier shall have the burden of persuasion that its rescission of a health benefit plan complies with subsection (b) of this section.

§15–1201.

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

(b) "Board" means the Board of Directors of the Pool established under § 15–1216 of this subtitle.

(c) "Carrier" means a person that:

(1) offers health benefit plans in the State covering eligible employees of small employers; and

(2) is:

(i) an authorized insurer that provides health insurance in the State;

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

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

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

(d) "Commission" means the Maryland Health Care Commission established under Title 19, Subtitle 1 of the Health – General Article.

(e) "Coverage level" has the meaning stated in § 31–101 of this article.

(f) (1) "Eligible employee" means an employee who is offered coverage under a health benefit plan by a small employer.

(2) "Eligible employee", at the option of the small employer, may include:

(i) only full–time employees; or

(ii) full–time employees and part–time employees.

(g) "Employee" means an individual who is employed by a small employer.

(h) (1) "Full–time employee" means, with respect to a calendar month, an employee of a small employer who works, on average, at least 30 hours per week.

(2) "Full–time employee" does not include a seasonal employee as defined in federal law.

(i) (1) "Health benefit plan" means:

(i) a policy or certificate for hospital or medical benefits issued by an insurer;

(ii) a nonprofit health service plan contract; or

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

(2) "Health benefit plan" includes a policy or certificate for hospital or medical benefits that covers residents of this State who are eligible employees and that is issued through:

(i) a multiple employer trust or association located in this State or another state; or

(ii) a professional employer organization, coemployer, or other organization located in this State or another state that engages in employee leasing.

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

(i) accident–only insurance;

(ii) credit health insurance;

(iii) disability income insurance;

(iv) coverage issued as a supplement to liability insurance;

(v) workers' compensation or similar insurance;

(vi) automobile medical payment insurance;

(vii) the following benefits, if the benefits are provided under a separate policy, certificate, or contract, or are not otherwise an integral part of a small employer health benefit plan:

1. dental benefits;

2. vision benefits; or

3. long–term care insurance as defined in § 18–101 of this article;

(viii) disease–specific insurance if:

1. the benefits are provided under a separate policy, certificate, or contract;

2. there is no coordination between the provision of the benefits and an exclusion of benefits under any group health plan maintained by the same employer; and

3. the benefits are paid with respect to an event, without regard to whether benefits are provided with respect to the event under any group health plan maintained by the same employer;

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

1. the benefits are provided under a separate policy, certificate, or contract;

2. there is no coordination between the provision of the benefits and an exclusion of benefits under any group health plan maintained by the same employer;

3. the benefits are paid with respect to an event, without regard to whether benefits are provided with respect to the event under any group health plan maintained by the same employer; and

4. the benefits are payable in a fixed dollar amount per period of time, regardless of the amount of expenses incurred; or

(x) the following supplemental benefits, if the benefits are provided under a separate policy, certificate, or contract:

1. a Medicare supplement policy as defined in § 15–901 of this title;

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

3. similar supplemental coverage provided to coverage under a group health plan if the coverage qualifies for the exception described in 45 C.F.R. § 146.145(b)(5)(i)(C).

(j) "Health care practitioner" has the meaning stated in § 1–301 of the Health Occupations Article.

(k) "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.

(l) "Late enrollee" means an eligible employee or dependent who requests enrollment in a health benefit plan after the initial enrollment period provided under the health benefit plan.

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

(n) "Part–time employee" means an employee of a small employer who:

(1) has a normal workweek of at least 17.5 hours; and

(2) is not a full–time employee.

(o) "Plan year" means a calendar year or other consecutive 12–month period during which a health benefit plan provides coverage for health care services.

(p) "Pool" means the Maryland Small Employer Health Reinsurance Pool established under this subtitle.

(q) "Preexisting condition" means:

(1) a condition existing during a specified period immediately preceding the effective date of coverage, that would have caused an ordinarily prudent person to seek medical advice, diagnosis, care, or treatment; or

(2) a condition for which medical advice, diagnosis, care, or treatment was recommended or received during a specified period immediately preceding the effective date of coverage.

(r) "Preexisting condition provision" means a provision in a health benefit plan that denies, excludes, or limits benefits for an enrollee for expenses or services related to a preexisting condition.

(s) "Qualified employer" has the meaning stated in § 31–101 of this article.

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

(u) "Reinsuring carrier" means a carrier that participates in the Pool.

(v) "Risk–assuming carrier" means a carrier that does not participate in the Pool.

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

(x) "Small employer" has the meaning stated in § 31–101 of this article.

(y) "Special enrollment period" means a period during which a group health plan shall permit certain individuals who are eligible for coverage, but not enrolled, to enroll for coverage under the terms of the group health benefit plan.

(z) "Standard Plan" means the Comprehensive Standard Health Benefit Plan adopted by the Commission in accordance with § 15–1207 of this subtitle and Title 19, Subtitle 1 of the Health – General Article.

(aa) "Wellness benefit" means a benefit that:

(1) includes a bona fide wellness program as defined in § 15–509 of this title; and

(2) complies with regulations adopted by the Commission.

(bb) (1) "Wellness program" means a program or activity that:

(i) is designed to improve health status and reduce health care costs; and

(ii) complies with guidelines developed by the Commission.

(2) "Wellness program" includes programs and activities for:

(i) smoking cessation;

(ii) reduction of alcohol misuse;

(iii) weight reduction;

(iv) nutrition education; and

(v) automobile and motorcycle safety.

§15–1202.

(a) This subtitle applies only to a health benefit plan that:

(1) covers eligible employees of small employers in the State; and

(2) is issued or renewed on or after July 1, 1994, if:

(i) any part of the premium or benefits is paid by or on behalf of the small employer;

(ii) any eligible employee or dependent is reimbursed, through wage adjustments or otherwise, by or on behalf of the small employer for any part of the premium;

(iii) the health benefit plan is treated by the employer or any eligible employee or dependent as part of a plan or program under the United States Internal Revenue Code, 26 U.S.C. § 106, § 125, or § 162; or

(iv) the small employer allows eligible employees to pay for the health benefit plan through payroll deductions.

(b) This subtitle applies to any health benefit plan offered by an association, a professional employer organization, or any other entity, including a plan issued under the laws of another state, if the health benefit plan covers eligible employees of one or more small employers and meets the requirements of subsection (a) of this section.

§15–1204.

(a) This section applies to a carrier with respect to any health benefit plan that is a grandfathered health plan, as defined in § 1251 of the Affordable Care Act.

(b) In addition to any other requirement under this article, a carrier shall:

(1) have demonstrated the capacity to administer the health benefit plan, including adequate numbers and types of administrative personnel;

(2) have a satisfactory grievance procedure and ability to respond to enrollees' calls, questions, and complaints;

(3) provide, in the case of individuals covered under more than one health benefit plan, for coordination of coverage under all of those health benefit plans in an equitable manner; and

(4) design policies to help ensure adequate access to providers of health care.

(c) A person may not offer a health benefit plan in the State unless the person offers at least the Standard Plan.

(d) A carrier may not offer a health benefit plan that has fewer benefits than those in the Standard Plan.

(e) A carrier may offer benefits in addition to those in the Standard Plan if:

(1) the additional benefits:

(i) are offered and priced separately from benefits specified in accordance with § 15–1207 of this subtitle; and

(ii) do not have the effect of duplicating any of those benefits; and

(2) the carrier:

(i) clearly distinguishes the Standard Plan from other offerings of the carrier;

(ii) indicates the Standard Plan is the only plan required by State law; and

(iii) specifies that all enhancements to the Standard Plan are not required by State law.

(f) Notwithstanding subsection (c) of this section, a health maintenance organization may provide a point of service delivery system as an additional benefit through another carrier regardless of whether the other carrier also offers the Standard Plan.

(g) A carrier may offer coverage for dental care and services as an additional benefit.

(h) (1) In this subsection, "prominent carrier" means a carrier that insures at least 10% of the total lives insured in the small group market.

(2) (i) A prominent carrier shall offer a wellness benefit for a health benefit plan offered under this subtitle.

(ii) A carrier that is not a prominent carrier may offer a wellness benefit for a health benefit plan offered under this subtitle.

(3) A carrier may not condition the sale of a wellness benefit to a small employer on participation of the eligible employees of the small employer in wellness programs or activities.

§15–1204.1.

(a) This section applies to a carrier with respect to any health benefit plan that:

(1) is not a grandfathered health plan, as defined in § 1251 of the Affordable Care Act; and

(2) is issued, delivered, or renewed in the State on or after January 1, 2014.

(b) (1) Except as provided in this subsection and § 31–110(f) of this article, a carrier may not offer health benefit plans to small employers in the State unless the carrier also offers qualified health plans, as defined in § 31–101 of this article, in the Small Business Health Options Program of the Maryland Health Benefit Exchange in compliance with the requirements of Title 31 of this article.

(2) A carrier is exempt from the requirement in paragraph (1) of this subsection if:

(i) the reported total aggregate annual earned premium from all health benefit plans offered to small employers in the State for the carrier and any other carriers in the same insurance holding company system, as defined in § 7–101 of this article, is less than $20,000,000;

(ii) the Commissioner determines that the carrier complies with the procedures established under paragraph (3) of this subsection; and

(iii) when the carrier ceases to meet the requirements for the exemption, the carrier provides to the Commissioner immediate notice and its plan for complying with the requirement in paragraph (1) of this subsection.

(3) The Commissioner shall establish procedures for a carrier to submit evidence each year that the carrier meets the requirements necessary to qualify for an exemption under paragraph (2) of this subsection.

(4) Notwithstanding the exemption provided in paragraph (2) of this subsection, the Commissioner, in consultation with the Maryland Health Benefit Exchange:

(i) may assess the impact of the exemption provided in paragraph (2) of this subsection and, based on that assessment, alter the limit on the amount of annual premiums that may not be exceeded to qualify for the exemption; and

(ii) shall make any change in the exemption requirement by regulation.

§15–1205.

(a) (1) This subsection applies to a carrier with respect to any health benefit plan that is a grandfathered health plan, as defined in § 1251 of the Affordable Care Act.

(2) In establishing a community rate for a health benefit plan, a carrier shall use a rating methodology that is based on the experience of all risks covered by that health benefit plan without regard to any factor not specifically authorized under this subsection or subsection (g) of this section.

(3) A carrier may adjust the community rate only for:

(i) age;

(ii) geography based on the following contiguous areas of the State:

1. the Baltimore metropolitan area;

2. the District of Columbia metropolitan area;

3. Western Maryland; and

4. Eastern and Southern Maryland; and

(iii) health status, as provided in subsection (g) of this section.

(4) Rates for a health benefit plan may vary based on family composition as approved by the Commissioner.

(5) (i) Subject to subparagraph (ii) of this paragraph, after applying the risk adjustment factors under paragraph (3) of this subsection, a carrier may offer a discount not to exceed 20% to a small employer for participation in a wellness program.

(ii) A discount offered under subparagraph (i) of this paragraph shall be:

1. applied to reduce the rate otherwise payable by the small employer;

2. actuarially justified;

3. offered uniformly to all small employers; and

4. approved by the Commissioner.

(b) (1) This subsection applies to a carrier with respect to any health benefit plan that:

(i) is not a grandfathered health plan, as defined in § 1251 of the Affordable Care Act; and

(ii) is issued, delivered, or renewed in the State on or after January 1, 2014.

(2) In establishing a premium rate for a health benefit plan, a carrier shall use a rating methodology that is based on the experience of all risks covered by that health benefit plan without regard to any factor not specifically authorized under this subsection.

(3) In accordance with § 2701(a) of the Affordable Care Act, a premium rate may vary only by:

(i) whether the health benefit plan covers an individual or a family;

(ii) rating area;

(iii) age, except that a rate may not vary by more than 3 to 1 for adults; and

(iv) tobacco use, except that a rate may not vary by more than 1.5 to 1.

(4) A rate may not vary by any factor that is not specified in paragraph (3) of this subsection.

(c) (1) A carrier shall apply all risk adjustment factors under subsections (a) and (g) of this section consistently with respect to all health benefit plans that are:

(i) issued, delivered, or renewed in the State; and

(ii) grandfathered health plans, as defined in § 1251 of the Affordable Care Act.

(2) A carrier shall apply all risk adjustment factors under subsection (b) of this section consistently with respect to all health benefit plans that are:

(i) issued, delivered, or renewed in the State; and

(ii) not grandfathered health plans, as defined in § 1251 of the Affordable Care Act.

(d) (1) This subsection applies to a carrier with respect to any health benefit plan that is a grandfathered health plan.

(2) Based on the adjustments allowed under subsection (a)(3)(i) and (ii) of this section, a carrier may charge a rate that is 50% above or 50% below the community rate.

(3) On or before October 1, 2007, the Commission shall adopt regulations that require carriers to collect and report to the Commission data on participation, by rate band, in health benefit plans issued, delivered, or renewed under this subtitle.

(e) (1) A carrier shall base its rating methods and practices on commonly accepted actuarial assumptions and sound actuarial principles.

(2) A carrier that is a health maintenance organization and that includes a subrogation provision in its contract as authorized under § 19–713.1(d) of the Health – General Article shall:

(i) use in its rating methodology an adjustment that reflects the subrogation; and

(ii) identify in its rate filing with the Administration, and annually in a form approved by the Commissioner, all amounts recovered through subrogation.

(f) (1) This subsection applies to a carrier with respect to any health benefit plan that is a grandfathered health plan, as defined in § 1251 of the Affordable Care Act.

(2) A carrier may offer an administrative discount to a small employer if the small employer elects to purchase, for its employees, an annuity, dental insurance, disability insurance, life insurance, long–term care insurance, vision insurance, or, with the approval of the Commissioner, any other insurance sold by the carrier.

(3) The administrative discount shall be offered under the same terms and conditions for all qualifying small employers.

(g) (1) A carrier may adjust the community rate for a health benefit plan that is a grandfathered health plan, as defined in § 1251 of the Affordable Care Act,

for health status only if a small employer has not offered a health benefit plan issued under this subtitle to its employees in the 12 months prior to the initial enrollment of the small employer in the health benefit plan.

(2) (i) Based on the adjustment allowed under paragraph (1) of this subsection, in addition to the adjustments allowed under subsection (d)(1) of this section, a carrier may charge:

1. in the first year of enrollment, a rate that is 10% above or below the community rate;

2. in the second year of enrollment, a rate that is 5% above or below the community rate; and

3. in the third year of enrollment, a rate that is 2% above or below the community rate.

(ii) A carrier may not make any adjustment for health status in the community rate of a health benefit plan issued under this subtitle after the third year of enrollment of a small employer in the health benefit plan.

(3) For a health benefit plan that is a grandfathered health plan, as defined in § 1251 of the Affordable Care Act, a carrier may use health statements, in a form approved by the Commissioner, and health screenings to establish an adjustment to the community rate for health status as provided in this subsection.

(4) A carrier may not limit coverage offered by the carrier, or refuse to issue a health benefit plan to any small employer that meets the requirements of this subtitle, based on a health status–related factor.

(5) It is an unfair trade practice for a carrier knowingly to provide coverage to a small employer that discriminates against an employee or applicant for employment, based on the health status of the employee or applicant or a dependent of the employee or applicant, with respect to participation in a health benefit plan sponsored by the small employer.

(h) A carrier shall set premium rates for the entire plan year for each small employer.

§15–1206.

(a) (1) A carrier may not arbitrarily transfer a small employer involuntarily into or out of a health benefit plan.

(2) A carrier may not offer to transfer a small employer into or out of a health benefit plan unless the offer to transfer is made to all small employers with similar risk adjustment factors.

(b) A carrier shall make a reasonable disclosure in its solicitation and sales materials of:

(1) the provisions that relate to the carrier's right to change premium rates, including any factors that may affect the changes in premium rates;

(2) the provisions that relate to renewability of policies and contracts;

(3) the provisions that relate to preexisting conditions; and

(4) the provisions of § 15–1209 of this subtitle that require an employer to make dependent coverage available to eligible employees but do not require the employer to make a contribution to the premium payments for that dependent coverage.

(c) (1) Subject to the approval of the Commissioner and as provided under this subsection and § 15–1209(d) of this subtitle, a carrier may impose reasonable minimum participation requirements.

(2) A carrier may not impose a requirement for minimum participation by the eligible employees of a small employer that is greater than 75%.

(3) In applying a minimum participation requirement to determine whether the applicable percentage of participation is met, a carrier may not consider as eligible employees:

(i) those who have group spousal coverage under a public or private plan of health insurance or another employer's health benefit arrangement, including Medicare, Medicaid, and CHAMPUS, that provides benefits similar to or exceeding the benefits provided under a bronze level health plan as described in 45 C.F.R. § 156.140; or

(ii) employees who are under the age of 26 years who are covered under their parent's health benefit plan.

(4) A carrier may not impose a minimum participation requirement for a small employer group if any member of the group participates in a medical savings account.

(5) A carrier may not impose a minimum participation requirement for a qualified employer if the qualified employer designates a coverage level within which its employees may choose any qualified health plan in the SHOP Exchange, as provided for in § 31–111(c)(1) of this article.

(6) A carrier may not impose a minimum participation requirement for a small employer group if the small employer group applies for coverage during the period that begins on November 15 and extends through December 15 of any year.

(d) (1) On or before March 15 of each year, each carrier shall file an actuarial certification with the Commissioner.

(2) The actuarial certification shall be written in a form that the Commissioner approves, by a member of the American Academy of Actuaries or another person acceptable to the Commissioner and shall state that the carrier is in compliance with this subtitle and has followed the rating practices imposed under § 15–1205 of this subtitle.

(3) The actuarial certification shall be based on an examination that includes a review of appropriate records and actuarial assumptions and methods used by the carrier.

(e) (1) To indicate compliance with subsections (b) and (c)(1) of this section and § 15–1205(e) of this subtitle, a carrier shall maintain information and documentation that is satisfactory to the Commissioner.

(2) A carrier shall:

(i) retain all information and documentation required under this subtitle at its principal place of business for a period of 5 years; and

(ii) make the information and documentation available to the Commissioner on request.

(f) A carrier may not implement a producer commission schedule that varies the amount of a commission based on the size of a small employer group unless the variation:

(1) is inversely related to the size of the small employer group;

(2) applies to the cumulative premium paid over a specific period of time, is uniformly applied, and is inversely related to the cumulative premium paid during the period of time; or

(3) is established by a contract between the carrier and each outside producer, and the carrier:

(i) specifies in the contract the group size to which the variation applies;

(ii) directs the outside producer to refer small employers of the specified size to an employee of the carrier who is a licensed producer or to a company affiliated with the carrier through common ownership within an insurance holding company; and

(iii) pays a commission to the employee producer described in item (ii) of this item.

(g) (1) A licensed insurance producer, in connection with the sale, solicitation, or negotiation of a health benefit plan to a small employer, shall:

(i) provide information to the small employer about wellness benefits; and

(ii) advise the small employer to consult a tax advisor about the tax advantages of a payroll deduction plan under § 125 of the Internal Revenue Code.

(2) The information shall be provided:

(i) whenever the employer purchases or renews a health benefit plan; and

(ii) on request.

(h) (1) In accordance with regulations adopted by the Commissioner, a licensed insurance producer may provide to a small employer information about the Maryland Medical Assistance Program and the Maryland Children's Health Program for the small employer to distribute to its employees during the enrollment period.

(2) The information provided under paragraph (1) of this subsection shall be restricted to general information about the Maryland Medical Assistance Program and the Maryland Children's Health Program, including:

(i) income eligibility thresholds; and

(ii) application instructions.

§15–1207.

(a) In accordance with Title 19, Subtitle 1 of the Health – General Article, the Commission shall adopt regulations that specify:

(1) the Comprehensive Standard Health Benefit Plan to apply under this subtitle; and

(2) the requirements for a wellness benefit offered by a carrier to apply under this subtitle.

(b) (1) Subject to paragraph (2) of this subsection, the Commission shall exclude or limit benefits or adjust cost–sharing arrangements in the Standard Plan if the average rate for the Standard Plan exceeds 10% of the average annual wage in the State.

(2) The Commission annually shall determine the average rate for the Standard Plan by using the average rate submitted by each carrier that offers the Standard Plan.

(c) In establishing benefits, the Commission shall judge preventive services, medical treatments, procedures, and related health services based on:

(1) their effectiveness in improving the health status of individuals;

(2) their impact on maintaining and improving health and on reducing the unnecessary consumption of health care services; and

(3) their impact on the affordability of health care coverage.

(d) The Commission may exclude:

(1) a health care service, benefit, coverage, or reimbursement for covered health care services that is required under this article or the Health – General Article to be provided or offered in a health benefit plan that is issued or delivered in the State by a carrier; or

(2) reimbursement required by statute, by a health benefit plan for a service when that service is performed by a health care provider who is licensed under the Health Occupations Article and whose scope of practice includes that service.

(e) The Commission shall include mental health and substance abuse benefits required under § 15–802 of this title and § 19–703.1 of the Health – General

Article for employers that meet the large employer definition under § 15–802 of this title and § 19–703.1 of the Health – General Article.

(f) The Commission shall specify the deductibles and cost–sharing associated with the benefits in the Standard Plan.

(g) In establishing cost–sharing as part of the Standard Plan, the Commission shall:

(1) include cost–sharing and other incentives to help prevent consumers from seeking unnecessary services;

(2) balance the effect of cost–sharing in reducing premiums and in affecting utilization of appropriate services; and

(3) limit the total cost–sharing that may be incurred by an individual in a year.

(h) Beginning January 1, 2014, this section applies only to grandfathered health plans as defined in § 1251 of the Affordable Care Act.

§15–1208.

The provisions of § 15–508 of this title apply to a policy or certificate issued to a small employer.

§15–1208.1.

(a) A carrier shall provide the special enrollment periods described in this section in each small employer health benefit plan.

(b) A carrier shall allow an eligible employee or dependent who is eligible, but not enrolled, for coverage under the terms of the employer's health benefit plan to enroll for coverage under the terms of the plan if:

(1) the eligible employee or dependent was covered under an employer–sponsored plan or group health benefit plan at the time coverage was previously offered to the employee or dependent;

(2) the eligible employee states in writing, at the time coverage was previously offered, that coverage under an employer–sponsored plan or group health benefit plan was the reason for declining enrollment, but only if the plan sponsor or carrier requires the statement and provides the employee with notice of the requirement;

(3) the eligible employee's or dependent's coverage described in item (1) of this subsection:

(i) was under a COBRA continuation provision, and the coverage under that provision was exhausted; or

(ii) was not under a COBRA continuation provision, and either the coverage was terminated as a result of loss of eligibility for the coverage, including loss of eligibility as a result of legal separation, divorce, death, termination of employment, or reduction in the number of hours of employment, or employer contributions towards the coverage were terminated; and

(4) under the terms of the plan, the eligible employee requests enrollment not later than 30 days after:

(i) the date of exhaustion of coverage described in item (3)(i) of this subsection; or

(ii) termination of coverage or termination of employer contributions described in item (3)(ii) of this subsection.

(c) All small employer health benefit plans shall provide a special enrollment period during which the following individuals may be enrolled under the health benefit plan:

(1) an individual who becomes a dependent of the eligible employee through marriage, birth, adoption, placement for adoption, or placement for foster care;

(2) an eligible employee who acquires a new dependent through marriage, birth, adoption, placement for adoption, placement for foster care, or through a child support order or other court order;

(3) the spouse of an eligible employee at the birth or adoption of a child, placement of a child for foster care, or through a child support order or other court order, provided the spouse is otherwise eligible for coverage;

(4) at the option of the SHOP Exchange, an enrollee who is the eligible employee or the spouse of the eligible employee, if:

(i) the enrollee loses a dependent or is no longer considered to be a dependent due to divorce or legal separation; or

(ii) the employee or the employee's dependent dies; and

(5) (i) an eligible employee who becomes pregnant, as confirmed by a health care practitioner; and

(ii) an eligible employee's spouse or dependent who becomes pregnant, as confirmed by a health care practitioner, provided the spouse or dependent is otherwise eligible for coverage.

(d) An eligible employee may not enroll a dependent during a special enrollment period unless the eligible employee:

(1) is enrolled under the health benefit plan; or

(2) applies for coverage for the eligible employee during the same special enrollment period.

(e) (1) The special enrollment period under subsection (c)(1) through (4) of this section shall be a period of not less than 31 days and shall begin on the later of:

(i) the date dependent coverage is made available; or

(ii) the date of the marriage, birth, adoption, placement for adoption, placement for foster care, child support order or other court order, divorce, legal separation, or death, whichever is applicable.

(2) The special enrollment period under subsection (c)(5) of this section shall:

(i) be open for a period of 90 days; and

(ii) begin on the date a health care practitioner confirms the pregnancy.

(f) (1) If an eligible employee enrolls any of the individuals described in subsection (c)(1) through (4) of this section during the first 31 days of the special enrollment period, the coverage shall become effective as follows:

(i) in the case of marriage, not later than the first day of the first month beginning after the date the completed request for enrollment is received;

(ii) in the case of a dependent's birth, as of the date of the dependent's birth;

(iii) in the case of a dependent's adoption or placement for adoption, the date of adoption or placement for adoption, whichever occurs first;

(iv) in the case of a dependent's placement for foster care, the date of placement; and

(v) in the case of a dependent added due to a child support order or any other court order:

1. the date the child support order or other court order is effective; or

2. for SHOP Exchange plans, if allowed by the SHOP Exchange and selected by the eligible employee, the first day of the month following receipt of the plan selection.

(2) If an eligible employee enrolls an individual described in subsection (c)(5) of this section in a health benefit plan, the coverage shall become effective on the first day of the month in which the individual receives confirmation of pregnancy.

(g) If the SHOP Exchange allows the special enrollment periods described in subsection (c)(4) of this section, the coverage shall become effective as follows:

(1) for special enrollment periods in the SHOP Exchange due to death of the employee or dependent, the first day of the month following plan selection; and

(2) for special enrollment periods in the SHOP Exchange due to divorce or legal separation, the first day of the month following receipt of the plan selection.

§15–1208.2.

(a) (1) In this section the following words have the meanings indicated.

(2) "Dependent" means an individual who is or who may become eligible for coverage under the terms of a health benefit plan because of a relationship with an eligible employee.

(3) "Qualifying coverage in an eligible employer–sponsored plan" has the meaning stated in 45 C.F.R. § 155.300.

(b) (1) A carrier shall establish a standardized annual open enrollment period of at least 30 days for each small employer.

(2) The annual open enrollment period shall occur before the end of the small employer's plan year.

(3) During the annual open enrollment period, each eligible employee of the small employer shall be permitted to:

(i) enroll in a health benefit plan offered by the small employer;

(ii) discontinue enrollment in a health benefit plan offered by the small employer; or

(iii) change enrollment from one health benefit plan offered by the small employer to a different health benefit plan offered by the small employer.

(c) A carrier shall provide an open enrollment period of at least 30 days for each employee who becomes an eligible employee outside the initial or annual open enrollment period.

(d) (1) A carrier shall provide an open enrollment period for each individual who experiences a triggering event described in paragraph (4) of this subsection.

(2) The open enrollment period shall be for at least 30 days, beginning on the date of the triggering event.

(3) During the open enrollment period for an individual who experiences a triggering event, a carrier shall permit the individual to enroll in or change from one health benefit plan offered by the small employer to another health benefit plan offered by the small employer.

(4) A triggering event occurs when:

(i) subject to paragraph (5) of this subsection, an eligible employee or dependent loses minimum essential coverage;

(ii) an eligible employee or a dependent loses:

1. pregnancy–related coverage described under § 1902(a)(10)(A)(i)(IV) and (a)(10)(A)(ii)(IX) of the Social Security Act, which is

considered to occur on the last day the eligible employee or dependent would have pregnancy–related coverage; or

2. access to health care services through a program providing prenatal care or services, which is considered to occur on the last day the eligible employee or dependent would have access to health care services;

(iii) an eligible employee or a dependent loses medically needy coverage as described under § 1902(a)(10)(C) of the Social Security Act, which is considered to occur on the last day the eligible employee or dependent would have medically needy coverage;

(iv) an eligible employee or a dependent who is enrolled in a qualified health plan in the SHOP Exchange adequately demonstrates to the SHOP Exchange that the qualified health plan in which the eligible employee or a dependent is enrolled substantially violated a material provision of the qualified health plan's contract in relation to the eligible employee or a dependent;

(v) an eligible employee or a dependent:

1. loses eligibility for coverage under a Medicaid plan under Title XIX of the Social Security Act or a state child health plan under Title XXI of the Social Security Act; or

2. becomes eligible for assistance, with respect to coverage under the SHOP Exchange, under a Medicaid plan or state child health plan, including any waiver or demonstration project conducted under or in relation to a Medicaid plan or a state child health plan;

(vi) for SHOP Exchange health benefit plans:

1. an eligible employee's or a dependent's enrollment or nonenrollment in a qualified health plan is, as evaluated and determined by the Exchange:

A. unintentional, inadvertent, or erroneous; and

B. the result of the error, misrepresentation, misconduct, or inaction of an officer, employee, or agent of the Exchange or the federal Department of Health and Human Services, or its instrumentalities, or a non–Exchange entity providing enrollment assistance or conducting enrollment activities;

2. an eligible employee is an Indian as defined in § 4 of the federal Indian Health Care Improvement Act;

3. subject to paragraph (11) of this subsection, a material error related to plan benefits, service area, cost–sharing, or premium influenced the eligible employee's or dependent's decision to purchase a qualified health plan through the Exchange; or

4. an eligible employee or dependent demonstrates to the SHOP Exchange, in accordance with guidelines issued by the federal Department of Health and Human Services, that the eligible employee or a dependent meets other exceptional circumstances as the SHOP Exchange may provide;

(vii) an eligible employee or dependent:

1. is a victim of domestic abuse or spousal abandonment, as defined by 26 C.F.R. § 1.36B–2T;

2. is enrolled in minimum essential coverage; and

3. seeks to enroll in coverage separate from the perpetrator of the abuse or abandonment;

(viii) an eligible employee or dependent:

1. applies for coverage through the Individual Exchange during the annual open enrollment period or a special enrollment period;

2. is assessed by the Individual Exchange as potentially eligible for the Maryland Medical Assistance Program or the Maryland Children's Health Program; and

3. is determined ineligible for the Maryland Medical Assistance Program or the Maryland Children's Health Program by the Maryland Department of Health either:

A. after open enrollment has ended; or

B. more than 60 days after the qualifying event;

(ix) an eligible employee or dependent:

1. applies for coverage through the Maryland Medical Assistance Program or the Maryland Children's Health Program during the annual open enrollment period; and

2. is determined ineligible for the Maryland Medical Assistance Program or the Maryland Children's Health Program after open enrollment has ended; or

(x) an eligible employee or dependent gains access to new qualified health plans as a result of a permanent move and either:

1. had minimum essential coverage as described in 26 C.F.R. § 1.5000a–1(b) for 1 or more days during the 60 days before the date of the permanent move;

2. lived in a foreign country or in a United States territory for 1 or more days during the 60 days before the date of the permanent move;

3. lived in a service area where no qualified health plan was available through the Exchange:

A. for 1 or more days during the 60 days before the date of the permanent move; or

B. during the eligible employee's or dependent's most recent preceding open enrollment period or special enrollment period;

4. had coverage for prenatal care or services as described in 45 C.F.R. § 155.420(d)(1)(iii) for 1 or more days during the 60 days before the date of the permanent move; or

5. had medically needy coverage as described in 45 C.F.R. § 155.420(d)(1)(iv) for 1 or more days during the 60 days before the date of the permanent move.

(5) Loss of minimum essential coverage under paragraph (4)(i) of this subsection does not include loss of coverage due to:

(i) voluntary termination of coverage;

(ii) failure to pay premiums on a timely basis, including COBRA premiums prior to expiration of COBRA coverage; or

(iii) a rescission authorized under 45 C.F.R. § 147.128.

(6) The triggering event described in paragraph (4)(iii) of this subsection is permitted only once per year per individual.

(7) If an eligible employee or a dependent meets the requirements for the triggering event described in paragraph (4)(vi)1 of this subsection, the Exchange may take any action necessary to correct or eliminate the effects of the error, misrepresentation, or inaction.

(8) If an eligible employee meets the requirements for the triggering event described in paragraph (4)(vi)2 of this subsection, the eligible employee and a dependent may enroll in a qualified health plan or change from one qualified health plan to another one time per month.

(9) An eligible employee or a dependent who meets the requirements for the triggering event described in paragraph (4)(v) of this subsection shall have 60 days from the triggering event to select a health benefit plan.

(10) If a victim of domestic abuse or spousal abandonment meets the requirements for the triggering event described in paragraph (4)(vii) of this subsection, the victim's dependents may enroll in a qualified health plan at the same time as the victim.

(11) A material error under paragraph (4)(vi)3 of this subsection is an error that is likely to have influenced the enrollment of an eligible employee or the dependent of the eligible employee in a qualified health plan.

(e) If an individual enrolls for coverage during one of the open enrollment periods described in this section, coverage shall be effective in accordance with the requirements in 45 C.F.R. § 155.420.

§15–1209.

(a) This section does not apply to any insurance enumerated in § 15–1201(i)(3)(i) through (xiii) of this subtitle.

(b) A carrier shall issue its health benefit plans to each small employer that meets the requirements of this section.

(c) (1) Nothing in this subsection requires a small employer to contribute to the premium payments for coverage of a dependent of an eligible employee.

(2) To be covered under a health benefit plan offered by a carrier, a small employer shall:

(i) elect to be covered;

(ii) agree to pay the premiums;

(iii) agree to offer coverage to any dependent of an eligible employee when coverage is sought by the eligible employee, in accordance with provisions governing late enrollees and any other provisions of this subtitle that apply to coverage;

(iv) agree to collect payments for premiums through payroll deductions for coverage of eligible employees and dependents and transmit those payments to the carrier or the SHOP Exchange, as applicable; and

(v) satisfy other reasonable provisions of the health benefit plan as approved by the Commissioner.

(d) (1) In determining whether a small employer satisfies the requirements of this section, a carrier shall apply its requirements uniformly among all small employers with the same number of eligible employees who apply for or receive coverage from the carrier, including a requirement that a minimum percentage of eligible employees of the small employer participate in the health benefit plan.

(2) A carrier may vary application of minimum participation of eligible employees only by the size of the group of the small employer.

(e) A carrier may not require a small employer to contribute to payment of premiums for a health benefit plan.

§15–1210.

(a) A carrier that offers coverage to a small employer shall:

(1) offer coverage to all of its eligible employees and all of their eligible dependents; and

(2) at the election of the small employer, offer coverage to all of its part–time employees who have a normal workweek of at least 17 1/2 but less than 30 hours per week.

(b) (1) A health maintenance organization need not offer coverage:

(i) to a small employer that is outside of the health maintenance organization's approved service areas;

(ii) to an eligible employee who resides outside of the health maintenance organization's approved service areas; or

(iii) within an area where the health maintenance organization reasonably anticipates, and demonstrates to the satisfaction of the Commissioner, that it will not have the capacity in its network of providers to deliver service adequately because of obligations to existing group contract holders and enrollees.

(2) A health maintenance organization that does not offer coverage under paragraph (1)(iii) of this subsection may not offer coverage in the applicable area to any employer groups until the later of:

(i) 180 days after a refusal to do so; or

(ii) the date on which the health maintenance organization notifies the Commissioner that it has regained capacity to deliver services to small employer groups in that area.

(c) A carrier may not be required to offer coverage under §§ 15–1209 and 15–1213 of this subtitle for as long as the Commissioner finds that the coverage would place the carrier in a financially impaired condition.

§15–1211.

(a) To sell health benefit plans to small employers in the State, a carrier shall file its proposed health benefit plans with the Commissioner on or before the date designated by the Commissioner.

(b) Unless the Commissioner previously has disapproved a health benefit plan, it is deemed approved 60 days after filing with the Commissioner.

§15–1212.

(a) (1) In this section the following words have the meanings indicated.

(2) "Plan" means, with respect to a product, the pairing of the health benefits under the product with a particular cost–sharing structure, provider network, and service area.

(3) (i) "Product" means a discrete package of health benefits that are offered using a particular product network type within a geographic service area.

(ii) "Product" comprises all plans offered within the product.

(4) "Uniform modification of coverage" means a change to a small employer's health benefit plan that meets the criteria stated in 45 C.F.R. § 147.106(e).

(b) Changes in benefits made in accordance with federal or State requirements are not subject to the plus or minus 2 percentage points referenced in 45 C.F.R. § 147.106(e)(3)(v).

(c) The combination of all plans offered with a product constitutes the total service area of the product.

(d) (1) With respect to a plan that has been modified at the time of coverage renewal consistent with this section, the plan shall be considered to be the same plan if:

(i) 1. the plan has the same cost–sharing structure as before the modification; or

2. any variation in cost sharing:

A. is solely related to changes in cost or utilization of medical care; or

B. is to maintain the same metal level described in § 1302(d) and (e) of the Affordable Care Act;

(ii) the plan continues to cover a majority of the same service area; and

(iii) the plan continues to cover a majority of the same provider network.

(2) Notwithstanding paragraph (1) of this subsection, the plan shall be considered to be the same plan to the extent that the modifications are:

(i) made uniformly and solely as a result of a federal or State requirement;

(ii) made within a reasonable time period after the imposition or modification of the federal or State requirement; and

(iii) directly related to the imposition or modification of the federal or State requirement.

(e) (1) Except as provided in subsections (f), (g), and (h) of this section, a carrier shall renew a health benefit plan at the option of the small employer.

(2) On renewal, a carrier may not exclude eligible employees or dependents from a health benefit plan.

(3) (i) A carrier shall mail a notice of renewal to the small employer at least 60 days before the expiration of a health benefit plan.

(ii) The notice of renewal shall include the dates of the renewal period, the health benefit plan rates, and the terms of coverage under the health benefit plan.

(4) Policies or certificates for hospital or medical benefits issued through a professional employer organization, coemployer, or other organization under this subtitle may, with the consent of the carrier, have a common renewal date.

(f) A carrier may cancel or refuse to renew a health benefit plan only:

(1) for nonpayment of premiums;

(2) for fraud or intentional misrepresentation of material fact by the small employer;

(3) for noncompliance with a material plan provision relating to employer contributions or group participation rules;

(4) when the carrier elects not to renew:

(i) all of its health benefit plans that are issued to small employers in the State; or

(ii) the particular product for all small employers in the State; or

(5) in the case of a health maintenance organization, where there is no longer any enrollee who lives, resides, or works in the health maintenance organization's approved service area, provided notice of the termination is provided to each small employer and to each employee covered under the health benefit plan at least 90 calendar days before the date coverage will be terminated.

(g) When a carrier elects not to renew all health benefit plans in the State, the carrier:

(1) shall give notice of its decision to the affected small employers and the insurance regulatory authority of each state in which an eligible employee or dependent resides at least 180 days before the effective date of nonrenewal;

(2) shall give notice to the Commissioner at least 30 working days before giving the notice specified in item (1) of this subsection; and

(3) may not write new business for small employers in the State for a period of 5 years beginning on the date of notice to the Commissioner.

(h) When a carrier elects not to renew a particular product for all small employers in the State, the carrier shall:

(1) provide notice of the nonrenewal at least 90 days before the date of the nonrenewal to:

(i) each affected:

1. small employer; and

2. enrolled employee; and

(ii) the Commissioner;

(2) offer to each affected small employer the option to purchase all other health benefit plans currently offered by the carrier in the small group market; and

(3) act uniformly without regard to the claims experience of any affected small employer, or any health status–related factor of any affected individual.

(i) (1) Within 7 days after cancellation or nonrenewal of a health benefit plan, the carrier shall send to each enrolled employee:

(i) written notice of its action; and

(ii) notice delivered by electronic means that complies with § 27–601.2 of this article.

(2) The notice required under paragraph (1) of this subsection shall include information on additional health benefit coverage options, including continuation of coverage through the Consolidated Omnibus Budget Reconciliation

Act (COBRA), if available, and plans available through the Maryland Health Benefit Exchange.

(j) A carrier may make a uniform modification of coverage for a product only at the time of renewal of the health benefit plan.

(k) A carrier will not be considered to have elected not to renew all health benefit plans that are issued to small employers in the State if the carrier complies with 45 C.F.R. § 147.106(d)(3).

§15–1213.

(a) This section does not apply to any insurance enumerated in § 15–1201(i)(3)(i) through (xiii) of this subtitle.

(b) Each benefit offered in addition to the Standard Plan that increases access to care choices or lowers the cost–sharing arrangement in the Standard Plan is subject to all of the provisions of this subtitle applicable to the Standard Plan, including:

(1) guaranteed issuance;

(2) guaranteed renewal; and

(3) adjusted community rating.

(c) (1) Each benefit offered in addition to the Standard Plan that increases the type of services available or the frequency of services is not subject to guaranteed issuance but is subject to all other provisions of this subtitle applicable to the Standard Plan, including:

(i) guaranteed renewal; and

(ii) adjusted community rating.

(2) For each additional benefit offered under this subsection, a carrier shall accept or reject the application of the entire group.

(3) The Commissioner may prohibit a carrier from offering an additional benefit under this subsection if the Commissioner finds that the additional benefit will be sold in conjunction with the Standard Plan in a manner designed to promote risk selection or underwriting practices otherwise prohibited by this subtitle.

(d) Beginning January 1, 2014, this section applies only to grandfathered health plans as defined in § 1251 of the Affordable Care Act.

§15–1214.

Notwithstanding any other provision of this subtitle, health benefit plans shall reimburse hospitals in accordance with rates approved by the State Health Services Cost Review Commission.

§15–1215.

(a) (1) Each carrier shall elect to become either a risk-assuming carrier or reinsuring carrier.

(2) The notification of election to become a risk-assuming carrier shall include an appropriate opinion by an independent qualified actuary that the risk-assuming carrier is able to assume and manage the risk of enrolling groups under this subtitle without the protection of the Pool.

(b) (1) The initial election under this section is binding for 3 years.

(2) After the initial 3 years, and every 5 years thereafter, each carrier shall again elect to be either a risk-assuming or reinsuring carrier.

(3) Each subsequent election is binding for 5 years.

(4) The Commissioner may allow a new carrier to make an election under conditions established by the Commissioner.

(c) (1) The Commissioner may allow a carrier to change its election at any time for good cause shown.

(2) In determining whether to approve an application by a carrier to change its election, the Commissioner shall consider:

(i) the applicant's financial condition and the financial condition of any parent or guaranteeing corporation;

(ii) the applicant's history of assuming and managing risk;

(iii) the applicant's commitment to market fairly to all small employers in the State or in the applicant's service area;

(iv) the applicant's ability to assume and manage the risk of enrolling groups under this subtitle without the protection of the Pool; and

(v) the effect of approval of the application on the financial viability of the Pool.

(3) While the Commissioner is considering an application under this subsection, the carrier may request a hearing as provided under Title 11, Subtitle 5 of this article.

§15–1216.

(a) The Commissioner shall establish the Maryland Small Employer Health Reinsurance Pool.

(b) The Pool shall be operational and may reinsure claims in accordance with this subtitle on or after July 1, 1994.

(c) (1) The reinsuring carriers shall elect a Board of Directors to be composed of seven members.

(2) The Board shall include representation from carriers whose principal business in health insurance comprises small employers and, to the extent possible, at least one nonprofit health service plan, at least one commercial carrier, and at least one health maintenance organization.

(3) A carrier, including its affiliates, may not be represented by more than one member on the Board.

(4) The term of a member is 3 years except that the terms of initial members shall be staggered for periods of 1 to 3 years.

(5) At the end of a term, a member continues to serve until a successor is elected.

(6) Vacancies shall be filled by an election of the remaining Board members.

(7) A member who is elected after a term has begun serves only for the rest of the term and until a successor is elected.

(8) A member who serves two consecutive full 3–year terms may not be reelected for 3 years after the completion of those terms.

(d) The Board shall choose a Chairman.

(e) (1) The Board shall appoint an Executive Director, who shall be the chief administrative officer of the Pool.

(2) The Executive Director serves at the pleasure of the Board.

(3) Under the direction of the Board, the Executive Director shall perform any duty or function that the Board requires.

(f) The Pool may employ a staff in accordance with the budget of the Pool.

(g) (1) The Board shall submit to the Commissioner a plan of operation to ensure the fair, reasonable, and financially sound administration of the Pool.

(2) The Commissioner may amend or rescind a plan of operation if the Commissioner finds that the Pool is not operating in a fair, reasonable, and financially sound manner.

§15–1217.

(a) At a minimum, the plan of operation shall:

(1) establish procedures for the handling and accounting of Pool assets and money and for an annual fiscal report to the Commissioner;

(2) establish procedures for reinsuring claims submitted to the Pool in accordance with this subtitle;

(3) establish procedures for collecting assessments from members to reinsure claims submitted to the Pool and to pay for administrative expenses incurred or estimated to be incurred during the period;

(4) establish procedures for recouping any net losses to the Pool for the calendar year by assessing reinsuring carriers under § 15–1221 of this subtitle; and

(5) provide for any additional matters at the discretion of the Board.

(b) The Board has the general powers and authority granted under the laws of the State to health insurers and health maintenance organizations authorized to transact business, except for the power to issue health benefit plans directly to groups or individuals.

(c) The Board may:

(1) enter into contracts as necessary or proper to carry out this subtitle and, with approval of the Commissioner, enter into contracts with similar programs of other states for the joint performance of common functions or with persons or other organizations for the performance of administrative functions;

(2) sue or be sued;

(3) take any legal action necessary or proper to recover assessments and penalties for, on behalf of, or against the Pool or reinsuring carriers or necessary to avoid the payment of improper claims against the Board;

(4) define the health benefit plans and medical conditions for which claims may be reinsured with the Pool in accordance with this subtitle;

(5) establish rules, conditions, and procedures that relate to reinsurance of claims by the Pool;

(6) establish actuarial functions as appropriate for the operation of the Pool;

(7) assess reinsuring carriers in accordance with the provisions of § 15–1221 of this subtitle;

(8) make advance interim assessments as may be reasonable and necessary for organizational and interim operating expenses, to be credited against any assessments due after the close of the fiscal year;

(9) appoint appropriate committees as necessary to provide technical assistance in the operation of the Pool, policy and other contract design, and any other function within the authority of the Pool; and

(10) borrow money to carry out the purposes of the Pool.

§15–1218.

(a) A reinsuring carrier may reinsure with the Pool as provided in this section.

(b) At a minimum, the Pool shall reinsure up to the level of coverage specified under the Standard Plan.

(c) A reinsuring carrier may reinsure an entire employer group within 60 days after commencement of the group's coverage under a health benefit plan.

(d) (1) A reinsuring carrier may reinsure an eligible employee or dependent within 60 days after commencement of coverage with the small employer.

(2) A reinsuring carrier may reinsure a newly eligible employee or dependent within 60 days after commencement of coverage of the eligible employee or dependent.

(e) (1) The Pool may not reimburse a reinsuring carrier with respect to the claims of an individual until the reinsuring carrier has incurred claims for the individual of $5,000 in a calendar year for benefits covered by the Pool.

(2) After the initial $5,000 of incurred claims, the reinsuring carrier is responsible for 10% of the next $50,000 of incurred claims during the calendar year, and the Pool shall reinsure the remainder.

(3) The liability of a reinsuring carrier under this subsection may not exceed $10,000 in any 1 calendar year with respect to any individual.

(f) (1) The Board annually shall adjust the initial level of claims and the maximum limit to be retained by the reinsuring carrier to reflect increases in costs and utilization within the standard market for health benefit plans in the State.

(2) Unless the Board proposes and the Commissioner approves a lower adjustment factor, the adjustment in paragraph (1) of this subsection may not be less than the annual change in the medical component of the "Consumer Price Index for all Urban Consumers" of the Department of Labor, Bureau of Labor Statistics.

(g) A reinsuring carrier may terminate reinsurance on a plan anniversary for one or more of the individuals in a small employer group.

§15–1219.

(a) (1) (i) As part of the plan of operation, the Board shall establish a methodology to determine premium rates to be charged by the Pool to reinsure small employers and individuals under this section and § 15-1218 of this subtitle.

(ii) The methodology shall provide for the development of base reinsurance premium rates that shall be multiplied by the factors set forth in paragraph (2) of this subsection to determine the premium rates for the Pool.

(iii) The Board shall establish the base reinsurance premium rates at levels that reasonably approximate gross premiums charged to small employers by carriers for health benefit plans up to the level of coverage that the Board determines.

(2) Premiums for the Pool shall be as follows:

(i) an entire group may be reinsured for a rate that is 1.5 times the base reinsurance premium rate for the group established under this subsection; and

(ii) an individual may be reinsured for a rate that is 5 times the base reinsurance premium rate for the individual established under this subsection.

(3) (i) The Board periodically shall review the methodology established under paragraph (1) of this subsection, including the system of classification and any rating factors, to ensure that it reasonably reflects the claims experience of the Pool.

(ii) The Board may propose changes to the methodology, subject to the approval of the Commissioner.

(b) If a health benefit plan for a small employer is entirely or partially reinsured with the Pool, the premium charged to the small employer for any rating period for the coverage issued shall meet the requirements that relate to premium rates set forth in § 15-1205 of this subtitle.

§15–1220.

(a) The Pool shall manage and invest all money collected by or on behalf of the Pool through premium charges, assessments, earnings from investments, or otherwise, through a financial management committee composed of the Executive Director and two members of the Board.

(b) All operating expenses of the Pool shall be paid from funds collected by or on behalf of the Pool.

(c) The account of the Pool is a special fund account and the money in the account is not part of the General Fund of the State.

(d) The State may not provide General Fund appropriations to the Pool and the obligations of the Pool are not a debt of the State or a pledge of the credit of the State.

(e) All debts, claims, obligations, and liabilities of the Pool, whenever incurred, shall be the debts, claims, obligations, and liabilities of the Pool only and not of the State or the State's agencies, instrumentalities, officers, or employees.

(f) The Pool is exempt from:

(1) taxation by the State and local government;

(2) the general procurement law provisions of Division II of the State Finance and Procurement Article; and

(3) Division I of the State Personnel and Pensions Article.

§15–1221.

(a) On or before the last day of February of each year, the Board shall determine and report to the Commissioner the net loss of the Pool for the previous calendar year, including administrative expenses and incurred losses for the year, taking into account investment income and other appropriate gains and losses.

(b) Any net loss for the year shall be recouped by assessments imposed on reinsuring carriers.

(c) (1) As part of the plan of operation, the Board shall establish a formula to make assessments against reinsuring carriers.

(2) The assessment formula shall be based on:

(i) each reinsuring carrier's share of the total premiums earned in the preceding calendar year from health benefit plans that are delivered or issued for delivery to small employers in the State by reinsuring carriers; and

(ii) each reinsuring carrier's share of the premiums earned in the preceding calendar year from newly issued health benefit plans that are delivered or issued for delivery during that calendar year to small employers in the State by reinsuring carriers.

(3) The assessment formula may not result in an assessment share for a reinsuring carrier that is less than 50% nor more than 150% of an amount that is based on the proportion of the reinsuring carrier's total premiums earned in the preceding calendar year from health benefit plans that are delivered or issued for delivery to small employers in the State to total premiums earned by all reinsuring

carriers in the preceding calendar year from health benefit plans that are delivered or issued for delivery to small employers in the State.

(4) As appropriate and with the approval of the Commissioner, the Board may change the assessment formula established in accordance with this subsection.

(5) The Board may provide for assessment shares attributable to premiums from all health benefit plans and to premiums from newly issued health benefit plans to vary during a transition period.

(6) Subject to approval by the Commissioner, the Board shall make an adjustment to the assessment formula for reinsuring carriers that are approved health maintenance organizations and that are federally qualified under the Health Maintenance Organization Act of 1973 to the extent that restrictions are imposed on the health maintenance organizations that are not imposed on other carriers.

(7) Premiums and benefits paid by a reinsuring carrier that are less than an amount determined by the Board to justify the cost of collection may not be considered in determining assessments.

(d) (1) On or before the last day of February of each year, the Board shall determine and file with the Commissioner an estimate of the assessments needed to fund the losses incurred by the Pool in the previous calendar year.

(2) If the Board determines that the assessments needed to fund the losses incurred by the Pool in the previous calendar year will exceed 5% of the total premiums earned that year from health benefit plans that are delivered or issued for delivery in the State, the Board shall evaluate the operation of the Pool and report its findings to the Commissioner within 90 days after the end of the calendar year in which the losses were incurred.

(3) The evaluation required under paragraph (2) of this subsection shall include:

(i) any recommendations for changes to the plan of operation;

(ii) an estimate of future assessments;

(iii) the administrative costs of the Pool;

(iv) the appropriateness of the premiums charged;

(v) the level of insurer retention under the Pool; and

(vi) the costs of coverage for small employers.

(4) If the Board fails to file the report with the Commissioner within 90 days after the end of the applicable calendar year, the Commissioner may evaluate the operations of the Pool and implement amendments to the plan of operation that the Commissioner considers necessary to reduce future losses and assessments.

(e) If assessments exceed net losses of the Pool, the excess shall be held in an interest-bearing account and used by the Board to offset future losses, including reserves for incurred but not reported claims, or to reduce Pool premiums.

(f) The Board annually shall determine the assessment share of each reinsuring carrier based on annual statements and other reports that the Board considers necessary and that reinsuring carriers file with the Board.

(g) The plan of operation shall provide for imposition of an interest penalty for late payment of assessments.

(h) (1) (i) A reinsuring carrier may seek from the Commissioner a deferment from all or part of an assessment imposed by the Board.

(ii) The request for deferment shall be made in writing to the Commissioner within 15 days after receipt of the assessment notice.

(2) The Commissioner may defer all or part of the assessment of a reinsuring carrier if the Commissioner determines that payment of the assessment would place the reinsuring carrier in a financially impaired condition.

(3) (i) Any amount deferred shall be assessed against the other reinsuring carriers in a manner consistent with the basis for assessment set forth in this section.

(ii) The reinsuring carrier receiving the deferment remains liable to the Pool for the amount deferred and may not reinsure any individuals or groups in the Pool until it pays that amount.

§15–1222.

(a) (1) The Board shall report to the Commissioner on or before June 1 of each year.

(2) At a minimum, the report shall include:

(i) a description of the operations of the Pool for the preceding calendar year;

(ii) an audited statement of the financial condition of the Pool as of the preceding December 31; and

(iii) an audited detailed statement of the revenues received and expenditures of the Pool made during the preceding calendar year.

(b) The operations of the Board are subject to an annual audit by an independent auditor, and the audit report and working papers are subject to review by the Legislative Auditor.

§15–1223.

Participation in the Pool as reinsuring carriers, establishment of rates, forms, or procedures, or any other joint or collective action required by §§ 15-1218, 15-1219, and 15-1221 of this subtitle may not be the basis of any legal action, criminal or civil liability, or penalty against the Pool or any of its reinsuring carriers either jointly or separately.

§15–1224.

The Commissioner may order the dissolution of the Pool if the Commissioner determines that the Pool is not financially viable, and provision is made to ensure the protection of those insured by the members of the Pool.

§15–1225.

This subtitle is the Maryland Health Insurance Reform Act.

§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. 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; and

3. 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."; 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 a group health plan if the coverage qualifies for the exception described in 45 C.F.R. § 146.145(b)(5)(i)(C).

(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; or

(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) "Short–term limited duration insurance" means health insurance coverage provided under a policy or contract with a carrier and that:

(1) has a policy term that is less than 3 months after the original effective date of the policy or contract;

(2) may not be extended or renewed;

(3) applies the same underwriting standards to all applicants regardless of whether they have previously been covered by short–term limited duration insurance; and

(4) contains the notice required by federal law prominently displayed in the contract and in any application materials provided in connection with enrollment.

(t) "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.

§15–1302.

(a) This subtitle applies to all carriers that offer health benefit plans to individuals in the State.

(b) This subtitle does not apply to a carrier that offers only conversion policies as required by law.

(c) This subtitle does not apply to a carrier that offers health insurance coverage only in connection with group health plans.

§15–1303.

(a) In addition to any other requirements under this article, a carrier that offers individual health benefit plans in the State shall:

(1) have demonstrated the capacity to administer the individual health benefit plans, including adequate numbers and types of administrative staff;

(2) have a satisfactory grievance procedure and ability to respond to calls, questions, and complaints from enrollees or insureds; and

(3) design policies to help ensure that enrollees or insureds have adequate access to providers of health care.

(b) (1) Except as provided in this subsection and § 31–110(f) of this article, a carrier may not offer individual health benefit plans in the State unless the carrier also offers qualified health plans, as defined in § 31–101 of this article, in the Individual Exchange of the Maryland Health Benefit Exchange in compliance with the requirements of Title 31 of this article.

(2) A carrier is exempt from the requirement in paragraph (1) of this subsection if:

(i) 1. the reported total aggregate annual earned premium from all individual health benefit plans in the State for the carrier and any other carriers in the same insurance holding company system, as defined in § 7–101 of this article, is less than $10,000,000; or

2. the only individual health benefit plans that the carrier offers in the State are student health plans as defined in 45 C.F.R. § 147.145;

(ii) the Commissioner determines that the carrier complies with the procedures established under paragraph (3) of this subsection; and

(iii) when the carrier ceases to meet the requirements for the exemption, the carrier provides to the Commissioner immediate notice and its plan for complying with the requirement in paragraph (1) of this subsection.

(3) The Commissioner shall establish procedures for a carrier to submit evidence each year that the carrier meets the requirements necessary to qualify for an exemption under paragraph (2) of this subsection.

(4) Notwithstanding the exemption provided in paragraph (2) of this subsection, any carrier that offers a catastrophic plan, as defined by the Affordable Care Act, in the State also must offer at least one catastrophic plan in the Maryland Health Benefit Exchange.

(5) Notwithstanding the exemption provided in paragraph (2) of this subsection, the Commissioner, in consultation with the Maryland Health Benefit Exchange:

(i) may assess the impact of the exemption provided in paragraph (2) of this subsection and, based on that assessment, alter the limit on the amount of annual premiums that may not be exceeded to qualify for the exemption; and

(ii) shall make any change in the exemption requirement by regulation.

§15–1307.

(a) The actuarial value of benefits provided under individual health insurance coverage shall be calculated based on a standardized population and a set of standardized utilization and cost factors.

(b) A carrier shall submit any information the Commissioner may require to support and justify the carrier's calculations of actuarial values.

§15–1308.

(a) In this section, "affiliate" means a person that directly or indirectly, through one or more intermediaries, controls, is controlled by, or is under common control with another person.

(b) A carrier may elect not to renew all individual health benefit plans in the State.

(c) When a carrier elects not to renew all individual health benefit plans in the State, the carrier:

(1) shall give notice of its decision to the affected individuals at least 180 days before the effective date of nonrenewal;

(2) at least 30 working days before that notice, shall give notice to the Commissioner;

(3) if the carrier has an affiliate in the individual market, shall give notice to each affected individual at least 180 days before the effective date of nonrenewal of the individual's option to purchase all other individual health benefit plans currently offered by the affiliate of the carrier; and

(4) may not write new business for individuals in the State for a 5-year period beginning on the date of notice to the Commissioner.

(d) A carrier that offers an individual health benefit plan shall offer an individual health benefit plan to an individual who is nonrenewed by an affiliate of the carrier under subsection (c) of this section on a guarantee issue basis, if the individual applies for coverage no later than 63 days after the effective date of nonrenewal.

(e) A carrier that issues coverage under subsection (d) of this section may not rate the coverage on a substandard basis unless the individual was rated on a substandard basis under the prior coverage provided to the individual by the affiliate of the carrier.

(f) (1) Subject to paragraph (2) of this subsection, a carrier that issues coverage under subsection (d) of this section shall waive the waiting period for coverage of a preexisting condition to the extent that the individual has satisfied a waiting period under the individual's prior contract or policy.

(2) The carrier that issues coverage under subsection (d) of this section may require the individual to satisfy the remaining part of the waiting period if any part of the waiting period under the individual's prior contract or policy has not been satisfied, unless the coverage issued under subsection (d) of this section has a shorter waiting period.

(g) A health maintenance organization need not offer coverage to an individual who does not live, reside, or work within the health maintenance organization's approved service areas.

(h) A carrier will not be considered to have elected not to renew all individual health benefit plans in the State if the carrier complies with 45 C.F.R. § 147.106(d)(3).

§15–1309.

(a) (1) In this section the following words have the meanings indicated.

(2) "Plan" means, with respect to a product, the pairing of the health benefits under the product with a particular cost–sharing structure, provider network, and service area.

(3) (i) "Product" means a discrete package of health benefits that are offered using a particular product network type within a geographic service area.

(ii) "Product" comprises all plans offered within the product.

(4) "Uniform modification of coverage" means a change to a health benefit plan that meets the criteria stated in 45 C.F.R. § 147.106(e).

(b) Changes in benefits made to comply with federal or State requirements are not subject to the plus or minus 2 percentage points referenced in 45 C.F.R. § 147.106(e)(3)(v).

(c) The combination of all plans offered with a product constitutes the total service area of the product.

(d) (1) With respect to a plan that has been modified at the time of coverage renewal consistent with this section, the plan shall be considered to be the same plan if:

(i) 1. the plan has the same cost–sharing structure as before the modification; or

2. any variation in cost sharing:

A. is solely related to changes in cost or utilization of medical care; or

B. is to maintain the same metal level described in § 1302(d) and (e) of the Affordable Care Act;

(ii) the plan continues to cover a majority of the same service area; and

(iii) the plan continues to cover a majority of the same provider network.

(2) Notwithstanding paragraph (1) of this subsection, the plan shall be considered to be the same plan to the extent that the modifications are:

(i) made uniformly and solely as a result of a federal or State requirement;

(ii) made within a reasonable time period after the imposition or modification of the federal or State requirement; and

(iii) directly related to the imposition or modification of the federal or State requirement.

(e) Except as provided in subsection (f) of this section, a carrier shall renew an individual health benefit plan at the option of the eligible individual.

(f) A carrier may not cancel or refuse to renew an individual health benefit plan except:

(1) for nonpayment of the required premiums;

(2) where the individual has performed an act or practice that constitutes fraud;

(3) where the individual has made an intentional misrepresentation of material fact under the terms of the coverage;

(4) where the carrier elects not to renew all of its individual health benefit plans in the State in accordance with this article;

(5) where the individual no longer resides, lives, or works in the service area, provided that:

(i) the coverage is terminated under this provision uniformly without regard to any health status–related factor of covered individuals; and

(ii) notice of the termination is provided to the individual at least 90 calendar days before the date coverage will be terminated; or

(6) for individual health benefit plans that are not grandfathered health plans, as defined in 45 C.F.R. § 147.140, where a carrier discontinues offering a particular product in the individual market, if the carrier:

(i) at least 90 days before discontinuation of the product, provides notice of the discontinuation to each individual provided coverage under the product;

(ii) offers each individual provided coverage under the product the option to purchase any other individual health benefit plan coverage offered by the carrier for individuals in the State; and

(iii) acts uniformly without regard to any health status–related factor of enrolled individuals or individuals who may become eligible for the coverage.

(g) A carrier may make a uniform modification of coverage for a product only at the time of renewal of the health benefit plan.

(h) A carrier shall provide notice of renewal or uniform modification of coverage for:

(1) grandfathered health plan coverage, at least 60 days before the date the coverage will be renewed; and

(2) a health benefit plan that is not grandfathered health plan coverage, before the date of the first day of the next annual open enrollment period, in a form and manner specified by the Secretary of Health and Human Services.

(i) A carrier may not cancel or refuse to renew an individual health benefit plan because an eligible individual is entitled to or enrolled in Medicare if the eligible individual is renewing coverage under the same policy or contract of insurance.

§15–1313.

The Administration shall provide on its Web site and in printed form on request a list of carriers, including contact information for each carrier, that offer individual health benefit plans in the State.

§15–1314.

(a) Except as provided in subsection (c) of this section, a carrier may not increase an individual's premium on an individual health benefit plan more frequently than once every 12 months.

(b) An increase in an individual's premium described in subsection (a) of this section includes an increase due to the individual moving into a higher age band.

(c) A carrier may increase an individual's premium on an individual health benefit plan more frequently than once every 12 months if the premium increase is due solely to the enrollment of a new family member to the individual health benefit plan of the individual.

§15–1315.

(a) (1) In this section the following words have the meanings indicated.

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

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

(4) "Qualified individual" has the meaning stated in § 31–101 of this article.

(b) This section applies to a qualified health plan that is issued on or after January 1, 2014, by a carrier through the Individual Exchange.

(c) A qualified health plan subject to this section shall include a grace period provision applicable to a qualified individual who:

(1) is receiving advance payments of federal premium tax credits; and

(2) fails to pay premiums timely.

(d) The grace period provision shall:

(1) provide a grace period of 3 consecutive months after the initial premium payment to begin coverage has been paid;

(2) apply to qualified health plans renewed in accordance with § 15–1309 of this subtitle without the qualified individual having to pay the first month's premium following renewal; and

(3) be in addition to any other grace period provision required by any other applicable State law.

(e) During the grace period, a carrier that issues a qualified health plan subject to this section:

(1) shall pay all appropriate claims for services rendered to the qualified individual during the first month of the grace period;

(2) may pend claims for services rendered to the qualified individual in the second and third months of the grace period;

(3) shall notify the federal Department of Health and Human Services that the qualified individual is in the grace period; and

(4) shall notify providers of the possibility that claims may be denied when a qualified individual is in the second and third months of the grace period.

§15–1316. IN EFFECT

(a) (1) In this section the following words have the meanings indicated.

(2) "Dependent" means an individual who is or who may become eligible for coverage under the terms of a health benefit plan because of a relationship with another individual.

(3) "Health care practitioner" has the meaning stated in § 1–301 of the Health Occupations Article.

(4) "Provider" means a health care practitioner or a health care facility that participates on a health benefit plan's provider panel.

(5) "Qualifying coverage in an eligible employer–sponsored plan" has the meaning stated in 45 C.F.R. § 155.300.

(b) (1) Beginning November 15, 2014, unless an alternative date is adopted by the federal Department of Health and Human Services, a carrier that sells health benefit plans to individuals in the State shall establish an annual open enrollment period.

(2) The annual open enrollment period for 2014 shall begin on November 15, 2014, and extend through January 15, 2015, unless alternative dates are adopted by the federal Department of Health and Human Services.

(3) The annual open enrollment period for years beginning on and after January 1, 2015, shall be:

(i) the dates adopted by the federal Department of Health and Human Services; or

(ii) if authorized by the federal Department of Health and Human Services, the dates adopted by the Exchange.

(4) During the annual open enrollment period, an individual shall be permitted to:

(i) enroll in a health benefit plan offered by the carrier;

(ii) discontinue enrollment in a health benefit plan offered by the carrier; or

(iii) change enrollment in a health benefit plan offered by the carrier to a different health benefit plan offered by the carrier.

(5) If an individual enrolls in a health benefit plan offered by the carrier during the annual open enrollment period for 2014, the effective date of coverage shall be:

(i) January 1, 2015, if the application is received by the carrier on or before December 15, 2014, unless an alternative date is adopted by the federal Department of Health and Human Services;

(ii) February 1, 2015, if the application is received by the carrier from December 16, 2014, through January 15, 2015, unless an alternative date is adopted by the federal Department of Health and Human Services; and

(iii) March 1, 2015, if the application is received by the carrier from January 16, 2015, through February 15, 2015, unless an alternative date is adopted by the federal Department of Health and Human Services.

(6) If an individual enrolls in a health benefit plan offered by the carrier during the annual open enrollment period for years beginning on and after January 1, 2015, the effective date of coverage shall be:

(i) the date adopted by the federal Department of Health and Human Services; or

(ii) if authorized by the federal Department of Health and Human Services, the date adopted by the Exchange.

(c) A carrier participating in the Individual Exchange shall provide:

(1) the special enrollment periods specified in 45 C.F.R. § 155.420 for individuals who purchase coverage through the Individual Exchange;

(2) a special enrollment period for an individual who purchases coverage through the Individual Exchange if the individual or a dependent of the individual becomes pregnant, as confirmed by a health care practitioner; and

(3) a special enrollment period for an individual who purchases coverage through the Individual Exchange if the individual or a dependent of the individual is:

(i) a patient being treated on a regular basis by or at a provider; and

(ii) enrolled in a health benefit plan in which the provider treating the individual or dependent is terminated from the health benefit plan's provider panel.

(d) A carrier shall provide:

(1) the special enrollment periods specified in 45 C.F.R. § 147.104(b)(2) for individuals who purchase coverage outside the Individual Exchange;

(2) a special enrollment period for an individual who purchases coverage outside the Individual Exchange if the individual or a dependent of the individual becomes pregnant, as confirmed by a health care practitioner; and

(3) a special enrollment period for an individual who purchases coverage outside the Individual Exchange if the individual or a dependent of the individual is:

(i) a patient being treated on a regular basis by or at a provider; and

(ii) enrolled in a health benefit plan in which the provider treating the individual or dependent is terminated from the health benefit plan's provider panel.

(e) (1) A special enrollment period described in subsection (c)(2) or (d)(2) of this section shall:

(i) be open for a period of 90 days; and

(ii) begin on the date the health care practitioner confirms the pregnancy.

(2) A special enrollment period described in subsection (c)(3) or (d)(3) of this section shall:

(i) be open for a period of 90 days; and

(ii) begin on:

1. the date of termination of the provider from the health benefit plan's provider panel; or

2. if the consumer did not receive notice of the termination before the termination date, the date of the notice of termination.

(f) (1) If an individual enrolls for coverage during one of the open enrollment periods described in subsection (b) of this section or during one of the special open enrollment periods described in subsections (c)(1) and (d)(1) of this section, coverage shall be effective in accordance with the requirements in 45 C.F.R. § 155.420.

(2) If an individual enrolls for coverage or enrolls a dependent for coverage during a special enrollment period described in subsection (c)(2) or (d)(2) of this section, the coverage shall become effective on the first day of the month in which the individual receives confirmation of pregnancy.

(3) If an individual enrolls for coverage or enrolls a dependent for coverage during a special enrollment period described in subsection (c)(3) or (d)(3) of this section, the individual shall select if coverage shall become effective:

(i) on the first day of the month following the date the health benefit plan was selected; or

(ii) on the first day of the month in which the termination of the provider on the health benefit plan's provider panel became effective.

(g) (1) A health maintenance organization may:

(i) limit the individuals who may apply for coverage to those who live or reside in the health maintenance organization's service area; and

(ii) deny coverage to individuals if the health maintenance organization has demonstrated to the Commissioner that:

1. it will not have the capacity to deliver services adequately to any additional individuals because of its obligations to existing enrollees; and

2. it is applying the provisions of this paragraph uniformly to all individuals without regard to the claims experience of those individuals and their dependents or any health status–related factor relating to the individuals and their dependents.

(2) A health maintenance organization that denies coverage to an individual in accordance with paragraph (1) of this subsection may not offer coverage in the individual market within the service area to any individual for a period of 180 days after the date the coverage is denied.

(3) Paragraph (2) of this subsection does not:

(i) limit the health maintenance organization's ability to renew coverage already in force; or

(ii) relieve the health maintenance organization of the responsibility to renew coverage already in force.

(h) (1) A carrier may deny a health benefit plan to an individual if the carrier has demonstrated to the Commissioner that:

(i) it does not have the financial reserves necessary to offer additional coverage; and

(ii) it is applying the provisions of this paragraph uniformly to all individuals in the individual market in the State without regard to the claims experience of those individuals and their dependents or any health status–related factor relating to the individuals and their dependents.

(2) A carrier that denies a health benefit plan to an individual in the State under paragraph (1) of this subsection may not offer coverage in the individual market before the later of:

(i) the 181st day after the date the carrier denies coverage; and

(ii) the date the carrier demonstrates to the Commissioner that the carrier has sufficient financial reserves to underwrite additional coverage.

(3) Paragraph (2) of this subsection does not:

(i) limit the carrier's ability to renew coverage already in force; or

(ii) relieve the carrier of the responsibility to renew coverage already in force.

(4) Health benefit plans offered after the time period described in paragraph (2) of this subsection are subject to the requirements of this section.

§15–1316. ** TAKES EFFECT JANUARY 1, 2027 PER CHAPTER 787 OF 2026 **

(a) (1) In this section the following words have the meanings indicated.

(2) "Dependent" means an individual who is or who may become eligible for coverage under the terms of a health benefit plan because of a relationship with another individual.

(3) "Health care practitioner" has the meaning stated in § 1–301 of the Health Occupations Article.

(4) "Provider" means a health care practitioner or a health care facility that participates on a health benefit plan's provider panel.

(5) "Qualifying coverage in an eligible employer–sponsored plan" has the meaning stated in 45 C.F.R. § 155.300.

(b) (1) Beginning November 15, 2014, unless an alternative date is adopted by the federal Department of Health and Human Services, a carrier that sells health benefit plans to individuals in the State shall establish an annual open enrollment period.

(2) The annual open enrollment period for 2014 shall begin on November 15, 2014, and extend through January 15, 2015, unless alternative dates are adopted by the federal Department of Health and Human Services.

(3) The annual open enrollment period for years beginning on and after January 1, 2015, shall be:

(i) the dates adopted by the federal Department of Health and Human Services; or

(ii) if authorized by the federal Department of Health and Human Services, the dates adopted by the Exchange.

(4) During the annual open enrollment period, an individual shall be permitted to:

(i) enroll in a health benefit plan offered by the carrier;

(ii) discontinue enrollment in a health benefit plan offered by the carrier; or

(iii) change enrollment in a health benefit plan offered by the carrier to a different health benefit plan offered by the carrier.

(5) If an individual enrolls in a health benefit plan offered by the carrier during the annual open enrollment period for 2014, the effective date of coverage shall be:

(i) January 1, 2015, if the application is received by the carrier on or before December 15, 2014, unless an alternative date is adopted by the federal Department of Health and Human Services;

(ii) February 1, 2015, if the application is received by the carrier from December 16, 2014, through January 15, 2015, unless an alternative date is adopted by the federal Department of Health and Human Services; and

(iii) March 1, 2015, if the application is received by the carrier from January 16, 2015, through February 15, 2015, unless an alternative date is adopted by the federal Department of Health and Human Services.

(6) If an individual enrolls in a health benefit plan offered by the carrier during the annual open enrollment period for years beginning on and after January 1, 2015, the effective date of coverage shall be:

(i) the date adopted by the federal Department of Health and Human Services; or

(ii) if authorized by the federal Department of Health and Human Services, the date adopted by the Exchange.

(c) A carrier participating in the Individual Exchange shall provide:

(1) the special enrollment periods specified in 45 C.F.R. § 155.420 for individuals who purchase coverage through the Individual Exchange;

(2) a special enrollment period for an individual who purchases coverage through the Individual Exchange if the individual or a dependent of the individual becomes pregnant, as confirmed by a health care practitioner; and

(3) a special enrollment period for an individual who purchases coverage through the Individual Exchange if the individual or a dependent of the individual is:

(i) a patient being treated on a regular basis by or at a provider; and

(ii) enrolled in a health benefit plan in which the provider treating the individual or dependent is terminated from the health benefit plan's provider panel.

(d) A carrier shall provide:

(1) the special enrollment periods specified in 45 C.F.R. § 147.104(b)(2) for individuals who purchase coverage outside the Individual Exchange;

(2) a special enrollment period for an individual who purchases coverage outside the Individual Exchange if the individual or a dependent of the individual becomes pregnant, as confirmed by a health care practitioner; and

(3) a special enrollment period for an individual who purchases coverage outside the Individual Exchange if the individual or a dependent of the individual is:

(i) a patient being treated on a regular basis by or at a provider; and

(ii) enrolled in a health benefit plan in which the provider treating the individual or dependent is terminated from the health benefit plan's provider panel.

(e) (1) A special enrollment period described in subsection (c)(2) or (d)(2) of this section shall:

(i) be open for a period of 90 days; and

(ii) begin on the date the health care practitioner confirms the pregnancy.

(2) A special enrollment period described in subsection (c)(3) or (d)(3) of this section shall:

(i) be open for a period of 90 days; and

(ii) begin on:

1. the date of termination of the provider from the health benefit plan's provider panel; or

2. if the consumer did not receive notice of the termination before the termination date, the date of the notice of termination.

(f) (1) If an individual enrolls for coverage during one of the open enrollment periods described in subsection (b) of this section or during one of the special open enrollment periods described in subsections (c)(1) and (d)(1) of this section, coverage shall be effective in accordance with the requirements in 45 C.F.R. § 155.420.

(2) (i) If an individual enrolls for coverage or enrolls a dependent for coverage during a special enrollment period described in subsection (c)(2) or (d)(2) of this section, the individual may choose whether the coverage becomes effective on:

1. the first day of the month in which the individual receives confirmation of pregnancy; or

2. the first day of the month following the date of plan selection.

(ii) If the individual fails to select the day on which coverage becomes effective, the carrier shall select the day from those listed under subparagraph (i) of this paragraph.

(3) If an individual enrolls for coverage or enrolls a dependent for coverage during a special enrollment period described in subsection (c)(3) or (d)(3) of this section, the individual shall select if coverage shall become effective:

(i) on the first day of the month following the date the health benefit plan was selected; or

(ii) on the first day of the month in which the termination of the provider on the health benefit plan's provider panel became effective.

(g) (1) A health maintenance organization may:

(i) limit the individuals who may apply for coverage to those who live or reside in the health maintenance organization's service area; and

(ii) deny coverage to individuals if the health maintenance organization has demonstrated to the Commissioner that:

1. it will not have the capacity to deliver services adequately to any additional individuals because of its obligations to existing enrollees; and

2. it is applying the provisions of this paragraph uniformly to all individuals without regard to the claims experience of those individuals and their dependents or any health status–related factor relating to the individuals and their dependents.

(2) A health maintenance organization that denies coverage to an individual in accordance with paragraph (1) of this subsection may not offer coverage in the individual market within the service area to any individual for a period of 180 days after the date the coverage is denied.

(3) Paragraph (2) of this subsection does not:

(i) limit the health maintenance organization's ability to renew coverage already in force; or

(ii) relieve the health maintenance organization of the responsibility to renew coverage already in force.

(h) (1) A carrier may deny a health benefit plan to an individual if the carrier has demonstrated to the Commissioner that:

(i) it does not have the financial reserves necessary to offer additional coverage; and

(ii) it is applying the provisions of this paragraph uniformly to all individuals in the individual market in the State without regard to the claims experience of those individuals and their dependents or any health status–related factor relating to the individuals and their dependents.

(2) A carrier that denies a health benefit plan to an individual in the State under paragraph (1) of this subsection may not offer coverage in the individual market before the later of:

(i) the 181st day after the date the carrier denies coverage; and

(ii) the date the carrier demonstrates to the Commissioner that the carrier has sufficient financial reserves to underwrite additional coverage.

(3) Paragraph (2) of this subsection does not:

(i) limit the carrier's ability to renew coverage already in force; or

(ii) relieve the carrier of the responsibility to renew coverage already in force.

(4) Health benefit plans offered after the time period described in paragraph (2) of this subsection are subject to the requirements of this section.

§15–1317.

(a) A carrier that sells health benefit plans to individuals in the State shall establish an initial open enrollment period that begins October 1, 2013, and extends through March 31, 2014.

(b) A carrier shall accept all applicants who apply for coverage during the initial open enrollment period.

(c) If an application is received by a carrier during the initial open enrollment period, coverage for the applicant shall begin no later than:

(1) January 1, 2014, if the application is received on or before December 15, 2013;

(2) the first day of the following month, if the application is received between the first and fifteenth day, inclusive, of January, February, or March; and

(3) the first day of the second following month, if the application is received between the sixteenth day and the last day, inclusive, of December, January, February, or March.

§15–1318.

(a) (1) In this section the following words have the meanings indicated.

(2) "Institution of higher education" has the meaning stated in the federal Higher Education Act of 1965.

(3) "Student administrative health fee" means a fee charged by an institution of higher education on a periodic basis to students of the institution of higher education to offset the cost of providing health care through health clinics regardless of whether the students utilize the health clinics or enroll in student health plan coverage.

(4) "Student health plan" means an individual health benefit plan that is provided to students enrolled in an institution of higher education and their dependents under a written agreement that:

(i) is between the institution of higher education and a carrier;

(ii) does not make coverage under the health benefit plan available other than in connection with enrollment as a student or as a dependent of a student in the institution of higher education; and

(iii) does not condition eligibility for the health benefit plan on any health status–related factor relating to a student or a dependent of a student.

(b) A carrier that offers student health plans is not required to:

(1) accept individuals who are not:

(i) students; or

(ii) dependents of students covered under the student health plan;

(2) establish open enrollment periods;

(3) establish effective dates that are based on a calendar year;

(4) offer health benefit plan contracts that are on a calendar year basis; or

(5) renew, or continue in force, coverage for individuals who are no longer students or dependents of students.

(c) A student health plan is not subject to the requirement of a single risk pool under § 1312(c) of the Affordable Care Act.

(d) A student health plan shall comply with the requirements of 45 C.F.R. § 147.145, as interpreted and implemented by the federal Centers for Medicare and Medicaid Services.

(e) A student administrative health fee is not considered a cost–sharing requirement with respect to specified recommended preventive services.

§15–1401.

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

(b) "Association" or "bona fide association" means, with respect to health insurance coverage offered in this State, 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 through a member 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.

(c) "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.

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

(e) "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.

(f) "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.

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

(h) (1) "Health benefit plan" means any:

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

(ii) policy or contract 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;

7. coverage for on–site medical clinics; and

8. other similar insurance coverage, specified in federal regulations issued under the federal Health Insurance Portability and Accountability Act, under which benefits for medical care are secondary or incidental to other insurance benefits;

(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 the plan:

1. limited scope dental or vision benefits;

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

3. such other similar, limited benefits as are specified in federal regulations issued under the federal Health Insurance Portability and Accountability Act;

(iii) the following benefits if offered as independent, noncoordinated benefits:

1. coverage only for a specified disease or illness; and

2. hospital indemnity or other fixed indemnity insurance, if the benefits are payable in a fixed dollar amount per period of time, regardless of the amount of expenses incurred; or

(iv) 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 if the coverage qualifies for the exception described in 45 C.F.R. § 146.145(b)(5)(i)(C).

(i) "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.

(j) "Late enrollee" means a member, subscriber, or dependent who enrolls in a group health benefit plan other than during:

(1) the first period in which the individual is eligible to enroll under the plan; or

(2) a special enrollment period.

(k) "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.

(l) "Preexisting condition provision" means a provision in a health benefit plan that denies, excludes, or limits benefits for an enrollee for expenses or services related to a preexisting condition.

(m) "Secretary" means the Secretary of the federal Department of Health and Human Services.

(n) "Special enrollment period" means a period during which a group health plan shall permit certain individuals who are eligible for coverage, but not enrolled, to enroll for coverage under the terms of the group health benefit plan.

(o) "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.

§15–1402.

(a) Subject to subsection (b) of this section, this subtitle applies to all carriers in connection with group health benefit plans.

(b) This subtitle does not apply to policies issued under Subtitle 12 of this title.

§15–1406.

(a) A carrier may not establish rules for eligibility of an individual to enroll under a group health benefit plan based on any health status-related factor.

(b) Subsection (a) of this section does not:

(1) require a carrier to provide particular benefits other than those provided under the terms of the particular health benefit plan; or

(2) prevent a carrier from establishing limitations or restrictions on the amount, level, extent, or nature of the benefits or coverage for similarly situated individuals enrolled in the health benefit plan.

(c) Rules for eligibility to enroll under a plan include rules defining any applicable waiting periods for enrollment.

(d) A carrier shall allow an employee or dependent who is eligible, but not enrolled, for coverage under the terms of a group health benefit plan to enroll for coverage under the terms of the plan if:

(1) the employee or dependent was covered under an employer-sponsored plan or group health benefit plan at the time coverage was previously offered to the employee or dependent;

(2) the employee states in writing, at the time coverage was previously offered, that coverage under an employer-sponsored plan or group health benefit plan was the reason for declining enrollment, but only if the plan sponsor or issuer requires the statement and provides the employee with notice of the requirement;

(3) the employee's or dependent's coverage described in item (1) of this subsection:

(i) was under a COBRA continuation provision, and the coverage under that provision was exhausted; or

(ii) was not under a COBRA continuation provision, and either the coverage was terminated as a result of loss of eligibility for the coverage, including loss of eligibility as a result of legal separation, divorce, death, termination of employment, or reduction in the number of hours of employment, or employer contributions towards the coverage were terminated; and

(4) under the terms of the plan, the employee requests enrollment not later than 30 days after:

(i) the date of exhaustion of coverage described in item (3)(i) of this subsection; or

(ii) termination of coverage or termination of employer contributions described in item (3)(ii) of this subsection.

§15–1406.1.

(a) In this section, "eligible employee" means:

(1) a participant under the group health benefit plan; or

(2) an individual who:

(i) has met any waiting period applicable to becoming a participant under the group health benefit plan;

(ii) is eligible to be enrolled under the plan; and

(iii) is not a participant in the group health benefit plan because of failure to enroll during a previous enrollment period.

(b) This section applies if a group health benefit plan makes coverage available to dependents of an eligible employee.

(c) A group health benefit plan subject to this section shall provide a special enrollment period during which the following individuals may be enrolled under the group health benefit plan:

(1) an individual who becomes a dependent of an eligible employee through marriage, birth, adoption, or placement for adoption;

(2) an eligible employee who acquires a new dependent through marriage, birth, adoption, or placement for adoption; and

(3) the spouse of an eligible employee at the birth or adoption of a child, provided the spouse is otherwise eligible for coverage.

(d) An eligible employee may not enroll a dependent during a special enrollment period unless the eligible employee:

(1) is enrolled under the health benefit plan; or

(2) applies for coverage for the eligible employee during the same special enrollment period.

(e) The special enrollment period under subsection (c) of this section shall be a period of not less than 31 days and shall begin on the later of:

(1) the date dependent coverage is made available; or

(2) the date of the marriage, birth, adoption, or placement for adoption, whichever is applicable.

(f) If an eligible employee enrolls any of the individuals described in subsection (c) of this section during the first 31 days of the special enrollment period, the coverage shall become effective as follows:

(1) in the case of marriage, not later than the first day of the first month beginning after the date the completed request for enrollment is received;

(2) in the case of a dependent's birth, as of the date of the dependent's birth; and

(3) in the case of a dependent's adoption or placement for adoption, the date of adoption or placement for adoption, whichever occurs first.

§15–1407.

A carrier may not require an individual member of a group to pay a premium or contribution that is greater than the premium or contribution for a similarly situated individual, based on any health status-related factor.

§15–1408.

A carrier shall renew group health benefit plans at the option of the policyholder or plan sponsor, except in any of the following cases:

(1) for nonpayment of the required premium;

(2) where the policyholder or plan sponsor has performed an act or practice that constitutes fraud;

(3) where the policyholder or plan sponsor has made an intentional misrepresentation of material fact under the terms of the coverage;

(4) where the policyholder or plan sponsor has failed to comply with a material plan provision relating to the employer contributions or group participation rules;

(5) where the carrier elects not to renew all group health benefit plans in the State;

(6) in the case of a health maintenance organization, where there is no longer any enrollee who lives, resides, or works in the health maintenance organization's approved service area, provided notice of the nonrenewal is provided to each employer and to each employee covered under the health benefit plan at least 90 days before the date coverage will be terminated;

(7) in the case of a carrier that offers coverage only through one or more bona fide associations, when the membership of an employer in the association ceases and nonrenewal under this item is applied uniformly without regard to any health status–related factor relating to any covered individual; or

(8) the carrier makes an election under § 15–1409 of this subtitle.

§15–1409.

(a) In this section, "product" means a discrete package of health benefits that are offered using a particular product network type within a geographic service area.

(b) A carrier that elects not to renew all of a particular product in the State shall:

(1) provide notice of the nonrenewal at least 90 days before the date of the nonrenewal to each affected:

(i) policyholder;

(ii) plan sponsor;

(iii) participant; and

(iv) beneficiary;

(2) offer to each affected plan sponsor the option to purchase any other health insurance coverage currently being offered by the carrier; and

(3) act uniformly without regard to the claims experience of any affected plan sponsor, or any health status–related factor of any affected individual.

(c) A carrier may elect not to renew all group health benefit plans in the State.

(d) When a carrier elects not to renew all group health benefit plans in the State, the carrier:

(1) shall give notice of its decision to the affected individuals at least 180 days before the effective date of nonrenewal;

(2) at least 30 working days before that notice, shall give notice to the Commissioner; and

(3) may not write new business for groups in the State for a 5–year period beginning on the date of notice to the Commissioner.

(e) A health maintenance organization need not offer coverage to an individual who does not live, reside, or work within the health maintenance organization's approved service areas.

(f) A carrier may make a uniform modification of coverage for a product only at the time of renewal of a health benefit plan.

(g) A carrier will not be considered to have elected not to renew all group health benefit plans in the State if the carrier complies with 45 C.F.R. § 147.106(d)(3).

§15–1410.

(a) In this section, "plan year" has the meaning stated in § 15–1201 of this title.

(b) The guaranteed issuance of coverage provision in Title I, Subtitle C of the Affordable Care Act applies to each health benefit plan with a plan year that begins on or after January 1, 2014.

§15–1411.

(a) (1) In this section the following words have the meanings indicated.

(2) "Aggregate incurred claims" means the total claims incurred in the experience period that the carrier uses to experience rate a large employer's health benefit plan.

(3) "Experience rating" means that a carrier develops the premium rates for an employer's health benefit plan based in whole or in part on the claims experience of the group that consists of the employer's employees or employees' dependents.

(4) "Large employer" means an employer that is not a small employer as defined in § 31–101 of this article.

(b) If a carrier is experience rating a large employer's health benefit plan, the carrier shall disclose the aggregate incurred claims of the group to the large employer within 30 days after receipt of a request from the large employer.

(c) The aggregate incurred claims required to be disclosed under subsection (b) of this section shall be provided in a format that complies with the privacy requirements of the federal Health Insurance Portability and Accessibility Act.

§15–1501.

(a) (1) In this subtitle the following words have the meanings indicated.

(2) "Commission" means the Maryland Health Care Commission.

(3) (i) "Mandated health insurance service" means a legislative proposal or statute that would require a particular health care service to be provided or offered in a health benefit plan, by a carrier, including a health maintenance organization, or other organization authorized to provide health benefit plans in the State.

(ii) "Mandated health insurance service", as applicable to all carriers, does not include services enumerated to describe a health maintenance organization under § 19–701(g)(2) of the Health – General Article.

(b) This subtitle does not affect the ability of the General Assembly to enact legislation on mandated health insurance services.

(c) (1) The Commission shall assess the social, medical, and financial impacts of a proposed mandated health insurance service.

(2) In assessing a proposed mandated health insurance service and to the extent that information is available, the Commission shall consider:

(i) social impacts, including:

1. the extent to which the service is generally utilized by a significant portion of the population;

2. the extent to which the insurance coverage is already generally available;

3. if coverage is not generally available, the extent to which the lack of coverage results in individuals avoiding necessary health care treatments;

4. if coverage is not generally available, the extent to which the lack of coverage results in unreasonable financial hardship;

5. the level of public demand for the service;

6. the level of public demand for insurance coverage of the service;

7. the level of interest of collective bargaining agents in negotiating privately for inclusion of this coverage in group contracts; and

8. the extent to which the mandated health insurance service is covered by self–funded employer groups of employers in the State who employ at least 500 employees;

(ii) medical impacts, including:

1. the extent to which the service is generally recognized by the medical community as being effective and efficacious in the treatment of patients;

2. the extent to which the service is generally recognized by the medical community as demonstrated by a review of scientific and peer review literature; and

3. the extent to which the service is generally available and utilized by treating physicians; and

(iii) financial impacts, including:

1. the extent to which the coverage will increase or decrease the cost of the service;

2. the extent to which the coverage will increase the appropriate use of the service;

3. the extent to which the mandated service will be a substitute for a more expensive service;

4. the extent to which the coverage will increase or decrease the administrative expenses of carriers, including health maintenance organizations, or other organizations authorized to provide health benefit plans in the State, and the premium and administrative expenses of policy holders and contract holders;

5. the impact of this coverage on the total cost of health care; and

6. the impact of all mandated health insurance services on employers' ability to purchase health benefits policies meeting their employees' needs.

(d) Subject to the limitations of the State budget, the Commission may contract for actuarial services and other professional services to carry out the provisions of this section.

(e) (1) On or before December 31, 1998, and each December 31 thereafter, the Commission shall submit a report on its findings, including any recommendations, to the Governor and, subject to § 2–1257 of the State Government Article, the General Assembly.

(2) The annual report prepared by the Commission shall include an evaluation of any mandated health insurance service legislatively proposed or otherwise submitted to the Commission by a member of the General Assembly prior to July 1 of that year.

§15–1502.

(a) (1) The Commission shall conduct an evaluation of existing mandated health insurance services and make recommendations to the General Assembly regarding decision making criteria for reducing the number of mandates or the extent of coverage.

(2) The evaluation shall include:

(i) an assessment of the full cost of each existing mandated health insurance service as a percentage of the State's average annual wage and of premiums:

1. under a typical group and individual health benefit plan in the State;

2. under the State employee health benefit plan; and

3. under the Comprehensive Standard Health Benefit Plan;

(ii) an assessment of the degree to which existing mandated health insurance services are covered in self–funded plans; and

(iii) a comparison of mandated health insurance services provided by the State with those provided in Delaware, the District of Columbia, Pennsylvania, and Virginia.

(3) The comparison described in paragraph (2)(iii) of this subsection shall include:

(i) the number of mandated health insurance services;

(ii) the type of mandated health insurance services;

(iii) the level and extent of coverage for each mandated health insurance service; and

(iv) the financial impact of differences in levels of coverage for each mandated health insurance service.

(4) On or before January 1, 2004, and every 4 years thereafter, the Commission shall submit a report of its findings to the General Assembly, subject to § 2–1257 of the State Government Article.

(b) The General Assembly may consider the information provided under subsection (a) of this section in determining:

(1) whether to enact proposed mandated health insurance services; and

(2) whether to repeal existing mandated health insurance services.

§15–1601.

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

(b) "Agent" means a pharmacy, a pharmacist, a mail order pharmacy, or a nonresident pharmacy acting on behalf or at the direction of a pharmacy benefits manager.

(c) "Beneficiary" means an individual who receives prescription drug coverage or benefits from a purchaser.

(d) (1) "Carrier" means the State Employee and Retiree Health and Welfare Benefits Program, an insurer, a nonprofit health service plan, or a health maintenance organization that:

(i) provides prescription drug coverage or benefits in the State; and

(ii) enters into an agreement with a pharmacy benefits manager for the provision of pharmacy benefits management services.

(2) "Carrier" does not include a person that provides prescription drug coverage or benefits through plans subject to ERISA and does not provide prescription drug coverage or benefits through insurance, unless the person is a multiple employer welfare arrangement as defined in § 514(b)(6)(a)(ii) of ERISA.

(e) "Compensation program" means a program, policy, or process through which sources and pricing information are used by a pharmacy benefits manager to determine the terms of payment as stated in a participating pharmacy contract.

(f) "Contracted pharmacy" means a pharmacy that participates in the network of a pharmacy benefits manager through a contract with:

(1) the pharmacy benefits manager; or

(2) a pharmacy services administration organization or a group purchasing organization.

(g) "ERISA" has the meaning stated in § 8–301 of this article.

(h) "Formulary" means a list of prescription drugs used by a purchaser.

(i) (1) "Manufacturer payments" means any compensation or remuneration a pharmacy benefits manager receives from or on behalf of a pharmaceutical manufacturer.

(2) "Manufacturer payments" includes:

(i) payments received in accordance with agreements with pharmaceutical manufacturers for formulary placement and, if applicable, drug utilization;

(ii) rebates, regardless of how categorized;

(iii) market share incentives;

(iv) commissions;

(v) fees under products and services agreements;

(vi) any fees received for the sale of utilization data to a pharmaceutical manufacturer; and

(vii) administrative or management fees.

(3) "Manufacturer payments" does not include purchase discounts based on invoiced purchase terms.

(j) "Nonprofit health maintenance organization" has the meaning stated in § 6–121(a) of this article.

(k) "Nonresident pharmacy" has the meaning stated in § 12–403 of the Health Occupations Article.

(l) "Participating pharmacy contract" means a contract filed with the Commissioner in accordance with § 15–1628(b) of this subtitle.

(m) "Pharmacist" has the meaning stated in § 12–101 of the Health Occupations Article.

(n) "Pharmacy" has the meaning stated in § 12–101 of the Health Occupations Article.

(o) "Pharmacy and therapeutics committee" means a committee established by a pharmacy benefits manager to:

(1) objectively appraise and evaluate prescription drugs; and

(2) make recommendations to a purchaser regarding the selection of drugs for the purchaser's formulary.

(p) (1) "Pharmacy benefits management services" means:

(i) the procurement of prescription drugs at a negotiated rate for dispensation within the State to beneficiaries;

(ii) the administration or management of prescription drug coverage provided by a purchaser for beneficiaries; and

(iii) any of the following services provided with regard to the administration of prescription drug coverage:

1. mail service pharmacy;

2. claims processing, retail network management, and payment of claims to pharmacies for prescription drugs dispensed to beneficiaries;

3. clinical formulary development and management services;

4. rebate contracting and administration;

5. patient compliance, therapeutic intervention, and generic substitution programs; or

6. disease management programs.

(2) "Pharmacy benefits management services" does not include any service provided by a nonprofit health maintenance organization that operates as a group model, provided that the service:

(i) is provided solely to a member of the nonprofit health maintenance organization; and

(ii) is furnished through the internal pharmacy operations of the nonprofit health maintenance organization.

(q) "Pharmacy benefits manager" means a person that performs pharmacy benefits management services.

(r) "Proprietary information" means:

(1) a trade secret;

(2) confidential commercial information; or

(3) confidential financial information.

(s) "Purchaser" means a person that offers a plan or program in the State, including the State Employee and Retiree Health and Welfare Benefits Program, that:

(1) provides prescription drug coverage or benefits in the State; and

(2) enters into an agreement with a pharmacy benefits manager for the provision of pharmacy benefits management services.

(t) "Rebate sharing contract" means a contract between a pharmacy benefits manager and a purchaser under which the pharmacy benefits manager agrees to share manufacturer payments with the purchaser.

(u) (1) "Therapeutic interchange" means any change from one prescription drug to another.

(2) "Therapeutic interchange" does not include:

(i) a change initiated pursuant to a drug utilization review;

(ii) a change initiated for patient safety reasons;

(iii) a change required due to market unavailability of the currently prescribed drug;

(iv) a change from a brand name drug to a generic drug in accordance with § 12–504 of the Health Occupations Article; or

(v) a change required for coverage reasons because the originally prescribed drug is not covered by the beneficiary's formulary or plan.

(v) "Therapeutic interchange solicitation" means any communication by a pharmacy benefits manager for the purpose of requesting a therapeutic interchange.

(w) "Trade secret" has the meaning stated in § 11–1201 of the Commercial Law Article.

§15–1604.

(a) A pharmacy benefits manager shall register with the Commissioner as a pharmacy benefits manager before providing pharmacy benefits management services in the State to purchasers.

(b) An applicant for registration shall:

(1) file with the Commissioner an application on the form that the Commissioner provides; and

(2) pay to the Commissioner a registration fee set by the Commissioner.

(c) The Commissioner may require any additional information or submissions from a pharmacy benefits manager that may be reasonably necessary to verify the information contained in the application.

(d) Subject to the provisions of § 15–1607 of this part, the Commissioner shall register each pharmacy benefits manager that meets the requirements of this section.

§15–1605.

(a) A pharmacy benefits manager registration expires on the second September 30 after its effective date unless it is renewed as provided under this section.

(b) A pharmacy benefits manager may renew its registration for an additional 2–year term, if the pharmacy benefits manager:

(1) otherwise is entitled to be registered;

(2) files with the Commissioner a renewal application on the form that the Commissioner requires; and

(3) pays to the Commissioner a renewal fee set by the Commissioner.

(c) An application for renewal of a pharmacy benefits manager registration shall be considered made in a timely manner if it is postmarked on or before the date the pharmacy benefits manager's registration expires.

(d) Subject to the provisions of § 15–1607 of this part, the Commissioner shall renew the registration of each pharmacy benefits manager that meets the requirements of this section.

(e) The Commissioner may require any additional information or submissions from a pharmacy benefits manager that may be reasonably necessary to verify the information contained in the application.

§15–1606.

A carrier may not enter into an agreement with a pharmacy benefits manager that has not registered with the Commissioner.

§15–1607.

(a) Subject to the applicable hearing provisions of Title 2 of this article, the Commissioner may deny a registration to a pharmacy benefits manager applicant or refuse to renew, suspend, or revoke the registration of a pharmacy benefits manager if the pharmacy benefits manager, or an officer, director, or employee of the pharmacy benefits manager:

(1) makes a material misstatement or misrepresentation in an application for registration;

(2) fraudulently or deceptively obtains or attempts to obtain a registration;

(3) in connection with the administration of pharmacy benefits management services, commits fraud or engages in illegal or dishonest activities; or

(4) violates any provision of this part or a regulation adopted under this part.

(b) This section does not limit any other regulatory authority of the Commissioner under this article.

§15–1608.

A pharmacy benefits manager shall maintain adequate books and records about each purchaser for which the pharmacy benefits manager provides pharmacy benefits management services:

(1) in accordance with prudent standards of record keeping;

(2) for the duration of the agreement between the pharmacy benefits manager and the purchaser; and

(3) for 3 years after the pharmacy benefits manager ceases to provide pharmacy benefits management services for the purchaser.

§15–1609.

(a) Whenever the Commissioner considers it advisable, the Commissioner may examine the affairs, transactions, accounts, and records of a registered pharmacy benefits manager.

(b) The examination shall be conducted in accordance with § 2–207 of this article.

(c) The expense of the examination shall be paid in accordance with § 2–208 of this article.

(d) The reports of the examination and investigation shall be issued in accordance with § 2–209 of this article.

§15–1610.

A pharmacy benefits manager may not ship, mail, or deliver prescription drugs or devices to a person in the State through a nonresident pharmacy unless the nonresident pharmacy holds a permit issued in accordance with the provisions of § 12–403 of the Health Occupations Article.

§15–1611.

(a) This section applies only to a pharmacy benefits manager that provides pharmacy benefits management services on behalf of a carrier.

(b) A pharmacy benefits manager may not prohibit a pharmacy or pharmacist from:

(1) providing a beneficiary with information regarding the retail price for a prescription drug or the amount of the cost share for which the beneficiary is responsible for a prescription drug;

(2) discussing with a beneficiary information regarding the retail price for a prescription drug or the amount of the cost share for which the beneficiary is responsible for a prescription drug; or

(3) if a more affordable drug is available than one on the purchaser's formulary and the requirements for a therapeutic interchange under §§ 15–1633.1 through 15–1639 of this subtitle are met, selling the more affordable alternative to the beneficiary.

(c) This section may not be construed to alter the requirements for a therapeutic interchange under §§ 15–1633.1 through 15–1639 of this subtitle.

§15–1611.1.

(a) This section applies only to a pharmacy benefits manager that provides pharmacy benefits management services on behalf of a carrier.

(b) Except as provided in subsection (c) of this section, a pharmacy benefits manager may not require that a beneficiary use a specific pharmacy or entity to fill a prescription if:

(1) the pharmacy benefits manager or a corporate affiliate of the pharmacy benefits manager has an ownership interest in the pharmacy or entity; or

(2) the pharmacy or entity has an ownership interest in the pharmacy benefits manager or a corporate affiliate of the pharmacy benefits manager.

(c) Except as provided in § 15–847.2 of this title, a pharmacy benefits manager may require a beneficiary to use a specific pharmacy or entity for a specialty drug as defined in § 15–847 of this title.

§15–1611.2.

(a) (1) In this section the following words have the meanings indicated.

(2) "Covered entity" has the meaning stated in § 602 of the federal Veterans Health Care Act of 1992.

(3) "Pharmacies or pharmacists that participate in the 340B Program" means:

(i) a pharmacy owned or operated by a covered entity that is eligible to or is actively participating in the 340B Program; or

(ii) a pharmacy or pharmacist under contract with a covered entity to dispense drugs purchased under the 340B Program to patients of the covered entity.

(4) "340B Program" means the drug pricing program established under § 602 of the federal Veterans Health Care Act of 1992.

(b) A pharmacy benefits manager shall:

(1) make formulary and coverage decisions for a pharmacy or pharmacist that participates in the 340B Program based on the normal course of business of the pharmacy benefits manager; and

(2) allow a beneficiary to use any in–network pharmacy or pharmacist that the beneficiary choses, without regard to whether the pharmacy or pharmacist participates in the 340B Program.

(c) A pharmacy benefits manager may not:

(1) transfer the 340B Program savings from a pharmacy or pharmacist that participates in the 340B Program to a pharmacy benefits manager;

(2) offer lower reimbursement for a prescription drug purchased under the 340B Program than the reimbursement it offers for the same prescription drug if it is not purchased under the 340B Program;

(3) refuse to cover the prescription drugs purchased under the 340B Program;

(4) refuse to allow pharmacies or pharmacists that participate in the 340B Program to participate in the pharmacy benefits manager's network on the sole basis that the pharmacy or pharmacist participates in the 340B Program;

(5) impose different reimbursement or network participation contract terms on pharmacies or pharmacists that participate in a pharmacy benefits

manager's network based on whether a pharmacy or pharmacist participates in the 340B Program;

(6) impose different fees, chargebacks, or other adjustments on pharmacies or pharmacists based on whether a pharmacy or pharmacist participates in the 340B Program;

(7) modify a beneficiary's copayment on the basis of whether a pharmacy or pharmacist participates in the 340B Program;

(8) establish or set network adequacy requirements based on whether a pharmacy or pharmacist participates in the 340B Program; or

(9) prohibit a covered entity authorized to participate in the 340B Program or a pharmacy or pharmacist under contract with a covered entity authorized to participate in the 340B Program from participating in the pharmacy benefits manager's network on the basis of the covered entity's participation in the 340B Program.

(d) A pharmacy benefits manager may not base formulary or prescription drug coverage decisions on:

(1) the price of the prescription drug under the 340B Program; or

(2) whether the dispensing pharmacy or pharmacist participates in the 340B Program.

§15–1612.

(a) This section applies only to a pharmacy benefits manager that provides pharmacy benefits management services on behalf of a carrier.

(b) This section does not apply to reimbursement:

(1) except as provided in § 15–847.2 of this title, for specialty drugs;

(2) for mail order drugs; or

(3) to a chain pharmacy with more than 15 stores or a pharmacist who is an employee of the chain pharmacy.

(c) A pharmacy benefits manager may not reimburse a pharmacy or pharmacist for a pharmaceutical product or pharmacist service in an amount less

than the amount that the pharmacy benefits manager reimburses itself or an affiliate for providing the same product or service.

§15–1613.

A pharmacy and therapeutics committee established by a pharmacy benefits manager performing pharmacy benefits management services on behalf of a carrier shall meet the requirements of this part.

§15–1614.

(a) (1) A pharmacy and therapeutics committee shall:

(i) include clinical specialists that represent the needs of a purchaser's beneficiaries; and

(ii) include at least one practicing pharmacist and one practicing physician who are independent of any developer or manufacturer of prescription drugs.

(2) A majority of the members of a pharmacy and therapeutics committee shall be practicing physicians or practicing pharmacists.

(b) Each member of a pharmacy and therapeutics committee shall sign a conflict of interest statement updated at least annually disclosing any economic interest or relationship that could influence the pharmacy and therapeutics committee's decisions.

§15–1615.

A pharmacy benefits manager may not require a pharmacist to participate on its pharmacy and therapeutics committee.

§15–1616.

On request of a purchaser for which the pharmacy and therapeutics committee makes recommendations, a pharmacy benefits manager shall disclose information about the composition of its pharmacy and therapeutics committee to the purchaser.

§15–1617.

A pharmacy benefits manager shall ensure that its pharmacy and therapeutics committee has:

(1) policies and procedures, including disclosure requirements, to address potential conflicts of interest that members of the pharmacy and therapeutics committee may have with developers or manufacturers of prescription drugs;

(2) a process to evaluate medical and scientific evidence concerning the safety and effectiveness of prescription drugs, including available comparative information on clinically similar prescription drugs, when deciding what prescription drugs to recommend to include on a formulary;

(3) a process to evaluate medical and scientific evidence concerning the safety and effectiveness of prescription drugs when recommending utilization review requirements, dose restrictions, and step therapy requirements; and

(4) a process to enable the pharmacy and therapeutics committee to consider the need to recommend a formulary change to a purchaser in a timely manner but at least annually.

§15–1618.

The Commissioner may consider a pharmacy and therapeutics committee of a pharmacy benefits manager as having met the requirements of §§ 15–1614 and 15–1617 of this part if the pharmacy benefits manager has obtained accreditation from an accrediting organization approved by the Commissioner.

§15–1619.

The Commissioner may adopt regulations to implement this part.

§15–1622.

(a) Except as provided for in subsection (b) of this section, the provisions of §§ 15–1623 and 15–1624 of this subtitle apply only to a pharmacy benefits manager that provides pharmacy benefits management services on behalf of a carrier.

(b) The provisions of §§ 15–1623 and 15–1624 of this subtitle do not apply to a pharmacy benefits manager when providing pharmacy benefits management services to a purchaser that is affiliated with the pharmacy benefits manager through common ownership within an insurance holding company.

§15–1623.

(a) Before entering into a contract with a purchaser, a pharmacy benefits manager:

(1) as applicable, shall inform the purchaser that the pharmacy benefits manager may:

(i) solicit and receive manufacturer payments;

(ii) pass through or retain the manufacturer payments depending on the contract terms with a purchaser;

(iii) sell aggregate utilization information; and

(iv) share aggregate utilization information with other entities; and

(2) shall offer to provide to the purchaser a report that contains the:

(i) net revenue of the pharmacy benefits manager from sales of prescription drugs to purchasers made through the pharmacy benefits manager's network of contractually affiliated retail pharmacies or through the pharmacy benefits manager's mail order pharmacies, with respect to the pharmacy benefits manager's entire client base of purchasers; and

(ii) amount of all manufacturer payments earned by the pharmacy benefits manager.

(b) (1) If a purchaser requests the information described in subsection (a)(2) of this section, a pharmacy benefits manager shall provide the information before entering into a contract with the purchaser.

(2) Notwithstanding the provisions of paragraph (1) of this subsection, if a pharmacy benefits manager requires a nondisclosure agreement under which a purchaser agrees that the information described in subsection (a)(2) of this section is proprietary information, the pharmacy benefits manager may not be required to provide the information until the purchaser has signed the nondisclosure agreement.

§15–1624.

(a) If a purchaser has a rebate sharing contract, a pharmacy benefits manager shall offer to provide the purchaser a report for each fiscal quarter and each fiscal year that contains the amount of the:

(1) net revenue of the pharmacy benefits manager from sales of prescription drugs to purchasers made through the pharmacy benefits manager's network of contractually affiliated retail pharmacies or through the pharmacy

benefits manager's mail order pharmacies, with respect to the pharmacy benefits manager's entire client base of purchasers;

(2) total prescription drug expenditures applicable to the purchaser;

(3) total manufacturer payments earned by the pharmacy benefits manager during the applicable reporting period; and

(4) total rebates applicable to the purchaser during the applicable reporting period.

(b) If the exact amount of each item to be reported under subsection (a) of this section is not known by the pharmacy benefits manager at the time of its report, the pharmacy benefits manager shall offer to provide:

(1) its current best estimate of the amount of each item; and

(2) an updated report containing the exact amount of each item immediately after it becomes available.

(c) (1) A pharmacy benefits manager shall provide the information described in subsections (a) and (b) of this section if requested by the purchaser.

(2) Notwithstanding the provisions of paragraph (1) of this subsection, if a pharmacy benefits manager requires a nondisclosure agreement under which a purchaser agrees that the information in subsections (a) and (b) of this section is proprietary information, the pharmacy benefits manager may not be required to provide the information until the purchaser has signed the nondisclosure agreement.

§15–1625.

This part does not diminish the authority of the Office of the Attorney General or the Commissioner to obtain information relating to a pharmacy benefits manager and use the information in any proceeding.

§15–1628.

(a) (1) At the time of entering into a contract with a pharmacy or a pharmacist, and at least 30 working days before any contract change, a pharmacy benefits manager shall disclose to the pharmacy or pharmacist:

(i) the applicable terms, conditions, and reimbursement rates;

(ii) the process and procedures for verifying pharmacy benefits and beneficiary eligibility;

(iii) the dispute resolution and audit appeals process; and

(iv) the process and procedures for verifying the prescription drugs included on the formularies used by the pharmacy benefits manager.

(2) (i) This paragraph does not apply to a requirement that a specialty pharmacy obtain national certification to be considered a specialty pharmacy in a pharmacy benefits manager's or carrier's network.

(ii) For purposes of credentialing a pharmacy or a pharmacist as a condition for participating in a pharmacy benefits manager's network for a carrier, the pharmacy benefits manager may not:

1. require a pharmacy or pharmacist to renew credentialing more frequently than once every 3 years; or

2. charge a pharmacy or pharmacist a fee for the initial credentialing or renewing credentialing.

(b) (1) Each contract form or an amendment to a contract form between a pharmacy benefits manager and a pharmacy or a pharmacy services administrative organization, as defined in § 15–2001 of this title, acting on behalf of a pharmacy may not become effective unless at least 30 days before the contract form or amendment to the contract form is to become effective, the pharmacy benefits manager files an informational filing with the Commissioner in the manner required by the Commissioner that includes a copy of the contract form or amendment to the contract form.

(2) The Commissioner is not required to review the informational filing to evaluate whether a contract form or amendment to a contract form is in violation of this subtitle at the time the informational filing is made.

(3) The Commissioner may review and disapprove a contract form or amendment to a contract form at any time after the contract form or amendment to the contract form has been submitted as part of an informational filing.

§15–1628.1.

(a) (1) In this section the following words have the meanings indicated.

(2) "Drug shortage list" means a list of drug products listed on the federal Food and Drug Administration's Drug Shortages website.

(3) (i) "Maximum allowable cost" means the maximum amount that a pharmacy benefits manager or a purchaser will reimburse a contracted pharmacy for the cost of a multisource generic drug, a medical product, or a device.

(ii) "Maximum allowable cost" does not include dispensing fees.

(4) "Maximum allowable cost list" means a list of multisource generic drugs, medical products, and devices for which a maximum allowable cost has been established by a pharmacy benefits manager or a purchaser.

(b) In each participating pharmacy contract, the pharmacy benefits manager shall include the sources used to determine maximum allowable cost pricing.

(c) A pharmacy benefits manager shall:

(1) update its pricing information at least every 7 days;

(2) establish a reasonable process by which a contracted pharmacy has access to the current and applicable maximum allowable cost price lists in an electronic format as updated in accordance with the requirements of this section; and

(3) immediately after a pricing information update under item (1) of this subsection, use the updated pricing information in calculating the payments made to all contracted pharmacies.

(d) (1) A pharmacy benefits manager shall maintain a procedure to eliminate products from the list of drugs subject to maximum allowable cost pricing as necessary to:

(i) remain consistent with pricing changes;

(ii) remove from the list drugs that no longer meet the requirements of subsection (e) of this section; and

(iii) reflect the current availability of drugs in the marketplace.

(2) A product on the maximum allowable cost list shall be eliminated from the list by the pharmacy benefits manager within 7 days after the pharmacy benefits manager knows of a change in the availability of the product.

(e) Before placing a prescription drug on a maximum allowable cost list, a pharmacy benefits manager shall ensure that:

(1) the drug is listed as "A" or "B" rated in the most recent version of the U.S. Food and Drug Administration's approved drug products with therapeutic equivalence evaluations, also known as the Orange Book, or has an "NR" or "NA" rating or similar rating by a nationally recognized reference;

(2) (i) if a drug is manufactured by more than one manufacturer, the drug is generally available for purchase by contracted pharmacies, including contracted retail pharmacies, in the State from a wholesale distributor with a permit in the State; or

(ii) if a drug is manufactured by only one manufacturer, the drug is generally available for purchase by contracted pharmacies, including contracted retail pharmacies, in the State from at least two wholesale distributors with a permit in the State; and

(3) the drug is not obsolete, temporarily unavailable, or listed on a drug shortage list as currently in shortage.

(f) For disputes regarding maximum allowable cost pricing, each participating pharmacy contract must include a process to appeal, investigate, and resolve disputes regarding maximum allowable cost pricing that includes:

(1) a requirement that an appeal be filed by the contract pharmacy no later than 21 days after the date of the initial adjudicated claim;

(2) a requirement that, within 21 days after the date the appeal is filed, the pharmacy benefits manager investigate and resolve the appeal and report to the contracted pharmacy on the pharmacy benefits manager's determination on the appeal;

(3) a requirement that a pharmacy benefits manager make available on its website information about the appeal process, including:

(i) a telephone number at which the contracted pharmacy may directly contact the department or office responsible for processing appeals for the pharmacy benefits manager to speak to an individual or leave a message for an individual who is responsible for processing appeals;

(ii) an e–mail address of the department or office responsible for processing appeals to which an individual who is responsible for processing appeals has access; and

(iii) a notice indicating that the individual responsible for processing appeals shall return a call or an e–mail made by a contracted pharmacy to the individual within 3 business days or less of receiving the call or e–mail;

(4) a requirement that a pharmacy benefits manager provide:

(i) a reason for any appeal denial;

(ii) the national drug code of a drug and the name of the wholesale distributor from which the drug was available on the date the claim was adjudicated at a price at or below the maximum allowable cost determined by the pharmacy benefits manager; and

(iii) the mathematical calculation used to determine the maximum allowable cost; and

(5) if an appeal is upheld, a requirement that a pharmacy benefits manager:

(i) for the appealing pharmacy:

1. adjust the maximum allowable cost for the drug as of the date of the original claim for payment; and

2. without requiring the appealing pharmacy to reverse and rebill the claims, provide reimbursement for the claim and any subsequent and similar claims under similarly applicable contracts with the pharmacy benefits manager:

A. for the original claim, in the first remittance to the pharmacy after the date the appeal was determined; and

B. for subsequent and similar claims under similarly applicable contracts, in the second remittance to the pharmacy after the date the appeal was determined; and

(ii) for a similarly situated contracted pharmacy in the State:

1. adjust the maximum allowable cost for the drug as of the date the appeal was determined; and

2. provide notice to the pharmacy or pharmacy's contracted agent that:

A. an appeal has been upheld; and

B. without filing a separate appeal, the pharmacy or the pharmacy's contracted agent may reverse and rebill a similar claim.

(g) A pharmacy benefits manager may not retaliate against a contracted pharmacy for exercising its right to appeal under this section or filing a complaint with the Commissioner under this subsection.

(h) A pharmacy benefits manager may not charge a contracted pharmacy a fee related to the readjudication of a claim or claims resulting from carrying out the requirement of a contract specified in subsection (f)(5) of this section or the upholding of an appeal under subsection (i) of this section.

(i) (1) If a pharmacy benefits manager denies an appeal and a contracted pharmacy or a designee of the contracted pharmacy files a complaint with the Commissioner, the Commissioner shall:

(i) review the compensation program of the pharmacy benefits manager to ensure that the reimbursement for pharmacy benefits management services paid to the pharmacist or a pharmacy complies with this subtitle and the terms of the participating pharmacy contract; and

(ii) based on a determination made by the Commissioner under item (i) of this paragraph, dismiss the appeal or uphold the appeal and order the pharmacy benefits manager to pay the claim or claims in accordance with the Commissioner's findings.

(2) On request, the pharmacy benefits manager shall provide to the Commissioner all mathematical calculations, accounts, records, documents, files, logs, correspondence, or other information necessary to complete the Commissioner's review under paragraph (1) of this subsection.

(3) All information and data collected by the Commissioner during a review:

(i) is considered to be confidential and proprietary information; and

(ii) is not subject to disclosure under the Public Information Act.

§15–1628.2

(a) For disputes regarding cost pricing and reimbursement under a participating pharmacy contract, each participating pharmacy contract must include a process to appeal, investigate, and resolve disputes regarding cost pricing and reimbursement that includes:

(1) a requirement that an appeal be filed by the contract pharmacy not later than 21 days after:

(i) the date a direct or indirect remuneration fee is charged; or

(ii) another date as determined by the Commissioner;

(2) a requirement that a pharmacy benefits manager make available on its website information about the appeal process, including:

(i) a telephone number at which the contracted pharmacy may directly contact the department or office responsible for processing appeals for the pharmacy benefits manager to speak to an individual or leave a message for an individual who is responsible for processing appeals;

(ii) an e–mail address of the department or office responsible for processing appeals to which an individual who is responsible for processing appeals has access; and

(iii) a notice indicating that the individual responsible for processing appeals shall return a call or an e–mail made by a contracted pharmacy to the individual within 3 business days or less after receiving the call or e–mail;

(3) a requirement that a pharmacy benefits manager provide:

(i) a reason for any appeal denial; and

(ii) the mathematical calculation used to determine the amount of reimbursement; and

(4) if an appeal is upheld, a requirement that a pharmacy benefits manager:

(i) make adjustments as necessary to comply with the compensation program as stated in the participating pharmacy contract as of the date the appeal was determined; and

(ii) provide notice to the pharmacy or pharmacy's contracted agent that an appeal has been upheld.

(b) A pharmacy benefits manager may not retaliate against a contracted pharmacy for exercising its right to appeal under this section or filing a complaint with the Commissioner under this section.

(c) A pharmacy benefits manager may not charge a contracted pharmacy a fee related to the readjudication of a claim or claims resulting from the upholding of an appeal under subsection (d) of this section.

(d) (1) If a pharmacy benefits manager denies an appeal and a contracted pharmacy or a designee of the contracted pharmacy files a complaint with the Commissioner, the Commissioner shall:

(i) review the compensation program of the pharmacy benefits manager to ensure that the reimbursement for pharmacy services paid to the pharmacist or a pharmacy complies with this subtitle and the terms of the participating pharmacy contract; and

(ii) based on a determination made by the Commissioner under item (i) of this paragraph, dismiss the appeal or uphold the appeal and order the pharmacy benefits manager to pay the claim or claims in accordance with the Commissioner's findings.

(2) On request, the pharmacy benefits manager shall provide to the Commissioner all mathematical calculations, accounts, records, documents, files, logs, correspondence, or other information necessary to complete the Commissioner's review.

(3) All information and data collected by the Commissioner during a review:

(i) is considered to be confidential and proprietary information; and

(ii) is not subject to disclosure under the Public Information Act.

§15–1628.3.

(a) A pharmacy benefits manager or a carrier may not directly or indirectly charge a contracted pharmacy, or hold a contracted pharmacy responsible for, a fee or performance–based reimbursement related to the adjudication of a claim or an incentive program.

(b) A pharmacy benefits manager or carrier may not make or allow any reduction in payment for pharmacy services by a pharmacy benefits manager or carrier or directly or indirectly reduce a payment for a pharmacy service under a reconciliation process to an effective rate of reimbursement, including generic effective rates, brand effective rates, direct and indirect remuneration fees, or any other reduction or aggregate reduction of payments.

§15–1629.

(a) This section applies only to a pharmacy benefits manager that provides pharmacy benefits management services on behalf of a carrier.

(b) This section does not apply to an audit that involves probable or potential fraud or willful misrepresentation by a pharmacy or pharmacist.

(c) A pharmacy benefits manager shall conduct an audit of a pharmacy or pharmacist under contract with the pharmacy benefits manager in accordance with this section.

(d) (1) A pharmacy benefits manager may conduct an audit through an auditing entity.

(2) The Commissioner may adopt regulations to carry out this subsection.

(e) A pharmacy benefits manager may not schedule an onsite audit to begin during the first 5 calendar days of a month unless requested by the pharmacy or pharmacist.

(f) When conducting an audit, a pharmacy benefits manager shall:

(1) if the audit is onsite, provide written notice to the pharmacy or pharmacist at least 2 weeks before conducting the initial onsite audit for each audit cycle;

(2) employ the services of a pharmacist if the audit requires the clinical or professional judgment of a pharmacist;

(3) allow its auditors to enter the prescription area of a pharmacy only when accompanied by or authorized by a member of the pharmacy staff;

(4) allow a pharmacist or pharmacy to use any prescription, or authorized change to a prescription, that meets the requirements of COMAR 10.34.20.02 to validate claims submitted for reimbursement for dispensing of original and refill prescriptions;

(5) for purposes of validating the pharmacy record with respect to orders or refills of a drug, allow the pharmacy or pharmacist to use records of a hospital or a physician or other prescriber authorized by law that are:

(i) written; or

(ii) transmitted electronically or by any other means of communication authorized by contract between the pharmacy and the pharmacy benefits manager;

(6) accept a completed cash register transaction to serve as proof of delivery or pickup for a pharmacy customer unless there is contradictory information;

(7) audit each pharmacy and pharmacist under the same standards and parameters as other similarly situated pharmacies or pharmacists audited by the pharmacy benefits manager;

(8) only audit claims submitted or adjudicated within the 2–year period immediately preceding the audit, unless a longer period is authorized under federal or State law;

(9) deliver the preliminary audit report to the pharmacy or pharmacist within 120 calendar days after the completion of the audit, with reasonable extensions allowed;

(10) in accordance with subsection (m) of this section, allow a pharmacy or pharmacist to produce documentation to address any discrepancy found during the audit; and

(11) deliver the final audit report to the pharmacy or pharmacist:

(i) within 6 months after delivery of the preliminary audit report if the pharmacy or pharmacist does not request an internal appeal under subsection (m) of this section; or

(ii) within 30 days after the conclusion of the internal appeals process under subsection (m) of this section if the pharmacy or pharmacist requests an internal appeal.

(g) If a contract between a pharmacy or pharmacist and a pharmacy benefits manager specifies a period of time in which a pharmacy or pharmacist is allowed to withdraw and resubmit a claim and that period of time expires before the pharmacy benefits manager delivers a preliminary audit report that identifies discrepancies, the pharmacy benefits manager shall allow the pharmacy or pharmacist to withdraw and resubmit a claim within 30 days after:

(1) the preliminary audit report is delivered if the pharmacy or pharmacist does not request an internal appeal under subsection (m) of this section; or

(2) the conclusion of the internal appeals process under subsection (m) of this section if the pharmacy or pharmacist requests an internal appeal.

(h) During an audit, a pharmacy benefits manager may not disrupt the provision of services to the customers of a pharmacy.

(i) (1) A pharmacy benefits manager may not:

(i) use the accounting practice of extrapolation to calculate overpayments or underpayments;

(ii) except as provided in paragraph (2) of this subsection:

1. share information from an audit with another pharmacy benefits manager; or

2. use information from an audit conducted by another pharmacy benefits manager;

(iii) recoup any funds from or charge any fees to a pharmacy or pharmacist for a prescription with regard to an incorrect days of supply calculation if the package size of the medication is unbreakable and the pharmacy benefits manager cannot accept the correct mathematically calculable days' supply during prescription adjudication;

(iv) have or request access to a pharmacy's or pharmacist's bank, credit card, or depository statements or data as it relates to cost–sharing; or

(v) audit claims that were reversed or for which there was no remuneration by the purchaser or cost to the pharmacy customer except if necessary to evaluate compliance to a contract.

(2) Paragraph (1)(ii) of this subsection does not apply to the sharing of information:

(i) required by federal or State law;

(ii) in connection with an acquisition or merger involving the pharmacy benefits manager; or

(iii) at the payor's request or under the terms of the agreement between the pharmacy benefits manager and the payor.

(j) A pharmacy benefits manager or purchaser may not audit more than 125 prescriptions during a desk or site audit.

(k) The recoupment of a claims payment from a pharmacy or pharmacist by a pharmacy benefits manager shall be based on an actual overpayment or denial of an audited claim unless the projected overpayment or denial is part of a settlement agreed to by the pharmacy or pharmacist.

(l) (1) In this subsection, "overpayment" means a payment by the pharmacy benefits manager to a pharmacy or pharmacist that is greater than the rate or terms specified in the contract between the pharmacy or pharmacist and the pharmacy benefits manager at the time that the payment is made.

(2) A clerical error, record–keeping error, typographical error, or scrivener's error in a required document or record may not constitute fraud or grounds for recoupment of a claims payment from a pharmacy or pharmacist by a pharmacy benefits manager if the prescription was otherwise legally dispensed and the claim was otherwise materially correct.

(3) Notwithstanding paragraph (2) of this subsection, claims remain subject to recoupment of overpayment or payment of any discovered underpayment by the pharmacy benefits manager.

(m) (1) A pharmacy benefits manager shall establish an internal appeals process under which a pharmacy or pharmacist may appeal any disputed claim in a preliminary audit report.

(2) Under the internal appeals process, a pharmacy benefits manager shall allow a pharmacy or pharmacist to request an internal appeal within 30

working days after receipt of the preliminary audit report, with reasonable extensions allowed.

(3) The pharmacy benefits manager shall include in its preliminary audit report a written explanation of the internal appeals process, including the name, address, and telephone number of the person to whom an internal appeal should be addressed.

(4) The decision of the pharmacy benefits manager on an appeal of a disputed claim in a preliminary audit report by a pharmacy or pharmacist shall be reflected in the final audit report.

(5) The pharmacy benefits manager shall deliver the final audit report to the pharmacy or pharmacist within 30 calendar days after conclusion of the internal appeals process.

(n) (1) A pharmacy benefits manager may not recoup by setoff any money for an overpayment or denial of a claim until:

(i) the pharmacy or pharmacist has an opportunity to review the pharmacy benefits manager's findings; and

(ii) if the pharmacy or pharmacist concurs with the pharmacy benefits manager's findings of overpayment or denial, 30 working days have elapsed after the date the final audit report has been delivered to the pharmacy or pharmacist.

(2) If the pharmacy or pharmacist does not concur with the pharmacy benefits manager's findings of overpayment or denial, the pharmacy benefits manager may not recoup by setoff any money pending the outcome of an appeal under subsection (m) of this section.

(3) A pharmacy benefits manager shall remit any money due to a pharmacy or pharmacist as a result of an underpayment of a claim within 30 working days after the final audit report has been delivered to the pharmacy or pharmacist.

(4) Notwithstanding the provisions of paragraph (1) of this subsection, a pharmacy benefits manager may withhold future payments before the date the final audit report has been delivered to the pharmacy or pharmacist if the identified discrepancy for all disputed claims in a preliminary audit report for an individual audit exceeds $25,000.

(o) (1) A pharmacy benefits manager shall provide a pharmacy or pharmacist being audited with a phone number and, if available, access to a secure portal that the pharmacy or pharmacist may use to ask questions regarding the audit.

(2) An individual who is familiar with the audit shall respond to all inquiries made through a phone number or secure portal provided under paragraph (1) of this subsection within 3 business days after the inquiry was made.

(p) (1) The pharmacy benefits manager shall give the pharmacy or pharmacist the option to provide requested audit documentation by postal mail, e–mail, or facsimile.

(2) If a document is requested regarding an audit, the pharmacy benefits manager shall provide a secure facsimile number and a mechanism for receiving secure e–mails.

(3) On or before October 1, 2025, a pharmacy benefits manager shall provide a mechanism for secure electronic communication for pharmacies and pharmacists to communicate with and submit documents to the auditing entity.

(q) (1) The Commissioner may adopt regulations regarding:

(i) the documentation that may be requested during an audit; and

(ii) the process a pharmacy benefits manager may use to conduct an audit.

(2) On request of the Commissioner or the Commissioner's designee, a pharmacy benefits manager shall provide a copy of its audit procedures or internal appeals process.

§15–1630.

(a) This section applies only to a pharmacy benefits manager that provides pharmacy benefits management services on behalf of a carrier.

(b) A pharmacy benefits manager shall establish a reasonable internal review process for a pharmacy to request the review of a failure to pay the contractual reimbursement amount of a submitted claim.

(c) A pharmacy may request a pharmacy benefits manager to review a failure to pay the contractual reimbursement amount of a claim within 180 calendar days after the date the submitted claim was paid by the pharmacy benefits manager.

(d) The pharmacy benefits manager shall give written notice of its review decision within 90 calendar days after receipt of a request for review from a pharmacy under this section.

(e) If the pharmacy benefits manager determines through the internal review process established under subsection (b) of this section that the pharmacy benefits manager underpaid a pharmacy, the pharmacy benefits manager shall pay any money due to the pharmacy within 30 working days after completion of the internal review process.

(f) This section may not be construed to limit the ability of a pharmacy and a pharmacy benefits manager to contractually agree that a pharmacy may have more than 180 calendar days to request an internal review of a failure of the pharmacy benefits manager to pay the contractual amount of a submitted claim.

§15–1631.

Except for an overpayment as defined in § 15–1629(h) of this subtitle, if a claim has been approved by a pharmacy benefits manager through adjudication, the pharmacy benefits manager may not retroactively deny or modify reimbursement to a pharmacy or pharmacist for the approved claim unless:

(1) the claim was fraudulent;

(2) the pharmacy or pharmacist had been reimbursed for the claim previously; or

(3) the services reimbursed were not rendered by the pharmacy or pharmacist.

§15–1633.

The provisions of §§ 15–1633.1 through 15–1639 of this subtitle apply only to a pharmacy benefits manager performing pharmacy benefits management services on behalf of a carrier.

§15–1633.1

A pharmacy benefits manager or its agent may not request a therapeutic interchange unless:

(1) the proposed therapeutic interchange is for medical reasons that benefit the beneficiary; or

(2) the proposed therapeutic interchange will result in financial savings and benefits to the purchaser or the beneficiary.

§15–1634.

(a) Before making a therapeutic interchange, a pharmacy benefits manager or its agent shall obtain authorization from a prescriber or an individual authorized by the prescriber.

(b) In any therapeutic interchange solicitation, the following shall be disclosed to the prescriber:

(1) that a therapeutic interchange is being solicited;

(2) the circumstances under which the originally prescribed drug will be covered by the purchaser;

(3) the difference in copayments or coinsurance to be paid by the beneficiary to obtain the proposed drug;

(4) the circumstances and extent to which health care costs related to the therapeutic interchange will be compensated; and

(5) any clinically significant differences, as determined by a pharmacy and therapeutics committee of the pharmacy benefits manager, with respect to efficacy, side effects, and potential impact on health and safety.

(c) When soliciting a therapeutic interchange from a prescriber, a pharmacy benefits manager or its agent may not make a claim that the therapeutic interchange will save the purchaser money unless the claim can be substantiated.

(d) If the pharmacy benefits manager or its agent receives payment for making a therapeutic interchange from a pharmaceutical manufacturer or other person, including the pharmacy benefits manager, that is not reflected in cost savings to the purchaser, the existence of the payment shall be communicated to the prescriber at the time of the therapeutic interchange solicitation.

§15–1635.

If a therapeutic interchange occurs, the pharmacy benefits manager or its agent shall:

(1) disclose to the beneficiary, orally or in writing:

(i) that the pharmacy benefits manager or its agent requested a therapeutic interchange by contacting the beneficiary's prescriber;

(ii) the prescriber approved the therapeutic interchange;

(iii) the names of the originally prescribed drug and the drug dispensed pursuant to the therapeutic interchange;

(iv) the difference in copayments or coinsurance to be paid by the beneficiary to obtain the drug dispensed pursuant to the therapeutic interchange;

(v) the circumstances under which the originally prescribed drug will be covered;

(vi) the circumstances under and the extent to which health care costs related to the therapeutic interchange will be compensated; and

(vii) that the beneficiary may decline the therapeutic interchange if the originally prescribed drug remains on the beneficiary's formulary, and the beneficiary is willing to pay any difference in the copayment or coinsurance; and

(2) include with the prescription drug dispensed:

(i) a patient package insert about potential side effects; and

(ii) a toll–free telephone number to communicate with the pharmacy benefits manager.

§15–1636.

(a) A pharmacy benefits manager or its agent shall cancel and reverse a therapeutic interchange on written or verbal instructions from a prescriber, the beneficiary, or the beneficiary's representative.

(b) If a therapeutic interchange is reversed, the pharmacy benefits manager or its agent shall:

(1) obtain a prescription for and dispense the originally prescribed prescription drug; and

(2) charge the beneficiary no more than one copayment.

(c) If the therapeutic interchange occurred through a mail order pharmacy and a beneficiary will exhaust an existing supply of the originally prescribed prescription drug before a replacement shipment will arrive to the beneficiary, the pharmacy benefits manager or its agent shall arrange for dispensing of an appropriate quantity of replacement prescription drugs at a local community pharmacy at no additional cost to the beneficiary.

(d) A pharmacy benefits manager or its agent may not be required to cancel and reverse a therapeutic interchange if a beneficiary is unwilling to pay a higher copayment or coinsurance associated with the originally prescribed prescription drug.

§15–1637.

(a) A pharmacy benefits manager shall maintain a toll–free telephone number Monday through Saturday for prescribers, pharmacies, pharmacists, and beneficiaries to request information regarding a therapeutic interchange.

(b) The toll–free telephone number shall be accessible from 8 a.m. until at least 8 p.m. Eastern Standard Time.

§15–1638.

All disclosures made under this part shall comply with the privacy standards set forth in State and federal law.

§15–1639.

A pharmacy benefits manager shall establish appropriate policies and procedures to implement the requirements of this part.

§15–1642.

(a) It is a violation of this subtitle for a pharmacy benefits manager to:

(1) misrepresent pertinent facts or policy provisions that relate to a claim or the compensation program at issue in a complaint or an appeal of a decision regarding a complaint;

(2) refuse to pay a claim for an arbitrary or capricious reason based on all available information;

(3) fail to settle a claim or dispute promptly whenever liability is reasonably clear under one part of a policy or contract, in order to influence settlements under other parts of the policy or contract; or

(4) fail to act in good faith.

(b) It is a violation of this subtitle for a pharmacy benefits manager, when committed at a frequency to indicate a general business practice, to:

(1) misrepresent pertinent facts or policy provisions that relate to a claim, the compensation program, or the coverage at issue in a complaint or an appeal of a decision regarding a complaint;

(2) fail to make a prompt, fair, and equitable good–faith attempt to settle claims for which liability has become reasonably clear;

(3) fail to settle a claim promptly whenever liability is reasonably clear under one part of a policy or contract, in order to influence settlements under other parts of the policy or contract; or

(4) refuse to pay a claim for an arbitrary or capricious reason based on all available information.

(c) If the Commissioner determines that a pharmacy benefits manager has violated any provision of this subtitle or any regulation adopted under this subtitle, the Commissioner may issue an order that requires the pharmacy benefits manager to:

(1) cease and desist from the identified violation and further similar violations;

(2) take specific affirmative action to correct the violation;

(3) make restitution of money, property, or other assets to a person that has suffered financial injury because of the violation; or

(4) pay a fine in an amount determined by the Commissioner.

(d) (1) An order of the Commissioner issued under this section may be served on a pharmacy benefits manager that is registered under Part II of this subtitle in the manner provided in § 2–204 of this article.

(2) An order of the Commissioner issued under this section may be served on a pharmacy benefits manager that is not registered under Part II of this subtitle in the manner provided in § 4–206 or § 4–207 of this article for service on an unauthorized insurer that does an act of insurance business in the State.

(3) A request for a hearing on any order issued under this section does not stay that portion of the order that requires the pharmacy benefits manager to cease and desist from conduct identified in the order.

(4) The Commissioner may file a petition in the circuit court of any county to enforce an order issued under this section, whether or not a hearing has been requested or, if requested, whether or not a hearing has been held.

(5) If the Commissioner prevails in an action brought under this section, the Commissioner may recover, for the use of the State, reasonable attorney's fees and the costs of the action.

(e) In addition to any other enforcement action taken by the Commissioner under this section, the Commissioner may impose a civil penalty not exceeding $10,000 for each violation of this subtitle.

(f) The Commissioner may adopt regulations:

(1) to carry out this subtitle; and

(2) to establish a complaint process to address grievances and appeals brought in accordance with this subtitle.

(g) This section does not limit any other regulatory authority of the Commissioner under this article.

§15–1701.

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

(b) "Carrier" has the meaning stated in § 15–1301 of this title.

(c) "Enrollee" means an individual entitled to health care benefits from a carrier.

(d) "Physician rating system" means any program that:

(1) measures, rates, or tiers the performance of physicians under contract with the carrier; and

(2) discloses the measures, rates, or tiers to enrollees or the public.

(e) "Ratings examiner" means an independent entity that is approved by the Maryland Health Care Commission to review physician rating systems.

§15–1702.

(a) A carrier may not use a physician rating system unless the physician rating system is approved by a ratings examiner.

(b) A carrier shall contract with and pay for a ratings examiner to review any physician rating system of the carrier.

(c) A physician rating system of a carrier is deemed to meet the requirements of this section if the physician rating system:

(1) is approved by a ratings examiner as of January 1, 2010; and

(2) notwithstanding any revisions to the physician rating system, maintains its approval by the ratings examiner.

§15–1703.

(a) A carrier that uses a physician rating system shall:

(1) establish an appeals process for physicians to use to contest their rating; and

(2) at least 45 days before making available to enrollees any new or revised quality of performance or cost–efficiency evaluations or any new or revised inclusions or exclusions from a physician rating system, provide each physician included in the physician rating system with:

(i) a notice of the proposed change;

(ii) an explanation of the data used to assess the physician and how the physician may access the data;

(iii) the methodology and measures used to assess the physician;

(iv) an explanation of the right to contest the rating of the physician through the appeals process of the carrier; and

(v) instructions on how to file a timely appeal with the carrier.

(b) If a physician files a timely appeal, as defined by the carrier, regarding the rating of the physician under a physician rating system, the carrier may not

disclose the rating of the physician or make a change in the quality of performance or cost–efficiency ratings of the physician until the carrier completes its investigation and renders a decision on the appeal.

(c) A carrier shall post the following information prominently on the section of the carrier's Web site that discloses the rating of a physician to enrollees or to the public:

(1) where an enrollee can find the physician performance ratings of the carrier;

(2) a disclosure that physician performance ratings are only a guide to choosing a physician because the ratings have a risk of error and should not be the sole basis for selecting a physician;

(3) an explanation of the physician rating system, including the basis on which physician performance is measured and the basis for determining that a physician is not currently rated due to insufficient data or a pending appeal;

(4) any limitations of the data that the carrier uses to measure physician performance;

(5) the factors and criteria used in the carrier's physician rating system, including quality of performance measures and cost efficiency measures; and

(6) how a physician may appeal a physician rating.

§15–1704.

(a) A carrier shall notify the Commissioner of the results of any final review conducted by a ratings examiner of a physician rating system of the carrier within 45 calendar days after receipt of the results by the carrier.

(b) If the review conducted by a ratings examiner of a physician rating system of a carrier indicates that the physician rating system does not comply with the requirements of Title 19, Subtitle 1, Part V of the Health – General Article, the Commissioner may order the carrier to:

(1) correct the deficiency; or

(2) cease the use of the physician rating system.

(c) A carrier using a physician rating system shall report annually to the Commissioner:

(1) the number of appeals filed by physicians under this subtitle; and

(2) the outcome of the appeals.

§15–1901.

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

(b) "Carrier" means:

(1) an insurer;

(2) a nonprofit health service plan; or

(3) a health maintenance organization.

(c) "Clinically integrated organization" means:

(1) a joint venture between a hospital and physicians that:

(i) has received an advisory opinion from the Federal Trade Commission or its staff; and

(ii) has been established to:

1. evaluate and improve the practice patterns of the health care providers; and

2. create a high degree of cooperation, collaboration, and mutual interdependence among the health care providers who participate in the joint venture in order to promote the efficient, medically appropriate delivery of covered medical services; or

(2) a joint venture between a hospital and physicians that:

(i) is accountable for total spending and quality; and

(ii) the Commissioner determines meets the criteria established by the federal Department of Health and Human Services for an accountable care organization.

(d) "Covered medical services" means the health care services that are included as benefits under a health benefit plan issued by a carrier.

(e) "Health benefit plan" has the meaning stated in § 15–1301 of this title.

(f) "Qualifying individual" means an individual covered under a health benefit plan issued by a carrier.

§15–1902.

(a) Notwithstanding any other provision of this article or the Health – General Article, a contract between a carrier and a clinically integrated organization may include a provision to pay:

(1) for services associated with the coordination of covered medical services to qualifying individuals; and

(2) a bonus, fee–based incentive, bundled fees, or other incentives to promote the efficient, medically appropriate delivery of covered medical services to qualifying individuals.

(b) The Commissioner, in consultation with the Maryland Health Care Commission, may adopt regulations specifying the types of payments and incentives permissible under this section.

(c) (1) A carrier shall file a copy of a contract between the carrier and a clinically integrated organization with the Commissioner.

(2) If the contract includes a provision to pay a bonus or other incentive that does not comply with § 15–113 of this title, the Commissioner shall provide a copy of the contract to the executive director of the Maryland Health Care Commission.

(3) Notwithstanding any other provision of law, a copy of a contract filed with the Commissioner or provided by the Commissioner to the executive director of the Maryland Health Care Commission under this subsection, is:

(i) confidential and privileged;

(ii) not subject to:

1. Title 4 of the General Provisions Article;

2. subpoena; or

3. discovery; and

(iii) not admissible in evidence in any private action.

§15–1903.

Notwithstanding any other provision of this article or the Health – General Article, a carrier shall share medical information about a qualifying individual with a clinically integrated organization and its members if:

(1) the carrier has a written agreement with the clinically integrated organization specifying the type and proposed use of medical information to be shared;

(2) the medical information is used by the clinically integrated organization to:

(i) promote the efficient, medically appropriate delivery of covered medical services to qualifying individuals;

(ii) coordinate care, including efforts to coordinate, plan, develop, monitor, share information related to, and otherwise initiate a treatment plan for a qualifying individual;

(iii) perform the functions of a medical review committee as described in § 1–401(c) of the Health Occupations Article; or

(iv) offer or provide covered medical services or seek payment for or evaluate covered medical services provided by the members of the clinically integrated organization; and

(3) the clinically integrated organization or the carrier implements procedures for disclosing to qualifying individuals how the clinically integrated organization and the carrier share medical information to deliver more coordinated, higher quality care.

§15–2001.

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

(b) "Independent pharmacy" means a pharmacy operating within the State that is under common ownership with not more than two other pharmacies.

(c) "Pharmacy benefits manager" has the meaning stated in § 15–1601 of this title.

(d) "Pharmacy services administrative contract" means a contractual agreement between a pharmacy services administrative organization and an independent pharmacy under which a pharmacy services administrative organization agrees to negotiate with purchasers or pharmacy benefits managers on behalf of one or more independent pharmacies.

(e) (1) "Pharmacy services administrative organization" means an entity that provides a contracted pharmacy with contracting administrative services relating to prescription drug benefits.

(2) "Pharmacy services administrative organization" does not include a nonprofit health maintenance organization that:

(i) operates as a group model;

(ii) provides services solely to a member or patient of the nonprofit health maintenance organization; and

(iii) furnishes services through the internal pharmacy operations of the nonprofit health maintenance organization.

(f) (1) "Purchaser" means the State Employee and Retiree Health and Welfare Benefits Program, an insurer, a nonprofit health services plan, or a health maintenance organization that provides prescription drug coverage or benefits in the State.

(2) "Purchaser" does not include a person that provides prescription drug coverage or benefits through plans subject to the Employee Retirement Income Security Act of 1974 and does not provide prescription drug coverage or benefits through insurance, unless the person is a multiple employer welfare arrangement as defined in § 514(b)(6)(A)(ii) of the Employee Retirement Income Security Act of 1974.

§15–2002.

(a) On or after July 1, 2021, a pharmacy services administrative organization shall register with the Commissioner as a pharmacy services administrative organization before providing services as a pharmacy services administrative organization in the State to independent pharmacies.

(b) An applicant for registration shall:

(1) file with the Commissioner an application on the form that the Commissioner provides; and

(2) pay to the Commissioner a registration fee set by the Commissioner.

§15–2003.

(a) A pharmacy services administrative organization registration expires on the second September 30 after its effective date unless it is renewed as provided under this section.

(b) A pharmacy services administrative organization may renew its registration for an additional 2–year term if the pharmacy services administrative organization:

(1) otherwise is entitled to be registered;

(2) files with the Commissioner a renewal application on the form that the Commissioner requires; and

(3) pays to the Commissioner a renewal fee set by the Commissioner.

§15–2004.

A pharmacy services administrative organization that has not registered with the Commissioner may not enter into an agreement or a contract with an independent pharmacy.

§15–2005.

Subject to the applicable hearing provisions of Title 2 of this article, the Commissioner may deny a registration to a pharmacy services administrative organization or refuse to renew, suspend, or revoke the registration of a pharmacy services administrative organization if the pharmacy services administrative organization, or an officer, a director, or an employee of the pharmacy services administrative organization:

(1) makes a material misstatement or misrepresentation in an application for registration;

(2) fraudulently or deceptively obtains or attempts to obtain a registration;

(3) in connection with the administration of pharmacy services administrative organization services, commits fraud or engages in illegal activities; or

(4) violates this subtitle or a regulation adopted under this subtitle.

§15–2006.

A pharmacy services administrative organization shall maintain adequate books and records regarding each independent pharmacy for which the pharmacy services administrative organization provides services as a pharmacy services administrative organization:

(1) in accordance with prudent standards of record keeping;

(2) for the duration of the agreement between the pharmacy services administrative organization and the independent pharmacy; and

(3) for 3 years after the pharmacy services administrative organization ceases to provide services as a pharmacy services administrative organization for the independent pharmacy.

§15–2007.

(a) Whenever the Commissioner considers it advisable, the Commissioner may examine the affairs, transactions, accounts, and records of a registered pharmacy services administrative organization.

(b) The examination shall be conducted in accordance with § 2–207 of this article.

(c) The expense of the examination shall be paid in accordance with § 2–208 of this article.

(d) The reports of the examination and investigation shall be issued in accordance with § 2–209 of this article.

§15–2008.

The Commissioner may adopt regulations to implement this subtitle.

§15–2009.

This subtitle may not be construed to diminish the authority of the Office of the Attorney General or the Commissioner to obtain information relating to a pharmacy services administrative organization and use the information in any proceeding.

§15–2010.

(a) A pharmacy services administrative contract or an amendment to a pharmacy services administrative contract may not become effective unless:

(1) at least 60 days before the contract or amendment is to become effective, the pharmacy services administrative organization files the contract or, if required, amendment with the Commissioner in the form required by the Commissioner; and

(2) the Commissioner does not disapprove the filing within 60 days after the contract or amendment is filed.

(b) Notice from the Commissioner that a filed contract or amendment to a contract may be used in the State constitutes a waiver of any unexpired part of the filing period.

(c) The Commissioner shall adopt regulations to:

(1) establish the circumstances under which the Commissioner may disapprove a contract; and

(2) specify the types of amendments to a contract required to be filed under subsection (a) of this section.

§15–2011.

(a) A pharmacy services administrative contract shall include a provision that requires the pharmacy services administrative organization to provide to the independent pharmacy an electronic or paper copy of any contracts, amendments, payment schedules, or reimbursement rates within 5 working days after the execution of a contract, or an amendment to a contract, signed on behalf of the independent pharmacy by the pharmacy services administrative organization.

(b) A pharmacy services administrative contract may prohibit an independent pharmacy from disclosing the documents provided to the independent pharmacy under subsection (a) of this section to any competitor of the pharmacy services administrative organization.

§15–2012.

(a) Each pharmacy services administrative organization shall disclose to the Commissioner the extent of any ownership or control of the pharmacy services administrative organization by any parent company, subsidiary, or other organization that:

(1) provides pharmacy services;

(2) provides prescription drug or device services; or

(3) manufactures, sells, or distributes prescription drugs, biologics, or medical devices.

(b) Each pharmacy services administrative organization shall notify the Commissioner in writing within 5 working days after any material change in its ownership or control relating to any company, subsidiary, or other organization described under subsection (a) of this section.

§15–2013.

(a) Before entering into a pharmacy services administrative contract, a pharmacy services administrative organization shall provide to an independent pharmacy a written disclosure of ownership or control.

(b) The disclosure required under subsection (a) of this section shall include the extent of any ownership or control by any parent company, subsidiary, or other organization that:

(1) provides pharmacy services;

(2) provides prescription drug or device services; or

(3) manufactures, sells, or distributes prescription drugs, biologics, or medical devices.

(c) A pharmacy services administrative contract shall require a pharmacy services administrative organization to notify an independent pharmacy in writing within 5 working days after any material change in its ownership or control related to any company, subsidiary, or other organization described under subsection (b) of this section.

§15–2014.

(a) Before entering into a contract with a purchaser or pharmacy benefits manager, a pharmacy services administrative organization shall provide to the purchaser or pharmacy benefits manager a written disclosure of ownership or control.

(b) The disclosure required under subsection (a) of this section shall include the extent of any ownership or control by any parent company, subsidiary, or other organization that:

(1) provides pharmacy services;

(2) provides prescription drug or device services; or

(3) manufactures, sells, or distributes prescription drugs, biologics, or medical devices.

(c) A contract with a purchaser or pharmacy benefits manager shall provide that a pharmacy services administrative organization shall notify the purchaser or pharmacy benefits manager in writing within 5 working days after any material change in its ownership or control related to any company, subsidiary, or other organization described in subsection (b) of this section.

§15–2015.

A pharmacy services administrative contract shall:

(1) require all remittances for claims submitted by a pharmacy benefits manager or purchaser on behalf of an independent pharmacy to be passed by the pharmacy services administrative organization to the independent pharmacy within a reasonable amount of time; and

(2) specify the reasonable amount of time in which the pharmacy services administrative organization is required to pass the remittances received from the pharmacy benefits manager or purchaser to the independent pharmacy.

§15–2016.

(a) A pharmacy services administrative organization that owns or is owned by, in whole or in part, an entity that manufactures, sells, or distributes prescription drugs, biologics, or medical devices may not require, as a condition of entering into a pharmacy services administrative contract, that an independent pharmacy purchase any drugs, biologics, or medical devices from the entity.

(b) A pharmacy services administrative organization that owns or is owned by, in whole or in part, any entity that manufactures, sells, or distributes prescription

drugs, biologics, or medical devices shall disclose to the Commissioner any agreement with an independent pharmacy under which the independent pharmacy purchases prescription drugs, biologics, or medical devices from the entity.

§15–2017.

(a) All disclosures made under this subtitle shall comply with the privacy standards established in federal and State law.

(b) A contract or amendment to a contract submitted to the Commissioner as required by this subtitle:

(1) is considered to be confidential and proprietary information; and

(2) is not subject to disclosure under the Public Information Act.

§15–2018.

A pharmacy services administrative organization shall establish appropriate policies and procedures to implement the requirements of this subtitle.

§15–2019.

(a) A pharmacy services administrative organization may not:

(1) misrepresent pertinent facts or policy provisions that relate to an issue in a dispute or an appeal of a decision regarding a dispute;

(2) refuse to pay or reimburse an independent pharmacy for an arbitrary or capricious reason based on all available information;

(3) fail to settle a dispute promptly whenever liability is reasonably clear under one part of a policy or contract, in order to influence settlements under other parts of the policy or contract;

(4) fail to act in good faith; or

(5) engage in any activity that is a prohibited activity for a pharmacy benefits manager under Subtitle 16 of this title or a regulation adopted under Subtitle 16 of this title.

(b) If the Commissioner determines that a pharmacy services administrative organization has violated any provision of this subtitle or any

regulation adopted under this subtitle, the Commissioner may issue an order that requires a pharmacy services administrative organization to:

(1) cease and desist from the identified violation and further similar violations;

(2) take specific affirmative action to correct the violation;

(3) make restitution of money, property, and other assets to a person that has suffered financial injury because of the violation; or

(4) pay a fine in the amount determined by the Commissioner.

(c) (1) An order of the Commissioner issued under this section may be served on a pharmacy services administrative organization that is registered under § 15–2002 of this subtitle in the manner provided in § 2–204 of this article.

(2) An order of the Commissioner issued under this section may be served on a pharmacy services administrative organization that is not registered under § 15–2002 of this subtitle in the manner provided in § 4–206 or § 4–207 of this article for service on an unauthorized insurer that does an act of insurance business in the State.

(3) A request for a hearing on any order issued under this section does not stay that portion of the order that requires the pharmacy services administrative organization to cease and desist from the conduct identified in the order.

(4) The Commissioner may file a petition in the circuit court of any county to enforce an order issued under this section, whether or not a hearing has been requested or, if requested, whether or not a hearing has been held.

(5) If the Commissioner prevails in an action brought under this section, the Commissioner may recover, for the use of the State, reasonable attorney's fees and the costs of the action.

(d) In addition to any other enforcement action taken by the Commissioner under this section, the Commissioner may impose a civil penalty not exceeding $10,000 for each violation of this subtitle.

(e) The Commissioner may adopt regulations:

(1) to carry out this section; and

(2) to establish a complaint process to address grievances and appeals brought in accordance with this section.

(f) This section does not limit any other regulatory authority of the Commissioner under this article.

§15–2101.

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

(b) "Administrator" means a carrier administering a self–funded group health plan.

(c) "Carrier" has the meaning stated in § 15–113 of this title.

(d) "Health benefit plan" has the meaning stated in § 2–112.2 of this article.

(e) "Health care practitioner" has the meaning stated in § 15–113 of this title.

(f) "Member" has the meaning stated in § 15–10A–01 of this title.

(g) "Network" has the meaning stated in § 15–112 of this title.

(h) "Participant" means an employee or an employee's dependent who participates in a self–funded group health insurance plan.

(i) "Set of health care practitioners" has the meaning stated in § 15–113 of this title.

§15–2102.

(a) This section applies to arrangements under a health benefit plan offered by a carrier or a self–funded group health insurance plan in which a capitated payment is:

(1) calculated as a fixed amount per member or participant assigned or attributed to the health care practitioner or set of health care practitioners;

(2) to cover the provision of a set of services defined in the health care practitioner's or set of health care practitioners' contract and rendered by the health care practitioner or set of health care practitioners; and

(3) paid periodically regardless of utilization of the services by the members or participants.

(b) Subject to the requirements of subsection (c) of this section, a health care practitioner or set of health care practitioners is not engaged in insurance business as described in § 4–205 of this article solely because the health care practitioner or set of health care practitioners enters into a contract with a carrier that includes capitated payments for services provided by the health care practitioner or set of health care practitioners.

(c) A health care practitioner or set of health care practitioners is not engaged in insurance business as described in § 4–205(c) of this article solely because the health care practitioner or set of health care practitioners enters into a contract with an administrator that includes capitated payments for services provided by the health care practitioner or set of health care practitioners to members of a self–funded group health plan if:

(1) the health care practitioner or set of health care practitioners participates in the administrator's network and accepts capitated payments;

(2) the self–funded group health plan retains the obligation to provide access to covered health care benefits to participants; and

(3) the contract does not include other reimbursement arrangements that are considered acts of an insurance business under § 4–205(c) of this article.

(d) Notwithstanding subsections (b) and (c) of this section, nothing in this section may be construed to:

(1) alter any requirement for a carrier or self–funded group health plan to pay a hospital or related institution the rate approved by the Health Services Cost Review Commission for hospital services; or

(2) supersede the Health Services Cost Review Commission's jurisdiction or authority over rate review and approval for hospital services.

§16–101.

Except as otherwise provided in this title, this title applies to contracts of life insurance and annuities, other than reinsurance, group life insurance, and group annuities.

§16–102.

An insurer that is authorized to issue ordinary life insurance in the State may issue wholesale life insurance.

§16–103.

A life insurer may not:

(1) issue or deliver in the State a policy of life insurance or an annuity contract that provides for the payment of an assessment by a policyholder or member in addition to the premium stated in the policy or annuity contract to be charged for the life insurance or annuity; or

(2) levy or collect an assessment prohibited by item (1) of this section.

§16–104.

(a) An insurer may not knowingly deliver or issue for delivery in the State a policy of life insurance that purports to be issued or to take effect as of a date more than 6 months before the application for the policy was made, if, as a result, the premium on the policy is reduced below the premium that would have been payable on the policy as determined by the insuring age of the insured when the application was made.

(b) An insurance producer or other representative of an insurer may not in the State prepare, submit, or accept an application for life insurance that bears a date earlier than the date when the application was made by the insured or applicant, if, as a result, the premium on the policy is reduced below the premium that would have been payable on the policy as determined by the insuring age of the insured when the application was made.

(c) This section does not:

(1) invalidate a contract made in violation of this section; or

(2) prohibit the exchange, alteration, or conversion of a policy of life insurance.

§16–105.

(a) This section does not apply to policies or contracts issued to an employee in connection with the funding of a pension, annuity, or profit-sharing plan that is qualified or exempt under § 401, § 403, § 404, or § 501 of the Internal Revenue Code, if participation in the plan is a condition of employment.

(b) Each policy of life insurance or annuity contract subject to this title shall have attached to or prominently printed on its face the following information:

(1) a notice to the policyholder that:

(i) for 10 days after the date the policy or annuity contract is delivered to the policyholder, the policyholder may surrender the policy or annuity contract to the insurer for cancellation by giving the insurer written notice of cancellation; and

(ii) the insurer shall return to the policyholder a pro rata premium for the unexpired term of the policy or annuity contract; or

(2) a similar notice to the policyholder that in the opinion of the Commissioner is not less favorable to the policyholder.

§16–106.

(a) On request of a policyholder, a life insurer may exchange, alter, or convert a policy of life insurance or endowment insurance or an annuity contract issued by the life insurer or any other benefits additional to the policy or annuity contract, for or into a policy that:

(1) conforms with the laws in force on the date of the original policy or annuity contract, if the rewritten policy is, by its terms, made effective as of that date; or

(2) conforms with the laws in force on a subsequent date as of which the rewritten policy is, by its terms, made effective.

(b) (1) This subsection applies only if the rewritten policy is made effective as of a date earlier than the date on which the exchange, alteration, or conversion occurs.

(2) The amount of insurance under a rewritten policy subject to this subsection may not exceed the greater of:

(i) the amount of insurance under the original policy or annuity contract; and

(ii) the amount of insurance that the premium paid for the original policy or annuity contract would have purchased if the rewritten policy had been applied for originally.

(3) If evidence of insurability is required in conjunction with an exchange, alteration, or conversion to a policy on a plan that requires a lower premium rate, or to a policy to which benefits or features are added that differ from the original policy, the rewritten policy may provide that the date on which the exchange, alteration, or conversion occurs shall be used to determine:

(i) the applicability of an incontestability clause in the rewritten policy to the right of the insurer to contest the exchange, alteration, or conversion; or

(ii) the applicability of a clause in the rewritten policy that limits liability in the event of the suicide of the insured.

§16–107.

(a) A reinstated policy of life insurance or reinstated annuity contract may be contested on account of fraud or misrepresentation of facts material to the reinstatement only for the same period after reinstatement and with the same conditions and exceptions as the policy or annuity contract provides with respect to contestability after original issue.

(b) (1) A reinstated policy of life insurance or reinstated annuity contract may exclude or restrict liability to the same extent that liability might have been or was excluded or restricted when the policy or annuity contract originally was issued.

(2) The exclusion or restriction is effective as of the date of reinstatement.

§16–108.

(a) A life insurer may hold under agreement the proceeds of a policy issued by it on the terms and restrictions as to revocation by the policyholder and control by beneficiaries, and with the exemptions from the claims of creditors of beneficiaries other than the policyholder, as set forth in the policy or as agreed to in writing by the life insurer and the policyholder.

(b) If a policyholder has not made an agreement described in subsection (a) of this section, on maturity of the policy the life insurer may hold the proceeds of the policy under an agreement with the beneficiaries.

(c) The life insurer need not segregate any funds held under this section, but may hold the funds as part of the life insurer's general assets.

§16–109.

(a) Except as provided in subsection (b) of this section, interest on benefits payable under a policy of life insurance issued in the State accrues and is payable from the date of death of the insured to the date the proceeds of the policy are paid.

(b) (1) An insurer need not pay interest on benefits if the proceeds of the policy are paid within 30 days after the date of death of the insured.

(2) If proof of death is submitted to the insurer more than 180 days after the date of death of the insured, interest accrues and is payable from the date on which proof of death is submitted to the date on which the proceeds of the policy are paid.

(c) Interest under this section accrues and is payable at a rate not less than the rate of interest payable on death proceeds left on deposit with the insurer.

§16–110.

(a) If a resident of the State dies intestate and leaves an estate that consists of assets, including life insurance proceeds, in a total amount not exceeding $1,000, an insurer may pay the life insurance proceeds to the decedent's surviving spouse, child, or parent, without the grant of letters of administration, if the individual to whom payment is to be made provides the insurer with:

(1) an affidavit that states that the entire estate of the decedent, including life insurance proceeds, does not exceed $1,000; or

(2) a letter of administration as provided by the Small Estate Law, §§ 5-601 through 5-607 of the Estates and Trusts Article.

(b) The insurer may pay the share of a minor to an institution or to a relative of the minor, with custody of the minor, without requiring the institution or relative to be appointed the legal guardian of the minor.

(c) Payment by an insurer under this section, or under a facility of payment clause in a policy of life insurance, discharges the insurer from all further liability with respect to the life insurance proceeds.

§16–111.

(a) The proceeds of a policy of life insurance or under an annuity contract on the life of an individual made for the benefit of or assigned to the spouse, child, or dependent relative of the individual are exempt from all claims of the creditors of the individual arising out of or based on an obligation created after June 1, 1945, whether

or not the right to change the named beneficiary is reserved or allowed to the individual.

(b) For purposes of this section, proceeds include death benefits, cash surrender and loan values, premiums waived, and dividends, whether used to reduce the premiums or used or applied in any other manner, except if the debtor has, after issuance of the policy, elected to receive the dividends in cash.

(c) This section does not prohibit a creditor from collecting a debt out of the proceeds of a life insurance policy pledged by the insured as security for the debt.

(d) A change of beneficiary, assignment, or other transfer is valid except for transfer with actual intent to hinder, delay, or defraud creditors.

§16–112.

A life insurer may not deliver in the State, as part of or in combination with an insurance, endowment, or annuity contract, and additional to the rights, dividends, and benefits arising out of the contract, an agreement or plan that:

(1) provides for the accumulation of profits over a period of years and for payment of all or part of the accumulated profits only to members or policyholders of a designated group or class who continue as members or policyholders until the end of a specified period of years;

(2) provides that, on the death of anyone other than a beneficiary or an insured under the contract, the owner or beneficiary of the contract shall receive the payment or granting of anything of value;

(3) provides that all or part of the premiums or consideration for the contract, dividends, coupons, reserves, special reserves, excess interest, or money in excess of the normal reserve required to meet the contractual guarantees of the contract are to be placed or invested in special funds or segregated accounts without insurance or life contingency features, if the funds or earnings are divided among those taking the contract or their beneficiaries or assignees; or

(4) as an inducement to or in connection with the sale or acceptance of the contract, provides for:

(i) the sale, solicitation, or delivery of stock or shares of stock in a company;

(ii) a benefit certificate, securities, or special advisory board contract, or other similar contracts or resolutions; or

(iii) policy dividends bearing a stated relationship to dividends on the stock of a company.

§16–113.

(a) Subject to the approval of the Commissioner, an insurer authorized to deliver or issue for delivery an annuity contract in the State may deliver or issue for delivery funding agreements.

(b) A funding agreement may be issued to:

(1) a person, or a subsidiary of the person, that is authorized by a state or foreign country to engage in the insurance business; or

(2) a person, other than a person or a subsidiary of the person that is authorized to engage in the insurance business, to fund:

(i) benefits directly or indirectly under an employee benefit plan, as defined in the federal Employee Retirement Income Security Act of 1974, that is maintained in the United States, or under a similar plan maintained in a foreign country;

(ii) the activities of an organization exempt from taxation under § 501(c) of the Internal Revenue Code, or of a similar organization in a foreign country;

(iii) a program, or plan as defined in § 457 of the Internal Revenue Code, of the federal government, a state or political subdivision of a state, or a foreign country or political subdivision of a foreign country;

(iv) an agreement that provides for periodic payments in satisfaction of a claim; or

(v) a program of an institution that has assets in excess of $25,000,000.

(c) (1) An amount may not be guaranteed or credited under a funding agreement except on a reasonable assumption as to investment income and expenses and on a basis equitable to all holders of funding agreements of a given class.

(2) A funding agreement may not provide for payment to or by the insurer based on a mortality or morbidity contingency.

(d) (1) Under a funding agreement, an insurer may allocate amounts paid to the insurer and proceeds applied under optional modes of settlement to the insurer's general account or to one or more separate accounts.

(2) Amounts allocated to the insurer's general account and any resulting accumulations shall be invested and reinvested in accordance with the provisions of this article governing investment of the reserves of life insurers.

(3) Amounts allocated to a separate account and any resulting accumulations may be invested and reinvested subject only to §§ 5–506, 5–507, and 5–512(b), (e), (f), (g), (h), and (i) of this article and regulations adopted under subsection (e) of this section.

(e) (1) The Commissioner may adopt regulations governing:

(i) the standards for approval of forms of funding agreements;

(ii) the reserves to be maintained by insurers that issue funding agreements;

(iii) the accounting and reporting of funds credited under funding agreements;

(iv) the disclosure of information to holders and prospective holders of funding agreements; and

(v) the qualification and compensation of persons that sell funding agreements on behalf of insurers.

(2) With respect to separate accounts and any resulting accumulations, the Commissioner shall adopt regulations governing the type and amount of investments that may be made under a funding agreement.

(3) Notwithstanding any other provision of law, the Commissioner has sole authority to regulate:

(i) the issuance and sale of funding agreements; and

(ii) the persons that sell funding agreements on behalf of insurers.

(f) (1) The issuance or delivery of a funding agreement is not the business of life insurance, annuities, health insurance, property insurance, casualty

insurance, surety insurance, marine insurance, wet marine and transportation insurance, title insurance, or reinsurance, but is an insurance business.

(2) Solely for the purpose of application of the Tax - General Article, the funding agreements authorized by this section are deemed to be annuity contracts.

§16–114.

(a) In this section, "community foundation" means a nonprofit organization that is:

(1) formed to receive contributions and distribute money to meet cultural, educational, charitable, environmental, civic, or other similar needs of a community; and

(2) governed by a board of private citizens who reside in the community.

(b) An educational or religious organization, hospital, or community foundation may not make or issue in the State agreements for annuity payments with donors until it has obtained from the Commissioner a special permit issued in accordance with this section.

(c) (1) On application, the Commissioner may issue a special permit to make agreements for annuity payments with donors to an educational or religious organization not conducted for profit and engaged in bona fide educational or religious activities, to a hospital in the State, or to a community foundation if the educational or religious organization, hospital, or community foundation:

(i) except as provided in paragraph (2) of this subsection, has been in active operation in the State for at least 10 years before issuance of the special permit; and

(ii) has been granted exemption from federal income taxation under § 501 of the Internal Revenue Code.

(2) The Commissioner may issue a special permit to a community foundation that has been in existence for at least 5 years but less than 10 years if the community foundation maintains assets in an amount up to 100% of the contributions made to the community foundation, as determined by the Commissioner.

(d) (1) Each special permit holder shall have and maintain assets at least equal to adequate reserves on its outstanding agreements for annuity payments with donors as indicated by its audited fiscal year–end financial statements.

(2) In determining the reserves of a special permit holder on outstanding agreements for annuity payments with donors, a deduction shall be made for all or part of an annuity risk that is reinsured by an authorized life insurer.

(3) (i) Subject to paragraph (5) of this subsection, a special permit holder shall submit annually audited fiscal year–end financial statements to the Commissioner within 180 days after the end of the special permit holder's fiscal year.

(ii) The financial statements required under subparagraph (i) of this paragraph shall be:

1. presented in conformity with generally accepted accounting principles; and

2. audited by a certified public accountant.

(4) The audited fiscal year–end financial statements shall be treated as confidential by the Commissioner and are not available for public inspection.

(5) On application by the special permit holder, the Commissioner:

(i) may waive the requirement of audited fiscal year–end financial statements; and

(ii) may require instead additional documents or information that the Commissioner considers necessary.

(e) A special permit issued under this section authorizes the special permit holder to receive gifts of money or other property conditional on, or in consideration of, the special permit holder's agreement to pay an annuity to the donor or the donor's nominee and to make and carry out agreements for annuity payments with donors.

(f) A special permit is in effect only as long as the special permit holder is exempt from federal income taxation under § 501 of the Internal Revenue Code.

(g) (1) If the Commissioner finds, after notice and hearing, that a special permit holder has failed to comply with the requirements of this section or is not exempt from federal income taxation under § 501 of the Internal Revenue Code, the Commissioner may:

(i) revoke or suspend the special permit; or

(ii) order the special permit holder to stop making new agreements for annuity payments with donors until the requirements have been satisfied.

(2) In case of revocation or suspension, outstanding agreements for annuity payments with donors shall remain in force.

(3) The action of the Commissioner under this subsection is subject to judicial review under § 2–215 of this article.

(h) (1) Except as otherwise provided in this section, a special permit holder is exempt from the provisions of this article with respect to issuing annuities.

(2) Special permit holders are not subject to a law enacted after June 1, 1957, unless they are expressly designated in the law.

(i) (1) Other than by agreements for annuity payments with donors, an educational or religious organization, hospital, or community foundation may agree to:

(i) accept conditional donations; and

(ii) pay to the donor or the donor's nominee a specified return established with reference to the actual net earnings of the particular donation or with reference to the actual or estimated earnings of a specified fund of the donee organization.

(2) An educational or religious organization, hospital, or community foundation that accepts conditional donations and pays a specified return to donors under paragraph (1) of this subsection is exempt from this section and all other provisions of this article with respect to issuing annuities.

(3) Educational or religious organizations, hospitals, or community foundations that accept conditional donations and pay specified returns to donors under this subsection are not subject to any law enacted after June 1, 1957, unless they are expressly designated in the law.

(j) Notwithstanding the absence of express power in the charter of a domestic educational, religious, or hospital corporation or community foundation, the corporation or community foundation may make the agreements for annuity payments with donors or other agreements with respect to conditional donations that are expressly allowed by this section.

§16–115.

(a) A person who engages in the business of burial insurance is subject to and shall comply with all of the provisions of this article relating to the organization, qualification, and conduct of life insurers.

(b) This section does not limit or restrict the definitions of life insurance or life insurer in § 1-101 of this article.

§16–116.

(a) In this section, "public entity" means:

(1) a political subdivision of the State;

(2) a unit of the State or a local government; or

(3) a nonprofit or nonstock corporation that:

(i) receives 50% or more of its annual operating budget from the State or a local government; and

(ii) is exempt from taxation under § 501(c)(3) or (4) of the Internal Revenue Code.

(b) Public entities may pool together to purchase life insurance or to self-insure against life risks.

§16–117.

(a) In this section, "retained asset account" means any mechanism whereby the settlement of proceeds payable under a life insurance policy or an annuity contract is accomplished by the insurer or an entity acting on behalf of the insurer depositing the proceeds into a checking or draft account, where those proceeds are retained by the insurer in accordance with a supplementary contract.

(b) An insurer may not offer a retained asset account as the mode of settlement of the proceeds payable under a life insurance policy or an annuity contract unless the insurer:

(1) offers the beneficiary at least one other mode of settlement of proceeds; and

(2) complies with the provisions of subsections (c) and (d) of this section.

(c) Except as provided in subsection (e) of this section, when a beneficiary files a claim for proceeds, if one of the settlement options is a retained asset account, the insurer shall disclose in writing to the beneficiary all the settlement options available under the policy or contract.

(d) (1) Except as provided in subsection (e) of this section, if an insurer offers to a beneficiary a retained asset account as a settlement option, the insurer shall provide to the beneficiary in writing:

(i) a recommendation to consult a tax advisor, an investment advisor, or any other financial advisor regarding tax liability and investment options;

(ii) an explanation of the features of the retained asset account, including:

1. the method used to determine interest rates applied to the retained asset account, when and how interest rates may change, and any dividends and other gains that may be paid or distributed to the account holder;

2. the custodian of the funds or assets of the retained asset account;

3. whether the funds in the retained asset account are guaranteed by the Federal Deposit Insurance Corporation (FDIC) and the amount of the coverage, if any;

4. the limitations, if any, on the numbers and amounts of withdrawals of funds from the retained asset account or investment, including any minimum or maximum withdrawal amounts;

5. the services provided for a fee, including a list of the fees or the method of their calculation;

6. the nature and frequency of statements of account;

7. a statement that the obligation of the insurer to pay the total policy or contract proceeds is satisfied by depositing the total proceeds in the retained asset account;

8. a statement that the entire proceeds are available to the account holder by the use of one check, draft, or other instrument;

9. a statement that the insurer or a related party may derive income, in addition to any fees charged on the retained asset account, from the total gains received on the investment of the balance of funds in the retained asset account; and

10. the telephone number, address, and other contact information, including Web site address, for obtaining additional information regarding the retained asset account; and

(iii) the statement "For further information, please contact your state insurance department".

(2) The information required under paragraph (1) of this subsection shall be in easy to read language.

(e) An insurer is not required to provide the disclosures or information specified in subsections (c) and (d) of this section if:

(1) the insurer permits the beneficiary to file the claim over the telephone;

(2) the insurer does not require the beneficiary to file a death certificate or other paperwork to file the claim for proceeds; and

(3) the beneficiary selects payment of a lump sum check, payable directly to the beneficiary, as the settlement option during the telephone call in which the beneficiary files the claim for proceeds.

(f) Failure to meet any requirement of this section is an unfair trade practice and a violation of Title 27 of this article.

§16–118.

(a) (1) In this section the following words have the meanings indicated.

(2) "Credit life insurance" has the meaning stated in § 13–101 of this article.

(3) "Death master file" means:

(i) the Social Security Administration's Death Master File; or

(ii) any other database or service that is at least as comprehensive as the Social Security Administration's Death Master File for determining that an individual reportedly has died.

(4) "Death master file match" means a match, resulting from a search of a death master file, of a Social Security number or a name and date of birth of an individual on the death master file with the Social Security number or the name and date of birth of an insured, annuitant, or retained asset account holder.

(5) "Pre–need insurance contract" means a life insurance policy or certificate, annuity contract, or other insurance contract that, by assignment or otherwise, has as a purpose the funding of an agreement relating to the purchase or provision of specific funeral or cemetery merchandise or services to be provided at the time of death of an individual.

(6) "Retained asset account" has the meaning stated in § 16–117(a) of this subtitle.

(b) This section does not apply to:

(1) an annuity contract that:

(i) is used to fund an employment–based retirement plan or program; and

(ii) does not require the insurer under the annuity contract to pay death benefits to the beneficiaries of specific plan or program participants;

(2) a policy or certificate of life insurance that provides a death benefit under:

(i) an employee benefit plan subject to the federal Employee Retirement Income Security Act of 1974; or

(ii) any federal employee benefit program;

(3) a pre–need insurance contract;

(4) a policy or certificate of credit life insurance; or

(5) a policy or certificate of accidental death and dismemberment insurance.

(c) (1) An insurer that issues, delivers, or renews a policy of life insurance or an annuity contract in the State shall perform a comparison of the insurer's in–force life insurance policies, annuity contracts, and retained asset accounts against the latest version of a death master file to identify any death benefit payments that may be due under the policies, contracts, or retained asset accounts as a result of the death of an insured, annuitant, or retained asset account holder.

(2) An insurer shall perform the comparison required under paragraph (1) of this subsection:

(i) at regular intervals, on at least a semiannual basis; and

(ii) in good faith, using criteria reasonably designed to identify individuals whose death would require the payment of benefits by the insurer under a life insurance policy, annuity contract, or retained asset account.

(3) For a group life insurance policy, an insurer is not required to perform the comparison required under paragraph (1) of this subsection unless the insurer provides full record–keeping services to the group life insurance policy holder.

(d) (1) If a comparison performed by an insurer under subsection (c) of this section results in a death master file match with an insured, annuitant, or retained asset account holder, the insurer, within 90 days after the comparison was performed, shall:

(i) conduct a good faith effort to confirm the death of the insured, annuitant, or retained asset account holder using other available records and information;

(ii) determine whether benefits are due under the applicable life insurance policy, annuity contract, or retained asset account; and

(iii) if benefits are due under the policy, contract, or retained asset account:

1. use good faith efforts to locate the beneficiary; and

2. provide to the beneficiary the appropriate claims forms and instructions necessary to make a claim.

(2) An insurer shall document the good faith efforts made to:

(i) confirm the death of an insured, annuitant, or retained asset account holder under paragraph (1)(i) of this subsection; and

(ii) locate a beneficiary under paragraph (1)(iii)1 of this subsection.

(3) To the extent permitted by law, an insurer may disclose the minimum necessary personal information about an insured, an annuitant, a retained asset account holder, or a beneficiary to a person that the insurer reasonably believes may be able to assist the insurer in locating a beneficiary as required under paragraph (1)(iii)1 of this subsection.

(e) An insurer may not charge an insured, an annuitant, a retained asset account holder, a beneficiary, or any other person for any fees or costs incurred by the insurer in connection with complying with subsections (c) and (d) of this section.

(f) The Commissioner may adopt regulations to implement this section.

§16–119.

(a) (1) A life insurer may refuse an application for a policy of life insurance on the life of a minor only if the refusal is consistent with § 27–501(a)(2) of this article.

(2) An application for a policy of life insurance on the life of a minor that is submitted for underwriting shall include:

(i) the signature of the applicant; and

(ii) unless the minor is emancipated or married, the consent and signature of the parent or legal guardian with whom the minor resides.

(3) The life insurer shall include on the first page of the application for a policy of life insurance on the life of a minor, on a disclosure provided to the applicant at the time of application, or on an endorsement to the policy the following statement in 12 point bold type:

"A person who feloniously and intentionally kills, conspires to kill, or procures the killing of the insured and who is a named beneficiary of a life insurance policy on the insured is not entitled to a benefit under the policy.".

(b) As part of the life insurer's written standards and procedures for policy application and acceptance, the life insurer shall:

(1) request that the applicant for a policy of life insurance on the life of a minor identify the amount of other life insurance coverage on the life of the minor that is in force or pending at the time of the application;

(2) document the applicant's response on the application; and

(3) take reasonable steps to verify the amount of other life insurance in force or pending.

(c) If an application for a life insurance policy on the life of a minor is for a policy that has a benefit of $50,000 or less and is issued without underwriting, the life insurer shall:

(1) request that the applicant for a policy of life insurance on the life of a minor identify the amount, if any, of other life insurance coverage on the life of the minor that is in force or pending at the time of the application;

(2) document the applicant's response on the application;

(3) take reasonable steps to verify the total amount of life insurance in force or pending; and

(4) document the steps taken on a particular application to verify the total amount of life insurance in force or pending.

(d) (1) For each application for a policy of life insurance on the life of a minor that is rejected by a life insurer, the life insurer shall maintain at the life insurer's home or principal office, for at least 3 years after the date the application was signed by the applicant, a complete file containing:

(i) the original signed application;

(ii) the life insurer's underwriting analysis;

(iii) any correspondence with the applicant; and

(iv) any other documents pertinent to the decision to reject the application.

(2) The life insurer shall obtain and keep records sufficient to demonstrate that the applicant for a policy of life insurance on the life of a minor has an insurable interest in the life of the minor in accordance with § 12–201 of this article.

§16–120.

Except as otherwise provided in this title, an insurer shall maintain records of insurance transactions related to each individual or group policy of life insurance and each individual or group annuity for a period of at least 7 years after the policy or annuity is no longer in effect.

§16–201.

(a) Except as otherwise provided in this section, a policy of life insurance may not be delivered or issued for delivery in the State unless it contains in substance each applicable provision required by §§ 16-202 through 16-213 of this subtitle.

(b) This section does not apply to:

(1) group life insurance;

(2) pure endowments;

(3) annuity contracts; or

(4) a provision of a policy of life insurance or contract supplemental to the policy that relates to disability benefits or to additional benefits for death by accident or accidental means.

(c) To the extent that a provision or part of a provision required by this subtitle does not apply to a single premium or term policy, the provision or part of the provision need not be included in the policy.

§16–202.

(a) (1) Each policy of life insurance shall contain a provision that a grace period shall be allowed within which the payment of any premium after the first may be made.

(2) The grace period shall be:

(i) 30 days;

(ii) at the option of the insurer, 1 month of not less than 30 days; or

(iii) 4 weeks, for a policy of industrial life insurance with premiums payable more frequently than monthly.

(b) The policy continues in full force during the grace period.

(c) If a claim arises under the policy during the grace period, the amount of any premium due or overdue may be deducted from the policy proceeds.

§16–203.

(a) Each policy of life insurance shall contain a provision that the policy is incontestable, except for nonpayment of premiums, after the policy has been in force during the lifetime of the insured for 2 years after its date of issue.

(b) The incontestability provision described in subsection (a) of this section does not apply to policy provisions that relate to disability benefits or to additional benefits for death by accident or accidental means.

(c) A provision in a policy of life insurance that provides that the policy is incontestable after a specified period:

(1) precludes only a contest of the validity of the policy; and

(2) does not preclude the assertion of defenses based on provisions in the policy that exclude or restrict coverage, whether or not the restrictions or exclusions are excepted in the provision.

§16–204.

(a) Each policy of life insurance shall contain a provision that the policy, or the policy and the application for the policy if a copy of the application is endorsed on or attached to the policy when issued, constitute the entire contract between the parties.

(b) If the application is made part of the policy, the policy shall contain a provision that the statements in the application, in the absence of fraud, are considered representations and not warranties.

§16–205.

(a) Each policy of life insurance shall contain a provision that if the age of the insured or of any other individual whose age is considered in determining the premium or benefit has been misstated, the amount payable or benefit accruing under the policy shall be the amount or benefit that the premium would have purchased had the correct age been stated.

(b) (1) If an application or policy expressly limits the insurable age and the correct age at the date of issue is outside the insurable age limit, the policy is voidable at the option of the insurer during the lifetime of the insured, but not later than 3 years after the date of issue of the policy.

(2) If the insurer exercises the option to void the policy, the insurer shall return to the insured the aggregate of gross premiums charged on the policy, less:

(i) dividends paid in cash or used to pay premiums on the policy; and

(ii) any indebtedness to the insurer on the policy, including interest due and accrued.

(3) The insurer may not exercise the option to void the policy more than 30 days after the correct age is established.

(4) Subject to paragraph (5) of this subsection, if the insurer does not exercise the option to void the policy or if the age discrepancy is not discovered within 3 years after the date of issue of the policy, the insurer may not void the policy and the amount payable shall be determined in accordance with subsection (a) of this section.

(5) If the premium rates of the insurer at the date of issue of the policy do not include a rate for the correct age, the amount payable shall be determined in accordance with established actuarial principles.

§16–206.

(a) (1) Each participating ordinary life insurance policy shall contain a provision that:

(i) each year the insurer shall determine and apportion any divisible surplus under the policy that will accrue on the policy anniversary or other dividend date specified in the policy; and

(ii) the dividends arising from the apportionment shall be credited each year beginning not later than the end of the third policy year.

(2) Each participating industrial life insurance policy shall contain a provision that:

(i) each year the insurer shall determine and apportion any divisible surplus under the policy that will accrue on the policy anniversary or other dividend date specified in the policy; and

(ii) the dividends arising from the apportionment shall be credited each year beginning not later than the end of the fifth policy year.

(3) The policy may not contain a provision that the payment of any dividend payable under this section is contingent on the payment of any premium due on or after the date when the dividend becomes payable.

(b) (1) Subject to paragraph (2) of this subsection, each policy shall contain a provision that the party entitled to the dividend may elect to have the dividend:

(i) paid in cash;

(ii) applied to the payment of any premium then due;

(iii) applied to provide paid-up additions to the policy; or

(iv) left to accumulate at an interest rate not less than the rate specified in the policy.

(2) A term policy need not provide the dividend options specified in paragraph (1)(iii) and (iv) of this subsection.

(3) Each participating ordinary life insurance policy shall contain a provision that a specified option becomes effective unless the party entitled to the dividend notifies the insurer in writing of a different option within 30 days after the date on which the dividend is payable.

(c) If a participating policy provides that the benefit under any paid-up nonforfeiture provision is to be participating, the policy may provide that any divisible surplus apportioned while the insurance is in force under the nonforfeiture provision shall be applied in any manner specified in the policy.

(d) This section does not prohibit an insurer from granting to the party entitled to the dividends the right to elect another dividend option offered by the insurer in addition to the options required by this section, whether or not the additional option is specified in the policy.

(e) This section does not prohibit payment of additional dividends on default of payment of premiums or on termination of the policy.

§16–207.

(a) This section does not apply to:

(1) term policies;

(2) term insurance benefits provided by rider or supplemental policy provisions; or

(3) industrial life insurance policies.

(b) Each policy of life insurance shall contain a provision that, on proper assignment or pledge of the policy and on the sole security of the policy, the insurer shall advance an amount equal to, or at the option of the party entitled to the advance, an amount not exceeding the loan value of the policy:

(1) after premiums have been paid for at least 3 years;

(2) after the policy has a cash surrender value; and

(3) while no premium is in default beyond the grace period.

(c) (1) Except as provided in paragraph (2) of this subsection and subject to § 16-208 of this subtitle, the insurer may charge interest on the advance at a rate specified in the policy not exceeding an effective rate of 6% per year.

(2) The Commissioner may authorize an interest rate exceeding an effective rate of 6% but not exceeding 8% per year if the Commissioner finds that a greater rate will reduce the net cost of life insurance offered by the insurer in direct relationship to the revenue from the increase.

(d) (1) Subject to paragraph (2) of this subsection, the loan value of a policy shall at least equal the cash surrender value of the policy at the end of the current policy year.

(2) In determining the cash surrender value of a policy, the insurer may deduct from the loan value or from the proceeds of the loan:

(i) any existing indebtedness to the insurer not already deducted including any interest then accrued but not due;

(ii) any unpaid balance of the premium for the current policy year; and

(iii) interest on the loan to the end of the current policy year.

(e) Each policy may also contain a provision that:

(1) interest on any indebtedness that is not paid when due shall be added to the existing indebtedness and shall bear interest at the same rate; and

(2) the policy terminates if:

(i) the total indebtedness on the policy, including interest due or accrued, equals or exceeds the amount of the loan value of the policy; and

(ii) at least 30 days before termination, the insurer mails notice to the last known address of the insured or policy owner and of any assignee of record at the home office of the insurer.

(f) Each policy shall allow the insurer to defer granting a loan, other than for the payment of a premium to the insurer, for 6 months after application for the loan.

(g) Except for those policies that require weekly premium payments, each policy shall provide for an automatic premium loan, subject to an election by the party entitled to elect.

§16–208.

(a) (1) In this section the following words have the meanings indicated.

(2) "Policy" includes:

(i) a certificate issued by a fraternal benefit society that provides for policy loans; and

(ii) an annuity contract that provides for policy loans.

(3) "Policyholder" includes:

(i) the owner of a policy; and

(ii) the person designated to pay premiums as shown on the records of the life insurer.

(4) "Policy loan" includes any premium loan made under a policy to pay one or more premiums that were not paid to the life insurer as the premiums fell due.

(5) "Published monthly average" means:

(i) Moody's corporate bond yield average - monthly average corporates as published by Moody's Investors Service, Inc. or its successor; or

(ii) if the Moody's corporate bond yield average - monthly average corporates is not published, a substantially similar average that the Commissioner establishes by regulation.

(b) Each policy of life insurance issued on or after July 1, 1983, shall contain a provision that:

(1) allows a maximum interest rate on a policy loan, including the interest rate charge on reinstatement of a policy loan during and after any lapse of a policy, not exceeding an effective rate of 8% per year; or

(2) allows an adjustable maximum annual interest rate on a policy loan, including the interest rate charge on reinstatement of a policy loan during and after any lapse of a policy, set by the insurer as allowed by law not exceeding the greater of:

(i) the published monthly average for the calendar month ending 2 months before the date the rate is determined; or

(ii) the annual rate used to calculate the cash surrender values under the policy during the applicable period plus 1%.

(c) (1) If the maximum rate of interest is determined under subsection (b)(2) of this section, the policy shall include provisions that disclose the frequency at which the rate will be determined for the policy.

(2) The maximum annual interest rate for each policy with an adjustable policy loan interest rate must be determined at regular intervals at least once every 12 months, but not more than once in any 3-month period.

(d) For a policy with an adjustable policy loan interest rate, at the intervals specified in the policy:

(1) the interest rate may be increased if the calculation under subsection (b)(2) of this section would increase the annual rate by at least 0.5%; and

(2) the interest rate shall be reduced if the calculation under subsection (b)(2) of this section would reduce the annual rate by at least 0.5%.

(e) (1) This subsection applies only to a policy with an adjustable policy loan interest rate.

(2) When a cash loan is made, the life insurer shall notify the policyholder of the beginning annual interest rate on the loan.

(3) When a premium loan is made, the life insurer shall notify the policyholder as soon as is reasonably practical after making the initial loan of the beginning annual interest rate on the loan.

(4) The life insurer shall give reasonable advance notice to policyholders with outstanding loans of any increase in interest rates.

(5) The notices required under this subsection shall include the substance of the relevant provisions of subsections (b) and (c)(2) of this section.

(f) (1) This subsection applies only to a policy with an adjustable policy loan interest rate.

(2) The loan value of the policy shall be determined under Subtitle 3 of this title.

(3) A policy may not terminate during a policy year solely as the result of a change in the interest rate during the policy year.

(4) The life insurer shall maintain coverage during the policy year until the time that the policy would otherwise have terminated had there been no change in interest rate during the policy year.

(g) Unless made specifically applicable to policy loan interest rates, other provisions of law do not apply to policy loan interest rates.

(h) On request, a life insurer shall notify the policyholder each year of the cash value of the policy for the current policy year.

(i) A life insurer that offers policies with an adjustable policy loan interest rate shall establish a written pricing or dividend policy that provides that the policyholders shall receive the benefits from increased earnings of the insurer that result from the use of an adjustable rate by receiving higher dividends, higher cash values, lower premiums, or a combination of benefits.

§16–209.

If a policy of life insurance provides that the proceeds may be paid in installments or as an annuity, the policy shall contain a provision that so states and shall include a table that shows the amount and period of the installment or annuity if determinable when the policy is issued.

§16–210.

(a) Each policy of life insurance shall contain a provision that, subject to subsection (b) of this section, a policy of industrial life insurance will be reinstated within 2 years and any other policy of life insurance will be reinstated within 3 years after the due date of the first premium in default on:

(1) written application for reinstatement;

(2) the production of evidence of insurability satisfactory to the insurer; and

(3) the payment of all premiums in arrears and the payment or reinstatement of any other indebtedness to the insurer on the policy, with interest on the premiums and other indebtedness at a specified rate not exceeding an effective rate of 6% per year compounded annually.

(b) The policy shall provide that reinstatement is not allowed if:

(1) the policy has been surrendered for its cash surrender value;

(2) the cash surrender value of the policy has been exhausted because of policy indebtedness; or

(3) any paid-up term insurance has expired.

§16–211.

(a) Each policy of life insurance shall contain a provision that when benefits become payable because of the death of the insured, settlement shall be made on receipt of proof of death and, at the insurer's option, on surrender of the policy, proof of the interest of the claimant, or both.

(b) The provision also shall state that benefits include the refund of premiums paid after the month in which death occurred.

§16–212.

(a) (1) Each policy of life insurance shall have the name of the beneficiary designated on the policy, or in the application or another form if attached to the policy, with a reservation of the right to designate or change the beneficiary after the policy is issued, unless the beneficiary is irrevocably designated.

(2) An insurer may include in the policy a provision that a designation or change of beneficiary is not binding on the insurer until endorsed on the policy or otherwise accepted by the insurer.

(b) (1) Subject to paragraph (2) of this subsection, a policy of life insurance may provide that the insurer may make a payment under the policy to:

(i) the estate of the insured;

(ii) any relative of the insured by blood, legal adoption, or connection by marriage; or

(iii) a person that appears to the insurer to be equitably entitled to the benefits because the person is a named beneficiary or has incurred expenses for the maintenance, medical attention, or burial of the insured.

(2) The insurer may make a payment under paragraph (1) of this subsection only if:

(i) within the period stated in the policy, which may not be less than 30 days after the death of the insured, the beneficiary designated in the policy does not make a claim under the policy or does not surrender the policy with proof of death;

(ii) the beneficiary is the estate of the insured;

(iii) the beneficiary is a minor;

(iv) the beneficiary dies before the insured; or

(v) the beneficiary is not legally competent to give a valid release.

(3) A policy of life insurance may include a provision that is similar to that described in paragraphs (1) and (2) of this subsection and is applicable to any other payment due under the policy.

(4) A policy of industrial life insurance also may provide that the insurer may refuse to endorse the name of any proposed beneficiary who does not appear to the insurer to have an insurable interest in the life of the insured.

§16–213.

(a) A policy of life insurance other than a policy of group life insurance may not be delivered or issued for delivery in the State unless the policy has a legible and brief description of the policy on the first page of the policy.

(b) The brief description shall include:

(1) the title or type or plan of policy, including the term "industrial" or "wholesale" if applicable;

(2) how long premiums are to be paid;

(3) if and when the premium may change, except for a change because of a supplementary agreement;

(4) if the benefit is not level, the use of the term "graded benefit" or a similar term to so indicate;

(5) whether the policy is participating or nonparticipating;

(6) if the policy is written on a rated underwriting basis, the terms "substandard class" or "rated class" or a substantially similar term; and

(7) if the policy provides for the return of premiums as an additional benefit, the period during which the benefit is applicable.

(c) Notwithstanding subsections (a) and (b) of this section, the brief description need not contain the items of information described in subsection (b) of this section, except for the items described in subsection (b)(1) and (5) of this section, if in the opinion of the Commissioner any of those items are:

(1) already contained in and presented conspicuously in tabular form on the first page of the policy; or

(2) presented conspicuously elsewhere in the policy and referred to in the description on the first page of the policy.

§16–214.

A policy of life insurance may include a rider or supplemental policy provision that offers an insured or certificate holder reimbursement or payment for long-term home health care or long-term care in a nursing home or other related institution:

(1) instead of or in addition to benefits payable because of the death of the insured or certificate holder; or

(2) instead of all or part of the cash surrender or other nonforfeiture value of the policy.

§16–215.

(a) Except as otherwise provided in this section, a policy of life insurance may not be delivered or issued for delivery in the State if the policy excludes or restricts liability for death that is caused in a specified manner or occurs while the insured has a specified status.

(b) (1) Except as provided in paragraph (2) of this subsection, a policy of life insurance may contain a provision that excludes or restricts coverage for death under any of the following circumstances:

(i) death as a direct or indirect result of:

1. a declared or undeclared war;

2. action by military forces;

3. an act or hazard of a declared or undeclared war or of an action by military forces;

4. service in the military forces or in civilian forces auxiliary to the military forces; or

5. any cause while the insured is a member of the military forces of any country at war, declared or undeclared, or of any country engaged in an action by military forces;

(ii) death as a result of aviation or air travel;

(iii) death that occurs within 2 years after the date of issue of the policy as a result of a specified hazardous occupation or avocation;

(iv) death that occurs within 2 years after the date of issue of the policy while the insured resides outside of the continental United States and Canada; or

(v) death that occurs within 2 years after the date of issue of the policy as a result of suicide while sane or insane.

(2) A policy of life insurance may not be delivered or issued for delivery in the State if the policy excludes or restricts liability for death that is the result of an act of terrorism that the covered person did not commit and in which the covered person did not participate.

(3) If a policy contains an exclusion or restriction listed in this subsection, the policy also shall provide that, for death under the circumstances to which the exclusion or restriction applies, the insurer shall pay a determinable amount of at least:

(i) the reserve calculated in accordance with the Commissioner's reserve valuation method on the basis of the mortality table and interest rate specified in the policy for the calculation of nonforfeiture benefits; or

(ii) if the policy does not provide nonforfeiture benefits, the reserve calculated in accordance with a mortality table and interest rate determined by the insurer and specified in the policy.

(4) The table and interest rate used under paragraph (3) of this subsection must be acceptable as a standard for the valuation of the policy in accordance with Title 5, Subtitle 3 of this article with adjustment for indebtedness or dividend credit.

(c) This section does not apply to:

(1) group life insurance;

(2) reinsurance; or

(3) a provision in a policy of life insurance that relates to additional disability benefits or to additional benefits for death by accident or accidental means.

(d) This section does not prohibit any policy provision that in the opinion of the Commissioner is more favorable to the policyholder than a provision allowed by this section.

(e) Notwithstanding any other provision of law, in any newly issued policy of life insurance, the 2-year exclusion for death as a result of suicide allowed in subsection (b)(1)(v) of this section is deemed to begin on the date on which the insurer first issued a life insurance policy to the insured except that:

(1) the exclusion for death as a result of suicide may begin on the date of issue of the new policy if the prior policy terminates:

(i) before the date of issue of the new policy; or

(ii) more than 12 months after the date of issue of the new policy;

(2) if the newly issued policy provides death benefits in excess of the amount of death benefits payable under the prior policy, the exclusion for death as a result of suicide as to the excess amount of death benefits only may begin on the date of issue of the new policy; and

(3) for purposes of the exclusion for death as a result of suicide, if more than one prior policy is terminated within the 12-month period specified in item (1) of this subsection, the suicide exclusion period for the amount of death benefits represented by the terminated policies is deemed to have begun on the dates of issue of those policies.

§16–216.

(a) Subject to subsection (b) of this section, a policy of life insurance may not contain:

(1) a provision that the insurer may reduce or deny liability under the policy because the insured has previously obtained other insurance from the same insurer;

(2) a provision that gives the insurer the right to declare the policy void because the insured has had a disease or ailment, whether specified or not, or has received institutional, hospital, medical, or surgical treatment or attention; or

(3) a provision that gives the insurer the right to declare the policy void because the insured has been rejected for insurance, unless the right is conditioned on a showing by the insurer that knowledge of the rejection would have led to a refusal by the insurer to issue the policy.

(b) Subsection (a)(2) of this section does not prohibit a policy provision that gives the insurer the right to declare the policy void if:

(1) the insured has received institutional, hospital, medical, or surgical treatment or attention within 2 years before the policy was issued; and

(2) the insured or a claimant under the policy fails to show that the condition occasioning the treatment or attention was not serious or was not material to the risk.

§16–217.

A policy of wholesale life insurance may not be delivered or issued for delivery in the State unless:

(1) the policy contains the provisions and conforms to the requirements that the Commissioner sets by regulation; and

(2) a copy of the form for the policy has been filed under § 12-203 of this article and approved by the Commissioner.

§16–218.

A policy of life insurance may include a rider or supplemental policy provision that operates to safeguard the contract from lapse in the event of involuntary unemployment.

§16–219.

(a) (1) If a policy of universal or variable life insurance contains a provision that allows a policyholder to reduce the face amount of the policy, the insurer shall provide a written notice to the policyholder.

(2) The notice shall state:

(i) that the policyholder's policy allows for a reduction of the face amount of the policy as an option to retain coverage;

(ii) the amount to be paid to prevent the policy from lapse; and

(iii) the insurer's customer service telephone number.

(b) The notice shall be sent to a policyholder's last known address:

(1) at the beginning of the grace period under § 16–202 of this subtitle; and

(2) at least 30 days before termination of coverage.

§16–301.

(a) This subtitle does not apply to:

(1) reinsurance;

(2) group life insurance;

(3) a pure endowment;

(4) an annuity contract or reversionary annuity contract;

(5) a term policy of a uniform amount that:

(i) does not provide guaranteed nonforfeiture or endowment benefits or provide for renewal;

(ii) is for 20 years or less and expires before the insured's age 71; and

(iii) requires uniform premiums, payable during the entire term of the policy;

(6) a term policy of a decreasing amount:

(i) that does not provide guaranteed nonforfeiture or endowment benefits; and

(ii) on which the adjusted premium, calculated under the applicable provisions of §§ 16-307 through 16-309 of this subtitle, is less than the adjusted premium on a policy or renewal of a policy of a uniform amount if the policy of the uniform amount:

1. does not provide guaranteed nonforfeiture or endowment benefits;

2. is issued at the same age and for the same initial amount of insurance;

3. is for 20 years or less and expires before the insured's age 71; and

4. requires uniform premiums, payable during the entire term of the policy; or

(7) a policy that:

(i) does not provide guaranteed nonforfeiture or endowment benefits; and

(ii) has a cash surrender value or present value for any paid-up nonforfeiture benefit, at the beginning of any policy year, calculated under the applicable provisions of §§ 16-305 through 16-309 of this subtitle, that does not exceed 1.5% of the amount of insurance at the beginning of the same policy year.

(b) For purposes of determining the applicability of this subtitle, the age at expiry for a joint term life insurance policy is the age at expiry of the oldest life.

§16–302.

The operative date of this subtitle is:

(1) a date from June 2, 1947, to April 29, 1949, both inclusive, as specified by the insurer if the insurer filed with the Commissioner written notice of an election to comply with this subtitle on a date before April 30, 1949;

(2) a date from May 1, 1949, to January 1, 1950, both inclusive, if allowed by the Commissioner; or

(3) April 30, 1949.

§16–303.

(a) Subject to § 16-304(a) of this subtitle, a policy of life insurance may not be delivered or issued for delivery in the State on or after the operative date of this subtitle unless the policy contains in substance:

(1) each provision in subsections (b) through (g) of this section; or

(2) corresponding provisions that in the opinion of the Commissioner are at least as favorable to a defaulting or surrendering policyholder as the corresponding minimum requirements in subsections (b) through (g) of this section and that essentially comply with § 16-312 of this subtitle.

(b) (1) Each policy shall contain a provision that if a premium payment is in default after premiums have been paid for at least 1 year, on proper request under paragraph (2) of this subsection the insurer will grant:

(i) a paid-up nonforfeiture benefit on a plan specified in the policy of the amount required by this subtitle, effective as of the due date of the premium in default; or

(ii) an actuarially equivalent paid-up nonforfeiture benefit that provides a greater amount or longer period of death benefits or a greater amount or earlier payment of any endowment benefits.

(2) The request for a paid-up nonforfeiture benefit must be made to the insurer within 60 days after the due date of the premium in default.

(c) Each policy shall contain a provision that unless a person entitled to elect another available option within 60 days after the due date of the premium in default makes the election, the specified paid-up nonforfeiture benefit becomes effective.

(d) Each policy shall contain a provision that on surrender of a policy within 60 days after the due date of a premium in default, instead of a paid-up nonforfeiture benefit, the insurer will pay a cash surrender value as specified in the policy of the amount required by this subtitle after premiums have been paid for at least:

(1) 3 years for ordinary life insurance; or

(2) 5 years for industrial life insurance.

(e) Each policy shall contain a provision that on surrender of a policy within 30 days after the policy anniversary, the insurer will pay a cash surrender value as specified in the policy of the amount required by this subtitle if the policy:

(1) is paid-up by completion of all premium payments; or

(2) is continued under a paid-up nonforfeiture benefit that became effective on or after:

(i) the third policy anniversary for ordinary life insurance; or

(ii) the fifth policy anniversary for industrial life insurance.

(f) (1) If a policy provides for unscheduled changes in benefits or premiums on a basis guaranteed by the policy or provides an option for changes in

benefits or premiums, other than a change to a new policy, the policy shall contain a statement of the mortality table, interest rate, and method used to calculate cash surrender values and paid-up nonforfeiture benefits available under the policy.

(2) (i) Each policy other than a policy described in paragraph (1) of this subsection shall contain:

1. a statement of the mortality table and interest rate used to calculate cash surrender values and paid-up nonforfeiture benefits available under the policy; and

2. a table that shows any cash surrender value and any paid-up nonforfeiture benefit available under the policy on each policy anniversary during the first 20 years of the policy or, if shorter, the term of the policy.

(ii) Cash surrender values and paid-up nonforfeiture benefits shall be calculated on the assumption that:

1. there are no dividends or paid-up additions credited to the policy; and

2. there is no indebtedness to the insurer on the policy.

(g) Each policy shall contain:

(1) a statement that cash surrender values and paid-up nonforfeiture benefits available under the policy are not less than the minimum values and benefits required by this article;

(2) an explanation how cash surrender values and paid-up nonforfeiture benefits are altered due to paid-up additions credited to the policy or indebtedness to the insurer on the policy;

(3) a statement that the method of calculating cash surrender values and paid-up nonforfeiture benefits has been filed with the Commissioner if a detailed statement of the calculation method is not stated in the policy; and

(4) a statement of the method of calculating the cash surrender value and paid-up nonforfeiture benefit available under the policy on any policy anniversary after the last anniversary for which the cash surrender values and paid-up nonforfeiture benefits are shown consecutively in the policy.

§16–304.

(a) Any provision required under § 16-303(b) through (g) of this subtitle may be omitted from a policy of life insurance to the extent that the provision does not apply under the insurance plan.

(b) The insurer shall reserve the right to defer the payment of any cash surrender value for up to 6 months after demand for payment with surrender of the policy.

§16–305.

(a) On default of a premium payment due on a policy anniversary, any cash surrender value available under the policy, regardless of whether the cash surrender value is required under § 16-303 of this subtitle, shall be at least:

(1) the present value of the future guaranteed benefits, calculated as of that policy anniversary, that would have been provided under the policy, including any existing paid-up additions; less

(2) the sum of:

(i) the present value of adjusted premiums, calculated as of that policy anniversary in accordance with the applicable provisions of §§ 16-307 through 16-309 of this subtitle, corresponding to premiums that would have fallen due on or after the anniversary; and

(ii) the amount of any indebtedness to the insurer on the policy.

(b) (1) This subsection applies only to a policy that:

(i) by rider or supplemental policy provision, provides supplemental life insurance or annuity benefits at the option of the insured for an identifiable additional premium; and

(ii) is issued on or after the operative date of § 16-309 of this subtitle.

(2) On a policy subject to this subsection, the cash surrender value referred to in subsection (a) of this section shall be at least the sum of:

(i) the cash surrender value for an otherwise similar policy issued at the same age without the rider or supplemental policy provision; and

(ii) the cash surrender value calculated under subsection (a) of this section for a policy that provides only the benefits otherwise provided by the rider or supplemental policy provision.

(c) (1) This subsection applies only to a family policy that:

(i) defines a primary insured and provides term insurance on the life of the spouse of the primary insured that expires before the spouse's age 71; and

(ii) is issued on or after the operative date of § 16-309 of this subtitle.

(2) On a policy subject to this subsection, the cash surrender value referred to in subsection (a) of this section shall be at least the sum of:

(i) the cash surrender value calculated under subsection (a) of this section for an otherwise similar policy issued at the same age without term insurance on the life of the spouse; and

(ii) the cash surrender value calculated under subsection (a) of this section for a policy that provides only the benefits otherwise provided by term insurance on the life of the spouse.

(d) (1) This subsection applies to a policy of life insurance that is paid-up by completion of all premium payments or is continued under any paid-up nonforfeiture benefit, regardless of whether the cash surrender value is required under § 16-303 of this subtitle.

(2) On a policy subject to this subsection, the cash surrender value available within 30 days after a policy anniversary shall be at least the present value, calculated as of the policy anniversary, of the future guaranteed benefits, including any existing paid-up additions, reduced by any indebtedness to the insurer on the policy.

§16–306.

On default of a premium payment due on a policy anniversary, the present value of any paid-up nonforfeiture benefit available under the policy, calculated as of that policy anniversary:

(1) shall at least equal the cash surrender value provided under the policy, calculated as of that policy anniversary; or

(2) if no cash surrender value is provided, shall equal the cash surrender value that would have been required under this subtitle absent a condition that premiums shall have been paid for at least a specified period.

§16–307.

(a) This section does not apply to a policy of life insurance issued on or after the operative date of § 16-309 of this subtitle.

(b) (1) For purposes of this section, the date of issue of a policy is the date as of which the rated age of the insured is determined.

(2) Subject to subsection (d) of this section, the adjusted premiums for a policy shall be calculated on an annual basis and shall be a uniform percentage of the premiums specified in the policy for each policy year, excluding extra premiums on a substandard policy, so that the present value of the adjusted premiums, calculated as of the date of issue, shall equal the sum of:

(i) the present value of the future guaranteed benefits, calculated as of the date of issue, provided by the policy;

(ii) 2% of the amount of insurance if the insurance is a uniform amount or of the equivalent uniform amount of insurance, calculated under subsection (c) of this section, if the amount of insurance varies with the duration of the policy;

(iii) subject to paragraph (3) of this subsection, 40% of the adjusted premium for the first policy year; and

(iv) subject to paragraph (3) of this subsection, 25% of the lesser of:

1. the adjusted premium for the first policy year; or

2. the adjusted premium for a whole life policy of the same uniform amount or equivalent uniform amount with uniform premiums for the duration of the insured's life, issued at the same age and for the same amount of insurance.

(3) In applying the percentages specified in paragraph (2)(iii) and (iv) of this subsection, adjusted premiums may not be considered to exceed 4% of the amount of insurance or of the equivalent uniform amount of insurance.

(c) (1) Subject to paragraph (2) of this subsection, if a policy has a variable amount of insurance over its duration, for purposes of subsection (b) of this section the equivalent uniform amount of insurance shall be based on the uniform amount of insurance provided by an otherwise similar policy that:

(i) contains the same endowment benefits;

(ii) is issued at the same age and for the same term;

(iii) has an amount of insurance that does not vary over the duration of the policy; and

(iv) provides benefits that have the same present value at the date of issue as the benefits under the policy that has the variable amount of insurance.

(2) If the policy that has a variable amount of insurance is issued on the life of a child under age 10, the equivalent uniform amount of insurance may be calculated as though the amount of insurance provided by the policy before age 10 was the amount provided by the policy at age 10.

(d) (1) Subject to paragraph (2) of this subsection, the adjusted premiums for a policy that provides term insurance benefits by rider or supplemental policy provision shall equal the sum of:

(i) the adjusted premiums for an otherwise similar policy issued at the same age without the term insurance benefits during the period for which premiums for the term insurance benefits are payable; and

(ii) the adjusted premiums for the term insurance during the period for which premiums for the term insurance are payable.

(2) Paragraph (1)(i) and (ii) of this subsection shall be calculated separately in accordance with subsections (b) and (c) of this section except that, for purposes of subsection (b)(2)(ii), (iii), and (iv) of this section, the amount of insurance or the equivalent uniform amount of insurance used in calculating the adjusted premiums in paragraph (1)(ii) of this subsection shall equal the corresponding amount determined for the entire policy less the amount used in calculating the adjusted premiums in paragraph (1)(i) of this subsection.

§16–308.

(a) This section does not apply to a policy of life insurance issued on or after the operative date of § 16–309 of this subtitle.

(b) (1) This subsection does not apply to a policy governed by subsection (c) or (d) of this section.

(2) (i) For policies of ordinary life insurance, the adjusted premiums and present values referred to in this subtitle shall be calculated based on the Commissioners 1941 Standard Ordinary Mortality Table.

(ii) Any differential based on sex shall reflect actuarial expectancies and is subject to the Commissioner's approval.

(3) For policies of industrial life insurance, the adjusted premiums and present values referred to in this subtitle shall be calculated based on the 1941 Standard Industrial Mortality Table.

(4) Adjusted premiums and present values shall be calculated at an interest rate, not exceeding a rate of 3.5% per year, specified in the policy for calculating cash surrender values and paid–up nonforfeiture values.

(5) In the calculation of the present value of paid–up term insurance with any accompanying pure endowment offered as a nonforfeiture benefit, the rates of mortality assumed may not exceed 130% of the rates of mortality according to the applicable table.

(6) In the calculation of adjusted premiums and present values for insurance issued on a substandard basis, the adjusted premiums and present values may be calculated based on another mortality table specified by the insurer and approved by the Commissioner.

(c) (1) This subsection applies to policies of ordinary life insurance issued:

(i) on or after January 1, 1966, but before the operative date of § 16–309 of this subtitle; or

(ii) on an operative date from June 2, 1959, to December 31, 1965, both inclusive, as specified by the insurer if the insurer filed with the Commissioner written notice of an election to comply with this subsection on a date before January 1, 1966.

(2) For policies of ordinary life insurance, the adjusted premiums and present values referred to in this subtitle shall be calculated based on the Commissioners 1958 Standard Ordinary Mortality Table and the rate of interest

specified in the policy for calculating cash surrender values and paid–up nonforfeiture benefits.

(3) Adjusted premiums and present values shall be calculated at an interest rate specified in the policy for calculating cash surrender values and paid–up nonforfeiture benefits, not exceeding a rate of:

(i) 3.5% per year for policies issued on or before June 30, 1978;

(ii) 4% per year for policies issued from July 1, 1978, to June 30, 1980, both inclusive; or

(iii) 5.5% per year for policies issued on or after July 1, 1980.

(4) Adjusted premiums and present values calculated for any category of ordinary life insurance issued on female risks may be calculated according to an age not more than 6 years younger than the actual age of the insured.

(5) In the calculation of the present value of paid–up term insurance with any accompanying pure endowment offered as a nonforfeiture benefit, the rates of mortality assumed may not exceed the rates in the Commissioners 1958 Extended Term Insurance Table.

(6) In the calculation of adjusted premiums and present values for insurance issued on a substandard basis, the adjusted premiums and present values may be calculated based on another mortality table specified by the insurer and approved by the Commissioner.

(d) (1) This subsection applies to policies of industrial life insurance issued:

(i) on or after January 1, 1968, but before the operative date of § 16–309 of this subtitle; or

(ii) on an operative date from January 1, 1964, to December 31, 1967, both inclusive, as specified by the insurer if the insurer filed with the Commissioner written notice of an election to comply with this subsection on a date before January 1, 1968.

(2) For policies of industrial life insurance, the adjusted premiums and present values referred to in this subtitle shall be calculated based on the Commissioners 1961 Standard Industrial Mortality Table and the rate of interest specified in the policy for calculating cash surrender values and paid–up nonforfeiture benefits.

(3) Adjusted premiums and present values shall be calculated at an interest rate specified in the policy for calculating cash surrender values and paid–up nonforfeiture benefits, not exceeding a rate of:

(i) 3.5% per year for policies issued on or before June 30, 1978;

(ii) 4% per year for policies issued from July 1, 1978, to June 30, 1980, both inclusive; or

(iii) 5.5% per year for policies issued on or after July 1, 1980.

(4) In the calculation of the present value of paid–up term insurance with any accompanying pure endowment offered as a nonforfeiture benefit, the rates of mortality assumed may not exceed the rates in the Commissioners 1961 Industrial Extended Term Insurance Table.

(5) In the calculation of adjusted premiums and present values for insurance issued on a substandard basis, the adjusted premiums and present values may be based on another mortality table specified by the insurer and approved by the Commissioner.

§16–309.

(a) (1) In this section the following words have the meanings indicated.

(2) "Operative date of the valuation manual" has the meaning stated in § 5–201.1(a) of this article.

(3) "Valuation manual" has the meaning stated in § 5–201.1(a) of this article.

(b) This section applies to policies of life insurance issued:

(1) on or after January 1, 1989; or

(2) on or after an operative date that is before January 1, 1989, as specified by the insurer if the insurer filed with the Commissioner written notice of an election to comply with this section on a date before January 1, 1989.

(c) (1) For purposes of this section, the date of issue of a policy is the date as of which the rated age of the insured is determined.

(2) Except as provided in subsection (h) of this section, and subject to paragraph (3) of this subsection, the adjusted premiums for a policy shall be calculated on an annual basis and shall be a uniform percentage of the premiums specified in the policy for each policy year so that the present value of the adjusted premiums shall equal the sum of:

(i) the present value of the future guaranteed benefits, calculated as of the date of issue, provided by the policy;

(ii) 1% of either:

1. the amount of insurance if the insurance is a uniform amount; or

2. the average amount of insurance at the beginning of each of the first 10 policy years; and

(iii) subject to paragraphs (4) and (5) of this subsection, 125% of the nonforfeiture net level premium.

(3) In calculating adjusted premiums, any extra premium for impairments or special hazards or any uniform annual contract charge or policy fee specified in the policy in a statement of the method used to calculate cash surrender values and paid–up nonforfeiture benefits is excluded.

(4) The nonforfeiture net level premium shall equal the present value of the guaranteed benefits, calculated as of the date of issue, provided by the policy divided by the present value of an annuity of 1 per year, calculated as of the date of issue, payable on the date of issue of the policy and on each anniversary on which a premium is due.

(5) In applying the percentage specified in paragraph (2)(iii) of this subsection, a nonforfeiture net level premium may not be considered to exceed 4% of:

(i) the amount of insurance if the insurance is a uniform amount; or

(ii) the average amount of insurance at the beginning of each of the first 10 policy years.

(d) (1) If a policy provides for unscheduled changes in benefits or premiums on a basis guaranteed by the policy or provides an option for changes in benefits or premiums, other than a change to a new policy, the adjusted premiums

and present values initially shall be calculated on the assumption that future benefits and premiums will not change from those stipulated at the date of issue of the policy.

(2) When benefits or premiums are changed, the future adjusted premiums, nonforfeiture net level premiums, and present values shall be recalculated as of the date of the change in the policy in accordance with this section on the assumption that future benefits and premiums will not change from those stipulated by the policy immediately after the change.

(e) (1) Except as provided in subsection (h) of this section, the future adjusted premiums recalculated under subsection (d)(2) of this section shall be a uniform percentage of the future premiums specified in the policy for each policy year so that the present value of the future adjusted premiums, calculated as of the time of the change to the newly defined benefits or premiums, shall equal the remainder of:

(i) the sum of the present value of the future guaranteed benefits, calculated as of the time of the change to the newly defined benefits or premiums, provided by the policy and any additional expense allowance; less

(ii) any cash surrender value or the present value of any paid–up nonforfeiture benefit under the policy, calculated as of the time of the change to the newly defined benefits or premiums.

(2) In recalculating future adjusted premiums, any extra premium for impairments or special hazards or any uniform annual contract charge or policy fee specified in the policy in a statement of the method used to calculate cash surrender values and paid–up nonforfeiture benefits is excluded.

(f) The additional expense allowance, calculated as of the time of the change to the newly defined benefits or premiums, is the sum of:

(1) 1% of the remainder, if positive, of:

(i) the average amount of insurance at the beginning of each of the first 10 policy years subsequent to the change; less

(ii) the average amount of insurance before the change at the beginning of each of the first 10 policy years subsequent to the most recent previous change or, if there has not been a previous change, subsequent to the date of issue of the policy; and

(2) 125% of the increase, if positive, in the nonforfeiture net level premium.

(g) The recalculated nonforfeiture net level premium equals the quotient of:

(1) the sum of:

(i) the nonforfeiture net level premium applicable before the change multiplied by the present value of an annuity of 1 per year payable on each anniversary of the policy on or subsequent to the date of change on which a premium would have been due had the change not occurred; and

(ii) the present value of the increase in future guaranteed benefits provided by the policy; divided by

(2) the present value of an annuity of 1 per year payable on each anniversary of the policy on or after the date of change on which a premium is due.

(h) (1) This subsection applies only to policies issued on a substandard basis that provide reduced graded amounts of insurance so that, in each policy year, the policy has the same tabular mortality cost as an otherwise similar policy issued on a standard basis that provides higher uniform amounts of insurance.

(2) Notwithstanding any other provision of this section, the adjusted premiums and present values for a substandard policy subject to this subsection may be calculated as if the policy was issued to provide the higher uniform amounts of insurance on the standard basis.

(i) (1) (i) For policies of ordinary life insurance, the adjusted premiums and present values referred to in this subtitle shall be calculated based on:

1. the Commissioners 1980 Standard Ordinary Mortality Table; or

2. at the election of the insurer for one or more specified life insurance plans, the Commissioners 1980 Standard Ordinary Mortality Table with 10–year select mortality factors.

(ii) For policies of industrial life insurance, the adjusted premiums and present values referred to in this subtitle shall be calculated based on the Commissioners 1961 Standard Industrial Mortality Table.

(2) Adjusted premiums and present values for policies issued in any calendar year shall be calculated based on an interest rate that does not exceed the nonforfeiture interest rate calculated under this section:

(i) for that calendar year; or

(ii) at the option of the insurer, for the immediately preceding calendar year.

(j) (1) Any cash surrender value available under a paid–up nonforfeiture benefit, including any paid–up dividend additions, regardless of whether required under § 16–303 of this subtitle, shall be calculated based on the mortality table and interest rate used to determine the amount of the paid–up nonforfeiture benefit and any paid–up dividend additions.

(2) An insurer may not calculate the amount of any guaranteed paid–up nonforfeiture benefit including any paid–up additions under the policy based on an interest rate lower than the rate specified in the policy for calculating cash surrender values.

(3) In calculating the present value of any paid–up term insurance with any accompanying pure endowment offered as a nonforfeiture benefit, an insurer may not assume a mortality rate greater than the mortality rates shown in:

(i) for policies of ordinary life insurance, the Commissioners 1980 Extended Term Insurance Table; and

(ii) for policies of industrial life insurance, the Commissioners 1961 Industrial Extended Term Insurance Table.

(4) The calculation of adjusted premiums and present values for insurance issued on a substandard basis may be based on appropriate modifications of the tables required under this section.

(5) (i) For policies issued before the operative date of the valuation manual, in determining the minimum nonforfeiture standard, an insurer may substitute any Commissioners standard ordinary mortality table adopted after 1980 by the National Association of Insurance Commissioners and approved by regulation of the Commissioner for the Commissioners 1980 Standard Ordinary Mortality Table, with or without 10–year select mortality factors or for the Commissioners 1980 Extended Term Insurance Table.

(ii) 1. Subject to subsubparagraph 2 of this subparagraph, for policies issued on or after the operative date of the valuation manual, the valuation manual shall provide the Commissioners standard mortality table for use in determining the minimum nonforfeiture standard that may be substituted for:

A. the Commissioners 1980 Standard Ordinary Mortality Table, with or without 10–year select mortality factors; or

B. the Commissioners 1980 Extended Term Insurance Table.

2. If the Commissioner approves by regulation any Commissioners standard ordinary mortality table adopted by the NAIC for use in determining the minimum nonforfeiture standard for policies issued on or after the operative date of the valuation manual, the minimum nonforfeiture standard approved by the Commissioner supersedes the minimum nonforfeiture standard provided by the valuation manual.

(6) (i) For policies issued before the operative date of the valuation manual, in determining the minimum nonforfeiture standard, an insurer may substitute any Commissioners standard industrial mortality table adopted after 1980 by the National Association of Insurance Commissioners and approved by regulation of the Commissioner for the Commissioners 1961 Standard Industrial Mortality Table or for the Commissioners 1961 Industrial Extended Term Insurance Table.

(ii) 1. Subject to subsubparagraph 2 of this subparagraph, for policies issued on or after the operative date of the valuation manual, the valuation manual shall provide the Commissioners standard mortality table for use in determining the minimum nonforfeiture standard that may be substituted for:

A. the Commissioners 1961 Standard Industrial Mortality Table; or

B. the Commissioners 1961 Industrial Extended Term Insurance Table.

2. If the Commissioner approves by regulation any Commissioners standard industrial mortality table adopted by the NAIC for use in determining the minimum nonforfeiture standard for policies issued on or after the operative date of the valuation manual, the minimum nonforfeiture standard approved by the Commissioner supersedes the minimum nonforfeiture standard provided by the valuation manual.

(k) (1) For policies issued before the operative date of the valuation manual, the nonforfeiture interest rate per year for a policy issued during a calendar year shall equal the greater of:

(i) 4%; or

(ii) 125% of the calendar year statutory valuation interest rate for the policy, in accordance with the standard valuation law, set forth in Title 5, Subtitle 3 of this article, rounded to the nearest 0.25%.

(2) For policies issued on or after the operative date of the valuation manual, the nonforfeiture interest rate per year for a policy issued during a calendar year shall be the interest rate provided by the valuation manual.

(l) Notwithstanding any other provision of this article, an insurer that refiles nonforfeiture values or refiles the method of calculating nonforfeiture values for a policy form that has been previously approved need not refile any other provision of the policy form if the refiling only involves a change in the interest rate or mortality table used to calculate nonforfeiture values.

§16–310.

(a) This section applies to a plan of life insurance:

(1) that provides that the insurer will determine future premiums based on future experience estimates; or

(2) the minimum values of which cannot be determined under the applicable provisions of §§ 16-303 through 16-309 of this subtitle.

(b) The Commissioner must be satisfied that:

(1) the benefits provided under the plan described in subsection (a) of this section are substantially as favorable to policyholders and insureds as the minimum benefits otherwise required by §§ 16-303 through 16-309 of this subtitle; and

(2) the benefits and the pattern of premiums under the plan do not mislead prospective policyholders or insureds.

(c) The cash surrender values and paid-up nonforfeiture benefits provided by a plan subject to this section may not be less than the minimum values and benefits required for the plan calculated by a method consistent with the principles of this subtitle, as determined by regulations adopted by the Commissioner.

§16–311.

(a) On default of a premium payment due on a policy of life insurance at a time other than the policy anniversary, any cash surrender value and paid-up

nonforfeiture benefit available under the policy shall be calculated with an allowance for the lapse of time and the payment of any fractional premiums since the immediately preceding policy anniversary.

(b) Values referred to in §§ 16-305 through 16-309 of this subtitle may be calculated on the assumption that a death benefit is payable at the end of the policy year of death.

(c) The net value of any paid-up additions, other than paid-up term additions, may not be less than the amounts used to provide the additions.

(d) Notwithstanding § 16-305 of this subtitle, the following additional benefits and premiums for the benefits shall be disregarded when calculating cash surrender values and nonforfeiture benefits required under this subtitle and need not be included in any paid-up nonforfeiture benefits:

(1) benefits payable for death by accident or accidental means;

(2) benefits payable for dismemberment or loss of sight;

(3) benefits payable for total and permanent disability;

(4) benefits payable as a reversionary annuity or deferred reversionary annuity benefits;

(5) benefits for long-term home health care and long-term care in a nursing home or similar institution;

(6) term insurance benefits provided by a rider or supplemental policy provision if this subtitle would not apply had the rider or supplemental policy provision been issued as a separate policy;

(7) term insurance benefits payable on the life of a child provided in a policy on the life of a parent of the child if the term insurance:

(i) expires before the child turns 26 years old;

(ii) is a uniform amount after the child is 1 year old;

(iii) has not become paid-up due to the death of a parent of the child; and

(8) other policy benefits additional to life insurance or endowment benefits.

§16–312.

(a) This section applies to policies of life insurance issued on or after January 1, 1986, and is in addition to any other applicable provisions of this subtitle.

(b) On default of a premium payment due on a policy anniversary, any cash surrender value available under the policy may not differ from the sum of the greater of the basic cash value calculated in accordance with subsection (c) of this section and zero and the present value of any existing paid-up additions less any indebtedness to the insurer on the policy by more than 0.2% of:

(1) the amount of insurance if the insurance is a uniform amount; or

(2) the average amount of insurance at the beginning of each of the first 10 policy years.

(c) The basic cash value on any anniversary equals the remainder of:

(1) the present value of the future guaranteed benefits, calculated as of the anniversary, that would have been provided by the policy, excluding any existing paid-up additions and before the deduction of any indebtedness to the insurer on the policy; less

(2) the present value of the nonforfeiture factors, calculated under subsection (e) of this section, corresponding to the premiums that would have fallen due on or after the anniversary.

(d) The effects on the basic cash value of supplemental life insurance, annuity benefits, or family coverage as described under the applicable provisions of §§ 16–305, 16–307, 16–308(b), and 16–309 of this subtitle shall be the same as the effects on cash surrender values under those applicable provisions.

(e) (1) The nonforfeiture factor for each policy year shall be equal to the percentage of the adjusted premium for that policy year calculated in accordance with the applicable provisions of § 16-307, § 16-308(b), or § 16-309 of this subtitle.

(2) Except as required under paragraph (4) of this subsection, the percentage of the adjusted premium shall be the same percentage for each policy year between:

(i) the second policy anniversary; and

(ii) the later of:

1. the fifth policy anniversary; or

2. the first policy anniversary when there is a cash surrender value available under the policy, excluding any paid-up additions but including any indebtedness on the policy, of at least 0.2% of the amount of insurance if the insurance is a uniform amount or of the average amount of insurance at the beginning of each of the first 10 policy years.

(3) The percentage of the adjusted premium after the later of the 2 policy anniversaries specified in paragraph (2) of this subsection shall apply for at least 5 consecutive policy years.

(4) The basic cash value may not be less than the value that would be obtained if the adjusted premiums for the policy calculated under the applicable provisions of § 16-307, § 16-308(b), or § 16-309 of this subtitle were substituted for the nonforfeiture factors in the calculation of the basic cash value.

(f) Adjusted premiums and present values referred to in this section shall be calculated for each policy on the same mortality and interest bases that are used to demonstrate compliance of the policy with other applicable provisions of this subtitle.

(g) Cash surrender values referred to in this section include endowment benefits provided by the policy.

(h) (1) Any cash surrender value available under a policy, other than on default of a premium due on a policy anniversary, and any paid-up nonforfeiture benefit available under a policy on default of a premium payment shall be determined in a manner consistent with the manner specified to determine the analogous minimum amounts under the applicable provisions of §§ 16-303 through 16-306, § 16-309, and § 16-311 of this subtitle.

(2) Any cash surrender value and any paid-up nonforfeiture benefits granted in connection with additional benefits similar to those under § 16-311(d)(1) through (7) of this subtitle shall conform to the principles of this section.

§16–313.

This subtitle is the Maryland Standard Nonforfeiture Law for Life Insurance.

§16–401.

(a) Except as otherwise provided in this section, an annuity contract or pure endowment contract may not be delivered or issued for delivery in the State unless it contains in substance each applicable provision required by §§ 16-402 through 16-407 of this subtitle.

(b) This section does not apply to:

(1) reversionary annuities or survivorship annuities;

(2) group annuities; or

(3) contracts for deferred annuities included in or on the lives of beneficiaries under policies of life insurance.

(c) To the extent that a provision required by this subtitle does not apply to a single premium annuity contract or single premium pure endowment contract, the provision need not be included in the annuity contract or pure endowment contract.

§16–402.

(a) Each annuity contract and each pure endowment contract shall contain a provision that a grace period of not less than 30 days shall be allowed within which any stipulated payment to the insurer due after the first may be made.

(b) The annuity contract or pure endowment contract continues in full force during the grace period.

(c) The insurer may charge interest on a payment made during the grace period at a rate specified in the annuity contract or pure endowment contract, not exceeding 6% per year, for the number of days that elapse in the grace period before the payment.

(d) If a claim arises under the annuity contract or pure endowment contract due to death during the grace period before the overdue payment to the insurer or any deferred payments of the current contract year are made, the amount of the payments, with interest on any overdue payments, may be deducted from any amount payable under the annuity contract or pure endowment contract in settlement.

§16–403.

(a) Subject to § 16-405 of this subtitle, if a statement, other than a statement about age, sex, or identity, is required as a condition to issuing an annuity contract or pure endowment contract, each annuity contract and each pure endowment contract shall contain a provision that the contract is incontestable,

except for nonpayment of stipulated payments to the insurer, after the contract has been in force during the lifetime of the individual or individuals as to whom the statements are required for 2 years after its date of issue.

(b) At the option of the insurer, the contract may also except from the incontestability provision described in subsection (a) of this section provisions that relate to disability benefits or to additional benefits for death by accident or accidental means.

§16–404.

Each annuity contract and each pure endowment contract shall contain a provision that the contract, or the contract and the application for the contract if a copy of the application is endorsed on or attached to the contract when issued, constitute the entire contract between the parties.

§16–405.

(a) Each annuity contract and each pure endowment contract shall contain a provision that, if the age or sex of the individual or individuals on whose life or lives the contract is made, or of any of them, has been misstated, the amount payable or benefit accruing under the contract shall be the amount or benefit that the stipulated payment would have purchased had the correct age or sex been stated.

(b) Each contract also shall contain a provision that if the insurer makes or has made an overpayment because of a misstatement of age or sex, the amount of the overpayment, with interest at a rate specified in the contract but not exceeding 6% per year, may be charged against the current or next payment or payments to be made by the insurer under the contract.

§16–406.

(a) (1) Each participating annuity contract and each participating pure endowment contract shall contain a provision that:

(i) each year the insurer shall determine and apportion any divisible surplus under the contract that will accrue on the contract anniversary or other dividend date specified in the contract; and

(ii) the dividends arising from the apportionment shall be credited each year beginning not later than the end of the third contract year.

(2) The payment of any dividend payable on or after the end of the third contract year may not be made contingent on the payment of any consideration due on or after the date when the dividend becomes payable.

(b) (1) Each contract shall contain a provision that the party entitled to the dividend may elect to have the dividend paid in cash or applied to the payment of any consideration then due.

(2) Each contract shall contain a provision that a specified option becomes effective unless the party entitled to the dividend notifies the insurer in writing of election of a different option within 30 days after the date on which the dividend is payable.

(c) A deferred annuity contract need not provide for participation in surplus after annuity payments begin.

(d) This section does not prohibit an insurer from granting to the party entitled to the dividend the right to elect another dividend option offered by the insurer in addition to the options required by this section, whether or not the additional option is specified in the contract.

§16–407.

(a) Each annuity contract and each pure endowment contract shall contain a provision that, unless the cash surrender value has been paid, the contract may be reinstated, within 1 year after default in making stipulated payments to the insurer, on the payment of all overdue stipulated payments and the payment or reinstatement of any other indebtedness to the insurer on the contract, with interest on the payments and other indebtedness at a rate specified in the contract not exceeding 6% per year.

(b) If applicable, the insurer may require evidence of insurability satisfactory to the insurer.

§16–408.

(a) A contract for a reversionary or survivorship annuity may not be delivered or issued for delivery in the State unless it contains in substance each provision required by this section.

(b) (1) Except as provided in paragraph (2) of this subsection, each contract for a reversionary or survivorship annuity shall include each provision specified in §§ 16-402 through 16-406 of this subtitle.

(2) As to the provision required by § 16-402(d) of this subtitle, the insurer may provide for an equitable reduction of the amount of annuity payments in settlement of an overdue payment instead of providing for deduction of payments from an amount payable on settlement under the contract.

(c) Each contract for a reversionary or survivorship annuity shall contain a provision that the contract may be reinstated within 3 years after the date of default in making stipulated payments to the insurer, on:

(1) the production of evidence of insurability satisfactory to the insurer; and

(2) (i) the payment of all overdue payments and any indebtedness to the insurer on the contract with interest at a rate specified in the contract not exceeding 6% per year compounded annually; or

(ii) the reinstatement as indebtedness on the contract of the amount stated in item (i) of this item, if this amount is within the limits allowed by the then cash value of the contract.

(d) (1) This section does not apply to group annuities or to annuities included in policies of life insurance.

(2) To the extent that a provision required by this section does not apply to a single premium annuity, the provision need not be incorporated in the contract.

§16–409.

An annuity contract may include a rider or supplemental contract provision that offers a contract holder reimbursement or payment for long–term home health care or long–term care in a nursing home or other related institution:

(1) instead of or in addition to the annuity benefits payable under the contract; or

(2) instead of all or part of the cash surrender or other nonforfeiture value of the contract.

§16–501.

This subtitle does not apply to:

(1) reinsurance;

(2) a group annuity purchased under a retirement plan or deferred compensation plan established or maintained by an employer, including a partnership or sole proprietorship, or employee organization, or by both, other than a plan that provides individual retirement accounts or individual retirement annuities under § 408 of the Internal Revenue Code;

(3) a premium deposit fund;

(4) a variable annuity;

(5) an investment annuity;

(6) an immediate annuity;

(7) a deferred annuity contract after annuity payments have begun;

(8) a reversionary annuity; or

(9) an annuity contract that is delivered outside the State through an insurance producer or other representative of the insurer issuing the contract.

§16–502.

The operative date of this subtitle is:

(1) a date from July 2, 1980, to June 30, 1982, both inclusive, as specified by the insurer if the insurer filed with the Commissioner written notice of an election to comply with this subtitle on a date before July 1, 1982; or

(2) July 1, 1982.

§16–503.

(a) An annuity contract may not be delivered or issued for delivery in the State on or after the operative date of this subtitle unless the annuity contract contains:

(1) each applicable provision of subsections (b) through (g) of this section; or

(2) corresponding provisions that the Commissioner believes are at least as favorable to the contract holder after payment of considerations under the annuity contract stops.

(b) Each annuity contract shall contain a provision that when payment of considerations under the annuity contract stops or on the written request of the contract owner, the insurer will grant a paid-up annuity benefit on a plan stipulated in the annuity contract in compliance with §§ 16-505 through 16-509 of this subtitle.

(c) (1) Each annuity contract shall contain a provision that if the annuity contract provides for a lump-sum settlement at maturity or at any other time, on surrender of the annuity contract on or before the start of annuity payments, the insurer will pay a cash surrender benefit in accordance with §§ 16-505, 16-506, 16-508, and 16-509 of this subtitle instead of a paid-up annuity benefit.

(2) (i) The annuity contract may state that the insurer shall reserve the right to defer the payment of the cash surrender value for up to 6 months after demand for payment with surrender of the annuity contract.

(ii) 1. Before making a deferment under subparagraph (i) of this paragraph, the insurer shall make a written request to the Commissioner to make the deferment under subparagraph (i) of this paragraph.

2. The request under subsubparagraph 1 of this subparagraph shall address the necessity of the deferral and the equitability to all policyholders of the deferral.

(iii) After receiving written approval from the Commissioner on the request made under subparagraph (ii)1 of this paragraph, the insurer may defer the payment of the cash surrender value.

(d) Each annuity contract shall contain a statement of any mortality table and interest rates used to calculate any minimum paid-up annuity, cash surrender, or death benefits, guaranteed by the annuity contract and shall provide sufficient information to determine the benefit amounts.

(e) (1) Each annuity contract shall contain a statement that any paid-up annuity, cash surrender, or death benefits available under the annuity contract are not less than the minimum benefits required under this article.

(2) Each annuity contract shall contain an explanation of how benefits are altered due to any additional amount that the insurer credits to the annuity contract, any indebtedness to the insurer on the annuity contract, and any prior withdrawal from or partial surrender of the annuity contract.

(f) If an annuity contract does not provide cash surrender benefits or does not provide death benefits that equal at least the minimum nonforfeiture amount

before the start of annuity payments, the annuity contract shall contain a provision that so states in a prominent place in the annuity contract.

(g) (1) Notwithstanding the requirements of this section, a deferred annuity contract may contain a provision that the insurer may terminate the contract by making a single payment calculated under paragraph (2) of this subsection if:

(i) no considerations have been received under the contract for 2 years; and

(ii) the part of the paid-up annuity benefit at maturity under the contract that is available from the considerations paid before termination would be less than $20 per month.

(2) The payment shall equal the present value of the part of the paid-up annuity benefit available under the contract, calculated as of the date of termination, based on any mortality table and interest rate specified in the contract for determining the paid-up annuity benefit.

(3) A payment by an insurer under this section shall relieve the insurer of any further obligation under the deferred annuity contract.

§16–504.

(a) The minimum values specified under §§ 16–505 through 16–509 of this subtitle of any paid–up annuity, cash surrender, or death benefits under an annuity contract shall be based on minimum nonforfeiture amounts calculated under this section.

(b) (1) At any time before or at the start of any annuity payments, the minimum nonforfeiture amount under an annuity contract shall equal the remainder of:

(i) the accumulation until that time, of the net considerations paid prior to that time, at an interest rate determined under subsection (c) of this section; less

(ii) the sum of:

1. any withdrawal from or partial surrender of the contract accumulated at the interest rate determined under subsection (c) of this section;

2. an annual contract charge of $50 accumulated at the interest rate determined under subsection (c) of this section;

3. any premium tax actually paid by the company for the contract, not to include a premium tax credited back to the company, accumulated at the interest rate determined under subsection (c) of this section; and

4. any indebtedness to the insurer on the contract, including interest due and accrued.

(2) The net considerations for a given contract year used to calculate the minimum nonforfeiture amount shall equal 87.5% of the gross considerations credited to the contract during that contract year.

(c) (1) The interest rate used to determine the minimum nonforfeiture amounts under subsection (b) of this section shall be an annual rate of interest that is equal to the lesser of:

(i) 3% per year; or

(ii) the 5–year constant maturity treasury rate reported by the Federal Reserve Board.

(2) The 5–year constant maturity treasury rate under paragraph (1)(ii) of this subsection shall be:

(i) 1. as of a date not more than 15 months before either the contract issue date or redetermination date; or

2. averaged over a period of not more than 15 months before the contract issue date or redetermination date; and

(ii) rounded to the nearest one–twentieth of 1% and then reduced by 125 basis points.

(3) The interest rate calculated under paragraphs (1) and (2) of this subsection may not be less than 0.15%.

(4) (i) The interest rate calculated under paragraphs (1) and (2) of this subsection:

1. shall apply to the initial contract period; and

2. may be redetermined for additional periods.

(ii) The contract shall state:

1. whether the interest rate will be redetermined; and

2. the interest rate redetermination date, basis, and period, if any.

(d) (1) During the period that a contract provides for substantive participation in an equity index benefit, the insurer may increase the 125 basis points under subsection (c)(2)(ii) of this section up to an additional 100 basis points to reflect the value of the equity index benefit.

(2) On the issue date of the contract, and on each redetermination date, the present value of the additional reduction may not exceed the market value of the equity index benefit.

(3) (i) The Commissioner may require the insurer to demonstrate that the present value of the additional reduction does not exceed the market value of the equity index benefit.

(ii) If the Commissioner finds that the demonstration under subparagraph (i) of this paragraph is inadequate, the Commissioner may disallow or limit the additional reduction.

(e) (1) The Commissioner may adopt regulations to implement the provisions of this section.

(2) The regulations under paragraph (1) of this subsection may provide for:

(i) adjustments to the calculation of the minimum nonforfeiture amount for contracts that provide substantive participation in an equity index benefit; and

(ii) adjustments for other contracts as determined by the Commissioner.

§16–505.

(a) Any paid-up annuity benefit available under an annuity contract shall be:

(1) the present value of the annuity benefit on the date annuity payments are to begin; and

(2) at least the minimum nonforfeiture amount on that date.

(b) The present value shall be calculated using any mortality table and the interest rate specified in the annuity contract to determine minimum paid-up annuity benefits guaranteed in the contract.

§16–506.

(a) This section applies only to annuity contracts that provide cash surrender benefits.

(b) Cash surrender benefits available before maturity under an annuity contract may not be less than the remainder of:

(1) the present value as of the surrender date of the part of the maturity value of the paid-up annuity benefit that would be provided at maturity from considerations paid before the surrender date and any existing additional amount credited by the insurer to the contract; less

(2) the appropriate amount that reflects prior withdrawals from or partial surrenders of the contract and any indebtedness to the insurer on the contract, including interest due and accrued.

(c) The present value under subsection (b)(1) of this section shall be calculated using an interest rate not more than 1% higher than the interest rate specified in the contract for accumulating net considerations to determine the maturity value.

(d) (1) A cash surrender benefit may not be less than the minimum nonforfeiture amount at the time of surrender.

(2) A death benefit under a contract subject to this section shall equal at least the cash surrender benefit.

§16–507.

(a) This section applies only to annuity contracts that do not provide cash surrender benefits.

(b) The present value of a paid-up annuity benefit available as a nonforfeiture option before maturity may not be less than the sum of:

(1) the present value of that part of the maturity value of the paid-up annuity benefit under the annuity contract from considerations paid before the contract is surrendered for or changed to a deferred paid-up annuity; and

(2) any existing additional amount credited by the insurer to the contract.

(c) (1) The present value under subsection (b)(1) of this section shall be calculated for the period before the maturity date using an interest rate specified in the annuity for accumulating the net considerations to determine the maturity value.

(2) If the contract does not provide a death benefit before the start of annuity payments, the present value shall be calculated using the interest rate and mortality table specified in the contract for determining the maturity value of the paid-up annuity benefit.

(d) The present value of a paid-up annuity benefit may not be less than the minimum nonforfeiture amount at the time of surrender.

§16–508.

(a) This section applies to a determination of the benefits calculated under § 16-506 or § 16-507 of this subtitle for an annuity contract that allows an election to have annuity payments begin at optional maturity dates.

(b) The maturity date of an annuity contract described in subsection (a) of this section shall be deemed to be the latest date for which an election is allowed under the contract, but may not be later than the later of the contract anniversary immediately following the annuitant's 70th birthday or the tenth anniversary of the contract.

§16–509.

(a) Any paid-up annuity, cash surrender, or death benefits available at any time other than on a contract anniversary under an annuity contract with fixed scheduled considerations shall be calculated with an allowance for the lapse of time and the payment of any scheduled considerations after the start of the contract year in which payment of considerations stops.

(b) (1) This subsection applies only to an annuity contract that provides by rider or supplemental contract provision both annuity benefits and life insurance benefits that exceed the greater of:

(i) the cash surrender benefits; or

(ii) a return of the gross considerations with interest.

(2) The minimum nonforfeiture benefits shall:

(i) be calculated separately as if the annuity benefits and life insurance benefits were provided under separate contracts; and

(ii) equal the sum of:

1. the minimum nonforfeiture benefits for the annuity part of the contract; and

2. the minimum nonforfeiture benefits for the life insurance part of the contract.

(c) Notwithstanding this section and §§ 16-505 through 16-508 of this subtitle, the following supplemental benefits and considerations for the benefits shall be disregarded when calculating the minimum nonforfeiture amounts, paid-up annuity, cash surrender, and death benefits required under this subtitle:

(1) benefits payable for total and permanent disability;

(2) benefits payable as reversionary annuity or deferred reversionary annuity benefits; or

(3) other policy benefits additional to life insurance, endowment, and annuity benefits.

(d) Additional benefits under subsection (c) of this section need not be included in any paid-up benefits unless the additional benefits separately would require minimum nonforfeiture amounts, paid-up annuity, cash surrender, and death benefits.

§16–510.

This subtitle is the Maryland Standard Nonforfeiture Law for Individual Deferred Annuities and shall be interpreted in a manner consistent with the Standard Nonforfeiture Model Law for Individual Deferred Annuities published by the National Association of Insurance Commissioners.

§16–601.

(a) (1) A stock insurer or mutual insurer may issue individual and group variable life insurance contracts that provide for payment varying directly with the investment experience of a segregated asset account if the stock insurer or mutual insurer:

(i) is authorized to issue life insurance contracts in the State; and

(ii) is authorized by the Commissioner to issue individual and group variable life insurance contracts.

(2) A stock insurer or mutual insurer may issue individual and group variable annuity contracts that provide for payment varying directly with the investment experience of a segregated asset account if the stock insurer or mutual insurer:

(i) is authorized to issue annuity contracts in the State; and

(ii) is authorized by the Commissioner to issue individual and group variable annuity contracts.

(b) To be authorized to issue variable contracts, a stock insurer or mutual insurer shall comply with regulations adopted by the Commissioner.

(c) The regulations of the Commissioner may include:

(1) requirements for a minimum capital and surplus in excess of the amount otherwise required for the issuance of life insurance contracts and annuity contracts that are not variable contracts; and

(2) other requirements that the Commissioner considers appropriate to safeguard the interests of variable contract holders, other policyholders, insurers, and the public.

§16–602.

(a) (1) A segregated asset account may invest in any investments contractually permitted for the segregated asset account and specified in a plan of operation, and the restrictions, limitations, and other provisions of this article relating to investments shall not apply to the investments contained in the segregated asset account, provided that prior to delivery or issuance for delivery in the State, the form of the policy or annuity contract and the plan of operation have been filed with and approved by the Commissioner.

(2) Preferred and common stock investments of amounts allocated to a segregated asset account may not be included in applying the 10% limitations under § 5–511(f) of this article.

(b) The investments of a segregated asset account shall comply with the regulations of the Commissioner.

(c) To the extent provided under the applicable contracts, the part of the assets of a segregated asset account equal to the reserves and other contract liabilities with respect to the account may not be chargeable with liabilities arising out of any other business that the insurer may conduct.

§16–603.

(a) A variable life insurance policy or variable annuity contract may not be delivered or issued for delivery in the State until the form of the policy or annuity contract has been filed with and approved by the Commissioner.

(b) By regulation, the Commissioner shall determine the grace, reinstatement, and nonforfeiture provisions and other required policy provisions that are appropriate to variable life insurance contracts and variable annuity contracts.

§17–101.

(a) Unless approved by the Commissioner, a group life insurance policy may not be offered to a resident of the State under a group life insurance policy issued:

(1) to a group other than one described in Subtitle 2 of this title; or

(2) in another jurisdiction unless the type of group to be covered conforms substantially to a type of group described in Subtitle 2 of this title.

(b) The premium for the policy shall be paid either from the policyholder's funds or from funds contributed by the covered persons, or from both.

(c) An insurer may exclude or limit the coverage on any person as to whom evidence of individual insurability is not satisfactory to the insurer.

(d) A policy of group life insurance may not be delivered or issued for delivery in the State if the policy excludes or restricts liability for death that is the result of an act of terrorism that the covered person did not commit and in which the covered person did not participate.

(e) An insurer who seeks to solicit coverage for Maryland residents under a group life insurance policy issued in another jurisdiction shall include in the certificate form used in connection with the coverage a notice on the first page in 12-point bold type that states:

"The group insurance policy providing coverage under this certificate was issued in a jurisdiction other than Maryland and may not provide all of the benefits required by Maryland law."

§17–102.

(a) Subject to subsection (b) of this section, interest on benefits payable under a policy of group life insurance issued in the State shall accrue and be payable from the date of death of the insured until the date on which the proceeds of the policy are paid.

(b) (1) An insurer is not required to pay interest on benefits if the proceeds of the policy are paid within 30 days after the date of death of the insured.

(2) If proof of death is submitted to the insurer more than 180 days after the date of death of the insured, interest shall accrue and be payable from the date on which proof of death is submitted to the insurer until the date on which the proceeds of the policy are paid.

(c) Interest under this section shall accrue and be payable at a rate not less than the rate of interest payable on death proceeds left on deposit with the insurer.

§17–103.

An insurer that issues a policy to a creditor to insure debtors of the creditor shall provide to the creditor for delivery to each debtor insured under the policy a form that states that:

(1) the life of the debtor is insured under the policy; and

(2) a death benefit paid under the policy because of the debtor's death shall be applied to reduce or extinguish the indebtedness.

§17–104.

(a) An insured under a policy of group life insurance, in accordance with an arrangement among the insured, the group policyholder, and the insurer, may assign to any person any or all of the rights and benefits conferred on the insured by the policy or by law, including:

(1) the right to have issued to the insured an individual policy of life insurance arising from conversion as set forth in §§ 17-309 through 17-311 of this title; and

(2) the right to name a beneficiary.

(b) An assignment made under this section, even if made before the effective date of this section:

(1) vests in the assignee all rights and benefits that are assigned; and

(2) entitles the insurer to deal with the assignee as the owner of all rights and benefits conferred on the insured under the policy:

(i) in accordance with the terms of the assignment; but

(ii) without prejudice to the insurer on account of a payment the insurer makes or an individual policy the insurer issues arising from conversion of the policy before receipt at the insurer's home office of notice of the assignment.

§17–201.

(a) Subject to the requirements of this section, a policy may be issued to an employer, or to the trustees of a fund established by an employer, in which the employer or trustees shall be deemed the policyholder, to insure employees of the employer for the benefit of persons other than the employer.

(b) (1) The employees eligible for insurance under the policy shall be all of the employees of the employer, or all of any class or classes of employees.

(2) The policy may provide that the term "employees" shall include:

(i) the employees of one or more subsidiary corporations, and the employees, individual proprietors, and partners of one or more affiliated corporations, proprietorships, or partnerships if the business of the employer and of the affiliated corporations, proprietorships, or partnerships is under common control; and

(ii) the individual proprietor or partners if the employer is an individual proprietorship or partnership.

(3) The policy may provide that the term "employees" may include retired employees, former employees, and directors of a corporate employer.

(4) A policy issued to insure the employees of a public body may provide that the term "employees" shall include elected or appointed officials.

(c) (1) The premium for the policy shall be paid either from the employer's funds, or from funds contributed by the insured employees, or from both.

(2) Except as provided in paragraph (3) of this subsection, a policy on which no part of the premium is to be derived from funds contributed by the insured employees must insure all eligible employees, except those who reject the coverage in writing.

(3) An insurer may exclude or limit the coverage on any person as to whom evidence of individual insurability is not satisfactory to the insurer.

§17–202.

(a) Subject to the requirements of this section, a policy may be issued to a labor union, or similar employee organization, which shall be deemed to be the policyholder, to insure members of the union or organization for the benefit of persons other than the union or organization or any of its officials, representatives, or agents.

(b) The members eligible for insurance under the policy shall be all of the members of the union or organization, or all of any class or classes of members.

(c) (1) The premium for the policy shall be paid either from funds of the union or organization, or from funds contributed by the insured members specifically for their insurance, or from both.

(2) Except as provided in paragraph (3) of this subsection, a policy on which no part of the premium is to be derived from funds contributed by the insured members specifically for their insurance must insure all eligible members, except those who reject the coverage in writing.

(3) An insurer may exclude or limit the coverage on any person as to whom evidence of individual insurability is not satisfactory to the insurer.

§17–203.

(a) Subject to the requirements of this section, a policy may be issued to a trust or to the trustees of a fund established or adopted by two or more employers, or by one or more labor unions or similar employee organizations, or by one or more employers and one or more labor unions or similar employee organizations, which trust or trustees shall be deemed the policyholder, to insure employees of the

employers or members of the unions or organizations for the benefit of persons other than the employers or the unions or organizations.

(b) (1) The persons eligible for insurance shall be all of the employees of the employers or all of the members of the unions or organizations, or all of any class or classes of employees or members.

(2) The policy may provide that the term "employees" shall include:

(i) the employees of one or more subsidiary corporations, and the employees, individual proprietors, and partners of one or more affiliated corporations, proprietorships, or partnerships if the business of the employer and of the affiliated corporations, proprietorships, or partnerships is under common control;

(ii) the individual proprietor or partners if the employer is an individual proprietorship or partnership;

(iii) retired employees, former employees, and directors of a corporate employer; and

(iv) trustees or their employees, or both, if their duties are principally connected with the trusteeship.

(c) (1) The premium for the policy shall be paid from funds contributed by the employer or employers of the insured persons, or by the union or unions or similar employee organizations, or by both, or from funds contributed by the insured persons or from both the insured persons and the employers or unions or similar employee organizations.

(2) Except as provided in paragraph (3) of this subsection, a policy on which no part of the premium is to be derived from funds contributed by the insured persons specifically for their insurance must insure all eligible persons, except those who reject the coverage in writing.

(3) An insurer may exclude or limit the coverage on any person as to whom evidence of individual insurability is not satisfactory to the insurer.

§17–204.

(a) (1) Subject to the requirements of this section, a policy may be issued to an association or to a trust or to the trustees of a fund established, created, or maintained for the benefit of members of one or more associations.

(2) The association or associations:

(i) shall have at the outset a minimum of 100 persons;

(ii) shall have been organized and maintained in good faith for purposes other than that of obtaining insurance;

(iii) shall have been in active existence for at least 2 years; and

(iv) shall have a constitution and bylaws that provide that:

1. the association or associations hold regular meetings not less than annually to further purposes of the members;

2. except for credit unions, the association or associations collect dues or solicit contributions from members; and

3. the members have voting privileges and representation on the governing board and committees.

(b) The policy may insure members of the association or associations, employees of the association or associations, or employees of members, or one or more of the preceding or all of any class or classes of members or employees for the benefit of persons other than the employee's employer.

(c) (1) The premium for the policy shall be paid from funds contributed by the association or associations, or by employer members, or by both, or from funds contributed by the covered persons or from both the covered persons and the association, associations, or employer members.

(2) Except as provided in paragraph (3) of this subsection, a policy on which no part of the premium is to be derived from funds contributed by the covered persons specifically for the insurance must insure all eligible persons, except those who reject the coverage in writing.

(3) An insurer may exclude or limit the coverage on any person as to whom evidence of individual insurability is not satisfactory to the insurer.

§17–205.

(a) (1) In this section the following words have the meanings indicated.

(2) "Public employees association" means an association of federal, State, county, or municipal corporation employees.

(3) "Public employer" means a county, municipal corporation, association of counties or municipal corporations, State college or university, or unit of State, county, or municipal corporation government.

(b) (1) Subject to the requirements of this section, the lives of a group of individuals may be insured under a policy issued to a public employer or public employees association to cover employees of the public employer or members of the public employees association for the benefit of persons other than the public employer or public employees association.

(2) The public employer or public employees association to which the policy is issued is deemed the policyholder.

(c) (1) All employees of the public employer, all members of the public employees association, or all of any class or classes of employees or members determined by conditions pertaining to their employment or membership in the public employees association or both are eligible for insurance under a policy issued in accordance with this section.

(2) A policy issued to insure employees of a public employer may provide that the term "employee" includes:

(i) a retired employee; and

(ii) an elected or appointed official.

(d) (1) The premium for the policy shall be paid from funds contributed by the public employer or public employees association, or by both, or from funds contributed by the covered persons or from both the covered persons and the public employer or public employees association.

(2) Except as provided in paragraph (3) of this subsection, a policy on which no part of the premium is to be derived from funds contributed by the covered persons specifically for the insurance must insure all eligible persons, except those who reject the coverage in writing.

(3) An insurer may exclude or limit the coverage on any person as to whom evidence of individual insurability is not satisfactory to the insurer.

(4) A public employer may require written authorization from an employee to deduct from the employee's salary the required contributions for the premium.

§17–206.

(a) Subject to the requirements of this section, a policy may be issued to a creditor or its parent holding company or to a trustee or trustees or agent designated by two or more creditors, which creditor, holding company, affiliate, trustee, trustees, or agent shall be deemed the policyholder, to insure debtors of the creditor, or creditors.

(b) (1) The debtors eligible for insurance under the policy shall be all of the debtors of the creditor or creditors, or all of any class or classes of debtors.

(2) The policy may provide that the term "debtors" shall include:

(i) borrowers of money or purchasers or lessees of goods, services, or property for which payment is arranged through a credit transaction;

(ii) the debtors of one or more subsidiary corporations; and

(iii) the debtors of one or more affiliated corporations, proprietorships, or partnerships if the business of the policyholder and of the affiliated corporations, proprietorships, or partnerships is under common control.

(c) (1) The premium for the policy shall be paid either from the creditor's funds, or from charges collected from the insured debtors, or from both.

(2) Except as provided in paragraph (3) of this subsection, a policy on which no part of the premium is to be derived from the funds contributed by insured debtors specifically for their insurance must insure all eligible debtors.

(3) An insurer may exclude any debtors as to whom evidence of individual insurability is not satisfactory to the insurer.

(d) (1) The amount of insurance on the life of any debtor shall at no time exceed the greater of the scheduled or actual amount of unpaid indebtedness to the creditor.

(2) (i) The insurance may be payable to the creditor or any successor to the right, title, and interest of the creditor.

(ii) The payment shall reduce or extinguish the unpaid indebtedness of the debtor to the extent of the payment and any excess of the insurance shall be payable to the beneficiary named by the insured other than the creditor or to the estate of the insured.

(3) Notwithstanding the provisions of paragraphs (1) and (2) of this subsection:

(i) insurance on agricultural credit transaction commitments not exceeding a term of 1 year may be written up to the amount of the loan commitment on a nondecreasing or level term plan; and

(ii) insurance on educational credit transaction commitments may be written up to the amount of the loan commitment less the amount of any repayments made on the loan.

§17–207.

(a) (1) Subject to the requirements of this section, the lives of a group of individuals may be insured under a policy issued to a credit union organized in accordance with State law or the Federal Credit Union Act to cover members of the credit union for the benefit of persons other than the credit union or its officials.

(2) The credit union to which the policy is issued is deemed the policyholder.

(b) All members of the credit union, or all of any class or classes of members determined by conditions pertaining to their age or membership in the credit union or both, are eligible for insurance under a policy issued in accordance with this section.

(c) (1) The premiums for the policy shall be paid from funds contributed by the credit union or insured members, or by both.

(2) Except as provided in paragraph (3) of this subsection, a policy on which no part of the premium is to be derived from funds contributed by the insured member for the insurer must insure all eligible persons, except those who reject the coverage in writing.

(3) An insurer may exclude or limit the coverage on any persons as to whom evidence of individual insurability is not satisfactory to the insurer.

§17–208.

(a) (1) Subject to the requirements of this section, the lives of a group of individuals may be insured under a policy issued to a volunteer fire, rescue squad, or ambulance service organization to cover the registered members of the organization for the benefit of persons other than the organization.

(2) The volunteer fire, rescue squad, or ambulance service organization to which the policy is issued is deemed the policyholder.

(b) All registered members of a volunteer fire, rescue squad, or ambulance service organization are eligible for insurance under a policy issued in accordance with this section.

(c) (1) The premiums for the policy shall be paid from funds contributed by the volunteer fire, rescue squad, or ambulance service organization or funds contributed by the insured members or from both.

(2) Except as provided in paragraph (3) of this subsection, a policy on which no part of the premium is to be derived from funds contributed by the insured member specifically for the insurance must insure all eligible persons, except those who reject the coverage in writing.

(3) An insurer may exclude or limit the coverage on any person as to whom evidence of individual insurability is not satisfactory to the insurer.

§17–209.

(a) (1) Insurance under a policy of group life insurance issued in accordance with §§ 17–201 through 17–205 of this subtitle may be extended to cover the spouse, domestic partner, or dependent children of each insured employee or member who elects to obtain the coverage.

(2) The policy may provide that the term "dependent children" includes:

(i) an insured employee's or member's child under 18 years of age; and

(ii) an insured employee's or member's child 18 years of age or older who attends an educational institution and relies on the insured employee or member for financial support.

(3) The term "domestic partner" has the meaning stated in the policy.

(4) The insurance on the life of a spouse, domestic partner, or child may not exceed the amount of the insurance on the life of the insured employee or member.

(b) The policyholder shall pay the premium for the insurance on the spouse, domestic partner, or child:

(1) wholly from the funds of the policyholder or funds contributed by the policyholder;

(2) wholly from funds contributed by the insured employees or members; or

(3) partly from the funds of the policyholder or funds contributed by the policyholder and partly from funds contributed by the insured employees or members.

(c) A spouse, domestic partner, or dependent child insured under this section is entitled to:

(1) the rights of conversion under § 17–309 of this title, if employment of the employee or membership in the class or classes eligible for insurance under the policy is terminated; and

(2) the rights of conversion under § 17–310 of this title, if the policy of group life insurance terminates or is amended to terminate the insurance of the spouse, domestic partner, or dependent child.

(d) Notwithstanding § 17–308 of this title, only one certificate must be issued for each family unit if a statement about a dependent's coverage is included in the certificate.

§17–301.

(a) Except as provided in subsection (b) of this section, a policy of group life insurance may not be delivered in the State unless it contains in substance:

(1) the provisions of §§ 17-302 through 17-311 of this subtitle; or

(2) provisions that in the opinion of the Commissioner are:

(i) more favorable to the insureds; or

(ii) at least as favorable to the insureds and more favorable to the policyholder.

(b) (1) Sections 17-307 through 17-311 of this subtitle do not apply to policies issued to a creditor to insure debtors of the creditor.

(2) The standard provisions required for individual life insurance policies do not apply to policies of group life insurance.

(3) If a policy of group life insurance is on a plan other than the term plan, the policy:

(i) shall contain a nonforfeiture provision that in the opinion of the Commissioner is equitable to the insured and the policyholder; but

(ii) need not contain the same nonforfeiture provisions required for individual life insurance policies.

§17–302.

(a) Each policy of group life insurance shall contain a provision that the policyholder is entitled to a grace period of 31 days for payment of any premium due except the first premium.

(b) The death benefit coverage continues in force during the grace period unless the policyholder has given the insurer written notice of discontinuance before the date of discontinuance and in accordance with the terms of the policy.

(c) The policy may provide that the policyholder is liable to the insurer for paying a pro rata premium for the time the policy was in force during the grace period.

§17–303.

Each policy of group life insurance shall contain a provision that:

(1) the policy is incontestable, except for nonpayment of premiums, after the policy has been in force for 2 years after its date of issue; and

(2) a statement made by an insured under the policy about insurability may not be used to contest the validity of the insurance as to which the statement was made unless:

(i) the insurance has been in force before the contest for less than 2 years during the insured's lifetime; and

(ii) the statement is in writing and signed by the insured.

§17–304.

Each policy of group life insurance shall contain a provision that:

(1) requires a copy of any application of the policyholder to be attached to the policy when issued;

(2) the statements made by the policyholder or the insured are considered representations and not warranties; and

(3) a statement made by an insured may not be used in a contest unless a copy of the instrument that contains the statement is provided to the insured or, in the event of death or incapacity of the insured, to the insured's beneficiary.

§17–305.

Each policy of group life insurance shall contain a provision that sets forth any conditions under which the insurer reserves the right to require an individual eligible for insurance to provide evidence of individual insurability satisfactory to the insurer as a condition to part or all of the coverage.

§17–306.

Each policy of group life insurance shall contain a provision that:

(1) specifies that an equitable adjustment of premiums or benefits or both will be made if the age of an insured is misstated; and

(2) clearly states the method of adjustment to be used.

§17–307.

Each policy of group life insurance shall contain a provision that any sum due because of the death of the insured is payable to the beneficiary designated by the insured, subject to:

(1) the provisions of the policy as to payment of all or part of the sum if a designated beneficiary is not alive at the death of the insured; and

(2) any right that the insurer reserves in the policy and sets forth in the certificate to pay at its option a part of the sum, not exceeding $2,500, to a person that the insurer considers equitably entitled to it for having incurred funeral or other expenses incident to the insured's death or last illness.

§17–308.

Each policy of group life insurance shall contain a provision that requires the insurer to issue to the policyholder, for delivery to each insured, an individual certificate that states:

(1) the insurance protection to which the insured is entitled;

(2) each person to whom the insurance benefits are payable; and

(3) the rights and conditions set forth in § 17–102 of this title and §§ 17–309 through 17–311 of this subtitle.

§17–309.

(a) Each policy of group life insurance shall contain a provision that if the insurance or any part of it on an insured ceases under the policy because of termination of employment or membership in the class or classes eligible for coverage under the policy, the insured is entitled to have issued by the insurer, without evidence of insurability, an individual policy of life insurance without disability or other supplementary benefits, subject to the following conditions:

(1) subject to subsection (b) of this section, application for the policy must be made and the first premium must be paid to the insurer within 31 days after the termination of employment or membership;

(2) the individual policy is, at the option of the insured, on any form, except term insurance, customarily issued by the insurer at the age and for the amount applied for;

(3) the individual policy is in an amount that does not exceed the amount of life insurance that ceases because of the termination of employment or membership, less the amount of life insurance for which the insured is eligible under the same or another group policy within 31 days after the termination of employment or membership;

(4) the premium on the individual policy is at the insurer's customary rate applicable to:

(i) the form and amount of the individual policy;

(ii) the class of risk to which the insured belongs; and

(iii) the age of the insured attained on the effective date of the individual policy; and

(5) the insured is entitled to written notice of the insured's rights under this section at least 15 days prior to the expiration of the conversion period provided for in item (1) of this subsection.

(b) (1) If the insured is not provided with the notice required under subsection (a)(5) of this section, the insured shall have an additional 15 days from the date on which written notice is received to make application for the individual policy and pay the first premium to the insurer.

(2) In no event shall the additional period provided under paragraph (1) of this subsection extend beyond 60 days after the expiration of the conversion period provided for in subsection (a)(1) of this section.

(c) For purposes of subsection (a)(3) of this section, insurance that matures on or before the date of the termination of employment or membership as an endowment payable to the insured, whether in one sum, in installments, or in the form of an annuity, may not be included in the amount of life insurance that is considered to cease because of the termination of employment or membership.

§17–310.

(a) Subject to subsection (b) of this section, each policy of group life insurance shall contain a provision that if the group policy terminates or is amended so as to terminate the insurance of a class of insureds, each insured at the date of the termination whose insurance terminates and who has been insured for at least 5 years before the termination date is entitled to have issued to that insured by the insurer an individual policy of life insurance subject to the same conditions and limitations provided in § 17-309 of this subtitle.

(b) The group policy may provide that the amount of an individual policy issued under this section may not exceed the lesser of:

(1) the amount of the insured's life insurance protection that has terminated, less the amount of life insurance for which the insured is or becomes eligible under a group policy issued or reinstated by the same or another insurer within 31 days after the termination; and

(2) $10,000.

§17–311.

Each policy of group life insurance shall contain a provision that if an insured under the policy dies while entitled to an individual policy under § 17-309 or § 17-310 of this subtitle but before the individual policy becomes effective, the amount of life

insurance to which the insured would have been entitled shall be payable as a claim under the group policy, whether or not application for the individual policy or payment of the first premium has been made.

§18–101.

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

(b) "Alzheimer's disease" means a progressive brain disease diagnosed as Alzheimer's disease by the licensed attending physician of the insured or certificate holder and confirmed by a second opinion of a licensed physician.

(c) "Applicant" means:

(1) for an individual policy or contract of long-term care insurance, the individual who seeks to contract for benefits; or

(2) for a group policy of long-term care insurance, the proposed certificate holder.

(d) "Carrier" means an insurer, nonprofit health service plan, health maintenance organization, or preferred provider organization.

(e) "Certificate" means a certificate that is issued under a group policy of long-term care insurance if the certificate is delivered or issued for delivery in the State and covers individuals who reside in the State.

(f) (1) "Long–term care insurance" means an individual or group policy, contract, certificate, or rider that:

(i) is issued, delivered, or offered by a carrier;

(ii) is advertised, marketed, offered, or designed to provide coverage for at least 24 consecutive months for each covered individual on an expense–incurred, indemnity, prepaid, or insured basis; and

(iii) provides one or more necessary or appropriate diagnostic, preventive, therapeutic, rehabilitative, maintenance, or personal care services in a setting other than an acute care unit of a hospital.

(2) "Long–term care insurance" includes any product that is advertised, marketed, or offered as long–term care insurance.

(3) "Long–term care insurance" does not include:

(i) a policy, contract, certificate, or rider that is offered primarily to provide:

1. basic Medicare supplement coverage;

2. hospital confinement indemnity coverage;

3. basic hospital expense or medical surgical expense coverage;

4. disability income protection coverage;

5. accident–only coverage;

6. specified disease or specified accident coverage; or

7. skilled nursing care;

(ii) a life insurance policy that:

1. accelerates the death benefit specifically for:

A. one or more of the qualifying events of terminal illness;

B. a medical condition that requires extraordinary medical intervention; or

C. permanent institutional confinement;

2. provides the option of lump–sum payments for the benefits listed in item 1 of this item; or

3. does not make benefits or eligibility for benefits conditional on receipt of long–term care; or

(iii) a certificate that is issued under an out–of–state employer group contract.

(g) "Loss ratio" means the ratio of losses incurred to premiums earned on policies that are issued, delivered, or renewed in the State.

(h) "Out-of-state employer group contract" means a group contract that:

(1) is entered into with an employer in a state other than this State; and

(2) is issued directly to an employer under the laws of that employer's state.

(i) "Preexisting condition" means a condition for which medical advice or treatment was recommended by or received from a provider of health care services within 6 months before the effective date of coverage of the insured or certificate holder.

§18–102.

The Commissioner may adopt regulations about long-term care insurance with respect to:

(1) form and content of disclosures;

(2) terms of renewals;

(3) initial and subsequent conditions of eligibility;

(4) nonduplication of coverage provisions;

(5) preexisting conditions;

(6) renewability of coverage;

(7) continuation and conversion;

(8) probationary periods, limitation of coverage provisions, and recurrent conditions;

(9) coverage of dependents;

(10) loss ratio standards; and

(11) any other matter that the Commissioner determines is in the best interest of the public.

§18–103.

(a) A carrier may not advertise, market, or offer a policy, contract, or certificate in the State as long-term care insurance or long-term nursing home insurance unless the policy or contract complies with this title.

(b) (1) Before a carrier advertises, on television or radio or in writing, a policy or contract of long-term care insurance or long-term nursing home insurance that is offered for sale in the State, the carrier shall submit a copy of the advertisement to the Commissioner for review.

(2) The carrier shall retain each advertisement for 3 years after the date the advertisement first was used.

(3) The Commissioner may exempt a carrier or a carrier's advertising form or material from the requirements of this section if in the opinion of the Commissioner the requirements may not reasonably be applied.

(c) A carrier that markets long-term care insurance in the State shall:

(1) establish marketing procedures to ensure that any comparison of policies by insurance producers of the carrier will be fair and accurate;

(2) establish marketing procedures to prevent the sale or issuance of excessive insurance;

(3) establish procedures for verifying compliance with this subsection;

(4) provide, to the extent possible, information on any senior citizen counseling program;

(5) display prominently on the first page of the outline of coverage and the policy the following:

"Notice to buyer: This policy may not cover all the costs associated with long-term care incurred by the buyer during the period of coverage. The buyer is advised to review carefully all policy limitations."; and

(6) make every reasonable effort to identify whether a prospective applicant:

(i) already has long-term care insurance and, if so, the types and amounts of the long-term care insurance;

(ii) had long-term care insurance in force during the last 12 months;

(iii) is covered under the medical assistance program; or

(iv) intends to replace any existing medical or health insurance coverage with long-term care insurance.

(d) An insurance producer who offers or sells policies or contracts of long–term care insurance in the State shall:

(1) advise an individual considering the purchase of a long–term care insurance policy or contract about the availability and benefits of a policy that qualifies under the Qualified State Long–Term Care Insurance Partnership established under Title 15, Subtitle 4 of the Health – General Article;

(2) provide a disclosure statement, approved by the Commissioner, to each applicant for long–term care insurance about the Qualified State Long–Term Care Insurance Partnership; and

(3) make the disclosure statement required under item (2) of this subsection available to the Commissioner for inspection.

§18–104.

(a) Each application for long-term care insurance, except applications that are for long-term care insurance that is guaranteed issue, shall contain clear and unambiguous questions to ascertain the health condition of the applicant.

(b) (1) If an application for long-term care insurance asks whether the applicant has had medication prescribed by a physician, the application also shall ask the applicant to list the medication that has been prescribed.

(2) If the carrier knew or should have known that the medication listed under paragraph (1) of this subsection at the time of application was directly related to a medical condition for which coverage would otherwise be denied, the policy or certificate of long-term care insurance may not be rescinded for that condition.

§18–105.

Before issuing a policy of long-term care insurance to an applicant who is at least 80 years old, unless the policy is guaranteed issue, the carrier shall obtain:

(1) a report of a physical examination;

(2) an assessment of functional capacity; or

(3) copies of medical records.

§18–106.

(a) (1) A carrier shall provide to each applicant an outline of coverage and buyer's guide.

(2) The carrier shall deliver the outline of coverage and buyer's guide:

(i) in the case of solicitation by the carrier or insurance producer of the carrier, before the presentation of an application or enrollment form; and

(ii) in the case of direct response solicitation, with the application or enrollment form.

(b) The outline of coverage shall include:

(1) a description of the principal benefits and coverage provided in the policy or contract;

(2) a statement of the principal exclusions, reductions, and limitations in the policy or contract;

(3) a statement of the renewal provisions, including any reservation in the policy or contract of a right to change the schedule of premiums;

(4) a statement that the outline of coverage is a summary of the policy or contract issued or applied for and the policy or contract should be consulted to determine the governing contractual provisions; and

(5) any expected premium increases or additional premiums to pay for automatic or optional benefit increases, including a reasonable hypothetical or graphic demonstration of the potential premiums that the applicant will need to pay at age 75 for benefit increases.

(c) The buyer's guide shall include information about buying a policy of long–term care insurance, including a reference to the right of the buyer to cancel a policy during the first 30 days after the policy is delivered.

(d) A carrier shall provide an applicant with a graphic comparison, over a period of at least 20 years, of the benefit levels of a policy that increases benefits over the policy or certificate period compared to the benefit levels of a policy that does not increase benefits.

§18–107.

A certificate that is issued under group long–term care insurance shall include:

(1) a description of the principal benefits and coverage provided in the policy or contract;

(2) a statement of the principal exclusions, reductions, and limitations of coverage in the policy or contract;

(3) a statement that the group master policy or contract determines the governing contractual provisions; and

(4) a statement as to whether the policy or contract is intended to qualify as a partnership policy under the Qualified State Long–Term Care Insurance Partnership under Title 15, Subtitle 4 of the Health – General Article.

§18–108.

(a) If long-term care benefits are part of a life insurance policy or rider, the carrier shall provide a policy summary at the time of policy delivery.

(b) The policy summary required to be delivered under subsection (a) of this section shall include:

(1) information required to be included in an outline of coverage under § 18-106 of this title;

(2) an explanation of how the long-term care benefits interact with other components of the life insurance policy, including deductions from death benefits;

(3) an illustration of the amount of benefits, length of benefit, and guaranteed lifetime benefits if any, for each covered individual;

(4) any exclusions, reductions, or limitations on benefits of long-term care; and

(5) if applicable to the policy type:

(i) a disclosure of the effects of exercising other rights under the policy;

(ii) a disclosure of guarantees related to long-term care costs of insurance charges; and

(iii) current and projected maximum lifetime benefits.

§18–109.

(a) Except as provided in subsection (b) of this section, a policy or certificate of long-term care insurance may not be delivered or issued for delivery in the State if the policy or certificate limits or excludes coverage by type of illness, treatment, medical condition, or accident.

(b) A policy or certificate of long–term care insurance may limit or exclude coverage of:

(1) preexisting conditions or diseases;

(2) mental or nervous conditions or diseases other than Alzheimer's disease;

(3) alcohol or drug addiction;

(4) unless otherwise provided by State or federal law, treatment provided in a government facility;

(5) services provided by a member of the covered individual's immediate family;

(6) services for which a charge normally is not made in the absence of insurance;

(7) services for which benefits are available under:

(i) Medicare or other governmental programs except Medicaid; or

(ii) a State or federal workers' compensation, employer's liability, or occupational disease law; and

(8) illness, treatment, or medical conditions arising out of:

(i) a declared or undeclared war or act of war;

(ii) participation in a felony, riot, or insurrection;

(iii) service in the uniformed services or auxiliary units;

(iv) suicide, attempted suicide, or intentionally self–inflicted injury; or

(v) aviation, if the insured is a passenger who does not pay a fare.

(c) This section does not prohibit:

(1) exclusions and limitations by type of provider; or

(2) limitations by territory.

§18–110.

(a) (1) In this section, "home health care services" means medical or nonmedical services provided to ill, disabled, or infirm individuals in their residences.

(2) "Home health care services" includes:

(i) homemaker services;

(ii) assistance with activities of daily living; and

(iii) respite care services.

(b) A policy or certificate of long-term care insurance that provides benefits for home health care services may not limit or exclude benefits by:

(1) requiring that the insured would need care in a nursing facility if home health care services were not provided;

(2) requiring that the insured first or simultaneously receive nursing or therapeutic services at home or in a community setting before home health care services are covered.

(3) limiting eligible services provided by registered nurses or licensed practical nurses;

(4) requiring that a nurse or therapist provide services covered by the policy or certificate of long-term care insurance that can be provided by a home health aide or other licensed or certified home care worker who acts within the scope of licensure or certification;

(5) requiring that the insured have an acute condition before home health care services are covered; or

(6) limiting benefits to services provided by Medicare-certified agencies or providers.

(c) Coverage for home health care services may be applied to the coverage for other benefits provided in the policy or certificate of long-term care insurance when determining maximum coverage under the terms of the policy or certificate.

§18–111.

Except for coverage excluded under a preexisting condition provision, long-term care insurance shall provide coverage for Alzheimer's disease or other senile dementia disorders without any condition, limitation, or reduction of coverage not applicable to coverage for other diseases or illnesses.

§18–112.

(a) Each group policy of long-term care insurance shall provide covered individuals with a basis for continuation of coverage or conversion to an individual policy of long-term care insurance.

(b) (1) For purposes of this section, a group policy of long-term care insurance provides a basis for continuation of coverage if the group policy:

(i) maintains coverage under the existing group policy when the coverage would otherwise terminate; and

(ii) is subject only to the continued timely payment of premiums.

(2) A group policy that restricts benefits and services to certain providers or facilities or contains incentives to use certain providers or facilities may provide continuation benefits that are substantially equivalent to the benefits of the existing group policy.

(c) For purposes of this section, a group policy provides a basis for conversion of coverage if the group policy provides for issuance of a policy that provides benefits that are identical to, substantially equivalent to, or in excess of the benefits of the terminated group policy without evidence of insurability to each individual:

(1) whose coverage under the group policy would otherwise be terminated for any reason; and

(2) who has been continuously insured under the group policy for at least 6 months before the date of termination.

(d) In determining whether benefits are substantially equivalent under this section, the Commissioner shall consider the difference between managed care plans and other plans.

§18–113.

(a) If a group policy of long-term care insurance is replaced by another group policy of long-term care insurance purchased by the same policyholder, the succeeding carrier shall offer coverage to each insured who was covered under the old group policy on its date of termination.

(b) Coverage under the new group policy of long-term care insurance may not result in an exclusion for preexisting conditions that would have been covered under the group policy being replaced.

§18–114.

(a) The requirements of this section:

(1) apply to individual and group policies of long-term care insurance; and

(2) do not apply to life insurance policies or riders on life insurance policies that contain accelerated long-term care benefits.

(b) (1) A carrier may not offer a policy or certificate of long-term care insurance unless, at the time of purchase, the carrier also offers the applicant the option to purchase a policy or certificate with an inflation protection feature as described under paragraph (2) of this subsection.

(2) The inflation protection feature under this subsection shall provide, in addition to any other inflation protection, that benefit levels will increase

with benefit maximums or reasonable durations that are meaningful to account for reasonably anticipated increases in the costs of long-term care services covered by the policy or certificate.

(c) The option to purchase a policy or certificate of long-term care insurance with an inflation protection feature under this section may not be less favorable than:

(1) a policy or certificate that increases benefit levels annually in a manner so that the increases are compounded annually at a rate of at least 5%;

(2) a policy or certificate that guarantees the insured the right to increase benefit levels periodically without providing evidence of insurability or health status so long as the option for the previous period has not been declined; or

(3) a policy that covers a specific percentage of actual or reasonable charges and does not include a maximum specified indemnity amount or limit.

(d) The amount of the additional benefit under subsection (c)(2) of this section may not be less than the difference between the benefit under an existing policy or certificate and that benefit compounded annually at a rate of at least 5% for the period beginning with the purchase of the existing benefit and extending until the year in which the offer is made.

§18–115.

In evaluating the expected and actual loss ratios, the Commissioner shall consider:

(1) the statistical credibility of incurred claims experience and earned premiums;

(2) the period for which rates are computed to provide coverage;

(3) experienced and projected trends;

(4) the concentration of experience within early policy duration;

(5) expected claim fluctuation;

(6) experienced refunds, adjustments, or dividends;

(7) renewability features;

(8) all appropriate expense factors;

(9) interest;

(10) the experimental nature of the coverage;

(11) policy reserves;

(12) the mix of business by risk classification; and

(13) product features, including long elimination periods, high deductibles, and high maximum limits.

§18–116.

(a) Except as provided in subsection (b) of this section, a premium increase under long-term care insurance may not be based on the age of the insured or certificate holder.

(b) A carrier may impose an across-the-board premium increase on policies or contracts of long-term care insurance that the carrier issues or delivers in the State after the carrier:

(1) submits to the Commissioner an actuarial memorandum that supports the proposed premium increase; and

(2) obtains the approval of the Commissioner.

(c) This section does not prohibit age-banding.

§18–116.1.

(a) This section applies only to policies or contracts of long–term care insurance issued or delivered in the State before April 1, 2003, for which rate increase filings have been approved by the Commissioner on or after June 1, 2019.

(b) Subject to subsection (c) of this section, a carrier shall provide to an insured under a policy or contract of long–term care insurance a contingent benefit upon lapse if:

(1) the carrier increases the premium rate for the insured;

(2) the insured has maintained the policy or contract of long–term care insurance through the carrier for at least 20 years; and

(3) the insured terminates the policy or contract of long–term care insurance within 120 days after the date the premium rate increase becomes effective for the policy or contract of long–term care insurance maintained by the insured.

(c) (1) The contingent benefit upon lapse required under subsection (b) of this section shall be a paid–up coverage:

(i) with no additional premiums due; and

(ii) with a reduced lifetime maximum benefit equal to the sum of all premiums paid minus any claims paid.

(2) Except for the maximum lifetime benefit calculated in accordance with paragraph (1) of this subsection, all other benefits of the policy or contract of long–term care insurance in effect on the date of the lapse of the policy or contract shall remain unchanged and may not be increased after the date of the lapse of the policy or contract.

§18–117.

(a) Whenever a long-term care benefit that is funded through a life insurance vehicle by the acceleration of the death benefit is in benefit payment status, the carrier shall provide a monthly report to the policyholder.

(b) A report under this section shall include:

(1) any long-term care benefits paid out during the month;

(2) an explanation of any changes in the policy, including changes to death benefits or cash values, that result from the payment of long-term care benefits; and

(3) the amount of long-term care benefits that remain.

§18–117.1.

Each carrier shall provide to each insured under a policy or contract of long–term care insurance in the State an annual notice, in writing or electronically, containing the insured's policy form number and the carrier's customer service telephone number.

§18–118.

(a) (1) A carrier may cancel, refuse to renew, or otherwise terminate long-term care insurance only for nonpayment of premiums or material misrepresentation.

(2) A carrier may not cancel a policy of long-term care insurance under this subsection for nonpayment of premiums unless the carrier provides written notice to:

(i) the insured; and

(ii) an individual designated by the insured under subsection (b) of this section to receive notice of cancellation not later than the date on which the carrier sends a second notice of the cancellation.

(b) (1) A carrier may not deliver an individual policy of long-term care insurance to an insured until the carrier has notified the insured of the option to designate in writing one individual in addition to the insured who will receive notice of cancellation of the policy for nonpayment of premiums under subsection (a) of this section.

(2) The insured may change the written designation under this subsection at any time.

(3) The written designation shall be on a form provided by the carrier that states that the insured may:

(i) designate one individual for receipt of notice of cancellation; and

(ii) change the written designation at any time.

(c) (1) Termination of a policy or certificate of long-term care insurance shall be without prejudice to any benefits payable for institutionalization if the institutionalization began while the policy or certificate of long-term care insurance was in effect and continues without interruption after termination.

(2) An extension of benefits beyond the period the policy of long-term care insurance was in effect may be:

(i) limited to the duration of the benefit period, if any, or to payment of the maximum benefits; and

(ii) subject to any policy waiting period and all other applicable provisions of the policy.

§18–119.

(a) This section does not apply to plans under § 125 of the Internal Revenue Code.

(b) (1) An insured or certificate holder who is insured under a policy or contract of long–term care insurance may surrender the policy or contract within 30 days after delivery for a return of any premium paid by providing written notice of surrender to the carrier.

(2) The right of surrender may not be waived.

(3) A contract to purchase long–term care insurance shall contain the following statement:

"Notice to buyer: You may surrender the contract or policy of long–term care insurance without penalty or obligation within 30 days from the date of delivery of the policy. If you decide to surrender the contract or policy, you must provide notice of the surrender to the insurer. Any attempt to obtain a waiver of your right to surrender is unlawful. Surrender entitles you to a refund of all money within 30 business days after receipt of notice of surrender."

(c) A policy surrendered under this section is deemed void from its effective date.

§18–120.

(a) (1) In this section the following words have the meanings indicated.

(2) (i) "Genetic information" means information derived from a genetic test:

1. about chromosomes, genes, gene products, or inherited characteristics that may derive from an individual or a family member;

2. not obtained for diagnostic and therapeutic purposes; and

3. obtained at a time when the individual to whom the information relates is asymptomatic for the disease, disorder, illness, or impairment to which the information relates.

(ii) "Genetic information" does not include information:

1. relating to a disease, disorder, illness, or impairment that is or has been manifested or for which the individual is or has been symptomatic; or

2. derived from:

A. routine physical measurements;

B. chemical, blood, and urine analyses;

C. tests for the use of drugs;

D. tests for the presence of the human immunodeficiency virus; or

E. tests for the purpose of diagnosing a manifested disease, disorder, illness, or impairment.

(3) "Genetic services" means health services that are provided to obtain, assess, or interpret genetic information or the results of genetic tests.

(4) (i) "Genetic test" means an analysis of human DNA, RNA, chromosomes, proteins, or metabolites that detects genotypes, mutations, or chromosomal changes.

(ii) "Genetic test" does not include:

1. routine physical measurements;

2. chemical, blood, and urine analyses;

3. tests for the use of drugs;

4. tests for the presence of the human immunodeficiency virus; or

5. tests that are directly related to a manifested disease, disorder, illness, or impairment that could reasonably be detected by a health care professional with appropriate training and expertise in the field of medicine involved.

(b) In addition to the other practices prohibited under this article, a carrier or insurance producer of a carrier that provides long–term care insurance may not:

(1) employ a method of marketing that induces or tends to induce the purchase of long–term care insurance through undue pressure;

(2) use a method of marketing that fails to disclose in a conspicuous manner that a purpose of the method of marketing is solicitation of insurance, and that contact will be made by an insurance producer or carrier;

(3) knowingly make a misleading representation or an incomplete or fraudulent comparison of policies or carriers to induce a person to lapse, forfeit, surrender, terminate, retain, pledge, assign, borrow on, or convert a policy or take out a policy with another carrier;

(4) request or require a genetic test to:

(i) deny or limit the amount, extent, or kind of long–term care insurance coverage available to an individual; or

(ii) charge a different rate for the same long–term care insurance coverage; or

(5) use a genetic test, the results of a genetic test, genetic information, or a request for genetic services to:

(i) deny or limit the amount, extent, or kind of long–term care insurance coverage available to an individual; or

(ii) charge a different rate for the same long–term care insurance.

(c) Notwithstanding subsection (b)(5) of this section, if the use is based on sound actuarial principles, the results of a genetic test or genetic information may be used to:

(1) deny or limit the amount, extent, or kind of long–term care insurance coverage made available to an individual; or

(2) charge a different rate for the same long–term care insurance.

§19–101.

(a) In addition to any requirement of this article and to the extent not inconsistent with this article, a workers' compensation insurance policy is subject to Titles 9 and 10 of the Labor and Employment Article.

(b) In addition to any requirement of this article and to the extent not inconsistent with this article, a motor vehicle liability insurance policy is subject to the Maryland Vehicle Law.

§19–102.

(a) A liability insurance policy issued in the State may not require the insured to pay for liability or loss under the policy.

(b) Each liability insurance policy issued in the State shall provide that:

(1) the bankruptcy or insolvency of the insured does not release the insurer from liability; and

(2) if an injured person or another person claiming by, through, or under the injured person is unable, after execution on a final judgment entered in an action against an insured, to recover the full amount of the final judgment, the person may bring an action against the insured's insurer in accordance with the terms of the policy for the lesser of the amount of the judgment recovered in the action against the insured or the amount of the policy.

(c) Notwithstanding anything to the contrary in the policy, each liability insurance policy issued in the State shall be construed to contain the provisions required by subsection (b) of this section.

§19–103.

Each policy issued to cover the liability of a charitable institution for negligence or any other tort shall provide that, for a claim covered by the policy, the insurer may not assert the defense that the insured is immune from liability because it is a charitable institution.

§19–104.

(a) Each policy that insures a health care provider against damages due to medical injury arising from providing or failing to provide health care shall contain provisions that:

(1) are consistent with the requirements of Title 3, Subtitle 2A of the Courts Article; and

(2) authorize the insurer, without restriction, to negotiate and effect a compromise of claims unless the settlement amount exceeds the limits of the insurer's liability.

(b) (1) An insurer may make payments to or on behalf of claimants for reasonable hospital and medical costs, loss of wages, and expenses for rehabilitation services and treatment, within the limits of the insurer's liability, before a final disposition of the claim.

(2) A payment made under this subsection:

(i) is not an admission of liability to or of damages sustained by a claimant; and

(ii) does not prejudice the insurer or any other party with respect to any right, claim, or defense.

(c) (1) A policy issued or delivered under subsection (a) of this section may include coverage for the defense of a health care provider in a disciplinary hearing arising out of the practice of the health care provider profession if the cost of the included coverage is:

(i) itemized in the billing statement, invoice, or declarations page for the policy; and

(ii) reported to the Commissioner in a form and manner required by the Commissioner.

(2) A policy providing coverage for the defense of a health care provider in a disciplinary hearing arising out of the practice of the health care provider's profession may be offered and priced separately from a policy issued or delivered under subsection (a) of this section.

§19–104.1.

On request, an insurer that issues or delivers medical professional liability insurance policies in the State shall provide the Maryland Department of Health with information regarding the insurer's policy related to coverage of obstetric services, including coverage for a vaginal birth after cesarean.

§19–105.

An insurer that provides a general liability insurance policy to a fire department, fire company, rescue department, or rescue company shall offer to provide coverage for:

(1) a volunteer firefighter or volunteer ambulance rescue squad member who, in response to an emergency, provides assistance to the fire department, fire company, rescue department, or rescue company; and

(2) any other individual who, in response to an emergency, provides assistance at the request and under the direction of the fire department, fire company, rescue department, or rescue company.

§19–106.

An insurer that issues or delivers a policy or contract of motor vehicle liability insurance in the State shall offer to provide to a policyholder, who is registered as a family child care provider under Title 9.5, Subtitle 3 of the Education Article, coverage in at least the amount required under § 17–103 of the Transportation Article for liability that results from bodily injury:

(1) to a family child care child while the child is a passenger in an automobile; and

(2) that arises out of an insured's activities as a family child care provider.

§19–107.

(a) An insurer may not refuse to issue or renew a contract of motor vehicle insurance, property insurance, or casualty insurance solely because the subject of the risk or the applicant's or insured's address is located in a certain geographic area of the State unless:

(1) at least 60 days before the refusal, the insurer has filed with the Commissioner a written statement designating the geographic area; and

(2) the designation has an objective basis and is not arbitrary or unreasonable.

(b) A statement filed with the Commissioner under this section is a public record.

§19–108.

An insurer may not issue a vehicle liability insurance policy on an assessable basis.

§19–109.

On or after January 1, 1972, an authorized insurer may not issue or deliver a policy or contract of bodily injury liability insurance on a motor vehicle that is principally garaged or principally used in the State when the policy or contract is issued or delivered if:

(1) the policy or contract contains a representation that the authorized insurer will pay all reasonable medical expenses incurred for bodily injury caused by an accident to the insured or another individual covered by the policy or contract; and

(2) the authorized insurer retains the right of subrogation to recover from a third party any amount paid under the policy or contract on behalf of the injured individual.

§19–110.

An insurer may disclaim coverage on a liability insurance policy on the ground that the insured or a person claiming the benefits of the policy through the insured has breached the policy by failing to cooperate with the insurer or by not giving the insurer required notice only if the insurer establishes by a preponderance of the evidence that the lack of cooperation or notice has resulted in actual prejudice to the insurer.

§19–111.

(a) This section only applies if an insurer, through its insurance producer, adjuster, or representative, has begun investigating, estimating, or adjusting a property loss resulting from fire or a hazard under an extended coverage endorsement.

(b) (1) Except as provided in paragraph (2) of this subsection, an insured that has failed to give an insurer a sworn statement in proof of loss or a written notice as required by an insurance contract is not prevented from recovering under the insurance contract.

(2) An insured may be prevented from recovering under an insurance contract if the insured fails to provide the sworn statement in proof of loss or written notice required by the insurance contract within 15 days after receiving the insurer's written request for the statement or notice.

§19–112.

(a) The Commissioner may request by bulletin from a property and casualty insurer data that relates to policies written by the insurer.

(b) A request by bulletin under this section shall specify:

(1) the line of insurance for which the data is being requested; and

(2) the period of time for which the data is requested.

(c) Data requested by bulletin under this section shall be filed with the Commissioner in a form required by the Commissioner.

(d) (1) A request by bulletin expires 2 years after the date of the request by the Commissioner.

(2) If the Commissioner needs additional data after the end of that 2-year period, the Commissioner shall issue another bulletin.

(e) At least 15 days prior to granting an application under § 4–203 of the General Provisions Article to inspect company–specific data that was requested by bulletin under this section, the Commissioner shall notify the insurer that supplied the data:

(1) that the Commissioner has received an application to inspect data filed by the insurer;

(2) which data the Commissioner intends to disclose in granting the application; and

(3) that, within 7 days of receipt of the notice, the insurer has the opportunity to provide any reason why the data is confidential commercial data or is otherwise protected from disclosure under the Public Information Act.

§19–113.

(a) A parent of a minor or person in loco parentis of the minor may settle a claim under a liability insurance policy brought by the parent or person in loco parentis for the benefit of the minor.

(b) The payment of a settlement of a claim made under this section for the benefit of a minor shall comply with Title 13, Subtitle 4 of the Estates and Trusts Article.

§19–114.

(a) Each insurer that issues or delivers a medical professional liability insurance policy in the State with an annual premium of $5,000 or more shall offer at a minimum, in addition to the basic policy, additional policies with deductibles in the following amounts:

(1) $25,000;

(2) $50,000; and

(3) $100,000.

(b) In a policy with a deductible described in subsection (a) of this section, the insurer shall apply the deductible only to the liability of the insured under the policy.

(c) (1) An insurer that issues or delivers a medical professional liability insurance policy with a deductible described in subsection (a) of this section may cancel the policy for nonpayment of the deductible when the deductible is due and payable under the policy.

(2) A medical professional liability insurer that cancels a policy under paragraph (1) of this subsection is subject to the notice provisions under § 27–603 of this article.

§19–115.

(a) (1) In this section the following words have the meanings indicated.

(2) "Health care provider" means an individual who is licensed, certified, or otherwise authorized under the Health Occupations Article to provide health care services.

(3) "HMO provider panel" means a provider panel for one or more health maintenance organizations.

(4) "Insurer provider panel" means a provider panel for one or more insurers engaged in the business of casualty insurance or property insurance.

(5) "Non–HMO provider panel" means a provider panel for one or more nonprofit health service plans or insurers.

(6) "Provider contract" means a contract between a health care provider and an entity that contracts with a health care provider to serve on an insurer provider panel, an HMO provider panel, or a non–HMO provider panel.

(b) (1) An insurer may not use an insurer provider panel if the provider contract for the insurer provider panel requires a provider to participate on the insurer provider panel as a condition of participating on an HMO provider panel or a non–HMO provider panel.

(2) An entity arranging an insurer provider panel shall provide a health care provider a schedule of applicable fees for up to the 50 most common services billed by a health care provider in the specialty of the health care provider:

(i) in writing at the time of execution of a provider contract;

(ii) in writing or electronically 30 days before a change in the schedule of applicable fees; and

(iii) in writing or electronically on request of the health care provider.

§19–116.

(a) (1) In this section the following words have the meanings indicated.

(2) "Certificate holder" means any person, other than a policyholder, that requests, obtains, or possesses a certificate of insurance.

(3) (i) "Certificate of insurance" or "certificate" means any document or instrument, however titled or described, that is prepared or issued by an insurer or insurance producer as evidence of property insurance or casualty insurance coverage.

(ii) "Certificate of insurance" or "certificate" does not include a policy of insurance or an insurance binder.

(4) "Insurer" includes a person that is self–insured.

(5) "Person" includes a unit of State or local government.

(6) "Policyholder" means the owner of a policy of property insurance or casualty insurance.

(b) (1) This section applies to all certificate holders, policyholders, insurers, insurance producers, and certificates of insurance prepared or issued as evidence of insurance coverage on property, operations, or risks located in the State, regardless of where the certificate holder, policyholder, insurer, or insurance producer is located.

(2) This section may not be construed to apply to a statement, summary, or evidence of property insurance, including a certificate, required by a lender that holds a loan secured by:

(i) a mortgage;

(ii) a lien;

(iii) a deed of trust; or

(iv) any other security interest in real or personal property as security for the loan.

(c) (1) Except as provided in paragraphs (2) and (3) of this subsection, a person may not prepare or issue or require the preparation or issuance of a certificate of insurance unless the certificate of insurance form has been filed with and approved by the Commissioner.

(2) Any standard certificate of insurance form adopted by the Association for Cooperative Operations Research and Development (ACORD) or the Insurance Services Office (ISO) that otherwise complies with the requirements of this section is deemed approved by the Commissioner.

(3) The Commissioner may designate a certificate of insurance form required by a federal agency as deemed approved.

(d) The Commissioner shall disapprove a certificate of insurance form filed with the Commissioner under this section, or withdraw approval of a certificate of insurance form, if the form:

(1) is unjust, unfair, misleading, or deceptive or violates public policy;

(2) fails to comply with the requirements of this section; or

(3) violates any law, including any regulation adopted by the Commissioner.

(e) A person may not require an insurer or insurance producer to prepare or issue, or a policyholder to provide, a certificate of insurance that contains false or misleading information relating to the policy of insurance referenced in the certificate.

(f) A person may not alter or modify an approved certificate of insurance.

(g) A person may not prepare or issue a certificate of insurance that the person knows contains false or misleading information or that purports to amend, alter, or extend the coverage provided by the policy of insurance referenced in the certificate.

(h) A person may not prepare, issue, or require, either in addition to or in lieu of a certificate of insurance, an opinion letter or other document that is inconsistent with this section.

(i) (1) A certificate of insurance is not a policy of insurance and does not amend, alter, or extend the coverage provided by the policy of insurance referenced in the certificate.

(2) A certificate of insurance does not confer on a certificate holder new or additional coverage beyond the coverage provided in the policy of insurance referenced in the certificate.

(j) The terms and conditions of a notice of cancellation, nonrenewal, material change, or other similar matters relating to a policy of insurance referenced in a certificate of insurance:

(1) shall be governed by the policy of insurance; and

(2) may not be altered by a certificate of insurance.

(k) A certificate of insurance or any other document prepared, issued, or required in violation of this section is void and unenforceable.

(l) The Commissioner may examine and investigate the activities of any person that the Commissioner reasonably believes has been or is engaged in an act or practice prohibited by this section.

(m) The Commissioner shall adopt regulations to carry out this section, including regulations that establish an approval process for certificate of insurance forms.

§19–117.

(a) (1) In this section, "adverse action" includes:

(i) refusing to renew or execute a contract or agreement with a health care practitioner;

(ii) making a report or commenting to an appropriate private or governmental entity regarding practices of legally protected health care as defined in § 2–312 of the State Personnel and Pensions Article; and

(iii) increasing a premium for or making another type of unfavorable change regarding terms of coverage under a medical professional liability insurance contract agreement with a health care practitioner.

(2) "Adverse action" does not include making a rate filing in accordance with § 11–206 of this article.

(b) An insurer that issues to, delivers to, or renews medical professional liability insurance for a health care practitioner licensed, certified, or otherwise authorized by law to practice in the State may not take adverse action against a health care practitioner in whole or in part because the health care practitioner provides legally protected health care or makes a referral for legally protected health care.

(c) This section does not prohibit the medical professional liability insurer from taking adverse action against a health care practitioner for conduct that would otherwise constitute professional misconduct.

§19–201.

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

(b) "Additional optional coverage" means a coverage or service that covers the structures, contents, property, or activities on property that is available for purchase in connection with a standard homeowner's insurance policy.

(c) "Insurer" means an insurer that issues or delivers a policy of homeowner's insurance in the State.

§19–202.

(a) An insurer that issues, sells, or delivers a homeowner's insurance policy shall at time of application and renewal offer in writing to provide coverage for loss that:

(1) is caused by or results from water that backs up through sewers or drains; and

(2) is not caused by the negligence of the insured.

(b) If an application or renewal is made by telephone, the insurer is deemed to be in compliance with subsection (a) of this section if, within 7 calendar days after the date of application or renewal, the insurer sends the offer to the applicant or insured by a first–class mail tracking method.

(c) If an application or renewal is made using the Internet, the insurer is deemed to be in compliance with subsection (a) of this section if the insurer provides the offer to the applicant or insured prior to submission of the application or renewal.

(d) An offer required by this section may be delivered by electronic means if the insurer complies with the requirements of § 27–601.2 of this article.

(e) An insurer may comply with the renewal notice requirements of this section by sending the notice authorized by § 19–216 of this subtitle.

§19–203.

An insurer that issues or delivers a policy or contract of homeowner's liability insurance in the State shall offer to provide to a policyholder, who is registered as a family child care provider under Title 9.5, Subtitle 3 of the Education Article, coverage of at least $300,000 for liability that results from bodily injury, property damage, or personal injury arising out of an insured's activities as a family child care provider.

§19–204.

A policy or contract of homeowner's liability insurance that contains a representation that the insurer will pay all reasonable medical expenses incurred for bodily injury caused by an accident to an individual covered by the policy or contract may not be issued unless the policy or contract also provides that the insurer will pay all medical expenses incurred within 3 years after the date of the accident.

§19–205.

(a) (1) An insurer shall provide a policyholder with an annual statement that summarizes the coverages and exclusions under the policy issued by the insurer.

(2) The insurer's statement shall be clear and specific.

(3) The insurer's statement shall state whether the coverages under the policy provide for replacement cost, actual cash value, or other method of loss payment for covered structures and contents.

(4) The insurer's statement shall include a disclosure that states:

(i) the policyholder should read the policy for complete information on coverages and exclusions;

(ii) the policyholder should refer to the declarations page for a listing of coverages purchased;

(iii) the policyholder should communicate with the insurance producer or the insurer for any additional information regarding the scope of coverages in the policy;

(iv) the statement does not include additional optional coverage purchased by the policyholder, if any;

(v) the statement is not part of the policy or contract of insurance and does not create a private right of action;

(vi) all rights, duties, and obligations are controlled by the policy and contract of insurance; and

(vii) the standard homeowner's insurance policy does not cover losses from flood.

(b) The statement under subsection (a) of this section:

(1) is not part of the policy or contract of insurance; and

(2) does not create a private right of action.

(c) The statement required by subsection (a) of this section may be delivered by electronic means if the insurer complies with the requirements of § 27–601.2 of this article.

(d) The Commissioner may adopt regulations to implement the provisions of this section.

§19–206.

(a) (1) An insurer that sells or negotiates homeowner's insurance in the State shall provide an applicant, at the time a policy of homeowner's insurance is initially purchased, with a written notice that states that a standard homeowner's insurance policy does not cover losses from flood.

(2) If an application is made by telephone, the insurer is deemed to be in compliance with this section if, within 7 calendar days after the date of application, the insurer sends the notice to the applicant or insured by a first–class mail tracking method.

(3) If an application is made using the Internet, the insurer is deemed to be in compliance with this section if the insurer provides the notice to the applicant prior to the submission of the application.

(b) The notice shall:

(1) state that flood insurance may be available through the National Flood Insurance Program or other sources;

(2) provide the applicant with the contact information for the National Flood Insurance Program;

(3) advise the applicant to confirm the need for flood insurance with the National Flood Insurance Program or the applicant's mortgage lender;

(4) advise the applicant to contact the National Flood Insurance Program, the applicant's insurer, or the applicant's insurance producer for information about flood insurance;

(5) advise the applicant that flood insurance may be available for covered structures and their contents;

(6) advise the applicant that a claim under a flood insurance policy may be adjusted and paid on a different basis than a claim under a homeowner's insurance policy; and

(7) advise the applicant that a separate application must be completed to purchase flood insurance.

(c) A notice required to be sent by a first–class mail tracking method under this section may be sent with the statement required under § 19–207 of this subtitle.

(d) A notice provided under this section does not create a private right of action.

(e) A notice required by this section may be delivered by electronic means if the insurer complies with the requirements of § 27–601.2 of this article.

§19–206.1.

(a) This section applies to an insurer that offers a homeowner's insurance or renter's insurance policy in the State that does not provide coverage for losses caused by specific breeds or specific mixed breeds of dogs.

(b) At the time of application for or issuance of a policy of homeowner's insurance or renter's insurance, and at each renewal of a policy of homeowner's insurance or renter's insurance, an insurer subject to this section shall provide to an applicant or an insured a written notice that:

(1) states that the policy does not provide coverage for losses caused by specific breeds or specific mixed breeds of dogs; and

(2) identifies the specific breeds or specific mixed breeds of dogs for which the policy does not provide coverage.

(c) An insurer subject to this section may provide the notice required under subsection (b) of this section in the annual statement required under § 19–205 of this subtitle.

(d) The notice required by this section may be delivered by electronic means if the insurer complies with the requirements of § 27–601.2 of this article.

§19–207.

(a) (1) An insurer that sells or negotiates homeowner's insurance in the State shall provide an applicant, at the time of application for homeowner's insurance, with a written statement that lists all additional optional coverage available from the insurer to the applicant.

(2) If an application is made by telephone, the insurer is deemed to be in compliance with this section if, within 7 calendar days after the date of application, the insurer sends the statement to the applicant or insured by a first–class mail tracking method.

(3) If an application is made using the Internet, the insurer is deemed to be in compliance with this section if the insurer provides the statement to the applicant prior to submission of the application.

(b) The statement shall:

(1) be on a separate form;

(2) be titled, in at least 12 point type, "Additional Optional Coverage Not Included in the Standard Homeowner's Insurance Policy";

(3) contain the following disclosure in at least 10 point type:

"Your standard homeowner's insurance policy does not cover all risks. You may need to obtain additional insurance to cover loss or damage to your home, property, and the contents of your home or to cover risks related to business or personal activities on your property.

This statement provides a list of the types of additional insurance coverage that are available. Contact your insurance company, insurance producer, or insurance agent to discuss these additional coverages."; and

(4) contain a list of additional optional coverage.

(c) A statement required to be sent by a first–class mail tracking method under this section may be sent with the notice required under § 19–206 of this subtitle.

(d) A statement provided under this section does not create a private right of action.

(e) A statement required by this section may be delivered by electronic means if the insurer complies with the requirements of § 27–601.2 of this article.

§19–208.

(a) A policy of homeowner's, fire, farmowner's, or dwelling insurance that provides coverage for additional living expenses incurred by an insured as a result of a covered loss may not be issued, sold, or delivered in the State if the policy contains language that limits coverage for additional living expenses to a period of time that is less than 12 months.

(b) A clause in a policy of homeowner's, fire, farmowner's, or dwelling insurance that purports to limit coverage for additional living expenses incurred by an insured as a result of a covered loss to a period of time that is less than 12 months is void and unenforceable.

(c) Notwithstanding subsection (a) of this section, the Commissioner may require an insurer to provide coverage for additional living expenses under a policy of homeowner's, fire, farmowner's, or dwelling insurance for up to 24 months if the Commissioner finds that covered property remains uninhabitable due to delays in repair or replacement caused:

(1) by the insurer; or

(2) by factors beyond the control of the insured.

(d) Nothing in this section shall be construed to:

(1) prohibit or prevent the enforcement of a monetary limit of liability for additional living expenses under a policy of homeowner's, fire, farmowner's, or dwelling insurance;

(2) prohibit an insurer from denying coverage for additional living expenses if the carrier determines that at the time the additional living expenses were incurred the covered property was not unfit to live in; or

(3) prohibit an insurer from denying coverage for additional living expenses on the grounds that the covered property was unfit to live in at the time that the additional living expenses were incurred because of delays in repair or replacement caused by the insured.

§19–209.

(a) (1) Subject to subsections (b), (c), and (d) of this section, an insurer may issue a policy of homeowner's insurance that includes a deductible that is equal to a percentage of the "Coverage A – Dwelling Limit" of the policy.

(2) The insurer may:

(i) require the deductible described in paragraph (1) of this subsection in a policy of the homeowner's insurance; or

(ii) offer the deductible described in paragraph (1) of this subsection as an option to an applicant or insured.

(b) An insurer that has adopted an underwriting standard that requires a mandatory hurricane deductible equal to a percentage of the "Coverage A – Dwelling Limit" of the policy shall apply the deductible:

(1) only beginning at the time the National Hurricane Center of the National Weather Service issues a hurricane warning for any part of the State and ending 24 hours following the termination of the last hurricane warning issued for any part of the State; and

(2) regardless of where the insured's home is located in the State.

(c) (1) An insurer that issues a policy of homeowner's insurance may not adopt an underwriting standard that requires a deductible that exceeds 5% of the "Coverage A – Dwelling Limit" of the policy in the case of a hurricane unless the insurer has filed the underwriting standard with the Commissioner.

(2) The filing required by paragraph (1) of this subsection shall:

(i) be made at least 60 days before the insurer proposes to implement the underwriting standard in the State; and

(ii) include:

1. a copy of the underwriting standard the insurer intends to implement; and

2. the date on which the insurer intends to implement the underwriting standard.

(3) An underwriting standard subject to this subsection shall comply with all applicable laws.

(d) (1) An insurer that issues a policy of homeowner's insurance that includes a deductible that is equal to a percentage of the "Coverage A – Dwelling Limit" of the policy or has adopted an underwriting standard that requires a mandatory hurricane deductible equal to a percentage of the "Coverage A – Dwelling Limit" of the policy shall provide a policyholder with an annual statement explaining the manner in which the deductible is applied in accordance with § 19–209.1 of this subtitle.

(2) The insurer shall send a copy of the form used to provide the statement required under paragraph (1) of this subsection to the Commissioner prior to its use.

(e) The Commissioner may adopt regulations to implement the provisions of this section.

§19–209.1.

(a) An insurer that issues a policy of homeowner's insurance that includes a deductible that is equal to a percentage of the "Coverage A – Dwelling Limit" of the policy, or has adopted an underwriting standard that requires a mandatory hurricane deductible equal to a percentage of the "Coverage A – Dwelling Limit" of the policy, shall provide an insured with a statement about the deductible at the time the policy of homeowner's insurance is first issued and at each renewal.

(b) (1) The statement required under subsection (a) of this section shall:

(i) be titled, in at least 12 point type, "Percentage Deductible Notice";

(ii) state the actual percentage of the percentage deductible;

(iii) state the circumstances under which the deductible applies;

(iv) include an example of how the deductible applies to a loss; and

(v) include the following statement, or a substantially similar statement, in at least 10 point type:

"Your homeowner's insurance policy contains a percentage deductible, which means that your deductible for a covered loss will be determined by multiplying the dollar amount of your Coverage A – Dwelling Limit of Liability by this percentage under the following circumstances: (insert explanation of circumstances under which a percentage deductible would be applied)".

(2) The example required under paragraph (1)(iv) of this subsection may be provided in the following manner:

"If, at the time of a covered loss, a homeowner's insurance policy's Coverage A – Dwelling Limit of Liability is $300,000 and the policy includes a 2% deductible, the policyholder will be responsible for paying a deductible of $6,000 on a claim for a covered loss ($300,000 x 2%). This means that, for example:

If the covered loss to the dwelling is $25,000 and the covered loss to personal property is $10,000 for a total covered loss of $35,000, the policyholder is responsible

for paying a $6,000 deductible and the insurer is responsible for the balance of the covered loss, or $29,000.

If the covered loss to the dwelling is $5,000, the policyholder is responsible for paying the entire covered loss because the total amount of the covered loss is less than the percentage deductible, which is $6,000.".

(c) (1) An insurer may satisfy the requirements of subsection (b) of this section if, on the declarations page of the policy of homeowner's insurance or in a separate statement, the insurer states:

(i) the actual percentage of the percentage deductible;

(ii) the dollar amount of the percentage deductible as it relates to the policy of homeowner's insurance; and

(iii) the circumstances under which the deductible applies.

(2) The statement shall be titled, in at least 12 point type, "Percentage Deductible Notice".

(d) The statement required by this section may be delivered by electronic means if the insurer complies with the requirements of § 27–601.2 of this article.

§19–210.

(a) An insurer shall offer at least one actuarially justified premium discount on a policy of homeowner's insurance to a policyholder who submits proof of improvements made to the insured premises as a means of mitigating loss from a hurricane or other storm.

(b) Means of mitigating loss include:

(1) the installation of one or more of the following:

(i) hurricane shutters;

(ii) secondary water barrier;

(iii) reinforced roof coverings;

(iv) braced gable ends;

(v) reinforced roof to wall connections;

(vi) tie downs; and

(vii) reinforced opening protections;

(2) repair or replacement of:

(i) exterior doors, including garage doors;

(ii) hurricane resistant trusses, studs, and other structural components; and

(iii) repair or replacement of manufactured home piers, anchors, and tie down straps; and

(3) any mitigation effort that materially mitigates loss from a hurricane or other storm otherwise covered under the policy.

(c) Improvements made to the insured premises under this section shall be inspected by a contractor licensed by the Maryland Department of Labor.

(d) (1) An insurer shall be allowed to inspect the improvements that are the basis of a premium discount under this section.

(2) (i) Verification of improvements that are the basis of a premium discount under this section rests with the insurer.

(ii) An insurer may accept an inspection certificate issued by a governmental agency as verification of improvements that are the basis of a premium discount under this section.

(e) A premium discount offered under this section shall:

(1) comply with the provisions of Title 11 of this article; and

(2) only be offered for improvements identified by the Commissioner as qualified mitigation actions made to the insured premises that may materially mitigate loss from a hurricane or other storm otherwise covered under the policy.

(f) (1) An insurer that offers a premium discount under this section shall provide a policyholder with an annual statement regarding the availability of the discount and the method of applying for the discount.

(2) The notice required under paragraph (1) of this subsection may be sent with the statement required under § 19–205 of this subtitle.

(3) An insurer may comply with the renewal notice requirements of this subsection by sending the notice authorized by § 19–216 of this subtitle.

(g) The notice required by this section may be delivered by electronic means if the insurer complies with the requirements of § 27–601.2 of this article.

(h) The Commissioner may adopt regulations to implement the provisions of this section.

§19–211.

(a) (1) If an insurer uses a catastrophic risk planning model or other model in setting homeowner's insurance rates or refusing to issue or renew homeowner's insurance because of the geographic location of the risk, the insurer shall:

(i) file with the Commissioner a description of the specific model used in setting the rate or refusing to issue or renew homeowner's insurance because of the geographic location of the risk; and

(ii) make arrangements for the vendor of the model to explain to the Commissioner and the People's Insurance Counsel the data used in the model and the manner in which the output is obtained.

(2) If at any time an insurer changes the catastrophic risk planning model or other model upon which it is relying, the insurer shall notify the Commissioner of the change and comply with paragraph (1) of this subsection.

(b) (1) The information filed under subsection (a) of this section is proprietary and confidential commercial information under § 4–335 of the General Provisions Article.

(2) The People's Insurance Counsel shall maintain the confidentiality of any proprietary and confidential commercial information to which the People's Insurance Counsel obtains access under subsection (a) of this section.

(c) The Commissioner may adopt regulations to implement the provisions of this section.

§19–212.

(a) (1) In this section the following words have the meanings indicated.

(2) (i) "Material reduction" means during a 1–year period a reduction of homeowner's insurance policies in force for an insurer on a statewide basis by 3% or more due to cancellations or nonrenewals solely because the subject of the risk or the insured's address is located in a certain geographic area of the State.

(ii) "Material reduction" does not include a homeowner's insurance policy:

1. cancelled, nonrenewed, or otherwise terminated by an insured; or

2. cancelled or nonrenewed by an insurer pursuant to reasons other than a material reduction plan.

(3) (i) "Minimizes market disruption" means actions to be taken by an insurer that intends to engage in a plan of material reduction of its volume of policies to provide for the orderly reduction in homeowner's insurance coverage.

(ii) "Minimizes market disruption" includes:

1. efforts by the insurer to maintain a service force in affected areas during the period of material reduction;

2. efforts to inform insureds of options available for replacement of coverage with authorized insurers; and

3. any actions serving to minimize market disruption.

(b) (1) At least 60 days in advance of implementing a plan of material reduction, an insurer shall file with the Commissioner a plan for orderly reduction.

(2) The plan shall:

(i) describe the insurer's contemplated actions;

(ii) set forth the reasons for the actions;

(iii) describe the measures the insurer intends to take in order to minimize market disruption; and

(iv) provide any other information required by the Commissioner.

(c) (1) Except as provided in this section, a filing under this section may not take effect until 60 days after it is filed with the Commissioner.

(2) During the initial 60–day waiting period, the Commissioner may extend the waiting period for an additional period, not to exceed 60 days, by written notice to the insurer that the Commissioner needs additional time for consideration of the filing.

(3) A filing is deemed approved unless disapproved by the Commissioner during the waiting period or any extension of the waiting period.

(d) If the Commissioner finds that compliance with subsection (b) of this section would result in impairment of the insurer or a significant financial loss to the insurer, the Commissioner may allow an insurer to implement its plan of material reduction within 60 days after the filing of the plan.

(e) The Commissioner shall approve the plan of material reduction if the insurer demonstrates that the material reduction is accomplished in a manner that minimizes market disruption in the areas of material reduction.

(f) In reviewing a plan of material reduction, the Commissioner shall assess the impact of the plan of material reduction in:

(1) each county of the State; and

(2) areas within 1 mile of any saltwater shoreline or any shoreline directly adjacent to the Chesapeake Bay.

(g) (1) If the Commissioner disapproves the plan of material reduction, the Commissioner shall state:

(i) the points of objection with the plan; and

(ii) any amendments to the plan that the Commissioner may require, consistent with this section, including amendments designed to accomplish the plan of material reduction in a manner that minimizes market disruption.

(2) The insurer shall file an amended plan within 15 days after the date of return of the disapproved plan.

(3) Any intended withdrawal in accordance with a plan of material reduction that is disapproved is prohibited until the original or an amended plan of material reduction is approved by the Commissioner.

(h) The Commissioner may adopt regulations to implement the provisions of this section.

§19–213.

(a) Each policy of homeowner's, farmowner's, or dwelling insurance issued, sold, or delivered in the State that provides property coverage for a dwelling or personal property on a replacement cost basis shall contain a provision that allows an insured to file a claim for the difference between the actual cash value and the replacement cost for the completed repairs or replacement for not less than 2 years after the date of loss.

(b) An insurer may require an insured seeking additional payments on a replacement cost basis to notify the insurer, within 180 days after the date of loss, of the insured's intent to repair or replace the dwelling or personal property.

§19–214.

(a) An insurer that offers homeowner's insurance in the State shall provide a written notice to the insured at the time of application or issuance and at each renewal of the policy that states, in substantially similar language, that, in addition to the other allowable reasons for cancellation or refusal to renew under Maryland law:

(1) the insurer may cancel or refuse to renew coverage on the basis of the number of claims made by the policyholder within the preceding 3–year period; and

(2) the insurer may cancel or refuse to renew coverage on the basis of:

(i) three or more weather–related claims made within the preceding 3–year period;

(ii) one or more weather–related claims made within the preceding 3–year period if the insurer has provided written notice to the insured for reasonable or customary repairs or replacement specific to the insured's premises or dwelling that:

1. the insured failed to make; and

2. if made, would have prevented the loss for which a claim was made; and

(iii) a change in the physical condition or contents of the premises that:

1. increases the hazard insured against; and

2. if present and known to the insurer before the issuance of the policy, would have caused the insurer to refuse to issue the policy.

(b) In order to support cancellation or refusal to renew under subsection (a)(2)(ii) of this section, the written notice:

(1) must refer to specific conditions known to the insurer concerning the insured's specific premises or dwelling; and

(2) may not be a general notification of repairs or replacements common to that type of premises or dwelling.

(c) A notice required by this section may be delivered by electronic means if the insurer complies with the requirements of § 27–601.2 of this article.

(d) An insurer may comply with the renewal notice requirements of this section by sending the notice authorized by § 19–216 of this subtitle.

§19–215.

(a) An insurer that issues a policy of homeowner's insurance in the State that contains an anti–concurrent causation (ACC) clause shall provide a policyholder each year with a notice that:

(1) is clear and specific;

(2) describes the ACC clause;

(3) informs the insured to read the policy for complete information on the exclusions; and

(4) states that the insured should communicate with the insurance producer or the insurer for additional information regarding the scope of the exclusions.

(b) The notice under subsection (a) of this section:

(1) is not part of the policy or contract of insurance; and

(2) does not create a private right of action.

(c) A notice required by this section may be delivered by electronic means if the insurer complies with the requirements of § 27–601.2 of this article.

(d) The Commissioner may adopt regulations to implement this section.

§19–216.

(a) The Commissioner shall adopt by regulation a notice to be provided to insureds or policyholders at each renewal regarding areas of concerns, including:

(1) flood;

(2) coverage for loss from water that backs up through sewers and drains;

(3) deductibles;

(4) storm loss protective device discount;

(5) claims history; and

(6) increased hazard.

(b) The notice provided under subsection (a) of this section shall:

(1) be written in clear and specific language; and

(2) contain the following language in at least 10 point type:

"This notice is not your policy, does not give you any new or additional rights beyond those expressly stated in your policy, and does not alter your policy in any way.".

(c) The notice provided under subsection (a) of this section does not create a private right of action.

(d) An insurer may provide the renewal notices required by §§ 19–202, 19–205(a)(4)(vii), 19–210(f), and 19–214(a) of this subtitle and § 27–501(n)(2) of this article by sending the notice authorized by subsection (a) of this section.

(e) The notice authorized by this section may be delivered by electronic means if the insurer complies with the requirements of § 27–601.2 of this article.

§19–301.

In this subtitle, "antiarson application" means an application for property insurance covering the peril of fire that:

(1) requires an applicant to provide the basic information normally supplied to an insurer by an applicant for that type of coverage; and

(2) includes certain additional questions to be answered by the applicant.

§19–302.

(a) The purpose of this subtitle is to promote the public welfare by reducing fire damage to property and loss of life that is caused by the crime of arson by requiring insurers to secure antiarson applications that contain information to control the incidence of arson fraud from applicants for new policies of property insurance.

(b) This subtitle does not apply to a renewal of an existing property insurance policy or contract.

§19–303.

The Commissioner may adopt regulations to carry out this subtitle.

§19–304.

(a) If, after a public hearing, the Commissioner finds that there is an abnormally high incidence of arson in properties that are insured through commercial monoline fire policies, have a certain type of occupancy, or are located in a certain geographic area of the State, the Commissioner shall require that an antiarson application be used to obtain property insurance covering the peril of fire for property that is insured through that type of policy, has that type of occupancy, or is located in that geographic area of the State.

(b) The Commissioner shall require that an antiarson application be completed when a property insurance policy or contract covering the peril of fire is assigned because of the transfer of a major financial interest in the insured real property, if an antiarson application otherwise would be required under this subtitle.

(c) If, after a public hearing, the Commissioner finds that properties that are insured through a type of policy other than a commercial monoline fire policy have an abnormally high incidence of arson, the Commissioner may extend the application of this subtitle to properties insured through that other type of policy.

(d) (1) The Commissioner may not require the use of any application for property insurance covering the peril of fire other than an antiarson application.

(2) Paragraph (1) of this subsection does not prohibit the Commissioner from requiring the use of alternative antiarson applications in accordance with § 19-306 of this subtitle.

§19–305.

(a) (1) The Commissioner shall adopt a two-tier antiarson application form that requires an applicant to complete a second-tier supplementary application if the initial first-tier application elicits certain predesignated answers.

(2) In adopting the antiarson application form, the Commissioner shall consider generally recognized two-tier application forms.

(b) An antiarson application shall include:

(1) the name and address of the applicant, any mortgagee, and any other party with an ownership interest in the property to be insured;

(2) the amount of insurance requested and the method of valuation used to establish that amount;

(3) the dates and selling prices of the property to be insured in all real estate transactions involving the property during the 3-year period immediately preceding the date of the antiarson application;

(4) the applicant's history of losses during the 5-year period immediately preceding the date of the antiarson application with regard to any property:

(i) in which the applicant held an interest, including a partnership or mortgage interest, that is substantial; and

(ii) that sustained a fire loss exceeding 25% of the insured value;

(5) all taxes that are unpaid or overdue for 1 or more years; and

(6) the present occupancy of the property to be insured.

§19–306.

(a) The Commissioner may require the use of an alternative antiarson application if, after a public hearing, the Commissioner finds that:

(1) there is an abnormally high incidence of arson in properties that are insured through a certain type of policy, are in a certain class of property, or are located in a certain geographic area of the State; and

(2) in accordance with this subtitle, the antiarson application described in § 19-305 of this subtitle was implemented with respect to that type of policy, class of property, or geographic area of the State.

(b) An alternative antiarson application may be mandated only for the types of policies, types of occupancies, and geographic areas of the State that otherwise would require the use of an antiarson application under this subtitle.

§19–307.

(a) (1) An antiarson application required under this subtitle is a material part of the policy to which the application pertains.

(2) A material misrepresentation in an antiarson application is grounds to rescind the policy.

(b) (1) Within a reasonable time as specified by the Commissioner, a policyholder shall notify the policyholder's insurer in writing of any change in the information contained in an antiarson application.

(2) A material failure to give the notice required in paragraph (1) of this subsection, or a material misrepresentation in a notification, is grounds to rescind the policy.

§19–308.

(a) (1) This subsection does not apply to a contract to insure an owner-occupied dwelling for one to four families.

(2) If an antiarson application is required under this subtitle with regard to a building, an insurer may not enter into a contract to be issued after July 1, 1982, to insure the building against the peril of fire unless the insurer first receives an antiarson application signed and affirmed by the insured.

(b) The designation of any geographic area of the State by the Commissioner under this subtitle is not a valid reason for an insurer to refuse to issue or renew or to terminate any policy or insurance contract.

§19–309.

(a) Notwithstanding any other law to the contrary, an insurer, for any reason not prohibited by law, may terminate any policy or insurance contract for which an antiarson application or alternative antiarson application is required under this subtitle at any time within 90 days after the insurer accepts the antiarson application or alternative antiarson application.

(b) An insurer shall state the specific reasons for terminating a policy or insurance contract in the notice of termination to the insured.

§19–402.

(a) An insurer may not issue a workers' compensation insurance policy unless the State Workers' Compensation Commission has approved the form of the policy.

(b) Each policy of workers' compensation insurance shall include the following provisions:

(1) the State Workers' Compensation Commission, in the name of the State and for the benefit of a person entitled to compensation under the policy, may enforce the liability of the insurer for payment of compensation by:

(i) making the insurer a party to the original claim application; or

(ii) filing a separate claim application;

(2) the bankruptcy or insolvency of an employer does not relieve the insurer from payment of compensation for injury or death of a covered employee occurring during the life of the policy;

(3) as between the employee and the insurer, if the employer receives notice or has knowledge of the occurrence of an accidental injury, occupational disease, hernia, or hearing loss, the insurer is deemed also to have received the notice or have the knowledge;

(4) for the purposes of Titles 9 and 10 of the Labor and Employment Article, the insurer is subject to the same jurisdiction as the employer; and

(5) each award, decision, finding, or order against the employer for payment of compensation under Titles 9 and 10 of the Labor and Employment Article also is binding on the insurer.

(c) (1) A person that violates subsection (a) of this section is guilty of a misdemeanor and on conviction is subject to a fine not exceeding $1,000.

(2) The Commissioner may revoke the certificate of authority of a person that is convicted under this section.

§19–403.

(a) The Commissioner may:

(1) determine whether the premium rates of an insurer adequately cover the risks applicable to a workers' compensation insurance policy under Titles 9 and 10 of the Labor and Employment Article; and

(2) require the insurer to set premium rates that are adequate to cover those risks.

(b) Each insurer shall set premium rates for workers' compensation insurance in accordance with the requirements of the Commissioner under subsection (a) of this section.

(c) (1) A person that violates subsection (b) of this section is guilty of a misdemeanor and on conviction is subject to a fine not exceeding $1,000.

(2) The Commissioner may revoke the certificate of authority of a person that is convicted under this section.

§19–404.

(a) A workers' compensation insurance policy issued or delivered in the State may provide for deductibles.

(b) When a claim is payable under a workers' compensation insurance policy with deductibles:

(1) the insurer shall pay the claim including any applicable deductible; and

(2) the employer shall reimburse the insurer for any amount paid up to the limit of any applicable deductible.

§19–405.

When a workers' compensation insurance policy is renewed, the insurer shall give the employer a conspicuous written notice that:

(1) the employer must have a work permit for each minor employee as required by Title 3, Subtitle 2 of the Labor and Employment Article; and

(2) if the employer does not have a work permit for a minor employee:

(i) the State Workers' Compensation Commission may award twice the compensation and death benefits otherwise allowed under Title 9, Subtitle 6 of the Labor and Employment Article in a claim by that employee or that employee's dependent; and

(ii) the employer is solely liable for any increase in compensation or death benefits in a claim by that employee or that employee's dependent.

§19–406.

(a) This section does not apply to the cancellation of a policy or binder of workers' compensation insurance by an insurer during the 45–day underwriting period in accordance with § 12–106 of this article.

(b) Except for a cancellation for nonpayment of premium, an insurer may not cancel or refuse to renew a workers' compensation insurance policy before its expiration unless, at least 45 days before the date of cancellation or nonrenewal, the insurer:

(1) serves on the employer, by personal service or certified mail addressed to the last known address of the employer, a notice of intention to cancel or nonrenew the policy; and

(2) files a copy of the notice with the State Workers' Compensation Commission's designee.

(c) Notice under this section may be given:

(1) if the employer is a corporation, to an agent or officer of the corporation on whom legal process may be served; and

(2) if the employer is a partnership, to a partner.

(d) Notice under this section shall state when the cancellation or nonrenewal takes effect.

(e) Whenever an employer receives a notice under this section, the employer immediately shall secure coverage in accordance with § 9–402 of the Labor and Employment Article that will be in effect when the cancellation takes effect.

(f) (1) The notice shall state the insurer's actual reason for proposing the cancellation or nonrenewal of the policy.

(2) The Commissioner may not disallow a proposed action of an insurer because the statement of actual reason contains:

(i) grammatical, typographical, or other errors, if the errors are not material to the proposed action and are not misleading;

(ii) surplus information, if the surplus information is not misleading; or

(iii) erroneous information, if in the absence of the erroneous information there is a sufficient basis to support the proposed action.

(g) (1) At least 10 days before the date of cancellation of a workers' compensation insurance policy for nonpayment of premium, the insurer shall send to the employer, by certificate of mail, a written notice of the intention to cancel for nonpayment of premium.

(2) An insurer shall file a copy of the notice sent under paragraph (1) of this subsection with the State Workers' Compensation Commission's designee.

§19–501.

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

(b) (1) "Motor vehicle" means a vehicle, including a trailer, that is operated or designed for operation on a public road by any power other than animal or muscular power.

(2) "Motor vehicle" does not include:

(i) a bus as defined in § 11-105 of the Transportation Article; or

(ii) a taxicab as defined in § 11-165 of the Transportation Article.

(c) (1) "Motor vehicle accident" means an occurrence involving a motor vehicle that results in damage to property or injury to a person.

(2) "Motor vehicle accident" does not include an occurrence that is caused intentionally by or at the direction of the insured.

(d) "Named insured" means the person denominated in the declarations in a motor vehicle liability insurance policy.

§19–502.

(a) This subtitle does not affect Title 17 of the Transportation Article.

(b) Neither this subtitle nor Title 17 of the Transportation Article prevents an insurer from issuing, selling, or delivering motor vehicle liability insurance policies that provide liability coverage in excess of the requirements of the Maryland Vehicle Law.

(c) (1) This subtitle does not prohibit an insurer from providing benefits for Christian Science care and treatment.

(2) Expenses for Christian Science care and treatment constitute economic loss for purposes of this subtitle.

(d) This subtitle does not affect the right of a person to claim and sue for damages or losses that the person sustains as the result of a motor vehicle accident.

§19–503.

(a) The Commissioner may adopt regulations to carry out this subtitle.

(b) The Commissioner may review any motor vehicle liability insurance policy issued, sold, or delivered in the State to determine whether it complies with this subtitle and regulations adopted under this subtitle.

§19–503.1.

(a) In this section, "insurance identification card" means a card issued by or on behalf of an insurer, in a form that the Commissioner prescribes or approves, as an indication that the insurer has issued a motor vehicle liability insurance policy meeting the requirements of this subtitle.

(b) (1) An insurer that issues, sells, or delivers a motor vehicle liability insurance policy in the State shall provide to an insured at the time the motor vehicle liability insurance policy is initially issued and at each renewal an insurance identification card that indicates:

(i) the first named insured on the motor vehicle liability insurance policy;

(ii) the motor vehicle covered under the motor vehicle liability insurance policy; and

(iii) the period for which coverage under the motor vehicle liability insurance policy is in effect.

(2) (i) If an insured and an insurer both consent, an insurance identification card may be produced in electronic format.

(ii) Acceptable electronic formats include display of electronic images on a cellular phone or any other type of portable electronic device.

(3) (i) Except as provided in subparagraphs (ii) and (iii) of this paragraph, an insurance identification card shall be valid only for the period for which motor vehicle liability insurance coverage has been paid by the insured.

(ii) If the insured is on an insurer–sponsored payment plan or has financed premiums through a premium finance company, the insurance identification card may be issued for periods of 6 months even if the payment by the insured is for a period of less than 6 months.

(iii) For a 12–month commercial motor vehicle liability insurance policy covering three or more vehicles, the insurance identification card may be issued for a period of 12 months even if the payment by the insured is for a period of less than 12 months.

§19–504.

Each motor vehicle liability insurance policy issued, sold, or delivered in the State shall provide the minimum liability coverage specified in Title 17 of the Transportation Article.

§19–504.1.

(a) This section applies only when the liability coverage under a policy or binder of private passenger motor vehicle liability insurance exceeds the amount required under § 17-103 of the Transportation Article.

(b) An insurer shall offer to the first named insured under a policy or binder of private passenger motor vehicle liability insurance liability coverage for claims made by a family member in the same amount as the liability coverage for claims made by a nonfamily member under the policy or binder.

(c) (1) An offer made under this section shall be made on the form that the Commissioner requires.

(2) The form may be part of the insurance application, policy, contract, or binder.

(3) The form shall clearly and concisely explain in 10 point boldface type:

(i) the nature, extent, benefit, and cost of the amount of liability coverage for claims made by family members that is available to the first named insured; and

(ii) that an insurer may not refuse to underwrite a first named insured because the first named insured requests or elects the liability coverage for claims made by family members in an amount equal to the coverage provided for claims made by nonfamily members.

(d) (1) An insurer may not refuse to underwrite a first named insured because the first named insured requests or elects the liability coverage for claims made by family members in an amount equal to the coverage provided for claims made by nonfamily members.

(2) An insurer that violates this subsection is subject to the penalties provided in §§ 4-113 and 4-114 of this article.

§19–505.

(a) Unless waived in accordance with § 19–506 of this subtitle or rejected in accordance with § 19–506.1 of this subtitle, each insurer that issues, sells, or delivers a motor vehicle liability insurance policy in the State shall provide coverage for the medical, hospital, and disability benefits described in this section for each of the following individuals:

(1) except for individuals specifically excluded under § 27–609 of this article:

(i) the first named insured, and any family member of the first named insured who resides in the first named insured's household, who is injured in any motor vehicle accident, including an accident that involves an uninsured motor vehicle or a motor vehicle the identity of which cannot be ascertained; and

(ii) any other individual who is injured in a motor vehicle accident while using the insured motor vehicle with the express or implied permission of the named insured;

(2) an individual who is injured in a motor vehicle accident while occupying the insured motor vehicle as a guest or passenger; and

(3) an individual who is injured in a motor vehicle accident that involves the insured motor vehicle:

(i) as a pedestrian; or

(ii) while in, on, or alighting from a vehicle that is operated by animal or muscular power.

(b) (1) In this subsection, "income" means:

(i) wages, salaries, tips, commissions, professional fees, and other earnings from work or employment;

(ii) earnings from a business or farm owned individually, jointly, or in partnership; and

(iii) to the extent earnings are paid or payable in property or services instead of in cash, the reasonable value of the property or services.

(2) The minimum medical, hospital, and disability benefits provided by an insurer under this section shall include up to $2,500 for:

(i) payment of all reasonable and necessary expenses that arise from a motor vehicle accident and that are incurred within 3 years after the accident for necessary prosthetic devices and ambulance, dental, funeral, hospital, medical, professional nursing, surgical, and X–ray services;

(ii) payment of benefits for 85% of income lost:

1. within 3 years after, and resulting from, a motor vehicle accident; and

2. by an injured individual who was earning or producing income when the accident occurred; and

(iii) payments made in reimbursement of reasonable and necessary expenses incurred within 3 years after a motor vehicle accident for essential services ordinarily performed for the care and maintenance of the family or family household by an individual who was injured in the accident and not earning or producing income when the accident occurred.

(3) As a condition of providing loss of income benefits under this subsection, an insurer may require the injured individual to furnish the insurer with reasonable medical proof of the injury causing loss of income.

(c) (1) An insurer may exclude from the coverage described in this section benefits for:

(i) an individual, otherwise insured under the policy, who:

1. intentionally causes the motor vehicle accident resulting in the injury for which benefits are claimed;

2. is a nonresident of the State and is injured as a pedestrian in a motor vehicle accident that occurs outside of the State;

3. is injured in a motor vehicle accident while operating or voluntarily riding in a motor vehicle that the individual knows is stolen; or

4. is injured in a motor vehicle accident while committing a felony or while violating § 21–904 of the Transportation Article; or

(ii) the named insured or a family member of the named insured who resides in the named insured's household for an injury that occurs while

the named insured or family member is occupying an uninsured motor vehicle owned by:

1. the named insured; or

2. an immediate family member of the named insured who resides in the named insured's household.

(2) In the case of motorcycles, mopeds, or motor scooters, an insurer may:

(i) exclude the economic loss benefits described in this section; or

(ii) offer the economic loss benefits with deductibles, options, or specific exclusions.

§19–506.

(a) (1) If the first named insured does not wish to obtain the benefits described in § 19-505 of this subtitle, the first named insured shall make an affirmative written waiver of those benefits.

(2) If the first named insured does not make an affirmative written waiver under this section, the insurer shall provide the coverage described in § 19-505 of this subtitle.

(b) (1) A waiver made under this section constitutes a waiver of all the benefits described in § 19-505 of this subtitle, whether provided under:

(i) the first named insured's policy;

(ii) any other motor vehicle liability insurance policy issued in the State; or

(iii) another form of security used in place of a motor vehicle liability insurance policy as authorized under § 17-103 of the Transportation Article.

(2) Subject to paragraph (3) of this subsection, a waiver made under this section is binding on the following individuals covered by the policy:

(i) each named insured;

(ii) each listed driver; and

(iii) each member of the first named insured's family residing in the first named insured's household who is at least 16 years old.

(3) An individual listed in paragraph (2)(ii) or (iii) of this subsection may recover the benefits described in § 19-505 of this subtitle under another motor vehicle liability insurance policy if that individual:

(i) is the first named insured under the other policy;

(ii) has not waived the benefits described in § 19-505 of this subtitle under the other policy; and

(iii) is not a named insured under any other motor vehicle liability insurance policy under which a waiver of the benefits described in § 19-505 of this subtitle is in effect.

(c) A waiver made under this section is not effective unless, prior to the waiver, the insurer gives the first named insured written notice of the nature, extent, and cost of the coverage described in § 19-505 of this subtitle.

(d) (1) A waiver made under this section shall be made on the form that the Commissioner requires.

(2) The form may be part of the insurance contract.

(3) The form shall clearly and concisely explain in 10 point boldface type:

(i) the nature, extent, and cost of the coverage that would be provided under the policy if not waived by the first named insured;

(ii) each effect of a waiver as stated in subsection (b) of this section;

(iii) that a failure of the first named insured to make a waiver requires an insurer to provide the coverage described in § 19-505 of this subtitle;

(iv) that an insurer may not refuse to underwrite a person because the person refuses to waive the coverage described in § 19-505 of this subtitle; and

(v) that a waiver made under this section must be an affirmative written waiver.

(e) A waiver made under this section by a person that is insured continuously by the Maryland Automobile Insurance Fund or the insurer is effective until the waiver is withdrawn in writing.

(f) (1) An insurer may not refuse to underwrite a person because the person refuses to waive the coverage described in § 19-505 of this subtitle.

(2) An insurer that violates this subsection is subject to the penalties provided by §§ 4-113 and 4-114 of this article.

§19–506.1.

(a) (1) Notwithstanding §§ 19–505 and 19–506 of this subtitle, a first named insured is not required to obtain coverage for the benefits described in §§ 19–505 and 19–506 of this subtitle under a motor vehicle liability insurance policy that:

(i) provides coverage that does not exceed the minimum liability coverage specified in § 17–103(b) of the Transportation Article; and

(ii) 1. subject to paragraph (2) of this subsection, is issued, sold, or delivered by the Maryland Automobile Insurance Fund; or

2. subject to paragraph (3) of this subsection, is issued, sold, or delivered by an insurer other than the Maryland Automobile Insurance Fund.

(2) The Maryland Automobile Insurance Fund shall offer a first named insured, at the time of application for a policy described in paragraph (1)(i) of this subsection, the option to reject coverage for the benefits described in §§ 19–505 and 19–506 of this subtitle if, prior to the application, the applicant has not been insured continuously by the Maryland Automobile Insurance Fund for at least 1 year.

(3) An insurer other than the Maryland Automobile Insurance Fund may offer a first named insured, at the time of application for a policy described in paragraph (1)(i) of this subsection, the option to reject coverage for the benefits described in §§ 19–505 and 19–506 of this subtitle if:

(i) prior to the application, the applicant was insured by an insurer other than the Maryland Automobile Insurance Fund; and

(ii) the insurer under the prior policy canceled the policy before the end of the policy's term.

(b) At the time of application for a policy described in subsection (a)(1)(i) of this section, the first named insured shall elect in writing to:

(1) obtain coverage for the benefits described in § 19–505 of this subtitle;

(2) waive coverage for the benefits described in § 19–505 of this subtitle in accordance with § 19–506 of this subtitle; or

(3) reject coverage for the benefits described in §§ 19–505 and 19–506 of this subtitle in accordance with this section.

(c) (1) The election under subsection (b) of this section shall be made on the form that the Commissioner requires.

(2) The form may be part of the insurance contract.

(3) The form shall clearly and concisely explain in 10 point boldface type:

(i) that the first named insured must elect in writing to:

1. obtain coverage for the benefits described in § 19–505 of this subtitle;

2. waive coverage for the benefits described in § 19–505 of this subtitle in accordance with § 19–506 of this subtitle; or

3. reject coverage for the benefits described in §§ 19–505 and 19–506 of this subtitle in accordance with this section;

(ii) the nature, extent, and cost of coverage for the benefits described in §§ 19–505 and 19–506 of this subtitle if not rejected by the first named insured;

(iii) that the election to reject coverage for the benefits described in §§ 19–505 and 19–506 of this subtitle in accordance with this section is effective until the end of the policy's term unless the first named insured:

1. withdraws the rejection in writing;

2. obtains a motor vehicle liability insurance policy for the insured motor vehicle from another insurer; or

3. increases any coverage under the policy to an amount that exceeds the minimum liability coverage specified in § 17–103(b) of the Transportation Article; and

(iv) that on renewal of the policy, unless the first named insured notifies the insurer in writing that the first named insured wishes to obtain coverage for the benefits described in § 19–505 of this subtitle, the insurer shall provide the coverage described in § 19–506 of this subtitle.

(d) (1) A rejection of coverage for the benefits described in §§ 19–505 and 19–506 of this subtitle in accordance with this section is effective until the end of the policy's term unless the first named insured:

(i) withdraws the rejection in writing;

(ii) obtains a motor vehicle liability insurance policy for the insured motor vehicle from another insurer; or

(iii) increases any coverage under the policy to an amount that exceeds the minimum liability coverage specified in § 17–103(b) of the Transportation Article.

(2) On renewal of the policy, unless the first named insured notifies the insurer in writing that the first named insured wishes to obtain coverage for the benefits described in § 19–505 of this subtitle, the insurer shall provide the coverage described in § 19–506 of this subtitle.

§19–507.

(a) The benefits described in § 19–505 of this subtitle shall be payable without regard to:

(1) the fault or nonfault of the named insured or the recipient of benefits in causing or contributing to the motor vehicle accident; and

(2) any collateral source of medical, hospital, or wage continuation benefits.

(b) (1) Subject to paragraph (2) of this subsection, if the insured has both coverage for the benefits described in § 19–505 of this subtitle and a collateral source of medical, hospital, or wage continuation benefits, the insurer or insurers may coordinate the policies to provide for nonduplication of benefits, subject to appropriate reductions in premiums for one or both of the policies approved by the Commissioner.

(2) The named insured may:

(i) elect to coordinate the policies by indicating in writing which policy is to be the primary policy; or

(ii) reject the coordination of policies and nonduplication of benefits.

(c) (1) In this subsection, "increase the premium" includes an increase in total premium for a policy due to:

(i) a surcharge;

(ii) retiering or other reclassification of the policy; or

(iii) removal or reduction of a discount.

(2) An insurer that issues a policy that contains the coverage described in § 19–505 of this subtitle:

(i) may not increase the premium on the policy due to a claim or payment made under that coverage; and

(ii) at the time the policy is issued, shall notify the policyholder in writing that the insurer may not increase the premium on the policy due to a claim or payment made under that coverage.

(d) An insurer that provides the benefits described in § 19–505 of this subtitle does not have a right of subrogation and does not have a claim against any other person or insurer to recover any benefits paid because of the alleged fault of the other person in causing or contributing to a motor vehicle accident.

§19–508.

(a) (1) Subject to paragraphs (2) and (3) of this subsection, an insurer shall make all payments of the benefits described in § 19-505 of this subtitle periodically as claims for the benefits arise and within 30 days after the insurer receives satisfactory proof of claim.

(2) A policy that contains the coverage described in § 19-505 of this subtitle may:

(i) set a period of not less than 12 months after the date of the motor vehicle accident within which the original claim for benefits must be filed with the insurer; and

(ii) provide that if, after a lapse in the period of total disability or in the medical treatment of an injured individual who has received benefits under that coverage, the individual claims additional benefits based on an alleged recurrence of the injury for which the original claim for benefits was made, the insurer may require reasonable medical proof of the alleged recurrence.

(3) The aggregate benefits payable to an individual under this subsection may not exceed the maximum limits stated in the policy.

(b) (1) When an insurer that provides the benefits described in § 19-505 of this subtitle receives written notice from an insured of the occurrence of a motor vehicle accident for which benefits may be available under § 19-505 of this subtitle, the insurer shall notify the insured by mail of the latest date on which a claim may be filed for benefits under § 19-505 of this subtitle as provided in subsection (a)(2)(i) of this section.

(2) An insurer is not required under paragraph (1) of this subsection to send any notice to the insured as to any first party claim for benefits other than the benefits under § 19-505 of this subtitle.

(c) Payments of benefits that are not made in accordance with this section and that are overdue shall bear simple interest at the rate of 1.5% per month.

§19–509. IN EFFECT

(a) In this section, "uninsured motor vehicle" means a motor vehicle:

(1) the ownership, maintenance, or use of which has resulted in the bodily injury or death of an insured; and

(2) for which the sum of the limits of liability under all valid and collectible liability insurance policies, bonds, and securities applicable to bodily injury or death:

(i) is less than the amount of coverage provided under this section; or

(ii) has been reduced by payment to other persons of claims arising from the same occurrence to an amount less than the amount of coverage provided under this section.

(b) The uninsured motorist coverage required by this section does not apply to a motor vehicle liability insurance policy:

(1) that insures a motor vehicle that:

(i) is not subject to registration under § 13–402 of the Transportation Article because it is not driven on a highway; or

(ii) is exempt from registration under § 13–402(c)(10) of the Transportation Article; or

(2) if the first named insured under a policy or binder of private passenger motor vehicle liability insurance has enhanced underinsured motorist coverage under § 19–509.1 of this subtitle.

(c) In addition to any other coverage required by this subtitle, each motor vehicle liability insurance policy issued, sold, or delivered in the State after July 1, 1975, shall contain coverage for damages, subject to the policy limits, that:

(1) the insured is entitled to recover from the owner or operator of an uninsured motor vehicle because of bodily injuries sustained in a motor vehicle accident arising out of the ownership, maintenance, or use of the uninsured motor vehicle;

(2) the insured is entitled to recover from the owner or operator of an uninsured motor vehicle because of property damage, including loss of use of the insured vehicle; and

(3) a surviving relative of the insured, who is described in § 3–904 of the Courts Article, is entitled to recover from the owner or operator of an uninsured motor vehicle because the insured died as the result of a motor vehicle accident arising out of the ownership, maintenance, or use of the uninsured motor vehicle.

(d) The uninsured motorist coverage required by this section shall be in the form and subject to the conditions that the Commissioner approves.

(e) (1) The uninsured motorist coverage contained in a motor vehicle liability insurance policy:

(i) shall at least equal:

1. the amounts required by Title 17 of the Transportation Article for bodily injury and property damage, including loss of use of the insured vehicle; and

2. the coverage provided to a qualified person under Title 20, Subtitle 6 of this article; and

(ii) may not exceed the amount of liability coverage provided under the policy.

(2) Unless waived in accordance with § 19–510 of this subtitle, the amount of uninsured motorist coverage provided under a private passenger motor vehicle liability insurance policy shall equal the amount of liability coverage provided under the policy.

(f) An insurer may exclude from the uninsured motorist coverage required by this section benefits for:

(1) the named insured or a family member of the named insured who resides in the named insured's household for an injury that occurs when the named insured or family member is occupying or is struck as a pedestrian by an uninsured motor vehicle that is owned by the named insured or an immediate family member of the named insured who resides in the named insured's household; and

(2) the named insured, a family member of the named insured who resides in the named insured's household, and any other individual who has other applicable motor vehicle insurance for an injury that occurs when the named insured, family member, or other individual is occupying or is struck as a pedestrian by the insured motor vehicle while the motor vehicle is operated or used by an individual who is excluded from coverage under § 27–609 of this article.

(g) The limit of liability for an insurer that provides uninsured motorist coverage under this section is the amount of that coverage less the amount paid to the insured, that exhausts any applicable liability insurance policies, bonds, and securities, on behalf of any person that may be held liable for the bodily injuries or death of the insured.

(h) (1) A policy that, as its primary purpose, provides coverage in excess of other valid and collectible insurance or qualified self–insurance may include the uninsured motorist coverage provided for in this section.

(2) The uninsured motorist coverage required by this section is primary to any right to recovery from the Maryland Automobile Insurance Fund under Title 20, Subtitle 6 of this article.

(i) An endorsement or provision that protects the insured against damages caused by an uninsured motor vehicle that is contained in a policy issued and delivered in the State is deemed to cover damages caused by a motor vehicle insured by a liability insurer that is insolvent or otherwise unable to pay claims to the same extent and in the same manner as if the damages were caused by an uninsured motor vehicle.

(j) A provision in a motor vehicle liability insurance policy issued after July 1, 1975, about coverage for damages sustained by the insured as a result of the operation of an uninsured motor vehicle that requires a dispute between the insured and the insurer to be submitted to binding arbitration is prohibited and is of no legal effect.

§19–509. // EFFECTIVE JUNE 30, 2029 PER CHAPTER 514 OF 2023 //

(a) In this section, "uninsured motor vehicle" means a motor vehicle:

(1) the ownership, maintenance, or use of which has resulted in the bodily injury or death of an insured; and

(2) for which the sum of the limits of liability under all valid and collectible liability insurance policies, bonds, and securities applicable to bodily injury or death:

(i) is less than the amount of coverage provided under this section; or

(ii) has been reduced by payment to other persons of claims arising from the same occurrence to an amount less than the amount of coverage provided under this section.

(b) The uninsured motorist coverage required by this section does not apply to a motor vehicle liability insurance policy:

(1) that insures a motor vehicle that:

(i) is not subject to registration under § 13–402 of the Transportation Article because it is not driven on a highway; or

(ii) is exempt from registration under § 13–402(c)(10) of the Transportation Article; or

(2) if the first named insured under a policy or binder of private passenger motor vehicle liability insurance has elected to obtain enhanced underinsured motorist coverage under § 19–509.1 of this subtitle instead of the uninsured motorist coverage required under this section.

(c) In addition to any other coverage required by this subtitle, each motor vehicle liability insurance policy issued, sold, or delivered in the State after July 1, 1975, shall contain coverage for damages, subject to the policy limits, that:

(1) the insured is entitled to recover from the owner or operator of an uninsured motor vehicle because of bodily injuries sustained in a motor vehicle accident arising out of the ownership, maintenance, or use of the uninsured motor vehicle;

(2) the insured is entitled to recover from the owner or operator of an uninsured motor vehicle because of property damage, including loss of use of the insured vehicle; and

(3) a surviving relative of the insured, who is described in § 3–904 of the Courts Article, is entitled to recover from the owner or operator of an uninsured motor vehicle because the insured died as the result of a motor vehicle accident arising out of the ownership, maintenance, or use of the uninsured motor vehicle.

(d) The uninsured motorist coverage required by this section shall be in the form and subject to the conditions that the Commissioner approves.

(e) (1) The uninsured motorist coverage contained in a motor vehicle liability insurance policy:

(i) shall at least equal:

1. the amounts required by Title 17 of the Transportation Article for bodily injury and property damage, including loss of use of the insured vehicle; and

2. the coverage provided to a qualified person under Title 20, Subtitle 6 of this article; and

(ii) may not exceed the amount of liability coverage provided under the policy.

(2) Unless waived in accordance with § 19–510 of this subtitle, the amount of uninsured motorist coverage provided under a private passenger motor

vehicle liability insurance policy shall equal the amount of liability coverage provided under the policy.

(f) An insurer may exclude from the uninsured motorist coverage required by this section benefits for:

(1) the named insured or a family member of the named insured who resides in the named insured's household for an injury that occurs when the named insured or family member is occupying or is struck as a pedestrian by an uninsured motor vehicle that is owned by the named insured or an immediate family member of the named insured who resides in the named insured's household; and

(2) the named insured, a family member of the named insured who resides in the named insured's household, and any other individual who has other applicable motor vehicle insurance for an injury that occurs when the named insured, family member, or other individual is occupying or is struck as a pedestrian by the insured motor vehicle while the motor vehicle is operated or used by an individual who is excluded from coverage under § 27–609 of this article.

(g) The limit of liability for an insurer that provides uninsured motorist coverage under this section is the amount of that coverage less the amount paid to the insured, that exhausts any applicable liability insurance policies, bonds, and securities, on behalf of any person that may be held liable for the bodily injuries or death of the insured.

(h) (1) A policy that, as its primary purpose, provides coverage in excess of other valid and collectible insurance or qualified self–insurance may include the uninsured motorist coverage provided for in this section.

(2) The uninsured motorist coverage required by this section is primary to any right to recovery from the Maryland Automobile Insurance Fund under Title 20, Subtitle 6 of this article.

(i) An endorsement or provision that protects the insured against damages caused by an uninsured motor vehicle that is contained in a policy issued and delivered in the State is deemed to cover damages caused by a motor vehicle insured by a liability insurer that is insolvent or otherwise unable to pay claims to the same extent and in the same manner as if the damages were caused by an uninsured motor vehicle.

(j) A provision in a motor vehicle liability insurance policy issued after July 1, 1975, about coverage for damages sustained by the insured as a result of the operation of an uninsured motor vehicle that requires a dispute between the insured

and the insurer to be submitted to binding arbitration is prohibited and is of no legal effect.

§19–509.1. IN EFFECT

(a) In this section, "underinsured motor vehicle" means a motor vehicle that has liability coverage in an amount less than, more than, or equal to the uninsured motorist coverage provided under the insured party's motor vehicle liability insurance policy.

(b) The enhanced underinsured motorist coverage required by this section does not apply to a motor vehicle liability insurance policy:

(1) that insures a motor vehicle that:

(i) is not subject to registration under § 13–402 of the Transportation Article because it is not driven on a highway; or

(ii) is exempt from registration under § 13–402(c)(10) of the Transportation Article;

(2) if a first named insured under a new policy or binder of private passenger motor vehicle liability insurance issued on or after July 1, 2024, has waived enhanced underinsured motorist coverage under this section; or

(3) if a first named insured on a renewal policy issued before July 1, 2024, has not elected to obtain enhanced underinsured motorist coverage under this section.

(c) (1) Unless waived in accordance with this subsection, an insurer shall provide enhanced underinsured motorist coverage at the time of purchase of a private passenger motor vehicle liability insurance policy.

(2) (i) The first named insured under a policy or binder of private passenger motor vehicle liability insurance may elect to waive enhanced underinsured motorist coverage and instead maintain uninsured motorist coverage required under § 19–509 of this subtitle.

(ii) If the first named insured does not wish to obtain the enhanced underinsured motorist coverage under this section, the first named insured shall make an affirmative written statement waiving the coverage.

(iii) A waiver made under this subsection is not effective unless, before the waiver, the insurer gives the first named insured written notice of the

nature, extent, benefit, and cost of the level of the enhanced underinsured motorist coverage being waived.

(iv) 1. A waiver made under this subsection shall be made on the form that the Commissioner requires.

2. The form may be part of the insurance contract.

3. The form shall clearly and concisely explain in at least 14 point boldface type:

A. the nature, extent, benefit, and cost of the level of the enhanced underinsured motorist coverage that would be provided under the policy if not waived by the first named insured;

B. that a failure of the first named insured to make a waiver requires the insurer to provide enhanced underinsured motorist coverage;

C. that the insurer may not refuse to underwrite a person because the person refuses to waive the enhanced underinsured motorist coverage under this subsection; and

D. that a waiver made under this subsection must be an affirmative written waiver.

(v) If the first named insured does not make an affirmative written statement waiving the enhanced underinsured motorist coverage, the insurer shall provide the coverage under this section.

(3) Unless the first named insured affirmatively makes a change in writing, the election to waive enhanced underinsured motorist coverage applies to all subsequent renewals of coverage and to all other policies or endorsements that extend, change, supersede, or replace an existing private passenger motor vehicle insurance policy issued to the first named insured.

(d) In addition to any other coverage required by this subtitle, each private passenger motor vehicle liability insurance policy issued, sold, or delivered in the State on or after July 1, 2024, to an insured that maintains enhanced underinsured motorist coverage instead of the uninsured motorist coverage required under § 19–509 of this subtitle shall contain coverage for damages, subject to the policy limits, that:

(1) the insured is entitled to recover from the owner or operator of an underinsured motor vehicle because of bodily injuries sustained in a motor vehicle

accident arising out of the ownership, maintenance, or use of the underinsured motor vehicle;

(2) the insured is entitled to recover from the owner or operator of an underinsured motor vehicle because of property damage, including loss of use of the insured vehicle; and

(3) a surviving relative of the insured, who is described in § 3–904 of the Courts Article, is entitled to recover from the owner or operator of an underinsured motor vehicle because the insured died as the result of a motor vehicle accident arising out of the ownership, maintenance, or use of the underinsured motor vehicle.

(e) The enhanced underinsured motorist coverage required by this section shall be on the form that the Commissioner requires.

(f) (1) The enhanced underinsured motorist coverage contained in a private passenger motor vehicle liability insurance policy:

(i) shall at least equal:

1. the amounts required by Title 17 of the Transportation Article for bodily injury and property damage, including loss of use of the insured vehicle; and

2. the coverage provided to a qualified person under Title 20, Subtitle 6 of this article; and

(ii) may not exceed the amount of liability coverage provided under the policy.

(2) The amount of enhanced underinsured motorist coverage provided under a private passenger motor vehicle liability insurance policy shall equal the amount of liability coverage provided under the policy.

(g) An insurer may exclude from the enhanced underinsured motorist coverage required by this section benefits for:

(1) the named insured or a family member of the named insured who resides in the named insured's household for an injury that occurs when the named insured or family member is occupying or is struck as a pedestrian by an underinsured motor vehicle that is owned by the named insured or an immediate family member of the named insured who resides in the named insured's household; and

(2) the named insured, a family member of the named insured who resides in the named insured's household, and any other individual who has other applicable motor vehicle insurance for an injury that occurs when the named insured, family member, or other individual is occupying or is struck as a pedestrian by the insured motor vehicle while the motor vehicle is operated or used by an individual who is excluded from coverage under § 27–609 of this article.

(h) The limit of liability for an insurer that provides enhanced underinsured motorist coverage under this section:

(1) is subject to § 19–511.1 of this subtitle; and

(2) is the amount of that coverage without any reduction for the amount paid to the insured, that exhausts any applicable liability insurance policies, bonds, and securities, on behalf of any person that may be held liable for the bodily injuries or death of the insured.

(i) (1) A policy that, as its primary purpose, provides coverage in excess of other valid and collectible insurance or qualified self–insurance may include the enhanced underinsured motorist coverage provided for in this section.

(2) The enhanced underinsured motorist coverage required by this section is primary to any right to recovery from the Maryland Automobile Insurance Fund under Title 20, Subtitle 6 of this article.

(j) An endorsement or a provision that protects the insured against damages caused by an underinsured motor vehicle that is contained in a policy issued and delivered in the State is deemed to cover damages caused by a motor vehicle insured by a liability insurer that is insolvent or otherwise unable to pay claims to the same extent and in the same manner as if the damages were caused by an underinsured motor vehicle.

(k) A provision in a private passenger motor vehicle liability insurance policy issued on or after July 1, 2018, about coverage for damages sustained by the insured as a result of the operation of an underinsured motor vehicle that requires a dispute between the insured and the insurer to be submitted to binding arbitration is prohibited and is of no legal effect.

§19–509.1. // EFFECTIVE JUNE 30, 2029 PER CHAPTER 514 OF 2023 //

(a) In this section, "underinsured motor vehicle" means a motor vehicle that has liability coverage in an amount less than, more than, or equal to the uninsured

motorist coverage provided under the insured party's motor vehicle liability insurance policy.

(b) The enhanced underinsured motorist coverage required by this section does not apply to a motor vehicle liability insurance policy:

(1) that insures a motor vehicle that:

(i) is not subject to registration under § 13–402 of the Transportation Article because it is not driven on a highway; or

(ii) is exempt from registration under § 13–402(c)(10) of the Transportation Article; or

(2) when a first named insured under a policy or binder of private passenger motor vehicle liability insurance has not elected to obtain enhanced underinsured motorist coverage under this section instead of the uninsured motorist coverage required under § 19–509 of this subtitle.

(c) (1) An insurer shall offer enhanced underinsured motorist coverage at the time of purchase of a private passenger motor vehicle liability insurance policy.

(2) The first named insured under a policy or binder of private passenger motor vehicle liability insurance may elect to obtain enhanced underinsured motorist coverage instead of the uninsured motorist coverage required under § 19–509 of this subtitle.

(3) Unless the first named insured affirmatively makes a change in writing, the election to obtain enhanced underinsured motorist coverage applies to all subsequent renewals of coverage and to all other policies or endorsements that extend, change, supersede, or replace an existing private passenger motor vehicle insurance policy issued to the first named insured.

(d) In addition to any other coverage required by this subtitle, each private passenger motor vehicle liability insurance policy issued, sold, or delivered in the State on or after July 1, 2018, to an insured that elects to obtain enhanced underinsured motorist coverage instead of the uninsured motorist coverage required under § 19–509 of this subtitle shall contain coverage for damages, subject to the policy limits, that:

(1) the insured is entitled to recover from the owner or operator of an underinsured motor vehicle because of bodily injuries sustained in a motor vehicle accident arising out of the ownership, maintenance, or use of the underinsured motor vehicle;

(2) the insured is entitled to recover from the owner or operator of an underinsured motor vehicle because of property damage, including loss of use of the insured vehicle; and

(3) a surviving relative of the insured, who is described in § 3–904 of the Courts Article, is entitled to recover from the owner or operator of an underinsured motor vehicle because the insured died as the result of a motor vehicle accident arising out of the ownership, maintenance, or use of the underinsured motor vehicle.

(e) The offer of enhanced underinsured motorist coverage required by this section shall be on the form that the Commissioner requires.

(f) (1) The enhanced underinsured motorist coverage contained in a private passenger motor vehicle liability insurance policy:

(i) shall at least equal:

1. the amounts required by Title 17 of the Transportation Article for bodily injury and property damage, including loss of use of the insured vehicle; and

2. the coverage provided to a qualified person under Title 20, Subtitle 6 of this article; and

(ii) may not exceed the amount of liability coverage provided under the policy.

(2) The amount of enhanced underinsured motorist coverage provided under a private passenger motor vehicle liability insurance policy shall equal the amount of liability coverage provided under the policy.

(g) An insurer may exclude from the enhanced underinsured motorist coverage required by this section benefits for:

(1) the named insured or a family member of the named insured who resides in the named insured's household for an injury that occurs when the named insured or family member is occupying or is struck as a pedestrian by an underinsured motor vehicle that is owned by the named insured or an immediate family member of the named insured who resides in the named insured's household; and

(2) the named insured, a family member of the named insured who resides in the named insured's household, and any other individual who has other applicable motor vehicle insurance for an injury that occurs when the named insured, family member, or other individual is occupying or is struck as a pedestrian by the insured motor vehicle while the motor vehicle is operated or used by an individual who is excluded from coverage under § 27–609 of this article.

(h) The limit of liability for an insurer that provides enhanced underinsured motorist coverage under this section:

(1) is subject to § 19–511.1 of this subtitle; and

(2) is the amount of that coverage without any reduction for the amount paid to the insured, that exhausts any applicable liability insurance policies, bonds, and securities, on behalf of any person that may be held liable for the bodily injuries or death of the insured.

(i) (1) A policy that, as its primary purpose, provides coverage in excess of other valid and collectible insurance or qualified self–insurance may include the enhanced underinsured motorist coverage provided for in this section.

(2) The enhanced underinsured motorist coverage required by this section is primary to any right to recovery from the Maryland Automobile Insurance Fund under Title 20, Subtitle 6 of this article.

(j) An endorsement or a provision that protects the insured against damages caused by an underinsured motor vehicle that is contained in a policy issued and delivered in the State is deemed to cover damages caused by a motor vehicle insured by a liability insurer that is insolvent or otherwise unable to pay claims to the same extent and in the same manner as if the damages were caused by an underinsured motor vehicle.

(k) A provision in a private passenger motor vehicle liability insurance policy issued on or after July 1, 2018, about coverage for damages sustained by the insured as a result of the operation of an underinsured motor vehicle that requires a dispute between the insured and the insurer to be submitted to binding arbitration is prohibited and is of no legal effect.

§19–509.2.

(a) A final judgment in an action for personal injury protection coverage under a motor vehicle liability insurance policy does not preclude a subsequent action for uninsured or underinsured motorist coverage arising out of the same motor vehicle accident or occurrence.

(b) A final judgment in an action for personal injury protection coverage under a private passenger motor vehicle liability insurance policy does not preclude a subsequent action for enhanced underinsured motorist coverage arising out of the same motor vehicle accident or occurrence.

§19–510. IN EFFECT

(a) This section applies only when:

(1) the liability coverage under a policy or binder of private passenger motor vehicle liability insurance exceeds the amount required under § 17–103 of the Transportation Article; and

(2) the first named insured under a policy or binder of private passenger motor vehicle liability insurance has uninsured motorist coverage required under § 19–509 of this subtitle and has not obtained enhanced underinsured motorist coverage under § 19–509.1 of this subtitle.

(b) (1) If the first named insured under a policy or binder of private passenger motor vehicle liability insurance does not wish to obtain uninsured motorist coverage in the same amount as the liability coverage provided under the policy or binder, the first named insured shall make an affirmative written waiver of having uninsured motorist coverage in the same amount as the liability coverage.

(2) If the first named insured does not make an affirmative written waiver under this section, the insurer shall provide uninsured motorist coverage in an amount equal to the amount of the liability coverage provided under the policy or binder.

(c) A waiver made under this section is not effective unless, prior to the waiver, the insurer gives the first named insured written notice of the nature, extent, benefit, and cost of the level of the uninsured motorist coverage being waived.

(d) (1) A waiver made under this section shall be made on the form that the Commissioner requires.

(2) The form may be part of the insurance contract.

(3) The form shall clearly and concisely explain in 10 point boldface type:

(i) the nature, extent, benefit, and cost of the level of the uninsured motorist coverage that would be provided under the policy if not waived by the first named insured;

(ii) that a failure of the first named insured to make a waiver requires an insurer to provide uninsured motorist coverage in an amount equal to the amount of the liability coverage provided under the policy or binder of private passenger motor vehicle liability insurance;

(iii) that an insurer may not refuse to underwrite a person because the person refuses to waive the excess uninsured motorist coverage under this section; and

(iv) that a waiver made under this section must be an affirmative written waiver.

(4) Subject to the Commissioner's approval, a waiver made under this section may be made on the same form as the waiver made under § 19–506 of this subtitle.

(e) A waiver made under this section by a person that is insured continuously by an insurer or by the Maryland Automobile Insurance Fund is effective until the waiver is withdrawn in writing.

(f) (1) An insurer may not refuse to underwrite a person because the person refuses to waive the excess uninsured motorist coverage under this section.

(2) An insurer that violates this subsection is subject to the penalties provided by §§ 4–113 and 4–114 of this article.

§19–510. // EFFECTIVE JUNE 30, 2029 PER CHAPTER 514 OF 2023 //

(a) This section applies only when:

(1) the liability coverage under a policy or binder of private passenger motor vehicle liability insurance exceeds the amount required under § 17–103 of the Transportation Article; and

(2) the first named insured under a policy or binder of private passenger motor vehicle liability insurance has not elected to obtain enhanced underinsured motorist coverage under § 19–509.1 of this subtitle instead of the uninsured motorist coverage required under § 19–509 of this subtitle.

(b) (1) If the first named insured under a policy or binder of private passenger motor vehicle liability insurance does not wish to obtain uninsured motorist coverage in the same amount as the liability coverage provided under the policy or binder, the first named insured shall make an affirmative written waiver of having uninsured motorist coverage in the same amount as the liability coverage.

(2) If the first named insured does not make an affirmative written waiver under this section, the insurer shall provide uninsured motorist coverage in an amount equal to the amount of the liability coverage provided under the policy or binder.

(c) A waiver made under this section is not effective unless, prior to the waiver, the insurer gives the first named insured written notice of the nature, extent, benefit, and cost of the level of the uninsured motorist coverage being waived.

(d) (1) A waiver made under this section shall be made on the form that the Commissioner requires.

(2) The form may be part of the insurance contract.

(3) The form shall clearly and concisely explain in 10 point boldface type:

(i) the nature, extent, benefit, and cost of the level of the uninsured motorist coverage that would be provided under the policy if not waived by the first named insured;

(ii) that a failure of the first named insured to make a waiver requires an insurer to provide uninsured motorist coverage in an amount equal to the amount of the liability coverage provided under the policy or binder of private passenger motor vehicle liability insurance;

(iii) that an insurer may not refuse to underwrite a person because the person refuses to waive the excess uninsured motorist coverage under this section; and

(iv) that a waiver made under this section must be an affirmative written waiver.

(4) Subject to the Commissioner's approval, a waiver made under this section may be made on the same form as the waiver made under § 19–506 of this subtitle.

(e) A waiver made under this section by a person that is insured continuously by an insurer or by the Maryland Automobile Insurance Fund is effective until the waiver is withdrawn in writing.

(f) (1) An insurer may not refuse to underwrite a person because the person refuses to waive the excess uninsured motorist coverage under this section.

(2) An insurer that violates this subsection is subject to the penalties provided by §§ 4–113 and 4–114 of this article.

§19–511. IN EFFECT

(a) This section does not apply when the first named insured under a policy or binder of private passenger motor vehicle liability insurance has enhanced underinsured motorist coverage under § 19–509.1 of this subtitle instead of the uninsured motorist coverage required under § 19–509 of this subtitle.

(b) If an injured person receives a written offer from a motor vehicle insurance liability insurer or that insurer's authorized agent to settle a claim for bodily injury or death, and the amount of the settlement offer, in combination with any other settlements arising out of the same occurrence, would exhaust the bodily injury or death limits of the applicable liability insurance policies, bonds, and securities, the injured person shall send by certified mail, to any insurer that provides uninsured motorist coverage for the bodily injury or death, a copy of the liability insurer's written settlement offer.

(c) Within 60 days after receipt of the notice required under subsection (b) of this section, the uninsured motorist insurer shall send to the injured person:

(1) written consent to acceptance of the settlement offer and to the execution of releases; or

(2) written refusal to consent to acceptance of the settlement offer.

(d) Within 30 days after a refusal to consent to acceptance of a settlement offer under subsection (c)(2) of this section, the uninsured motorist insurer shall pay to the injured person the amount of the settlement offer.

(e) (1) Payment as described in subsection (d) of this section shall preserve the uninsured motorist insurer's subrogation rights against the liability insurer and its insured.

(2) Receipt by the injured person of the payment described in subsection (d) of this section shall constitute the assignment, up to the amount of the

payment, of any recovery on behalf of the injured person that is subsequently paid from the applicable liability insurance policies, bonds, and securities.

(f) The injured person may accept the liability insurer's settlement offer and execute releases in favor of the liability insurer and its insured without prejudice to any claim the injured person may have against the uninsured motorist insurer:

(1) on receipt of written consent to acceptance of the settlement offer and to the execution of releases; or

(2) if the uninsured motorist insurer has not met the requirements of subsection (c) or subsection (d) of this section.

(g) Written consent by an uninsured motorist insurer to acceptance of a settlement offer under subsection (c)(1) of this section:

(1) may not be construed to limit the right of the uninsured motorist insurer to raise any issue relating to liability or damages in an action against the uninsured motorist insurer; and

(2) does not constitute an admission by the uninsured motorist insurer as to any issue raised in an action against the uninsured motorist insurer.

§19–511. // EFFECTIVE JUNE 30, 2029 PER CHAPTER 514 OF 2023 //

(a) This section does not apply when the first named insured under a policy or binder of private passenger motor vehicle liability insurance has elected to obtain enhanced underinsured motorist coverage under § 19–509.1 of this subtitle instead of the uninsured motorist coverage required under § 19–509 of this subtitle.

(b) If an injured person receives a written offer from a motor vehicle insurance liability insurer or that insurer's authorized agent to settle a claim for bodily injury or death, and the amount of the settlement offer, in combination with any other settlements arising out of the same occurrence, would exhaust the bodily injury or death limits of the applicable liability insurance policies, bonds, and securities, the injured person shall send by certified mail, to any insurer that provides uninsured motorist coverage for the bodily injury or death, a copy of the liability insurer's written settlement offer.

(c) Within 60 days after receipt of the notice required under subsection (b) of this section, the uninsured motorist insurer shall send to the injured person:

(1) written consent to acceptance of the settlement offer and to the execution of releases; or

(2) written refusal to consent to acceptance of the settlement offer.

(d) Within 30 days after a refusal to consent to acceptance of a settlement offer under subsection (c)(2) of this section, the uninsured motorist insurer shall pay to the injured person the amount of the settlement offer.

(e) (1) Payment as described in subsection (d) of this section shall preserve the uninsured motorist insurer's subrogation rights against the liability insurer and its insured.

(2) Receipt by the injured person of the payment described in subsection (d) of this section shall constitute the assignment, up to the amount of the payment, of any recovery on behalf of the injured person that is subsequently paid from the applicable liability insurance policies, bonds, and securities.

(f) The injured person may accept the liability insurer's settlement offer and execute releases in favor of the liability insurer and its insured without prejudice to any claim the injured person may have against the uninsured motorist insurer:

(1) on receipt of written consent to acceptance of the settlement offer and to the execution of releases; or

(2) if the uninsured motorist insurer has not met the requirements of subsection (c) or subsection (d) of this section.

(g) Written consent by an uninsured motorist insurer to acceptance of a settlement offer under subsection (c)(1) of this section:

(1) may not be construed to limit the right of the uninsured motorist insurer to raise any issue relating to liability or damages in an action against the uninsured motorist insurer; and

(2) does not constitute an admission by the uninsured motorist insurer as to any issue raised in an action against the uninsured motorist insurer.

§19–511.1. IN EFFECT

(a) This section applies only when the first named insured under a policy or binder of private passenger motor vehicle liability insurance has enhanced underinsured motorist coverage under § 19–509.1 of this subtitle instead of the uninsured motorist coverage required under § 19–509 of this subtitle.

(b) If an injured person receives a written offer from a motor vehicle liability insurer or that insurer's authorized agent to settle a claim for bodily injury or death, and the amount of the settlement offer, in combination with any other settlements arising out of the same occurrence, would exhaust the bodily injury or death limits of the applicable liability insurance policies, bonds, and securities, the injured person shall send by certified mail, to any insurer that provides enhanced underinsured motorist coverage for the bodily injury or death, a copy of the liability insurer's written settlement offer.

(c) Within 60 days after receipt of the notice required under subsection (b) of this section, the enhanced underinsured motorist insurer shall send to the injured person:

(1) written consent to acceptance of the settlement offer and to the execution of releases; or

(2) written refusal to consent to acceptance of the settlement offer.

(d) Within 30 days after a refusal to consent to acceptance of a settlement offer under subsection (c)(2) of this section, the enhanced underinsured motorist insurer shall pay to the injured person the amount of the settlement offer.

(e) (1) Payment as described in subsection (d) of this section shall preserve the extended enhanced underinsured motorist insurer's subrogation rights against the motor vehicle liability insurer and its insured.

(2) Receipt by the injured person of the payment described in subsection (d) of this section shall constitute the assignment, up to the amount of the payment, of any recovery on behalf of the injured person that is subsequently paid from the applicable liability insurance policies, bonds, and securities.

(f) The injured person may accept the motor vehicle liability insurer's settlement offer and execute releases in favor of the liability insurer and its insured without prejudice to any claim the injured person may have against the enhanced underinsured motorist insurer:

(1) on receipt of written consent to acceptance of the settlement offer and to the execution of releases; or

(2) if the enhanced underinsured motorist insurer has not met the requirements of subsection (c) or (d) of this section.

(g) Written consent by an enhanced underinsured motorist insurer to acceptance of a settlement offer under subsection (c)(1) of this section:

(1) may not be construed to limit the right of the enhanced underinsured motorist insurer to raise any issue relating to liability or damages in an action against the enhanced underinsured motorist insurer; and

(2) does not constitute an admission by the uninsured motorist insurer as to any issue raised in an action against the enhanced underinsured motorist insurer.

§19–511.1. // EFFECTIVE JUNE 30, 2029 PER CHAPTER 514 OF 2023 //

(a) This section applies only when the first named insured under a policy or binder of private passenger motor vehicle liability insurance has elected to obtain enhanced underinsured motorist coverage under § 19–509.1 of this subtitle instead of the uninsured motorist coverage required under § 19–509 of this subtitle.

(b) If an injured person receives a written offer from a motor vehicle liability insurer or that insurer's authorized agent to settle a claim for bodily injury or death, and the amount of the settlement offer, in combination with any other settlements arising out of the same occurrence, would exhaust the bodily injury or death limits of the applicable liability insurance policies, bonds, and securities, the injured person shall send by certified mail, to any insurer that provides enhanced underinsured motorist coverage for the bodily injury or death, a copy of the liability insurer's written settlement offer.

(c) Within 60 days after receipt of the notice required under subsection (b) of this section, the enhanced underinsured motorist insurer shall send to the injured person:

(1) written consent to acceptance of the settlement offer and to the execution of releases; or

(2) written refusal to consent to acceptance of the settlement offer.

(d) Within 30 days after a refusal to consent to acceptance of a settlement offer under subsection (c)(2) of this section, the enhanced underinsured motorist insurer shall pay to the injured person the amount of the settlement offer.

(e) (1) Payment as described in subsection (d) of this section shall preserve the extended enhanced underinsured motorist insurer's subrogation rights against the motor vehicle liability insurer and its insured.

(2) Receipt by the injured person of the payment described in subsection (d) of this section shall constitute the assignment, up to the amount of the

payment, of any recovery on behalf of the injured person that is subsequently paid from the applicable liability insurance policies, bonds, and securities.

(f) The injured person may accept the motor vehicle liability insurer's settlement offer and execute releases in favor of the liability insurer and its insured without prejudice to any claim the injured person may have against the enhanced underinsured motorist insurer:

(1) on receipt of written consent to acceptance of the settlement offer and to the execution of releases; or

(2) if the enhanced underinsured motorist insurer has not met the requirements of subsection (c) or (d) of this section.

(g) Written consent by an enhanced underinsured motorist insurer to acceptance of a settlement offer under subsection (c)(1) of this section:

(1) may not be construed to limit the right of the enhanced underinsured motorist insurer to raise any issue relating to liability or damages in an action against the enhanced underinsured motorist insurer; and

(2) does not constitute an admission by the uninsured motorist insurer as to any issue raised in an action against the enhanced underinsured motorist insurer.

§19–512.

(a) (1) Each insurer that issues, sells, or delivers a motor vehicle insurance policy in the State shall offer collision coverage for damage to insured motor vehicles subject to deductibles of $50 to $250 in $50 increments.

(2) Collision coverage shall provide insurance, without regard to fault, against accidental property damage to the insured motor vehicle caused by physical contact of the insured motor vehicle with another motor vehicle or other object or by upset of the insured motor vehicle, if the motor vehicle accident occurs in a state, Canada, or Mexico.

(b) (1) In this subsection, "passenger car" means a motor vehicle that is:

(i) a Class A (passenger) vehicle under § 13–912 of the Transportation Article; or

(ii) a Class M (multipurpose) vehicle under § 13–937 of the Transportation Article used primarily for transporting passengers.

(2) If a private passenger motor vehicle insurance policy issued, sold, or delivered in the State includes:

(i) collision coverage under this section, the motor vehicles insured under that coverage shall include any passenger car that is rented or used by an insured for a period of 30 days or less under a rental agreement or a peer–to–peer car sharing program agreement as otherwise defined in § 14–2101 of the Commercial Law Article; or

(ii) comprehensive coverage, the motor vehicles insured under that coverage shall include any replacement vehicle as defined under § 18–102(a)(2)(i) or § 18.5–102(a)(2)(i) of the Transportation Article.

(3) Each insurer that provides a private passenger motor vehicle insurance policy that includes collision coverage shall give the insured a separate notice written in boldface type that the insured does not need a collision damage waiver or any additional collision coverage when renting or peer–to–peer car sharing a passenger car for a period of 30 days or less during the term of the policy.

(4) An insurer may not deny coverage to an insured for collision damage to a rental passenger car because:

(i) the motor vehicle accident involved an uninsured motorist; or

(ii) the identity of the motor vehicle causing the damage cannot be ascertained.

(c) An insurer may offer to provide to the insured coverage for damages incurred by the insured as a result of the loss of use of a rental vehicle or a shared motor vehicle that sustains collision damage while rented by the insured.

§19–513.

(a) This section does not prohibit a nonprofit health service plan or an authorized insurer, with the approval of the Commissioner, from providing medical, hospital, and disability benefits in connection with motor vehicle accidents.

(b) (1) Notwithstanding any other provision of this subtitle, a person may not recover benefits under the coverages described in §§ 19–504, 19–505, 19–509, 19–509.1, and 19–512 of this subtitle from more than one motor vehicle liability insurance policy or insurer on a duplicative basis.

(2) Except as provided in § 19–509.1 of this subtitle, and notwithstanding any other provision of this subtitle, a person may not recover benefits under the coverages described in §§ 19–504, 19–505, 19–509, and 19–512 of this subtitle from more than one motor vehicle liability insurance policy or insurer on a supplemental basis.

(c) (1) The insurer of a motor vehicle for which the coverage described in § 19–505 of this subtitle is in effect shall pay the benefits described in § 19–505 of this subtitle to an individual who is injured in a motor vehicle accident:

(i) while occupying the insured motor vehicle; or

(ii) by the insured motor vehicle as a pedestrian, while in, on, or alighting from a vehicle powered by animal or muscular power, or while on or alighting from an animal.

(2) An insurer may not pay benefits under paragraph (1) of this subsection to an individual who is in violation of § 17–103 of the Transportation Article.

(d) (1) The insurer under a policy that contains the coverages described in §§ 19–505 and 19–509 of this subtitle shall pay the benefits described in §§ 19–505 and 19–509 to an individual insured under the policy who is injured in a motor vehicle accident:

(i) while occupying a motor vehicle for which the coverages described in §§ 19–505 and 19–509 of this subtitle are not in effect; or

(ii) by a motor vehicle for which the coverages described in §§ 19–505 and 19–509 of this subtitle are not in effect as a pedestrian, while in, on, or alighting from a vehicle powered by animal or muscular power, or while on or alighting from an animal.

(2) Benefits payable under paragraph (1) of this subsection shall be reduced to the extent of any medical or disability benefits coverage that is:

(i) applicable to the motor vehicle for which the coverages described in §§ 19–505 and 19–509 of this subtitle are not in effect; and

(ii) collectible from the insurer of that motor vehicle.

(e) Benefits payable under the coverages described in §§ 19–505 and 19–509 of this subtitle shall be reduced to the extent that the recipient has recovered benefits under the workers' compensation laws of a state or the federal government

for which the provider of the workers' compensation benefits has not been reimbursed.

§19–514.

Authorized insurers that issue, sell, or deliver motor vehicle liability or physical damage insurance policies in the State shall arbitrate and settle all motor vehicle physical damage claims between the authorized insurers in accordance with an automobile subrogation program sponsored by the intercompany arbitration organization chosen by the authorized insurer that requests the arbitration.

§19–515.

An insurer may not refuse to issue or renew a motor vehicle liability insurance policy under this subtitle on the ground that the applicant has been issued a citation under § 3-8A-33 of the Courts Article.

§19–516.

(a) This section applies to a motor vehicle insurance policy issued, sold, or delivered in the State that covers a motor vehicle that is specially equipped for the transportation of or operation by an individual with a disability.

(b) If a motor vehicle insurance policy described in subsection (a) of this section provides for reimbursement of the costs of a rental motor vehicle, the insurer shall, upon request of the applicant or insured, make available for the appropriate premium at the time of the issuance or renewal of the policy a daily reimbursement rate of up to $100, for a maximum of $1,500 per policy period, to allow the insured to rent a motor vehicle that is equipped similarly to the covered motor vehicle.

§19–517.

(a) (1) In this section the following words have the meanings indicated.

(2) "Transportation network company" has the meaning stated in § 10–101 of the Public Utilities Article.

(3) "Transportation network operator" has the meaning stated in § 10–101 of the Public Utilities Article.

(4) "Transportation network services" has the meaning stated in § 10–101 of the Public Utilities Article.

(b) Insurance required under § 10–405 of the Public Utilities Article shall be deemed to satisfy the financial responsibility requirement for a motor vehicle under §§ 19–505 and 19–509 of this subtitle and Title 17, Subtitle 1 of the Transportation Article.

(c) (1) An authorized insurer that writes motor vehicle liability insurance in the State and the Maryland Automobile Insurance Fund may exclude any and all coverage and the duty to defend afforded under an owner's or operator's personal motor vehicle insurance policy for any loss or injury that occurs while the vehicle operator is providing transportation network services.

(2) If an insurer that writes motor vehicle liability insurance in the State defends or indemnifies a claim against a driver for which coverage is excluded under the terms of its policy, the insurer shall have a right of contribution against other insurers that provide insurance to the same driver in satisfaction of the requirements of § 10–405 of the Public Utilities Article at the time of the loss.

(3) Nothing in this section or § 10–405 of the Public Utilities Article shall be deemed to invalidate or limit an exclusion contained in a policy, including any policy in use or approved for use before July 1, 2015, that excludes coverage for motor vehicles that are used to transport passengers or property for a charge or are available for hire by the public.

(4) The right to exclude coverage and the duty to defend under paragraph (1) of this subsection applies to any coverage included in a motor vehicle liability insurance policy, including:

(i) liability coverage for bodily injury and property damage;

(ii) uninsured and underinsured motorist coverage;

(iii) medical payments coverage;

(iv) personal injury protection coverage;

(v) comprehensive physical damage coverage; and

(vi) collision physical damage coverage.

(5) If an insurer that writes motor vehicle liability insurance in the State excludes coverage for providing transportation network services, the insurer shall provide written notice to the named insured stating that the policy excludes coverage for providing transportation network services:

(i) for a policy initially purchased on or after January 1, 2016, at the time of issuance; and

(ii) for a policy in force before January 1, 2016, at the time the policy first renews after January 1, 2016.

(d) (1) Nothing in this section or § 10–405 of the Public Utilities Article:

(i) may be construed to require a personal motor vehicle insurance policy to provide primary or excess coverage; or

(ii) implies or requires that a personal motor vehicle insurance policy provide coverage while the vehicle operator is providing transportation network services.

(2) Coverage under a motor vehicle insurance policy maintained by a transportation network company may not be dependent on a personal insurer that writes motor vehicle liability insurance in the State first denying a claim, nor may a personal motor vehicle insurance policy be required to first deny a claim.

(3) Nothing in this section or § 10–405 of the Public Utilities Article precludes an insurer that writes motor vehicle liability insurance in the State from providing coverage for an operator's motor vehicle while the operator is providing transportation network services if the insurer elects to do so by contract or endorsement.

§19–517.1.

(a) Beginning July 1, 2017, and annually thereafter through July 1, 2021, the Commissioner shall make a determination whether, with regard to the required coverages under § 10–405(a) of the Public Utilities Article, there is a viable, affordable, and adequate market of authorized insurers in the State, including the Maryland Automobile Insurance Fund, available to provide the required coverages to the transportation network services industry.

(b) To the extent that the Commissioner makes an affirmative finding of availability, and in accordance with the provisions of Title 3, Subtitle 3 of this article, it is the intent of the General Assembly that required coverages be obtained from authorized insurers and the Maryland Automobile Insurance Fund.

§19–518.

(a) In this section, "volunteer driver" means an individual who provides driving services, including transportation of individuals or goods, without compensation other than for expenses to:

(1) a charitable organization, as defined in § 6–101 of the Business Regulation Article, in the State; or

(2) a not–for–profit organization in the State that is exempt from taxation under § 501(c)(3), (4), or (6) of the Internal Revenue Code.

(b) An insurer that issues, sells, or delivers a motor vehicle liability insurance policy in the State may not:

(1) cancel the policy of a named insured or refuse to issue the policy to an applicant solely because the named insured or applicant is a volunteer driver; or

(2) impose a surcharge on or otherwise increase the rate for the policy solely because the named insured or applicant, a member of the named insured's or applicant's household, or an individual who customarily operates the named insured's or applicant's motor vehicle is a volunteer driver.

(c) This section does not prohibit an insurer from canceling, refusing to renew, imposing a surcharge on, or otherwise increasing the rate for a motor vehicle liability insurance policy based on factors other than the status of a driver under the policy as a volunteer driver.

§19–519.

(a) Notwithstanding any other provision of law, an authorized motor vehicle insurer and the Maryland Automobile Insurance Fund may reinstate, without a lapse in coverage, a private passenger motor vehicle liability insurance policy that was canceled by the insurer or the Fund for nonpayment of premium on payment by the policyholder of:

(1) all earned premiums owed to the insurer or the Fund; and

(2) any reasonable fee approved by the Commissioner under § 27–216(b)(5) of this article.

(b) Before an authorized motor vehicle insurer or the Maryland Automobile Insurance Fund reinstates a policy under this section, the policyholder shall provide to the insurer or the Fund a written certification, in the form and manner specified by the insurer or the Fund, that no losses were incurred by the policyholder from the

time and date the policy was canceled through the time and date the policy is reinstated.

(c) A reinstatement of a policy by an authorized motor vehicle insurer or the Maryland Automobile Insurance Fund under this section:

(1) shall be implemented in accordance with written underwriting guidelines adopted by the insurer or the Fund; and

(2) is subject to the requirements of § 27–501(a) of this article in the same manner as a cancellation, a refusal to underwrite, or a refusal to renew a risk or class of risk.

§19–520.

(a) (1) In this section the following words have the meanings indicated.

(2) "Car sharing delivery period" means the period of time during which a shared motor vehicle is being delivered to the location of the car sharing start time, as documented by the shared vehicle owner under a peer–to–peer car sharing program agreement.

(3) "Car sharing period" means the period of time that commences with the car sharing delivery period and ends at the car sharing termination time.

(4) "Car sharing start time" means the time when a shared motor vehicle becomes subject to the control of the shared vehicle driver at or after the time the reservation of a shared motor vehicle is scheduled to begin as documented in the records of a peer–to–peer car sharing program.

(5) "Car sharing termination time" means:

(i) the time when the shared motor vehicle is returned to the location designated by the shared vehicle owner through a peer–to–peer car sharing program; and

(ii) the earliest of the following occurs:

1. the expiration of the agreed period of time established for the use of the shared motor vehicle;

2. the intent to terminate the use of the shared motor vehicle is verifiably communicated to the peer–to–peer car sharing program; or

3. the shared vehicle owner, or the shared vehicle owner's authorized designee, takes possession and control of the shared motor vehicle.

(6) "Intentional or fraudulent material misrepresentation" means an affirmative statement or an omission by a shared vehicle owner that misrepresents material facts about the shared vehicle owner or the shared motor vehicle.

(7) "Motor vehicle" has the meaning stated in § 11–135 of the Transportation Article.

(8) "Peer–to–peer car sharing" means the authorized use of a motor vehicle by an individual other than the vehicle's owner through a peer–to–peer car sharing program.

(9) "Peer–to–peer car sharing program" means a platform that is in the business of connecting vehicle owners with drivers to enable the sharing of motor vehicles for financial consideration.

(10) "Peer–to–peer car sharing program agreement" means the written terms and conditions applicable to a shared vehicle owner and a shared vehicle driver that govern the use of a shared vehicle through a peer–to–peer car sharing program under the provisions of this section and Title 18.5 of the Transportation Article.

(11) "Shared motor vehicle" means a motor vehicle that is available for sharing through a peer–to–peer car sharing program.

(12) "Shared vehicle driver" means an individual who has:

(i) reserved the use of a shared motor vehicle through a peer–to–peer car sharing program; and

(ii) been authorized to drive the shared motor vehicle by the peer–to–peer car sharing program.

(13) "Shared vehicle owner" means the registered owner of a motor vehicle made available for sharing to shared vehicle drivers through a peer–to–peer car sharing program.

(b) (1) Solely on the basis that a motor vehicle is shared through a peer–to–peer car sharing program:

(i) a peer–to–peer car sharing program may not be considered to have rented the vehicle under Title 18, Subtitle 1 of the Transportation Article;

(ii) the shared vehicle owner may not be considered to have rented a vehicle under Title 18, Subtitle 1 of the Transportation Article; and

(iii) a peer–to–peer car sharing program may not be considered to be:

1. a rental vehicle company under § 18–108 of the Transportation Article; or

2. a motor vehicle rental company under Title 10, Subtitle 6 of this article.

(2) Subject to subsection (e)(1) of this section, the use of a shared motor vehicle through a peer–to–peer car sharing program does not constitute a commercial use solely on the basis that the motor vehicle is available for sharing or used through a peer–to–peer car sharing program.

(c) (1) (i) Except as provided in subparagraph (ii) of this paragraph, a peer–to–peer car sharing program shall assume the liability of a shared vehicle owner for any bodily injury or property damage to third parties or uninsured and underinsured motorist or personal injury protection losses during the car sharing period in an amount stated in the peer–to–peer car sharing program agreement, which amount may not be less than the minimum amount of security required under § 17–103 of the Transportation Article.

(ii) Except for the minimum security required under § 17–103 of the Transportation Article for any injured person who did not make the intentional or fraudulent misrepresentation, the assumption of liability under paragraph (1) of this subsection does not apply if the shared vehicle owner made an intentional or fraudulent material misrepresentation to the peer–to–peer car sharing program before the car sharing period in which the loss occurred.

(2) Paragraph (1) of this subsection does not limit:

(i) the liability of the peer–to–peer car sharing program for any act or omission of the peer–to–peer car sharing program itself that results in injury to any person as a result of the use of a shared motor vehicle through a peer–to–peer car sharing program; or

(ii) the ability of the peer–to–peer car sharing program to, by contract, seek indemnification from the shared vehicle owner or the shared vehicle

driver for economic loss sustained by the peer–to–peer car sharing program resulting from a breach of the terms and conditions of the peer–to–peer car sharing program agreement.

(3) Each peer–to–peer car sharing program agreement made with respect to a car sharing arrangement in the State shall disclose to the shared vehicle owner and the shared vehicle driver:

(i) any right of the peer–to–peer car sharing program to seek indemnification from the shared vehicle owner or the shared vehicle driver for economic loss sustained by the peer–to–peer car sharing program resulting from a breach of the terms and conditions of the peer–to–peer car sharing program agreement;

(ii) that a motor vehicle liability insurance policy issued to the shared vehicle owner for the shared motor vehicle or to the shared vehicle driver does not provide a defense or indemnification for any claim asserted by the peer–to–peer car sharing program under item (i) of this paragraph;

(iii) that the peer–to–peer car sharing program's insurance coverage on the shared vehicle owner and the shared vehicle driver is in effect only during each car sharing period and that, for any use of the shared motor vehicle by the shared vehicle driver after the car sharing termination time, the shared vehicle driver and the shared vehicle owner should contact the shared vehicle driver's or the shared vehicle owner's insurer about insurance coverage; and

(iv) the daily rate, fees, any insurance costs, and any protection package costs that are charged to the shared vehicle owner or the shared vehicle driver.

(4) At the time when a vehicle owner registers as a shared vehicle owner on a peer–to–peer car sharing program and prior to the time when the shared vehicle owner makes a shared motor vehicle available for car sharing on the peer–to–peer car sharing program, the peer–to–peer car sharing program shall notify the shared vehicle owner that, if the shared motor vehicle has a lien against it, the use of the shared motor vehicle through a peer–to–peer car sharing program, including use without physical damage coverage, may violate the terms of the contract with the lienholder.

(d) (1) A peer–to–peer car sharing program shall ensure that, during each car sharing period, the shared vehicle owner and the shared vehicle driver are insured under a motor vehicle liability insurance policy that:

(i) provides coverage in amounts not less than those required under § 17–103 of the Transportation Article; and

(ii) 1. recognizes that the vehicle insured under the policy is made available and used through a peer–to–peer car sharing program; or

2. does not exclude the use of the shared motor vehicle by a shared vehicle driver.

(2) The insurance described under paragraph (1) of this subsection may be satisfied by motor vehicle liability insurance maintained by:

(i) a shared vehicle owner;

(ii) a shared vehicle driver;

(iii) a peer–to–peer car sharing program; or

(iv) any combination of a shared vehicle owner, a shared vehicle driver, and a peer–to–peer car sharing program.

(3) (i) In this paragraph, "replacement vehicle" means a shared motor vehicle that is used in a peer–to–peer car sharing program while a motor vehicle owned by the shared motor vehicle driver is not in use because of loss, as "loss" is defined in that individual's applicable private passenger automobile insurance policy, or because of breakdown, repair, service, or damage.

(ii) Notwithstanding paragraph (2)(ii) of this subsection, the Maryland Automobile Insurance Fund may not be required to provide coverage to a shared vehicle driver for use of a shared vehicle that is not a replacement vehicle.

(4) (i) A peer–to–peer car sharing program shall have an insurable interest in a shared motor vehicle during the car sharing period.

(ii) A peer–to–peer car sharing program may own and maintain as the named insured one or more policies of motor vehicle liability insurance that provides coverage in the amount of, in excess of, or optional to the minimum amount of coverage required to be provided under paragraph (1) of this subsection, including coverage for:

1. liabilities assumed by the peer–to–peer car sharing program under a peer–to–peer car sharing program agreement;

2. any liability of the shared vehicle owner;

3. damage or loss to the shared motor vehicle; and

4. any liability of the shared vehicle driver.

(iii) An offer by a peer–to–peer car sharing program to provide coverage to a shared vehicle driver in the amount of, in excess of, or optional to the minimum amount of coverage required to be provided under paragraph (1) of this subsection, whether on a stand–alone basis or as part of a financial protection package, shall be considered the sale or offer of insurance under Title 10, Subtitle 6A of this article.

(5) The insurance described under paragraph (1) of this subsection or authorized under paragraph (4) of this subsection shall:

(i) as to coverage of the shared vehicle driver, pay claims on a first dollar basis; and

(ii) be issued by:

1. an insurer authorized to do business in the State; or

2. solely with respect to insurance maintained by a peer–to–peer car sharing program under paragraph (4) of this subsection, an eligible surplus lines insurer:

A. in accordance with the requirements of Title 3, Subtitle 3 of this article; and

B. having an A.M. Best financial strength rating of A– or better.

(6) (i) The insurance described under paragraph (1) of this subsection shall, as to coverage of the shared vehicle owner, pay claims on a first dollar basis.

(ii) This paragraph may not apply to the terms and conditions under the insurance policy applicable to the peer–to–peer car sharing program.

(7) Consumer complaints concerning claims against a surplus lines policy issued in connection with, and incidental to, a peer–to–peer car sharing program agreement are subject to the Commissioner's authority under § 27–303 of this article.

(8) If the insurance maintained by a shared vehicle driver has lapsed, or is otherwise not in force, the peer–to–peer car sharing program's insurance coverage required under paragraph (1) of this subsection shall be primary.

(9) If a claim that arises out of an occurrence during the car sharing period occurred in another state with minimum financial responsibility limits higher than those required under § 17–103 of the Transportation Article, the coverage required under paragraph (1) of this subsection shall be in an amount up to the minimum coverage amount required in the state in which the claim occurred.

(e) (1) An authorized insurer that writes motor vehicle liability insurance in the State and the Maryland Automobile Insurance Fund may exclude any and all coverage and the duty to defend or indemnify for any claim afforded under a shared vehicle owner's personal motor vehicle liability insurance policy for any loss or injury that occurs during the car sharing period.

(2) A motor vehicle insurer that defends or indemnifies a claim against a driver that is excluded under the terms of its policy shall have the right to seek contribution against the motor vehicle insurer of the peer–to–peer car sharing program if the claim is:

(i) made against the shared vehicle owner or the shared vehicle driver for loss or injury that occurs during the car sharing period; and

(ii) excluded under the terms of its policy.

(3) Nothing in this section invalidates or limits an exclusion contained in a motor vehicle liability insurance policy, including any insurance policy in use or approved for use before October 1, 2018, that excludes coverage for motor vehicles made available for rent, sharing, or hire or for any business use.

(4) The right to exclude any and all coverage and the duty to defend under paragraph (1) of this subsection applies to any coverage included in a motor vehicle liability insurance policy, including:

(i) liability coverage for bodily injury and property damage;

(ii) uninsured and underinsured motorist coverage;

(iii) medical payments coverage;

(iv) personal injury protection coverage;

(v) comprehensive physical damage coverage; and

(vi) collision physical damage coverage.

(f) This section does not invalidate or limit an exclusion contained in a motor vehicle liability insurance policy, including an insurance policy in use or approved for use that excludes coverage for motor vehicles made available for rent, sharing, or hire or for a business use.

(g) (1) Coverage under a motor vehicle liability insurance policy maintained by a peer–to–peer car sharing program may not be dependent on the denial of a claim by another motor vehicle insurer.

(2) A motor vehicle insurer of a personal motor vehicle liability insurance policy may not be required to first deny a claim.

(h) A peer–to–peer car sharing program and a shared vehicle owner shall be exempt from vicarious liability consistent with 49 U.S.C. § 30106 and under any state or local law that imposes liability solely based on vehicle ownership.

(i) In a claim coverage investigation following a vehicular accident, a peer–to–peer car sharing program shall cooperate to facilitate the exchange of information with directly involved parties and any motor vehicle insurer of a shared vehicle owner regarding the vehicle's use in a peer–to–peer car sharing program.

§19–601.

The following may pool together to purchase property insurance or casualty insurance:

(1) associations, corporations, institutions, organizations, or societies that are exempt from taxation under § 501(c)(3) of the Internal Revenue Code;

(2) clubs that are organized and operated exclusively for recreational purposes and are exempt from taxation under § 501(c)(7) of the Internal Revenue Code;

(3) nonprofit associations, corporations, or other organizations that are comprised of residents of a community and are operated exclusively for the promotion of social welfare and general neighborhood improvement; and

(4) nonprofit organizations that are comprised of property owners in a subdivision or group of subdivisions and whose purpose is to represent the mutual

interests of the property owners regarding the construction, protection, and maintenance of commonly owned or used property and improvements.

§19–602.

(a) In this section, "public entity" means:

(1) a political subdivision of the State;

(2) a unit of the State or a local government;

(3) a nonprofit or nonstock corporation that:

(i) receives 50% or more of its annual operating budget from the State or a local government; and

(ii) is exempt from taxation under § 501(c)(3) or (4) of the Internal Revenue Code; or

(4) a Resilience Authority as defined in § 22–101 of the Local Government Article.

(b) Public entities may pool together to purchase casualty insurance, property insurance, or health insurance or to self–insure against casualty, property, or health risks.

§19–603.

(a) In this section, "local government" means a county or municipal corporation in the State.

(b) A local government:

(1) may enter into an agreement to fund an insurance pool established under this subtitle; and

(2) except as otherwise provided in this section, may determine by resolution the provisions, terms, conditions, and duration of the agreement.

(c) (1) Except as provided in paragraph (2) of this subsection, a payment obligation in an agreement authorized by this section:

(i) shall be a general obligation of the local government to which its full faith and credit and unlimited taxing power is pledged; and

(ii) may not be subject to annual appropriation by the local government.

(2) If a provision of the Maryland Constitution limits a local government in undertaking a payment obligation described in paragraph (1) of this subsection, or requires a local government to comply with certain procedures before undertaking a payment obligation described in paragraph (1) of this subsection, the local government may provide that the payment obligation is:

(i) a limited obligation of the local government repayable from assets and revenues as provided in the agreement; or

(ii) subject to annual appropriation by the local government.

(d) Subject to the limitations of this section, a local government may undertake a payment obligation in an agreement authorized by this section:

(1) without regard to any limitations contained in its charter or other applicable public local or public general law that otherwise would apply; and

(2) without complying with any procedures contained in its charter or other applicable public local or public general law that otherwise would be required.

(e) On the date a local government executes an agreement authorized by this section, the aggregate outstanding and unpaid principal amount that the local government is obligated to pay under the agreement may not exceed 0.2% of the local government's assessable base for real property tax purposes for the fiscal year in which the agreement is executed, as determined by the State Department of Assessments and Taxation.

§19–701.

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

(b) (1) "Affected property" means:

(i) 1. a residential rental property constructed before 1950 that contains not more than one rental dwelling unit; or

2. a residential rental property that contains not more than one rental dwelling unit for which the owner makes an election under § 6–803(a)(2) of the Environment Article; or

(ii) an individual rental dwelling unit within:

1. a residential rental property constructed before 1950 that contains more than one rental dwelling unit; or

2. a residential rental property that contains more than one rental dwelling unit for which the owner makes an election under § 6–803(a)(2) of the Environment Article.

(2) "Affected property" does not include property exempted under § 6–803(b) of the Environment Article.

(c) "Owner" has the meaning stated in § 6–801(o) of the Environment Article.

(d) "Rental dwelling unit" has the meaning stated in § 6–801(u) of the Environment Article.

§19–702.

This subtitle applies only to authorized insurers that deliver or issue for delivery in the State third party bodily injury liability insurance under:

(1) homeowner's coverage;

(2) owners', landlords', and tenants' coverage; or

(3) any other premises liability coverage.

§19–703.

(a) The Commissioner may adopt regulations to carry out this subtitle.

(b) The Commissioner shall review policy forms and endorsements to implement and enforce compliance with this subtitle.

§19–704.

(a) This section applies only to lead hazard coverage for affected properties.

(b) This section does not affect coverage for property damage or any other form of coverage provided in a policy or insurance contract for an affected property.

(c) Notwithstanding subsection (g) of this section, whenever an authorized insurer issues or renews a policy for an affected property, the authorized insurer may include in the policy a lead hazard coverage exclusion.

(d) If a policy issued or renewed by an authorized insurer on or after February 24, 1996, for an affected property contains a lead hazard coverage exclusion, the authorized insurer shall waive the exclusion to the extent of a qualified offer made or to be made under Title 6, Subtitle 8, Part V of the Environment Article:

(1) if the owner of the affected property complies with Title 6, Subtitle 8, Part III of the Environment Article;

(2) if at the election of the insured, and whether or not a change in occupancy has occurred, the affected property:

(i) passes the test for lead-contaminated dust under § 6-816 of the Environment Article; or

(ii) has undergone the lead hazard reduction treatments and complies with the risk reduction standard under § 6-815(a)(2) of the Environment Article; and

(3) if the insured submits to the authorized insurer a current verified report completed by an accredited inspector under § 6-818 of the Environment Article certifying that the affected property complies with the standards set forth in item (2) of this subsection.

(e) Instead of waiving a lead hazard coverage exclusion as required by subsection (d) of this section, after receiving approval from the Commissioner, an authorized insurer may offer an alternative form of coverage for a qualified offer made or to be made under Title 6, Subtitle 8, Part V of the Environment Article.

(f) An authorized insurer may exclude lead hazard coverage for an affected property in excess of the amount of a qualified offer made or to be made under Title 6, Subtitle 8, Part V of the Environment Article.

(g) (1) An authorized insurer may cancel or nonrenew lead hazard coverage or reimpose a lead hazard coverage exclusion in a policy for an affected property only if:

(i) the insured fails to:

1. pay the applicable premium;

2. provide the authorized insurer or the authorized insurer's designee reasonable access to the affected property to inspect for the presence or condition of lead;

3. comply with the terms or conditions of the policy; or

4. perform lead hazard reduction treatments; or

(ii) the affected property fails to comply or maintain compliance with the risk reduction standard under § 6-815(a)(2) of the Environment Article.

(2) (i) An authorized insurer may cancel or nonrenew lead hazard coverage or reimpose a lead hazard coverage exclusion under paragraph (1)(i)4 or (ii) of this subsection only if the authorized insurer:

1. mails written notice to the insured that the authorized insurer intends to cancel or nonrenew the coverage or to reimpose the exclusion; and

2. provides an opportunity to the insured to correct the violation within 30 days after the notice is mailed.

(ii) Coverage is automatically reinstated if the violation is corrected within 30 days after the notice is mailed.

(iii) Within 45 days after mailing a notice of cancellation or nonrenewal of coverage or reimposition of an exclusion under this paragraph, the authorized insurer shall send a copy of the notice to the Secretary of the Environment or a designee of the Secretary, and include the results of any inspection of the affected property.

§19–705.

An authorized insurer that provides lead hazard coverage for an affected property under this subtitle shall offer the coverage without a deductible, and may also offer the coverage with a deductible.

§19–706.

(a) Subject to reasonable notice provisions contained in a policy or insurance contract, the notice provided to an insured under § 6-828(b)(1) of the Environment Article that a person at risk has an elevated blood lead level shall be deemed a claim against the insured for the purpose of triggering the authorized

insurer's duty to respond on behalf of the insured in accordance with Title 6, Subtitle 8, Part V of the Environment Article.

(b) Notwithstanding § 6-831 of the Environment Article and §§ 19-704 and 19-705 of this subtitle, an authorized insurer is not liable for a qualified offer made under Title 6, Subtitle 8, Part V of the Environment Article if the qualified offer was made in violation of the terms of the policy or insurance contract.

§19–901.

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

(b) "Covered customer" has the meaning stated in § 10–701 of this article.

(c) "Customer" has the meaning stated in § 10–701 of this article.

(d) "Portable electronics" has the meaning stated in § 10–701 of this article.

(e) "Portable electronics insurance" has the meaning stated in § 10–701 of this article.

(f) "Vendor" has the meaning stated in § 10–701 of this article.

§19–902.

(a) Portable electronics insurance may be offered on a month–to–month or other periodic basis as a group or master commercial inland marine policy issued to a vendor under which individual customers may elect to purchase coverage under the policy.

(b) Eligibility and underwriting standards for customers purchasing coverage under a policy of portable electronics insurance shall be established for each portable electronics insurance policy.

§19–903.

(a) Notwithstanding any other provision of law and except as otherwise provided in this section, an insurer may not terminate or otherwise change the terms and conditions of a policy of portable electronics insurance unless the insurer provides the policyholder and covered customers with at least 60 days' notice.

(b) If the insurer changes the terms and conditions of a policy of portable electronics insurance in accordance with subsection (a) of this section, the insurer shall:

(1) provide the policyholder with a revised policy or endorsement; and

(2) provide each covered customer with:

(i) a revised certificate, endorsement, updated brochure, or other evidence that indicates that a change in the terms and conditions of the policy has occurred; and

(ii) a summary of material changes.

(c) An insurer may terminate coverage of a covered customer under a policy of portable electronics insurance:

(1) after 45 days' notice for discovery of fraud or material misrepresentation in obtaining coverage or in the presentation of a claim under the policy; or

(2) after 10 days' notice for nonpayment of premium.

(d) (1) An insurer may automatically terminate coverage of a covered customer under a policy of portable electronics insurance:

(i) if the covered customer ceases to have active service related to the use of portable electronics with the vendor; or

(ii) if:

1. the covered customer exhausts the aggregate limit of liability, if any, under the terms of the policy of portable electronics insurance; and

2. the insurer sends notice of termination to the covered customer within 15 business days after exhaustion of the limit, subject to paragraph (2) of this subsection.

(2) If the insurer does not send timely notice in accordance with paragraph (1)(ii) of this subsection, coverage shall continue under the policy of portable electronics insurance notwithstanding the aggregate limit of liability until the insurer sends notice of termination to the covered customer.

(e) Notwithstanding subsection (d)(1)(ii) of this section, on request of a covered customer, the covered customer shall be eligible for reinstatement of coverage not more than 12 months after the date of exhaustion of the coverage limit in

accordance with the terms of the policy and subject to the enrollment criteria then applicable to prospective customers generally.

(f) If a vendor terminates a policy of portable electronics insurance, the vendor shall mail or deliver, at least 45 days before termination, written notice to each covered customer that advises the covered customer of the termination of the policy and the effective date of termination.

(g) (1) An insurer is not required to give notice of termination to a covered customer if the insurer has been advised by either the vendor or another insurer that substantially similar coverage under a policy of portable electronics insurance has been obtained from another insurer without lapse of coverage.

(2) A vendor is not required to give notice of termination to a covered customer if substantially similar coverage under a policy of portable electronics insurance has been obtained from another insurer without lapse of coverage.

(h) (1) Whenever notice is required in accordance with this section, the notice shall be in writing and sent by mail or electronic means as specified in this subsection.

(2) (i) Unless notice by electronic means is authorized under paragraph (3) or (4) of this subsection, notice under this section shall be provided by mail in accordance with subparagraphs (ii) and (iii) of this paragraph.

(ii) Notice shall be mailed to the vendor at the vendor's last known mailing address on file with the insurer.

(iii) Notice shall be mailed to a covered customer at the covered customer's last known mailing address on file with the insurer or vendor.

(iv) The insurer or vendor responsible for mailing the notice under this section shall maintain proof of mailing.

(3) An insurer responsible for providing notice to a covered customer under this section may provide notice by electronic means if:

(i) the covered customer has provided an electronic mail address to the insurer or vendor to receive notices about coverage;

(ii) notice is sent to the electronic mail address provided by the covered customer; and

(iii) the insurer or vendor maintains proof that the notice was sent to the covered customer at the covered customer's electronic mail address.

(4) An insurer responsible for providing notice to a vendor under this section may provide notice by electronic means if:

(i) the vendor has provided an electronic mail address to the insurer at which the vendor consents to receive notices about the policy;

(ii) notice is sent to the electronic mail address provided by the vendor; and

(iii) the insurer maintains proof that the notice was sent to the vendor at the vendor's electronic mail address.

§19–1001.

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

(b) "Affiliated insurer" means:

(1) an insurer in the same corporate system as the insurer's parent; or

(2) a member organization having common ownership, control, operation, or management with the insurer.

(c) "Aggregator site" means a website that provides access to information regarding insurance products from more than one insurer, including product and insurer information, for use in comparison shopping.

(d) "Blanket travel insurance" means a policy of travel insurance issued to any eligible group providing coverage for specific classes of persons defined in the policy with coverage provided to all members of the eligible group without a separate charge to individual members of the eligible group.

(e) "Cancellation fee waiver" means a noninsurance contractual agreement between a person engaged in the business of arranging or supplying travel and the person's customer to waive some or all of a nonrefundable cancellation fee provision of the supplier's underlying travel contract, with or without regard to the reason for cancellation or form of reimbursement.

(f) "Eligible group" means two or more persons who are engaged in a common enterprise or who have an economic, educational, or social affinity or relationship, including:

(1) an entity engaged in the business of providing travel or travel services in which, with regard to any particular travel or type of travel or travelers, all members or customers of the group have common exposure to risk attendant to that travel, including:

(i) a tour operator;

(ii) a lodging provider;

(iii) a vacation property owner;

(iv) a hotel or resort;

(v) a travel club;

(vi) a travel agency;

(vii) a property manager;

(viii) a cultural exchange program;

(ix) a common carrier; and

(x) the operator, owner, or lessor of a means of transportation of passengers, including:

1. an airline;

2. a cruise line;

3. a railroad;

4. a steamship company; and

5. a public bus carrier;

(2) a college, school, or any other institution of learning providing travel insurance coverage for students, teachers, employees, or volunteers;

(3) an employer providing travel insurance coverage for employees, volunteers, contractors, boards of directors, or dependents, or guests of those persons;

(4) a sports team, camp, or sponsor of a sports team or camp providing travel insurance coverage for participants, members, campers, employees, officials, supervisors, or volunteers;

(5) a religious, charitable, recreational, educational, or civic organization or branch of the religious, charitable, recreational, educational, or civic organization providing travel insurance coverage for members, participants, or volunteers;

(6) a financial institution or financial institution vendor, or parent holding company, trustee, or agent of, or designated by, a financial institution or financial institution vendor, providing travel insurance coverage for account holders, credit card holders, debtors, guarantors, or purchasers;

(7) an incorporated or unincorporated association, including a labor union, that:

(i) has a common interest, constitution, and bylaws;

(ii) is organized and maintained in good faith for purposes other than obtaining insurance for members or participants of the association; and

(iii) provides travel insurance coverage for members of the association;

(8) a trust or the trustees of a fund, subject to the Commissioner's authorizing the use of a trust and the State's premium tax provisions under § 6–102 of this article:

(i) established, created, or maintained for the benefit of members, employees, or customers of an association described under item (7) of this subsection; and

(ii) providing travel insurance coverage for members, employees, or customers of the association;

(9) an entertainment production company providing travel insurance coverage for participants, volunteers, audience members, contestants, or workers;

(10) a volunteer fire department, an ambulance, a rescue, a police, a court, or any other volunteer agency having jurisdiction as a first aid or civil defense

group and providing travel insurance coverage for members, participants, or volunteers;

(11) a preschool, a day care institution for children or adults, or a senior citizen club providing travel insurance coverage for attendees or participants;

(12) an automobile or truck rental or leasing company:

(i) providing travel insurance coverage for individuals who may become renters, lessees, or passengers defined by the travel status of the individuals on the rented or leased vehicles; and

(ii) if the common carrier, operator, owner, or lessor of a means of transportation, or the automobile or truck rental or leasing company, is the policyholder or certificate holder of the travel insurance policy; and

(13) any other group for which the Commissioner determines that:

(i) the members of the group are engaged in a common enterprise or have an economic, educational, or social affinity or relationship; and

(ii) the issuance of the policy would not be contrary to the best interests of the public.

(g) "Fulfillment material" means documentation sent to the purchaser of a travel protection plan confirming the purchase and providing the travel protection plan's assistance and coverage details, including access to the policy or certificate of coverage, as applicable.

(h) "Group travel insurance" means travel insurance that provides coverage for certificate holders of an eligible group under a travel insurance policy issued to a policyholder.

(i) "Limited lines travel insurance producer" has the meaning stated in § 10–101 of this article.

(j) "Offer and disseminate" has the meaning stated in § 10–101 of this article.

(k) (1) "Travel assistance services" means noninsurance services that do not result in any transfer or shifting of risk that would constitute the business of insurance.

(2) "Travel assistance services" includes:

(i) a security advisory service;

(ii) a destination information service;

(iii) a vaccination and immunization information service;

(iv) a travel reservation service;

(v) an entertainment service;

(vi) an activity and event planning service;

(vii) a translation assistance service;

(viii) an emergency messaging service;

(ix) an international legal and medical referral service;

(x) a medical case monitoring service;

(xi) coordination of transportation arrangements;

(xii) emergency cash transfer assistance;

(xiii) medical prescription replacement assistance;

(xiv) passport and travel document replacement assistance;

(xv) lost luggage assistance;

(xvi) a concierge service; and

(xvii) any other services that are furnished in connection with planned travel.

(l) "Travel insurance" has the meaning stated in § 10–101 of this article.

(m) "Travel protection plan" means a plan that provides, in addition to travel insurance:

(1) travel assistance services; or

(2) a cancellation fee waiver.

(n) "Travel retailer" has the meaning stated in § 10–101 of this article.

§19–1002.

(a) The purpose of this subtitle is to promote the public welfare by creating a comprehensive legal framework within which travel insurance may be sold in the State.

(b) (1) This subtitle applies to travel insurance under policies and certificates delivered or issued for delivery in the State.

(2) (i) Except as otherwise expressly provided in this subtitle, this subtitle does not apply to a cancellation fee waiver or travel assistance services.

(ii) The following may not be construed to be insurance, as defined in § 1–101 of this article:

1. a cancellation fee waiver; or

2. travel assistance services.

(c) All other applicable provisions of this article apply to travel insurance, except that specific provisions of this subtitle supersede any general provisions of this article.

§19–1003.

Notwithstanding § 27–214 of this article, travel protection plans may be offered for one price for the combined features that the travel protection plan offers in the State if:

(1) the travel protection plan:

(i) clearly discloses to the consumer at or before the time of purchase that the plan includes travel insurance and, as applicable, travel assistance services or a cancellation fee waiver; and

(ii) provides information and an opportunity at or before the time of purchase for the consumer to obtain additional information regarding the features and pricing of the travel insurance, travel assistance services, and a cancellation fee waiver, as applicable; and

(2) the fulfillment material for the travel protection plan:

(i) describes and delineates the travel insurance, travel assistance services, and cancellation fee waiver in the travel protection plan;

(ii) includes the travel insurance disclosures required under State law; and

(iii) includes the contact information for the person providing the travel assistance services or cancellation fee waiver, as applicable.

§19–1004.

(a) Except as otherwise provided in this section, a person offering travel insurance to residents of the State is subject to Title 27 of this article.

(b) It is an unfair trade practice under Title 27 of this article for a person to offer or sell a travel insurance policy that could never result in payment of any claim for any insured under the policy.

(c) (1) Documents provided to a consumer before the purchase of travel insurance, including sales materials, advertising materials, and marketing materials, shall be consistent with the travel insurance policy itself, including forms, endorsements, policies, rate filings, and certificates of insurance.

(2) If a travel insurance policy or certificate contains a preexisting condition exclusion, information and an opportunity to learn more about the preexisting condition exclusion shall be provided any time before the time of purchase and in the travel protection plan's fulfillment material.

(3) (i) An insurer shall provide a policyholder or certificate holder at least 10 days after the later of the date of purchase of a travel protection plan or the policyholder's or certificate holder's receipt, either by physical or electronic means, of the travel protection plan's fulfillment material to review and, if desired, cancel the policy or certificate.

(ii) If the policyholder or certificate holder cancels the policy or certificate within the time period under subparagraph (i) of this paragraph, the insurer shall provide the policyholder or certificate holder a full refund of the travel protection plan price unless the insured has started the covered trip or filed a claim under the travel insurance coverage.

(4) (i) The fulfillment material shall disclose whether the travel insurance is primary or secondary to other applicable coverage.

(ii) Travel insurance is not subject to coordination of benefits for health insurance coverage.

(5) Subject to § 10–122 of this article, an action may not be deemed an unfair trade practice in violation of Title 27 of this article or other violation of law if:

(i) travel insurance is marketed directly to a consumer through an insurer's website or by another person through an aggregator site;

(ii) the insurer's website or aggregator site provides an accurate summary or short description of travel insurance coverage; and

(iii) the consumer has access to the full provisions of the travel insurance policy through electronic means.

(d) A person offering or selling travel insurance or a travel protection plan may not offer or sell the travel insurance or travel protection plan on an individual or group basis by using a negative option or an opt out provision that requires a consumer to take an affirmative action to refuse coverage, including unchecking a box on an electronic form, when the consumer purchases a trip.

(e) It is not an unfair trade practice under Title 27 of this article for a person to include blanket travel insurance with the purchase of a trip if the blanket travel insurance is not marketed as free of charge.

§19–1005.

The Commissioner may adopt regulations to carry out this subtitle.

§19–1101.

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

(b) "Chronic condition" means a condition that can be treated or managed, but not cured.

(c) "Congenital anomaly or disorder" means a condition that is present from birth, whether inherited or caused by the environment, that may cause or contribute to illness or disease.

(d) "Hereditary disorder" means an abnormality that is genetically transmitted from parent to offspring and may cause illness or disease.

(e) (1) "Orthopedic condition" means a condition affecting the bones, skeletal muscle, cartilage, tendons, ligaments, or joints.

(2) "Orthopedic condition" includes elbow dysplasia, hip dysplasia, intervertebral disc degeneration, patellar luxation, and ruptured cranial cruciate ligaments.

(3) "Orthopedic condition" does not include:

(i) cancer; or

(ii) a metabolic, hemopoietic, or autoimmune disease.

(f) (1) "Pet insurance policy" means a property insurance policy that is sold by a pet insurer or pet insurance producer that provides coverage for accidents and illnesses of pets.

(2) "Pet insurance policy" includes a certificate or add–on coverage.

(g) (1) "Preexisting condition" means a condition for which any of the following are true before the effective date of a pet insurance policy or during any waiting period:

(i) a veterinary practitioner provided medical advice;

(ii) the pet received treatment; or

(iii) based on information from verifiable sources, the pet had signs or symptoms directly related to the condition for which a claim is being made.

(2) "Preexisting condition" does not include, for a renewal of a pet insurance policy, a condition for which coverage was afforded on the previous policy.

(h) "Renewal" means the issuance and delivery at the end of a pet insurance policy period of a policy that:

(1) supersedes the policy previously issued and delivered by the same pet insurer or affiliated pet insurer; and

(2) provides types and limits of coverage substantially similar to those contained in the prior policy.

(i) (1) "Veterinary expenses" means the costs associated with medical advice, diagnosis, care, or treatment provided by a veterinary practitioner.

(2) "Veterinary expenses" includes the cost of drugs prescribed by a veterinary practitioner.

(j) "Veterinary practitioner" has the meaning stated in § 2–301 of the Agriculture Article.

(k) "Waiting period" means the period of time specified in a new pet insurance policy that must elapse before some or all of the coverage in the policy begins.

(l) "Wellness program" means a subscription– or reimbursement–based program that:

(1) is separate from a pet insurance policy; and

(2) provides goods and services to promote the general health, safety, or well–being of the pet.

§19–1102.

It is the intent of the General Assembly to promote the public welfare by creating a comprehensive legal framework within which pet insurance may be sold in the State.

§19–1103.

(a) This subtitle applies only to pet insurance policies or certificates that are:

(1) issued to a resident of the State; or

(2) sold, solicited, negotiated, or offered in the State.

(b) All other applicable provisions of this article apply to pet insurance, except that specific provisions of this subtitle supersede any general provisions of this article.

§19–1104.

(a) A pet insurer transacting pet insurance shall disclose the following to consumers:

(1) all policy exclusions, including exclusions of coverage due to:

(i) a preexisting condition;

(ii) a hereditary disorder;

(iii) a congenital anomaly or disorder; or

(iv) a chronic condition;

(2) any policy provision that limits coverage through a waiting period, a deductible, coinsurance, or an annual or lifetime policy limit;

(3) whether the pet insurer reduces coverage or increases premiums based on the insured's claim history, the age of the covered pet, or a change in the geographic location of the insured; and

(4) the identity of the underwriting company if the company differs from the brand name used to market and sell the pet insurance policy.

(b) (1) A notice shall be prominently printed on or attached to the face of the pet insurance policy that states that:

(i) the policy may be surrendered to the insurer for cancellation within 10 days after the date the policy is delivered to the insured; and

(ii) if a policy is canceled during the 10–day period, a pro rata premium for the unexpired term of the policy shall be returned to the insured.

(2) An insured is not entitled to a pro rata premium in accordance with paragraph (1)(ii) of this subsection if the insured has made a claim under the pet insurance policy.

(c) A pet insurer shall clearly disclose a summary description of the basis or formula on which the pet insurer determines claim payments under a pet insurance policy:

(1) within the policy;

(2) before issuing the policy; and

(3) through a clear and conspicuous link on the main page of the website of the pet insurer or pet insurer's program administrator.

(d) If a pet insurer uses a benefit schedule to determine claim payment under a pet insurance policy, the pet insurer shall:

(1) clearly disclose the applicable benefit schedule in the policy; and

(2) disclose all benefit schedules used by the pet insurer under its pet insurance policies through a clear and conspicuous link on the main page of the website of the pet insurer or pet insurer's program administrator.

(e) If a pet insurer determines claim payments under a pet insurance policy that are based on usual and customary fees, or any other reimbursement limitation based on prevailing veterinary practitioner charges, the pet insurer shall:

(1) include a usual and customary fee limitation provision in the policy that clearly describes:

(i) the pet insurer's basis for determining usual and customary fees; and

(ii) how the basis is applied in calculating claim payments; and

(2) disclose the pet insurer's basis for determining usual and customary fees through a clear and conspicuous link on the main page of the website of the pet insurer or pet insurer's program administrator.

(f) If a medical examination by a veterinary practitioner is required to begin coverage, the pet insurer shall:

(1) clearly and conspicuously disclose the required aspects of the examination before purchase of the pet insurance policy; and

(2) disclose that examination documentation may result in a preexisting condition exclusion.

(g) A pet insurer shall clearly and prominently disclose any waiting periods and the requirements applicable to the waiting periods before purchase of the pet insurance policy.

(h) (1) A pet insurer shall:

(i) include with a copy of the pet insurance policy a summary of all policy provisions required in accordance with subsections (a) through (g) of this section in a separate document in at least 12 point type titled: "Insurer Disclosure of Important Policy Provisions"; and

(ii) include the document required under item (i) of this paragraph on the website of the pet insurer or pet insurer's program administrator through a clear and conspicuous link on the main page of the website.

(2) The document required under paragraph (1)(i) of this subsection shall include all relevant definitions established under § 19–1101 of this subtitle.

(i) At the time a pet insurance policy is issued or delivered to a policyholder, the pet insurer shall include the following information, printed in 12 point boldface type:

(1) the Administration's mailing address, toll–free telephone number, and website address;

(2) the address and customer service telephone number of the pet insurer or the insurance producer of record for the pet insurer; and

(3) if the policy was issued or delivered by an insurance producer, a statement advising the policyholder to contact the insurance producer for assistance.

(j) The disclosure requirements required in accordance with this section shall be in addition to any other applicable disclosure requirements under this article or regulations adopted under this article.

§19–1105.

(a) (1) A pet insurer may issue policies that exclude coverage on the basis of one or more preexisting conditions with appropriate disclosure to the consumer.

(2) The pet insurer has the burden of proving that the preexisting condition exclusion applies to the condition for which a claim is made.

(b) (1) (i) Subject to subparagraphs (ii) and (iii) of this paragraph, a pet insurer may issue a policy that imposes a waiting period before coverage under the policy begins.

(ii) A waiting period may not exceed 30 days for an illness or orthopedic condition that does not result from an accident.

(iii) A pet insurer may not impose a waiting period for an illness or orthopedic condition that results from an accident.

(2) (i) A pet insurer that imposes a waiting period under paragraph (1) of this subsection shall include a provision in the pet insurance policy that allows for the waiving of waiting periods on completion of a medical examination.

(ii) 1. A pet insurer may require a medical examination under subparagraph (i) of this paragraph to be conducted by a veterinary practitioner after the purchase of the policy.

2. Unless the pet insurance policy specifies that the pet insurer will pay for a medical examination under subparagraph (i) of this paragraph, a policyholder shall pay for the medical examination.

3. A pet insurer may:

A. specify elements to be included as part of a medical examination under subparagraph (i) of this paragraph; and

B. if the specifications do not unreasonably restrict a policyholder's ability to waive the waiting period, require documentation of the medical examination.

(3) A pet insurer shall clearly and prominently disclose requirements with respect to applicable waiting periods before purchase of the policy.

(c) A pet insurer shall require that an insured submit a claim under the pet insurance policy after submitting payment to the veterinary practitioner for veterinary expenses.

(d) A pet insurer may not require a medical examination of the covered pet as a condition for the renewal of a policy.

(e) A prescriptive, wellness, or noninsurance benefit included in the policy form for a pet insurance policy is part of the policy and subject to this article and regulations adopted under this article.

(f) A pet insurer may not condition an insured's eligibility to purchase a pet insurance policy on participation, or lack of participation, in a separate wellness program.

§19–1106.

(a) A pet insurer or pet insurance producer may not, except as provided in subsection (c) of this section and § 19–1107 of this subtitle, market a wellness program as a pet insurance policy.

(b) If a pet insurer or pet insurance producer sells a wellness program:

(1) the purchase of the wellness program may not be a requirement to purchase the pet insurance;

(2) the costs and the terms and conditions of the wellness program shall be separate and identifiable from any pet insurance policy sold by a pet insurer or pet insurance producer;

(3) the products or coverages available through the wellness program may not duplicate products or coverages available through the pet insurance policy;

(4) the advertising of the wellness program shall accurately and clearly describe the wellness program; and

(5) the pet insurer or pet insurance producer shall clearly and in 12 point boldface type disclose to consumers:

(i) that, except as provided in subsection (c) of this section and § 19–1107 of this subtitle, wellness programs are not insurance;

(ii) the Administration's mailing address, toll–free telephone number, and website address; and

(iii) the address and customer service telephone number of the pet insurer or producer or insurance producer of record for the pet insurer.

(c) Coverage that is included in the pet insurance policy contract described as a "wellness" benefit is insurance.

§19–1107.

If a wellness program contracts to indemnify or to pay or provide a specified determinable amount or benefit on the occurrence of a determinable contingency, the wellness program shall be considered insurance and be subject to the provisions of this article and regulations adopted under this article.

§20–101.

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

(b) "Association" means the Industry Automobile Insurance Association.

(c) (1) "Association member" means an insurer that is licensed to write motor vehicle liability insurance or motor vehicle physical damage insurance in the State.

(2) "Association member" does not include the Fund.

(d) "Board of Directors" means the Board of Directors of the Association.

(e) "Board of Trustees" means the Board of Trustees of the Fund.

(f) "Executive Director" means the Executive Director of the Fund.

(g) "Fund" means the Maryland Automobile Insurance Fund.

(h) "Motor vehicle liability insurance" means insurance coverage that is reported as private passenger auto no-fault, other private passenger auto liability, commercial auto no-fault, or other commercial auto liability on the exhibit of premiums and losses page of the annual statement that Association members are required to file with the Commissioner.

(i) "Motor vehicle physical damage insurance" means insurance coverage that is reported as private passenger auto physical damage or commercial auto physical damage on the exhibit of premiums and losses page of the annual statement that Association members are required to file with the Commissioner.

(j) "Person" includes a governmental unit.

(k) "Uninsured Division" means the unit within the Fund that is responsible for claims under Subtitle 6 of this title and activities related to reducing the rate of uninsured motorists in the State.

(l) "Uninsured motor vehicle" means a motor vehicle for which:

(1) the security required under § 17–103 of the Transportation Article is not in force; or

(2) the security required under § 17–103 of the Transportation Article is in force but a receiver or conservator has been appointed by a court for the insurer that issued the security.

§20–201.

(a) There is a Maryland Automobile Insurance Fund.

(b) The Fund is independent of all State units.

(c) The Fund is a member of the Property and Casualty Insurance Guaranty Corporation.

(d) (1) Except as otherwise provided by law, the Fund is subject to the provisions of this article.

(2) Except as provided in paragraph (3) of this subsection, the Fund is not subject to any law, including § 6–106 of the State Government Article, that affects governmental units.

(3) The Fund is subject to:

(i) Title 4 of the General Provisions Article;

(ii) the Maryland Public Ethics Law;

(iii) Title 10, Subtitle 1 of the State Government Article with respect to regulations adopted under Subtitle 6 of this title;

(iv) Title 12 of the State Government Article; and

(v) Title 5, Subtitle 3 of the State Personnel and Pensions Article.

(4) Paragraph (2) of this subsection does not affect the exemption from property tax under § 7–210 of the Tax – Property Article.

§20–202.

(a) There is a Board of Trustees of the Fund.

(b) (1) The Board of Trustees consists of nine members appointed by the Governor with the advice and consent of the Senate.

(2) Of the nine members:

(i) at least three shall have insurance industry expertise; and

(ii) at least two shall have financial management expertise.

(3) Of the members described in paragraph (2)(i) of this subsection, at least one shall be appointed from a list of two or more individuals recommended by the Board of Directors.

(c) A member may not be actively affiliated with an insurance agency, insurance producer, insurer, or premium finance company that does business with the Fund.

(d) (1) Each member shall be a resident of the State.

(2) In deciding which individuals to appoint, the Governor, to the extent practicable, shall consider the geographic and demographic, including race and gender, diversity of the State.

(e) Before taking office, each appointee to the Board of Trustees shall take the oath required by Article I, § 9 of the Maryland Constitution.

(f) (1) The term of a member is 5 years.

(2) The terms of members are staggered as required by the terms provided for members of the Board of Trustees on October 1, 2013.

(3) At the end of a term, a member continues to serve until a successor is appointed and qualifies.

(4) A member may not serve for more than:

(i) two full terms; or

(ii) a total of 10 years.

(5) If a member of the Board of Trustees ceases to be a member of the Board, the Governor shall appoint a successor for the unexpired term.

(g) The Board of Trustees shall choose a chair from among its members.

(h) The Governor may remove a member of the Board of Trustees for incompetence or misconduct.

(i) (1) Each member of the Board of Trustees is entitled to:

(i) reasonable compensation:

1. in the form of salary for work performed for the benefit of the Fund; and

2. as provided in the budget of the Board of Trustees; and

(ii) reimbursement for expenses:

1. incurred in the performance of the member's duties; and

2. as provided in the budget of the Board of Trustees.

(2) Nothing in paragraph (1)(i) of this subsection requires a member of the Board of Trustees to take compensation if the member has a conflict of interest with other employment that precludes the member from taking compensation for work performed for the benefit of the Fund.

(j) The Board of Trustees:

(1) shall adopt rules, bylaws, and procedures; and

(2) may adopt any policy to carry out this title.

§20–203.

(a) (1) The Board of Trustees shall:

(i) appoint the Executive Director of the Fund; and

(ii) employ attorneys to advise and represent the Fund in all legal matters and, where necessary, to sue or defend suits in the name of the Fund.

(2) The Executive Director serves at the pleasure of the Board of Trustees.

(3) If the Board of Trustees fails to agree on a successor Executive Director, the Governor shall appoint the successor.

(b) (1) The Executive Director:

(i) is the administrative head of the Fund; and

(ii) shall exercise the powers and perform the duties conferred on the Fund by this title, except for those powers and duties conferred on the Board of Trustees.

(2) The Board of Trustees shall advise the Executive Director on the exercise of the powers and duties conferred on the Executive Director by this title.

(c) The Board of Trustees shall determine the compensation of the Executive Director.

§20–204.

(a) (1) Except as provided in paragraph (2) of this subsection, employees of the Fund are not in the State Personnel Management System.

(2) A skilled service employee of the Fund hired before July 1, 2013, in a nonprofessional or nontechnical position shall remain in the skilled service in the State Personnel Management System or its equivalent as long as the employee remains in a nonprofessional or nontechnical position with the Fund.

(3) The Executive Director shall appoint and remove employees of the Fund in accordance with the policies of the Board of Trustees.

(4) Notwithstanding any other provision of law, the Executive Director may appoint claims adjusters, attorneys, and other necessary personnel directly as employees or on a contract basis.

(b) The Executive Director shall determine and administer the compensation of the employees of the Fund with the approval of the Board of Trustees.

(c) Except as otherwise provided in this subtitle, an employee of the Fund is not subject to any law, regulation, or executive order governing State employee compensation, including furloughs, salary reductions, and any other General Fund cost–saving measure.

§20–301.

(a) The purpose of the Fund is to provide the financial security required under § 17–103 of the Transportation Article to those eligible persons that are unable to obtain it from an Association member.

(b) Money of the Fund consists of revenues, premiums, and other receipts provided by law.

(c) (1) All operating expenses of the Fund shall be paid from the money collected by or for the Fund.

(2) (i) Subject to subparagraphs (ii) through (iv) of this paragraph, money and property available to the Fund may be used for the general purposes of the Fund.

(ii) Premiums collected and income accruing from those premiums may be used only for the payment of claims arising under policies issued by the Fund and for the administrative expenses of the Fund.

(iii) The Fund shall keep separate records of any income and expenses directly attributable to the Uninsured Division, including the processing and payment of unsatisfied claims under Subtitle 6 of this title.

(iv) The Fund shall keep separate records of any income and expenses directly attributable to its commercial policy and claims operations.

§20–302.

(a) The account of the Fund is a special fund account and is not a part of the State Treasury.

(b) The State may not provide General Fund appropriations to the Fund.

(c) The debts and obligations of the Fund are not a debt of the State or a pledge of the credit of the State.

§20–303.

(a) (1) A financial management committee of the Fund shall manage and invest all money collected by or for the Fund through premiums, earnings from investments, or from other sources.

(2) The financial management committee consists of the Executive Director and two members of the Board of Trustees who have financial management expertise, chosen by the Board of Trustees.

(b) (1) Whenever the amount of money in the Fund exceeds the amount that the Executive Director believes is likely to be required immediately, the financial management committee may manage the excess as it considers appropriate and invest the excess in investments legal for casualty insurers under §§ 5–601 through 5–609 of this article.

(2) If use of the excess becomes necessary or expedient, the financial management committee may collect, sell, or otherwise realize on the investment and any accrued interest.

(c) (1) (i) Consistent with minority business purchasing standards applicable to units of State government under the State Finance and Procurement Article and consistent with the fiduciary duties of the financial management committee, the financial management committee shall attempt to use to the greatest extent feasible minority business enterprises to provide brokerage and investment management services to the committee.

(ii) For purposes of this subsection, brokerage and investment management services shall include services relating to all allocated asset classes.

(2) (i) To assist it in achieving the goal described under paragraph (1) of this subsection, the financial management committee shall undertake measures to remove any barriers that limit full participation by minority business enterprises in brokerage and investment management services opportunities afforded by the Fund.

(ii) The measures undertaken by the financial management committee shall include the use of a wide variety of media, including the Fund's website, to provide notice to a broad and varied range of potential providers about the brokerage and investment management services opportunities afforded by the Fund.

(3) In conjunction with the Governor's Office of Small, Minority, and Women Business Affairs, the financial management committee shall develop guidelines to assist the committee in identifying and evaluating qualified minority business enterprises in order to help the Fund achieve the objective for greater use of minority business enterprises for brokerage and investment management services.

(4) On or before September 1 each year, the financial management committee shall submit a report to the Governor's Office of Small, Minority, and Women Business Affairs and, subject to § 2–1257 of the State Government Article, the General Assembly on:

(i) the identity of the minority business enterprise brokerage and investment management services firms used by the financial management committee in the immediately preceding fiscal year;

(ii) the percentage and dollar value of the Fund assets that are under the investment control of minority business enterprise brokerage and investment management services firms in each allocated asset class; and

(iii) the measures the financial management committee undertook in the immediately preceding fiscal year in accordance with paragraph (2)(ii) of this subsection.

§20–304.

(a) (1) An audit committee, composed of members of the Board of Trustees, shall require the Fund's internal auditor to conduct fiscal compliance and fiscal audits of the accounts and transactions of the Fund each year.

(2) A fiscal compliance audit shall:

(i) examine financial transactions and records and internal controls;

(ii) evaluate compliance with applicable laws and regulations; and

(iii) examine electronic data processing operations.

(b) If an independent auditor conducts a fiscal audit of the Fund, the audit committee shall direct the Fund's internal auditors not to duplicate the fiscal audit for the same period.

§20–305.

(a) The Fund shall provide each commercial policyholder with a notice stating the expiration date of the current policy at least 45 days before the expiration of the current policy.

(b) If a commercial policyholder requests a rewritten policy with the Fund and the policyholder's fund producer is unable to generate a new rewritten policy quote without the assistance of the Fund, the Fund shall provide the policyholder's fund producer with a rewritten policy quote within 7 days after the Fund has received all necessary information from the fund producer.

§20–306.

(a) In this section, "company action level RBC" has the meaning stated in § 4–301(n)(1) of this article.

(b) The Fund shall calculate and report its RBC level in accordance with Title 4, Subtitle 3 of this article.

(c) Beginning December 31, 2026, the Fund shall maintain total adjusted capital, as defined in § 4–301(r) of this article, in an amount that is greater than or equal to its company action level RBC.

§20–401.

There is an Industry Automobile Insurance Association.

§20–402.

(a) The Association consists of all insurers except for the Fund that are licensed to write on a direct basis motor vehicle liability insurance or motor vehicle physical damage insurance in the State.

(b) As a condition of its authority to write motor vehicle liability insurance or motor vehicle physical damage insurance in the State, an insurer must be and remain an Association member.

§20–403.

(a) There is a Board of Directors to administer the Association.

(b) (1) The Board of Directors consists of nine members elected by Association members.

(2) Of the nine members of the Board of Directors:

(i) four shall be nominated by the American Property Casualty Insurance Association;

(ii) one shall be associated with a domestic insurer that is not affiliated with the American Property Casualty Insurance Association;

(iii) two may not be affiliated with a member company of the American Property Casualty Insurance Association or with a domestic insurer that is otherwise represented on the Board of Directors; and

(iv) two shall be nominated by the members of the Board of Directors selected under items (i) through (iii) of this paragraph.

(3) The term of a member of the Board of Directors is 1 year.

(4) If the American Property Casualty Insurance Association fails to submit the name of a nominee at least 10 days before the election, the requirement that four directors be from among nominees of that group need not be met for that year.

§20–404.

(a) On or before March 15 of each year, the Fund shall determine and the Board of Trustees shall certify to the Board of Directors the information required under subsections (b) and (c) of this section.

(b) Subject to subsection (f) of this section, the following information certified to the Board of Directors shall be separately identified by commercial auto and private passenger auto results:

(1) the statutory operating loss for the immediately preceding calendar year;

(2) a calculation to yield a private passenger auto assessment limit that is determined by subtracting the year–end total surplus of the Fund for the immediately preceding calendar year from an amount equal to 25% of the average of net direct written private passenger auto premiums of the Fund for each of the three immediately preceding calendar years; and

(3) a calculation to yield a commercial auto assessment limit that is determined by subtracting the year–end commercial auto surplus of the Fund for the immediately preceding calendar year from an amount equal to 25% of the average of net direct written commercial auto premiums of the Fund for each of the 3 immediately preceding calendar years.

(c) The assessment certified to the Board of Directors shall be equal to:

(1) subject to subsection (d) of this section, the assessment limit, if the assessment limit is less than or equal to the statutory operating loss; or

(2) the statutory operating loss, if the assessment limit is greater than the statutory operating loss.

(d) If the calculation under subsection (b)(2) of this section yields a number that is less than or equal to zero, the assessment limit is zero.

(e) The statutory operating loss or assessment certified to the Board of Directors may not include:

(1) assessment money received for a prior year; or

(2) money transferred between the commercial auto and private passenger auto divisions within the Fund.

(f) In a calculation made under this section, income or expenses not clearly attributable to either commercial auto or private passenger auto may be allocated pro rata for that year.

(g) Promptly after the certification of an assessment by the Board of Trustees for commercial auto or private passenger auto under subsection (c) of this section the Board of Directors shall notify the Commissioner of the certification.

(h) On the Commissioner's verification of the Board of Trustees' certification, the Board of Directors shall authorize the Fund to withdraw:

(1) an amount equal to the commercial auto or private passenger auto assessment, if the assessment balance for that portion exceeds the assessment; or

(2) the entire commercial auto or private passenger auto balance, if the assessment equals or exceeds the balance for that portion.

(i) Association members may not be subject to an annual assessment if the amount of money held by the Fund from a prior overassessment is equal to or greater than the assessment.

(j) Association members are subject to an annual assessment under § 20–405 of this subtitle if the amount of money held by the Fund from a prior overassessment is less than the assessment, based on the difference between:

(1) the commercial auto assessment or private passenger auto assessment; and

(2) the applicable amount of money held by the Fund from a prior overassessment.

(k) (1) On June 1, 2023, the Board of Directors shall authorize the Fund to withdraw from the money held by the Fund from a prior overassessment.

(2) The funds withdrawn:

(i) shall be allocated to the surplus of the Fund; and

(ii) may not be credited to Association members.

(l) On or before July 1, 2023, the Fund shall submit a report to the General Assembly, in accordance with § 2–1257 of the State Government Article, on the application of the funds withdrawn under this section and all fund balances in the Fund's Insured and Uninsured Divisions.

§20–405. IN EFFECT

(a) In this section, "net direct written premiums" means direct gross premiums written on all policies of motor vehicle liability insurance and motor vehicle physical damage insurance less return premiums or dividends paid or credited to policyholders with respect to those policies.

(b) On or before June 30 of each year in which the Board of Directors receives the certification of an actual commercial auto or private passenger auto assessment for a preceding calendar year, the Board of Directors shall perform the duties specified in this section.

(c) The Board of Directors shall obtain from the Commissioner the aggregate net direct written premiums of all Association members during the most recent calendar year determined by the Commissioner for commercial auto and private passenger auto divisions of motor vehicle liability insurance and motor vehicle physical damage insurance.

(d) (1) The Board of Directors shall calculate assessment allocation percentages for commercial auto and private passenger auto divisions by dividing the most recent certified assessment for commercial auto and private passenger auto divisions by the total of:

(i) the respective aggregate net direct written premiums obtained under subsection (c) of this section; and

(ii) the respective total net direct written premiums of the Fund for the same period.

(2) The assessment allocation percentage for the private passenger auto division may not exceed 3%.

(e) The Board of Directors shall give notice of the assessment allocation percentages determined under this section to the Fund, the Commissioner, and all Association members.

(f) The Board of Directors promptly shall assess and collect from each Association member for the commercial auto and private passenger auto divisions an assessment obtained by:

(1) multiplying the Association member's net direct written premiums in each division for the most recent calendar year determined by the Commissioner by the appropriate assessment allocation percentage, calculated under subsection (d) of this section; and

(2) adjusting the resulting product for any shortfall experienced by the Association member for the previous applicable surcharge year.

(g) An Association member may deduct an assessment payment from a retaliatory tax but may not deduct the payment from any other assessment or tax required by law.

(h) (1) The Association:

(i) first, shall deposit the certified assessment into the Insufficiency Assessment Reserve Fund that is created under § 20–410 of this subtitle and apply the appropriate parts of the certified assessment to the private passenger auto and commercial auto divisions of the Insufficiency Assessment Reserve Fund; and

(ii) then, shall pay to the Fund the entire certified assessment in one sum, less the part of the certified assessment allocated to the Fund.

(2) Any money in the Insufficiency Assessment Reserve Fund from a previous year shall be paid to the Fund on December 31 of each year.

§20–405. ** TAKES EFFECT JULY 1, 2027 PER CHAPTERS 741 AND 742 OF 2026 **

// EFFECTIVE UNTIL JUNE 30, 2029 PER CHAPTERS 741 AND 742 OF 2026 //

(a) In this section, "net direct written premiums" means direct gross premiums written on all policies of motor vehicle liability insurance and motor vehicle physical damage insurance less return premiums or dividends paid or credited to policyholders with respect to those policies.

(b) On or before June 30 of each year in which the Board of Directors receives the certification of an actual commercial auto or private passenger auto

assessment for a preceding calendar year, the Board of Directors shall perform the duties specified in this section.

(c) The Board of Directors shall obtain from the Commissioner the aggregate net direct written premiums of all Association members during the most recent calendar year determined by the Commissioner for commercial auto and private passenger auto divisions of motor vehicle liability insurance and motor vehicle physical damage insurance.

(d) (1) The Board of Directors shall calculate assessment allocation percentages for commercial auto and private passenger auto divisions by dividing the most recent certified assessment for commercial auto and private passenger auto divisions by the total of:

(i) the respective aggregate net direct written premiums obtained under subsection (c) of this section; and

(ii) the respective total net direct written premiums of the Fund for the same period.

(2) The assessment allocation percentage for the private passenger auto division may not exceed 1%.

(e) The Board of Directors shall give notice of the assessment allocation percentages determined under this section to the Fund, the Commissioner, and all Association members.

(f) The Board of Directors promptly shall assess and collect from each Association member for the commercial auto and private passenger auto divisions an assessment obtained by:

(1) multiplying the Association member's net direct written premiums in each division for the most recent calendar year determined by the Commissioner by the appropriate assessment allocation percentage, calculated under subsection (d) of this section; and

(2) adjusting the resulting product for any shortfall experienced by the Association member for the previous applicable surcharge year.

(g) An Association member may deduct an assessment payment from a retaliatory tax but may not deduct the payment from any other assessment or tax required by law.

(h) (1) The Association:

(i) first, shall deposit the certified assessment into the Insufficiency Assessment Reserve Fund that is created under § 20–410 of this subtitle and apply the appropriate parts of the certified assessment to the private passenger auto and commercial auto divisions of the Insufficiency Assessment Reserve Fund; and

(ii) then, shall pay to the Fund the entire certified assessment in one sum, less the part of the certified assessment allocated to the Fund.

(2) Any money in the Insufficiency Assessment Reserve Fund from a previous year shall be paid to the Fund on December 31 of each year.

§20–405. // EFFECTIVE JUNE 30, 2029 PER CHAPTERS 741 AND 742 OF 2026 //

(a) In this section, "net direct written premiums" means direct gross premiums written on all policies of motor vehicle liability insurance and motor vehicle physical damage insurance less return premiums or dividends paid or credited to policyholders with respect to those policies.

(b) On or before June 30 of each year in which the Board of Directors receives the certification of an actual commercial auto or private passenger auto assessment for a preceding calendar year, the Board of Directors shall perform the duties specified in this section.

(c) The Board of Directors shall obtain from the Commissioner the aggregate net direct written premiums of all Association members during the most recent calendar year determined by the Commissioner for commercial auto and private passenger auto divisions of motor vehicle liability insurance and motor vehicle physical damage insurance.

(d) (1) The Board of Directors shall calculate assessment allocation percentages for commercial auto and private passenger auto divisions by dividing the most recent certified assessment for commercial auto and private passenger auto divisions by the total of:

(i) the respective aggregate net direct written premiums obtained under subsection (c) of this section; and

(ii) the respective total net direct written premiums of the Fund for the same period.

(2) The assessment allocation percentage for the private passenger auto division may not exceed 3%.

(e) The Board of Directors shall give notice of the assessment allocation percentages determined under this section to the Fund, the Commissioner, and all Association members.

(f) The Board of Directors promptly shall assess and collect from each Association member for the commercial auto and private passenger auto divisions an assessment obtained by:

(1) multiplying the Association member's net direct written premiums in each division for the most recent calendar year determined by the Commissioner by the appropriate assessment allocation percentage, calculated under subsection (d) of this section; and

(2) adjusting the resulting product for any shortfall experienced by the Association member for the previous applicable surcharge year.

(g) An Association member may deduct an assessment payment from a retaliatory tax but may not deduct the payment from any other assessment or tax required by law.

(h) (1) The Association:

(i) first, shall deposit the certified assessment into the Insufficiency Assessment Reserve Fund that is created under § 20–410 of this subtitle and apply the appropriate parts of the certified assessment to the private passenger auto and commercial auto divisions of the Insufficiency Assessment Reserve Fund; and

(ii) then, shall pay to the Fund the entire certified assessment in one sum, less the part of the certified assessment allocated to the Fund.

(2) Any money in the Insufficiency Assessment Reserve Fund from a previous year shall be paid to the Fund on December 31 of each year.

§20–406.

(a) (1) The Commissioner promptly shall review the assessment allocation percentages calculated by the Association.

(2) Unless the Commissioner finds the calculation to be inaccurate, the Commissioner shall authorize each Association member to impose an assessment

surcharge on each policy of motor vehicle liability insurance or motor vehicle physical damage insurance that is written or renewed in the State during the 1-year period beginning on the next July 1 following notice of the assessment.

(3) Subject to § 20-407 of this subtitle, the assessment surcharge shall be calculated by applying the appropriate assessment allocation percentage that is adjusted for any excess or shortfall to the premium at the inception or renewal of the policy.

(4) The assessment surcharge may not be:

(i) subject to change or refund; or

(ii) considered premium income for the State premium tax or the payment of commissions.

(b) (1) In conformity with §§ 20-405 through 20-409 of this subtitle, each year the Fund shall impose an assessment surcharge on all of its policyholders as if the Fund were a member of the Association.

(2) The Fund may not make a payment to the Insufficiency Assessment Reserve Fund.

(3) The Fund shall account separately for the assessment surcharges that the Fund assesses and receives.

§20–407.

(a) On or before June 30 of each year, each Association member shall elect whether to recoup its share of the assessment for the immediately preceding year by imposing an assessment surcharge, where appropriate, on each of the Association member's commercial auto policyholders or private passenger auto policyholders, or both.

(b) An Association member that does not elect on or before June 30 to recoup its share of an assessment is considered to have recouped that assessment and to have waived its option to impose an assessment surcharge on its policyholders.

(c) (1) This section does not deny an Association member the right to:

(i) absorb an annual assessment; or

(ii) recover all or part of an annual assessment as costs in rate filings made under this article.

(2) An Association member that recovers assessments as costs in rate filings shall identify the assessment on any premium billing to the policyholder.

§20–408.

(a) (1) Each Association member shall apply and collect any assessment surcharge that the Association member elects to recoup under § 20-407 of this subtitle.

(2) Policyholders of an Association member shall receive any excess surcharge credits and may be charged for any surcharge shortfall that the Association member receives from or is charged by the Association.

(b) (1) If an Association member elects on or before June 30 to recoup its share of an assessment, the Association member must identify clearly the assessment surcharge imposed on its policyholders by stating on the premium billing of each policyholder: "Recoupment of MAIF assessment, $_____".

(2) No other statement may accompany the premium billing.

(c) Each Association member shall:

(1) report quarterly to the Association; and

(2) require an officer of the Association member to certify, in the manner required by the Board of Directors, that any amounts collected and paid are an accurate accounting of the assessment surcharges of the Association member.

(d) (1) Each Association member may keep separate and detailed records of any expenses actually incurred that are directly attributable to collection of the assessment surcharge authorized under subsection (a) of this section.

(2) The Commissioner shall consider verified and relevant expenses to be appropriate cost items in a subsequent rate filing by the Association member.

(e) If a policyholder fails to pay the assessment surcharge when due, the Association member may cancel the policy in accordance with the terms of the policy for nonpayment of premium.

§20–409.

(a) If the aggregate amount of assessment surcharges received by an Association member during a surcharge year is less than that Association member's

assessment payment, the Association member's assessment surcharge authorized under § 20–406 of this subtitle shall be increased accordingly for the next appropriate surcharge year.

(b) (1) If the aggregate amount of assessment surcharges received by an Association member during a recoupment year exceeds the Association member's assessment payment, the Association shall promptly return the excess to the association member.

(2) An Association member to whom an excess is returned under paragraph (1) of this subsection shall:

(i) refund the excess to the policyholders who paid the excess; or

(ii) apply the excess as an expense reduction in a subsequent rate filing.

§20–410.

(a) There is an Insufficiency Assessment Reserve Fund.

(b) The Insufficiency Assessment Reserve Fund shall be maintained by the Association and shall consist of assessment payments collected by the Association and interest, if any.

(c) (1) Except as provided in paragraph (2) of this subsection, the Association shall hold money of the Insufficiency Assessment Reserve Fund in trust in a separate interest–bearing account in a financial institution in the State for the use of the Fund.

(2) The Association may authorize the financial institution where the money is deposited to invest all or part of the money in investments allowed for casualty insurers, as provided in §§ 5–601 through 5–609 of this article.

(d) An Association member shall deposit with the Association any gross excess surcharges received because of a future assessment not later than October 15 after the surcharge year in which the gross excess surcharge was received.

§20–411.

(a) All money that the Fund receives from the Association to pay an assessment during the calendar year shall be considered a direct contribution to surplus for purposes of the annual statement.

(b) (1) The Fund shall include in its annual statement to the Commissioner an accounting of all money received during the preceding calendar year from the Insufficiency Assessment Reserve Fund.

(2) When filing a rate with the Commissioner, the Fund may not consider money that is received from or that remains in the Insufficiency Assessment Reserve Fund.

§20–501.

(a) In this subtitle, "covered vehicle" means a vehicle for which the Fund is required to provide coverage under this subtitle.

(b) "Covered vehicle" includes:

(1) any motor vehicle required to be registered under Title 13 of the Transportation Article;

(2) a moped; and

(3) a motor scooter.

§20–502.

(a) On payment of the premium set by the Fund, the Fund is authorized to and shall sell, issue, and deliver a policy that provides the security required under § 17–103 of the Transportation Article to a person:

(1) that owns a covered vehicle registered with the Motor Vehicle Administration, has a license issued by the Motor Vehicle Administration to drive a covered vehicle, or is a lessee under a "lease not intended as security", as defined in § 11–127.2(b) of the Transportation Article;

(2) that does not owe to the Fund:

(i) an unpaid premium with respect to a policy that has expired or been canceled; or

(ii) a claim payment obtained by fraud;

(3) that:

(i) has attempted in good faith to obtain a policy that provides the security required under § 17–103 of the Transportation Article from at least two Association members and has been rejected or refused the policy by two Association members for any reason other than nonpayment of premiums;

(ii) has had a policy that provides the security required under § 17–103 of the Transportation Article canceled or nonrenewed by an Association member for any reason other than nonpayment of premiums; or

(iii) has had a motor vehicle liability insurance policy but has been uninsured for a continuous period of 12 months or more immediately preceding the effective date of the Fund policy, as verified by a commercial third–party database or a State agency; and

(4) that meets the requirements of subsection (b) of this section.

(b) To be eligible for a policy issued under this subtitle, a person must:

(1) be domiciled in the State;

(2) own, lease, or rent a primary place of residence in the State and, regardless of the person's domicile, reside in the State for more than 1 year;

(3) maintain a main or branch office or warehouse facility in the State, and base and operate motor vehicles intrastate in the State;

(4) have filed as a State resident for income tax purposes; or

(5) have a nonresident permit issued under § 13–402.1(e) of the Transportation Article.

(c) (1) Except as provided in paragraph (2) of this subsection, this section does not apply to a person to the extent that the person:

(i) leases a covered vehicle that is a private passenger vehicle to an individual who does not meet the requirements of subsection (b) of this section; or

(ii) garages the covered vehicle principally outside of the State.

(2) This section applies to a person described in paragraph (1) of this subsection who is:

(i) a member, on active duty, of the uniformed services; or

(ii) a student enrolled in an accredited school, college, or university or serving a medical internship.

(d) The eligibility of an applicant for insurance from the Fund shall be certified at a time and in a manner approved by the Fund.

(e) (1) If a prospective insured fails to qualify under this section, any policy issued is void and a commission may not be paid by the Fund to a fund producer.

(2) (i) Subject to the provisions of subparagraph (ii) of this paragraph, if a person fails to meet the requirements of subsection (b) of this section, the Fund may charge and collect the greater of:

1. a policy processing fee to cover its expenses; or

2. the amount that the person would have received after the Fund returns to a fund producer, or any other person other than the person who fails to meet the requirements of subsection (b) of this section, any gross unearned premiums that are due under the policy.

(ii) Prior to charging and collecting a policy processing fee or the amount allowed under subparagraph (i) of this paragraph, the Fund shall refer to the Insurance Fraud Division in the Administration for investigation and possible prosecution of the person who fails to meet the requirements of subsection (b) of this section.

§20–503.

(a) Each policy issued by the Fund shall contain the minimum coverages required under Title 19, Subtitle 5 of this article and may contain other provisions determined by the Executive Director and approved by the Board of Trustees and the Commissioner.

(b) At the time a policy of private passenger auto liability insurance is issued to an applicant, the Fund shall include in the policy a written notice to the applicant that contains the following disclosures:

(1) the time and the conditions under which the applicant is eligible to seek insurance from an Association member;

(2) that if the applicant seeks insurance from an Association member, the Association member may not refuse to underwrite the private passenger

auto liability insurance risk solely because the applicant or named insured previously obtained insurance from the Fund; and

(3) that if the applicant seeks insurance from an Association member and the Association member refuses to underwrite the applicant solely because the applicant or named insured previously obtained insurance from the Fund, the applicant may file a complaint with the Commissioner against that Association member.

(c) Whenever the Fund issues a policy of commercial auto liability insurance under this subtitle, the Fund:

(1) may provide coverages in addition to and in excess of the minimum coverages required by Title 19, Subtitle 5 of this article and by Title 17 of the Transportation Article; but

(2) is not required to provide coverages in addition to and in excess of the required minimum coverages except to the extent that reinsurance for the additional or excess coverage is available and acceptable to the Fund.

§20–504.

(a) (1) In this section, "add–on coverage" means coverages or services sold in connection with a policy issued by the Fund, other than coverages authorized to be offered by the Fund under this subtitle.

(2) "Add–on coverage" includes:

(i) rental reimbursement coverage;

(ii) personal effects theft coverage;

(iii) collision and comprehensive deductible waiver coverage, other than collision and comprehensive coverages provided by the Fund or other authorized insurers;

(iv) supplemental hospital benefit coverage;

(v) emergency living expense coverage;

(vi) vehicle towing coverage;

(vii) emergency vehicle repair service coverage; and

(viii) motor club services.

(3) "Add–on coverage" does not include fire, life, and health insurance coverages that are not directly related to the underlying motor vehicle insurance coverage and are written by an authorized insurer.

(b) (1) At the time coverage provided by the Fund is bound and before any add–on coverage is sold, a fund producer shall provide a clear and conspicuous written disclosure, in the form approved by the Commissioner, that:

(i) states that the cost of add–on coverage is not part of the premium for the related policy issued by the Fund;

(ii) includes an itemized list of any add–on coverages to be sold to the insured;

(iii) states the nature and cost of each add–on coverage to be sold; and

(iv) states that add–on coverage is optional and is not required under § 17–103 of the Transportation Article.

(2) Before an insured may purchase add–on coverage, the insured shall expressly consent to the purchase by signing the disclosure form.

(c) On continuation of a policy that includes add–on coverage, an insured need not sign a disclosure form if:

(1) the number and type of add–on coverages under the continuation do not change from the preceding policy; and

(2) the insured has signed the original disclosure form.

(d) (1) A fund producer may not:

(i) require an insured or prospective insured to purchase an add–on coverage as a condition to purchasing the related policy issued by the Fund; or

(ii) sell add–on coverage or any combination of add–on coverages in an amount that exceeds $200 per covered vehicle in connection with a private passenger auto insurance policy.

(2) A pattern or practice of violations of this section by a fund producer is subject to the same penalties as a violation of § 20–513 of this subtitle.

§20–505.

(a) The Executive Director shall settle, compromise, or defend claims against the Fund.

(b) Notwithstanding § 9-602 of the Criminal Law Article, the Executive Director may authorize an employee of the Fund to record a telephone conversation with a policyholder, witness, claimant, investigating officer, or other interested party if:

(1) the conversation is relevant to an accident or claim;

(2) the party to be recorded has or might have information that is relevant to the accident or claim; and

(3) before recording, the party to be recorded is advised of and consents to the recording.

§20–506.

(a) The Executive Director shall:

(1) establish and maintain reasonable and adequate reserves for payment of claims against the Fund; and

(2) use the same criteria as is required for use by an Association member in determining the amount of reserves that are necessary.

(b) At least annually, the Board of Trustees shall review the reasonableness and adequacy of reserves.

§20–507. IN EFFECT

(a) Subject to the authority of the Commissioner to determine whether rates are excessive, inadequate, or unfairly discriminatory, as provided in Title 11, Subtitle 2 or Subtitle 3 of this article, the Executive Director shall determine the premiums to be charged on policies issued by the Fund.

(b) (1) Except as provided in subsections (c) and (d) of this section, the provisions of Title 11, Subtitle 3 of this article apply to the determination of premiums by the Executive Director and the filing of rates with the Commissioner.

(2) Notwithstanding Title 11, Subtitle 2 or Subtitle 3 of this article or any other provision of this title, the Executive Director may base premiums on one or both of the following items:

(i) the number of points accumulated by an insured or applicant for insurance under the point system provided for in Title 16, Subtitle 4 of the Transportation Article; or

(ii) the prior claims experience of an insured or applicant for insurance.

(c) The provisions of Title 11, Subtitle 2 of this article apply to the determination of premiums by the Executive Director and the filing of rates with the Commissioner:

(1) between July 1, 2025, and December 31, 2025, both inclusive; and

(2) beginning January 1, 2026, if the Fund's total adjusted capital is less than the amount required under § 20–306(c) of this title.

(d) (1) Premiums for all commercial coverage shall be determined in accordance with this section and § 20–508 of this subtitle.

(2) Notwithstanding paragraph (1) of this subsection, the rating principles under subsection (e) of this section may not be used to determine the premium for commercial coverage.

(e) In reviewing rates filed by the Fund, the Commissioner shall consider not only the rating principles under Title 11, Subtitle 2 or Subtitle 3 of this article but also the statutory purpose of the Fund under § 20–301 of this title.

(f) (1) The Motor Vehicle Administration and Executive Director may arrange for the Motor Vehicle Administration to collect premiums on policies issued by the Fund when the Motor Vehicle Administration issues a driver's license or certificate of registration.

(2) A premium collected under this subsection shall be paid to the State Treasurer for the account of the Fund.

(g) (1) The Fund may not provide directly or indirectly for the financing of premiums.

(2) A premium may be financed only by a premium finance company registered with the Commissioner in accordance with § 23–201 of this article.

(3) If a prospective insured's initial payment to the Fund, a fund producer, or premium finance company is not honored, a policy or endorsement issued in reliance on that payment is void.

(h) (1) (i) Subject to the approval of the Commissioner and in accordance with this subsection, the Fund may accept premiums on an installment payment basis.

(ii) In approving the Fund's plan for accepting premiums on an installment payment basis, the Commissioner shall:

1. consider as factors:

A. the percentage of the initial premium payment in comparison to the total premium under the policy;

B. the number of installment premium payments accepted on a policy under the installment payment plan; and

C. the overall affordability of the installment payment plan in comparison to other payment options available to the policyholder; and

2. ensure that the Fund's installment payment plan meets the requirements of § 27–216 of this article.

(2) The Fund may not discriminate among insureds by charging different premiums to insureds who select, as a payment option, the Fund's installment payment plan instead of a premium finance agreement.

(3) In determining commissions paid to a fund producer, the Fund may not consider whether the fund producer placed an insured in an installment payment plan.

(4) (i) In accordance with this paragraph, written and electronic communications, including the Fund's website, affecting the placement of coverage by the Fund or a fund producer shall include a statement, on a form approved by the Commissioner, advising an applicant or an insured of the payment options available to the applicant or insured.

(ii) The statement shall state that the applicant or insured has the following payment options:

1. the Fund's installment payment plan;

2. a premium finance agreement; or

3. payment of the policy in full.

(iii) The statement shall be included on written or electronic communications at the time the applicant or insured:

1. is issued a new policy; or

2. is issued a reissuance, rewrite, or renewal of an existing policy.

(iv) The statement shall state that the applicant or insured should consult a fund producer who will fully describe the terms of each payment option.

(i) (1) If the Fund makes a change to its plan for accepting premiums on an installment payment basis, within 90 days after the change, the Commissioner shall submit a report to the General Assembly providing the reason for the change.

(2) The report required under paragraph (1) of this subsection shall:

(i) include the effect the change will have on the required factors for consideration under subsection (h)(1)(ii)1 of this section; and

(ii) be submitted in accordance with § 2–1257 of the State Government Article.

§20–507. ** TAKES EFFECT JULY 1, 2027 PER CHAPTERS 741 AND 742 OF 2026 **

// EFFECTIVE UNTIL JUNE 30, 2029 PER CHAPTERS 741 AND 742 OF 2026 //

(a) Subject to the authority of the Commissioner to determine whether rates are excessive, inadequate, or unfairly discriminatory, as provided in Title 11, Subtitle 2 or Subtitle 3 of this article, the Executive Director shall determine the premiums to be charged on policies issued by the Fund.

(b) (1) Except as provided in subsections (c) and (d) of this section, the provisions of Title 11, Subtitle 3 of this article apply to the determination of premiums by the Executive Director and the filing of rates with the Commissioner.

(2) Notwithstanding Title 11, Subtitle 2 or Subtitle 3 of this article or any other provision of this title, the Executive Director may:

(i) base premiums on one or both of the following items:

1. the number of points accumulated by an insured or applicant for insurance under the point system provided for in Title 16, Subtitle 4 of the Transportation Article; or

2. the prior claims experience of an insured or applicant for insurance; and

(ii) establish an affordability program in accordance with § 20–521 of this subtitle.

(c) The provisions of Title 11, Subtitle 2 of this article apply to the determination of premiums by the Executive Director and the filing of rates with the Commissioner:

(1) between July 1, 2025, and December 31, 2025, both inclusive; and

(2) beginning January 1, 2026, if the Fund's total adjusted capital is less than the amount required under § 20–306(c) of this title.

(d) (1) Premiums for all commercial coverage shall be determined in accordance with this section and § 20–508 of this subtitle.

(2) Notwithstanding paragraph (1) of this subsection, the rating principles under subsection (e) of this section may not be used to determine the premium for commercial coverage.

(e) In reviewing rates filed by the Fund, the Commissioner shall consider not only the rating principles under Title 11, Subtitle 2 or Subtitle 3 of this article but also the statutory purpose of the Fund under § 20–301 of this title.

(f) (1) The Motor Vehicle Administration and Executive Director may arrange for the Motor Vehicle Administration to collect premiums on policies issued by the Fund when the Motor Vehicle Administration issues a driver's license or certificate of registration.

(2) A premium collected under this subsection shall be paid to the State Treasurer for the account of the Fund.

(g) (1) The Fund may not provide directly or indirectly for the financing of premiums.

(2) A premium may be financed only by a premium finance company registered with the Commissioner in accordance with § 23–201 of this article.

(3) If a prospective insured's initial payment to the Fund, a fund producer, or premium finance company is not honored, a policy or endorsement issued in reliance on that payment is void.

(h) (1) (i) Subject to the approval of the Commissioner and in accordance with this subsection, the Fund may accept premiums on an installment payment basis.

(ii) In approving the Fund's plan for accepting premiums on an installment payment basis, the Commissioner shall:

1. consider as factors:

A. the percentage of the initial premium payment in comparison to the total premium under the policy;

B. the number of installment premium payments accepted on a policy under the installment payment plan; and

C. the overall affordability of the installment payment plan in comparison to other payment options available to the policyholder; and

2. ensure that the Fund's installment payment plan meets the requirements of § 27–216 of this article.

(2) The Fund may not discriminate among insureds by charging different premiums to insureds who select, as a payment option, the Fund's installment payment plan instead of a premium finance agreement.

(3) In determining commissions paid to a fund producer, the Fund may not consider whether the fund producer placed an insured in an installment payment plan.

(4) (i) In accordance with this paragraph, written and electronic communications, including the Fund's website, affecting the placement of coverage

by the Fund or a fund producer shall include a statement, on a form approved by the Commissioner, advising an applicant or an insured of the payment options available to the applicant or insured.

(ii) The statement shall state that the applicant or insured has the following payment options:

1. the Fund's installment payment plan;

2. a premium finance agreement; or

3. payment of the policy in full.

(iii) The statement shall be included on written or electronic communications at the time the applicant or insured:

1. is issued a new policy; or

2. is issued a reissuance, rewrite, or renewal of an existing policy.

(iv) The statement shall state that the applicant or insured should consult a fund producer who will fully describe the terms of each payment option.

(i) (1) If the Fund makes a change to its plan for accepting premiums on an installment payment basis, within 90 days after the change, the Commissioner shall submit a report to the General Assembly providing the reason for the change.

(2) The report required under paragraph (1) of this subsection shall:

(i) include the effect the change will have on the required factors for consideration under subsection (h)(1)(ii)1 of this section; and

(ii) be submitted in accordance with § 2–1257 of the State Government Article.

§20–507. // EFFECTIVE JUNE 30, 2029 PER CHAPTERS 741 AND 742 OF 2026 //

(a) Subject to the authority of the Commissioner to determine whether rates are excessive, inadequate, or unfairly discriminatory, as provided in Title 11, Subtitle 2 or Subtitle 3 of this article, the Executive Director shall determine the premiums to be charged on policies issued by the Fund.

(b) (1) Except as provided in subsections (c) and (d) of this section, the provisions of Title 11, Subtitle 3 of this article apply to the determination of premiums by the Executive Director and the filing of rates with the Commissioner.

(2) Notwithstanding Title 11, Subtitle 2 or Subtitle 3 of this article or any other provision of this title, the Executive Director may base premiums on one or both of the following items:

(i) the number of points accumulated by an insured or applicant for insurance under the point system provided for in Title 16, Subtitle 4 of the Transportation Article; or

(ii) the prior claims experience of an insured or applicant for insurance.

(c) The provisions of Title 11, Subtitle 2 of this article apply to the determination of premiums by the Executive Director and the filing of rates with the Commissioner:

(1) between July 1, 2025, and December 31, 2025, both inclusive; and

(2) beginning January 1, 2026, if the Fund's total adjusted capital is less than the amount required under § 20–306(c) of this title.

(d) (1) Premiums for all commercial coverage shall be determined in accordance with this section and § 20–508 of this subtitle.

(2) Notwithstanding paragraph (1) of this subsection, the rating principles under subsection (e) of this section may not be used to determine the premium for commercial coverage.

(e) In reviewing rates filed by the Fund, the Commissioner shall consider not only the rating principles under Title 11, Subtitle 2 or Subtitle 3 of this article but also the statutory purpose of the Fund under § 20–301 of this title.

(f) (1) The Motor Vehicle Administration and Executive Director may arrange for the Motor Vehicle Administration to collect premiums on policies issued by the Fund when the Motor Vehicle Administration issues a driver's license or certificate of registration.

(2) A premium collected under this subsection shall be paid to the State Treasurer for the account of the Fund.

(g) (1) The Fund may not provide directly or indirectly for the financing of premiums.

(2) A premium may be financed only by a premium finance company registered with the Commissioner in accordance with § 23–201 of this article.

(3) If a prospective insured's initial payment to the Fund, a fund producer, or premium finance company is not honored, a policy or endorsement issued in reliance on that payment is void.

(h) (1) (i) Subject to the approval of the Commissioner and in accordance with this subsection, the Fund may accept premiums on an installment payment basis.

(ii) In approving the Fund's plan for accepting premiums on an installment payment basis, the Commissioner shall:

1. consider as factors:

A. the percentage of the initial premium payment in comparison to the total premium under the policy;

B. the number of installment premium payments accepted on a policy under the installment payment plan; and

C. the overall affordability of the installment payment plan in comparison to other payment options available to the policyholder; and

2. ensure that the Fund's installment payment plan meets the requirements of § 27–216 of this article.

(2) The Fund may not discriminate among insureds by charging different premiums to insureds who select, as a payment option, the Fund's installment payment plan instead of a premium finance agreement.

(3) In determining commissions paid to a fund producer, the Fund may not consider whether the fund producer placed an insured in an installment payment plan.

(4) (i) In accordance with this paragraph, written and electronic communications, including the Fund's website, affecting the placement of coverage by the Fund or a fund producer shall include a statement, on a form approved by the Commissioner, advising an applicant or an insured of the payment options available to the applicant or insured.

(ii) The statement shall state that the applicant or insured has the following payment options:

1. the Fund's installment payment plan;

2. a premium finance agreement; or

3. payment of the policy in full.

(iii) The statement shall be included on written or electronic communications at the time the applicant or insured:

1. is issued a new policy; or

2. is issued a reissuance, rewrite, or renewal of an existing policy.

(iv) The statement shall state that the applicant or insured should consult a fund producer who will fully describe the terms of each payment option.

(i) (1) If the Fund makes a change to its plan for accepting premiums on an installment payment basis, within 90 days after the change, the Commissioner shall submit a report to the General Assembly providing the reason for the change.

(2) The report required under paragraph (1) of this subsection shall:

(i) include the effect the change will have on the required factors for consideration under subsection (h)(1)(ii)1 of this section; and

(ii) be submitted in accordance with § 2–1257 of the State Government Article.

§20–508.

(a) A policyholder is entitled to continuation of coverage from the Fund at rates that are reasonably comparable to those charged by standard insurers and approved by the Commissioner if, for 3 continuous years of coverage under a policy issued by the Fund, the policyholder has not:

(1) been charged with a moving traffic violation;

(2) had a chargeable traffic accident; and

(3) been assessed more than one point by the Motor Vehicle Administration.

(b) A policyholder who meets the requirements of subsection (a) of this section is not entitled to a safe driver credit as defined in the rules and rate schedules of the Fund filed with the Commissioner.

(c) In determining eligibility for rates that are reasonably comparable to those charged by standard insurers, the Fund may not consider:

(1) a lapse in coverage of 30 days or less; and

(2) the addition of a driver to the policy who has certified in a manner approved by the Fund for the immediately preceding 3 continuous years that the driver has not had a moving traffic violation, has not been assessed more than one point, and has not had a chargeable traffic accident.

§20–509.

(a) (1) Subject to this section and the policies adopted by the Board of Trustees that relate to the binding of coverage, a fund producer may bind the minimum required coverage for an applicant in the Fund if the applicant submits an application to the fund producer and pays the appropriate premium.

(2) To effect coverage, the fund producer must receive payment of the appropriate premium required under the policies adopted by the Board of Trustees that relate to the binding of coverage.

(3) Payment of the appropriate premium does not occur so as to effect coverage if payment of all or part of the premium is made by an instrument that is later dishonored.

(b) (1) The Board of Trustees shall adopt and make available to each fund producer reasonable policies that relate to the authority of fund producers to bind coverage.

(2) The policies shall include:

(i) the amount of premium to be collected;

(ii) the evidence necessary to establish the qualification of an applicant to be insured by the Fund;

(iii) procedures for notifying the Fund of the binding of coverage; and

(iv) the time within which the fund producer is to give notice.

(c) The Fund:

(1) may refuse to grant the authority of a fund producer to an insurance producer that has been previously terminated as a fund producer or that has had its license previously revoked or surrendered; and

(2) subject to the hearing provisions of § 20-514 of this subtitle, may discipline a fund producer that:

(i) employs or otherwise retains a person described in item (1) of this subsection; and

(ii) allows the person to become involved in the fund producer's operations or management contrary to a requirement of this article or order of the Administration.

(d) Subject to subsection (e) of this section, the Fund is liable for coverage from the date that the fund producer binds coverage.

(e) (1) On review of an application, the Fund may cancel coverage and refuse to issue a policy if the Fund finds that:

(i) the applicant is not qualified for insurance issued by the Fund;

(ii) the applicant has not paid the appropriate premium; or

(iii) the Fund is authorized to reject the application under § 20-516 of this subtitle.

(2) Cancellation of coverage may occur not later than 60 days after coverage is effective.

(f) Whenever coverage is canceled:

(1) the Fund promptly shall notify the applicant, fund producer, and Motor Vehicle Administration of the cancellation;

(2) the applicant has the right of appeal under § 20-517 of this subtitle; and

(3) if the cancellation occurred because an applicant did not pay the appropriate premium, the Fund shall give the applicant a reasonable opportunity to pay the appropriate premium.

§20–510.

(a) Each fund producer is a fiduciary as to all premiums, return premiums, or other money that the fund producer receives from any person in connection with a policy or policy application issued by, to be issued by, or bound in the Fund.

(b) Each fund producer shall deposit as trust money into an account for premiums all money received under subsection (a) of this section to be accounted for and paid over to the Fund as the law requires.

§20–511.

(a) (1) On application to the Fund for appointment as a fund producer, an applicant shall file with the Fund a bond for the benefit of the Fund for the balance of the current year.

(2) On or before December 31 of each year, each fund producer shall file with the Fund a bond for the benefit of the Fund for the next succeeding year.

(b) A bond required under this section shall be:

(1) in the amount of $10,000;

(2) executed by an authorized surety insurer; and

(3) conditioned that the fund producer will account for and pay over to the person entitled to it all money belonging to the person that comes into the fund producer's possession in accordance with this subtitle and the regulations that relate to the binding of coverage.

(c) (1) A fund producer is considered to have complied with this section if an Association member certifies to the Fund that:

(i) the Association member has a bond in effect that covers the fund producer and complies with the requirements of this section; and

(ii) the bond coverage extends to the Fund when persons apply to the Fund for coverage through the fund producer.

(2) The certification shall be made by an authorized representative of the Association member.

(3) A copy of the certification shall be mailed promptly to the Fund.

(d) A fund producer's authority to bind coverage in the Fund may be terminated on 10 days' written notice if the bond is not:

(1) filed with the Fund in a timely manner; or

(2) continuously maintained in effect while the fund producer has authority to bind coverage in the Fund.

§20–512.

(a) Except as provided in subsection (b) of this section, the Fund shall pay to a fund producer of a policyholder to whom a policy is issued a commission:

(1) for private passenger auto insurance issued by the Fund, at a rate determined by the Fund but not less than 5% and not to exceed 15% of the total premium; and

(2) for any other insurance issued by the Fund, at a rate determined by the Fund but not to exceed 10% of the total premium.

(b) The Fund may not pay a commission:

(1) on a fully earned basis;

(2) if a prospective insured fails to qualify under § 20–502 of this subtitle;

(3) if a prospective insured's initial payment to the Fund, a fund producer, or premium finance company is not honored; or

(4) on a policy written directly by the Fund without the involvement of a fund producer.

(c) If a policy issued by the Fund is canceled, the Fund shall refund any unearned commissions.

§20–513.

The Fund may refuse to accept further applications from a fund producer or may terminate the authority of the fund producer to bind coverage or both if:

(1) the Fund finds that the fund producer has engaged in the practice of binding coverage in the Fund in violation of policies adopted by the Board of Trustees; or

(2) after demand has been made by the Fund, the fund producer fails to pay money owed the Fund as a result of:

(i) the binding or change of coverage; or

(ii) a commission paid to the fund producer on a policy that is canceled after the effective date of coverage.

§20–514.

(a) Except as provided in subsection (b) of this section, the Fund shall give prior written notice to a fund producer of its intended action under § 20–513 of this subtitle and give the fund producer an opportunity for a hearing before taking the action.

(b) (1) The Fund may exercise immediately any option under § 20–513 of this subtitle if the Fund determines that there is a likelihood of substantial and immediate harm to the Fund, its policyholders, or others because of:

(i) a violation of a policy adopted by the Board of Trustees that relates to the binding of coverage; or

(ii) a failure to pay money owed.

(2) After taking an action under § 20–513 of this subtitle, the Fund promptly shall give notice to the fund producer and hold a hearing within 10 working days before a member of the Board of Trustees.

(c) The Board of Trustees shall adopt policies to provide procedures for notice and hearings under this section.

§20–515.

(a) The Fund may use the Maryland Tax Refund Intercept Program to recover money owed to the Fund by a fund producer if the Fund makes a demand for the money and the fund producer does not make payment.

(b) (1) If the Fund makes payment to a claimant, the Fund is subrogated to the rights of the claimant against a responsible party and is entitled to recover all money that the Fund paid out and actual collection costs, including reasonable attorney's fees.

(2) The Fund may recover from its insureds all past-due premiums and from the responsible party all money that the Fund paid out under this subtitle in any manner provided by law, including the Maryland Tax Refund Intercept Program.

§20–516.

(a) Subject to § 20-517 of this subtitle, the Fund:

(1) may reject an application of insurance if the applicant owes to the Fund an unpaid premium on an expired or canceled policy;

(2) at any time may cancel a policy for nonpayment of premiums; or

(3) may reject an application of insurance or at any time may cancel a policy if it is found that the driver's license of the applicant or policyholder is:

(i) suspended, unless the suspension is for a first offense under § 16-205.1 of the Transportation Article for driving with an alcohol concentration of 0.08 or more; or

(ii) revoked.

(b) The Fund shall notify the applicant or policyholder promptly after the Fund rejects an application or cancels a policy.

(c) If a person does not have a valid license or other privilege to drive a covered vehicle in the State, or is otherwise ineligible to be insured by the Fund, the Fund may issue the appropriate policy with an excluded driver endorsement under § 27-609 of this article.

(d) (1) The Fund may cancel a policy if:

(i) the temporary registration issued for the covered vehicle under § 13-405 or § 23-107(b) of the Transportation Article has expired; and

(ii) the covered vehicle is not otherwise validly registered in the State.

(2) The cancellation may not take effect until the day after the temporary registration of the covered vehicle expires.

§20–517.

(a) An applicant whose application for insurance has been rejected or a policyholder whose policy has been canceled for a reason other than nonpayment of premiums may appeal the decision to a special board within 10 days after receipt of notice of the rejection or cancellation.

(b) (1) The special board consists of two members of the Board of Trustees and the Commissioner or designee of the Commissioner.

(2) The Executive Director may not sit on the special board.

(c) (1) The special board:

(i) may affirm, reverse, or modify the decision on the record; or

(ii) on at least 10 days' written notice to the applicant, may hold a hearing and then affirm, reverse, or modify the decision.

(2) The current policy of a policyholder who appeals the decision to the special board remains in effect until the special board decides the appeal.

(d) The Fund shall notify the Motor Vehicle Administration immediately after:

(1) the Fund cancels a policy or terminates coverage of an insured; or

(2) the Fund rejects an application for insurance and the action is final because:

(i) the rejection was not appealed to the special board; or

(ii) the special board does not reverse or modify the decision to cancel as to require issuance of a policy.

§20–518.

(a) (1) The Executive Director shall refer the status of an insured's driver's license to the Motor Vehicle Administration for a determination whenever the Executive Director finds that the insured, in the last 12-month period, had three or more chargeable accidents under the rules and rate schedules of the Fund filed with the Commissioner involving third-party liability, regardless of the number of points assessed for those accidents.

(2) The Executive Director may refer any other matter about an insured's driving record to the Motor Vehicle Administration for a determination.

(b) If, after a hearing, the Motor Vehicle Administration suspends or revokes the insured's driver's license, the Executive Director shall cancel or refuse to continue the coverage after having given the notice required under § 27-602 of this article.

(c) If the Motor Vehicle Administration does not suspend or revoke the insured's driver's license under subsection (b) of this section, the Executive Director may not cancel or refuse to continue the coverage of the insured.

§20–519.

If a policy covers a spouse or other household member of the family of the policyholder:

(1) cancellation of the policy of an insured whose driver's license is suspended or revoked does not result in the cancellation of the coverage of the spouse or other family member whose driver's license is not suspended or revoked; and

(2) the Fund shall reclassify the rate of risk of the spouse or other family member for the purpose of setting the premium.

§20–520.

(a) Except as provided in subsection (b) of this section, an insurer that issues, sells, or delivers private passenger motor vehicle insurance in the State may not refuse to issue a policy of private passenger motor vehicle insurance to any person who, for the immediately preceding 3 continuous years:

(1) has been insured by the Fund;

(2) has not had a moving traffic violation; and

(3) has not had a chargeable traffic accident.

(b) Subject to § 27-501 of this article, an insurer may refuse to issue a policy under subsection (a) of this section if the person does not satisfy the insurer's eligibility or underwriting standards.

(c) A person who is entitled to insurance under subsection (a) of this section:

(1) shall be rated by the insurer in the same manner as any other policyholder not previously insured by the Fund having the same risk characteristics; and

(2) may not be surcharged or rated by the insurer solely because the person was insured by the Fund.

(d) (1) At least 60 days before expiration or renewal of a policy of private passenger motor vehicle insurance, the Fund shall provide written notice to each person entitled to insurance under subsection (a) of this section.

(2) The notice shall:

(i) inform the person of the person's right to insurance under subsection (a) of this section;

(ii) advise the person to contact the fund producer that bound the person's coverage with the Fund during the most recent coverage period;

(iii) include a copy of a sample rate guide produced by the Administration; and

(iv) provide the toll-free telephone number established under § 2-109 of this article.

§20–521. NOT IN EFFECT

** TAKES EFFECT JULY 1, 2027 PER CHAPTERS 741 AND 742 OF 2026 **

// EFFECTIVE UNTIL JUNE 30, 2029 PER CHAPTERS 741 AND 742 OF 2026 //

(a) In this section, "affordability program" means a program that limits the maximum premium rate for a policy of private passenger auto insurance issued by the Fund in an amount that may be inadequate.

(b) Subject to review and approval by the Commissioner, the Executive Director may establish an affordability program if:

(1) rates are not excessive or unfairly discriminatory; and

(2) the affordability program does not result in:

(i) an overall inadequacy greater than 20% of the Fund's net written premium; or

(ii) an assessment allocation percentage that exceeds the limit established in § 20–405(d) of this title.

(c) An individual is eligible for a policy through the affordability program if the individual:

(1) meets the eligibility requirements for policyholders under § 20–502 of this subtitle; and

(2) has a household income that is not more than 250% of the federal poverty level.

(d) The Commissioner may require the Fund to modify the affordability program if the Commissioner determines that:

(1) the rates offered through the affordability program do not meet the requirements of this section;

(2) the affordability program will no longer meet the condition established under subsection (b)(2)(i) or (ii) of this section; or

(3) the affordability program violates other provisions of this article to which the Fund is subject.

(e) The Commissioner may not disapprove or require the modification of an affordability program based on the Fund's noncompliance with § 20–306 of this title.

§20–601.

(a) (1) In this section, "qualified person" means:

(i) a resident of the State;

(ii) the owner of a motor vehicle registered in the State, unless the owner is not a resident of the State and the motor vehicle bears temporary registration plates issued under Title 13, Subtitle 6, Part I of the Transportation Article;

(iii) a resident of another state or foreign country that affords recourse to residents of this State that is substantially similar to that provided under this title; or

(iv) an individual injured by an uninsured motorist who later files for bankruptcy or other protection from creditors that bars the Fund from a subrogation recovery.

(2) "Qualified person" does not include:

(i) an automobile collision insurer or other insurer that seeks by subrogation to recover payment for damages to a motor vehicle or real or other personal property, or injuries to individuals under any insurance coverages, including collision, fire, theft, medical payments, and uninsured motorist coverages;

(ii) a holder of a certificate of self-insurance under this article; or

(iii) an insured under a policy provision that:

1. provides coverage for damages sustained by the insured as a result of the operation of an uninsured motor vehicle; and

2. is authorized to be included in an automobile liability policy delivered or issued for delivery in the State.

(b) To the extent that a policy of motor vehicle liability insurance does not provide coverage, a claim that arises out of circumstances described in subsection (c), (d), or (e) of this section may be made against the Fund if:

(1) the claim is for:

(i) damage to property greater than $250; or

(ii) the death of or personal injury to a qualified person;

(2) (i) at the time of the accident, the claimant was not driving or riding in an uninsured motor vehicle owned by the claimant or a member of the claimant's family who resides in the claimant's household; and

(ii) the claimant is not the personal representative of the individual who was driving or riding in the uninsured motor vehicle; and

(3) (i) at the time of the accident, the claimant was not driving a motor vehicle with a certificate of registration that was suspended, canceled, or revoked, or was holding a driver's license that was suspended, canceled, or revoked; and

(ii) the claimant is not the personal representative or a member of the family who resides in the household of the individual who was driving the motor vehicle.

(c) A claim that arises out of the ownership, maintenance, or use of a motor vehicle in the State may be made against the Fund if:

(1) the requirements of subsection (b) of this section are met;

(2) (i) the identity of the motor vehicle and of its driver and owner cannot be established; or

(ii) the identity of the individual who was driving the motor vehicle cannot be established and it is established that, at the time of the accident, the motor vehicle was in the possession of an individual other than the owner without the owner's consent;

(3) the claimant has a cause of action against the driver or owner of the motor vehicle; and

(4) all reasonable efforts to establish the identity of the motor vehicle and of its owner and driver are unsuccessful.

(d) A claim that arises out of ownership, maintenance, or use of a motor vehicle in the State may be made against the Fund if:

(1) the requirements of subsection (b) of this section are met;

(2) the claimant has a cause of action against the driver or owner of the motor vehicle;

(3) despite all reasonable efforts, the driver or owner of the motor vehicle cannot be located; and

(4) (i) at the time of the accident the motor vehicle was an uninsured motor vehicle; or

(ii) despite all reasonable efforts, it is impossible to establish whether the motor vehicle was insured.

(e) (1) Subject to paragraph (2) of this subsection, a claim that arises out of the ownership, maintenance, or use of a motor vehicle in the State may be made against the Fund if:

(i) the requirements of subsection (b) of this section are met;

(ii) the driver or owner of the motor vehicle is uninsured and can be located for service of process;

(iii) 1. the claimant is not the uninsured driver's spouse who resides in the uninsured driver's household or another family member who resides in the uninsured driver's household; and

2. the claimant is not the personal representative of the spouse who resided in that household;

(iv) the claim is not made for damage to or destruction of an uninsured motor vehicle owned wholly or partly by the claimant; and

(v) the claimant is not eligible to make a claim arising from the same accident against the Property and Casualty Insurance Guaranty Corporation under Title 9, Subtitle 3 of this article.

(2) A claim under this subsection may not be made by or for:

(i) an insurer under a policy that makes the insurer liable to pay, wholly or partly, the amount of the claim; or

(ii) an insurer for any amount sought or claimed for damages or destruction to the property of the claimant or an insured by reason of:

1. collision with a motor vehicle or other object, or by upset of the motor vehicle; or

2. coverage of the insured that provides indemnification from injury or damages caused by uninsured motorists.

(3) The amount to be paid out of the Fund may not be sought, wholly or partly, to:

(i) take the place of making a claim or receiving a payment that is payable under a policy specified in paragraph (2)(i) of this subsection; or

(ii) reimburse or otherwise indemnify an insurer for an amount paid or payable under a policy specified in paragraph (2)(i) of this subsection.

§20–602.

(a) The maximum amount payable from the Fund, exclusive of interest and costs, for claims filed under this subtitle arising from one accident is:

(1) $30,000 on account of injury to or death of one individual;

(2) subject to the limit specified in item (1) of this subsection, $60,000 on account of injury to or death of more than one individual; and

(3) $15,000 for damages to property.

(b) (1) The following deductions shall be made from the smaller of the applicable maximum amount under subsection (a) of this section and the amount of the judgment:

(i) $250 from a judgment or part of a judgment for damages to property; and

(ii) the total amount that the claimant has received or is likely to receive:

1. from any source toward payment of the settlement or judgment;

2. toward payment of a judgment against a person against whom the claimant has a cause of action, arising out of the same accident, for damages for bodily injury or death or damage to property;

3. under a policy affording indemnity for damage to or destruction of property of the applicant; and

4. by reason of the accident out of which the claim arises under any workers' compensation law.

(2) For the purposes of this subtitle, medical, hospital, funeral, or other benefits paid or payable for the applicant under the Maryland Workers' Compensation Act shall be considered to be received or receivable by the claimant.

(c) The Fund may recover any amount paid out of the Fund that exceeds the amount authorized under this subtitle by bringing an action against the person that received the excess payment.

(d) (1) Notwithstanding any workers' compensation law or similar law to the contrary, whenever the amount of a payment by the Fund has been reduced by the amount of benefits paid or to be paid in accordance with a workers' compensation law or similar law, the employer of an injured person or decedent and the insurer of that employer is not entitled to a lien on payment from the Fund.

(2) Workers' compensation benefits may not be reduced because of the reduced payment from the Fund.

§20–603.

(a) (1) Except as provided in paragraph (2) of this subsection, notice of a claim for damages must be filed with the Fund within 180 days after the accident out of which the cause of action arises before a person may apply or sue for payment from the Fund under this subtitle.

(2) If notice of a claim is not filed within the time required under paragraph (1) of this subsection, a claim or suit may not be filed or maintained unless the claimant provides proof:

(i) that the claimant was physically incapable of filing notice within the time required and filed notice within 30 days after becoming physically capable of doing so or, if the claimant did not become capable of filing notice, that a notice was filed for the claimant within a reasonable period;

(ii) that the claimant filed notice within 30 days after having received notice that an insurer had disclaimed on a policy and thus removed or withdrew liability insurance coverage for the claim against a defendant; or

(iii) that the claimant gave the notice required under paragraph (1) of this subsection within 30 days after receiving notice that the insurer of the defendant was insolvent if:

1. the insurer of the defendant is not authorized to transact insurance business in the State; and

2. the claimant is not eligible to make a claim against the Property and Casualty Insurance Guaranty Corporation.

(b) The notice of a claim shall contain:

(1) evidence that the claimant:

(i) has fulfilled all requirements to file a claim; and

(ii) is not eligible for uninsured motorist coverage benefits from a policy issued to the claimant or a family member who resides in the claimant's household;

(2) certification by the claimant's employer of all lost wages incurred up to the filing of notice of a claim;

(3) evidence of all medical expenses incurred up to the filing of notice of a claim;

(4) all reports of medical treatment and consultation for injuries sustained;

(5) evidence of all other damages claimed up to the filing of the notice of claim;

(6) all available police or other accident reports; and

(7) additional information that the Executive Director requires by regulation.

(c) To the extent practicable, information required in notice of a claim shall be submitted in one filing.

§20–604.

(a) (1) The Executive Director shall adopt regulations and the Supreme Court of Maryland shall adopt rules that set forth procedural requirements for claims and actions against the Fund filed under this subtitle.

(2) Before the Fund becomes liable under this subtitle, a claimant must comply with each procedural requirement for claims and actions against the Fund.

(3) On behalf of the Fund, the Executive Director or designee of the Executive Director may stipulate that the procedural requirements have been met and consent to the claimant bringing an action against the Fund.

(4) A stipulation or consent does not waive any defense that the Fund may have with respect to the case.

(b) (1) At any time and without filing a petition for payment or other court approval, the Fund may settle, compromise, and pay claims and actions brought and judgments obtained under this subtitle.

(2) The Executive Director shall adopt regulations setting forth the procedure for settlement or payment.

(3) Interest shall accrue from the date of judgment in accordance with § 11–107 of the Courts Article.

§20–605.

(a) (1) After the Fund negotiates with a plaintiff or claimant a settlement offer that the Fund finds reasonable, the Fund shall give notice to the defendant or uninsured party of the offer in accordance with regulations of the Fund.

(2) If a defendant or uninsured party approves the settlement offer, the plaintiff or claimant shall proceed to settlement in accordance with regulations of the Fund and the Maryland Rules.

(b) (1) If a defendant or uninsured party rejects a settlement offer, the Fund shall cause notice to be served on the defendant or uninsured party by any lawful manner, including:

(i) a sheriff;

(ii) a private process server; and

(iii) certified mail bearing a postmark from the United States Postal Service to the last known address of the defendant or uninsured party or the last address on file with the Motor Vehicle Administration of this State or the state where the defendant or uninsured was last known to reside.

(2) The notice served under this subsection shall state that:

(i) without further notice, the Fund will withdraw from the claim or action 30 days after the date of the notice;

(ii) within 30 days after the date of the notice, an appearance may be entered by the defendant or uninsured party or by defense counsel whom the defendant or uninsured party chooses; and

(iii) if the provisions of item (ii) of this paragraph are not met, at any time after 30 days following the date of the notice and without further notice, suit may be filed or judgment may be entered against the defendant or uninsured party in the amount of the settlement offer.

(c) After the end of the 30-day period following notice served to a defendant or uninsured party under subsection (b) of this section, the Fund may settle the claim, file suit, or request the court to set the action for an expedited hearing.

(d) At a hearing authorized under subsection (c) of this section, the court may proceed in a summary manner and, if satisfied that each applicable provision of this title has been met, enter judgment in favor of the plaintiff or Fund in the amount of the settlement offer.

(e) (1) The defendant or uninsured party may file an appeal within 10 days after the date of entry of the judgment.

(2) Absent proof of fraud, mutual mistake, or obvious irregularity, the judgment is not subject to appeal, amendment, or other action of the court after the period for filing an appeal has expired.

§20–606.

(a) When a claim subject to this subtitle results in a default judgment that is entered for want of a plea by a defendant other than the Fund, or in a judgment that is entered with the consent of the defendant without the knowledge and approval of the Fund, the Fund shall answer or apply for relief against the judgment and for permission to answer and defend the claim within 30 days after receipt of actual notice of the judgment.

(b) (1) The Fund may elect to intervene in or defend a claim subject to this subtitle.

(2) The Fund is entitled to each defense that would have been or is available to the uninsured owner or driver.

(c) (1) A defendant shall cooperate with the Fund in defense of a claim in which the Fund has intervened under this subtitle.

(2) If the defendant fails to cooperate, the Fund may apply to the court for an order that directs cooperation or proceed as provided under this subtitle.

§20–607.

An appeal to the appropriate court may be taken from a final order, decree, or judgment of a court made under this subtitle:

(1) that debars a claimant from further proceeding against the Fund or denies the claim;

(2) that awards the claimant less than that to which the claimant believes the claimant is entitled; or

(3) except as provided in § 20-605 of this subtitle, that causes the defendant, the uninsured party, the Fund, or other party to be aggrieved.

§20–608.

(a) All money paid out by the Fund under this subtitle may be recovered by the Fund from the uninsured party at fault in any manner provided by law, including the Maryland Tax Refund Intercept Program.

(b) A judgment that is assigned to or obtained by the Fund:

(1) is considered in its entirety as taken for the use of the State; and

(2) shall be indexed in the appropriate court records in the name of the State of Maryland, Maryland Automobile Insurance Fund.

(c) If the Fund brings suit to enforce a judgment obtained under this subtitle against an uninsured party at fault, the Fund may recover the actual costs of collection, including reasonable attorney's fees.

§20–609.

(a) Whenever the Fund makes payment in an action brought or claim made under this subtitle, the Fund shall be subrogated to the cause of action of the claimant receiving the payment against the driver or owner of the motor vehicle by which the accident was occasioned.

(b) The Fund:

(1) if the identity and whereabouts are established of the person that is the driver or owner, may bring an action against that person for the amount of damage the claimant sustains; and

(2) may recover that amount out of any money payable with respect to death or injury under any policy in force when the accident occurred.

(c) If the amount recovered in an action under subsection (b) of this section is greater than the amount paid out of the Fund, the Fund:

(1) first, shall reimburse itself as provided in § 20-608 of this subtitle; and

(2) second:

(i) shall collect and pay the unpaid balance to the claimant; or

(ii) shall assign and transfer to the claimant any judgment, note, or other right, interest, or cause of action that the Fund has against the uninsured driver or owner.

(d) Notwithstanding any other statute of limitations, the Fund may bring an action against the person that is the driver or owner within 6 months after the identity and whereabouts of that person are established.

§20–610.

The General Assembly finds and declares that:

(1) there is an unacceptably large number of uninsured motorists in the State;

(2) uninsured motorists cause harm to insured drivers by increasing the cost of automobile insurance for everyone required to purchase uninsured motorist coverage;

(3) uninsured motorists are a financial drain on the State and require substantial funding for the Uninsured Division of the Fund to cover legitimate claims of innocent pedestrians, passengers, and drivers who are injured by uninsured motorists;

(4) to encourage uninsured motorists to become insured, the law for many years has provided financial penalties to be imposed on uninsured motorists and a substantial number of penalties are issued every year;

(5) to further address the rate of uninsured motorists, the General Assembly passed legislation (Chapter 446 of the Acts of 2016) to require the Motor Vehicle Administration to conduct a program that waived substantial portions of delinquent uninsured motorist fines as an incentive for eligible participants to become insured, but less than 4% of eligible uninsured motorists actually entered the program;

(6) the General Assembly also passed legislation (Chapter 401 of the Acts of 2016) to require drivers to carry proof of automobile insurance;

(7) despite these statutory efforts, the rate of uninsured motorists has remained stubbornly high, hovering at about 12% according to the Insurance Research Council;

(8) it is in the best interests of the State to address the rate of uninsured motorists in the State in a comprehensive and coordinated fashion;

(9) the Fund was established in 1973 to provide the financial security required under the Maryland Vehicle Law to individuals who are unable to obtain automobile insurance from private insurers;

(10) in addition to the Fund, motor vehicle liability insurance in the State is provided through a system of private insurers, insurance producers, and independent insurance producers;

(11) the Uninsured Division is uniquely positioned to reduce the rate of uninsured motorists by conducting outreach and incentivizing, educating, and encouraging uninsured motorists to obtain automobile insurance from private insurers or the Fund; and

(12) the effort to reduce the rate of uninsured motorists would be greatly enhanced by making the Uninsured Division the primary State agency with responsibility to conduct outreach and incentivize, educate, and encourage uninsured motorists to become insured.

§20–611.

(a) In this section, "Uninsured Motorist Fund" means the Uninsured Motorist Education and Enforcement Fund.

(b) There is an Uninsured Motorist Education and Enforcement Fund.

(c) The purpose of the Uninsured Motorist Fund is to provide funding for the education of drivers about, and the enforcement of, the security requirements for motor vehicles under the Maryland Vehicle Law.

(d) The Uninsured Division shall administer the Uninsured Motorist Fund.

(e) The Uninsured Motorist Fund is a special, nonlapsing fund that is not subject to § 7–302 of the State Finance and Procurement Article.

(f) The Uninsured Motorist Fund consists of:

(1) revenues deposited to the Uninsured Motorist Fund under § 17–104.2 of the Transportation Article;

(2) interest and investment earnings of the Uninsured Motorist Fund; and

(3) any other money from any other source accepted for the benefit of the Uninsured Motorist Fund.

(g) Money in the Uninsured Motorist Fund shall be used solely for:

(1) the administration of the Uninsured Motorist Fund; and

(2) the education of drivers and the public about:

(i) the security requirements under the Maryland Vehicle Law; and

(ii) the sources of automobile insurance in the State, including private insurers and the Fund.

§20–612.

(a) (1) In this section the following words have the meanings indicated.

(2) "Central Collection Unit fee" means the fee the Central Collection Unit in the Department of Budget and Management is authorized under § 3–304 of the State Finance and Procurement Article to assess on debts or claims collected.

(3) "Program" means the Program to Incentivize and Enable Uninsured Vehicle Owners to Be Insured established under subsection (b)(1) of this section.

(4) "Program period" means the period during which vehicle owners may have a portion of delinquent uninsured vehicle penalties waived under the Program.

(5) "Uninsured vehicle penalty" means the fine the Motor Vehicle Administration may assess a vehicle owner under § 17–106 of the Transportation Article for a lapse of the required security on a vehicle during a registration year.

(b) (1) There is a Program to Incentivize and Enable Uninsured Vehicle Owners to Be Insured in the Uninsured Division.

(2) The Program is administered by the Uninsured Division.

(3) The purpose of the Program is to reduce the number of uninsured vehicles in the State by incentivizing and enabling individuals with delinquent uninsured vehicle penalties to become:

(i) eligible to register a vehicle in the State; and

(ii) insured after paying a reduced uninsured vehicle penalty.

(c) The Program period:

(1) may not exceed 180 calendar days; and

(2) shall begin not earlier than July 1, 2018, and end not later than December 31, 2019.

(d) An individual is eligible to participate in the Program if the individual:

(1) is a State resident;

(2) has delinquent uninsured vehicle penalties that became delinquent on or before December 31, 2016;

(3) does not have the required insurance on any vehicle owned by the individual; and

(4) has not been issued a judgment by the Central Collection Unit.

(e) (1) The Motor Vehicle Administration and the Central Collection Unit shall provide the Uninsured Division with contact information and the total amount of delinquent uninsured vehicle penalties of each individual who may be eligible to participate in the Program.

(2) The Uninsured Division shall notify individuals who may be eligible to participate in the Program at the individual's last known address.

(3) The notification required under paragraph (2) of this subsection shall include:

(i) the website addresses of the Motor Vehicle Administration, the Fund, and the Administration, where individuals may find contact information for insurers that write motor vehicle liability insurance in the State and other information about motor vehicle insurance; and

(ii) the total amount of delinquent uninsured vehicle penalties that the individual owes and the amount of the penalties that may be waived under the Program.

(f) (1) On notification by the Uninsured Division that an applicant meets the eligibility requirements for the Program, the Motor Vehicle Administration shall waive 80% of an eligible individual's delinquent uninsured vehicle penalties that became delinquent on or before December 31, 2016.

(2) (i) As a condition of receiving a waiver under paragraph (1) of this subsection, the eligible individual shall pay the balance of the delinquent uninsured vehicle penalties owed after subtracting the waived amount under paragraph (1) of this subsection.

(ii) If a claim against an eligible individual has been sent to the Central Collection Unit, in addition to the balance owed under subparagraph (i) of this paragraph, the eligible individual shall pay a Central Collection Unit fee calculated as a percentage of the amount of the balance owed under subparagraph (i) of this paragraph.

(iii) 1. Except as provided in subsubparagraph 2 of this subparagraph, an eligible individual shall pay the balance owed under subparagraph (i) of this paragraph and any Central Collection Unit fee owed under subparagraph (ii) of this paragraph before the end of the Program period.

2. An eligible individual may pay the balance owed under subparagraph (i) of this paragraph and any Central Collection Unit fee owed under subparagraph (ii) of this paragraph using a monthly installment payment plan that extends payments beyond the end of the Program period if the terms of the monthly installment payment plan require:

A. the first payment to be due on entry into the Program; and

B. the remaining balance owed to be paid within 6 months after entry into the Program.

(3) (i) As a condition of receiving a waiver under paragraph (1) of this subsection, an eligible individual who owns a vehicle at the time of the waiver, or an eligible individual who does not own a vehicle at the time of the waiver but subsequently registers a vehicle, shall purchase and maintain the required security on the vehicle for the period of time specified in subparagraph (ii) of this paragraph.

(ii) The eligible individual shall maintain the required security on the vehicle for a period of:

1. at least 6 months; or

2. at least 1 year if the waived amount under paragraph (1) of this subsection exceeds $3,000.

(g) (1) On behalf of the State, the Uninsured Division may collect the amount of the delinquent uninsured vehicle penalties due together with any Central Collection Unit fee that is due and transmit the money that is owed to the Motor Vehicle Administration and the Central Collection Unit.

(2) On notification from the Uninsured Division that the required amount of the uninsured vehicle penalties and Central Collection Unit fees have been received from an eligible individual, the Motor Vehicle Administration and the Central Collection Unit shall take the necessary steps to allow the eligible individual to register a vehicle.

§20–613.

An applicant for a policy from the Fund who is participating in the Program under § 20–612 of this subtitle may:

(1) be considered by the Fund to have met the requirements of § 20–502(a)(3) of this title; and

(2) pay the premium for the policy in installments in accordance with § 20–507(g)(1)(ii)1B of this title, regardless of the amount of the premium.

§20–614.

(a) If the Uninsured Division receives information from the Motor Vehicle Administration as required under § 17–106 of the Transportation Article regarding an owner of a vehicle who has been notified by the Motor Vehicle Administration that the registration of the vehicle has been suspended, the Uninsured Division may not, in any fashion, contact the owner until at least 60 days after the effective date of the final termination or lapse of the required security, as reported to the Motor Vehicle Administration by an insurer.

(b) If the Uninsured Division uses the information received from the Motor Vehicle Administration under § 17–106 of the Transportation Article to contact an owner, the Uninsured Division shall send a notice to the owner that:

(1) provides the website addresses of the Motor Vehicle Administration, the Fund, and the Administration where the owner may find contact information for insurers that write motor vehicle liability insurance in the State and other information about motor vehicle liability insurance; and

(2) advises the owner that the owner may contact the owner's insurance producer, if any, or the owner's prior insurer to determine whether motor vehicle liability insurance may be placed for the owner by the insurance producer or the insurer.

§20–701.

(a) A person may not knowingly file with the Fund a notice or document required under this title that is false or that contains a material misstatement of fact.

(b) A person that violates this section is guilty of a misdemeanor and on conviction is subject to a fine not exceeding $500 or imprisonment not exceeding 30 days or both.

§21–101.

(a) A surety insurer qualified to act as surety or guarantor under this article may execute:

(1) a bond, undertaking, recognizance, or other obligation that is required or allowed to be made, given, tendered, or filed with a surety by law or in the charter, ordinances, rules, or regulations of a municipal corporation, board, body, organization, court, judge, or public officer; and

(2) a guaranty of the performance of an act, duty, or obligation, or the refraining from an act, that is required or allowed to be guaranteed.

(b) The execution by a qualified surety insurer of a bond, undertaking, recognizance, obligation, or guaranty is in full compliance with each requirement of each law, charter, ordinance, rule, or regulation that:

(1) the bond, undertaking, recognizance, obligation, or guaranty shall be executed by a surety; or

(2) the surety shall be a resident, householder, or freeholder, or either or both, or shall have any other qualifications.

(c) Each court, judge, department head, board, body, municipal corporation, and public officer shall accept a bond, undertaking, recognizance, obligation, or guaranty executed by a qualified surety insurer and treat it as conforming to and fully complying with each requirement of each applicable law, charter, ordinance, rule, or regulation.

(d) A surety insurer may be released from its liability on a bond, undertaking, recognizance, obligation, or guaranty executed under subsection (a) of this section on the same terms and conditions provided by law for the release of an individual surety.

§21–102.

A certificate of authority, or certified copy of a certificate of authority, issued by the Commissioner to a surety insurer shall be accepted as evidence of qualification to become sole surety on a bond, undertaking, recognizance, or other obligation required or allowed by law, or in the charter, ordinances, rules, or regulations of a municipal corporation, board, organization, court, judge, or public officer, without further proof or qualification regarding solvency, credit, or financial sufficiency to act as a surety.

§21–103.

(a) A surety insurer that is removed by the District Court from the list of surety insurers eligible to post bonds with the court because that surety insurer failed to timely resolve or satisfy one or more bail bond forfeitures appearing on the District Court's list of absolute bond forfeitures in default shall be subject to the penalties under § 4–113 of this article.

(b) A surety insurer that is precluded or removed by a circuit court from the list of surety insurers eligible to post bonds with any circuit court because that surety insurer failed to timely resolve or satisfy one or more bail bond forfeiture judgments shall be subject to the penalties under § 4–113 of this article.

(c) Within 14 days after the failure of a surety insurer to resolve or satisfy all bond forfeitures in default by the District Court's or circuit court's deadline, the clerk of the applicable court shall notify the Commissioner, in writing, of the name of that surety insurer and each bond forfeiture that was not resolved or satisfied by the applicable court's deadline.

§22–101.

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

(b) (1) "Abstract of title" means a representation of the state of title to property based on a review of the records that impart constructive notice relating to title to property in the State.

(2) "Abstract of title" includes a report of title and any other written or electronically created or preserved representation of the state of title to property.

(c) (1) "Title insurance commitment" means a written statement of the terms and conditions on which a title insurer is willing to issue a policy of title insurance if the title insurer accepts a premium for the policy.

(2) "Title insurance commitment" includes a binder.

§22–102.

Premiums for title insurance shall be set out clearly and subject to the approval of the Commissioner.

§22–103.

(a) Except as provided in subsection (d) of this section, when, in connection with a real estate transaction that involves a purchase money mortgage or deed of trust on land in the State, a title insurer accepts a premium for a policy that insures the title to the property or the title insurer, its agent, or employee accepts a premium for mortgagee title insurance, the person first accepting the premium:

(1) shall insert the name of each insured in the title insurance commitment for the title insurance; and

(2) immediately on receipt of the premium, shall deliver to the buyer or agent or attorney of the buyer written notice:

(i) of the name of each insured under the policy;

(ii) of the face amount of the policy;

(iii) of the buyer's right and opportunity to obtain simultaneous title insurance in the buyer's favor;

(iv) of the additional premium that will be required for purchase of simultaneous title insurance in the buyer's favor;

(v) that the buyer's title insurance will be subject only to the contingencies and conditions contained in the title insurance commitment and policy;

(vi) of the buyer's right to review the title insurance commitment or a sample of the form of policy in which the contingencies and conditions will be inserted;

(vii) that contains a clear statement of the contingencies that must be satisfied to make the buyer's policy effective, if the buyer's policy is not effective on payment of the premium; and

(viii) that the title insurance commitment or sample of the form of policy into which the contingencies and conditions for insuring will be inserted:

1. does constitute a statement of the terms and conditions on which the title insurer is willing to issue its policy of title insurance if the title insurer accepts a premium for the policy;

2. is not a representation as to the state of title; and

3. does not constitute an abstract of title.

(b) Before disbursing any funds, the person required to give notice under subsection (a) of this section shall obtain from the buyer, at the time the person delivers the notice, a statement in writing that the buyer has received the notice described in subsection (a) of this section and that the buyer wants or does not want owner's title insurance.

(c) (1) The person required to give notice under subsection (a) of this section shall retain the original signed statement of receipt required by subsection (b) of this section and a copy of the notice required by subsection (a) of this section for 3 years.

(2) The statement of receipt and notice shall be available for inspection by the Commissioner on request.

(d) This section does not apply to a real estate transaction involving a mortgage or deed of trust securing an extension of credit made:

(1) solely to acquire an interest in or to carry on a business or commercial enterprise; or

(2) to any business or commercial organization.

§22–104.

(a) A title insurance commitment or sample of the form of policy into which the contingencies and conditions for insuring will be inserted:

(1) constitutes a statement of the terms and conditions on which a title insurer is willing to issue a policy of title insurance if the title insurer accepts the premium for the policy;

(2) is not a representation as to the state of title; and

(3) does not constitute an abstract of title.

(b) The rights, duties, and responsibilities applicable to the preparation or issuance of an abstract of title do not apply to the issuance of a title insurance commitment or sample of the form of policy into which the contingencies and conditions for insuring will be inserted.

(c) A title insurance commitment or sample of the form of policy into which the contingencies and conditions for insuring will be inserted shall contain the following statement:

"This document constitutes a statement of the terms and conditions on which a title insurer is willing to issue a policy of title insurance if the title insurer accepts the premium for the policy. It is not a representation as to the state of title and does not constitute an abstract of title.".

§22–105.

(a) (1) In this section the following words have the meanings indicated.

(2) "Beneficial owner" means a person, other than the buyer in a real estate transaction, for whose benefit a title insurer or its agent is entrusted to hold trust money.

(3) "Trust money" means a deposit, payment, or other money that a person entrusts to a title insurer or its agent to hold for the benefit of a buyer in a real estate transaction or for a beneficial owner, in connection with an escrow, settlement, closing, or title indemnification.

(b) A title insurer or its agent shall pool and commingle trust money received from clients or beneficial owners in connection with escrows, settlements, closings, or title indemnifications if, in the judgment of the title insurer or its agent, a separate deposit of the trust money would generate interest in an amount not greater than $50 or the cost of administering a separate account.

(c) At least quarterly, the financial institution in which a commingled account is maintained under this section shall pay the interest earned on the account, less any service charges of the financial institution, to the Maryland Affordable Housing Trust to enhance the availability of affordable housing throughout the State as provided in § 10–102 of the Housing and Community Development Article.

(d) Trust money required to be commingled under subsection (b) of this section in connection with a real estate transaction shall be deposited and maintained until disbursed in accordance with the transaction:

(1) in a financial institution located in the State; or

(2) subject to approval of the Commissioner of Financial Regulation, in a financial institution outside the State that complies with the requirements of this subtitle.

(e) A title insurer or its agent does not violate, and may not be charged by the Commissioner with a violation of, any ethical or legal duties by placing trust money in an account under subsection (b) of this section with the interest paid to the Maryland Affordable Housing Trust under subsection (c) of this section.

(f) Except for trust money that a title insurer or its agent places in a commingled account under subsections (b) and (c) of this section, and subject to regulations of the Commissioner, trust money in the possession of the title insurer or its agent may be deposited in any other deposit or investment vehicle:

(1) specified by the client or beneficial owner; or

(2) as agreed on by the client or beneficial owner and the title insurer or its agent.

§23–101.

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

(b) "Actuarial method" has the meaning stated in § 12–1009 of the Commercial Law Article.

(c) (1) "Premium finance agreement" means an agreement:

(i) by which an insured or prospective insured promises to pay a premium finance company the amount advanced or to be advanced under the agreement, together with interest and a service fee, to an insurer or an insurance producer in payment of premiums; and

(ii) that contains an assignment of or is otherwise secured by the unearned premium or refund obtainable from the insurer on cancellation of the insurance contract.

(2) "Premium finance agreement" does not include a premium financed in connection with a time sale of goods or services or an extension of credit without charge by an insurance producer.

(d) "Premium finance company" means a person that engages in the business of entering into or accepting premium finance agreements.

§23–102.

No bank, savings bank, trust company, savings and loan association, credit union, industrial finance company, small loan company, or other similar organization that is regulated under the laws of the State or the United States nor any bank, savings bank, trust company, savings and loan association, or credit union that is organized in another state and has a branch in this State nor any authorized insurer that does not engage in the insurance financing business is subject to this title.

§23–103.

(a) The Commissioner may conduct investigations and examine the books, records, and accounts of a person under this title to the same extent as is authorized with respect to insurers under this article.

(b) The expense of an examination shall be paid by the person examined as provided in § 2-208 of this article.

(c) The Commissioner or an examiner shall make a complete report of each investigation or examination as provided in § 2-209 of this article.

§23–201.

(a) A premium finance company must register with the Commissioner before engaging in business as a premium finance company in the State.

(b) An insurer or insurance producer must register with the Commissioner before engaging in the business of financing premiums in the State.

§23–202.

(a) To engage in business as a premium finance company in the State, each premium finance company shall elect to:

(1) maintain a net worth of at least $250,000 calculated under generally accepted accounting principles;

(2) file with the Commissioner an irrevocable letter of credit in the amount of $50,000 issued by a financial institution;

(3) deposit with the State Treasurer cash in the amount of $50,000; or

(4) file with the Commissioner a bond that:

(i) is in favor of the State;

(ii) is in the penal sum of $50,000;

(iii) is executed by an authorized surety insurer; and

(iv) is conditioned that the premium finance company will account for and pay over to the person entitled to receive it all money belonging to the person that comes into the possession of the premium finance company, including unearned premiums due to an insured and unearned commissions due to an insurer.

(b) A bond shall remain in force until the surety insurer is released from liability by the Commissioner or until the bond is canceled by the surety insurer.

(c) The total liability of the surety insurer under a bond may not exceed the penal sum of the bond.

(d) (1) (i) The surety insurer may cancel a bond after filing written notice with the Commissioner at least 30 days before the effective date of the cancellation.

(ii) A cancellation under this paragraph does not affect any liability that accrued before the cancellation.

(2) After notification of the cancellation of the bond, the premium finance company shall act promptly to replace the bond.

(3) If the premium finance company fails to act promptly to replace the bond, the Commissioner shall deny, suspend, revoke, or refuse to renew the registration of the premium finance company until the required bond is filed.

(e) If, at any time, the premium finance company fails to comply with subsection (a) of this section, the Commissioner shall deny, suspend, revoke, or refuse to renew the registration of the premium finance company until the premium finance company complies with subsection (a) of this section.

§23–203.

(a) An applicant for initial registration shall:

(1) file with the Commissioner:

(i) an application on the form that the Commissioner requires;

(ii) in the case of a corporation or limited liability company, a certificate of good standing issued by the State Department of Assessments and Taxation;

(iii) evidence of compliance with § 23-202 of this subtitle;

(iv) the form of the premium finance agreement to be used; and

(v) the finance charge, initial service fee, and all other fees and charges to be applied; and

(2) pay to the Commissioner an application fee of $250.

(b) The registration application shall include the following information:

(1) the name, business address, and telephone number of the premium finance company; and

(2) the name and business address of each officer, director, principal, and partner of the premium finance company.

(c) A registration application may require the applicant to disclose the identity, trade names, and names of managers and owners of the applicant.

§23–204.

(a) When an applicant complies with the filing requirements and pays the registration fee to the Commissioner in accordance with § 23-203 of this subtitle, the Commissioner shall determine whether the applicant meets the requirements of this title.

(b) The Commissioner shall deny registration to an applicant if the Commissioner determines that the applicant has submitted an incomplete registration.

(c) The Commissioner shall register each applicant that meets the requirements of this title.

§23–205.

(a) A registration expires on the first July 1 after its effective date unless it is renewed as provided in this section.

(b) Before a registration expires, the registrant may renew it for an additional 1-year term if the registrant:

(1) files with the Commissioner:

(i) a renewal application on the form that the Commissioner requires;

(ii) in the case of a corporation or limited liability company, a certificate of good standing issued by the State Department of Assessments and Taxation; and

(iii) evidence of compliance with § 23-202 of this subtitle; and

(2) pays to the Commissioner a renewal fee of $50.

(c) The Commissioner shall renew the registration of each registrant that meets the requirements of this section.

§23–206.

(a) The Commissioner shall require a premium finance company to report, on forms provided by the Commissioner, changes in officers, directors, owners, trade names, principals, partners, business addresses, and telephone numbers within 30 days after a change occurs.

(b) (1) A premium finance company shall file all changes to:

(i) the form of the premium finance agreement used by the premium finance company; and

(ii) the finance charge, initial service fee, and any other fees and charges applied by the premium finance company.

(2) A premium finance company may not use a premium finance agreement form or apply a fee or charge unless the filing required under paragraph (1) of this subsection is approved by the Commissioner.

(3) A premium finance company shall disclose to the Commissioner, on written request, the method or formula used to calculate the finance charges and amount of refund on cancellation of the insurance contract.

§23–207.

Each premium finance company:

(1) shall maintain records of its premium finance transactions for at least 3 years after making the final entry with respect to a premium finance agreement;

(2) shall allow the Commissioner to examine the records; and

(3) may keep the records in photographic, imaging, microfilm, microfiche, electronic data processing, computer, or facsimile form.

§23–208.

(a) Subject to the hearing provisions of Title 2 of this article, the Commissioner may deny a registration to an applicant or suspend, revoke, or refuse to renew the registration of a registrant if the Commissioner finds that the applicant or registrant has:

(1) failed to comply with a lawful requirement of the Commissioner under this title;

(2) violated a provision of this title;

(3) made a material misstatement in the application for registration;

(4) engaged in fraudulent or dishonest practices; or

(5) demonstrated incompetency or untrustworthiness to engage in the business of a premium finance company.

(b) (1) Instead of or in addition to suspending, revoking, or refusing to renew a registration, the Commissioner may:

(i) impose on the registrant a penalty of not less than $25 but not exceeding $1,000 for each violation of this article, up to a maximum of $20,000 in the event of multiple violations; or

(ii) require that restitution be made by a registrant that violates this title to a person that has suffered financial injury as a result of a violation of this title.

(2) For purposes of this subsection, restitution means the sum of money that, if paid to a person that suffers financial injury as a result of violation of this title, will restore the person to the same financial position the person would have been in had the violation not occurred.

(c) (1) A premium finance company that delegates administration of a premium finance agreement to a third party is responsible for a violation of any provision of this title by the third party in the administration of the premium finance agreement, regardless of the delegation.

(2) For purposes of this subsection, the following acts by an insurance producer in relation to a premium finance agreement are not considered to be the administration of the premium finance agreement:

(i) signing a premium finance agreement;

(ii) accepting payments; or

(iii) issuing receipts.

§23–209.

(a) A registrant may surrender a registration by delivering to the Commissioner written notice of the surrender.

(b) Surrender of a registration does not affect the registrant's civil or criminal liability for acts committed before the surrender.

§23–210.

Suspension, revocation, or surrender of a registration does not affect the obligation of an insured under a lawful premium finance agreement previously acquired or held by the registrant.

§23–301.

(a) (1) A premium finance agreement shall be dated and signed by or on behalf of the insured.

(2) Except as provided under subsection (b)(5)(viii) of this section, the printed part of the premium finance agreement shall be in approximately 8–point type and be easily readable by an average individual.

(b) A premium finance agreement shall contain:

(1) the name and place of business of the insurance producer negotiating the related insurance contract;

(2) the name and residence or place of business of the insured as specified by the insured;

(3) the name and place of business of the premium finance company to which payments may be made;

(4) an itemized list for each insurance contract or coverage financed under the premium finance agreement that includes:

(i) the applicable application number, binder number, or policy number;

(ii) the effective date of the insurance contract or coverage;

(iii) the name of the company issuing the insurance contract or coverage; and

(iv) the premium for the insurance contract or coverage; and

(5) if applicable, the following items:

(i) the total amount of the premiums;

(ii) the amount of the down payment;

(iii) the principal balance (the difference between items (i) and (ii) of this item);

(iv) the amount of the finance charge;

(v) the balance payable by the insured (the sum of items (iii) and (iv) of this item);

(vi) the number of installments required, the amount of each installment expressed in dollars, and the due date or period of each installment;

(vii) the electronic payment fee; and

(viii) in at least 12–point type, the following statement: "If this agreement is canceled or the loan is prepaid in full before the end of its term, the actuarial method will be used to calculate the earned finance charge. Under this method, most of the finance charge is earned in the early months of the loan term rather than equally in each month. You may request a sample illustration of how the finance charge is earned.".

(c) (1) The items set out in subsection (b)(5) of this section need not be stated in the sequence in which they appear.

(2) Additional items may be included to explain the computations made in determining the amount to be paid by the insured.

(3) With respect to commercial automobile, fire, or liability insurance, a premium finance agreement may include separate provisions requiring representations, warranties, or other obligations of the insurance producer who sells, solicits, or negotiates the insurance policy, the premiums for which are financed under the premium finance agreement.

(d) A premium finance agreement may provide for additional insurance premiums to be financed and added to the initial premium finance agreement.

(e) Subject to §§ 23–501.1 and 23–505.2 of this title, a premium finance agreement may include monthly payments for the purchase price of a motor club service contract.

§23–301.1.

In addition to financing the premium of a surplus lines insurance contract, a premium finance agreement may include any:

(1) premium receipts tax that a surplus lines broker is required to charge under § 3-324 of this article and pay to the Commissioner under § 3-325 of this article;

(2) policy fee that a surplus lines broker is allowed to charge under § 27-216 of this article; and

(3) inspection fee that a surplus lines broker is allowed to charge under § 27-216 of this article.

§23–301.2.

(a) (1) With respect to private passenger motor vehicle insurance and personal insurance, a premium finance company may:

(i) assign all rights and obligations under a premium finance agreement to another premium finance company that is registered in the State under this title; or

(ii) pledge a premium finance agreement as collateral for a loan.

(2) If a premium finance company assigns the obligation to service a premium finance agreement to another premium finance company under paragraph (1)(i) of this subsection, the assigning premium finance company shall notify the insured in accordance with subsection (c) of this section:

(i) that the obligation to service the premium finance agreement has been assigned to another premium finance company that is registered in the State under this title; and

(ii) of the name, address, and telephone number of the premium finance company to which the obligation has been assigned.

(b) (1) With respect to commercial automobile, fire, or liability insurance, a premium finance company:

(i) except as provided in paragraph (2) of this subsection, may assign all rights and obligations under a premium finance agreement to another

person if the premium finance agreement expressly confers the right to assign all rights and obligations under the premium finance agreement; or

(ii) may pledge a premium finance agreement as collateral for a loan.

(2) A premium finance company that assigns rights and obligations under paragraph (1)(i) of this subsection shall:

(i) retain the obligation to service the premium finance agreement; or

(ii) assign the obligation to service the premium finance agreement to another premium finance company that is registered in the State under this title.

(3) If a premium finance company assigns the obligation to service a premium finance agreement to another premium finance company under paragraph (2)(ii) of this subsection, the assigning premium finance company shall notify the insured in accordance with subsection (c) of this section:

(i) that the obligation to service the premium finance agreement has been assigned to another premium finance company that is registered in the State under this title; and

(ii) of the name, address, and telephone number of the premium finance company to which the obligation has been assigned.

(c) A notice required under subsection (a)(2) or (b)(3) of this section shall be by:

(1) first–class mail; or

(2) if the premium finance company meets the requirements for delivering a notice under § 27–601.2 of this article, electronic means.

§23–302.

(a) A copy of each premium finance agreement or other notice of a premium finance agreement that describes the policy or policies involved shall be given to the agency issuing the policy or policies or to the insurers involved.

(b) (1) If a policy is procured through a surplus lines broker licensed in the State, and payment is not made directly to the surplus lines broker or the insurer,

a copy of the premium finance agreement or other notice of the premium finance agreement shall be sent to the surplus lines broker by the insurance producer or premium finance company.

(2) A premium finance company may require an insurance producer who procures premium financing to:

(i) send to the surplus lines broker the notice required under paragraph (1) of this subsection within 10 business days of the execution of a premium finance agreement; and

(ii) provide to the premium finance company, within 10 business days of receipt of a policy, the insurer's name, policy number, and any other information necessary to complete a premium finance agreement.

(c) When a premium finance agreement is signed, the premium finance company, or the insurance producer, if applicable, shall provide the insured with, or cause the insured to be provided with, a legible copy of the fully completed and executed premium finance agreement.

§23–302.1.

(a) An insured may finance an additional premium if:

(1) the insured has paid the down payment, if any, required by the premium finance company on the additional premium; and

(2) the premium finance company delivers or mails a written notice to the insured at the last known address of the insured indicating that:

(i) there is a revised premium finance agreement; and

(ii) in the event of default in payment of the revised premium finance agreement, the policy may be canceled.

(b) An insurer may not delay cancellation for the sole purpose of applying premiums on deposit to any additional premium.

§23–302.2.

If an insurer receives notice of a financed insurance premium, the insurer shall, within 10 business days after its calculation, notify the insured, the insurer's insurance producer, and premium finance company of any additional premium arising under the financed policy.

§23–303.

(a) The maximum charges stated in §§ 23-304 and 23-305 of this subtitle shall include all interest, fees, and charges incident to the premium finance agreement and the resulting extension of credit.

(b) Notwithstanding subsection (a) of this section, delinquency, collection, cancellation, reinstatement, and electronic payment fee charges may be made in accordance with the limitations of §§ 23-306, 23-307, and 23-307.1 of this subtitle.

§23–304.

(a) The finance charge shall be computed:

(1) on the amount of the entire premium loan advanced, including any taxes or fees that are financed under § 23–301.1 of this subtitle, after subtracting any down payment on the premium loan made by the insured;

(2) from the inception date of the insurance contract or from the due date of the premium, disregarding any grace period or credit allowed for payment of the premium, through the date when the final installment under the premium finance agreement is payable; and

(3) in an amount not exceeding the sum of 1.15% for each 30 days of the loan, computed in advance.

(b) (1) An insured shall receive a refund of a finance charge that exceeds any amount due under the premium finance agreement if:

(i) the insurance contract is canceled; or

(ii) the insured prepays the loan in full at any time.

(2) The amount of the refund under paragraph (1) of this subsection may be calculated by the actuarial method.

(3) (i) A finance charge:

1. is earned in 30–day increments; and

2. in accordance with subparagraph (ii) of this paragraph, may be earned on the first day of each 30–day period.

(ii) If a finance charge is earned on the first day of each 30–day period, the premium finance agreement shall contain a notification that the finance charge is earned on the first day of each 30–day period.

(4) A premium finance company may not retain more of the finance charge than is earned under this section.

(c) With respect to commercial automobile, fire, or liability insurance only, a finance charge may be imposed on any unpaid principal balance of the loan remaining after all unearned premiums have been returned if the unearned premiums are less than the unpaid principal balance due to:

(1) an audit by the insurer resulting in additional premium;

(2) the application of a minimum premium on a policy;

(3) an endorsement that is made after a policy is issued and results in additional premium; or

(4) a lawful delay in canceling an insurance policy that is beyond the control of the premium finance company.

(d) Notwithstanding any other provision of law, a premium finance company may not use the Rule of 78s in computing a finance charge under this section.

§23–305.

(a) A premium finance company may charge an initial service fee, which may not exceed $20, for actual expenses.

(b) The initial service fee may not be refunded on cancellation or repayment.

§23–306.

(a) A premium finance agreement may require the insured to pay a delinquency and collection charge on each installment that is in default for a period of not less than 5 days.

(b) A delinquency and collection charge shall be at least $1, up to a maximum of 5% of the installment in default, but may not exceed:

(1) $8, with respect to private passenger automobile or personal fire or liability insurance; and

(2) $100, with respect to commercial automobile, fire, or liability insurance.

(c) Only one delinquency and collection charge may be collected on an installment, regardless of the period during which the installment remains in default.

§23–307.

(a) Except as provided in subsection (d) of this section, a premium finance agreement may require the insured to pay a cancellation charge if a default in paying an installment results in the cancellation of an insurance contract listed in the premium finance agreement.

(b) A cancellation charge shall be:

(1) with respect to private passenger automobile or personal fire or liability insurance, equal to the difference between a delinquency and collection charge imposed under § 23–306 of this subtitle with respect to the installment in default and:

(i) $15 for a default before or during calendar year 2014;

(ii) $16 for a default during calendar year 2015;

(iii) $17 for a default during calendar year 2016;

(iv) $18 for a default during calendar year 2017;

(v) $19 for a default during calendar year 2018; and

(vi) $20 for a default during or after calendar year 2019; and

(2) with respect to commercial automobile, fire, or liability insurance, 5% of the installment, not to exceed an amount equal to the difference between a delinquency and collection charge imposed under § 23–306 of this subtitle with respect to the installment in default and $100.

(c) A premium finance company may require the payment of a reinstatement charge that is in place of and in the same amount as the cancellation charge if, after a cancellation charge is imposed in accordance with the requirements of subsection (d) of this section, the insured pays the defaulted installment.

(d) A premium finance agreement may impose a cancellation charge:

(1) on or after the effective date stated in the notice of cancellation issued to the insurer under § 23–403 of this title; or

(2) on or after the cancellation effective date stated in the notice of intent to cancel delivered or mailed to the insured under § 23–402 of this title, if:

(i) the premium finance company has notified the insured in the notice of intent to cancel that a cancellation fee will be imposed on the cancellation effective date stated in the notice of intent to cancel; and

(ii) the notice of intent to cancel includes the following statement in 12–point or larger type: "If you do not pay the delinquent amount before the cancellation effective date stated in this notice, at any time within 30 days of the cancellation effective date, your insurance policy is subject to cancellation on the cancellation effective date. This means that if you have a loss on or after the cancellation effective date stated in this notice, you may not have coverage for the loss.".

§23–307.1.

(a) (1) In this section the following words have the meanings indicated.

(2) (i) "Electronic check" means a form of payment in which a fund transfer is made electronically from a payer's bank account to a premium finance company's bank account.

(ii) "Electronic check" does not include a written check that is delivered to a premium finance company or an agent by hand delivery, regular mail, or other form of personal delivery.

(3) "Electronic payment" includes payment by credit card, debit card, or electronic check.

(b) A premium finance agreement may require the insured to pay an electronic payment fee if the insured elects to pay a premium finance company by means of an electronic payment.

(c) A premium finance company may charge an electronic payment fee, which may not exceed $8, for actual expenses incurred by the premium finance company for the electronic payment.

§23–308.

A premium finance company may charge a dishonored check fee, which may not exceed $25, for actual expenses incurred in the processing of a dishonored check.

§23–309.

A premium finance company may not charge an insured or a prospective insured any fee for the expense that the premium finance company incurs in obtaining a comprehensive loss underwriting exchange automobile report (CLUE report) regarding the insured or prospective insured if a producer already has charged the insured or prospective insured for obtaining the report.

§23–310.

Filing of a premium finance agreement is not needed to perfect the validity of the premium finance agreement as a secured transaction as against creditors, subsequent purchasers, pledgees, encumbrancers, trustees in bankruptcy or any other insolvency proceeding under any law, or anyone having the status or power of any of those persons, their successors, or assigns.

§23–311.

A premium finance company is not required to reinstate a policy if:

(1) the insurer requires a reinstatement fee, as authorized under § 27–216(b)(5) of this article, to be paid by the insured; and

(2) the insured does not timely pay the reinstatement fee.

§23–401.

When in connection with a premium finance agreement a power of attorney or other authority to cancel an insurance contract on behalf of an insured is given to a premium finance company, the premium finance company may not cancel the insurance contract except in accordance with this subtitle.

§23–401.1.

(a) Subject to subsection (b) of this section, at the option of the insured a premium finance company may send any notice required under this subtitle by personal delivery, first–class mail, commercial delivery service, electronic mail, or facsimile transmission.

(b) A premium finance company may send any notice required under this subtitle by electronic means only if the premium finance company meets the requirements for delivering a notice under § 27–601.2 of this article.

§23–402.

(a) At least 10 days before canceling an insurance contract, a premium finance company shall deliver or mail to the insured written notice of intent to cancel the insurance contract unless the defaulted installment payment is received within the 10–day notice period.

(b) For an automobile liability insurance contract, the notice of intent to cancel shall include a statement in clear and specific terms that if the insured fails to replace the automobile liability insurance within the 10–day notice period, § 17–106 of the Transportation Article provides that uninsured motorist penalties be assessed and that all evidences of registration be surrendered to the Motor Vehicle Administration and that failure to surrender the evidences of registration may result in suspension of current and future registration privileges.

(c) The cancellation of an insurance contract on the date stated in a notice of intent to cancel or a notice of cancellation is not superseded by a premium finance company's issuance of a subsequent notice of intent to cancel sent under this section or a notice of cancellation sent under § 23–403 of this subtitle.

§23–403.

(a) (1) After the end of the notice period under § 23–402(a) of this subtitle, the premium finance company may cancel the insurance contract by submitting to the insurer a notice of cancellation that specifies the effective date of the cancellation.

(2) (i) The premium finance company shall deliver or mail a copy of the notice of cancellation to the insured at the last known address of the insured.

(ii) With respect to commercial automobile, fire, or liability insurance, the premium finance company shall deliver the notice in accordance with the insured's request under § 23–401.1 of this subtitle.

(b) (1) If the insurer receives a notice of cancellation issued under subsection (a) of this section within 30 days after the effective date of cancellation specified in the notice, the insurer shall cancel the insurance contract effective on the date specified in the notice.

(2) Subject to paragraph (3) of this subsection, if the insurer receives a notice of cancellation issued under subsection (a) of this section more than 30 days after the effective date of cancellation specified in the notice, the insurance contract shall be canceled effective on the date the insurer receives the notice.

(3) If a premium finance company fails to meet the 30–day notice requirement under paragraph (1) of this subsection because the installment payment of the insured is dishonored after the effective date specified in the notice of cancellation, the dishonored payment is ineffective and the insurer may waive the 30–day notice requirement.

(c) A cancellation under this section shall be made as if the notice of cancellation had been submitted by the insured, but without requiring the return of the policy.

§23–403.1.

If, within 15 business days after the date of written notice from a financial institution that the initial down payment for the coverage being financed has been dishonored, an insurer receives notice of the dishonor from an insurance producer or premium finance company, there is no valid insurance contract or insurance contracts, and the policy shall be voided.

§23–404.

(a) All statutory, regulatory, and contractual restrictions that provide that the insured may not cancel an insurance contract unless notice is given to a governmental agency, mortgagee, or other third party shall apply to a cancellation made under this subtitle.

(b) If an insurer is required under subsection (a) of this section to give notice on behalf of itself or the insured, the insurer shall:

(1) give notice to the governmental agency, mortgagee, or other third party; and

(2) compute the effective date of cancellation from the day the insurer receives the notice of cancellation from the premium finance company.

§23–405.

(a) (1) Notwithstanding any other provision of this article, when an insurance contract is canceled, whether by a premium finance company, an insurer, or an insured, the insurer shall return any gross unearned premiums that are due

under the insurance contract, computed pro rata, and excluding any expense constant, administrative fee, or any nonrefundable charge filed with and approved by the Commissioner, to the premium finance company for the account of the insured within a reasonable time not exceeding 45 days after:

(i) receipt by the insurer of a notice of cancellation from the premium finance company or the insured;

(ii) the date the insurer cancels the insurance contract; or

(iii) with respect to commercial automobile, fire, or liability insurance, completion of any audit necessary to determine the amount of premium earned while the insurance contract was in force.

(2) An audit under paragraph (1)(iii) of this subsection shall be performed within 45 days after the insurer receives the notice of cancellation.

(b) (1) After the insurer returns to the premium finance company any gross unearned premiums that are due under the insurance contract, the premium finance company shall refund to the insured the amount of unearned premium that exceeds any amount due under the premium finance agreement.

(2) A premium finance company need not make a refund to the insured if the amount of the refund would be less than $5.

(c) Whenever an insurer, after receiving notice of the existence of a premium finance agreement, returns any unearned premiums to a person other than the premium finance company named in the premium finance agreement, the insurer shall be directly responsible to the premium finance company for all unearned premiums arising from the cancellation of the premium finance agreement.

(d) (1) An insurer that fails to return any premium required under this section shall pay interest of 1% per month on the unearned premium that has not been returned until the unearned premium is returned.

(2) Any payment under this subsection to the premium finance company shall be credited to the account of the insured.

(e) An insurer may not deduct from any return premium any amount owed to the insurer by the insured under any other insurance contract.

(f) An insurance producer shall return any gross unearned commissions, calculated as provided in subsection (a)(1) of this section, to an insurer within a reasonable period of time as required by the insurer.

§23–406.

Whenever an insurance contract is canceled in accordance with this subtitle, the premium finance company may not collect from an insured an amount due under the premium finance agreement that is less than $5.

§23–501.

A premium finance company, or an insurance producer, if applicable, may not require an insured or prospective insured to purchase or finance add-on coverage, as defined in § 20-504 of this article, as a condition of financing the premium for an insurance contract issued by the Maryland Automobile Insurance Fund.

§23–501.1.

(a) A premium finance company may not impose any finance charge or other charge on any payment for the purchase price of a motor club service contract.

(b) A premium finance company may not cancel an insurance contract if any payment under the premium finance agreement:

(1) is sufficient to pay the installment due under the premium finance agreement that is related to the insurance contract obligation; but

(2) is not sufficient to cover the amount of the monthly payment for the motor club service contract.

§23–502.

(a) A person may not pay any part of an initial service fee or any other fee or charge to an insurance producer, employee of an insurance producer, or to any other person as an inducement to financing an insurance contract with a premium financing company.

(b) An insurance producer, employee of an insurance producer, or any other person may not accept, directly or indirectly, any valuable consideration as an inducement to facilitate an agreement to finance an insurance premium that contains an assignment of or is otherwise secured by the unearned premium or refund obtainable from an insurer on cancellation of an insurance contract.

§23–503.

A premium finance company may not induce an insured to enter into more than one premium finance agreement in order to obtain more than one initial service fee.

§23–504.

Unless otherwise authorized by law, a person may not charge, take, receive from, reserve, or impose on an insured or prospective insured greater charges than those allowed by this title.

§23–505.

The holder of a power of attorney may not cancel an insurance contract because a delinquency and collection charge under § 23-306 of this title has not been paid.

§23–505.1.

An insurer that markets through independent insurance producers as defined in this article may not:

(1) refuse to issue or deny the issuance of a policy because premiums have been advanced by a registered premium finance company not affiliated with the insurer; or

(2) require an insured to use a particular premium finance company or other installment plan.

§23–505.2.

(a) An insurer that markets through independent insurance producers as defined in this article may not discriminate, intimidate, or retaliate against an insurance producer or insured that uses premium financing by denying the insurance producer or insured the same rights accorded to insurance producers or insureds who pay premiums in a different manner.

(b) With respect to personal lines automobile insurance, an insurance producer, who directly or indirectly has an ownership interest in a premium finance company, shall provide a disclosure to be signed by the insured comparing the costs and terms of premium financing with the insurer's alternative payment plan.

(c) The disclosure required by subsection (b) of this section shall:

(1) state the total amount to be paid by the insured under the premium finance agreement during the policy term, including premium, any down

payment, and all interest, fees, and charges incident to the premium finance agreement and resulting extension of credit; and

(2) state the total amount to be paid by the insured under the insurer's alternative payment plan during the policy term, including premium, any down payment, and all fees and charges incident to the alternative payment plan.

(d) An insurance producer, or an employee or agent of the insurance producer, who directly or indirectly has an ownership interest in a motor club shall provide a disclosure to be signed by the insured informing the insured of the insurance producer's or the insurance producer's employee's or agent's interest in the motor club.

§23–506.

In addition to any other applicable administrative or civil penalty, a premium finance company, insurer, or insurance producer that willfully and knowingly violates any provision of this title is guilty of a misdemeanor and on conviction is subject to a fine not exceeding $1,000 or imprisonment not exceeding 1 year or both.

§24–201.

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

(b) "Health care facility" has the meaning stated in § 19–114 of the Health – General Article.

(c) "Health care provider" means a person licensed or authorized to practice a health occupation.

(d) "Physician" means an individual who:

(1) is licensed to practice medicine in the State; or

(2) lawfully practices medicine without a license under § 14–302 (a)(1) through (4) of the Health Occupations Article.

(e) "Practice medicine" has the meaning stated in § 14–101 of the Health Occupations Article.

(f) "Society" means the Medical Mutual Liability Insurance Society of Maryland.

(g) "Surplus" does not include debt of the Society incurred in accordance with § 3–116(a)(1) of this article to enable it to comply with a surplus requirement.

§24–202.

Subject to the limitations and immunities of this subtitle, the purpose of this subtitle is to provide:

(1) for the payment of indemnities to persons that suffer injuries arising out of the rendering of or failure to render professional services by physicians or other health care providers;

(2) a means for physicians or other health care providers to obtain insurance against liability for injuries arising out of the rendering of or failure to render professional services; and

(3) property insurance and casualty insurance related to the provision of health care or to health care facilities used by physicians or other health care providers.

§24–203.

(a) (1) There is a Medical Mutual Liability Insurance Society of Maryland.

(2) The Society is a nonstock corporation.

(b) Except as otherwise provided in this subtitle, the Society has the powers, privileges, and immunities granted by and is subject to the provisions imposed on mutual insurers by this article and by the applicable provisions of the Corporations and Associations Article.

(c) The Society is a member of the Joint Insurance Association and the Property and Casualty Insurance Guaranty Corporation.

(d) (1) The Society is not and may not be deemed a department, unit, agency, or instrumentality of the State for any purpose.

(2) All debts, claims, obligations, and liabilities of the Society, whenever incurred, shall be the debts, claims, obligations, and liabilities of the Society only and not of the State or the State's agencies, instrumentalities, officers, or employees.

(e) (1) The money of the Society is not part of the General Fund of the State.

(2) The State may not budget for or provide General Fund appropriations to the Society.

(3) The debts, claims, obligations, and liabilities of the Society are not a debt of the State or a pledge of the credit of the State.

§24–204.

(a) There is a Board of Directors of the Society.

(b) (1) There shall be at least 11 directors on the Board.

(2) The directors shall be elected by the members of the Society in accordance with the articles of incorporation and bylaws of the Society.

(3) The bylaws of the Society shall provide that:

(i) not more than five directors may be licensed physicians;

(ii) at least two directors must have had substantial experience as an officer or employee of an insurer;

(iii) at least two directors must be officers and employees of the Society who are responsible for the daily management of the Society; and

(iv) the Board of Directors must consist of individuals who live in different geographical areas of the State.

(c) The Board of Directors governs the Society and exercises the corporate powers of the Society.

§24–205.

(a) (1) If the Board of Directors determines that the affairs of the Society may be administered suitably and efficiently, the Society may enter into a contract with a licensed insurer or licensed nonprofit health service plan to administer the affairs of the Society, subject to the continuing direction of the Board of Directors specified in the articles of incorporation and bylaws of the Society and the contract.

(2) A contract may not exceed 5 years.

(b) (1) On execution of the contract, the Society promptly shall file a true copy of the contract with the Commissioner.

(2) The contract is effective 30 days after the date of filing unless, before the effective date, the Commissioner disapproves the contract as contrary to law or public policy or as unduly onerous and states the reasons for the disapproval.

§24–206.

On approval of the application for a certificate of authority, the Commissioner shall issue to the Society a certificate of authority that authorizes the Society to issue:

(1) the following policies of casualty insurance:

(i) insurance against the liability of physicians or other health care providers for injury arising out of the rendering of or failure to render professional services by the insured;

(ii) insurance against the liability of a person for whose acts or omissions a physician or other health care provider is responsible under item (i) of this item or with whom the physician or other health care provider is associated, including partners, employees, employers, associates, consultants, or a professional service corporation whose stock the insured owns; and

(iii) insurance against other liability for injury by persons employed in, by property used in, or by activities incidental to, practicing medicine or practicing another health occupation by the named insured, when issued as incidental coverage with or supplemental to insurance specified in item (i) of this item; and

(2) policies of property insurance and casualty insurance that are related to the provision of health care or to health care facilities that physicians or other health care providers use where health care is practiced on a regular basis.

§24–207.

(a) Each policyholder is subject to assessment as provided in §§ 3-110, 3-111, and 3-112 of this article.

(b) Notwithstanding subsection (a) of this section, if the Society meets all applicable requirements of this article about the sale of nonassessable policies, including the requirements of §§ 4-104, 4-105, and 4-106 of this article, the Society may issue nonassessable policies subject to:

(1) § 3-113 of this article;

(2) all other applicable provisions of this article; and

(3) the Corporations and Associations Article.

§24–208.

(a) The directors of the Society may establish membership fees in amounts they consider reasonable, to be paid by the members of the Society.

(b) Each physician who paid the special one-time tax imposed by former Article 48A, § 552(b) of the Code shall be credited with the amount of the tax paid against the liability of the physician for the membership fee.

(c) On payment of the membership fee, a physician or other health care provider may be insured by the Society for any and all hazards customarily insured by the Society, subject to any coverage limitations specified by the Society in accordance with policy limitations, exclusions, conditions, deductibles, and loss-sharing requirements.

§24–209.

(a) Policies that the Society issues to each class of physicians and other health care providers shall be essentially uniform in terms and conditions of coverage.

(b) Notwithstanding subsection (a) of this section, the Society may:

(1) establish reasonable classifications of physicians and other health care providers, insured activities, and exposures based on a good faith determination of relative exposures and hazards among classifications;

(2) vary the limits, coverages, exclusions, conditions, and loss-sharing provisions among classifications; and

(3) establish, for an individual physician or other health care provider within a classification, reasonable variations in the terms of coverage, including deductibles and loss-sharing provisions, based on the insured's prior loss experience and current professional training and capability.

(c) (1) In this subsection, "nursing facility" has the meaning stated in § 19-301 of the Health - General Article.

(2) The Society may not deny, cancel, or refuse to renew medical professional liability insurance coverage for a physician, based solely on the physician's:

(i) employment by, or provision of health care services at, an assisted living or nursing facility;

(ii) provision of mammography services; or

(iii) provision of services in an emergency room.

§24–210.

(a) Notwithstanding any other provision of this subtitle, the Society may establish, own, or control a subsidiary for any business purpose.

(b) A subsidiary that is established, owned, or controlled by the Society is not subject to this subtitle.

(c) (1) A subsidiary of the Society is not and may not be deemed a department, unit, agency, or instrumentality of the State for any purpose.

(2) The State may not be held in any way liable or responsible for any of the debts, claims, obligations, or liabilities of a subsidiary of the Society or the Society.

(d) Without the prior approval of the Board of Directors, including at least 80% of the physician members of the Board of Directors, the Society may not directly or indirectly capitalize, transfer moneys to, or purchase stock in an insurance subsidiary beyond the $3,250,000 used by the Society before December 31, 1989, to capitalize the insurance subsidiaries.

§24–211.

(a) (1) Not later than June 30 of each year, the Society shall report to the Commissioner and to the General Assembly:

(i) salaries and other compensation paid to officers, executives, and directors for the preceding calendar year;

(ii) a summary and detailed financial statement for the four preceding calendar years indicating amounts for and changes in:

1. insurance reserves and losses;

2. assets and liabilities;

3. income and expenses; and

4. return on invested surplus; and

(iii) management's evaluation of the financial position of the Society.

(2) The evaluation under paragraph (1)(iii) of this subsection shall include an analysis indicating whether sufficient resources exist to justify providing a dividend or similar distribution to members in the current year and, if not, how the current circumstances vary from prior years in which such distributions have been made.

(b) Any rate filing by the Society shall include the information required under subsection (a) of this section.

(c) (1) Before the Society may pay to its members a dividend or similar distribution, the Society shall provide to the Commissioner, using a methodology prescribed by the Commissioner, an analysis indicating the extent to which the distribution results from any excess of premiums collected over accumulated losses for incidents arising in any premium year during which the State provided financial assistance.

(2) (i) To the extent the analysis required under paragraph (1) of this subsection determines that funds available for distribution are attributed to a year in which financial assistance is provided, the Commissioner shall order the Society to pay a portion of the distribution to the State.

(ii) The amount paid to the State shall be determined based on the ratio of State expenditures for financial assistance to total premiums earned for each premium year for which State financial assistance was made.

§24–212.

(a) If the Society requests a rate increase of more than 7.5% and, at the time of the rate filing, the Society's surplus is more than 500% of its authorized control level risk-based capital, the Commissioner may determine whether the Society's surplus is excessive.

(b) If, after a hearing, the Commissioner determines that the surplus is excessive, the Commissioner may order the rates filed to be reduced.

§24–213.

(a) The Legislative Auditor shall conduct a fiscal and compliance audit of the accounts and transactions of the Society for each year in which the Society receives a disbursement from the Rate Stabilization Account under § 19–805 of this article.

(b) Within one year of the date of an audit report required under subsection (a) of this section, the Legislative Auditor shall conduct a follow–up audit to determine the status of any audit recommendations.

(c) The Society shall pay the cost of each audit.

§24–214.

For policies that take effect on or after January 11, 2005 and through December 31, 2009, the Society may not pay a commission at a rate that exceeds 5% of the premium.

§24–301.

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

(b) "Board" means the Board for the Chesapeake Employers' Insurance Company.

(c) "Company" means the Chesapeake Employers' Insurance Company.

(d) "Fund" means the Injured Workers' Insurance Fund established under Title 10 of the Labor and Employment Article.

§24–302.

The General Assembly finds and determines that:

(1) employers' access to affordable workers' compensation insurance is of utmost importance to the economy of the State;

(2) the Fund has been the State's insurer of last resort for workers' compensation insurance since 1914;

(3) since its creation, the Fund was permitted to compete with the private insurance market; however, the Fund did not become an effective competitive

insurer until the General Assembly exempted the Fund from most laws that apply to State government agencies and required the Fund to be a regulated insurer;

(4) the most effective way to ensure that Maryland's workers' compensation system remains stable and affordable is to encourage and create as much competition in the marketplace as possible;

(5) the long–term competitive success of the Fund would be enhanced if the final barriers to full competition were eliminated by converting the Fund into a fully competitive, fully regulated, private insurer;

(6) converting the Fund into a private, nonstock, nonprofit insurer would level the competitive playing field for all workers' compensation insurers operating in the State;

(7) converting the Fund into a private, nonstock, nonprofit insurer would provide assurance to Maryland employers that the financial success of the Fund would inure to their benefit as policyholders through dividends and lower rates and that surplus funds could not be transferred to the State's General Fund;

(8) the interests of the State would be protected if the Fund's statutory purpose of insurer of last resort for workers' compensation insurance is preserved and the Governor retains the right to appoint two members of the board of the new company;

(9) (i) the interests of the employees of the Fund would be satisfied by ensuring that current employees have the option to remain State employees of the Fund after the conversion of the Fund to a private, nonstock, nonprofit insurer; and

(ii) the interests of employees of the Fund would further be satisfied by ensuring that current long–term State employees who remain State employees of the Fund after the conversion of the Fund to a private, nonstock, nonprofit insurer shall remain in the State retirement system and, therefore, would not be unfairly penalized by being prematurely forced out of the State retirement system due to the conversion; and

(10) the interests of the residents of the State, both employers and employees, will be best met by converting the Fund into a private, nonstock, nonprofit, fully regulated, competitive insurer.

§24–303.

(a) There is a Chesapeake Employers' Insurance Company.

(b) The Company shall be:

(1) a private, nonprofit, nonstock corporation organized under State law; and

(2) subject to the applicable provisions of the Corporations and Associations Article as a nonstock corporation.

(c) Before October 1, 2013, the Company shall:

(1) file articles of incorporation under the Corporations and Associations Article; and

(2) take all steps necessary to be a private, nonprofit, nonstock corporation organized under State law.

§24–304.

(a) Before October 1, 2013, the Company shall:

(1) file an application for a certificate of authority under this article and a statement of the risk–based capital levels of the Company as of the date of the application prepared in accordance with § 4–303 of this article; and

(2) take all steps necessary to be an authorized domestic insurer under State law.

(b) On approval of the application for a certificate of authority, the Commissioner shall issue to the Company a certificate of authority that authorizes the Company to issue policies under Title 9 of the Labor and Employment Article.

(c) Except as otherwise provided in this subtitle, the Company has the powers, privileges, and immunities granted by and is subject to the provisions applicable to insurers authorized to write workers' compensation insurance under this article.

(d) The Company may issue policies for:

(1) employer's liability insurance; and

(2) insurance under a federal compensation law.

(e) Except as otherwise provided in this subtitle, the Company shall be:

(1) authorized, examined, and regulated by the Commissioner in the same manner and to the same extent as other authorized property and casualty insurers; and

(2) subject to each provision of this article that is applicable to other authorized property and casualty insurers.

(f) The Company is a member of the Property and Casualty Insurance Guaranty Corporation.

§24–306.

(a) The Company:

(1) shall be an authorized insurer; and

(2) on and after October 1, 2013, as a condition of being an authorized insurer, shall be the workers' compensation insurer of last resort for employers covered under Title 9 of the Labor and Employment Article.

(b) Before October 1, 2013, the Fund shall serve as the workers' compensation insurer of last resort for workers' compensation insurance and as a competitive workers' compensation insurer under the same terms and conditions as the Fund served before October 1, 2012.

(c) The Company may not cancel or refuse to renew or issue a policy except for:

(1) nonpayment of a premium for current or prior policies issued by the Fund or the Company;

(2) failure to provide payroll information to the Fund or the Company;

(3) failure to cooperate in any payroll audit conducted by the Fund or the Company; or

(4) failure to reimburse the Company under a policy with deductibles as required under § 19–404 of this article.

(d) The Company may engage only in the business of workers' compensation insurance in accordance with State law.

(e) Subject to the requirements of Title 7 of this article, the Company may establish, own, or acquire a subsidiary for any lawful purpose if the subsidiary:

(1) is, or after acquisition will be, wholly owned by the Company;

(2) engages in a business activity that is ancillary to the workers' compensation insurance business; and

(3) is operated for the purpose of benefiting the Company.

§24–307.

(a) (1) There is a Board for the Chesapeake Employers' Insurance Company.

(2) The Board shall manage the business and affairs of the Company as a private, nonprofit corporation in accordance with State law.

(b) (1) The Board shall consist of nine members, of which:

(i) two members shall be appointed by the Governor; and

(ii) subject to paragraph (3) of this subsection, seven members shall be appointed by the policyholders of the Company under procedures provided in the bylaws of the Board.

(2) To the extent practicable, the Board shall reflect the geographic and demographic, including race and gender, diversity of the State.

(3) Of the seven members appointed by the policyholders:

(i) two members shall have substantial experience as officers or employees of an insurer, but may not be employed by an insurer that is in direct competition with the Company while serving on the Board;

(ii) one member shall be a policyholder of the Company;

(iii) one member shall have significant experience in the investment business;

(iv) one member shall have significant experience in the accounting or auditing field; and

(v) one member shall have significant experience as a representative, employee, or member of a labor union.

(c) Each member shall be a resident of the State.

(d) (1) The term of a member is 5 years.

(2) The terms of members are staggered as required by the terms provided for members of the Board for the Fund on October 1, 2015.

(3) At the end of a term, a member continues to serve until a successor is appointed and qualifies.

(4) A member who is appointed after a term has begun serves only for the rest of the term and until a successor is appointed and qualifies.

(5) A member may not serve for more than:

(i) two full terms; or

(ii) a total of 10 years.

(e) (1) The Governor may remove a member appointed by the Governor for incompetence or misconduct.

(2) (i) The policyholders may remove a member appointed by the policyholders at any time, with or without cause, by the affirmative vote of a majority of all of the votes entitled to be cast generally in the election of directors.

(ii) The Commissioner may remove a member appointed by the policyholders for incompetence, misconduct, or malfeasance after notice and opportunity for a hearing under §§ 2–210 through 2–214 of this article.

(f) The Board shall adopt rules, bylaws, and procedures.

§24–308.

(a) Subject to subsection (b) of this section, the Board may declare a policyholder dividend in the form of a cash refund or credit to:

(1) a policyholder based on the actual loss ratio that is better than the loss ratio used to calculate the policyholder's premium; or

(2) all policyholders whose loss ratio contributed to the Company's surplus for that year.

(b) (1) The Board may not issue a policyholder dividend under subsection (a)(2) of this section unless the Commissioner has approved the policyholder dividend.

(2) In determining whether to approve the policyholder dividend under paragraph (1) of this subsection, the Commissioner shall consider:

(i) the Company's surplus;

(ii) material changes in premium rates, claims, market share, or types of insured risks;

(iii) the methodology the Board used to determine that policyholders are eligible for the policyholder dividend; and

(iv) any other factor the Commissioner considers relevant.

§24–309.

(a) The Company is not and may not be deemed to be a department, unit, agency, or instrumentality of the State for any purpose.

(b) Employees of the Company are not:

(1) employees of the State; or

(2) members of the State Retirement and Pension System.

(c) All debts, claims, obligations, and liabilities of the Company, whenever incurred, shall be the debts, claims, obligations, and liabilities of the Company only and not of the State or the State's departments, units, agencies, instrumentalities, officers, or employees.

(d) (1) Money of the Company is not part of the General Fund of the State.

(2) The State may not budget for or provide General Fund appropriations to the Company.

(3) The debts, claims, obligations, and liabilities of the Company are not a debt of the State or a pledge of the credit of the State.

§24–310.

(a) Consistent with minority business purchasing standards applicable to units of State government under the State Finance and Procurement Article and consistent with the fiduciary duties of the Board, the Board shall attempt to use to the greatest extent feasible minority business enterprises to provide brokerage and investment management services to the Board.

(b) For purposes of this section, brokerage and investment management services shall include services relating to all allocated asset classes.

(c) (1) To assist the Board in achieving the goal described under subsection (a) of this section, the Board shall undertake measures to remove any barriers that limit full participation by minority business enterprises in brokerage and investment management services opportunities afforded by the Company.

(2) The measures undertaken by the Board shall include the use of a wide variety of media, including the Board's Web site, to provide notice to a broad and varied range of potential providers about the brokerage and investment management services opportunities afforded by the Company.

(d) In conjunction with the Governor's Office of Small, Minority, and Women Business Affairs, the Board shall develop guidelines to assist it in identifying and evaluating qualified minority business enterprises in order to help the Company achieve the objective for greater use of minority business enterprises for brokerage and investment management services.

(e) On or before September 1 each year, the Board shall submit a report to the Governor's Office of Small, Minority, and Women Business Affairs and, in accordance with § 2–1257 of the State Government Article, the General Assembly on:

(1) the identity of the minority business enterprise brokerage and investment management services firms used by the Board in the immediately preceding fiscal year;

(2) the percentage and dollar value of the Company assets that are under the investment control of minority business enterprise brokerage and investment management services firms; and

(3) the measures the Board undertook in the immediately preceding fiscal year in accordance with subsection (c)(2) of this section.

§24–311.

(a) Except as provided in subsections (b) and (c) of this section, on October 1, 2013, all the functions, powers, duties, assets, real and personal property, accounts, liabilities, contracts, and obligations of the Fund shall be irrevocably transferred to the Company, including liability for all claims, whether known or unknown, arising out of any insurance policy previously issued by the Fund.

(b) Any contract or agreement with the State for the third party administration of the State's Self–Insured Workers' Compensation Program for State Employees may not be transferred or assigned to the Company until the Fund no longer has employees.

(c) The Fund shall retain those assets necessary to perform its duties under Title 10 of the Labor and Employment Article.

§24–312.

The Company may not:

(1) be converted to a mutual or stock company;

(2) be sold; or

(3) be dissolved.

§25–101.

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

(b) "Board of directors" or "board" means the governing body of a risk retention group elected by the shareholders or members of the risk retention group to establish policy, elect or appoint officers and committees, and make other governing decisions.

(c) (1) "Completed operations liability" means liability arising out of the installation, maintenance, or repair of a product at a site that is not owned or controlled by:

(i) a person that performs that work; or

(ii) a person that hires an independent contractor to perform that work.

(2) "Completed operations liability" includes liability for activities that are completed or abandoned before the date of the occurrence giving rise to the liability.

(d) "Director" means an individual designated in the articles of incorporation of a risk retention group, or designated, elected, or appointed by any other manner, name, or title to act as a director of the risk retention group.

(e) "Domicile" means, for the purpose of determining the state in which a purchasing group has its domicile:

(1) the state of incorporation of a purchasing group that is a corporation; or

(2) the state of the principal place of business of a purchasing group that is an unincorporated entity.

(f) "Hazardous financial condition" means the condition of a risk retention group in which, based on its present or reasonably anticipated financial condition, the risk retention group:

(1) is not yet financially impaired or insolvent; but

(2) is unlikely to be able to:

(i) meet obligations to policyholders with respect to known claims and reasonably anticipated claims; or

(ii) pay other obligations in the normal course of business.

(g) "Immediate family member" means an individual's:

(1) spouse;

(2) child;

(3) child's spouse;

(4) parent;

(5) spouse's parent;

(6) sibling; or

(7) sibling's spouse.

(h) "Insurance" means primary insurance, excess insurance, reinsurance, surplus lines insurance, and any other arrangement for shifting and distributing risk that is determined to be insurance under the laws of the State.

(i) (1) "Liability" means legal liability for damages, including costs of defense, legal costs and fees, and other claims expenses, because of injuries to persons, damage to their property, or other damage or loss to those persons, resulting from or arising out of:

(i) a business, whether profit or nonprofit, trade, products, services, including professional services, premises, or operations; or

(ii) an activity of a state or local government, or an agency or political subdivision of a state or local government.

(2) "Liability" does not include:

(i) personal risk liability, which is liability for damages because of injury to a person, damage to property, or other damage or loss resulting from personal, familial, or household responsibilities or activities; or

(ii) the liability of an employer with respect to its employees other than legal liability under the federal Employers' Liability Act.

(j) "Plan of operation or feasibility study" means an analysis that presents the expected activities and results of a risk retention group including, at a minimum:

(1) information sufficient to verify that the members of the risk retention group are engaged in businesses or activities that are similar or related with respect to the liability to which the members are exposed by virtue of related, similar, or common business, trade, products, services, premises, or operations;

(2) for each state in which the risk retention group intends to operate, the coverages, deductibles, coverage limits, rates, and rating classification systems for each line of insurance that the risk retention group intends to offer;

(3) historical and expected loss experience of the proposed members and national experience of similar exposures, to the extent this experience is reasonably available;

(4) pro forma financial statements and projections;

(5) appropriate opinions by a qualified, independent casualty actuary, including a determination of minimum premium or participation levels required to begin operations and to prevent a hazardous financial condition;

(6) identification of management, underwriting and claims procedures, marketing methods, managerial oversight methods, investment policies, and reinsurance agreements;

(7) identification of each state in which the risk retention group has obtained or sought to obtain a charter and license, and a description of its status in each state identified; and

(8) any other matters required by the commissioner of the state in which the risk retention group is chartered for liability insurance companies authorized by the insurance laws of that state.

(k) (1) "Product liability" means liability for damages because of personal injury, death, emotional harm, consequential economic damage, or property damage, including damages resulting from the loss of use of the property, arising out of the manufacture, design, importation, distribution, packaging, labeling, lease, or sale of a product.

(2) "Product liability" does not include the liability of a person for damages if the product involved was in the possession of the person when the incident giving rise to the claim occurred.

(l) "Purchasing group" means a group that:

(1) has as a purpose the purchase of liability insurance on a group basis;

(2) purchases liability insurance only for its group members and only to cover the similar or related liability exposure of the group members;

(3) is composed of members engaged in businesses or activities that are similar or related with respect to the liability to which the members are exposed by virtue of related, similar, or common business, trade, products, services, premises, or operations; and

(4) has its domicile in a state.

(m) "Risk retention group" means a corporation or other limited liability association:

(1) that is formed under the laws of a state, Bermuda, or the Cayman Islands;

(2) the primary activity of which consists of assuming and spreading all or part of the liability exposure of its group members;

(3) that is organized for the primary purpose of conducting the activity described in item (2) of this subsection;

(4) that:

(i) is chartered and licensed as a liability insurance company and authorized to engage in the insurance business under the laws of a state; or

(ii) 1. on or before December 31, 1984, was chartered or licensed and authorized to engage in the insurance business under the laws of Bermuda or the Cayman Islands and, on or before December 31, 1984, had certified to the insurance commissioner of at least one state that it satisfied the capitalization requirements of that state; and

2. has been engaged in business continuously since January 1, 1985 and only for the purpose of continuing to provide insurance to cover product liability or completed operations liability;

(5) that does not exclude a person from membership in the group solely to provide for members of the group a competitive advantage over that person;

(6) that:

(i) has as its members only persons that have an ownership interest in the group and has as its owners only persons that are members of the group and are provided insurance by the group; or

(ii) has as its sole owner an organization that:

1. has as its members only persons that are members of the group; and

2. has as its owners only persons that are members of the group and are provided insurance by the group;

(7) the members of which are engaged in businesses or activities that are similar or related with respect to the liability to which the members are exposed

by virtue of related, similar, or common business, trade, products, services, premises, or operations;

(8) the activities of which do not include the provision of insurance other than:

(i) liability insurance for assuming and spreading all or part of the liability of its group members; and

(ii) reinsurance with respect to the liability of another risk retention group, or a member of the other risk retention group, that is engaged in businesses or activities so that the risk retention group or member meets the requirement of item (7) of this subsection of membership in the risk retention group that provides the reinsurance; and

(9) the name of which includes the phrase "risk retention group".

(n) (1) Except as provided in paragraph (2) of this subsection, "state" means a state of the United States or the District of Columbia.

(2) When capitalized, "State" means Maryland.

§25–102.

(a) A risk retention group that seeks to be chartered in the State:

(1) shall be chartered and licensed as a liability insurance company in conformance with all insurance laws and regulations of the State; and

(2) except as otherwise provided in this subtitle, shall comply with:

(i) all the laws, regulations, and requirements applicable to insurers chartered and licensed in the State; and

(ii) the requirements of § 25–103 of this subtitle, to the extent that those requirements are not a limitation on the laws, regulations, or requirements of the State.

(b) (1) Before a risk retention group may offer insurance in a state, the risk retention group shall submit a plan of operation or feasibility study to the Commissioner for approval.

(2) Within 10 days after a change to an item of the plan of operation or feasibility study, the risk retention group shall submit to the Commissioner an appropriate revision of the plan of operation or feasibility study.

(3) A risk retention group may not offer additional lines of liability insurance in this State or in another state until a revision of the plan of operation or feasibility study is approved by the Commissioner.

(c) When a risk retention group files an application for charter, the risk retention group shall provide to the Commissioner the following information:

(1) the name of the risk retention group;

(2) the identity of the initial members of the risk retention group;

(3) the identity of the individuals who organized the risk retention group, or who will provide administrative services or otherwise influence or control the activities of the risk retention group;

(4) the amount and nature of initial capitalization;

(5) the coverages to be afforded; and

(6) the states in which the risk retention group intends to operate.

(d) (1) On receipt of the information required by subsection (c) of this section, the Commissioner shall forward the information to the National Association of Insurance Commissioners.

(2) Providing notification to the National Association of Insurance Commissioners is in addition to and may not be sufficient to satisfy the other requirements of this subtitle.

(e) (1) The board of directors of the risk retention group shall have a majority of independent directors.

(2) If the risk retention group is a reciprocal:

(i) the attorney–in–fact shall be required to adhere to the same standards regarding independence of operation and governance that are imposed on the risk retention group's board of directors or subscribers advisory committee; and

(ii) to the extent permissible under State law, service providers of a reciprocal risk retention group:

1. shall contract with the risk retention group; and

2. may not contract with the attorney–in–fact.

(3) (i) A director qualifies as independent when the board of directors affirmatively determines that the director has no material relationship with the risk retention group.

(ii) A person that is a direct or indirect owner of or subscriber in the risk retention group, as contemplated by 15 U.S.C. § 3901(a)(4)(e)(ii), the federal Liability Risk Retention Act, or that is an officer, a director, or an employee of the owner or insured, is considered to be independent unless some other position of the officer, director, or employee constitutes a material relationship.

(iii) The risk retention group annually shall disclose the board's determinations to the Commissioner.

(4) (i) For purposes of this section, a person is deemed to have a material relationship with a risk retention group if any of the following receive, in any one 12–month period, compensation, payment, or any other item of value greater than or equal to the threshold value described in subparagraph (ii) of this paragraph:

1. the person;

2. a member of the person's immediate family;

3. any business with which the person is affiliated from the risk retention group; or

4. a consultant or service provider to the risk retention group.

(ii) The threshold value for determining whether receipt of compensation, payment, or any other item of value under subparagraph (i) of this paragraph demonstrates a material relationship is the greater of:

1. 5% of the risk retention group's gross written premium for the 12–month period; or

2. 2% of its surplus, as measured at the end of any fiscal quarter falling in the 12–month period.

(iii) In addition to the standard set under subparagraph (i) of this paragraph, the board of directors may determine that any other relationship of the person to the risk retention group is a material relationship.

(iv) The person or immediate family member of the person is not independent until 1 year after the compensation, payment, or other item of value described in subparagraph (ii) of this paragraph received from the risk retention group falls below the applicable threshold.

(v) A director who is affiliated with or employed in a professional capacity by a present or former internal or external auditor of the risk retention group is not considered independent until 1 year after the end of the affiliation, employment, or auditing relationship.

(vi) A director or an immediate family member of a director who is employed as an executive officer of another company where any of the risk retention group's present executives serve on the board of directors is not considered independent until 1 year after the end of the service or the employment relationship.

(f) (1) In this subsection, "service provider" includes:

(i) a captive manager;

(ii) an auditor;

(iii) an accountant;

(iv) an actuary;

(v) an investment advisor;

(vi) a lawyer other than defense counsel that the risk retention group retains to defend claims, unless the amount of fees paid to the lawyer is material under subsection (e)(4) of this section; and

(vii) a managing general underwriter or other party responsible for underwriting, determining rates, collecting premium, adjusting and settling claims, or preparing financial statements.

(2) A material service provider contract with the risk retention group:

(i) may not have a term exceeding 5 years;

(ii) shall require the issuance and renewal of the contract to be approved by a majority of the risk retention group's independent directors;

(iii) shall provide that the risk retention group's board of directors shall have the right to terminate any service provider contract, audit contract, or actuarial contract at any time for cause after providing adequate notice as defined in the contract; and

(iv) shall be deemed material if the amount to be paid for the contract is greater than or equal to the greater of:

1. 5% of the risk retention group's annual gross written premium; or

2. 2% of its surplus.

(3) A risk retention group may not enter into a service provider contract that involves a relationship that is material under subsection (e)(4) of this section unless:

(i) the risk retention group notifies the Commissioner in writing of its intention to enter into the transaction at least 30 days before the transaction; and

(ii) the Commissioner has not disapproved the transaction within that period.

(g) The risk retention group's board of directors shall adopt a written policy in the plan of operation approved by the board that requires the board to:

(1) assure that all owners and insureds of the risk retention group receive evidence of ownership interest;

(2) develop a set of governance standards applicable to the risk retention group;

(3) oversee the evaluation of the risk retention group's management, including the performance of the captive manager, managing general underwriter, or other party or parties responsible for underwriting, determining rates, collecting premium, adjusting or settling claims, or preparing financial statements;

(4) review and approve the amount to be paid for all material service providers; and

(5) review and approve, at least annually:

(i) the risk retention group's goals and objectives relevant to the compensation of officers and service providers;

(ii) the officers' and service providers' performance in light of those goals and objectives; and

(iii) the continued engagement of the officers and material service providers.

(h) (1) The risk retention group shall have an audit committee.

(2) The audit committee shall be composed of at least three board members who have been determined to be independent under subsection (e) of this section.

(3) The audit committee shall have a written charter that defines the committee's purposes, including, at a minimum, to:

(i) assist board oversight of:

1. the integrity of the financial statements;

2. the compliance with legal and regulatory requirements; and

3. the qualifications, independence, and performance of the independent auditor and actuary;

(ii) discuss the annual audited financial statements and quarterly financial statements with management;

(iii) discuss the annual audited financial statements with its independent auditor and, if advisable, discuss its quarterly financial statements with its independent auditor;

(iv) discuss policies with respect to risk assessment and risk management;

(v) meet separately and periodically, either directly or through a designated representative of the committee, with management and independent auditors;

(vi) review with the independent auditor any audit problems or difficulties and management's response;

(vii) set clear hiring policies of the risk retention group as to the hiring of employees or former employees of the independent auditor;

(viii) require the external auditor to rotate the lead or coordinating audit partner having primary responsibility for the risk retention group's audit as well as the audit partner responsible for reviewing that audit so that neither individual performs audit services for more than 5 consecutive fiscal years; and

(ix) report regularly to the board of directors.

(4) A nonindependent board member may participate in the activities of the audit committee if invited by the members of the audit committee but may not be a member of the audit committee.

(5) Notwithstanding paragraph (1) of this subsection, the Commissioner may waive the requirement to establish an audit committee composed of independent board members if the risk retention group is able to demonstrate to the Commissioner that:

(i) it is impracticable to do so; and

(ii) the risk retention group's board of directors itself is otherwise able to accomplish the purposes of an audit committee as described in paragraph (3) of this subsection.

(i) (1) The board of directors shall adopt governance standards.

(2) The governance standards shall include:

(i) a process by which the directors are elected by the owners or insureds;

(ii) director qualification standards;

(iii) director responsibilities;

(iv) director access to management and, as necessary and appropriate, independent advisors;

(v) director compensation;

(vi) director orientation and continuing education;

(vii) the policies and procedures that are followed for management succession; and

(viii) the policies and procedures that are followed for annual performance evaluation of the board.

(3) The board of directors shall disclose the governance standards:

(i) by electronic means, which may include posting on the risk retention group's website, or other reasonable means; and

(ii) on the request of members and insureds.

(j) (1) The board of directors shall adopt a code of business conduct and ethics for directors, officers, and employees.

(2) The code of business conduct and ethics shall include provisions that address:

(i) conflicts of interest;

(ii) matters covered under the corporate opportunities doctrine;

(iii) confidentiality;

(iv) fair dealing;

(v) protection and proper use of risk retention group assets;

(vi) compliance with all applicable laws, rules, and regulations; and

(vii) the reporting of any illegal or unethical behavior that affects the operation of the risk retention group.

(3) The board of directors shall disclose the code of business conduct and ethics:

(i) by electronic means, which may include posting on the risk retention group's website, or other reasonable means; and

(ii) on the request of members and insureds.

(4) Any waiver of the code of business conduct and ethics for any director or executive officer shall promptly be disclosed to the board of directors.

(k) The captive manager and the president or chief executive officer of the risk retention group shall promptly notify the Commissioner in writing if either becomes aware of any material noncompliance with any of the governance standards required under subsections (e) through (j) of this section.

§25–103.

(a) A risk retention group that is chartered and licensed in a state other than this State and that seeks to do business as a risk retention group in this State shall comply with the requirements of this section.

(b) (1) Before a risk retention group offers insurance in this State, the risk retention group shall submit to the Commissioner:

(i) a statement that identifies:

1. the state or states in which the risk retention group is chartered and licensed as a liability insurance company;

2. the date of chartering and licensing;

3. the principal place of business of the risk retention group; and

4. any other information, including information on membership of the risk retention group, that the Commissioner requires to verify that the risk retention group qualifies as a risk retention group, as defined in § 25–101 of this subtitle;

(ii) subject to paragraphs (2) and (3) of this subsection, a copy of the plan of operation or feasibility study of the risk retention group and any revisions of the plan of operation or feasibility study submitted to the state in which the risk retention group is chartered and licensed;

(iii) a statement of registration that designates the Commissioner as its agent for service of legal process;

(iv) a copy of the financial statement of the risk retention group that:

1. was submitted to the state in which the risk retention group is chartered and licensed;

2. is certified by an independent certified public accountant; and

3. contains a statement of opinion on loss and loss adjustment expense reserves made by a member of the American Academy of Actuaries or a qualified loss reserve specialist;

(v) a copy of each examination of the risk retention group that is certified by the Commissioner or other public official that conducts the examination;

(vi) on request of the Commissioner, a copy of any information or document that relates to an outside audit performed with respect to the risk retention group; and

(vii) any other information that the Commissioner requires in order to verify the continuing qualification of the risk retention group as a risk retention group, as defined in § 25–101 of this subtitle.

(2) Subsection (b)(1)(ii) of this section does not apply to a line or classification of liability insurance that:

(i) was defined in the Product Liability Risk Retention Act of 1981 on or before October 26, 1986; and

(ii) was offered on or before October 26, 1986 by a risk retention group that had been chartered and operating for not less than 3 years on or before October 26, 1986.

(3) The risk retention group shall submit a copy of any material revision to its plan of operation or feasibility study equivalent to that required by § 25–102 of this subtitle within 30 days after the date of the approval of the revision by the commissioner of its chartering state or, if that approval is not required, within 30 days after filing.

(4) The Commissioner shall determine the filing fee for the statement of registration required by subsection (b)(1)(iii) of this section.

(c) (1) All premiums paid in this State to risk retention groups chartered in another state for coverages are subject to taxation at the same rate and are subject to the same interest, fines, and penalties for nonpayment as are foreign admitted insurers.

(2) Each risk retention group subject to this subsection is liable for the payment of premium taxes and taxes on premiums of direct business for risks resident or located in the State.

(3) On or before March 1 of each year, each risk retention group shall report all premiums paid to it for risks resident or located in the State.

(4) If the risk retention group fails to pay the specified taxes, the taxes shall be paid by each of the risk retention group's members whose risks are resident or located in the State.

(d) Each risk retention group, and each agent or representative of a risk retention group, shall comply with Title 27, Subtitle 3 of this article.

(e) (1) Each risk retention group, and each agent or representative of a risk retention group, shall comply with all applicable insurance laws of the State regarding deceptive, false, or fraudulent acts or practices.

(2) The Commissioner may seek from a court an injunction regarding deceptive, false, or fraudulent acts or practices.

(f) (1) A risk retention group shall submit to an examination by the Commissioner to determine its financial condition if the insurance commissioner of the jurisdiction in which the risk retention group is chartered and licensed has not initiated an examination or does not initiate an examination within 60 days after a request by the Commissioner.

(2) Each examination shall be coordinated to avoid unjustified repetition and conducted in an expeditious manner and in accordance with the National Association of Insurance Commissioners' Examiner Handbook.

(g) Each application form for insurance from a risk retention group and each policy issued by a risk retention group for or on behalf of a resident of the State shall contain, in 10 point type on the front page and the declaration page, the following notice:

"Notice

This policy is issued by your risk retention group. Your risk retention group may not be subject to all of the insurance laws and regulations of your state. State insurance insolvency guaranty funds are not available for your risk retention group."

(h) (1) A risk retention group may not solicit or sell insurance to a person that is not eligible for membership in the risk retention group.

(2) A risk retention group that is in a hazardous financial condition or is financially impaired may not solicit or sell insurance, or operate as a risk retention group.

(i) Unless a risk retention group is comprised entirely of insurance companies, the risk retention group may not conduct business in this State if an insurance company is directly or indirectly a member or owner of the risk retention group.

(j) A risk retention group may not offer coverage that is prohibited by this article or declared unlawful by the Supreme Court of Maryland.

(k) If there has been a finding of financial impairment after an examination under subsection (f) of this section, a risk retention group that is not chartered in the State and that is doing business in the State shall comply with a lawful order issued in a voluntary dissolution proceeding or in a delinquency proceeding commenced by an insurance commissioner of a state.

§25–104.

(a) (1) A risk retention group may not join or contribute financially to an insurance insolvency guaranty fund or similar mechanism in the State.

(2) A risk retention group and its insureds may not receive a benefit from an insurance insolvency guaranty fund or similar mechanism for claims arising out of the operations of the risk retention group.

(b) (1) When a purchasing group obtains insurance that covers the risks of its members from an unauthorized insurer or from a risk retention group, the risks, whether resident or located, may not be covered by an insurance insolvency guaranty fund or similar mechanism in the State.

(2) When a purchasing group obtains insurance that covers the risks of its members from an authorized insurer, only risks resident or located in the State shall be covered by the Property and Casualty Insurance Guaranty Corporation under Title 9, Subtitle 3 of this article.

§25–105.

A policy issued to a risk retention group or a member of that risk retention group may not be required to be countersigned.

§25–106.

(a) (1) Except as otherwise provided in paragraphs (2) and (3) of this subsection, a purchasing group is subject to all applicable laws of the State.

(2) A purchasing group that meets the criteria established under the federal Liability Risk Retention Amendments of 1986 is exempt from any law of the State that relates to the creation of groups for the purchase of insurance, prohibition of group purchasing, or any law that would discriminate against a purchasing group or its members.

(3) An insurer is exempt from any law of the State that prohibits providing or offering to provide to a purchasing group or its members advantages based on their loss and expense experience that are not afforded to other persons with respect to rates, policy forms, coverages, or other matters.

(b) (1) Before doing business in the State, a purchasing group shall furnish notice to the Commissioner.

(2) The notice shall include:

(i) the state in which the purchasing group has its domicile;

(ii) the lines and classifications of liability insurance that the purchasing group intends to purchase;

(iii) the identity of all states in which the purchasing group intends to do business;

(iv) the insurance company from which the purchasing group intends to purchase liability insurance and the domicile of that company;

(v) the method by which and any person through whom liability insurance will be offered to purchasing group members whose risks are resident or located in the State;

(vi) the principal place of business of the purchasing group; and

(vii) any other information that the Commissioner requires to verify that the purchasing group qualifies as a purchasing group, as defined in § 25-101 of this subtitle.

(3) Within 10 days of a change in an item set forth in paragraph (2) of this subsection, the purchasing group shall notify the Commissioner of the change in writing.

(c) (1) A purchasing group shall provide to the Commissioner a statement of registration that designates the Commissioner as its agent for service of legal process.

(2) The Commissioner shall determine the filing fee for the statement of registration required by paragraph (1) of this subsection.

(3) The requirements of paragraph (1) of this subsection do not apply to a purchasing group that:

(i) 1. had its domicile on or before March 31, 1986 in a state; and

2. has its domicile on or after October 27, 1986 in a state;

(ii) 1. on or before October 26, 1986, purchased insurance from an insurer licensed in a state; and

2. on or after October 27, 1986, purchased insurance from an insurer licensed in a state;

(iii) was a purchasing group under the requirements of the Product Liability Risk Retention Act of 1981 on or before October 26, 1986; and

(iv) only purchases insurance that was authorized under the Product Liability Risk Retention Act of 1981, as in effect on or before October 26, 1986.

(d) (1) Unless the purchase is effected through a licensed insurance producer acting under the surplus lines insurance laws and regulations of a state, a purchasing group may not purchase insurance from a risk retention group that is not chartered in that state or from an insurer not authorized in the state in which the purchasing group is located.

(2) A purchasing group that obtains liability insurance from an unauthorized insurer or from a risk retention group shall inform each member of the purchasing group that has a risk resident or located in this State that:

(i) the risk is not protected by the Property and Casualty Insurance Guaranty Corporation; and

(ii) the risk retention group or unauthorized insurer may not be subject to all insurance laws and regulations of the State.

(3) (i) A purchasing group may not purchase insurance coverage that provides for a deductible or self-insured retention applicable to the purchasing group as a whole.

(ii) Notwithstanding subparagraph (i) of this paragraph, a purchasing group may purchase insurance coverage that provides for a deductible or self-insured retention applicable to individual members.

(e) (1) Taxes on premiums paid for coverage of risks resident or located in the State by a purchasing group or member of the purchasing group shall be imposed in accordance with Title 6 of this article.

(2) If the taxes imposed by Title 6 of this article are not paid by the insurer, then the taxes shall be paid by the purchasing group.

(3) If the purchasing group fails to pay the specified taxes, the taxes shall be paid by each of the purchasing group's members whose risks are resident or located in the State.

§25–107.

(a) A person must obtain a license from the Commissioner before the person acts or offers to act as an insurance producer for a risk retention group or purchasing group that solicits members, sells insurance coverage, purchases coverage for its members that are located in the State, or otherwise does business in the State.

(b) (1) Each insurance producer acting on behalf of a risk retention group or purchasing group shall keep a complete and separate record of all policies procured from or on behalf of the risk retention group or purchasing group.

(2) The records required by paragraph (1) of this subsection shall be open to inspection by the Commissioner in accordance with § 2-206 of this article.

(3) The records required by paragraph (1) of this subsection shall include:

(i) the limits of liability;

(ii) the policy period;

(iii) the effective date of the policy;

(iv) the name of the insurer that issued the policy;

(v) the gross premium charged;

(vi) the name of the purchasing group that purchased the policy, if applicable; and

(vii) the amount of any return premiums.

§25–108.

(a) The Commissioner may exercise any powers granted by this article to enforce the laws of the State if the powers are not specifically preempted by the federal Product Liability Risk Retention Act of 1981 as amended by the risk retention amendments of 1986.

(b) The Commissioner may adopt regulations relating to risk retention groups to carry out this subtitle.

§25–109.

On a finding that a risk retention group is in a hazardous financial condition or is financially impaired, an order issued by a District Court of the United States that enjoins the risk retention group from soliciting or selling insurance or operating in a state, in all states, or in a territory or possession of the United States is enforceable in the courts of this State.

§25–110.

A risk retention group that violates any provision of this subtitle is subject to fines and penalties applicable to licensed insurers generally, including revocation of its license and the right to do business in the State.

§25–111.

This subtitle is the Maryland Risk Retention Act.

§25–201.

The purpose of this subtitle is to allow employees of small farms to be entitled to protection under the Maryland Workers' Compensation Act.

§25–202.

This subtitle applies to the following employers of agricultural labor, some or all of whom may not be required to carry workers' compensation insurance:

(1) members of a nonprofit agricultural association; and

(2) members of or stockholders in a nonprofit cooperative agricultural marketing association of producers.

§25–203.

Employers subject to this subtitle may be insured under a group workers' compensation insurance policy under the conditions that the Commissioner sets.

§25–204.

The nonprofit agricultural association or nonprofit cooperative agricultural marketing association of producers shall guarantee premium payment by its members that are covered under the group workers' compensation policy.

§25–301.

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

(b) "Administrator" means a person engaged by a workers' compensation self-insurance group to carry out the policies established by the self-insurance group and to provide management of the self-insurance group.

(c) "Insolvent self-insurance group" means a self-insurance group in which each individual member of the group is unable to meet the member's debts as they mature in the ordinary course of business, as determined by the Commissioner.

(d) "Self-insurance agreement" means the partnership arrangement between the members of a self-insurance group that defines the rights, obligations, and liabilities of the members of the self-insurance group.

(e) (1) "Self-insurance group" means two or more employers organized in accordance with this subtitle.

(2) "Self-insurance group" does not include a governmental self-insurance group organized under § 9-404 of the Labor and Employment Article.

§25–302.

An employer may satisfy the requirements of § 9-402 of the Labor and Employment Article by participating in a self-insurance group that meets the requirements of this subtitle.

§25–303.

(a) In this section, "service company" means a person that provides services that are not provided by the administrator, including:

(1) claims adjustment;

(2) safety engineering;

(3) compilation of statistics and the preparation of premium, loss, and tax reports;

(4) preparation of other required self-insurance reports;

(5) development of members' assessments and fees; and

(6) administration of a claim fund.

(b) The Commissioner shall adopt regulations to carry out this subtitle.

(c) The regulations shall include:

(1) classifications of businesses and industries, based on the type of activity conducted by the business or industry, within which employers may join together in self-insurance groups;

(2) for each classification:

(i) a minimum level of contribution of at least $250,000 in premiums collected from or pledged by members of a self-insurance group to a fund from which workers' compensation claims will be paid;

(ii) a minimum level of excess insurance coverage that must be obtained by each self-insurance group;

(iii) a requirement that the minimum levels of excess insurance adopted under this subtitle may be satisfied by placing, in a depository that the Commissioner designates, securities in a form and amount that the Commissioner requires; and

(iv) a surety bond of at least $100,000 that must be obtained by each self-insurance group;

(3) conditions under which contributions by members of a self-insurance group may be rebated or temporarily suspended;

(4) for each administrator or service company, a bond that the Commissioner may require in addition to any other required bond; and

(5) a requirement that the governance of the group be under the control of its members.

§25–304.

(a) Before a self-insurance group may operate, the self-insurance group must obtain the approval of the Commissioner, including approval of its self-insurance agreement.

(b) Each self-insurance group must have combined net assets of at least $1,000,000.

(c) (1) A self-insurance group shall pay all workers' compensation benefits for which each member incurs liability during its period of membership.

(2) Each member of a self-insurance group is jointly and severally liable for the workers' compensation obligations of the group and its members that are incurred during its period of membership.

(3) A member who elects to terminate its membership in or is canceled by a group remains jointly and severally liable for workers' compensation obligations of the group and its members which were incurred during the canceled or terminated member's period of membership.

(4) The insolvency or bankruptcy of a member does not relieve the self-insurance group or any other member of liability for the payment of workers'

compensation benefits incurred during the insolvent or bankrupt member's period of membership.

§25–305.

(a) A self-insurance group is not liable for payments to the Property and Casualty Insurance Guaranty Corporation.

(b) There is a Self-Insurers' Guaranty Fund.

(c) The Uninsured Employers' Fund established under § 10-304 of the Labor and Employment Article shall administer the Self-Insurers' Guaranty Fund.

(d) Each self-insurance group shall pay an assessment into the Self-Insurers' Guaranty Fund at the same level assessed against other workers' compensation insurers by the Property and Casualty Insurance Guaranty Corporation under Title 9, Subtitle 3 of this article.

(e) (1) The Self-Insurers' Guaranty Fund shall pay any outstanding obligations of a self-insurance group that becomes insolvent.

(2) If the Self-Insurers' Guaranty Fund becomes insolvent, any outstanding obligations of an insolvent self-insurance group are a joint and several liability of each member of the self-insurance group.

§25–306.

(a) The Commissioner may not grant the request of a self-insurance group to terminate its self-insurance agreement unless the self-insurance group has insured or reinsured all incurred workers' compensation obligations with an authorized insurer under an agreement filed with and approved in writing by the Commissioner.

(b) (1) Subject to the approval of the Commissioner, a self-insurance group may merge with another self-insurance group engaged in the same or similar type of business only if the resulting self-insurance group assumes all the obligations of the merging self-insurance groups.

(2) The Commissioner shall hold a hearing on the merger at the request of any party including a member of either self-insurance group.

(c) For purposes of this section, obligations include known claims and associated expenses and claims incurred but not reported and associated expenses.

§25–307.

The Commissioner may:

(1) require actuarial studies and audits to determine the financial solvency of each self-insurance group as often as the Commissioner desires;

(2) assess each self-insurance group an annual amount of not more than $500 to be used for the actuarial studies and audits; and

(3) require an annual report that may include payroll audit reports, summary loss reports, and quarterly financial statements.

§25–308.

(a) (1) After notice and opportunity for a hearing, the Commissioner may impose a monetary penalty on a person or self–insurance group that the Commissioner finds to be in violation of this subtitle or a regulation adopted under this subtitle.

(2) A monetary penalty imposed under this subsection may not exceed $1,000 for each violation or $10,000 in the aggregate.

(3) A person or self–insurance group that is assessed a monetary penalty under this subsection shall pay the penalty to the Commissioner for the use of the State.

(b) (1) After written notice and opportunity for a hearing, the Commissioner may issue an order that requires a person or self–insurance group to cease and desist from engaging in an act or practice that the Commissioner finds to be in violation of this subtitle or a regulation adopted under this subtitle.

(2) If the Commissioner finds, after notice and opportunity for a hearing, that a person or self–insurance group has violated an order issued under this subsection, the Commissioner may:

(i) impose a monetary penalty of not more than $10,000 for each violation of the order or $100,000 in the aggregate; and

(ii) suspend or revoke the authority of the self–insurance group to operate.

(c) Notwithstanding any other provision of this subtitle, after notice and opportunity for a hearing, the Commissioner may suspend or revoke the authority of

a self–insurance group to operate if the Commissioner determines that the self–insurance group:

(1) is insolvent;

(2) failed to pay the special fund contribution or regulatory fee imposed on the self–insurance group;

(3) failed to comply within the time set with a provision of this subtitle, a regulation adopted under this subtitle, or a lawful order of the Commissioner;

(4) obtained its authority to operate by fraud, including making a material misrepresentation in the application for authority to operate as a self–insurance group;

(5) misappropriated, converted, illegally withheld, or refused to pay on proper demand money that has been entrusted to the self–insurance group or its administrator in its fiduciary capacity and that belongs to a member of the self–insurance group, an employee of a member, or a person entitled to payment; or

(6) for any other reason, must have its authority to operate suspended or revoked to protect the members or insureds of a self–insurance group or the public.

§25–401.

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

(b) "Association" means the Joint Insurance Association.

(c) "Association member" means an insurer that is licensed to write in the State, on a direct basis, essential property insurance or a component of essential property insurance in multi-peril policies.

(d) (1) "Essential property insurance" means insurance against direct loss to property from the perils of fire, lightning, removal, explosion, windstorm, hail, smoke, aircraft, vehicles, riot, civil commotion, or vandalism as defined and limited in property insurance forms that the Association files with the Commissioner.

(2) "Essential property insurance" does not include:

(i) motor vehicle insurance;

(ii) inland marine insurance; or

(iii) insurance on property that:

1. is used for fabrication, processing, or assembly of products or components of products;

2. has an insurable value in excess of $250,000; and

3. is used in a business that employs at least 25 individuals.

(e) "Homeowner's insurance" means insurance for residential property that provides a combination of coverages including:

(1) fire;

(2) extended coverage;

(3) vandalism and malicious mischief;

(4) burglary;

(5) theft; and

(6) personal liability.

(f) (1) "Premiums written" means, as computed by the Association, gross direct premiums charged during the second preceding calendar year with respect to property in the State on all policies of essential property insurance and the essential property insurance components of multi-peril policies, less return premiums, dividends paid or credited to policyholders, or the unused or unabsorbed parts of premium deposits.

(2) "Premiums written" does not include premiums or parts of premiums relating to risks ceded to the Association.

§25–402.

The purposes of this subtitle are:

(1) to authorize and establish:

(i) the Joint Insurance Association;

(ii) a program to make essential property insurance available from the Association to qualified applicants with the least possible administrative detail and expense; and

(iii) a program to make the homeowner's insurance that is provided by the Association available to qualified applicants with the least possible administrative detail and expense;

(2) to encourage the improvement of the condition of properties located in the State;

(3) to further orderly community development in general;

(4) to publicize the purposes and procedures of this subtitle so that no one fails to seek assistance from the Association because of ignorance;

(5) to utilize fully the voluntary insurance market as a source of essential property insurance and homeowner's insurance; and

(6) to encourage the delivery of essential property insurance, and the homeowner's insurance that is provided by the Association, at the most reasonable cost possible, provided that insurance pricing by the Association:

(i) is actuarially self-supporting; and

(ii) does not actively compete with insurance pricing in the voluntary insurance market.

§25–403.

(a) (1) There is a Joint Insurance Association.

(2) The Association is an unincorporated association.

(b) (1) The Association consists of all insurers that are licensed to write in the State, on a direct basis, essential property insurance or a component of essential property insurance in multi-peril policies.

(2) As a condition of its authority to transact essential property insurance business in the State, an insurer must be and remain an Association member.

(c) The Association may:

(1) establish a program of operation, subject to the approval of the Commissioner; and

(2) cause policies to be issued and assume and cede reinsurance on risks written in conformity with the program of operation.

(d) Each Association member shall participate in the Association's expenses, profits, and losses in the proportion that the Association member's premiums written bear to the aggregate premiums written by all Association members.

(e) (1) A Governing Committee shall administer the Association.

(2) The Governing Committee consists of nine Association members.

(3) All Association members annually shall elect the members of the Governing Committee.

(4) Votes shall be weighted in accordance with the premiums written by each Association member.

(f) (1) An Association member, the Association or its agents or employees, the Board of Directors, and the Commissioner or the Commissioner's representatives shall have the immunity from liability described in § 5-411(a) of the Courts Article.

(2) An Association member, the Association, the Governing Committee, their agents or employees, the Commissioner, and the Commissioner's authorized representatives shall have the immunity from liability described in § 5-411(b) of the Courts Article.

§25–404.

(a) (1) The Association is not and may not be deemed a department, unit, agency, or instrumentality of the State.

(2) All debts, claims, obligations, and liabilities incurred by the Association shall be the debts, claims, obligations, and liabilities of the Association only and not of the State or the State's agencies, instrumentalities, officers, or employees.

(b) (1) The money of the Association is not part of the General Fund of the State.

(2) The State may not budget for or provide General Fund appropriations to the Association.

(3) The debts, claims, obligations, and liabilities of the Association are not debts of the State or pledges of the credit of the State.

(c) The records, reports, and communications of the Association, the Governing Committee, the committees of the Association, and their representatives, agents, and employees are not public documents.

§25–405.

(a) The Governing Committee shall adopt a program of operation in accordance with this subtitle.

(b) The program of operation shall provide for economical, fair, and nondiscriminatory administration and for the prompt and efficient delivery of essential property insurance and homeowner's insurance to promote orderly community development.

(c) (1) With the approval of the Commissioner, the Association may amend the program of operation.

(2) Association members shall vote on proposed amendments to the program of operation.

(3) Votes shall be cast and counted on a weighted basis in accordance with the premiums written by each Association member.

(4) An amendment to the program of operation is not effective until approved by a majority of the votes cast by Association members.

(d) The program of operation shall provide for:

(1) establishment of adequate service facilities and other necessary facilities;

(2) management of the Association;

(3) assessment of Association members to defray losses and expenses;

(4) commission arrangements;

(5) reasonable and objective underwriting standards;

(6) acceptance and cession of reinsurance;

(7) procedures to determine amounts of insurance to be provided;

(8) immediate binding of eligible risks;

(9) a premium installment plan; and

(10) notwithstanding Title 27, Subtitle 6 of this article, underwriting guidelines and procedures that allow the Association to shorten the cancellation period for policies of essential property insurance and homeowner's insurance for certain conditions that are determined to exist.

(e) The program of operation shall provide that the Association may not appoint insurance producers to act on its behalf and shall do business directly with applicants or with licensed insurance producers that represent applicants.

(f) The program of operation shall establish:

(1) a maximum limit of liability of $1,500,000 on real or personal property composed of or contained in a single building; and

(2) appropriate sublimits of liability based on construction, protection, and class of occupancy.

(g) (1) The program of operation shall implement procedures to make homeowner's insurance coverage available through the Association.

(2) The homeowner's insurance policies that the Association issues may be limited to basic market value, repair cost, or actual cash value contracts for owner-occupants of one- to four-family dwellings, as approved by the Commissioner.

(3) The homeowner's insurance shall be implemented through a program that entitles eligible applicants to immediate binding of coverage through the Association for a reasonable period of time pending underwriting and inspection of the premises to determine whether the premises meet the eligibility standards of the program.

(h) (1) The program of operation shall provide a method of recoupment by which Association members may recover losses and expenses that have been incurred by the Association and assessed to Association members.

(2) To recoup loss and expense assessments, the program of operation shall provide for:

(i) the calculation of the surcharge or rating factors to be added to direct premiums written for essential property insurance and homeowner's insurance covering property located in the State; and

(ii) an adjustment each year for over or under recoupment of assessment.

(i) (1) The program of operation shall develop a participation credit for dwellings as an offset to Association member assessment for voluntary writings in those areas of the State with a significant proportion of essential property insurance policies or homeowner's insurance policies issued by or for the Association.

(2) After consultation with the Governing Committee, the Commissioner shall determine whether an area has a significant proportion of Association policies.

§25–406.

A person with an insurable interest in real or tangible personal property at a fixed location may apply to the Association for essential property insurance or homeowner's insurance if the person has been:

(1) unable to obtain essential property insurance or homeowner's insurance;

(2) able to obtain essential property insurance or homeowner's insurance only after application under § 11-210 or § 11-311 of this article; or

(3) able to obtain only partial coverage for the value of the property.

§25–407.

(a) The Association may inspect the property of an applicant for essential property insurance or homeowner's insurance coverage.

(b) (1) Except as provided in paragraph (2) of this subsection, the Association shall inspect the property without cost to the owner.

(2) If the Association is unable to complete an inspection of the property due to the fault of the owner or applicant, the Association may require the

applicant to pay in advance the reasonable cost of subsequent efforts to inspect the property.

(c) (1) The applicant or representative of the applicant shall be afforded the opportunity to be present during the inspection.

(2) The inspector does not have authority to advise whether the Association will provide coverage to the property being inspected.

(3) The inspector may take photographs of the property during the inspection.

(d) The inspection report shall:

(1) cover pertinent structural and occupancy features and the general condition of the building and surrounding structures;

(2) indicate the pertinent features of building, construction, maintenance, occupancy, and surrounding property; and

(3) include a rate makeup statement that covers any condition charges or surcharges imposed:

(i) as a result of the inspection;

(ii) under the program of operation; or

(iii) under a substandard rating plan approved by the Commissioner.

(e) On request, the Association shall make available a copy of the inspection report to the applicant or the applicant's licensed insurance producer.

§25–408.

(a) The Commissioner shall have the same powers over the Association as are granted under this article with respect to domestic insurers that are authorized insurers.

(b) If the Commissioner determines that the rate structure for policies of essential property insurance and homeowner's insurance offered by or through the Association does not compete with the rate structure of the voluntary insurance market in the State, the Commissioner shall approve the rate structure.

(c) (1) The Commissioner shall monitor and review the financial condition of Association members to ensure that the Association members are able to pay assessments that the Association may levy on them.

(2) The Commissioner may use the annual statements of Association members and other available data to monitor and review their financial condition.

§25–409.

(a) (1) An applicant for essential property insurance or homeowner's insurance or an affected insurer may appeal to the Governing Committee.

(2) A decision of the Governing Committee may be appealed to the Commissioner within 30 days after the decision.

(b) An order or decision of the Commissioner made under this subtitle is subject to judicial review.

§25–410.

This subtitle is the Maryland Property Insurance Availability Act.

§26–101.

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

(b) "Emergency road service" means the adjustment, repair, or replacement of the equipment, tires, or mechanical parts of a motor vehicle so that the motor vehicle may be operated under its own power.

(c) "License" means a license issued by the Commissioner to provide motor club service.

(d) "Licensee" means a motor club that is licensed by the Commissioner to provide motor club service.

(e) "Member" means a member or subscriber of a motor club.

(f) "Motor club" means a person engaged directly or indirectly in selling or offering for sale, furnishing, or procuring motor club service.

(g) "Motor club service" means, in connection with the ownership, operation, use, or maintenance of a motor vehicle by a person, and in consideration of the person being or becoming a member of a motor club, affiliated with a motor

club, or entitled to receive membership or other service from a motor club because of an agreement between the person and the motor club, the rendering, furnishing, or procuring of or the payment or reimbursement for, wholly or partly, any or all of the following services to the person:

(1) emergency road service, including the replacement of a motor vehicle key or key fob if the key or key fob becomes inoperable or is lost or stolen;

(2) bail bond service, which is the furnishing of or arranging for a cash deposit, bond, or other form of security required by law for a member accused of a violation of a motor vehicle law or traffic ordinance, to obtain the member's release from custody pending trial;

(3) financing service, which is the arranging for a loan or other advance of money to a member in connection with providing any other motor club service;

(4) insurance service, which is the furnishing of coverage to a member under an approved group or blanket policy, subject to the limitations of this article, issued to the motor club by an authorized insurer;

(5) legal reimbursement service, which is the payment for or reimbursement of a member of fees charged by an attorney for services rendered to the member in defense of a traffic offense;

(6) theft service, which is the offering of assistance in locating, identifying, or recovering a stolen or missing motor vehicle owned by a member, or the offering of a reward for the purpose of detecting or apprehending the person guilty of the theft; and

(7) towing service, which is the furnishing to a member of the means to move a motor vehicle, under power other than its own, from one place to another.

(h) "Representative" means an individual who, for compensation, solicits or sells memberships, subscriptions, or franchises for a motor club.

§26–102.

(a) (1) The offering of motor club service is regulated under this title but is not engaging in insurance business.

(2) This title does not otherwise exempt a licensee or its representatives from the requirements of the laws relating to insurance or insurance services.

(b) This title does not apply to:

(1) a motor vehicle manufacturer, distributor, or a wholly owned subsidiary of a manufacturer or distributor, as those terms are defined in § 15–201 of the Transportation Article, that offers for sale, furnishes, or procures emergency road service, towing service, or other service that may be offered by a licensed motor club under this title as part of a mechanical repair contract as defined in § 15–311.2 of the Transportation Article; or

(2) a licensed vehicle dealer or any person that offers for sale, furnishes, or procures emergency road service, towing service, or other service that may be offered by a licensed motor club under this title as part of a mechanical repair contract if the provider of services maintains adequate insurance reserves as defined by the Commissioner and the mechanical repair contract is offered in compliance with § 15–311.2 of the Transportation Article.

(c) This title does not limit or prohibit a motor club from selling, offering for sale, or furnishing to or procuring for members services or products not defined in this title.

§26–103.

(a) The Commissioner may conduct investigations and examine the books, records, and accounts of a person at the person's expense under this title to the same extent as is authorized with respect to insurers under this article.

(b) The Commissioner may:

(1) investigate possible violations of this title and subpoena persons and documents that the Commissioner considers appropriate in connection with the investigation;

(2) require a licensee to stop doing business through a particular representative on finding, after notice and opportunity for a hearing, that the representative has intentionally or negligently made false or misleading statements about the services offered by the licensee; and

(3) adopt regulations to administer, carry out, or enforce this title.

(c) (1) The Commissioner may approve or disapprove the name, trademarks, emblems, and forms that an applicant or licensee uses or proposes to use in connection with its business.

(2) The Commissioner shall approve a name, trademark, or emblem if the name, trademark, or emblem:

(i) is distinctive;

(ii) is not similar to or in conflict with the name, trademark, or emblem of a local organization or a nationally registered or copyrighted name, trademark, or emblem;

(iii) is not likely to confuse or mislead the public about the nature or identity of the applicant or licensee using or proposing to use the name, trademark, or emblem; and

(iv) will not interfere with the transactions of a licensee already operating in the State.

(3) The Commissioner may disapprove the use of, and order that the licensee stop using, a name, trademark, or emblem not approved under paragraph (2) of this subsection.

§26–201.

Except as provided in §§ 10–14A–03 and 10–14B–03 of the State Government Article, a person may not provide motor club service or engage in the business of a motor club in the State unless the person meets the requirements of this title and has a license issued by the Commissioner.

§26–202.

(a) To qualify for a license to engage in the business of a motor club, a motor club with capital stock must have and maintain:

(1) paid-in capital stock with a fixed nominal or par value in an amount not less than $5,000; and

(2) surplus in an amount not less than $10,000.

(b) A motor club formed under the laws of the State without paid-in capital stock shall have and maintain unencumbered assets, in addition to required reserves and other liabilities, in an amount equal to that required under subsection (a) of this section.

§26–203.

(a) An applicant for an initial license shall:

(1) file with the Commissioner an application on the form that the Commissioner provides; and

(2) pay to the Commissioner an application fee of $200.

(b) (1) An applicant for a license shall submit to the Commissioner the information that the Commissioner considers reasonably necessary to determine, in accordance with this title, whether to issue a license to the applicant.

(2) The application shall be executed under oath by the applicant or, if the applicant is not an individual, by an authorized officer of the applicant.

(c) The application shall include:

(1) if the applicant is a corporation:

(i) a certificate of good standing from the Department of Assessments and Taxation;

(ii) the names and addresses of the officers and directors of the corporation; and

(iii) the names and addresses of each owner of more than 10% of the capital stock of the corporation issued and outstanding;

(2) if the applicant is not a corporation:

(i) a list of all the owners of interests in the applicant;

(ii) a list of the officers of the applicant; and

(iii) a list of the parties to any operating or management agreement that affects the applicant, together with a copy of the agreement;

(3) a financial statement certified by a certified public accountant within the previous 6 months, that presents fairly, in accordance with generally accepted accounting principles, the financial position of the applicant and contains the information that the Commissioner requires;

(4) a copy of the applicant's service contract and the fees to be charged to members, as described in § 26–402 of this title; and

(5) evidence of security in accordance with § 26–204 of this subtitle.

§26–204.

(a) An applicant for a license shall deposit with the Treasurer, who shall maintain in trust:

(1) registered United States government bonds with a market value at all times not less than $100,000 or, in the discretion of the Commissioner, a lower amount not less than $15,000;

(2) a corporate surety bond in the form that the Commissioner requires in a penal sum not less than $100,000 or, in the discretion of the Commissioner, a lower amount not less than $15,000; or

(3) a letter of credit in the form that the Commissioner requires in an amount not less than $100,000 or, in the discretion of the Commissioner, a lower amount not less than $15,000.

(b) (1) The bond or letter of credit described under subsection (a)(2) or (3) of this section shall be:

(i) in favor of the State for the members of the applicant that reside in the State;

(ii) issued by a surety insurer or bank authorized to do business in the State; and

(iii) conditioned on the faithful performance by the applicant of its obligations under this title, including payment of any fines, fees, or penalties imposed on it or restitution ordered under this title.

(2) The total liability of the surety insurer under the bond may not exceed the penal sum of the bond.

(3) The total liability of the bank under the letter of credit may not exceed the amount of the letter of credit.

(4) (i) The surety insurer or bank may cancel the bond or letter of credit after notifying the Commissioner at least 30 days before the effective date of the cancellation.

(ii) Neither the surety insurer nor the bank is liable for any breach of condition that occurs after the effective date of the cancellation.

(5) The Commissioner may adopt regulations that specify conditions for surety bonds and letters of credit required by this section and provide methods for their termination.

(c) (1) The security required by subsection (a) of this section shall be maintained as long as the licensee has any outstanding liability or obligation in the State.

(2) Subject to approval by the Commissioner, the licensee may substitute any type of security required by subsection (a) of this section for any other type of security required by subsection (a) of this section.

(3) On proof satisfactory to the Commissioner that the licensee has stopped doing business and that all of the licensee's liabilities and obligations have been satisfied, the Commissioner shall authorize the Treasurer to return the security to the licensee.

§26–205.

(a) Within a reasonable time after an application for a license is filed, the Commissioner shall issue a license to the applicant unless:

(1) the applicant has not met all of the requirements of this title;

(2) in the judgment of the Commissioner, the applicant does not have sufficient financial responsibility to engage in the business of a motor club; or

(3) the applicant has failed to make a reasonable showing that all of its owners, managers, officers, directors, or representatives are persons of reliability and integrity.

(b) If the Commissioner disapproves the application for a license, the Commissioner shall notify the applicant as soon as practicable of the reason for the disapproval and inform the applicant of its right to a hearing on the matter as provided in § 26-209 of this subtitle.

(c) If an application for a license filed under this subtitle is disapproved, the Commissioner shall:

(1) retain $50 of the application fee paid by the applicant; and

(2) return the balance of the application fee to the applicant.

§26–206.

(a) A license expires on the first December 31 after its effective date unless it is renewed as provided in this section.

(b) At least 1 month before a license expires, the Commissioner shall send to the licensee, at the last known address of the licensee or electronic mail address of the holder on record a notice that states:

(1) the process for renewing the license;

(2) the date by which the Commissioner must receive the renewal application; and

(3) the amount of the renewal fee.

(c) Before a license expires, the licensee may renew it for an additional 1–year term if the holder:

(1) otherwise is entitled to a license;

(2) files with the Commissioner a renewal application:

(i) on the form that the Commissioner provides; or

(ii) in an electronic format that the Commissioner approves;

(3) files with the Commissioner the fees to be charged to members;

(4) provides a financial statement as required under § 26–203(c)(3) of this subtitle; and

(5) pays to the Commissioner a renewal fee of $100.

(d) The Commissioner shall renew the license of each licensee that meets the requirements of this section.

§26–207.

(a) (1) Each licensee must appoint the Commissioner as attorney for service of process issued against the licensee under this title.

(2) The appointment of the Commissioner must:

(i) be in writing; and

(ii) state that the licensee agrees that:

1. lawful process against the licensee that is served on the Commissioner, or in the Commissioner's absence, on an employee in charge of the office of the Commissioner, has the same effect as if served on the licensee; and

2. the authority of the Commissioner to act as attorney for service of process continues in force as long as any liability remains outstanding against the licensee under this title in the State.

(3) A certified certificate of the appointment shall be filed with the Commissioner.

(b) (1) When lawful process against a licensee under this title is served on the Commissioner, three copies of the process shall be furnished to the Commissioner.

(2) The Commissioner immediately shall forward:

(i) one copy of the process to the licensee by certified mail, return receipt requested; and

(ii) one copy of the process to the resident agent or other similar official, if any, of the licensee in the State.

(c) (1) At the time of the service, the plaintiff shall pay to the Commissioner a fee of $2 for each service of process.

(2) If the plaintiff prevails in the suit, the plaintiff may recover, as part of the taxable costs, any fee paid under this subsection.

§26–208.

After notice and opportunity for a hearing, the Commissioner may suspend or revoke a license if the Commissioner finds that the licensee:

(1) has violated any provision of this title;

(2) has failed to maintain the standards required under this title for the issuance of an initial license;

(3) is insolvent;

(4) has liabilities that exceed its assets;

(5) has engaged in a fraudulent or deceptive act; or

(6) has entered into a service contract the form of which has not been approved by the Commissioner.

§26–209.

(a) An applicant for a license or a licensee is entitled to a hearing before the Commissioner if the application is denied or not acted on within a reasonable time or if the license is suspended or revoked.

(b) An applicant or licensee that is adversely affected by an order of the Commissioner may seek judicial review of the order in accordance with § 2-215 of this article.

§26–301.

(a) Through its proper officer or agent, each licensee promptly shall notify the Commissioner of the name, title, and address of each individual the licensee desires to appoint as a representative in the State.

(b) The notice required by this section shall be:

(1) filed with the Commissioner on the form that the Commissioner provides; and

(2) accompanied by:

(i) an initial registration fee of $5; and

(ii) a statement in writing, by the appointee, that gives:

1. the appointee's name, age, residence address, business address, present occupation, and occupation for the 5 years immediately preceding the date of the notice;

2. the names of motor clubs represented during the 5 years immediately preceding the date of the notice and where represented; and

3. any other information the Commissioner requires.

§26–302.

The Commissioner shall issue a registration certificate to an appointee if it appears to the Commissioner that the appointee:

(1) is a suitable and competent individual of good moral character;

(2) intends to represent to the public in good faith that the appointee is a representative;

(3) has not previously been denied registration or had a registration revoked under § 26-307 of this subtitle; and

(4) otherwise meets the requirements of this subtitle.

§26–303.

A registration certificate shall state in substance that the individual named in the registration certificate is a registered representative of a licensee in the State.

§26–304.

While a representative's registration remains in effect, a licensee is bound by the acts of the representative named in the registration certificate within the representative's apparent or actual authority.

§26–305.

(a) A registration expires on the first August 31 after its effective date unless it is renewed as provided in this section.

(b) At least 1 month before a registration expires, the Commissioner shall send to the licensee, at the last known address of the licensee or electronic mail address of the licensee on record a notice that states:

(1) the process for renewing the registration;

(2) the date by which the Commissioner must receive the renewal application; and

(3) the amount of the renewal fee.

(c) Before a registration expires, the licensee may renew the registration of a representative for an additional 1–year term if:

(1) the representative otherwise is entitled to a registration;

(2) the licensee files with the Commissioner a renewal application:

(i) on the form that the Commissioner provides; or

(ii) in an electronic format that the Commissioner approves; and

(3) the licensee pays to the Commissioner a registration renewal fee of $2.

(d) The Commissioner shall renew the registration of a representative if the licensee and representative meet the requirements of this section.

§26–306.

If a licensee cancels a representative's authority to act for the licensee, the licensee immediately shall provide written notice of the cancellation to the Commissioner.

§26–307.

(a) Subject to subsection (c) of this section, the Commissioner shall deny a registration to an appointee or revoke the registration of a registered representative if the Commissioner, for cause and after a hearing, determines that the appointee or representative:

(1) has made a false or misleading statement about the services offered by, or the business of, the licensee represented by the appointee or representative;

(2) has been convicted of a crime involving moral turpitude; or

(3) is otherwise unsuitable to act as a representative.

(b) If the Commissioner denies or revokes a registration under this section, the Commissioner shall notify the licensee and the representative or appointee of the denial or revocation in writing.

(c) The Commissioner need not deny or revoke a registration under this section if the Commissioner concludes, based on all the facts and circumstances, that the public interest would not be served by the denial or revocation.

§26–308.

A representative or appointee that is adversely affected by an order of the Commissioner may seek judicial review of the order in accordance with § 2-215 of this article.

§26–401.

A motor club may not:

(1) refer to its license or approval from the Commissioner or the State in any advertising, circular, contract, or membership card; or

(2) advertise or describe its motor club service in a manner that would lead the public to believe that its motor club services include motor vehicle insurance.

§26–402.

(a) Each motor club shall provide to its members:

(1) a service contract;

(2) a membership card; and

(3) the following information:

(i) the exact name of the motor club;

(ii) the street address of the motor club's home office;

(iii) the street address of the motor club's principal place of business in the State;

(iv) the telephone numbers of the motor club's home and business offices; and

(v) a description of the motor club services or benefits to which the member is entitled.

(b) Unless a motor club provides and the Commissioner approves another form of service contract, the service contract consists of:

(1) the completed application or renewal application of the motor club;

(2) the filed fees to be charged to members of the motor club; and

(3) the description of motor club services or benefits to which the members are entitled.

(c) A service contract may not:

(1) contain inconsistent, ambiguous, or misleading clauses, exceptions, or conditions that deceptively affect the risk purported to be assumed or the motor club service to be performed;

(2) contain an inequitable provision that does not have a substantial benefit to the member;

(3) require the payment of fees that are unreasonable in relation to the motor club service agreed to be performed; or

(4) offer reimbursement only, unless the contract clearly states that emergency road service will not be provided.

§26–501.

(a) A person may not act as a representative of a licensee unless the person is registered under Subtitle 3 of this title.

(b) A person may not sell, solicit, or act as a representative for an unlicensed motor club doing business in the State.

§26–501.1.

(a) This title does not apply to:

(1) an authorized property and casualty insurer that provides emergency road service, towing service, or a similar type of indemnification under a policy that has been filed with and approved by the Commissioner; or

(2) an obligor under a mechanical repair contract that provides emergency road service, towing service, or other service that may be offered by a licensed motor club under this title if the mechanical repair contract is offered in compliance with § 15–311.2 of the Transportation Article.

(b) Unless a person holds a license issued by the Commissioner, the person may not represent to the public, by use of a title, including "motor club" or "licensed motor club", by description of services, or otherwise, that the person is licensed or otherwise authorized to provide motor club service or engage in the business of a motor club in the State.

§26–502.

(a) A person that willfully violates this title is guilty of a misdemeanor and on conviction is subject to a fine not exceeding $1,000 or imprisonment not exceeding 1 year or both.

(b) In addition to any other penalty provided in this title, the Commissioner after notice and hearing may impose on a licensee or representative for each violation of this title a penalty:

(1) not exceeding $25,000 for a licensee; or

(2) not exceeding $5,000 for a representative.

(c) Instead of or in addition to a penalty imposed under this section, the Commissioner may require that restitution be made to any citizen who has suffered financial injury because of a violation of this title.

§27–101.

The purpose of this title is to regulate trade practices in the business of insurance in accordance with the intent of Congress expressed in the McCarran-Ferguson Act, 15 U.S.C. §§ 1011 through 1015, by defining, or providing for the determination of, all trade practices in the business of insurance in the State that are unfair methods of competition or unfair or deceptive acts or practices and by prohibiting those trade practices.

§27–102.

A person may not engage in the State in a trade practice that is defined in this title as, or determined under this title to be, an unfair method of competition or an unfair or deceptive act or practice in the business of insurance.

§27–103.

(a) (1) If the Commissioner finds that a person in the State has engaged or is engaging in an act or practice that is defined in or prohibited under this title, the Commissioner shall order the person to cease and desist from the act or practice.

(2) The Commissioner shall hold a hearing before the Commissioner issues a cease and desist order under this subsection.

(3) The Commissioner shall give the person notice of the hearing and the charges against the person.

(b) The cease and desist order is final:

(1) if no appeal is taken, when the time allowed for taking an appeal from an order of the Commissioner expires; or

(2) if an appeal is taken, when the court issues a final decision that affirms the cease and desist order or dismisses the appeal.

(c) If an appeal is taken, the court shall issue its own order that requires compliance with the terms of the cease and desist order to the extent that the cease and desist order is affirmed.

(d) Violation of a cease and desist order issued under this section is deemed to be and is punishable as a violation of this article.

(e) A cease and desist order issued under this section or an order of court that enforces it does not relieve any person affected by the order from any other liability, penalty, or forfeiture under law.

(f) Regardless of whether a hearing is scheduled or held or a cease and desist order is issued, this section does not affect or prevent the imposition of a penalty provided by this article or other law for violation of another provision of this title.

§27–104.

(a) If the Commissioner believes that a person engaged in the insurance business is engaging in the State in a method of competition or in an act or practice in the conduct of insurance business that, although not defined in this title, is an unfair method of competition or an unfair or deceptive act or practice and that a proceeding by the Commissioner with respect to the method of competition, act, or practice would be in the public interest, the Commissioner shall:

(1) give the person notice of the hearing and the charges against the person;

(2) hold the hearing;

(3) make a written report of the Commissioner's findings of fact about the charges; and

(4) serve a copy of the report on the person against whom the charges were brought and any intervenor at the hearing.

(b) (1) If the report charges a violation of this title and the unfair method of competition or unfair or deceptive act or practice continues, the Commissioner, through the Attorney General, after service of the report, may bring an action to enjoin and restrain the person from engaging in the method of competition, act, or practice.

(2) The Commissioner's report and findings, all evidence taken in the hearing, and, if a stenographic record of the proceedings in the hearing before the Commissioner was made, a certified transcript of the hearing shall be received in evidence in an action under this subsection.

(3) In an action under this subsection, the court may issue an injunction or restraining order on any terms that are just.

(4) The court may not require the Commissioner to give security before the court issues the injunction or restraining order.

§27–105.

If an order issued by the Commissioner under § 27-103 of this subtitle or a report of the Commissioner made under § 27-104 of this subtitle does not charge a violation of this title, any intervenor in the proceedings may appeal from the order or report in the time and manner provided in this article for appeals from orders of the Commissioner generally.

§27–201.

The commission of an act prohibited under this subtitle is defined as an unfair method of competition and an unfair and deceptive act or practice in the business of insurance.

§27–202.

A person may not:

(1) make, issue, circulate, or cause to be made, issued, or circulated an estimate, circular, or statement that misrepresents the terms of a policy issued or

to be issued, the benefits or advantages promised by the policy, or the dividends or share of the surplus to be received on the policy;

(2) make a false or misleading statement about the dividends or share of the surplus previously paid on similar policies;

(3) make a misleading representation or any misrepresentation about the financial condition of an insurer or about the legal reserve system on which a life insurer operates; or

(4) use a name or title of a policy or class of policies that misrepresents the true nature of the policy or class of policies.

§27–203.

A person may not make, publish, disseminate, circulate, place before the public, or cause directly or indirectly to be made, published, disseminated, circulated, or placed before the public in a newspaper, magazine, or other publication, in the form of a notice, circular, pamphlet, letter, or poster, over a radio or television station, or in any other way, an advertisement, announcement, or statement that contains an assertion, representation, or statement about the business of insurance or about a person in the conduct of the person's insurance business that is untrue, deceptive, or misleading.

§27–204.

A person may not make, publish, disseminate, or circulate, directly or indirectly, or aid, abet, or encourage the making, publishing, disseminating, or circulating of an oral or written statement or a pamphlet, circular, article, or literature that:

(1) is false or maliciously critical of or derogatory to the financial condition of an insurer or person proposing to become an insurer; and

(2) is calculated to injure a person engaged in or proposing to engage in the business of insurance.

§27–205.

(a) A person may not knowingly file with a supervisory or other public official, make, publish, disseminate, circulate, deliver to another person, place before the public, or cause directly or indirectly to be made, published, disseminated, circulated, delivered to another person, or placed before the public a false statement of the financial condition of an insurer.

(b) A person may not:

(1) make a false entry in a book, report, or statement of an insurer with intent to deceive an agent or examiner lawfully appointed to examine the condition or affairs of the insurer or a public official to whom the insurer is required by law to report or who has authority by law to examine the condition or affairs of the insurer; or

(2) with intent to deceive, willfully omit to make a true entry of a material fact about the business of the insurer in a book, report, or statement of the insurer.

§27–206.

A person may not enter into an agreement to commit, or by concerted action commit, an act of boycott, coercion, or intimidation that results in or tends to result in unreasonable restraint of or monopoly in the business of insurance.

§27–207.

A person may not issue, deliver, or allow an agent, officer, or employee of the person to issue or deliver agency company stock or other capital stock, benefit certificates or shares in a corporation, or an advisory board contract or other similar contract that promises returns and profits as an inducement to insurance.

§27–208.

(a) (1) A person may not make or allow unfair discrimination between individuals of the same class and equal expectation of life in:

(i) the rates charged for a contract of life insurance or an annuity contract;

(ii) the dividends or other benefits payable on a contract of life insurance or an annuity contract; or

(iii) any of the other terms or conditions of a contract of life insurance or an annuity contract.

(2) (i) Notwithstanding any other provision of this section, an insurer may not make or allow a differential in ratings, premium payments, or dividends for contracts of life insurance or annuity contracts for a reason based on the blindness or other physical handicap or disability of an applicant or policyholder.

(ii) Actuarial justification for the differential may be considered for a physical handicap or disability other than blindness or hearing impairment.

(3) Unless there is actuarial justification, an insurer may not refuse to insure or make or allow a differential in ratings, premium payments, or dividends in connection with life insurance and annuity contracts solely because the applicant or policyholder has the sickle–cell trait, thalassemia–minor trait, hemoglobin C trait, Tay–Sachs trait, or a genetic trait that is harmless in itself.

(4) With respect to a life insurance contract, an insurer may not refuse to insure, refuse to continue to insure, limit the amount or extent or kind of coverage available to an individual, or charge an individual a different rate for the same coverage solely for reasons associated with an applicant's or insured's past lawful travel experiences.

(5) (i) Except as provided in subparagraph (ii) of this paragraph, with respect to a life insurance contract, an insurer may not refuse to insure, refuse to continue to insure, limit the amount or extent or kind of coverage available to an individual, or charge an individual a different rate for the same coverage solely for reasons associated with an applicant's or insured's future lawful travel.

(ii) 1. Subparagraph (i) of this paragraph does not prohibit an insurer from excluding or limiting coverage of specific future lawful travel, or charging a differential rate for such coverage, when bona fide differences in risk or exposure have been substantiated by the use of relevant data from at least one independent reliable source, including statistical or other mathematical analysis of available data that establishes a material variation in actual or reasonably anticipated experience that correlates to the risk of specific future lawful travel.

2. Travel advisories issued by the United States Department of State do not qualify as the sole source of data for purposes of this subparagraph.

3. An insurer shall:

A. maintain the data and documents that support the insurer's determination that bona fide differences in risk or exposure exist; and

B. make the data and documents available on request by the Commissioner.

(b) (1) A person may not make or allow unfair discrimination between individuals of the same class and of essentially the same hazard:

(i) in the amount of premium, policy fees, or rates charged for a policy or contract of health insurance;

(ii) in the benefits payable under a policy or contract of health insurance;

(iii) in any of the terms or conditions of a policy or contract of health insurance; or

(iv) in any other manner.

(2) Notwithstanding any other provision of this section, an insurer may not make or allow a differential in ratings, premium payments, or dividends for a reason based on the sex of an applicant or policyholder unless there is actuarial justification for the differential.

(3) (i) Except as provided in § 27-909 of this title and notwithstanding any other provision of this section, an insurer may not make or allow a differential in ratings, premium payments, or dividends for contracts of health insurance for a reason based on the blindness or other physical handicap or disability of an applicant or policyholder.

(ii) Except as provided in § 27-909 of this title, actuarial justification for the differential may be considered for a physical handicap or disability other than blindness or hearing impairment.

§27–209.

(a) Except as otherwise expressly provided by law, a person, including a health maintenance organization, may not knowingly:

(1) allow, make, or offer to make a contract of life insurance or health insurance or an annuity contract or an agreement as to the contract other than as plainly expressed in the contract;

(2) pay, allow, give, or offer to pay, allow, or give directly or indirectly as an inducement to the insurance or annuity:

(i) a rebate of premiums payable on the contract;

(ii) a special favor or advantage in the dividends or other benefits under the contract;

(iii) paid employment or a contract for services of any kind; or

(iv) any valuable consideration or other inducement not specified in the contract;

(3) directly or indirectly give, sell, purchase, offer or agree to give, sell, or purchase, or allow as inducement to the insurance or annuity or in connection with the insurance or annuity, regardless of whether specified in the policy or contract, an agreement that promises returns and profits, or stocks, bonds, or other securities, or a present or contingent interest in or measured by stocks, bonds, or other securities, of an insurer or other corporation, association, or partnership, or dividends or profits accrued or to accrue on stocks, bonds, or other securities; or

(4) offer, promise, or give any valuable consideration not specified in the contract, except for educational materials, promotional materials, or articles of merchandise that cost no more than $50.

(b) A person may not make receipt of any educational materials, promotional materials, or articles of merchandise under subsection (a)(4) of this section contingent on the sale or purchase of insurance.

(c) (1) This section does not prohibit an insurer, a nonprofit health service plan, or a health maintenance organization from offering or providing products or services in conjunction with a policy at no charge or at a discounted price if:

(i) 1. A. the products or services are offered or provided to educate persons regarding, or to assess, monitor, control, or prevent, risk of loss to persons; and

B. the risk of loss to persons is associated with risks insured against by the policy or insurance or annuity contract; or

2. the products or services are:

A. substantially related to the insurance provided under the policy or contract; or

B. offered or provided to enhance the health of the insured or beneficiary; and

(ii) the offer or provision of products or services is available to all policyholders that have purchased the policy or contract associated with the offer or provision.

(2) An insurer, a nonprofit health service plan, or a health maintenance organization may include an offer or a provision of products or services under this subsection in an applicable contract or form or rate filing.

(3) (i) If the offer or provision of specific products or services under this subsection is included in any policy of insurance, health maintenance organization contract, nonprofit health service plan, or annuity contract, the products or services may not be discontinued during the term of the policy or contract unless discontinuation of the product or services is:

1. consented to in writing by the policyholder; or

2. the result of a uniform modification under § 15–1212, § 15–1309, or § 15–1409 of this article.

(ii) This paragraph does not prohibit a carrier from terminating a contract as otherwise authorized under this article.

(4) An insurer, a nonprofit health service plan, or a health maintenance organization may not increase the premium or deny a claim of a policyholder if the policyholder accepts, rejects, uses, or fails to use a product or service under this subsection.

(5) (i) Subject to subparagraph (ii) of this paragraph, the Commissioner may determine by regulation the types of products or services that meet the criteria in paragraph (1) of this subsection.

(ii) A product or service offered or provided in conjunction with an insurance policy or annuity contract that is primarily designed to enhance financial wellness shall be allowed if the Commissioner determines that the product or service includes an enhancement to the financial protection component of the insurance policy or annuity contract.

§27–210.

(a) Sections 27–208 and 27–209 of this subtitle may not be construed to include within the definition of discrimination or rebates any of the practices set forth in this section.

(b) For a contract of life insurance or an annuity contract, it is not discrimination or a rebate to pay bonuses to policyholders or otherwise abate their premiums wholly or partly out of the surplus accumulated from nonparticipating insurance, if the bonuses or abatement of premiums is fair, equitable to, and in the best interest of policyholders.

(c) For policies of life insurance or health insurance issued on the industrial debit, preauthorized check, bank draft, or similar plans, it is not discrimination or a rebate to make an allowance to policyholders who have continuously for a specified period made premium payments directly to an office of the insurer or by preauthorized check, bank draft, or similar plans in an amount that fairly represents the savings in collection expense.

(d) It is not discrimination or a rebate to readjust the rate of premium for a group policy based on the loss or expense experience under the policy, at the end of any policy year, retroactive only for that policy year.

(e) It is not discrimination or a rebate to reduce the premium rate for policies of large amount, if the reduction does not exceed savings in issuance and administrative expenses reasonably attributable to policies of large amount as compared with policies of similar plan issued in smaller amounts.

(f) It is not discrimination or a rebate to issue policies of life insurance or health insurance or annuity contracts on a salary savings or payroll deduction plan or other distribution plan at a reduced rate reasonably commensurate with the savings made by use of the plan.

(g) It is not discrimination or a rebate to issue policies of health insurance that provide for increases in benefits to policyholders who maintain their policies continuously in force without lapse for specified periods.

(h) (1) In this subsection, "wellness program" means a program that:

(i) meets the requirements of a participatory wellness program or a health–contingent wellness program under § 15–509 of this article; and

(ii) is provided as a benefit outside of the health insurance or health maintenance organization contract.

(2) It is not discrimination or a rebate for a carrier to provide reasonable incentives to an individual who is an insured, a subscriber, or a member for participation in a wellness program offered by the carrier.

(3) Any incentive offered for participation in a wellness program:

(i) shall be reasonably related to the wellness program; and

(ii) may not have a value that exceeds any limit established in regulations adopted by the Commissioner.

(4) The Commissioner shall adopt regulations to implement the provisions of this subsection.

§27–211.

(a) This section does not apply to:

(1) insurance on the life of a debtor in connection with a specific loan or other credit transaction;

(2) insurance on a debtor that provides indemnity for payments that are due on a specific loan or other credit transaction while the debtor is disabled as defined in the policy; or

(3) life insurance or an annuity used to fund a pre-need contract as defined in § 7-101 of the Health Occupations Article or a preneed burial contract as defined in § 5-701 of the Business Regulation Article.

(b) An insurer may not directly or indirectly, or by an insurance producer or representative of the insurer, participate in a plan to offer or effect a kind or kinds of life insurance, health insurance, or annuities in the State as an inducement to, or in combination with, the purchase by the public of goods, securities, commodities, services or subscriptions to periodicals.

§27–212.

(a) This section does not apply to life insurance, health insurance, and annuities.

(b) Except to the extent provided for in an applicable filing with the Commissioner as provided by law, an insurer, employee or representative of an insurer or insurance producer may not pay, allow, give, or offer to pay, allow, or give directly or indirectly as an inducement to insurance or after insurance has become effective:

(1) a rebate, discount, abatement, credit, or reduction of the premium stated in the policy;

(2) a special favor or advantage in the dividends or other benefits to accrue on the policy; or

(3) any valuable consideration or other inducement not specified in the policy.

(c) An insured named in a policy or an employee of the insured may not knowingly receive or accept directly or indirectly a rebate, discount, abatement, credit, reduction of premium, special favor, advantage, valuable consideration, or inducement described in subsection (b) of this section.

(d) (1) Except as otherwise provided by law, a person may not knowingly offer, promise, or give any valuable consideration not specified in the policy, except for educational materials, promotional materials, or articles of merchandise that cost no more than $50.

(2) A person may not make receipt of any educational materials, promotional materials, or articles of merchandise under this subsection contingent on the sale or purchase of insurance.

(e) (1) An insurer may not make or allow unfair discrimination between insureds or properties having like insuring or risk characteristics in:

(i) the premium or rates charged for insurance;

(ii) the dividends or other benefits payable on the insurance; or

(iii) any of the other terms or conditions of the insurance.

(2) Notwithstanding any other provision of this section, an insurer may not make or allow a differential in ratings, premium payments, or dividends for a reason based on the sex, physical handicap, or disability of an applicant or policyholder unless there is actuarial justification for the differential.

(f) (1) This section does not prohibit an insurer from:

(i) paying commissions or other compensation to licensed insurance producers;

(ii) paying commissions to licensed insurance producers on a variable basis on policies issued to qualified exempt commercial policyholders, as defined in § 11–206 of this article, if:

1. the payment of the commission to the insurance producer on a variable basis results in a lower total cost of the policy to the qualified exempt commercial policyholder; and

2. the insurance producer receiving the commission has agreed to the specific level of commission to be paid on the policy;

(iii) allowing or returning to its participating policyholders, members, or subscribers lawful dividends, savings, or unabsorbed premium deposits; or

(iv) offering or providing products or services in conjunction with a policy at no charge or at a discounted price to educate a person regarding, or to assess, monitor, control, or prevent, risk of loss to persons or property if:

1. the risk of loss to persons or property is associated with the risks insured against by the policy; and

2. the offer or provision of products or services is available to all policyholders that have purchased the policy associated with the offer or provision.

(2) An insurer may include in an applicable contract or form or rate filing an offer or a provision of products or services under this subsection.

(3) An insurer may not increase the premium or deny a claim of a policyholder if the policyholder accepts, rejects, uses, or fails to use a product or service under this subsection.

(4) The Commissioner may determine by regulation the types of products or services that meet the criteria in paragraph (1)(iv) of this subsection.

§27–213.

A person may not make, issue, or cause to be made or issued an oral or written statement that misrepresents or makes incomplete comparisons about the terms, conditions, or benefits contained in a policy for the purpose of inducing or attempting or tending to induce the policyholder to forfeit, surrender, retain, exchange, or convert a policy or allow a policy to lapse.

§27–214.

(a) (1) A person may not require another person to buy insurance through a particular insurance producer or insurer as a condition, agreement, or

understanding with respect to selling or providing a loan, credit, sale, goods, property, contract, lease, or service to the other person.

(2) An insurance producer or insurer may not participate in a combination plan or transaction prohibited by paragraph (1) of this subsection.

(b) (1) A person may not solicit the combination of insurance and other matters prohibited by subsection (a) of this section.

(2) An insurance producer or insurer may not participate in a plan of public solicitation of the combination of insurance and other matters prohibited by subsection (a) of this section.

(3) This subsection does not prohibit a person from being an insurance producer and engaging in another business at the same time or place if:

(i) the sales of insurance and other matters are not combined or coerced as prohibited by subsection (a) of this section; and

(ii) the buyer or other person has the free choice of insurance.

(c) (1) Violation of this section does not invalidate any contract or transaction.

(2) Notwithstanding a combination contract, tying agreement, understanding, or condition to the contrary, the person required to buy or pay for insurance or to bid ex–insurance may substitute at any time other insurance from insurance producers or insurers chosen by the person, or may decline further insurance coverage if the insurance is other than to protect the interest of a lender, property owner, or other person.

§27–215.

(a) An insurer may retain, invest in, or acquire all or part of the capital stock of another insurer or have common management with another insurer, unless the retention, investment, acquisition, or common management is inconsistent with another provision of this article or causes the business of the insurers with the public to be conducted in a manner that substantially lessens competition generally in the insurance business or tends to create a monopoly in the insurance business.

(b) An individual otherwise qualified may be director of two or more insurers that are competitors, unless the effect substantially lessens competition between insurers generally or tends materially to create a monopoly.

§27–216.

(a) A person may not willfully collect a premium or charge for insurance if the insurance is not then provided, or is not in due course to be provided subject to acceptance of the risk by the insurer, in a policy issued by an insurer as authorized by this article.

(b) (1) A person may not willfully collect a premium or charge for insurance that:

(i) exceeds or is less than the premium or charge applicable to that insurance under the applicable classifications and rates as filed with and approved by the Commissioner; or

(ii) if classifications, premiums, or rates are not required by this article to be filed with and approved by the Commissioner, exceeds or is less than the premium or charge specified in the policy and set by the insurer.

(2) Paragraph (1) of this subsection does not prohibit:

(i) a surplus lines broker that holds a certificate of qualification under Title 3, Subtitle 3 of this article from charging and collecting applicable State and federal taxes in addition to the required premium;

(ii) a life insurer from charging and collecting the amount actually expended for a medical examination of an applicant for life insurance or reinstatement of a policy of life insurance;

(iii) an insurance producer from charging a fee, not exceeding 15% of the premium, for services rendered in placing insurance in an insurer if commissions are not payable by the insurer;

(iv) an insurer from paying commissions to licensed insurance producers on a variable basis on policies issued to qualified exempt commercial policyholders, as defined in § 11–206 of this article, if:

1. the payment of the commission to the insurance producer on a variable basis results in a lower total cost of the policy to the qualified exempt policyholder; and

2. the insurance producer receiving the commission has agreed to the specific level of commission to be paid on the policy; or

(v) a fund producer from charging and collecting, as actual expenses incurred in placing automobile insurance with the Maryland Automobile Insurance Fund:

1. a maximum charge of $25 plus $1 more than the actual charge by the Motor Vehicle Administration for a driving record required to be presented with the application, unless otherwise provided by the Fund; or

2. the amount provided in subsection (e) of this section.

(3) (i) Subject to subparagraphs (ii), (iii), (iv), and (v) of this paragraph, paragraph (1) of this subsection does not prohibit an authorized insurer or the Maryland Automobile Insurance Fund from charging and collecting, if approved by the Commissioner, reasonable installment fees or reasonable fees for late payment of premiums by policyholders or both.

(ii) The Commissioner:

1. shall review administrative expenses submitted by an authorized insurer or the Maryland Automobile Insurance Fund that are associated with late payments or installment payments, including the cost incurred by an authorized insurer or a vendor of the authorized insurer to accept late payments or installment payments by credit card, debit card, electronic funds transfer, or electronic check payment; and

2. may approve a late fee or installment fee not to exceed $10.

(iii) A late fee may not be imposed:

1. during any grace period required by law or regulation on a policy of insurance; or

2. if no grace period is required by law or regulation on a policy of insurance, until 2 business days after the date the payment amount becomes due.

(iv) An authorized insurer or the Maryland Automobile Insurance Fund shall credit each payment received from an insured to the premium owed by the insured before crediting the payment to a late fee or installment fee owed by the insured.

(v) A policy of insurance may not be canceled for the failure to pay a single late fee or single installment fee.

(4) (i) Subject to subparagraphs (ii) and (iii) of this paragraph, paragraph (1) of this subsection does not prohibit an insurance producer from charging and collecting from an insured actual expenses incurred by the insurance producer for payment of the premium for a policy by use of a credit card.

(ii) Any point of service credit card expenses may not be considered premium for any purpose under this paragraph.

(iii) An insurance producer that accepts alternative payment methods for premiums shall disclose fully to the insured or prospective insured:

1. the availability of all payment methods accepted by the insurer or insurance producer; and

2. any charge for actual expenses incurred by the insurance producer for payment of a premium by use of a credit card.

(5) (i) Paragraph (1) of this subsection does not prohibit an authorized motor vehicle insurer or the Maryland Automobile Insurance Fund from charging and collecting a reasonable fee approved by the Commissioner under subparagraph (iii) of this paragraph for the reinstatement of a private passenger motor vehicle liability insurance policy in accordance with § 19–519 of this article.

(ii) Paragraph (1) of this subsection does not prohibit a licensed insurance producer or a fund producer from charging and collecting a reasonable fee approved by the Commissioner under subparagraph (iii) of this paragraph for the reinstatement of a private passenger motor vehicle liability insurance policy in accordance with § 19–519 of this article.

(iii) The Commissioner:

1. shall review the administrative expenses submitted by an authorized motor vehicle insurer or the Maryland Automobile Insurance Fund that are associated with reinstatements under § 19–519 of this article; and

2. may approve a reinstatement fee not to exceed:

A. $10 to be charged and collected by the insurer or the Fund; and

B. $15 to be charged and collected by the insurance producer or the fund producer.

(c) An insurer may not raise the policy limits of coverage, if the effect could be an increase in the premium without the prior consent of the insured.

(d) (1) Notwithstanding subsection (a) of this section, a surplus lines broker that holds a certificate of qualification under Title 3, Subtitle 3 of this article may charge a reasonable policy fee on a policy issued by a surplus lines insurer to an exempt commercial policyholder, as defined in § 11–206(j) of this article.

(2) Notwithstanding subsection (a) of this section, a surplus lines broker that holds a certificate of qualification under Title 3, Subtitle 3 of this article may charge a reasonable policy fee on a policy issued by a surplus lines insurer not exceeding:

(i) $200 on each personal lines policy procured by a licensed insurance producer not affiliated with or controlled by the surplus lines broker and to whom the surplus lines broker pays a commission; or

(ii) $500 or 7% of the policy premium, whichever is greater, on each commercial lines policy procured by a licensed insurance producer not affiliated with or controlled by the surplus lines broker and to whom the surplus lines broker pays a commission.

(3) A surplus lines broker that holds a certificate of qualification under Title 3, Subtitle 3 of this article and a license as an insurance producer under Title 10, Subtitle 1 of this article may charge a reasonable policy fee on a policy issued by an authorized insurer not exceeding $500 or 7% of the policy premium, whichever is greater, on each commercial lines policy procured by a licensed insurance producer not affiliated with or controlled by the surplus lines broker and to whom the surplus lines broker pays a commission.

(4) The policy fee charged in accordance with this subsection must be reasonably related to the cost of underwriting, issuing, processing, and servicing the policy by the surplus lines broker for the surplus lines insurer or the authorized insurer.

(5) Notwithstanding subsection (a) of this section, a surplus lines broker that holds a certificate of qualification under Title 3, Subtitle 3 of this article may recoup from the prospective insured the actual cost of an inspection required for the placement of surplus lines insurance with a surplus lines insurer if:

(i) the inspection is required by the surplus lines insurer;

(ii) the cost of the inspection is actually incurred by the surplus lines broker and not retained by the surplus lines broker; and

(iii) the cost of the inspection is documented and verifiable.

(6) A surplus lines broker that holds a certificate of qualification under Title 3, Subtitle 3 of this article and a license as an insurance producer under Title 10, Subtitle 1 of this article may recoup from the prospective insured the actual cost of an inspection required for the placement of insurance with an authorized insurer if:

(i) the inspection is required by the authorized insurer;

(ii) the cost of the inspection is actually incurred by the surplus lines broker and not retained by the surplus lines broker; and

(iii) the cost of the inspection is documented and verifiable.

(7) Regardless of the number of insurers participating on a risk:

(i) only one inspection fee may be charged to recoup the actual cost of an inspection under paragraphs (5) and (6) of this subsection for each policy or certificate of coverage; and

(ii) only one policy fee may be charged under paragraph (2) or (3) of this subsection for each policy or certificate of coverage.

(8) (i) Subject to subparagraph (ii) of this paragraph, a surplus lines broker that holds a certificate of qualification under Title 3, Subtitle 3 of this article may charge and collect from an insured actual expenses incurred by the surplus lines broker for payment of the premium, policy fee, and any other fees and taxes relating to the policy by use of a credit card.

(ii) Any point of service credit card expenses may not be considered premium for any purpose under this paragraph.

(9) On a form approved by the Commissioner, the surplus lines broker shall:

(i) make a clear and conspicuous written disclosure of:

1. any inspection fee;

2. the total amount of the policy fee;

3. the premium tax on the policy;

4. any financial interest in the person performing the inspection, if applicable;

5. whether the surplus lines broker will receive compensation from the person that performs the inspection; and

6. any charge for actual expenses incurred by the surplus lines broker for payment of the premium, policy fee, and any other fees and taxes relating to the policy by use of a credit card; and

(ii) notify the prospective insured of the option to obtain the inspection from another person who meets the requirements of or is approved by the surplus lines insurer.

(e) (1) (i) In this subsection, "accident history report" means a report that details an individual's accident history.

(ii) "Accident history report" includes a comprehensive loss underwriting exchange automobile report (CLUE report).

(iii) "Accident history report" does not include a report that details an individual's credit standing or history.

(2) (i) The Maryland Automobile Insurance Fund may sponsor a fund producer or premium finance company registered under Title 23 of this article for the purpose of obtaining accident history reports directly from a person that provides accident history reports.

(ii) When placing automobile insurance through the Fund, a fund producer or premium finance company sponsored by the Fund under this paragraph may obtain accident history reports directly from a person that provides accident history reports.

(3) Unless provided otherwise by the Fund, a person that provides accident history reports to a fund producer or premium finance company sponsored by the Fund under paragraph (2) of this subsection shall direct all billing for the reports to the fund producer or premium finance company.

(4) Subsection (b)(1) of this section does not prohibit a fund producer or premium finance company from charging and collecting actual expenses that are imposed by a person for providing accident history reports under this subsection in connection with the placement of automobile insurance through the Fund.

(f) In addition to any other sanction otherwise applicable, a person that violates subsection (b)(1) of this section with regard to a bail bond is subject to a penalty not exceeding $5,000 for each violation.

(g) (1) (i) In this subsection the following words have the meanings indicated.

(ii) "Administrative service" means a service, other than a service related to the sale, solicitation, negotiation, or servicing of a health benefit plan, that an insurance producer provides to assist an employer in:

1. complying with a statutory or regulatory requirement;

2. providing an employee benefit on behalf of the employer; or

3. performing functions related to the management of employees of the employer.

(iii) "Health benefit plan" has the meaning stated in § 2–112.2 of this article.

(2) (i) Notwithstanding subsection (a) of this section and subject to subparagraph (ii) of this paragraph, an insurance producer who is licensed under Title 10 of this article to sell health insurance may charge reasonable fees for an administrative service that is sold by the insurance producer to an employer.

(ii) An insurance producer may not charge fees under this subsection for services that are:

1. compensated by commissions or other compensation paid to the insurance producer by an insurer, nonprofit health service plan, or health maintenance organization related to a health benefit plan of an employer; or

2. performed by the insurance producer acting as an administrator under Title 8, Subtitle 3 of this article or an adviser under Title 10, Subtitle 2 of this article.

(3) Before a fee for administrative services is charged, an insurance producer, on a form adopted by the Commissioner by regulation, shall disclose in a clear and conspicuous manner:

(i) each administrative service to be provided;

(ii) the fee for each administrative service to be provided; and

(iii) if the insurance producer sells a health benefit plan to the employer, the amount of commission or other compensation that the insurance producer will receive from an insurer, nonprofit health service plan, or health maintenance organization related to the health benefit plan.

(4) The disclosure form required under paragraph (3) of this subsection shall be:

(i) signed by the insurance producer and an authorized representative of the employer; and

(ii) retained by the insurance producer as required by regulations adopted by the Commissioner.

§27–217.

(a) This section does not apply to:

(1) life insurance;

(2) health insurance;

(3) annuity contracts; or

(4) a pooling arrangement by athletic clubs, charitable organizations, community associations, homeowners' associations, and public entities under Title 19, Subtitle 6 of this article to purchase insurance under this section.

(b) An authorized insurer or unauthorized insurer may not make available to a firm, corporation, or association of individuals through a rating plan or form, property insurance, casualty insurance, or surety insurance at a preferred rate or premium based on a fictitious group of the firm, corporation, or association of individuals.

(c) A form or plan of insurance that covers a group or combination of persons or risks may not be written or delivered in or outside the State to cover persons or risks in the State at a preferred rate or on a form other than the rate or form offered to the public generally, including persons not in the group or combination, unless the form, plan of insurance, and rates or premiums to be charged have been submitted to and approved by the Commissioner as:

(1) not unfairly discriminatory; and

(2) not otherwise in conflict with subsection (b) of this section or, to the extent applicable, Title 11, Subtitle 2 of this article.

(d) The Commissioner shall adopt regulations to carry out subsection (c) of this section as it applies to property insurance or casualty insurance on motor vehicles.

§27–218.

(a) All burial insurance benefits shall be paid in cash to the beneficiary.

(b) A person engaged in the business of burial insurance may not pay or contract to pay wholly or partly burial insurance or its benefits to:

(1) an official mortician, funeral director, or undertaker;

(2) a designated mortician, funeral director, undertaker, or funeral directing or undertaking concern; or

(3) a particular tradesperson or businessperson.

(c) This section does not apply to life insurance or an annuity used to fund a pre-need contract as defined in § 7-101 of the Health Occupations Article or a preneed burial contract as defined in § 5-701 of the Business Regulation Article.

§27–219.

A person that is not an insurer may not assume or use a name that deceptively implies or suggests that it is an insurer.

§27–220.

An insurance producer or insurer may not refer an individual employee or dependent of an employee to the Maryland Children's Health Program established under Title 15, Subtitle 3 of the Health - General Article or arrange for an individual employee or dependent of an employee to apply for the Maryland Children's Health Program established under Title 15, Subtitle 3 of the Health - General Article if the insurance producer or insurer has an economic interest in the referral or the arrangement and the insurance producer's or insurer's sole purpose is to separate that employee or that employee's dependent from group health insurance coverage provided in connection with the employee's employment.

§27–221.

(a) (1) In this section the following words have the meanings indicated.

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

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

(ii) a health maintenance organization that holds a certificate of authority to operate in the State; or

(iii) a nonprofit health service plan that holds a certificate of authority to operate in the State.

(3) "Health coverage" means any of the following:

(i) a health insurance contract that is issued or delivered in the State by an insurer;

(ii) a contract that is issued or delivered in the State by a nonprofit health service plan; or

(iii) a contract that is issued or delivered in the State by a health maintenance organization.

(4) "Health status-related factor" has the meaning stated in § 15-1301 of this article.

(5) "Individual contract" means a contract between a carrier and an individual covering:

(i) the individual;

(ii) the individual and the individual's family members; or

(iii) the family members of the individual.

(6) (i) "Reunderwrite" means to reevaluate any health status-related factor, occupation, hobby, or activity of an individual for the purpose of:

1. terminating health coverage of the individual; or

2. moving the individual from a more favorable rate class to a less favorable rate class.

(ii) "Reunderwrite" does not include:

1. moving an individual from one rate tier to another rate tier solely due to the addition or deletion of a family member under the health coverage;

2. increasing the premium under an attained age rated contract solely due to the increasing age of the individual covered under the health coverage;

3. on receipt of an application from an insured to increase the benefits under an existing contract, evaluating the health status-related factors, occupation, hobbies, or activities of the insured for the purpose of increasing the benefits under the contract; or

4. during the period in which a carrier has the right to contest a policy, denying a claim, amending the policy, making an adjustment to the premium, or rescinding the policy based on a material misrepresentation or fraud in the application.

(b) A carrier may not reunderwrite an individual for health coverage under an individual contract after the individual contract has been issued.

§27–222.

A person may not violate § 15–112(h) of this article.

§27–223.

(a) It is unlawful for any insurance producer to use a senior or retiree credential or designation in a way that is or would be misleading in connection with the offer, sale, or purchase of life insurance, health insurance, or annuities.

(b) (1) The Commissioner, in consultation with the Securities Commissioner of the Division of Securities in the Office of the Attorney General, shall adopt regulations to define what constitutes a misleading use of a senior or retiree credential or designation for purposes of subsection (a) of this section.

(2) The regulations adopted by the Commissioner may provide exemptions from subsection (a) of this section, if the exemptions are consistent with

the public interest and within the purposes intended by the policy and provisions of this title.

(c) A violation of subsection (a) of this section constitutes a lack of trustworthiness for the purposes of § 10–126(a)(13) of this article.

(d) This section may not be construed to limit any powers of the Commissioner granted under this title.

§27–224.

When soliciting or advertising the sale of a Medicare Advantage Plan, Medicare Advantage Prescription Drug Plan, Medicare Prescription Drug Plan (Part D), or Medicare Section 1876 cost plan, an insurance producer shall comply with the Centers for Medicare and Medicaid Services' Medicare Marketing Guidelines, as may be amended from time to time, including the prohibitions against:

(1) engaging in door–to–door solicitation, including leaving written information at a residence or on a vehicle;

(2) approaching a Medicare beneficiary in a common area, including a parking lot, hallway, lobby, or sidewalk; and

(3) engaging in telephone or electronic solicitation.

§27–225.

(a) In this section "bail bond" has the meaning stated in § 10–301 of this article.

(b) A confessed judgment clause that waives a consumer's right to assert a legal defense to an action may not be included in a bail bond agreement.

§27–301.

(a) The intent of this subtitle is to provide an additional administrative remedy to a claimant for a violation of this subtitle or a regulation that relates to this subtitle.

(b) (1) This subtitle provides administrative remedies only.

(2) This subtitle does not provide or prohibit a private right or cause of action to, or on behalf of, a claimant or other person in any state.

(3) This subtitle does not impair the right of a person to seek redress in law or equity for conduct that otherwise is actionable.

§27–302.

(a) This subtitle applies to each individual or group policy, contract, or certificate of an insurer, nonprofit health service plan, or health maintenance organization that:

(1) is delivered or issued in the State;

(2) is issued to a group that has a main office in the State; or

(3) covers individuals who reside or work in the State.

(b) This subtitle does not apply to:

(1) reinsurance;

(2) workers' compensation insurance; or

(3) surety insurance.

§27–303.

It is an unfair claim settlement practice and a violation of this subtitle for an insurer, nonprofit health service plan, or health maintenance organization to:

(1) misrepresent pertinent facts or policy provisions that relate to the claim or coverage at issue;

(2) refuse to pay a claim for an arbitrary or capricious reason based on all available information;

(3) attempt to settle a claim based on an application that is altered without notice to, or the knowledge or consent of, the insured;

(4) fail to include with each claim paid to an insured or beneficiary a statement of the coverage under which payment is being made;

(5) fail to settle a claim promptly whenever liability is reasonably clear under one part of a policy, in order to influence settlements under other parts of the policy;

(6) fail to provide promptly on request a reasonable explanation of the basis for a denial of a claim;

(7) fail to meet the requirements of Title 15, Subtitle 10B of this article for preauthorization for a health care service;

(8) fail to comply with the provisions of Title 15, Subtitle 10A of this article;

(9) fail to act in good faith, as defined under § 27–1001 of this title, in settling a first–party claim under a policy of property and casualty insurance; or

(10) fail to comply with the provisions of § 16–118 of this article.

§27–304.

It is an unfair claim settlement practice and a violation of this subtitle for an insurer, nonprofit health service plan, or health maintenance organization, when committed with the frequency to indicate a general business practice, to:

(1) misrepresent pertinent facts or policy provisions that relate to the claim or coverage at issue;

(2) fail to acknowledge and act with reasonable promptness on communications about claims that arise under policies;

(3) fail to adopt and implement reasonable standards for the prompt investigation of claims that arise under policies;

(4) refuse to pay a claim without conducting a reasonable investigation based on all available information;

(5) fail to affirm or deny coverage of claims within a reasonable time after proof of loss statements have been completed;

(6) fail to make a prompt, fair, and equitable good faith attempt, to settle claims for which liability has become reasonably clear;

(7) compel insureds to institute litigation to recover amounts due under policies by offering substantially less than the amounts ultimately recovered in actions brought by the insureds;

(8) attempt to settle a claim for less than the amount to which a reasonable person would expect to be entitled after studying written or printed advertising material accompanying, or made part of, an application;

(9) attempt to settle a claim based on an application that is altered without notice to, or the knowledge or consent of, the insured;

(10) fail to include with each claim paid to an insured or beneficiary a statement of the coverage under which the payment is being made;

(11) make known to insureds or claimants a policy of appealing from arbitration awards in order to compel insureds or claimants to accept a settlement or compromise less than the amount awarded in arbitration;

(12) delay an investigation or payment of a claim by requiring a claimant or a claimant's licensed health care provider to submit a preliminary claim report and subsequently to submit formal proof of loss forms that contain substantially the same information;

(13) fail to settle a claim promptly whenever liability is reasonably clear under one part of a policy, in order to influence settlements under other parts of the policy;

(14) fail to provide promptly a reasonable explanation of the basis for denial of a claim or the offer of a compromise settlement;

(15) refuse to pay a claim for an arbitrary or capricious reason based on all available information;

(16) fail to meet the requirements of Title 15, Subtitle 10B of this article for preauthorization for a health care service;

(17) fail to comply with the provisions of Title 15, Subtitle 10A of this article; or

(18) fail to act in good faith, as defined under § 27–1001 of this title, in settling a first–party claim under a policy of property and casualty insurance.

§27–304.1.

The Commissioner shall adopt regulations that establish standards and procedures for:

(1) the settlement of claims involving the total loss of a private passenger motor vehicle; and

(2) the determination of the private passenger motor vehicle's total loss value.

§27–305.

(a) The Commissioner may impose a penalty:

(1) not exceeding $2,500 for each violation of § 27–303 of this subtitle or a regulation adopted under § 27–303 of this subtitle; and

(2) not exceeding $125,000 for each violation of § 27–303(9) of this subtitle or a regulation adopted under § 27–303(9) of this subtitle.

(b) The penalty for a violation of § 27–304 of this subtitle is as provided in §§ 1–301, 4–113, and 4–114 of this article and § 27–103 of this title.

(c) (1) On finding a violation of this subtitle, the Commissioner may require an insurer, nonprofit health service plan, or health maintenance organization to:

(i) make restitution to each claimant who has suffered actual economic damage because of the violation; or

(ii) provide to a claimant a payment that has been determined to be denied in violation of this subtitle.

(2) Subject to paragraph (3) of this subsection, restitution may not exceed the amount of actual economic damage sustained, subject to the limits of any applicable policy.

(3) For a violation of § 27–303(9) of this subtitle, the Commissioner may require restitution to an insured for the following:

(i) actual damages, which actual damages may not exceed the limits of any applicable policy;

(ii) expenses and litigation costs incurred by the insured in pursuing an administrative complaint under § 27–303(9) of this subtitle, including reasonable attorney's fees; and

(iii) interest on all actual damages, expenses, and litigation costs incurred by the insured computed:

1. at the rate allowed under § 11–107(a) of the Courts Article; and

2. from the date on which the insured's claim would have been paid if the insurer acted in good faith.

(4) The amount of attorney's fees recovered from an insurer under paragraph (3) of this subsection may not exceed one–third of the actual damages recovered.

§27–306.

An appeal from an order issued by the Commissioner under this subtitle shall be taken in accordance with § 2-215 of this article.

§27–401.

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

(b) (1) "Claim" means a demand for payment or benefit under a policy or contract by an insured, third party, or representative of the insured or third party.

(2) "Claim" includes a demand for payment or benefit made against:

(i) the State under Title 12 of the State Government Article, Title 2, Subtitle 5 of the State Personnel and Pensions Article, or Title 9 of the Labor and Employment Article; or

(ii) the Maryland Transit Administration when acting as a self–insurer under § 7–703 of the Transportation Article.

(c) "Motor vehicle accident" means an occurrence involving a motor vehicle that results in damage to property or injury to a person.

§27–402.

The provisions of this subtitle that apply to insurers also apply to:

(1) a corporation that operates a nonprofit health service plan under Title 14, Subtitle 2 of this article;

(2) a dental plan organization as defined in § 14–401 of this article;

(3) a health maintenance organization as defined in Title 19, Subtitle 7 of the Health – General Article;

(4) a surplus lines insurer;

(5) the Maryland Automobile Insurance Fund;

(6) the State when a claim has been filed against the State under Title 12 of the State Government Article;

(7) the State when a claim has been filed against the State under Title 2, Subtitle 5 of the State Personnel and Pensions Article;

(8) the State, including the Uninsured Employers' Fund, when a claim has been filed against the State under Title 9 of the Labor and Employment Article;

(9) the Maryland Transit Administration when acting as a self–insurer under § 7–703 of the Transportation Article;

(10) a third party administrator under Title 8, Subtitle 3 of this article;

(11) a self–insurer under § 17–103(a)(2) of the Transportation Article;

(12) the Maryland Health Insurance Plan;

(13) a governmental self–insurer group formed in accordance with § 9–404 of the Labor and Employment Article;

(14) an employer who self–insures or participates in a self–insurance group in accordance with § 9–405 of the Labor and Employment Article; and

(15) an agent, employee, or representative of an entity described in items (1) through (14) of this section.

§27–403.

It is a fraudulent insurance act for a person:

(1) knowingly to fail to return any money or premiums paid for a policy to an insured, designee of the insured, or another person entitled to the money or premiums if the insurance contracted for is not ultimately provided;

(2) to present or cause to be presented to an insurer documentation or an oral or written statement made in support of a claim, including a claim that alleges the theft of a motor vehicle, with knowledge that the documentation or statement contains false or misleading information about a matter material to the claim;

(3) except for the prepayment of periodic payments or excess contributions allowed under the terms of the policy, willfully to collect as a premium a sum in excess of the premium applicable to the insurance under approved classifications and rates or, for cases in which classifications and rates are not subject to approval, the premiums and charges applicable to the insurance as specified in the policy and set by the insurer;

(4) to misappropriate or withhold unreasonably funds received or held if the funds represent premiums or return premiums;

(5) to misappropriate benefits under a policy; and

(6) knowingly or willfully to present, or cause to be presented, documentation or an oral or written statement made in, with reference to, or in support of an application for a viatical settlement contract, the financing of a viatical settlement contract, the transfer of a viatical settlement contract, or the settlement in support of a claim made under a viatical settlement contract with knowledge that the documentation or statement contains false or misleading information about matters material to the application, financing, transfer, settlement, or claim.

§27–404.

It is a fraudulent insurance act for an insurer doing business in the State knowingly to write or place a policy or insurance contract in the State through, or pay a commission or other consideration to, a person that is required to have a certificate of qualification under this article but does not have a certificate of qualification.

§27–405.

(a) It is a fraudulent insurance act for a person to act as or represent to the public that the person is:

(1) an insurance producer or a public adjuster in the State if the person has not received the appropriate license under or otherwise complied with Title 10 of this article;

(2) a navigator of the Small Business Health Options Program of the Maryland Health Benefit Exchange if the person has not received the appropriate license under or otherwise complied with § 31–112 of this article;

(3) a navigator of the Individual Exchange of the Maryland Health Benefit Exchange if the person has not received the appropriate certification under or otherwise complied with § 31–113 of this article; or

(4) an application counselor certified by the Individual Exchange of the Maryland Health Benefit Exchange if the person has not received the appropriate certification under or otherwise complied with § 31–113(r) of this article.

(b) It is a fraudulent insurance act for an insurance producer:

(1) to solicit or take application for, procure, or place for others insurance for which the insurance producer has not obtained an appropriate license;

(2) knowingly to violate § 10–130 of this article; or

(3) intentionally to fail to report to an insurer the exact amount of consideration charged as a premium for an insurance contract, if different from the policy premium, and to fail to maintain records that show that information.

§27–406.

It is a fraudulent insurance act for a person:

(1) knowingly or willfully to make a false or fraudulent statement or representation in or with reference to an application for insurance;

(2) to place insurance with an unauthorized insurer not regulated by the Commissioner and refuse to obey an order of the Commissioner to produce for examination all policies and other documents that evidence the insurance and the amount of premiums paid or agreed to be paid for the insurance;

(3) if a certificate of authority is required, to operate an insurer or conduct an insurance business without obtaining a certificate of authority issued by the Commissioner;

(4) to make a false sworn statement that the person does not believe to be true about matter material to an examination, investigation, or hearing conducted by the Commissioner; or

(5) with intent to deceive, knowingly to exhibit a false account, document, or advertisement about the affairs of an insurer.

§27–406.1.

(a) In this section, "individual surety" means a person that:

(1) issues surety bonds or contracts of surety insurance; and

(2) does not have a certificate of authority issued by the Commissioner.

(b) It is a fraudulent insurance act for an individual surety to solicit or issue a surety bond or contract of surety insurance except as provided in:

(1) §§ 13–207 and 17–104 of the State Finance and Procurement Article; and

(2) for an uncompensated person, §§ 5–203 and 5–204 of the Criminal Procedure Article.

§27–407.

(a) It is a fraudulent insurance act for:

(1) a person, for personal gain, to solicit an individual injured by or in a motor vehicle to sue or retain a lawyer to represent that individual in a lawsuit;

(2) a person, for personal gain, to solicit an individual injured by or in a motor vehicle to seek care from a health care practitioner; and

(3) a lawyer or health care practitioner to employ, directly or indirectly, or in any way compensate a person for the purpose of having that person solicit or attempt to solicit clients for the lawyer or health care practitioner.

(b) This section does not prohibit public communications or activity allowed by applicable rules of professional conduct or activity protected under the State or federal Constitution.

§27–407.1.

It is a fraudulent insurance act for a person, with the purpose of submitting a claim under a policy of motor vehicle insurance, to organize, plan, or knowingly participate in:

(1) an intentional motor vehicle accident; or

(2) a scheme to create documentation of a motor vehicle accident that did not occur.

§27–407.2.

It is a fraudulent insurance act for a contractor offering home repair or remodeling services for damages to a private residence, to directly or indirectly pay or otherwise compensate an insured, or offer or promise to pay or compensate an insured, with the intent to defraud an insurer, for any part of the insured's deductible under the insured's property or casualty insurance policy, if payment for the services will be made from the proceeds of the policy.

§27–408.

(a) (1) A person that violates § 27–407 of this subtitle, or another provision of this subtitle in which the claim or act that is the subject of the fraud has a value of $300 or more is guilty of a felony and on conviction, for each violation, is subject to:

(i) liability for restoring to the victim the property taken or the value of the property taken; and

(ii) 1. for a violation of any provision of § 27–403 of this subtitle, a fine, the maximum of which is the greater of three times the value of the claim or act that is the subject of the fraud and $10,000 and the minimum of which is $500, or imprisonment not exceeding 15 years or both; and

2. for a violation of any provision of § 27–404, § 27–405, § 27–406, § 27–406.1, § 27–407, § 27–407.1, or § 27–407.2 of this subtitle, a fine not exceeding $10,000 or imprisonment not exceeding 15 years or both.

(2) A person that violates a provision of this subtitle in which the claim or act that is the subject of the fraud has a value of less than $300 is guilty of a misdemeanor and on conviction, for each violation, is subject to:

(i) liability for restoring to the victim the property taken or the value of the property taken; and

(ii) 1. for a violation of any provision of § 27–403 of this subtitle, a fine, the maximum of which is the greater of three times the value of the

claim or act that is the subject of the fraud and $10,000 and the minimum of which is $500, or imprisonment not exceeding 18 months or both; and

2. for a violation of any provision of § 27–404, § 27–405, § 27–406, § 27–406.1, § 27–407, § 27–407.1, or § 27–407.2 of this subtitle, a fine not exceeding $10,000 or imprisonment not exceeding 18 months or both.

(b) (1) The penalties imposed under this section may be imposed separately from and consecutively to or concurrently with a sentence for another offense based on the act that constitutes a violation of this subtitle.

(2) Each act of solicitation under § 27–407 of this subtitle constitutes a separate violation for purposes of the penalties imposed under this section.

(3) Notwithstanding any other provision of law, a fine imposed under subsection (a) of this section is mandatory and not subject to suspension.

(c) (1) In addition to any criminal penalties that may be imposed under this section, on a showing by clear and convincing evidence that a violation of this subtitle has occurred, the Commissioner may:

(i) impose an administrative penalty not exceeding $25,000 for each act of insurance fraud; and

(ii) order restitution to an insurer or self–insured employer of any insurance proceeds paid relating to a fraudulent insurance claim.

(2) In determining the amount of an administrative penalty, the Commissioner shall consider:

(i) the nature, circumstances, extent, gravity, and number of violations;

(ii) the degree of culpability of the violator;

(iii) prior offenses and repeated violations of the violator; and

(iv) any other matter that the Commissioner considers appropriate and relevant.

(3) If an administrative penalty is not paid after all rights of appeal have been waived or exhausted, the Commissioner may bring a civil action in a court of competent jurisdiction to collect the administrative penalty, including expenses and litigation costs, reasonable attorney's fees, and interest.

(d) This section does not affect an insurer's right to take any independent action to seek recovery against a person that violates this subtitle.

§27–501.

(a) (1) An insurer or insurance producer may not cancel or refuse to underwrite or renew a particular insurance risk or class of risk for a reason based wholly or partly on race, color, creed, sex, or blindness of an applicant or policyholder or for any arbitrary, capricious, or unfairly discriminatory reason.

(2) Except as provided in this section, an insurer or insurance producer may not cancel or refuse to underwrite or renew a particular insurance risk or class of risk except by the application of standards that are reasonably related to the insurer's economic and business purposes.

(b) (1) An insurer may not require special conditions, facts, or situations as a condition to its acceptance or renewal of a particular insurance risk or class of risks in an arbitrary, capricious, unfair, or discriminatory manner based wholly or partly on race, creed, color, sex, religion, national origin, place of residency, blindness, or other physical handicap or disability.

(2) Actuarial justification may be considered with respect to sex.

(c) (1) Except as provided in paragraph (2) of this subsection, an insurer or insurance producer may not make an inquiry about race, creed, color, or national origin in an insurance form, questionnaire, or other manner of requesting general information that relates to an application for insurance.

(2) Subject to § 27–914 of this title, an insurer that provides health insurance, a nonprofit health service plan, or a health maintenance organization may make an inquiry about race and ethnicity in an insurance form, questionnaire, or other manner requesting general information, provided the information is used solely for the evaluation of quality of care outcomes and performance measurements, including the collection of information required under § 19–134 of the Health – General Article.

(d) (1) (i) With respect to automobile liability insurance, an insurer may not:

1. cancel, refuse to renew, or otherwise terminate coverage for an automobile insurance risk because of a claim, traffic violation, or traffic accident that occurred more than 3 years before the effective date of the policy or renewal;

2. refuse to underwrite an automobile insurance risk because of a claim, traffic violation, or traffic accident that occurred more than 3 years before the date of application; or

3. subject to subparagraph (ii) of this paragraph, cancel, refuse to renew, or otherwise terminate coverage for a private passenger motor vehicle insurance policy because of a claim under the towing or emergency roadside service coverage in the policy.

(ii) An insurer may:

1. remove the towing or emergency roadside service coverage at renewal from a private passenger motor vehicle insurance policy based on the number of claims made under the towing or emergency roadside service coverage in a manner that complies with § 27–613 of this title; and

2. increase the premium of the private passenger motor vehicle insurance policy as a result of a towing or emergency roadside service claim in accordance with its filed rates in a manner that complies with § 11–317 of this article and § 27–614 of this title.

(2) With respect to homeowner's insurance, an insurer may not:

(i) cancel, refuse to renew, or otherwise terminate coverage for a homeowner's insurance risk because of a claim that occurred more than 3 years before the effective date of the policy or renewal; or

(ii) refuse to underwrite a homeowner's insurance risk because of a claim that occurred more than 3 years before the date of application.

(3) An insurer may cancel a policy of homeowner's insurance under which a onetime guaranteed fully refundable deposit is required for a stated amount of coverage, if the cancellation:

(i) takes effect on the anniversary date of the inception of the policy;

(ii) is not based on a claim that occurred more than 3 years before the anniversary date of the policy on which the proposed cancellation would take effect; and

(iii) is otherwise in accordance with this subtitle.

(4) This subsection does not apply to a claim involving conviction of the insured or applicant for fraud or arson.

(e) An insurer may not refuse to underwrite a private passenger motor vehicle insurance risk solely because the applicant or named insured previously obtained insurance coverage from any authorized insurer or the Maryland Automobile Insurance Fund.

(e–1) An insurer may not require a particular payment plan for an insured for coverage under a private passenger or homeowner's insurance policy based on the credit history of the insured.

(e–2) (1) In this subsection, "credit history" means any written, oral, or other communication of any information by a consumer reporting agency bearing on a consumer's creditworthiness, credit standing, or credit capacity that is used or expected to be used, or collected in whole or in part, for the purpose of determining personal lines insurance premiums or eligibility for coverage.

(2) With respect to homeowner's insurance, an insurer may not:

(i) refuse to underwrite, cancel, or refuse to renew a risk based, in whole or in part, on the credit history of an applicant or insured;

(ii) rate a risk based, in whole or in part, on the credit history of an applicant or insured in any manner, including:

1. the provision or removal of a discount;

2. assigning the insured or applicant to a rating tier; or

3. placing an insured or applicant with an affiliated company; or

(iii) require a particular payment plan based, in whole or in part, on the credit history of the insured or applicant.

(3) (i) With respect to private passenger motor vehicle insurance, an insurer may not:

1. refuse to underwrite, cancel, refuse to renew, or increase the renewal premium based, in whole or in part, on the credit history of the insured or applicant; or

2. require a particular payment plan based, in whole or in part, on the credit history of the insured or applicant.

(ii) 1. An insurer may, subject to paragraphs (4) and (5) of this subsection, use the credit history of an applicant to rate a new policy of private passenger motor vehicle insurance.

2. For purposes of this subsection, rating includes:

A. the provision or removal of a discount;

B. assigning the applicant to a rating tier; or

C. placing an applicant with an affiliated company.

(4) With respect to private passenger motor vehicle insurance, an insurer that rates a new policy based, in whole or in part, on the credit history of the applicant:

(i) may not use a factor on the credit history of the applicant that occurred more than 5 years prior to the issuance of the new policy;

(ii) 1. shall advise an applicant at the time of application that credit history is used; and

2. shall, on request of the applicant, provide a premium quotation that separately identifies the portion of the premium attributable to the applicant's credit history;

(iii) may not use the following factors in rating the policy:

1. the absence of credit history or the inability to determine the applicant's credit history; or

2. the number of credit inquiries about an applicant's credit history;

(iv) 1. shall review the credit history of an insured who was adversely impacted by the use of the insured's credit history at the initial rating of the policy:

A. every 2 years; or

B. on request of the insured; and

2. shall adjust the premium of an insured whose credit history was reviewed under this subparagraph to reflect any improvement in the insured's credit history; or

(v) shall disclose to the applicant at the time of the issuance of a policy that the insurer is required to:

1. review the credit history of an insured who was adversely impacted by the use of the insured's credit history at the initial rating or underwriting of the policy:

A. every 2 years; or

B. on request of the insured; and

2. adjust the premium of an insured whose credit history was reviewed to reflect any improvement in the insured's credit history.

(5) With respect to private passenger motor vehicle insurance, an insurer that rates a new policy based, in whole or in part, on the credit history of the applicant may, if actuarially justified, provide a discount of up to 40% or impose a surcharge of up to 40%.

(6) With respect to private passenger motor vehicle insurance, an insurer may not increase the premium for an insured who becomes a surviving spouse based solely on the insured's change in marital status.

(7) With respect to homeowner's insurance, an insurer may not increase the premium for an insured who becomes a surviving spouse based solely on the insured's change in marital status.

(8) (i) At the time a policy of private passenger motor vehicle insurance is initially issued, an insurer may consider the applicant's homeowner's insurance claim history when rating the policy.

(ii) At renewal, an insurer may not increase the premium for a policy of private passenger motor vehicle insurance based on a homeowner's insurance claim.

(9) (i) At the time a policy of homeowner's insurance is initially issued, an insurer may consider the applicant's motor vehicle claim history when rating the policy.

(ii) At renewal, an insurer may not increase the premium for a policy of homeowner's insurance based on a private passenger motor vehicle insurance claim.

(f) Except as provided in § 27–505(a)(2) of this subtitle, in the case of cancellation of or refusal to renew a policy, the policy remains in effect until a finding is issued under § 27–505 of this subtitle if:

(1) the insured asks the Commissioner to review the cancellation or refusal to renew before the effective date of the termination of the policy; and

(2) the Commissioner begins action to issue a finding under § 27–505 of this subtitle.

(g) At a hearing to determine whether this section has been violated, the burden of persuasion is on the insurer to show that the cancellation or refusal to underwrite or renew is justified under the underwriting standards demonstrated.

(h) (1) This subsection applies to insurance underwriting standards for all health, life, disability, property, and casualty coverages provided in the State.

(2) At the request of the Commissioner, each insurer, nonprofit health service plan, and health maintenance organization shall file with the Commissioner a copy of its underwriting standards, including any amendments or supplements.

(3) The Commissioner may review and examine the underwriting standards to ensure compliance with this article.

(4) Each insurer, nonprofit health service plan, and health maintenance organization may request a finding by the Commissioner that its underwriting standards filed with the Commissioner be considered confidential commercial information under § 4–335 of the General Provisions Article.

(5) The Commissioner shall adopt regulations to carry out this subsection.

(i) (1) Except as provided in paragraph (2) of this subsection, with respect to homeowner's insurance, an insurer may not cancel or refuse to renew coverage for homeowner's insurance based on the claims history of an insured for weather–related claims, unless there were three or more weather–related claims within the preceding 3–year period.

(2) An insurer may consider claims for weather–related events for the purpose of canceling or refusing to renew coverage if the insurer provided written notice to the insured for reasonable or customary repairs or replacement specific to the insured's premises or dwelling which the insured failed to make and which, if made, would have prevented the loss for which a claim was made.

(j) (1) In the case of homeowner's insurance, standards reasonably related to an insurer's economic and business purpose under subsection (a)(2) of this section, include, but are not limited to, the following and do not require statistical validation:

(i) a material misrepresentation in connection with the application, policy, or presentation of a claim;

(ii) nonpayment of premium;

(iii) a change in the physical condition or contents of the premises or dwelling which results in an increase in a hazard insured against and which, if present and known to the insurer prior to the issuance of the policy, the insurer would not have issued the policy;

(iv) conviction:

1. within the preceding 5–year period, of arson; or

2. within the preceding 3–year period, of a crime which directly increases the hazard insured against;

(v) subject to subsection (i) of this section, the claims history of the insured where the insured makes more than three claims in the preceding 3–year period;

(vi) subject to subsection (o)(2) of this section, any other standard approved by the Commissioner that is based on factors that adversely affect the losses or expenses of the insurer under its approved rating plan and for which statistical validation is unavailable or is unduly burdensome to produce; and

(vii) subject to subsection (o)(2) of this section, any other standard set forth in regulations adopted by the Commissioner that is found to be reasonably related to the insurer's economic and business purposes.

(2) An insurer is not required to produce statistical validation that excludes weather–related claims or that makes any distinction between weather–related claims and nonweather–related claims in order to sustain the insurer's

burden of persuasion under subsection (g) of this section with respect to a cancellation or refusal to renew for a reason that is not listed in this subsection.

(k) With respect to private passenger motor vehicle insurance, an insurer may not cancel or refuse to renew coverage based on the claims history of an insured where two or fewer of the claims within the preceding 3–year period were for accidents or losses where the insured was not at fault for the loss.

(l) (1) In the case of private passenger motor vehicle insurance, standards reasonably related to the insurer's economic and business purposes under subsection (a)(2) of this section include, but are not limited to, the following and do not require statistical validation:

(i) a material misrepresentation in connection with the application, policy, or presentation of a claim;

(ii) nonpayment of premium;

(iii) subject to § 27–609 of this title, revocation or suspension of the driver's license or motor vehicle registration within the preceding 2–year period:

1. of the named insured or covered driver under the policy; and

2. for reasons related to the driving record of the driver;

(iv) subject to § 27–609 of this title, two or more motor vehicle accidents or any combination of three or more accidents and moving violations within the preceding 3–year period for which the insured was at fault for the accidents;

(v) subject to § 27–609 of this title, three or more moving violations against the insured or a covered driver under the policy within the preceding 2–year period;

(vi) subject to § 27–609 of this title, conviction of the named insured or a covered driver under the policy of any of the following:

1. a violation of § 21–902(a), (b), (c), or (d) of the Transportation Article;

2. homicide, assault, reckless endangerment, or criminal negligence arising out of the operation of the motor vehicle; or

3. using the motor vehicle to participate in a felony;

(vii) subject to subsection (o)(1) of this section, any other standard approved by the Commissioner that is based on factors that adversely affect the losses or expenses of the insurer under its approved rating plan and for which statistical validation is unavailable or is unduly burdensome to produce; and

(viii) subject to subsection (o)(1) of this section, any other standard set forth in regulations adopted by the Commissioner that is found to be reasonably related to the insurer's economic and business purposes.

(2) An insurer is not required to produce statistical validation that excludes at fault accidents or that makes any distinction between not at fault accidents and at fault accidents in order to sustain the insurer's burden of persuasion under subsection (g) of this section with respect to a cancellation or refusal to renew for a reason that is not listed in this subsection.

(m) In the case of commercial insurance or insurance issued or provided by nonadmitted insurers, an insurer is not required to produce statistical validation of its underwriting standards in order to meet its burden of persuasion under this section.

(n) (1) Subject to the requirements of this article, if an insurer considers claims history for the purposes of canceling or refusing to renew coverage, the insurer may consider the following factors in mitigation of the proposed decision without producing statistical validation:

(i) the severity of the losses;

(ii) the length of time that an insured has been a policyholder with the insurer;

(iii) loss mitigation of previous losses; and

(iv) the availability of a higher deductible for the particular policy and types of losses.

(2) If an insurer considers claims history for purposes of canceling or refusing to renew coverage, the insurer shall disclose the practice to an insured at the inception of the policy and at each renewal.

(3) An insurer may comply with the disclosure required at renewal by paragraph (2) of this subsection by sending the notice authorized by § 19–216 of this article.

(o) (1) With respect to private passenger motor vehicle insurance, an insurer may not deny, refuse to renew, or cancel coverage or increase rates for applicants or policyholders who are uniformed services personnel returning from active duty overseas solely because they fail to meet underwriting standards that require continuous coverage unless the failure to maintain continuous coverage existed prior to the applicant's or policyholder's assignment to active duty overseas.

(2) With respect to homeowner's insurance, an insurer may not deny, refuse to renew, or cancel coverage or increase rates for applicants or policyholders who are uniformed services personnel returning from active duty overseas solely because they fail to meet:

(i) underwriting standards that require continuous coverage unless the failure to maintain continuous coverage existed prior to the applicant's or policyholder's assignment to active duty overseas; or

(ii) occupancy requirements if the uniformed services personnel can demonstrate that reasonable steps were taken to maintain and protect the property during the applicant's or policyholder's assignment to active duty overseas.

(p) (1) In this subsection, "inquiry" means a telephone call or other communication to an insurer regarding the terms and conditions of a homeowner's insurance policy, including a telephone call or other communication about whether the policy provides coverage for a particular loss or the process for filing a claim.

(2) With respect to homeowner's insurance, an insurer may not refuse to underwrite a risk, increase a premium, or cancel or refuse to renew coverage based in whole or in part on an inquiry by an insured or an insurance producer on behalf of an insured that does not result in the payment of a claim.

(q) For purposes of this section, with respect to private passenger motor vehicle insurance policies, homeowner's insurance policies, commercial insurance policies, and workers' compensation insurance policies, the transfer of a policyholder between admitted insurers within the same insurance holding company system, as defined in § 7–101 of this article, is a renewal if:

(1) the policyholder's premium does not increase; and

(2) the policyholder does not experience a reduction in coverage.

(r) (1) This subsection applies to homeowner's insurance, renter's insurance, and private passenger motor vehicle insurance.

(2) With respect to homeowner's insurance or renter's insurance, an insurer may not deny, refuse to renew, or cancel coverage for an applicant or a policyholder solely because the applicant or policyholder does not carry private passenger motor vehicle insurance with the insurer or another insurer in the same insurance holding company system, as defined in § 7–101 of this article.

(3) With respect to private passenger motor vehicle insurance, an insurer may not deny, refuse to renew, or cancel coverage for an applicant or a policyholder solely because the applicant or policyholder does not carry homeowner's insurance or renter's insurance with the insurer or another insurer in the same insurance holding company system, as defined in § 7–101 of this article.

(4) This subsection does not prohibit:

(i) an applicant or a policyholder from bundling homeowner's insurance or renter's insurance and private passenger motor vehicle insurance policies if the applicant or policyholder chooses to do so; or

(ii) an insurer from offering discounts or other incentives to applicants or policyholders who choose to bundle homeowner's insurance or renter's insurance and private passenger motor vehicle insurance policies.

(s) (1) This subsection applies only to life insurance, disability insurance, or long–term care insurance.

(2) An insurer may not, based solely on the status of an applicant or individual as an organ donor:

(i) cancel, refuse to underwrite or renew, or refuse to issue an insurance policy;

(ii) refuse to pay a claim, cancel, or otherwise terminate an insurance policy;

(iii) increase premium rates for an insurance policy; or

(iv) add a surcharge, apply a rating factor, or use any other underwriting practice that adversely takes the information into account.

(3) With respect to all other medical conditions, an applicant or individual who is an organ donor shall be subject to the same standards of sound actuarial principles or actual or reasonably anticipated experience as an applicant or individual who is not an organ donor.

(4) An insurer may not prohibit an applicant or individual from donating all or part of an organ as a condition of insurance.

(t) With respect to private passenger motor vehicle insurance, an insurer may not require an applicant or a policyholder to participate in a program that measures the operation of an insured vehicle as a condition for underwriting a private passenger motor vehicle insurance risk unless the insurer:

(1) only offers private passenger motor vehicle insurance products that require insureds to participate in a program that measures the operation of an insured vehicle;

(2) discloses the information in item (1) of this subsection to:

(i) the applicant at the time of application; and

(ii) the policyholder at the time of renewal; and

(3) includes the information in item (1) of this subsection in any advertising materials for the insurance products offered by the insurer.

(u) If an applicant for residential condominium unit insurance experiences a lapse in coverage of the applicant's prior residential condominium unit due to an insurer's withdrawal from the market, an insurer from whom the applicant seeks new residential condominium unit coverage may not refuse to issue a policy based solely on the applicant's lapse in coverage on the unit if:

(1) the lapse in coverage was for not longer than 90 days;

(2) if required by the new insurer, the applicant provides an affidavit that the applicant has not incurred any losses during the lapse in coverage; and

(3) the applicant provides any other documentation required by the insurer.

§27–502.

(a) A surety insurer may not cancel or refuse to issue or renew a surety bond for a reason based wholly or partly on race, color, creed, sex, or physical handicap or disability of an applicant or principal or for any other arbitrary, capricious, or unfairly discriminatory reason.

(b) A surety insurer may not require special conditions, facts, or situations as a condition to its acceptance or renewal of a particular surety risk in an arbitrary, capricious, unfair, or discriminatory manner based wholly or partly on race, creed, color, sex, religion, national origin, place of residence, or physical handicap or disability.

(c) A surety insurer may not make an inquiry about race, creed, color, or national origin in a surety form, questionnaire, or other manner of requesting general information that relates to an application for a surety bond.

(d) On request, a surety insurer that intends to cancel or refuse to issue or renew a surety bond shall send to the bondholder or applicant written notice that states the reason for the proposed action.

(e) (1) A person aggrieved under this section shall notify the Commissioner in writing within 30 days after the occurrence giving rise to the complaint and shall state the facts giving rise to the complaint.

(2) On receipt of a complaint, the Commissioner shall forward a copy of the complaint to the surety insurer.

(3) If the Commissioner finds that the complaint is without merit, the Commissioner shall dismiss the complaint without a hearing and shall notify the surety insurer and complainant promptly in writing.

(4) If the complaint is not dismissed without a hearing, the Commissioner shall:

(i) hold a hearing on the complaint within 30 days after receipt of the complaint; and

(ii) give written notice of the time and place of the hearing to all parties at least 10 days before the hearing.

(5) At a hearing to determine whether this section has been violated, the burden of persuasion is on the surety insurer to show that the cancellation or refusal to underwrite or renew is not based wholly or partly on race, color, creed, sex, or physical handicap or disability of an applicant or principal or for any unfairly discriminatory reason.

(6) If, after the hearing, the Commissioner finds that the surety insurer has violated this section, the Commissioner may issue an appropriate order that:

(i) states the manner in which the surety insurer has violated this section;

(ii) provides relief under subsection (g) or (h) of this section; and

(iii) states when, within a reasonable period but not less than 10 days after the hearing, the order shall be effective.

(f) (1) Any information or testimony provided by a surety insurer pursuant to a complaint under this section is privileged and confidential.

(2) There is no liability on the part of and no cause of action against a surety insurer, its representatives, or another person who in good faith provides to the surety insurer information or testimony that relates to the complaint.

(g) If the Commissioner finds that a surety insurer has willfully violated this section, the Commissioner may impose a fine on the surety insurer in accordance with § 1-301 of this article.

(h) Instead of the fine provided in subsection (g) of this section, the Commissioner may order the surety insurer to write the bond if, at the hearing, the Commissioner finds by a preponderance of the evidence that the violation of subsection (a) or (b) of this section was knowing and willful and was the basis for the surety insurer's action.

§27–503.

(a) An insurer may not cancel a written agreement with an insurance producer about insurance or refuse to accept insurance business from the insurance producer unless the insurer complies with this section.

(b) (1) This subsection does not apply to:

(i) policies of life insurance, health insurance, surety insurance, wet marine and transportation insurance, and title insurance; or

(ii) insurance producers or policies of a company or group of companies represented by insurance producers who by contractual agreement represent only that company or group of companies if:

1. the business is owned by the company or group of companies; and

2. the cancellation of any contractual agreement does not result in the cancellation or refusal to renew any policies.

(2) If an insurer intends to cancel a written agreement with an insurance producer or intends to refuse a class of renewal business from an insurance producer, the insurer shall give the insurance producer at least 90 days' written notice.

(3) Notwithstanding any provision of the agreement to the contrary, the insurer shall continue for at least 2 years after termination of the agency agreement to renew through the insurance producer any of the policies that have not been replaced with other insurers as expirations occur.

(c) An insurer may not cancel or refuse to renew a policy of the insured because of the termination of the insurance producer's contract.

(d) Notwithstanding any other provision of this section, an insurer may not cancel or amend a written agreement with an insurance producer or refuse to accept business from the insurance producer if the cancellation, amendment, or refusal is arbitrary, capricious, unfair, or discriminatory or is based wholly or partly on the race, creed, color, sex, religion, national origin, or place of residency of the insurance producer or the applicants or policyholders of the insurance producer.

(e) If an insurer or insurance producer that accepts business from an insurance producer acting on behalf of an insured or prospective insured rejects the business of an insurance producer acting on behalf of an insured or prospective insured, the insurer or insurance producer shall give to the Commissioner and the insurance producer acting on behalf of an insured or prospective insured, on request of that insurance producer, the reasons for the rejection in writing.

(f) An insurer may not cancel or amend a written agreement with an insurance producer about property insurance or casualty insurance because of an adverse loss ratio experience on the insurance producer's book of business if:

(1) the insurer required the insurance producer to submit the application for underwriting approval, all material information on the application was completed, and the insurance producer did not omit or alter any information provided by the applicant; or

(2) the insurer accepted, without prior approval, policies issued by the insurance producer, if all material information on the application for the policy or on the insurer's copy of any policy issued by the insurance producer was completed and the insurance producer did not omit or alter any information provided by the applicant.

§27–504.

(a) (1) In this section the following words have the meanings indicated.

(2) "Abuse" has the meaning stated in § 4–501 of the Family Law Article.

(3) "Cohabitant" means an individual who has had a sexual relationship with another individual with whom the individual has resided for a period of at least 90 days.

(4) "Victim of domestic violence" means an individual who:

(i) has received deliberate, severe, and demonstrable physical injury from a current or former spouse or current or former cohabitant; or

(ii) is in fear of imminent deliberate, severe, and demonstrable physical injury from a current or former spouse or current or former cohabitant.

(b) Except as otherwise provided in this article, if an individual is a victim of domestic violence or subject to abuse, an insurer, nonprofit health service plan, or health maintenance organization may not use information about abuse or the individual's status as a victim of domestic violence to:

(1) cancel, refuse to underwrite or renew, or refuse to issue a policy of life insurance or health insurance or a health benefits plan;

(2) refuse to pay a claim, cancel, or otherwise terminate a policy of life insurance or health insurance or a health benefits plan;

(3) increase rates for life insurance, health insurance, or a health benefits plan; or

(4) for policies of life insurance or health benefits plans, add a surcharge, apply a rating factor, or use any other underwriting practice that adversely takes the information into account.

(c) If an insurer acts in good faith, the insurer is not subject to tort liability for a cause of action arising from the insurer's lawful issuance of and lawful compliance with a policy of life insurance on an insured who subsequently suffers abuse or is a victim of domestic violence.

(d) This section does not require an insurer:

(1) to make a payment to an individual who willfully caused an injury that gave rise to a loss under a policy of life insurance; or

(2) to issue, without the consent of the proposed insured, life insurance or disability income insurance to an applicant known to have abused the proposed insured.

(e) This section may not be interpreted to preclude an insurer or a health maintenance organization from using mental or physical medical conditions, regardless of cause, in determining the eligibility, rate, or underwriting classification of the applicant, insured, member, or subscriber.

§27–504.1.

(a) (1) In this section the following words have the meanings indicated.

(2) "Crime of violence" has the meaning stated in § 14–101 of the Criminal Law Article.

(3) "Victim" means a policyholder or claimant who suffers personal injury, death, or property loss as a result of a crime of violence.

(b) Except as otherwise provided in this article, if an individual is a victim of a crime of violence, an insurer may not, based solely on information about the individual's status as a victim of a crime of violence:

(1) cancel, refuse to underwrite or renew, or refuse to issue a policy of homeowner's insurance;

(2) refuse to pay a claim under a policy of homeowner's insurance; or

(3) for a policy of homeowner's insurance, increase a premium, add a surcharge, apply a rating factor, retier a policy, remove a discount, or take any other adverse underwriting or rating action.

(c) (1) If a policy of homeowner's insurance excludes property coverage for intentional acts, the insurer may not deny payment for a loss to a victim who:

(i) is an innocent coinsured;

(ii) did not commit, cause to be committed, or direct the crime of violence leading to the loss; and

(iii) cooperates in any criminal investigation, including the filing of an official police report, and if undertaken, any prosecution of the perpetrator.

(2) Payment to the innocent coinsured may be limited to the amount of the loss up to the homeowner's insurance policy limits, less any applicable deductible and coinsurance and any payment to any secured party.

(3) An insurer may exclude property owned solely by the perpetrator from coverage under the policy of homeowner's insurance.

(4) An insurer making payment to the innocent coinsured under this section shall have the right of subrogation against the perpetrator who committed, caused to be committed, or directed the crime of violence leading to the loss.

(d) This section does not:

(1) require payment in excess of a homeowner's insurance policy limits;

(2) prohibit an insurer from applying reasonable standards of proof of a claim; or

(3) prohibit an insurer or insurance producer from:

(i) asking an applicant, a policyholder, or a claimant about a claim under this section; or

(ii) using information obtained by investigation to evaluate a claim and exercise the insurer's rights and perform its duties.

§27–505.

(a) (1) If the Commissioner finds that an insurer has violated § 27–501, § 27–503, § 27–504, or § 27–504.1 of this subtitle, the Commissioner, in addition to any other power granted by this article, may order the insurer to accept the risk, or accept the business, as appropriate.

(2) (i) With respect to medical professional liability insurance, the Commissioner shall issue a finding within 90 days after receiving a request to review the cancellation or refusal to renew a policy under § 27–501(f) of this subtitle.

(ii) A medical professional liability insurer may terminate the policy if:

1. the Commissioner fails to issue a finding within 90 days after receiving a request to review the cancellation or refusal to renew; or

2. the Commissioner finds that the policy may be canceled or not renewed and issued the finding within 90 days after receiving a request to review the cancellation or refusal to renew.

(iii) If a medical professional liability insurer terminates the policy under subparagraph (ii)1 of this paragraph and the Commissioner subsequently issues a finding that the insurer may not cancel or refuse to renew the policy:

1. the insurer immediately shall reinstate the policy; and

2. the reinstatement shall be retroactive to the date that the policy was terminated.

(b) A party to a hearing or proceeding under this subtitle may appeal from the hearing, proceeding, or a decision of the Commissioner in accordance with § 2-215 of this article.

§27–601.

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

(b) (1) "Commercial insurance" means property insurance or casualty insurance issued to an individual, a sole proprietor, partnership, corporation, limited liability company, or similar entity and intended to insure against loss arising from the business pursuits of the insured entity.

(2) "Commercial insurance" does not include:

(i) policies issued by the Maryland Automobile Insurance Fund;

(ii) policies issued by the Joint Insurance Association;

(iii) workers' compensation insurance; or

(iv) title insurance.

(c) (1) "Personal insurance" means property insurance or casualty insurance issued to an individual, trust, estate, or similar entity that is intended to insure against loss arising principally from the personal, noncommercial activities of the insured.

(2) "Personal insurance" does not include:

(i) motor vehicle liability insurance policies subject to § 27-613 of this subtitle;

(ii) policies issued by the Maryland Automobile Insurance Fund;

(iii) policies issued by the Joint Insurance Association; or

(iv) surety insurance.

§27–601.1.

(a) For purposes of this subtitle, with respect to policies of personal insurance, private passenger motor vehicle liability insurance, commercial insurance, and workers' compensation insurance, the issuance by an insurer of a new policy to replace an expiring policy issued by that insurer is a renewal.

(b) For purposes of this subtitle, with respect to policies of personal insurance, private passenger motor vehicle liability insurance, commercial insurance, and workers' compensation insurance, the issuance by an insurer of a new policy to replace an expiring policy issued by another admitted insurer within the same insurance holding company system, as defined in § 7–101 of this article, is a renewal if:

(1) the policyholder's premium does not increase; and

(2) the policyholder does not experience a reduction in coverage.

§27–601.2.

(a) (1) In this section the following words have the meanings indicated.

(2) "Delivered by electronic means" includes:

(i) delivery to an electronic mail address at which a party has consented to receive notice; and

(ii) posting on an electronic network, together with separate notice to a party directed to the electronic mail address at which the party has consented to receive notice of the posting.

(3) "Party" means an applicant, an insured, or a policyholder.

(b) Subject to subsection (d) of this section, any notice to a party required under this subtitle may be delivered by electronic means provided the process used to obtain consent of the party to have notice delivered by electronic means meets the requirements of Title 21, Subtitle 1 of the Commercial Law Article.

(c) Delivery of a notice in accordance with subsection (b) of this section shall be considered equivalent to any delivery method required under this subtitle, including delivery by first–class mail, certified mail, or a first–class mail tracking method.

(d) A notice may be delivered by electronic means by an insurer to a party under this section if:

(1) the party has affirmatively consented to that method of delivery and has not withdrawn the consent;

(2) the party, before giving consent, is provided with a clear and conspicuous statement:

(i) informing the party of:

1. any right or option of the party to have the notice provided or made available in paper or another nonelectronic form;

2. the right of the party to withdraw consent to have notice delivered by electronic means and any fees, conditions, or consequences imposed in the event consent is withdrawn;

3. whether the party's consent applies:

A. only to the particular transaction as to which the notice must be given; or

B. to identified categories of notices that may be delivered by electronic means during the course of the parties' relationship;

4. A. how, after consent is given, the party may obtain a paper copy of a notice delivered by electronic means; and

B. the fee, if any, for the paper copy; and

5. the procedures the party must use to withdraw consent to have notice delivered by electronic means and to update information needed to contact the party electronically;

(3) the party:

(i) before giving consent, is provided with a statement of the hardware and software requirements for access to and retention of a notice delivered by electronic means; and

(ii) consents electronically, or confirms consent electronically, in a manner that reasonably demonstrates that the party can access information in the electronic form that will be used for notices delivered by electronic means as to which the party has given consent; and

(4) after consent of the party is given, the insurer, in the event a change in the hardware or software requirements needed to access or retain a notice delivered by electronic means creates a material risk that the party will not be able to access or retain a subsequent notice to which the consent applies:

(i) provides the party with a statement of:

1. the revised hardware and software requirements for access to and retention of a notice delivered by electronic means; and

2. the right of the party to withdraw consent without the imposition of any fee, condition, or consequence that was not disclosed under item (2)(i)2 of this subsection; and

(ii) complies with item (2) of this subsection.

(e) This section does not affect the content or timing of any notice required under this subtitle.

(f) If a provision of this subtitle requiring notice to be provided to a party expressly requires verification or acknowledgment of receipt of the notice, the notice may be delivered by electronic means only if the method used provides for verification or acknowledgment of receipt.

(g) The legal effectiveness, validity, or enforceability of any contract or policy of insurance executed by a party may not be denied solely because of the failure

to obtain electronic consent or confirmation of consent of the party in accordance with subsection (d)(3)(ii) of this section.

(h) (1) A withdrawal of consent by a party does not affect the legal effectiveness, validity, or enforceability of a notice delivered by electronic means to the party before the withdrawal of consent is effective.

(2) A withdrawal of consent by a party is effective within a reasonable period of time after receipt of the withdrawal by the insurer.

(3) Failure to comply with subsection (d)(4) of this section may be treated, at the election of the party, as a withdrawal of consent for purposes of this section.

(i) This section does not apply to a notice delivered by an insurer in an electronic form before October 1, 2011, to a party who, before October 1, 2011, has consented to receive notice in an electronic form otherwise allowed by law.

(j) If the consent of a party to receive notice in an electronic form is on file with an insurer before October 1, 2011, the insurer shall notify the party of:

(1) the notices that may be delivered by electronic means under this section; and

(2) the party's right to withdraw consent to have notices delivered by electronic means.

(k) (1) Except as otherwise provided by law, if an oral communication or a recording of an oral communication can be reliably stored and reproduced by an insurer, the oral communication or recording may qualify as a notice delivered by electronic means for purposes of this section.

(2) If a provision of this subtitle requires a signature or record to be notarized, acknowledged, verified, or made under oath, the requirement is satisfied if the electronic signature of the person authorized to perform those acts, together with all other information required to be included by the provision, is attached to or logically associated with the signature or record.

(l) This section may not be construed to modify, limit, or supersede the provisions of the federal Electronic Signatures in Global and National Commerce Act relating to the use of an electronic record to provide or make available information that is required to be provided or made available in writing to a party.

§27–602.

(a) (1) This section applies only to policies of:

(i) personal insurance; and

(ii) homeowner's insurance under which a onetime guaranteed fully refundable deposit is required for a stated amount of coverage.

(2) This section does not apply to policies in effect for 45 days or less, as provided in § 12–106 of this article.

(b) (1) Whenever an insurer, as required by subsection (c) of this section, gives notice of its intention to cancel or not to renew a policy subject to this section issued in the State or before an insurer cancels a policy subject to this section issued in the State for a reason other than nonpayment of premium, the insurer shall notify the insured of the possible right of the insured to replace the insurance under the Maryland Property Insurance Availability Act or through another plan for which the insured may be eligible.

(2) The notice required by paragraph (1) of this subsection must:

(i) be in writing;

(ii) contain the current address and telephone number of the offices of the appropriate plan; and

(iii) be sent to the named insured at the named insured's last known address in the same manner and at the same time as the first written notice of cancellation or of intention not to renew given or required by law, regulation, or contract.

(c) (1) Subject to paragraph (5) of this subsection, at least 45 days before the date of the proposed cancellation or expiration of the policy, the insurer shall send to the named insured at the named insured's last known address, by a first–class mail tracking method, a written notice of intention to cancel for a reason other than nonpayment of premium or notice of intention not to renew a policy issued in the State.

(2) An insurer shall maintain proof of mailing in a form authorized or accepted by the United States Postal Service.

(3) Notice given to the insured by an insurance producer on behalf of the insurer is deemed to have been given by the insurer for purposes of this subsection.

(4) Notwithstanding paragraph (3) of this subsection, no notice is required under this section if the insured has replaced the insurance.

(5) An insurer may not cancel a policy midterm except:

(i) when there exists:

1. a material misrepresentation or fraud in connection with the application, policy, or presentation of a claim;

2. a matter or issue related to the risk that constitutes a threat to public safety; or

3. a change in the condition of the risk that results in an increase in the hazard insured against;

(ii) for nonpayment of premium; or

(iii) in the case of homeowner's insurance, conviction of arson.

(d) At least 10 days before the date an insurer proposes to cancel a policy for nonpayment of premium, the insurer shall send to the named insured, at the named insured's last known address, by a first–class mail tracking method, a written notice of intention to cancel for nonpayment of premium.

§27–603.

(a) (1) This section applies only to policies of commercial insurance.

(2) This section does not apply to:

(i) policies in effect for 45 days or less, as provided in § 12–106 of this article; or

(ii) policies issued to exempt commercial policyholders under § 11–206 of this article, if the policies provide for written notice of not less than 30 days of the insurer's intent to cancel or nonrenew.

(b) (1) Whenever an insurer, as required by subsection (c) of this section, gives notice of its intention to cancel or not to renew a policy issued in this State for a reason other than nonpayment of premium, the insurer shall notify the insured of the possible right to replace the insurance under the Maryland Property Insurance

Availability Act, through the Maryland Automobile Insurance Fund, or through another plan for which the insured may be eligible.

(2) The notice required by paragraph (1) of this subsection shall:

(i) be in writing;

(ii) if applicable, include the current address and telephone number of the offices of the Joint Insurance Association, the Maryland Automobile Insurance Fund, or other appropriate plan; and

(iii) be sent to the insured in the same manner and at the same time as the first written notice of cancellation or of intention not to renew that is given or required by law, regulation, or contract.

(c) (1) Subject to paragraph (5) of this subsection, at least 45 days before the date of the proposed cancellation or expiration of the policy, the insurer shall send to the insured, by a first–class mail tracking method or by commercial mail delivery service, written notice of intention to cancel for a reason other than nonpayment of premium or notice of intention not to renew a policy issued in the State.

(2) The insurer shall maintain proof of mailing in a form authorized or accepted by the United States Postal Service or other commercial mail delivery service.

(3) Notice given to the insured by an insurance producer on behalf of the insurer is deemed to have been given by the insurer for the purposes of this subsection.

(4) No notice is required under this subsection if the insured has replaced the insurance.

(5) An insurer may not cancel a policy midterm except:

(i) when there exists:

1. a material misrepresentation or fraud in connection with the application, policy, or presentation of a claim;

2. a matter or issue related to the risk that constitutes a threat to public safety; or

3. a change in the condition of the risk that results in an increase in the hazard insured against;

(ii) for nonpayment of premium; or

(iii) due to the revocation or suspension of the driver's license or motor vehicle registration:

1. of the named insured or covered driver under the policy; and

2. for reasons related to the driving record of the named insured or covered driver.

(d) At least 10 days before the date an insurer proposes to cancel a policy for nonpayment of premium, the insurer shall send to the insured, by a first–class mail tracking method, a written notice of intention to cancel for nonpayment of premium.

(e) (1) If an insurer provides a renewal policy and notice of premium due to an insured at least 45 days before the renewal date of the policy and the insured fails to make the required payment by the renewal date, the insurer may terminate the policy on the renewal date for nonpayment of premium after sending to the insured, by a first–class mail tracking method, a written offer to reinstate the renewal policy without lapse in coverage.

(2) An offer to reinstate under this subsection shall provide not less than 10 days for the insured to make the required premium payment.

§27–604.

(a) (1) This section applies only to policies of personal insurance and insurance issued under the Maryland Property Insurance Availability Act or any similar act instituted to ensure the availability of insurance.

(2) This section does not apply to policies in effect for 45 days or less, as provided in § 12-106 of this article.

(b) (1) Whenever an insurer cancels or refuses to renew a policy subject to this section, the insurer must provide to the named insured a statement of the actual reason for the cancellation or refusal to renew.

(2) The Commissioner may not disallow a proposed action of an insurer because the statement of actual reason contains:

(i) grammatical, typographical, or other errors, if the errors are not material to the proposed action and are not misleading;

(ii) surplus information, if the surplus information is not misleading; or

(iii) erroneous information, if in the absence of the erroneous information there is a sufficient basis to support the proposed action.

(c) A statement of actual reason is privileged and does not constitute grounds for an action against the insurer, its representatives, or another person that in good faith provides to the insurer information on which the statement is based.

(d) (1) The reason given in the statement of actual reason shall be clear and specific.

(2) The use of generalized terms such as "personal habits", "physical handicap or disability", "living conditions", "poor morals", or "violation or accident record" does not meet the requirement of this subsection.

§27–605.

(a) (1) This section applies only to policies of commercial insurance.

(2) This section does not apply to:

(i) policies in effect for 45 days or less, as provided in § 12–106 of this article; or

(ii) policies issued to exempt commercial policyholders under § 11–206 of this article, if the policies provide for written notice of not less than 30 days of the insurer's intent to cancel or nonrenew.

(b) (1) Whenever an insurer cancels or refuses to renew a policy subject to this section for a reason other than nonpayment of premium, the insurer must provide to the named insured a written statement of the actual reason for the cancellation or refusal to renew.

(2) The reason given in the statement of actual reason shall be clear and specific.

(3) The statement shall include the insurer's offer to provide additional information in support of the proposed action upon the written request of the insured and an address for the insured to submit the request.

(4) A written request for information under this subsection shall be sent not more than 30 days from the date of the notice containing the actual reason.

(5) On receiving a written request from an insured for additional information under this subsection and prior to the effective date of the proposed action, an insurer shall respond in writing within 15 days.

(6) Except as provided in § 27–501 of this title, a request for additional information under this section does not stay the proposed action.

(c) The Commissioner may not disallow a proposed action of an insurer because the statement of actual reason contains:

(1) grammatical, typographical, or other errors, if the errors are not material to the proposed action and are not misleading;

(2) surplus information, if the surplus information is not misleading; or

(3) erroneous information, if in the absence of the erroneous information there is a sufficient basis to support the proposed action.

(d) Information concerning the actual reason is privileged and does not constitute grounds for an action against the insurer, the insurer's representatives, an insurance producer, or any other person that in good faith provides information on which the statement is based.

§27–606.

(a) (1) Except for life insurance, health insurance, and annuities, an insurer that intends to cancel or not renew a line of business shall file a plan of withdrawal with the Commissioner at least 180 days before the date of the proposed withdrawal.

(2) Notwithstanding paragraph (1) of this subsection, the Commissioner may allow an insurer to file a plan of withdrawal at least 60 days before the date of proposed withdrawal if the Commissioner determines that compliance by the insurer with paragraph (1) of this subsection may result in:

(i) the impairment of the insurer;

(ii) the loss of or substantial changes in applicable reinsurance; or

(iii) significant financial losses to the insurer.

(3) For health insurance:

(i) an insurer that intends to cancel or not renew a health insurance product, as defined by the Commissioner, for all of its covered insureds in the State shall file a plan of withdrawal with the Commissioner at least 90 days before the date of the proposed cancellation or nonrenewal; and

(ii) an insurer that intends to withdraw completely from the health insurance market in the State by canceling or not renewing all of its health insurance products in the State shall file a plan of withdrawal with the Commissioner at least 180 days before the date of the proposed withdrawal.

(b) The plan of withdrawal shall contain:

(1) a statement by an elected officer of the insurer that the cancellation or nonrenewal action is necessary as a result of:

(i) the loss of or substantial changes in applicable reinsurance;

(ii) financial losses of the insurer; or

(iii) another business or economic reason of the insurer;

(2) if the reason for cancellation or nonrenewal is loss of or substantial changes in reinsurance, a statement that explains:

(i) that the insurer made a good faith effort to obtain replacement reinsurance, but was unable to do so due to either the unavailability or unaffordability of replacement reinsurance;

(ii) how the loss of or reduction in reinsurance affects the insurer's risks throughout the entire line or category of insurance proposed for cancellation or nonrenewal; and

(iii) why cancellation or nonrenewal is necessary to cure the loss of or reduction in available reinsurance; and

(3) notwithstanding the reason for cancellation or nonrenewal, a statement that:

(i) identifies the category of risk, the total number of risks written by the insurer in that line of business, and the number of risks intended to be canceled or not renewed;

(ii) explains how the cancellation or nonrenewals, if approved, will be implemented with respect to individual risks and the steps that will be taken to ensure that the cancellation or nonrenewal decisions will not be applied in an arbitrary, capricious, or unfairly discriminatory manner or in violation of § 27–501 of this title; and

(iii) includes any other information that the Commissioner reasonably requires.

(c) If a plan of withdrawal filed with the Commissioner is not accompanied by the information required by this section, the Commissioner may so inform the insurer and the plan of withdrawal will be deemed filed when the information is provided to the Commissioner.

(d) After an insurer has filed a plan of withdrawal with the Commissioner, the insurer shall notify in writing each of its insurance producers in the State that the insurer has filed a plan of withdrawal.

(e) The Commissioner shall review each plan of withdrawal to determine its compliance with this section and § 27–501 of this title.

(f) (1) (i) The Commissioner shall disapprove each plan of withdrawal that does not comply with this section.

(ii) If the Commissioner disapproves a plan, the Commissioner shall issue an order of disapproval that includes specific reasons for the disapproval.

(2) (i) Subject to paragraph (3) of this subsection, a plan filed under this section is deemed approved if the Commissioner fails to approve or disapprove the plan within 60 days after the date of filing by the insurer.

(ii) If a filing is deemed approved under this paragraph, the filing becomes effective on the 60th day after the date of filing.

(3) If the Commissioner does not have sufficient information to determine whether a filing or amended filing meets the requirements of this section, the Commissioner:

(i) shall require the insurer to provide the necessary information; and

(ii) may extend the period for approval until the information is provided.

(4) A plan may be withdrawn or amended by the insurer at any time before approval.

(5) After approval or disapproval of a plan, the withdrawal or amendment of the plan is subject to the approval of the Commissioner.

(g) The Commissioner may disapprove a plan of withdrawal for health insurance if an insurer, nonprofit health service plan, or health maintenance organization has failed to demonstrate compliance with § 15–1212 or § 15–1308 of this article.

(h) The provisions of subsections (a)(3) and (b) through (f) of this section that apply to insurers also apply to health maintenance organizations.

§27–607.

(a) This section applies only to policies of personal insurance and insurance issued under the Maryland Property Insurance Availability Act or any similar act instituted to ensure the availability of property insurance.

(b) At least 45 days prior to the renewal date of a policy subject to this section, the insurer shall send a notice to the named insured and the insurance producer, if any, by first-class mail stating both the amount of the renewal policy premium and the amount of the expiring policy premium.

§27–608.

(a) (1) This section applies to:

(i) policies of commercial insurance; and

(ii) policies of workers' compensation insurance.

(2) This section does not apply to policies:

(i) issued to exempt commercial policyholders, as defined in § 11–206(j) of this article; or

(ii) for which the renewal policy premium is an increase over the expiring policy premium of 15% or less.

(b) Unless an insurer has given notice of its intention not to renew a policy subject to this section, if the insurer seeks to increase the renewal policy premium, the insurer shall send a notice to the named insured and insurance producer, if any, not less than 45 days prior to the renewal date of the policy.

(c) Subject to subsection (d) of this section, a notice under this section shall include:

(1) both the expiring policy premium and the renewal policy premium; and

(2) the telephone number for the insurer or insurance producer, if any, together with a statement that the insured may call to request additional information about the premium increase.

(d) (1) If an insurer seeks to increase the renewal policy premium and the insurer's rating methodology requires the insured to provide information to calculate the renewal policy premium, an insurer shall provide a reasonable estimate of the renewal policy premium if:

(i) the insurer has requested the required information from the insured; and

(ii) the insurer has not received the requested information.

(2) A reasonable estimate under this subsection shall be based upon the information available to the insurer at the time the notice is sent.

(e) The requirements of this section do not apply to the extent that the premium increase results from:

(1) an increase in the units of exposure;

(2) the application of an experience rating plan;

(3) the application of a retrospective rating plan;

(4) a change made by the insured that increases the insurer's exposure; or

(5) an audit of the insured.

(f) A notice required by this section shall be sent by first–class mail and may be sent together with the renewal policy.

(g) An insurer may not be required to comply with any notice requirement of this section if, not less than 45 days before the effective date of the renewal policy, the insurer has sent:

(1) (i) to the named insured, a renewal policy that includes the renewal policy premium; and

(ii) to the independent insurance producer, if any:

1. a copy of the renewal policy that includes the renewal policy premium through postal or electronic mail; or

2. at the same time as the insurer sends the renewal policy to the insured, a notice of the availability of the renewal policy through the insurer's online electronic system;

(2) to the named insured and insurance producer, if any, a written notice of renewal or continuation of coverage that includes the renewal or continuation premium; or

(3) to the named insured and insurance producer, if any, a renewal offer that includes a reasonable estimate of the renewal policy premium.

§27–608.1.

(a) This section applies to policies of commercial insurance and policies of workers' compensation insurance.

(b) (1) If a policyholder is being transferred between admitted insurers within the same insurance holding company system, as defined in § 7–101 of this article, the insurer providing the new policy shall provide notice of the transfer to the policyholder.

(2) An insurer shall be considered to have met the notice requirement of this section if the insurer has sent to the named insured a renewal policy that includes a notice of transfer, or a notice on the declaration page of the renewal policy, notifying the insured that the policy has been transferred from the prior named insurer to the new or renewing named insurer.

§27–609.

(a) This section does not apply to a premium increase for a driver or vehicle due to a program that measures the operation of an insured vehicle during the current policy period.

(b) (1) (i) This paragraph applies to a private passenger motor vehicle liability insurance policy issued in the State under which more than one individual is insured.

(ii) If an insurer is authorized under this article to cancel, nonrenew, or increase the premiums on a policy of private passenger motor vehicle liability insurance subject to this paragraph because of the claim experience or driving record of one or more but less than all of the individuals insured under the policy, the insurer, instead of cancellation, nonrenewal, or premium increase, shall offer to continue or renew the insurance, but to exclude all coverage when a motor vehicle is operated by the specifically named excluded individual or individuals whose claim experience or driving record could have justified the cancellation, nonrenewal, or premium increase.

(2) (i) This paragraph applies to a motor vehicle liability insurance policy issued in the State, other than a policy subject to paragraph (1) of this subsection, under which more than one individual is insured.

(ii) If an insurer is authorized under this article to cancel, nonrenew, or increase the premiums on a policy of motor vehicle liability insurance subject to this paragraph because of the claim experience or driving record of one or more but less than all of the individuals insured under the policy, the insurer, instead of cancellation, nonrenewal, or premium increase, may offer to continue or renew the insurance, but to exclude all coverage when a motor vehicle is operated by the specifically named excluded individual or individuals whose claim experience or driving record could have justified the cancellation, nonrenewal, or premium increase.

(c) If an insurer legally could refuse to issue a policy of motor vehicle liability insurance under which more than one individual is insured because of the claim experience or driving record of one or more but less than all of the individuals applying to be insured under the policy, the insurer may issue the policy but exclude all coverage when a motor vehicle is operated by the specifically named excluded individual or individuals whose claim experience or driving record could have justified the refusal to issue.

(d) A policy described in subsection (b) or (c) of this section may be endorsed to exclude specifically all coverage for any of the following when the named excluded driver is operating a motor vehicle covered under the policy whether or not that

operation or use was with the express or implied permission of an individual insured under the policy:

(1) the excluded operator or user;

(2) the motor vehicle owner;

(3) family members residing in the household of the excluded operator or user or motor vehicle owner; and

(4) any other person, except for the coverage required by §§ 19–505 and 19–509 of this article if that coverage is not available under another motor vehicle policy.

(e) The premiums charged on a policy that excludes a named driver or drivers under this section may not reflect the claim experience or driving record of the excluded named driver or drivers.

§27–610.

(a) (1) This section applies only to policies of personal insurance and private passenger motor vehicle liability insurance policies subject to § 27–613 of this subtitle.

(2) Unless an insurer has provided notice of its intention not to renew a policy in compliance with this subtitle, the insurer must provide each policyholder with notice of renewal premium due at least 45 days before the due date.

(3) If a policyholder is being transferred between admitted insurers within the same insurance holding company system, as defined in § 7–101 of this article, the notice required under paragraph (2) of this subsection shall include disclosure of the transfer.

(4) A licensed insurance producer may provide notice under paragraph (2) of this subsection on behalf of the insurer.

(5) The duty to provide notice under paragraph (2) of this subsection is deemed discharged if:

(i) the insurer shows that its established procedures would have resulted in placing the notice of renewal premium due in the United States mail; and

(ii) there is no showing that in fact the notice was not placed in the mail.

(b) If an insurer fails to provide notice of renewal premium due under subsection (a) of this section, and subsequently the policyholder fails to make timely payment of the renewal premium, the insurer must:

(1) provide coverage for each claim that:

(i) would have been covered under the policy; and

(ii) arises within 45 days after the date the insured discovers or should have discovered that the policy was not renewed; and

(2) renew the policy on tender of payment within 30 days after the policyholder discovers or should have discovered that the policy was not renewed.

§27–611.

Before the actual expiration of a policy of motor vehicle insurance that results from nonpayment of a renewal premium, the insurer shall provide notice to the insured in clear and specific terms that if the insured fails to renew or replace the motor vehicle insurance before the due date, § 17-106 of the Transportation Article provides that uninsured motorist penalties be assessed and that evidences of registration be surrendered to the Motor Vehicle Administration and that failure to surrender the evidences of registration may result in suspension of current and future registration privileges.

§27–612.

(a) (1) If an insurer fails to comply with any provision of § 27-602, § 27-603, § 27-604, § 27-605, § 27-606, § 27-607, § 27-608, § 27-610, or § 27-613 of this subtitle, the insurer is liable to the applicant for the coverage that was requested, or that would have become effective except for the failure to comply with these provisions, unless the person seeking coverage:

(i) no longer wishes the coverage;

(ii) has obtained other substantially equivalent coverage; or

(iii) fails to tender or pay the premium after reasonable demand for the premium has been made.

(2) The liability of an insurer under paragraph (1) of this subsection is in addition to any other penalties applicable by law.

(b) Liability for coverage does not apply to failure to comply with § 27-611 of this subtitle, as it relates to motor vehicle liability insurance.

§27–613.

(a) (1) This section applies only to private passenger motor vehicle liability insurance.

(2) This section does not apply to the Maryland Automobile Insurance Fund.

(3) This section does not apply to the cancellation of a policy or binder of private passenger motor vehicle liability insurance by an insurer during the 45–day underwriting period in accordance with § 12–106 of this article.

(b) (1) In accordance with this section, with respect to a policy of private passenger motor vehicle liability insurance or a binder of private passenger motor vehicle liability insurance, if the binder has been in effect for at least 45 days, issued in the State to any resident of the household of the named insured, an insurer may:

(i) cancel or fail to renew the policy or binder; or

(ii) reduce coverage under the policy.

(2) Notwithstanding paragraph (1) of this subsection, the requirements of this section do not apply if:

(i) the reduction in coverage described in paragraph (1)(ii) of this subsection is part of a general reduction in coverage approved by the Commissioner or satisfies the requirements of Title 19, Subtitle 5 of this article; or

(ii) the failure to renew the policy takes place under a plan of withdrawal that:

1. is approved by the Commissioner under § 27–606 of this subtitle; and

2. provides that each insured affected by the plan of withdrawal shall be sent by a first–class mail tracking method at least 45 days before the nonrenewal of the policy a written notice that states the date that the policy will

be nonrenewed and that the nonrenewal is the result of the withdrawal of the insurer from the market.

(3) Notwithstanding paragraph (1) of this subsection, an insurer may not cancel a policy midterm except:

(i) when there exists:

1. a material misrepresentation or fraud in connection with the application, policy, or presentation of a claim;

2. a matter or issue related to the risk that constitutes a threat to public safety; or

3. a change in the condition of the risk that results in an increase in the hazard insured against;

(ii) for nonpayment of premium; or

(iii) due to the revocation or suspension of the driver's license or motor vehicle registration:

1. of the named insured or covered driver under the policy; and

2. for reasons related to the driving record of the named insured or covered driver.

(c) (1) At least 45 days before the proposed effective date of the action, an insurer that intends to take an action subject to this section shall send written notice of its proposed action to the insured at the last known address of the insured:

(i) for notice of cancellation or nonrenewal, by certified mail; and

(ii) for all other notices of actions subject to this section, by a first–class mail tracking method.

(2) The notice must be on a form approved by the Commissioner.

(3) The notice must state in clear and specific terms:

(i) the proposed action to be taken, including for a reduction in coverage, the type of coverage reduced and the extent of the reduction;

(ii) the proposed effective date of the action;

(iii) subject to paragraph (4) of this subsection, the actual reason of the insurer for proposing to take the action;

(iv) if there is coupled with the notice an offer to continue or renew the policy in accordance with § 27–609 of this subtitle:

1. the name of the individual or individuals to be excluded from coverage; and

2. the premium amount if the policy is continued or renewed with the named individual or individuals excluded from coverage;

(v) the right of the insured to replace the insurance through the Maryland Automobile Insurance Fund and the current address and telephone number of the Fund;

(vi) the right of the insured to protest the proposed action of the insurer and request a hearing before the Commissioner on the proposed action by:

1. signing a copy of the notice and sending it to the Commissioner within 30 days after the mailing date of the notice; or

2. filing the protest electronically through the consumer complaint portal on the Administration's website within 30 days after the mailing date on the notice;

(vii) that if a protest is filed by the insured, the insurer must maintain the current insurance in effect until a final determination is made by the Commissioner, subject to the payment of any authorized premium due or becoming due before the determination; and

(viii) that the Commissioner shall order the insurer to pay reasonable attorney's fees incurred by the insured for representation at the hearing if the Commissioner finds that:

1. the actual reason for the proposed action is not stated in the notice or the proposed action is not in accordance with § 27–501 of this title, the insurer's filed rating plan, its underwriting standards, or the lawful terms and conditions of the policy related to a cancellation, nonrenewal, or reduction in coverage; and

2. the insurer's conduct in maintaining or defending the proceeding was in bad faith or the insurer acted willfully in the absence of a bona fide dispute.

(4) (i) The insurer's statement of actual reason for proposing to take an action subject to this section must be clear and specific and include a brief statement of the basis for the action, including, at a minimum:

1. if the action of the insurer is due wholly or partly to an accident:

A. the name of the driver;

B. the date of the accident; and

C. if fault is a material factor for the insurer's action, a statement that the driver was at fault;

2. if the action of the insurer is due wholly or partly to a violation of the Maryland Vehicle Law or the vehicle laws of another state or territory of the United States:

A. the name of the driver;

B. the date of the violation; and

C. a description of the violation;

3. if the action of the insurer is due wholly or partly to the claims history of an insured, a description of each claim;

4. whether the insurer's action is based on a violation of law, policy terms or conditions, or the insurer's underwriting standards;

5. whether the insurer's action is based on a material misrepresentation; and

6. any other information that is the basis for the insurer's action.

(ii) The use of generalized terms such as "personal habits", "living conditions", "poor morals", or "violation or accident record" does not meet the requirements of this paragraph.

(iii) The Commissioner may not disallow a proposed action of an insurer because the statement of actual reason contains:

1. grammatical errors, typographical errors, or other errors provided that the errors are nonmaterial and not misleading;

2. surplus information, provided that the surplus information is nonmaterial and not misleading; or

3. erroneous information, provided that in absence of the erroneous information, there remains a sufficient basis to support the action.

(d) At least 10 days before the date an insurer proposes to cancel a policy for nonpayment of premium, the insurer shall send to the insured, by a first–class mail tracking method, a written notice of intention to cancel for nonpayment of premium.

(e) A statement of actual reason contained in the notice given under subsection (c) of this section is privileged and does not constitute grounds for an action against the insurer, its representatives, or another person that in good faith provides to the insurer information on which the statement is based.

(f) (1) This subsection does not apply to an action of an insurer taken under subsection (d) of this section.

(2) An insured may protest a proposed action of the insurer under this section by:

(i) signing a copy of the notice and sending it to the Commissioner within 30 days after the mailing date of the notice; or

(ii) filing the protest electronically through the consumer complaint portal on the Administration's website within 30 days after the mailing date on the notice.

(3) On receipt of a protest, the Commissioner shall notify the insurer of the filing of the protest.

(4) A protest filed with the Commissioner stays the proposed action of the insurer pending a final determination by the Commissioner.

(5) The insurer shall maintain in effect the same coverage and premium that were in effect on the day the notice of proposed action was sent to the

insured until a final determination is made, subject to the payment of any authorized premium due or becoming due before the determination.

(g) (1) Based on the information contained in the notice, the Commissioner shall:

(i) determine whether the protest by the insured has merit; and

(ii) dismiss the protest or disallow the proposed action of the insurer.

(2) The Commissioner shall notify the insurer and the insured of the action of the Commissioner promptly in writing.

(3) Subject to paragraph (4) of this subsection, within 30 days after the mailing date of the Commissioner's notice of action, the aggrieved party may request a hearing.

(4) The Commissioner shall:

(i) Hold a hearing within a reasonable time after the request for a hearing; and

(ii) give written notice of the time and place of the hearing at least 10 days before the hearing.

(5) A hearing held under this subsection shall be conducted in accordance with Title 10, Subtitle 2 of the State Government Article.

(6) At the hearing the insurer has the burden of proving its proposed action to be in accordance with the insurer's filed rating plan, its underwriting standards, or the lawful terms and conditions of the policy related to a cancellation, nonrenewal, or reduction in coverage, as applicable, and not in violation of § 27–501 of this title and, in doing so, may rely only on the reasons set forth in its notice to the insured.

(h) (1) The Commissioner shall issue an order within 30 days after the conclusion of the hearing.

(2) If the Commissioner finds the proposed action of the insurer to be in accordance with the insurer's filed rating plan, its underwriting standards, or the lawful terms and conditions of the policy related to a cancellation, nonrenewal, or

reduction in coverage, as applicable, and not in violation of § 27–501 of this title, the Commissioner shall:

(i) dismiss the protest; and

(ii) allow the proposed action to be taken on the later of:

1. its proposed effective date; and

2. 30 days after the date of the determination.

(3) If the Commissioner finds that the actual reason for the proposed action is not stated in the notice or the proposed action is not in accordance with § 27–501 of this title, the insurer's filed rating plan, its underwriting standards, or the lawful terms and conditions of the policy related to a cancellation, nonrenewal, or reduction in coverage, the Commissioner shall:

(i) disallow the action; and

(ii) order the insurer to pay reasonable attorney's fees incurred by the insured for representation at the hearing if the Commissioner finds that the insurer's conduct in maintaining or defending the proceeding was in bad faith or the insurer acted willfully in the absence of a bona fide dispute.

(i) The Commissioner may delegate the powers and duties of the Commissioner under this section to one or more employees or hearing examiners.

(j) A party to a proceeding under this section may appeal the decision of the Commissioner in accordance with § 2–215 of this article.

§27–614.

(a) In this section, "increase in premium" and "premium increase" include an increase in total premium for a policy due to:

(1) a surcharge;

(2) retiering or other reclassification of an insured; or

(3) removal or reduction of a discount.

(b) (1) This section applies only to private passenger motor vehicle liability insurance.

(2) This section does not apply to the Maryland Automobile Insurance Fund.

(3) This section does not apply to an increase in premium made by an insurer during the 45–day underwriting period in accordance with § 12–106(d)(2) and (3) of this article.

(c) (1) Except as provided in paragraph (2) of this subsection, at least 45 days before the effective date of an increase in the total premium for a policy of private passenger motor vehicle liability insurance, the insurer shall send written notice of the premium increase to the insured at the last known address of the insured by a first–class mail tracking method.

(2) The notice required by paragraph (1) of this subsection need not be given if the premium increase is part of a general increase in premiums that is filed in accordance with Title 11 of this article and does not result from a reclassification of the insured.

(3) The notice may accompany or be included in the renewal offer or policy.

(4) The notice must be on a form approved by the Commissioner.

(5) The notice must state in clear and specific terms:

(i) the premium for the current policy period;

(ii) the premium for the renewal policy period;

(iii) the basis for the action, including, at a minimum:

1. if the premium increase is due wholly or partly to an accident:

A. the name of the driver;

B. the date of the accident; and

C. if fault is a material factor for the insurer's action, a statement that the driver was at fault;

2. if the premium increase is due wholly or partly to a violation of the Maryland Vehicle Law or the vehicle laws of another state or territory of the United States:

A. the name of the driver;

B. the date of the violation; and

C. a description of the violation;

3. if the premium increase is due wholly or partly to the claims history of an insured, a description of each claim;

4. if the premium increase is due to a program that measures the operation of an insured vehicle during the current policy period:

A. a specific description of the factor or factors in the program resulting in the premium increase; and

B. the amount of the premium increase that is attributable to the program; and

5. any other information that is the basis for the insurer's action;

(iv) that the insured should contact the insured's insurance producer or insurer for a review of the premium if the insured has a question about the increase in premium or believes the information in the notice is incorrect;

(v) the right of the insured to protest the premium increase and, in the case of a premium increase of more than 15% for the entire policy, to request a hearing before the Commissioner by mailing, transmitting by facsimile to the Commissioner, or filing electronically through the consumer complaint portal on the Administration's website a protest that includes:

1. a copy of the notice;

2. the insured's address and daytime telephone number; and

3. a statement of the reason that the insured believes the premium increase is incorrect;

(vi) the address and facsimile number of the Administration; and

(vii) that the Commissioner shall order the insurer to pay reasonable attorney's fees incurred by the insured for representation at a hearing if the Commissioner finds that:

1. the actual reason for the proposed action is not stated in the notice or the proposed action is not in accordance with this article or the insurer's filed rating plan; and

2. the insurer's conduct in maintaining or defending the proceeding was in bad faith or the insurer acted willfully in the absence of a bona fide dispute.

(d) (1) If the insured believes that the premium increase is incorrect, the insured may protest the proposed action of the insurer within 30 days after the mailing date of the notice by mailing, transmitting by facsimile to the Commissioner, or filing electronically through the consumer complaint portal on the Administration's website a protest that includes:

(i) a copy of the notice;

(ii) the insured's address and daytime telephone number; and

(iii) a statement of the reason that the insured believes the premium increase is incorrect.

(2) On receipt of a protest, the Commissioner shall notify the insurer of the filing of the protest.

(3) (i) Except as provided in subparagraph (ii) of this paragraph, a protest filed with the Commissioner does not stay the proposed action of the insurer.

(ii) If a premium increase for a policy exceeds 15%, the Commissioner may order a stay of the premium increase pending a final decision if the Commissioner makes a finding that the premium increase:

1. may cause the policyholder undue harm; and

2. is in violation of the insurer's filed rating plan.

(4) Based on the information contained in the notice, the Commissioner shall:

(i) determine whether the insurer's action is in accordance with the insurer's filed rating plan and this article; and

(ii) dismiss the protest or disallow the proposed action of the insurer.

(5) The Commissioner shall notify the insurer and the insured of the action of the Commissioner promptly in writing.

(6) For a premium increase of more than 15% for the entire policy, within 30 days after the mailing date of the Commissioner's notice of action, the aggrieved party may request a hearing.

(7) The Commissioner shall:

(i) hold a hearing within a reasonable time after the request for a hearing; and

(ii) give written notice of the time and place of the hearing at least 10 days before the hearing.

(8) A hearing requested under this subsection shall be conducted in accordance with Title 10, Subtitle 2 of the State Government Article.

(9) At the hearing the insurer has the burden of proving its proposed action to be in accordance with its filed rating plan and this article and, in doing so, may rely only on the reasons set forth in its notice to the insured.

(e) (1) The Commissioner shall issue an order within 30 days after the conclusion of the hearing.

(2) If the Commissioner finds the proposed action of the insurer to be in accordance with the insurer's filed rating plan and this article, the Commissioner shall:

(i) dismiss the protest; and

(ii) if the insurer's action is stayed, allow the proposed action of the insurer to be taken on the later of:

1. its proposed effective date; and

2. 30 days after the date of the determination.

(3) If the Commissioner finds that the actual reason for the proposed action is not stated in the notice or the proposed action is not in accordance with the insurer's filed rating plan or this article, the Commissioner shall:

(i) disallow the action; and

(ii) order the insurer to pay reasonable attorney's fees incurred by the insured for representation at the hearing if the Commissioner finds that the insurer's conduct in maintaining or defending the proceeding was in bad faith or the insurer acted willfully in the absence of a bona fide dispute.

(4) The Commissioner may not dismiss a protest solely because of the insured's failure to state a reason that the insured believes the premium increase is incorrect.

(f) (1) If the Commissioner disallows a premium increase for the entire policy, the insurer, within 30 days after the disallowance, shall:

(i) return to the insured all disallowed premium received from the insured; and

(ii) pay to the insured interest on the disallowed premium received from the insured calculated at 10% a year from the date the disallowed premium was received to the date the disallowed premium was returned.

(2) If an insurer fails to return any disallowed premium and interest to the insured as provided in paragraph (1) of this subsection within 30 days after the Commissioner disallows the action of the insurer, the insurer shall pay interest on the disallowed premium calculated at 20% a year beginning on the 31st day following the disallowance to the date the disallowed premium is returned.

(3) If an insurer fails to return any disallowed premium or fails to pay interest to an insured in violation of paragraphs (1) and (2) of this subsection, the insurer is subject to the penalties under § 4–113(d) of this article.

(g) A party to a proceeding under this section may appeal the decision of the Commissioner in accordance with § 2–215 of this article.

§27–701.

In this subtitle, "resident" includes a domestic, alien, or foreign person, partnership, or corporation.

§27–702.

(a) (1) The General Assembly declares that it is in the interest of citizens of the State who buy insurance from unauthorized insurers that solicit business in the State by placing in or sending into the State false advertising designed to induce residents of the State to buy insurance from them, that those unauthorized insurers be subject to this subtitle.

(2) The purpose of this subtitle is to subject to the jurisdiction of the Commissioner and the courts of the State those unauthorized insurers described in paragraph (1) of this subsection.

(3) In furtherance of this State interest, the General Assembly provides a method of substituted service of process on those unauthorized insurers described in paragraph (1) of this subsection.

(4) The General Assembly declares that by enacting this subtitle, the General Assembly is exercising:

(i) its power to protect the residents of the State; and

(ii) its powers and privileges under the McCarran-Ferguson Act, 15 U.S.C. §§ 1011 through 1015.

(b) The authority provided in this subtitle is in addition to any other powers of the State.

(c) This subtitle shall be construed liberally.

§27–703.

An unauthorized foreign insurer or unauthorized alien insurer may not make, issue, circulate, or cause to be made, issued, or circulated to residents of the State an estimate, illustration, circular, pamphlet, or letter, or cause to be made in a newspaper, magazine, or other publication or over a radio or television station an announcement or statement to residents that misrepresents the insurer's financial condition, the terms of or benefits or advantages promised by insurance contracts issued or to be issued, or the dividends or share of the surplus to be received on the insurance contracts in violation of this title.

§27–704.

(a) (1) If the Commissioner has reason to believe that an unauthorized foreign insurer or unauthorized alien insurer is engaging in unlawful advertising in violation of § 27–703 of this subtitle, the Commissioner shall give notice of the

violation by certified mail, or by electronic means in accordance with § 2–116 of this article, to the insurer and the insurance supervisory official of the domiciliary state of the insurer.

(2) For purposes of this section, the domiciliary state of an alien insurer is deemed to be the state of entry or the state of the principal office of the alien insurer in the United States.

(b) If, after 30 days after the Commissioner gives notice under subsection (a) of this section, the insurer continues to violate § 27-703 of this subtitle, the Commissioner shall take action against the insurer under this title if the Commissioner believes that:

(1) a proceeding by the Commissioner with respect to a violation of § 27-703 of this subtitle would be in the public interest; and

(2) the insurer is:

(i) issuing or delivering insurance contracts to residents of the State;

(ii) collecting premiums on the insurance contracts; or

(iii) doing any of the acts listed in § 27-705 of this subtitle.

§27–705.

(a) An unauthorized foreign insurer or unauthorized alien insurer is deemed to have appointed the Commissioner to be the attorney of the unauthorized insurer for purposes of service of statements of charges, notices, and process in a proceeding instituted under this title for a misrepresentation set forth in § 27-703 of this subtitle or in a proceeding for the recovery of a penalty under this title and to have agreed that service on the Commissioner has the same legal effect as personal service in the State on the unauthorized insurer if the unauthorized insurer in the State, by mail or otherwise:

(1) issues or delivers insurance contracts to residents of the State;

(2) solicits applications for insurance contracts;

(3) collects premiums, membership fees, assessments, or other consideration for insurance contracts; or

(4) transacts any other insurance business.

(b) (1) Service of statements of charges and notices under this title shall be made by a deputy or employee of the Administration by delivering to and leaving with the Commissioner or an individual in apparent charge of the office of the Commissioner two copies of the statement of charges or notice.

(2) Service of process issued by a court in a proceeding to collect a penalty under this title shall be made by delivering to and leaving with the Commissioner or an individual in apparent charge of the office of the Commissioner two copies of the process.

(3) Immediately after receipt of a statement of charges, notice, or process, the Commissioner shall cause one copy of the statement of charges, notice, or process to be sent by certified mail to the unauthorized insurer at its last known principal place of business.

(4) Service of statements of charges, notices, or process under this subsection is sufficient if:

(i) the statement of charges, notice, or process is mailed as provided in paragraph (3) of this subsection; and

(ii) on or before the date that the unauthorized insurer is required to appear or within any further time that may be allowed, the following items are filed with the Commissioner, in the case of a statement of charges or notice, or with the clerk of the court in which the action is pending, in the case of process:

1. the unauthorized insurer's receipt, or the receipt issued by the United States Postal Service, showing the name of the sender of the letter and the name and address of the addressee; and

2. an affidavit of the individual who did the mailing showing compliance with paragraph (1) of this subsection.

(5) The Commissioner shall keep a record of all statements of charges, notices, and process served on the Commissioner under this subsection.

(c) As an alternative to service under subsection (b) of this section, service of statements of charges, notices, or process is valid if:

(1) service is made on any person in the State that, on behalf of the unauthorized insurer:

(i) solicits insurance in the State;

(ii) makes, issues, or delivers an insurance contract in the State; or

(iii) collects or receives in the State a premium for insurance;

(2) within 10 days after service under item (1) of this subsection, a copy of the statement of charges, notice, or process is sent by certified mail by or on behalf of the Commissioner to the unauthorized insurer at its last known principal place of business; and

(3) on or before the date that the unauthorized insurer is required to appear or within any further time that the court allows, the following items are filed with the Commissioner, in the case of a statement of charges or notice, or with the clerk of the court in which the action is pending, in the case of process:

(i) the unauthorized insurer's receipt, or the receipt issued by the United States Postal Service, showing the name of the sender of the letter and the name and address of the addressee; and

(ii) an affidavit of the individual who did the mailing showing compliance with item (1) of this subsection.

(d) A cease or desist order, judgment by default, or judgment by confession under this section may not be entered until the expiration of 30 days after the date of the filing of the affidavit of compliance.

(e) (1) Service of process and notice under this article is in addition to all other methods of service provided by law.

(2) This article does not limit or prohibit the right to serve any statement of charges, notice, or process on an insurer in any other manner authorized by law.

§27–706.

This subtitle is the Unauthorized Insurers False Advertising Process Act.

§27–801.

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

(b) "Fraud Division" means the Insurance Fraud Division in the Administration.

(c) "Insurance fraud" means:

(1) a violation of Subtitle 4 of this title;

(2) theft, as set out in §§ 7–101 through 7–104 of the Criminal Law Article:

(i) from a person regulated under this article; or

(ii) by a person regulated under this article or an officer, director, agent, or employee of a person regulated under this article;

(3) a violation of § 9–1106 of the Labor and Employment Article; or

(4) any other fraudulent activity that is committed by or against a person regulated under this article and is a violation of:

(i) Title 1, Subtitle 3 of the Agriculture Article;

(ii) Title 19, Subtitle 2 or Subtitle 3 of the Business Regulation Article;

(iii) Title 14, Subtitle 29, § 11–810 or § 14–1317 of the Commercial Law Article;

(iv) the Criminal Law Article other than Title 8, Subtitle 2, Part II or § 10–614;

(v) Title 12, Subtitle 9 of the Financial Institutions Article;

(vi) § 14–127 of the Real Property Article;

(vii) § 6–301 of the Alcoholic Beverages and Cannabis Article;

(viii) § 109 of the Code of Public Local Laws of Caroline County;

(ix) § 4–103 of the Code of Public Local Laws of Carroll County; or

(x) § 8A–1 of the Code of Public Local Laws of Talbot County.

§27–802.

(a) (1) An authorized insurer, its employees, fund producers, insurance producers, a viatical settlement provider, or a viatical settlement broker who in good faith has cause to believe that insurance fraud has been or is being committed shall report the suspected insurance fraud in writing to the Commissioner, the Fraud Division, or the appropriate federal, State, or local law enforcement authorities.

(2) An independent insurance producer shall meet the reporting requirement of this subsection by reporting the suspected insurance fraud in writing to the Fraud Division.

(3) A registered premium finance company shall meet the requirement of this subsection by reporting suspected insurance fraud in writing to the Fraud Division.

(4) A governmental self–insurance group formed in accordance with § 9–404 of the Labor and Employment Article or an employer who self–insures or participates in a self–insurance group in accordance with § 9–405 of the Labor and Employment Article shall meet the reporting requirement of this subsection by reporting suspected insurance fraud in writing to the Fraud Division.

(b) In addition to any protection provided under Title 4, Subtitle 4, Part IV of the General Provisions Article, any information, documentation, or other evidence provided under this section by an insurer, its employees, fund producers, or insurance producers, a viatical settlement provider, a viatical settlement broker, an independent insurance producer, a registered premium finance company, a governmental self–insurance group, or an employer who self–insures or participates in a self–insurance group to the Commissioner, the Fraud Division, or a federal, State, or local law enforcement authority in connection with an investigation of suspected insurance fraud is not subject to public inspection for as long as the Commissioner, Fraud Division, or law enforcement authority considers the withholding to be necessary to complete an investigation of the suspected fraud or to protect the person investigated from unwarranted injury.

(c) A person is not subject to civil liability for a cause of action by virtue of reporting suspected insurance fraud, or furnishing or receiving information relating to suspected, anticipated, or completed fraudulent insurance acts, if:

(1) the report was made, or the information was furnished to or received from:

(i) the Commissioner, Fraud Division, or an appropriate federal, State, or local law enforcement authority;

(ii) the National Association of Insurance Commissioners or its agent, employee, or designee;

(iii) a nonprofit organization established to detect and prevent fraudulent insurance acts or its agent, employee, or designee;

(iv) a person that contracts to provide special investigative unit services to an insurer; or

(v) a provider of a recognized comprehensive database system that the Commissioner approves to monitor activities involving insurance fraud or an employee of the provider; and

(2) the person that reported the suspected insurance fraud, or furnished or received the information, acted in good faith when making the report or furnishing or receiving the information.

§27–803.

(a) (1) Each authorized insurer that has in force policies or certificates of insurance in the State shall institute and maintain an insurance antifraud plan.

(2) Within 30 days after instituting or modifying an antifraud plan, the authorized insurer shall notify the Commissioner in writing.

(b) Each antifraud plan shall establish specific procedures to:

(1) prevent insurance fraud, including:

(i) internal fraud that involves the authorized insurer's employees or insurance producers;

(ii) fraud that results from misrepresentations on insurance applications; and

(iii) claims fraud;

(2) report insurance fraud to appropriate law enforcement authorities;

(3) cooperate with the prosecution of insurance fraud cases; and

(4) report fraud–related data to the Commissioner and Fraud Division.

(c) (1) Each authorized insurer that has in force policies or certificates of insurance in the State shall file its antifraud plan with the Commissioner.

(2) The Commissioner may review each antifraud plan to determine whether it complies with the requirements of this section.

(3) An antifraud plan is deemed approved unless disapproved by the Commissioner within 30 days after the date of filing.

(d) (1) If the Commissioner finds that an antifraud plan does not comply with the requirements of this section, the Commissioner shall disapprove the antifraud plan and send a notice of disapproval, including the reasons for disapproval, to the authorized insurer.

(2) If the Commissioner disapproves an antifraud plan, the authorized insurer shall submit a new antifraud plan to the Commissioner within 60 days after the date of disapproval.

(e) During an examination under § 2–205 of this article, the Commissioner shall examine the authorized insurer's procedures to determine whether the authorized insurer is complying with its antifraud plan.

(f) The Commissioner may withhold from public inspection any part of an antifraud plan for as long as the Commissioner considers the withholding to be in the public interest.

(g) (1) As part of an antifraud plan, an authorized insurer may require in writing that an individual who is receiving benefits under a disability insurance policy must affirm on a periodic basis that the individual:

(i) remains entitled to the benefits; and

(ii) has had no change in the condition entitling the individual to the benefits.

(2) An authorized insurer that requires the affirmation permitted under paragraph (1) of this subsection shall disclose to the individual who is receiving benefits that if the individual knowingly and willfully provides false information or knowingly and willfully fails to provide material information in connection with the individual's eligibility or continued eligibility for benefits under a disability insurance policy, the individual is guilty of a crime and may be subject to a fine and imprisonment.

(h) The Commissioner shall adopt regulations that establish minimum standards for antifraud plans required to be filed under this section.

(i) It is a violation of this subtitle if the Commissioner finds that an authorized insurer that has in force policies or certificates of insurance in the State has failed to:

(1) file an antifraud plan;

(2) file a revised antifraud plan after disapproval by the Commissioner of the initial antifraud plan; or

(3) comply with the antifraud plan filed by the authorized insurer.

§27–804.

(a) Each viatical settlement provider shall have in place an antifraud plan reasonably calculated to detect, prosecute, and prevent fraudulent viatical settlement acts.

(b) Within 30 days after instituting or modifying an antifraud plan, the viatical settlement provider shall notify the Commissioner in writing.

(c) Each antifraud plan shall include:

(1) the use of fraud investigators;

(2) a description of the procedures for detecting and investigating possible fraudulent viatical settlement acts and procedures for resolving material inconsistencies between medical records and insurance applications;

(3) a description of the procedures for reporting possible fraudulent viatical settlement acts to the Commissioner;

(4) a description of the plan for antifraud education and training of underwriters, and other personnel; and

(5) a description or chart outlining the organizational arrangement of the antifraud personnel who are responsible for the investigation and reporting of possible fraudulent viatical settlement acts and investigating unresolved material inconsistencies between medical records and insurance applications.

(d) An antifraud plan submitted to the Commissioner shall be privileged and confidential and shall not be a public record and shall not be subject to discovery or subpoena in a civil or criminal action.

(e) (1) Each viatical settlement provider shall file its antifraud plan with the Commissioner.

(2) The Commissioner may review each antifraud plan to determine whether it complies with the requirements of this section.

(3) An antifraud plan is deemed approved unless disapproved by the Commissioner within 30 days after the date of filing.

(f) (1) If the Commissioner finds that an antifraud plan does not comply with the requirements of this section, the Commissioner shall disapprove the antifraud plan and send a notice of disapproval, including the reasons for disapproval, to the viatical settlement provider.

(2) If the Commissioner disapproves an antifraud plan, the viatical settlement provider shall submit a new antifraud plan to the Commissioner within 60 days after the date of disapproval.

(g) It is a violation of this subtitle if the Commissioner finds that a viatical settlement provider has failed to:

(1) file an antifraud plan;

(2) file a revised antifraud plan after disapproval by the Commissioner of the initial antifraud plan; or

(3) comply with the antifraud plan filed by the viatical settlement provider.

§27–805.

(a) In this section, "claim form" means any document supplied by an insurer to a claimant that a claimant is required to complete and submit in support of a claim for benefits.

(b) (1) Except as provided in subsection (c) of this section, all applications for insurance and all claim forms, regardless of the form of transmission, shall contain the following statement or a substantially similar statement:

"Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison."

(2) The lack of the statement required by paragraph (1) of this subsection does not constitute a defense in any legal proceeding.

(c) Subsection (b)(1) of this section does not apply to:

(1) reinsurance applications or claim forms; or

(2) the uniform claims form for reimbursement of hospital services or the uniform claims form for reimbursement of health care practitioners services adopted by the Commissioner under § 15–1003 of this article.

§27–806.

The penalty for a violation of this subtitle is as provided in §§ 4–113 and 4–114 of this article.

§27–901.

(a) (1) In this section the following words have the meanings indicated.

(2) "Credit life or disability insurance" means a type of insurance that will pay all or part of an individual's debt on the death or disability of the individual.

(3) "Finance charge" has the meaning stated in § 12-501 of the Commercial Law Article.

(4) "Retail credit account" has the meaning stated in § 12-501 of the Commercial Law Article.

(b) A person may not make, issue, charge, or cause to be made, issued, or charged to an individual any type of premium for credit life or disability insurance without the express written consent of the individual.

(c) The computation of a finance charge in a retail credit account may not be based in any part on the premiums due under a policy of credit life or disability insurance.

§27–902.

(a) A policy or contract of motor vehicle insurance may not be canceled or nonrenewed solely because of:

(1) the age of the holder of the policy or contract; or

(2) the physical handicap or disability of the holder of the policy or contract.

(b) The premium for a policy or contract of motor vehicle insurance may not be increased solely because:

(1) an insured under the policy or contract is older than 65 years of age; or

(2) the holder of the policy or contract has a physical handicap or disability, unless there is actuarial justification for the increase.

§27–903.

An insurer that submits to its policyholder a notice of initial or renewal premium due shall indicate the kind of insurance coverage for which the policyholder is being charged.

§27–904.

An annuity contract may not contain a provision that reduces payments to an individual entitled to receive annuity payments under the contract because the individual receives an increase in Social Security payments.

§27–905.

(a) An insurer may not send a billing statement to a policyholder under a policy or contract of motor vehicle liability insurance unless the billing statement includes a date by which any payment due under the billing statement must be received by the insurer for the insurance coverage to continue without penalty.

(b) An insurer may not use false or misleading language in a billing statement to induce the policyholder to pay a premium before it is required by the insurer.

§27–906.

An insurer that issues or delivers in the State a policy of motor vehicle liability insurance that provides coverage for the repair of physical damage to the motor vehicle shall provide, on request of the insured, a copy of the warranty for aftermarket crash parts, if available.

§27–907.

An insurer that issues or renews a private passenger motor vehicle insurance policy in the State shall give an actuarially justified discount in rate to each individual who has completed the immediately preceding 3 years of continuous coverage with that insurer without a moving traffic violation, with not more than one point, and with no chargeable traffic accident.

§27–909.

(a) (1) In this section the following words have the meanings indicated.

(2) "Gene product" means the biochemical material, either RNA or protein, made by a gene.

(3) (i) "Genetic information" means information:

1. about chromosomes, genes, gene products, or inherited characteristics that may derive from an individual or a family member;

2. obtained for diagnostic and therapeutic purposes; and

3. obtained at a time when the individual to whom the information relates is asymptomatic for the disease.

(ii) "Genetic information" does not include:

1. routine physical measurements;

2. chemical, blood, and urine analyses that are widely accepted and in use in clinical practice;

3. tests for use of drugs; or

4. tests for the presence of the human immunodeficiency virus.

(4) "Genetic services" means health services that are provided to obtain, assess, and interpret genetic information for diagnostic and therapeutic purposes and for genetic education and counseling.

(5) "Genetic test" means a laboratory test of human chromosomes, genes, or gene products that is used to identify the presence or absence of inherited or congenital alterations in genetic material that are associated with disease or illness.

(b) This section does not apply to life insurance policies, annuity contracts, long–term care insurance policies, or disability insurance policies.

(c) An insurer, nonprofit health service plan, or health maintenance organization may not:

(1) use a genetic test, the results of a genetic test, genetic information, or a request for genetic services, to reject, deny, limit, cancel, refuse to renew, increase the rates of, affect the terms or conditions of, or otherwise affect a health insurance policy or contract;

(2) request or require a genetic test, the results of a genetic test, or genetic information for the purpose of determining whether or not to issue or renew health benefits coverage; or

(3) release identifiable genetic information or the results of a genetic test to any person who is not an employee of the insurer, nonprofit health service plan, or health maintenance organization or a participating health care provider who provides medical services to insureds or enrollees without the prior written authorization of the individual from whom the test results or genetic information was obtained.

(d) Disclosure of identifiable genetic information to an employee or health care provider authorized under subsection (c)(3) of this section shall only be for the purpose of:

(1) providing medical care to patients; or

(2) conducting research that has been approved by an institutional review board established in accordance with federal law.

(e) The authorization described in subsection (c)(3) of this section is required for each disclosure and shall describe the individual or entities making the disclosure, to whom the disclosure is to be made, and the information to be disclosed.

(f) (1) For purposes of this subsection, §§ 4–113 and 4–114 of this article and §§ 27–501 and 27–505 of this title apply to nonprofit health service plans and health maintenance organizations.

(2) The Commissioner may issue an order under §§ 4–113 and 4–114 of this article and §§ 27–501 and 27–505 of this title if the Commissioner finds a violation of this section.

§27–909.1.

(a) (1) In this section the following words have the meanings indicated.

(2) "Genetic test" means an analysis of human DNA, RNA, chromosomes, proteins, or metabolites that detects genotypes, mutations, or chromosomal changes.

(3) "Insurance carrier" means a company authorized to sell insurance policies in the State.

(b) (1) This section applies only to life insurance and disability insurance policies or contracts.

(2) This section does not prohibit an insurance carrier that offers, issues, or delivers a life insurance or disability insurance policy or contract in the State from:

(i) accessing an applicant's medical record as part of the application process; or

(ii) considering a medical diagnosis included in an individual's medical record, even if the diagnosis was based on the results of a genetic test.

(c) (1) Except as provided in paragraph (2) of this subsection and subject to paragraph (3) of this subsection, an insurance carrier that offers, issues, or delivers a life insurance or disability insurance policy or contract in the State may not unfairly discriminate against an individual by conditioning insurance rates, the provision or renewal of insurance coverage, or other conditions of insurance based on medical information, including the results of a genetic test for which there is not a relationship between the medical information and the cost of the insurance risk that the insurer would assume by insuring the applicant.

(2) In demonstrating the relationship described in paragraph (1) of this subsection, the insurer may rely on actuarially sound principles or actual or reasonably anticipated experience.

(3) An insurance carrier that offers, issues, or delivers a life insurance or disability insurance policy or contract in the State may not:

(i) access sensitive medical information, including the genetic data of an individual, without first obtaining the individual's signed, written consent; or

(ii) mandate existing or new genetic testing or full genome sequencing as a prerequisite for life insurance or disability insurance eligibility or coverage.

(4) The insurance carrier, applicant, or policy or contract holder may not waive the provisions of paragraph (3)(ii) of this subsection under any circumstances.

(d) The Commissioner may issue an order under §§ 4–113 and 4–114 of this article or §§ 27–501 and 27–505 of this title if the Commissioner finds a violation of this section.

§27–910.

(a) (1) In this section the following words have the meanings indicated.

(2) "Enrollee" means an individual or member of an association or other private group arrangement entitled to health care services from a health network.

(3) "Health care service" has the meaning stated in § 19-701 of the Health - General Article.

(4) "Health network" means an entity that:

(i) holds a certificate of authority under this article or Title 19, Subtitle 7 of the Health - General Article; and

(ii) is organized to provide health care services to individuals or an enrolled population in a regional or service area.

(b) A health network may not deny health care services to an enrollee on the basis of sex, sexual orientation, gender identity, race, age, religion, national origin, or a protected category under the Americans with Disabilities Act.

§27–911.

(a) Each authorized insurer doing business in the State shall accept and honor each request by a policyholder for a change of insurance producer of record within 30 working days after receipt of the request unless the policyholder withdraws the request in writing.

(b) The new insurance producer of record must have a current appointment and contract with the authorized insurer before the change of insurance producer of record will be effective.

(c) (1) Subject to the provisions of paragraph (2) of this subsection, the new insurance producer of record shall be paid all commissions payable on the policy effective not later than the next anniversary date of the policy following the effective date of change.

(2) The commissions payable under paragraph (1) of this subsection do not include:

(i) vested life insurance commissions;

(ii) supplemental health insurance commissions; or

(iii) commissions or other compensation payable under an insurer's retirement or deferred compensation plan with the insurance producer.

(d) A request for a change of insurance producer of record shall:

(1) be in writing; and

(2) include:

(i) the policyholder's name and address;

(ii) the authorized insurer's name and address;

(iii) the policy number;

(iv) the name and address of the new insurance producer of record;

(v) the date of the request;

(vi) the signature of the policyholder; and

(vii) the signature of acceptance by the new insurance producer.

(e) This section does not require an authorized insurer to:

(1) appoint and contract with an insurance producer of record;

(2) alter an insurer's existing contract with an insurance producer which provides for direct compensation in lieu of commission; and

(3) require the payment of full commissions to a new insurance producer where the original writing insurance producer or current insurance producer continues to have responsibility for processing and matters relating to the policyholder.

§27–912.

An insurer that accepts a transfer of the insurance business of a group of policyholders from an independent insurance producer may treat the policies transferred as renewals and not as new policies for underwriting purposes.

§27–913.

(a) This section applies to:

(1) insurers and nonprofit health service plans that provide hospital, medical, or surgical benefits to individuals or groups on an expense-incurred basis under health insurance policies or contracts that are issued or delivered in the State; and

(2) health maintenance organizations that provide hospital, medical, or surgical benefits to individuals or groups under contracts that are issued or delivered in the State.

(b) Unless otherwise provided by law, an entity subject to this section may not make benefits under a policy or contract issued or delivered by the entity in the State for the treatment of a specified disease or diagnosis subject to different copayment amounts, coinsurance, deductibles, annual maximum limits, or lifetime maximum limits than those that apply to all other diseases covered under the policy or contract.

§27–914.

(a) This section does not apply to life insurance policies, annuity contracts, long–term care insurance policies, or disability insurance policies.

(b) An insurer that provides health insurance, a nonprofit health service plan, or a health maintenance organization may not use race or ethnicity data to reject, deny, limit, cancel, refuse to renew, increase the rates of, affect the terms or conditions of, or otherwise affect a health insurance policy or contract.

(c) The Commissioner may issue an order under §§ 4–113 and 4–114 of this article and §§ 27–501 and 27–505 of this title if the Commissioner finds a violation of this section.

§27–915.

(a) In this section, "organ transplantation" means the transplantation or transfusion of a human body part into the body of another individual for the purpose of treating or curing a medical condition.

(b) This section applies to:

(1) insurers and nonprofit health service plans that provide coverage for organ transplantation to individuals or groups on an expense–incurred basis under health insurance policies or contracts that are issued or delivered in the State; and

(2) health maintenance organizations that provide coverage for organ transplantation to individuals or groups under contracts that are issued or delivered in the State.

(c) An entity subject to this section may not deny coverage for an organ transplantation solely on the basis of an insured's or enrollee's disability.

(d) This section may not be construed to require an entity subject to this section to provide coverage for an organ transplantation that is not medically necessary.

§27–1001.

(a) In this section, "good faith" means an informed judgment based on honesty and diligence supported by evidence the insurer knew or should have known at the time the insurer made a decision on a claim.

(b) This section applies only to actions under § 3–1701 of the Courts Article.

(c) (1) Except as provided in paragraph (2) of this subsection, a person may not bring or pursue an action under § 3–1701 of the Courts Article in a court unless the person complies with this section.

(2) Paragraph (1) of this subsection does not apply to an action:

(i) within the small claim jurisdiction of the District Court under § 4–405 of the Courts Article;

(ii) if the insured and the insurer agree to waive the requirement under paragraph (1) of this subsection; or

(iii) under a commercial insurance policy on a claim with respect to which the applicable limit of liability exceeds $1,000,000.

(d) (1) A complaint stating a cause of action under § 3–1701 of the Courts Article shall first be filed with the Administration.

(2) The complaint shall:

(i) be accompanied by each document that the insured has submitted to the insurer for proof of loss;

(ii) specify the applicable insurance coverage and the amount of the claim under the applicable coverage; and

(iii) state the amount of actual damages, and the claim for expenses and litigation costs described under subsection (e)(2) of this section.

(3) The Administration shall forward the filing to the insurer.

(4) Within 30 days after the date the filing is forwarded to the insurer by the Administration, the insurer shall:

(i) file with the Administration, except for good cause shown, a written response together with a copy of each document from the insurer's claim file that enables reconstruction of the insurer's activities relative to the insured's claim, including documentation of each pertinent communication, transaction, note, work paper, claim form, bill, and explanation of benefits form relative to the claim; and

(ii) mail to the insured a copy of the response and, except for good cause shown, each document from the insurer's claim file that enables reconstruction of the insurer's activities relative to the insured's claim, including

documentation of each pertinent communication, transaction, note, work paper, claim form, bill, and explanation of benefits form relative to the claim.

(e) (1) (i) Within 90 days after the date the filing was received by the Administration, the Administration shall issue a decision that determines:

1. whether the insurer is obligated under the applicable policy to cover the underlying first–party claim;

2. the amount the insured was entitled to receive from the insurer under the applicable policy on the underlying covered first–party claim;

3. whether the insurer breached its obligation under the applicable policy to cover and pay the underlying covered first–party claim, as determined by the Administration;

4. whether an insurer that breached its obligation failed to act in good faith; and

5. the amount of damages, expenses, litigation costs, and interest, as applicable and as authorized under paragraph (2) of this subsection.

(ii) The failure of the Administration to issue a decision within the time specified in subparagraph (i) of this paragraph shall be considered a determination that the insurer did not breach any obligation to the insured.

(2) With respect to the determination of damages under paragraph (1)(i)5 of this subsection:

(i) if the Administration finds that the insurer breached an obligation to the insured, the Administration shall determine the obligation of the insurer to pay:

1. actual damages, which actual damages may not exceed the limits of any applicable policy; and

2. interest on all actual damages incurred by the insured computed:

A. at the rate allowed under § 11–107(a) of the Courts Article; and

B. from the date on which the insured's claim should have been paid; and

(ii) if the Administration also finds that the insurer failed to act in good faith, the Administration shall also determine the obligation of the insurer to pay:

1. expenses and litigation costs incurred by the insured, including reasonable attorney's fees, in pursuing recovery under this subtitle; and

2. interest on all expenses and litigation costs incurred by the insured computed:

A. at the rate allowed under § 11–107(a) of the Courts Article; and

B. from the applicable date or dates on which the insured's expenses and costs were incurred.

(3) An insurer may not be found to have failed to act in good faith under this section solely on the basis of delay in determining coverage or the extent of payment to which the insured is entitled if the insurer acted within the time period specified by statute or regulation for investigation of a claim by an insurer.

(4) The amount of the attorney's fees determined to be payable to an insured under paragraph (2) of this subsection may not exceed one–third of the actual damages payable to the insured.

(5) The Administration shall serve a copy of the decision on the insured and the insurer in accordance with § 2–204(c) of this article.

(f) (1) If a party receives an adverse decision, the party shall have 30 days after the date of service of the Administration's decision to request a hearing.

(2) All hearings requested under this section shall:

(i) be referred by the Commissioner to the Office of Administrative Hearings for a final decision under Title 10, Subtitle 2 of the State Government Article;

(ii) be heard de novo; and

(iii) result in a final decision that makes the determinations set forth in subsection (e) of this section.

(3) If no administrative hearing is requested in accordance with paragraph (1) of this subsection, the decision issued by the Administration shall become a final decision.

(g) (1) If a party receives an adverse decision, the party may appeal a final decision by the Administration or an administrative law judge under this section to a circuit court in accordance with § 2–215 of this article and Title 10, Subtitle 2 of the State Government Article.

(2) (i) This paragraph applies only if more than one party receives an adverse decision from the Administration.

(ii) If a party requests a hearing before the Office of Administrative Hearings and another party files an appeal to a circuit court:

1. jurisdiction over the request for hearing is transferred to the circuit court;

2. the request for hearing, the Administration's decision, and the Administration's case file, including the complaint, response, and all documents submitted to the Administration, shall be transmitted promptly to the circuit court; and

3. the request for hearing shall be docketed in the circuit court and consolidated for trial with the appeal.

(3) Notwithstanding any other provision of law, an appeal to a circuit court under this section shall be heard de novo.

(h) On or before January 1 of each year beginning in 2009, in accordance with § 2–1257 of the State Government Article, the Administration shall report to the General Assembly on the following for the prior fiscal year:

(1) the number and types of complaints under this section or § 3–1701 of the Courts Article from insureds regarding first–party insurance claims under property and casualty insurance policies;

(2) the number and types of complaints under this section or § 3–1701 of the Courts Article from insureds regarding first–party insurance claims under individual disability insurance policies;

(3) the administrative and judicial dispositions of the complaints described in items (1) and (2) of this subsection;

(4) the number and types of regulatory enforcement actions instituted by the Administration for unfair claim settlement practices under § 27–303(9) or § 27–304(18) of this title; and

(5) the administrative and judicial dispositions of the regulatory enforcement actions for unfair claim settlement practices described under item (4) of this subsection.

§28–101.

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

(b) "Areas under Nazi influence" means the country of Nazi Germany, areas occupied by Nazi Germany, those European countries allied with Nazi Germany, areas occupied by those European countries allied with Nazi Germany, or any other neutral European country or area in Europe under the influence or threat of invasion by Nazi Germany or by any European country allied with or occupied by Nazi Germany.

(c) "Holocaust victim" means an individual, claimant, or the estate, heir, legatee, descendant, survivor, beneficiary, or other successor-in-interest of the individual, who died or lost property as a result of discriminatory laws, policies, or actions targeted against discrete groups of individuals based on race, religion, ethnicity, sexual orientation, or national origin, whether or not the individual was actually a member of any of those groups, or because the individual assisted or allegedly assisted any of those groups, between January 1, 1929, and December 31, 1945, in areas under Nazi influence.

(d) (1) "Insurance policy" means a policy of insurance substantially similar to any kind of insurance that was authorized at any time in Maryland between and including the years 1929 and 1945 or authorized by the jurisdiction in which the policy was sold at the time it was sold.

(2) "Insurance policy" includes any form of life, accident, health, annuities, property, casualty, education, or dowry insurance.

(e) "International Commission" means the twelve member commission, and any successor organization, established by the September 1998 Memorandum of Understanding executed by the Maryland Insurance Commissioner, insurance regulators from other states, European insurers, and international Jewish organizations.

(f) "Nazi Germany" means:

(1) for the period from 1929 to 1933, the Republic of Germany, commonly referred to as the Weimar Republic; and

(2) for the period from 1933 through 1945, Deutsche Reich.

(g) "Proceeds" means the face or other pay-out value of an insurance policy or annuity plus reasonable interest to date of payment as required by regulations adopted by the Commissioner.

§28–102.

The Commissioner shall arrange for a toll-free telephone number, available in English as well as other appropriate languages, to assist any person seeking to recover proceeds from an insurance policy issued to or covering the life or property of a Holocaust victim.

§28–103.

(a) Notwithstanding any inconsistent provision of this title, any insurer authorized to do insurance business in the State, in receipt of a claim against it arising from an occurrence during the period between January 1, 1929, and December 31, 1945, from an individual that the insurer knows, or reasonably should have known, is a Holocaust victim shall:

(1) diligently and expeditiously investigate the claim;

(2) allow claimants to provide alternative documentation that does not meet the usual standards of proof required by the insurer to substantiate the particular claim, subject to standards established for alternative documentation as required by regulations adopted by the Commissioner; and

(3) attempt to resolve, settle, and, if appropriate, make payments on claims irrespective of any statute of limitations or notice requirements imposed by law or the insurance policy issued to or covering the life, property, or interests of a Holocaust victim, if the claim is submitted to the insurer within 10 years after the effective date of this title.

(b) A violation of this section is an unfair or deceptive act or practice in the business of insurance in violation of Title 27 of this article.

(c) (1) This title shall serve as additional and conclusive notice that the Commissioner is currently investigating all claims pertaining to the victims of the Holocaust.

(2) Evidence of the intentional destruction or alteration of any records or other materials pertaining to a claim shall be admissible in both administrative and judicial proceedings as evidence in support of any claim being made against the insurer involving the destroyed or altered material.

(3) It may be inferred in an administrative or judicial proceeding that the intentional destruction or alteration of any records or other materials pertaining to a claim was done in order to prevent discovery of information to support any claim of a Holocaust victim.

§28–104.

(a) Notwithstanding any law or agreement among the parties to an insurance policy to the contrary, any action arising from an occurrence during the period between January 1, 1929, and December 31, 1945, brought by a Holocaust victim seeking proceeds of an insurance policy issued to or covering the life or property of a Holocaust victim before December 31, 1945, may not be dismissed for failure to comply with any statute of limitations or laches or other similar provision of any applicable law relating to the timeliness of the filing of claims that might prevent a claim from being heard on its merits, or any notice requirements imposed by any insurance policy if the action is commenced within 10 years after the effective date of this title.

(b) Any action arising from an occurrence during the period between January 1, 1929, and December 31, 1945, brought by a Holocaust victim seeking proceeds of an insurance policy issued to or covering the life or property of a Holocaust victim before December 31, 1945, may not be stayed or dismissed under the Maryland Rules of Civil Procedure.

(c) In recognition of the significant period of time that has passed and in order to effect the goals of substantial justice, the rules regarding the admissibility of evidence, and principles of law or other rules relating to the admission of hearsay evidence shall be relaxed at the discretion of the trial judge in any action or proceeding authorized by this section.

§28–105.

(a) (1) If directed to do so by the Commissioner, an insurer authorized to do insurance business in the State shall file or cause its holding company to file with the Commissioner, a report setting forth the insurer's plan for complying with this title.

(2) Each insurer that has determined that it does not have any of the information requested in subsection (b) of this section shall file or cause its holding company to file a report stating that they have no information.

(3) In addition, an insurer may request to be relieved from filing any further reports after providing evidence satisfactory to the Commissioner that the insurer has fulfilled its obligations under this title.

(b) If directed to do so by the Commissioner, an insurer authorized to do insurance business in the State shall report or cause its holding company to report to the Commissioner the following information:

(1) whether it is a member of a holding company system including any insurer, any other member, subsidiary, or division in each case whether a licensee or not, that could possibly be expected to have issued an insurance policy to a Holocaust victim between January 1, 1920, and December 31, 1945, and a list of each entity;

(2) the approximate number and the total value of all insurance policies issued to Holocaust victims between January 1, 1920, and December 31, 1945, by the insurer or by any other member, subsidiary, or division within the reporting insurer's holding company system, that, as of the date of the report, remain unpaid or were paid to, or expropriated by, a government located in areas under Nazi influence, that was not the named beneficiary of the insurance policy;

(3) attempts made by the insurer to locate the beneficiaries of any insurance policies issued to Holocaust victims between January 1, 1920, and December 31, 1945, for which no claim of benefits has been made;

(4) if requested by the Commissioner and to the extent consistent with applicable laws and confidentiality obligations, with respect to each insurance policy issued to Holocaust victims between January 1, 1920, and December 31, 1945, the name of the owner, the name of the beneficiary, and the face amount or pay-out value;

(5) the number of claims filed by individuals who allege or have alleged that they are Holocaust victims and whether each claim has been paid or payment has been denied;

(6) if requested by the Commissioner, an explanation of any denial or pending payment of a claim to any individual who alleges or has alleged to be a Holocaust victim;

(7) a summary of the length of time for the processing and disposition of a claim to an individual who alleges or has alleged to be a Holocaust victim by the insurer; and

(8) if the insurer is unable to provide any of the information required by this section, an explanation of the reasons why and whether the information may, in the future, be ascertainable.

(c) The Commissioner shall direct an insurer in this State to file a report under this section if:

(1) the Commissioner determines that the International Commission is not moving effectively toward the swift and equitable resolution of insurance claims made by Holocaust victims; or

(2) the Commissioner determines that an insurer is not meaningfully participating in the work of the International Commission or cooperating with the International Commission in a manner reasonably calculated to effect the prompt investigation and resolution of claims made by Holocaust victims.

(d) Except as provided in subsection (a) of this section, the reports required by subsection (b) of this section shall be made within 30 days after the end of the calendar year in which the insurer was directed by the Commissioner to file a report and then annually for each of the succeeding 10 years.

(e) A report submitted to the Commissioner under this section shall be certified and affirmed under oath as being true and not misleading and as containing the most accurate information available at the time of the submission of the report.

(f) The Commissioner may waive penalties and fines imposed by this title for those insurers that, through no fault of their own, were unaware that they, or members of a holding company system that includes the insurer, were obligated to file reports under this title and to comply with this title.

(g) The Commissioner is authorized to use any power available to the State to compel holding company systems that include issuers of insurance policies to Holocaust victims to submit reports under this title and to comply with this title.

(h) (1) An insurer that knowingly or recklessly files a false or misleading certification required by this section is subject to a fine of not less than $100,000 or a greater amount as the Commissioner considers appropriate based on the degree of misrepresentation, the willfulness of the misconduct, and the amount of funds misappropriated.

(2) The insurer also may be barred from further sales of insurance in the State for a period of up to 10 years.

§28–106.

(a) On or before December 1, 1999, and then on December 1 for each of the succeeding 10 years, the Commissioner shall report to the Governor and, subject to § 2-1257 of the State Government Article, the General Assembly the following information:

(1) the progress of the International Commission in receiving, investigating, and resolving insurance claims of Holocaust victims; and

(2) the status of any reports that insurers were directed to file under § 28-105 of this title.

(b) The Commissioner's report under this section shall include:

(1) the number of insurers authorized to do business in the State and the number of other insurers that may be in the same holding company system as an authorized insurer that could possibly be expected to have issued an insurance policy to a Holocaust victim between January 1, 1920, and December 31, 1945;

(2) the approximate number and total value of all insurance policies issued to Holocaust victims between January 1, 1920, and December 31, 1945, that, as of the date of the report, remain unpaid or were paid to, or expropriated by, a government located in areas under Nazi influence that was not the named beneficiary of the insurance policy;

(3) a listing by insurer of the number of claims filed by individuals who allege or have alleged that they are Holocaust victims and whether each claim has been paid or payment has been denied;

(4) a summary of the length of time for the processing and disposition of claims filed by individuals who allege or have alleged that they are Holocaust victims by the insurer; and

(5) a listing of the circumstances of the activities of the Commissioner under item (4) of this subsection and § 28-107 of this title.

§28–107.

(a) In addition to any other penalty authorized by this title, any insurer or person that violates this title is subject to a civil penalty of up to $100,000 for each day the violation continues.

(b) If the Commissioner finds that a violation of this title is willful, the insurer shall be fined an amount that the Commissioner considers appropriate based on the degree of willful misconduct and the nature of the violation.

§28–108.

An insurer may not be considered to be in violation of any provision of Title 27 of this article for complying with this title.

§28–109.

The Commissioner shall adopt regulations to carry out this title and to facilitate, monitor, and verify compliance with this title.

§28–110.

This title is the Holocaust Victims Insurance Act.

§29–101.

The State of Maryland hereby enters the Interstate Insurance Product Regulation Compact as set forth in this section. The Compact shall take effect in accordance with Article XIII of the Compact. The text of the Compact is as follows:

Article I. Purposes.

The purposes of this Compact are, through means of joint and cooperative action among the compacting states:

1. to promote and protect the interest of consumers of individual and group annuity, life insurance, disability income, and long-term care insurance products;

2. to develop uniform standards for insurance products covered under the Compact;

3. to establish a central clearinghouse to receive and provide prompt review of insurance products covered under the Compact and, in certain cases, advertisements related to the insurance products, submitted by insurers authorized to do business in one or more compacting states;

4. to give appropriate regulatory approval to those product filings and advertisements satisfying the applicable uniform standard;

5. to improve coordination of regulatory resources and expertise between state insurance departments regarding the setting of uniform standards and review of insurance products covered under the Compact;

6. to create the Interstate Insurance Product Regulation Commission; and

7. to perform these and such other related functions as may be consistent with the state regulation of the business of insurance.

Article II. Definitions.

For purposes of this Compact:

1. "Advertisement" means any material designed to create public interest in a product, or induce the public to purchase, increase, modify, reinstate, borrow on, surrender, replace, or retain a policy, as more specifically defined in the rules and operating procedures of the Commission.

2. "Bylaws" mean those bylaws established by the Commission for its governance or for directing or controlling the Commission's actions or conduct.

3. "Compacting state" means any state that has enacted this compact legislation and has not withdrawn pursuant to Article XIV, Section 1, or been terminated pursuant to Article XIV, Section 2.

4. "Commission" means the Interstate Insurance Product Regulation Commission established by this Compact.

5. "Commissioner" means the chief insurance regulatory official of a state, including a commissioner, superintendent, director, or administrator.

6. "Domiciliary state" means the state in which an insurer is incorporated or organized, or, in the case of an alien insurer, its state of entry.

7. "Insurer" means any entity licensed by a state to issue contracts of insurance for any of the lines of insurance covered by this Compact.

8. "Member" means the person chosen by a compacting state as its representative to the Commission or the person's designee.

9. "Non-compacting state" means any state which is not at the time a compacting state.

10. "Operating procedures" means procedures promulgated by the Commission implementing a rule, uniform standard, or a provision of this Compact.

11. "Product" means the form of a policy or contract, including any application, endorsement, or related form which is attached to and made a part of the policy or contract, and any evidence of coverage or certificate, for an individual or group annuity, life insurance, disability income, or long-term care insurance product that an insurer is authorized to issue.

12. "Rule" means a statement of general or particular applicability and future effect promulgated by the Commission, including a uniform standard developed pursuant to Article VII of this Compact, designed to implement, interpret, or prescribe law or policy or describing the organization, procedure, or practice requirements of the Commission, which shall have the force and effect of law in the compacting states.

13. "State" means any state, district, or territory of the United States of America.

14. "Third-party filer" means an entity that submits a product filing to the Commission on behalf of an insurer.

15. "Uniform standard" means a standard adopted by the Commission for a product line, pursuant to Article VII of this Compact, and shall include all of the product requirements in the aggregate; provided, that each uniform standard shall be construed, whether express or implied, to prohibit the use of any inconsistent, misleading, or ambiguous provisions in a product, and the form of the product made available to the public shall not be unfair, inequitable, or against public policy as determined by the Commission.

Article III. Establishment of the Commission and Venue.

1. The compacting states hereby create and establish a joint public agency known as the "Interstate Insurance Product Regulation Commission." Pursuant to Article IV, the Commission will have the power to develop uniform standards for product lines, receive and provide prompt review of products filed therewith, and give approval to those product filings satisfying applicable uniform standards; provided that it is not intended for the Commission to be the exclusive entity for receipt and review of insurance product filings. Nothing herein shall prohibit any insurer from filing its product in any state in which the insurer is licensed to conduct the business of insurance; and any such filing shall be subject to the laws of the state where filed.

2. The Commission is a body corporate and politic and an instrumentality of the compacting states.

3. The Commission is solely responsible for its liabilities except as otherwise specifically provided in this Compact.

4. Venue is proper and judicial proceedings by or against the Commission shall be brought solely and exclusively in a court of competent jurisdiction where the principal office of the Commission is located.

Article IV. Powers of the Commission.

The Commission shall have the following powers:

1. to promulgate rules, pursuant to Article VII of this Compact, which shall have the force and effect of law and shall be binding in the compacting states to the extent and in the manner provided in this Compact;

2. to exercise its rule-making authority and establish reasonable uniform standards for products covered under the Compact, and any advertisement related thereto, which shall have the force and effect of law and shall be binding in the compacting states, but only for those products filed with the Commission; provided, that a compacting state shall have the right to opt out of such uniform standard pursuant to Article VII, to the extent and in the manner provided by this Compact; and provided further, that any uniform standard established by the Commission for long-term care insurance products may provide the same or greater protections for consumers as, but shall not provide less than, those protections set forth in the National Association of Insurance Commissioner's Long-Term Care Insurance Model Act and Long-Term Care Insurance Model Regulation, respectively, adopted as of 2001. The Commission shall consider whether any subsequent amendments to the NAIC Long-Term Care Insurance Model Act or the Long-Term Care Insurance Model Regulation adopted by the NAIC require amending of the uniform standards established by the Commission for long-term care insurance products;

3. to receive and review in an expeditious manner products filed with the Commission, and rate filings for disability income and long-term care insurance products, and give approval of those products and rate filings that satisfy the applicable uniform standard, where such approval shall have the force and effect of law and be binding in the compacting states to the extent and in the manner provided by the Compact;

4. to receive and review in an expeditious manner advertisement relating to long-term care insurance products for which uniform standards have been adopted

by the Commission, and give approval to all advertisement that satisfies the applicable uniform standard. For any product covered under this Compact, other than long-term care insurance products, the Commission shall have the authority to require an insurer to submit all or any part of its advertisement with respect to that product for review or approval prior to use, if the Commission determines that the nature of the product is such that an advertisement of the product could have the capacity or tendency to mislead the public. The actions of the Commission as provided in this section shall have the force and effect of law and shall be binding in the compacting states to the extent and in the manner provided in the Compact;

5. to exercise its rule-making authority and designate products and advertisement that may be subject to a self-certification process without the need for prior approval by the Commission;

6. to promulgate operating procedures, pursuant to Article VII of this Compact, which shall be binding in the compacting states to the extent and in the manner provided in the Compact;

7. to bring and prosecute legal proceedings or actions in its name as the Commission; provided, that the standing of any state insurance department to sue or be sued under applicable law shall not be affected;

8. to issue subpoenas requiring the attendance and testimony of witnesses and the production of evidence;

9. to establish and maintain offices;

10. to purchase and maintain insurance and bonds;

11. to borrow, accept, or contract for services or personnel, including employees of a compacting state;

12. to hire employees, professionals, or specialists, and elect or appoint officers and to fix their compensation, define their duties, give them appropriate authority to carry out the purposes of the Compact, and determine their qualifications; and to establish the Commission's personnel policies and programs relating to, among other things, conflicts of interest, rates of compensation, and qualifications of personnel;

13. to accept any and all appropriate donations and grants of money, equipment, supplies, materials, and services, and to receive, use, and dispose of the same; provided that at all times the Commission shall strive to avoid any appearance of impropriety;

14. to lease, purchase, accept appropriate gifts or donations of, or otherwise to own, hold, improve, or use, any property, real, personal, or mixed; provided that at all times the Commission shall strive to avoid any appearance of impropriety;

15. to sell, convey, mortgage, pledge, lease, exchange, abandon, or otherwise dispose of any property, real, personal, or mixed;

16. to remit filing fees to compacting states as may be set forth in the bylaws, rules, or operating procedures;

17. to enforce compliance by compacting states with rules, uniform standards, operating procedures, and bylaws;

18. to provide for dispute resolution among compacting states;

19. to advise compacting states on issues relating to insurers domiciled or doing business in non-compacting jurisdictions, consistent with the purposes of this Compact;

20. to provide advice and training to those personnel in state insurance departments responsible for product review, and to be a resource for state insurance departments;

21. to establish a budget and make expenditures;

22. to borrow money;

23. to appoint committees, including advisory committees comprised of members, state insurance regulators, state legislators or their representatives, insurance industry and consumer representatives, and such other interested persons as may be designated in the bylaws;

24. to provide and receive information from, and to cooperate with, law-enforcement agencies;

25. to adopt and use a corporate seal; and

26. to perform such other functions as may be necessary or appropriate to achieve the purposes of this Compact consistent with the state regulation of the business of insurance.

Article V. Organization of the Commission.

1. Membership, voting, and bylaws.

A. Each compacting state shall have and be limited to one member. Each member shall be qualified to serve in that capacity pursuant to applicable law of the compacting state. Any member may be removed or suspended from office as provided by the law of the state from which the member is appointed. Any vacancy occurring in the Commission shall be filled in accordance with the laws of the compacting state in which the vacancy exists. Nothing herein shall be construed to affect the manner in which a compacting state determines the election or appointment and qualification of its own commissioner.

B. Each member shall be entitled to one vote and shall have an opportunity to participate in the governance of the Commission in accordance with the bylaws. Notwithstanding any provision herein to the contrary, no action of the Commission with respect to the promulgation of a uniform standard shall be effective unless two-thirds of the members vote in favor thereof.

C. The Commission, by a majority of the members, shall prescribe bylaws to govern its conduct as may be necessary or appropriate to carry out the purposes, and exercise the powers, of the Compact, including:

I. establishing the fiscal year of the Commission;

II. providing reasonable procedures for appointing and electing members and holding meetings of the management committee;

III. providing reasonable standards and procedures: (i) for the establishment and meetings of other committees; and (ii) governing any general or specific delegation of any authority or function of the Commission;

IV. providing reasonable procedures for calling and conducting meetings of the Commission that consists of a majority of Commission members, ensuring reasonable advance notice of each such meeting, and providing for the right of citizens to attend each such meeting with enumerated exceptions designed to protect the public's interest, the privacy of individuals, and insurers' proprietary information, including trade secrets. The Commission may meet in camera only after a majority of the entire membership votes to close a meeting in whole or in part. As soon as practicable, the Commission must make public: (i) a copy of the vote to close the meeting revealing the vote to each member with no proxy votes allowed; and (ii) votes taken during the meeting;

V. establishing the titles, duties, and authority and reasonable procedures for the election of the officers of the Commission;

VI. providing reasonable standards and procedures for the establishment of the personnel policies and programs of the Commission. Notwithstanding any civil service or other similar laws of any compacting state, the bylaws shall exclusively govern the personnel policies and programs of the Commission;

VII. promulgating a code of ethics to address permissible and prohibited activities of Commission members and employees; and

VIII. providing a mechanism for winding up the operations of the Commission and the equitable disposition of any surplus funds that may exist after the termination of the Compact after the payment and/or reserving of all of its debts and obligations.

D. The Commission shall publish its bylaws in a convenient form and file a copy of the bylaws, and a copy of any amendment to the bylaws, with the appropriate agency or officer in each of the compacting states.

2. Management committee, officers, and personnel.

A. A management committee comprised of no more than 14 members shall be established as follows:

I. one member from each of the six compacting states with the largest premium volume for individual and group annuities, life, disability income, and long-term care insurance products, determined from the records of the NAIC for the prior year;

II. four members from those compacting states with at least 2% of the market, based on the premium volume described above, other than the six compacting states with the largest premium volume, selected on a rotating basis as provided in the bylaws; and

III. four members from those compacting states with less than 2% of the market, based on the premium volume described above, with one selected from each of the four zone regions of the NAIC as provided in the bylaws.

B. The management committee shall have such authority and duties as may be set forth in the bylaws, including:

I. managing the affairs of the Commission in a manner consistent with the bylaws and purposes of the Commission;

II. establishing and overseeing an organizational structure within, and appropriate procedures for, the Commission to provide for the creation of uniform standards and other rules, receipt and review of product filings, administrative and technical support functions, review of decisions regarding the disapproval of a product filing, and the review of elections made by a compacting state to opt out of a uniform standard; provided that a uniform standard shall not be submitted to the compacting states for adoption unless approved by two-thirds of the members of the management committee;

III. overseeing the offices of the Commission; and

IV. planning, implementing, and coordinating communications and activities with other state, federal, and local government organizations in order to advance the goals of the Commission.

C. The Commission shall elect annually officers from the management committee, with each having such authority and duties as may be specified in the bylaws.

D. The management committee, subject to the approval of the Commission, may appoint or retain an executive director for such period, on such terms and conditions and for such compensation as the Commission may deem appropriate. The executive director shall serve as secretary to the Commission, but shall not be a member of the Commission. The executive director shall hire and supervise such other staff as may be authorized by the Commission.

3. Legislative and advisory committees.

A. A legislative committee comprised of state legislators or their designees shall be established to monitor the operations of, and make recommendations to, the Commission, including the management committee; provided that the manner of selection and term of any legislative committee member shall be as set forth in the bylaws. Prior to the adoption by the Commission of any uniform standard, revision of the bylaws, annual budget, or other significant matter as may be provided in the bylaws, the management committee shall consult with and report to the legislative committee.

B. The Commission shall establish two advisory committees, one of which shall be comprised of consumer representatives independent of the insurance industry and the other comprised of insurance industry representatives.

C. The Commission may establish additional advisory committees as its bylaws may provide for the carrying out of its functions.

4. Corporate records of the Commission.

The Commission shall maintain its corporate books and records in accordance with the bylaws.

5. Qualified immunity, defense, and indemnification.

A. The members, officers, executive director, employees, and representatives of the Commission shall be immune from suit and liability, either personally or in their official capacity, for any claim for damage to or loss of property or personal injury or other civil liability caused by or arising out of any actual or alleged act, error, or omission that occurred, or that the person against whom the claim is made had a reasonable basis for believing occurred, within the scope of Commission employment, duties, or responsibilities; provided, that nothing in this paragraph shall be construed to protect any such person from suit and/or liability for any damage, loss, injury, or liability caused by the intentional or willful and wanton misconduct of that person.

B. The Commission shall defend any member, officer, executive director, employee, or representative of the Commission in any civil action seeking to impose liability arising out of any actual or alleged act, error, or omission that occurred within the scope of Commission employment, duties, or responsibilities, or that the person against whom the claim is made had a reasonable basis for believing occurred within the scope of Commission employment, duties, or responsibilities; provided, that nothing herein shall be construed to prohibit that person from retaining the person's own counsel; and provided further, that the actual or alleged act, error, or omission did not result from that person's intentional or willful and wanton misconduct.

C. The Commission shall indemnify and hold harmless any member, officer, executive director, employee, or representative of the Commission for the amount of any settlement or judgment obtained against that person arising out of any actual or alleged act, error, or omission that occurred within the scope of Commission employment, duties, or responsibilities, or that such person had a reasonable basis for believing occurred within the scope of Commission employment, duties, or responsibilities; provided, that the actual or alleged act, error, or omission did not result from the intentional or willful and wanton misconduct of that person.

Article VI. Meetings and Acts of the Commission.

1. The Commission shall meet and take such actions as are consistent with the provisions of the Compact and the bylaws.

2. Each member of the Commission shall have the right and power to cast a vote to which that compacting state is entitled and to participate in the business and affairs of the Commission. A member shall vote in person or by such other means as provided in the bylaws. The bylaws may provide for members' participation in meetings by telephone or other means of communication.

3. The Commission shall meet at least once during each calendar year. Additional meetings shall be held as set forth in the bylaws.

Article VII. Rules and Operating Procedures, Rule Making Functions of the Commission, and Opting Out of Uniform Standards.

1. Rule making authority. The Commission shall promulgate reasonable rules, including uniform standards, and operating procedures in order to effectively and efficiently achieve the purposes of this Compact. Notwithstanding the foregoing, in the event the Commission exercises its rule making authority in a manner that is beyond the scope of the purposes of this Compact, or the powers granted under this Compact, then such an action by the Commission shall be invalid and have no force and effect.

2. Rule making procedure. Rules and operating procedures shall be made pursuant to a rule making process that conforms to the Model State Administrative Procedure Act of 1981, as amended, as may be appropriate to the operations of the Commission. Before the Commission adopts a uniform standard, the Commission shall give written notice to the relevant state legislative committees in each compacting state responsible for insurance issues of its intention to adopt the uniform standard. The Commission, in adopting a uniform standard, shall consider fully all submitted materials and issue a concise explanation of its decision.

3. Effective date and opt out of a uniform standard. A uniform standard shall become effective 90 days after its promulgation by the Commission or such later date as the Commission may determine; provided, however, that a compacting state may opt out of a uniform standard as provided in this article. "Opt out" shall be defined as any action by a compacting state to decline to adopt or participate in a promulgated uniform standard. All other rules and operating procedures, and amendments thereto, shall become effective as of the date specified in each rule, operating procedure, or amendment.

4. Opt out procedure. A compacting state may opt out of a uniform standard, either by legislation or regulation duly promulgated by the insurance department under the compacting state's administrative procedure act or duly promulgated pursuant to the compacting state's law. If a compacting state elects to opt out of a uniform standard by regulation, it must: (i) give written notice to the Commission no later than 10 business days after the uniform standard is

promulgated, or at a time the state becomes a compacting state; and (ii) find that the uniform standard does not provide reasonable protections to the citizens of the state, given the conditions in the state. The commissioner shall make specific findings of fact and conclusions of law, based on a preponderance of the evidence, detailing the conditions in the state which warrant a departure from the uniform standard and determining that the uniform standard would not reasonably protect the citizens of the state. The commissioner must consider and balance the following factors and find that the conditions in the state and needs of the citizens of the state outweigh: (i) the intent of the legislature to participate in, and the benefits of, an interstate agreement to establish national uniform consumer protections for the products subject to this Compact; and (ii) the presumption that a uniform standard adopted by the Commission provides reasonable protections to consumers of the relevant product.

Notwithstanding the foregoing, a compacting state may, at the time of its enactment of this Compact, prospectively opt out of all uniform standards involving long-term care insurance products by expressly providing for such opt out in the enacted Compact, and such an opt out shall not be treated as a material variance in the offer or acceptance of any state to participate in this Compact. Such an opt out shall be effective at the time of enactment of this Compact by the compacting state and shall apply to all existing uniform standards involving long-term care insurance products and those subsequently promulgated.

5. Effect of opt out. If a compacting state elects to opt out of a uniform standard, the uniform standard shall remain applicable in the compacting state electing to opt out until such time as the opt out legislation is enacted into law or the regulation opting out becomes effective.

Once the opt out of a uniform standard by a compacting state becomes effective as provided under the laws of that state, the uniform standard shall have no further force and effect in that state unless and until the legislation or regulation implementing the opt out is repealed or otherwise becomes ineffective under the laws of the state. If a compacting state opts out of a uniform standard after the uniform standard has been made effective in that state, the opt out shall have the same prospective effect as provided under Article XIV for withdrawals.

6. Stay of uniform standard. If a compacting state has formally initiated the process of opting out of a uniform standard by regulation, and while the regulatory opt out is pending, the compacting state may petition the Commission, at least 15 days before the effective date of the uniform standard, to stay the effectiveness of the uniform standard in that state. The Commission may grant a stay if it determines the regulatory opt out is being pursued in a reasonable manner and there is a likelihood of success. If a stay is granted or extended by the Commission, the stay or extension thereof may postpone the effective date by up to 90 days, unless affirmatively extended by the Commission; provided, that a stay may not be

permitted to remain in effect for more than 1 year unless the compacting state can show extraordinary circumstances which warrant a continuance of the stay, including the existence of a legal challenge which prevents the compacting state from opting out. A stay may be terminated by the Commission on notice that the rule making process has been terminated.

7. Not later than 30 days after a rule or operating procedure is promulgated, any person may file a petition for judicial review of the rule or operating procedure; provided, that the filing of such a petition shall not stay or otherwise prevent the rule or operating procedure from becoming effective unless the court finds that the petitioner has a substantial likelihood of success. The court shall give deference to the actions of the Commission consistent with applicable law and shall not find the rule or operating procedure to be unlawful if the rule or operating procedure represents a reasonable exercise of the Commission's authority.

Article VIII. Commission Records and Enforcement.

1. The Commission shall promulgate rules establishing conditions and procedures for public inspection and copying of its information and official records, except such information and records involving the privacy of individuals and insurers' trade secrets. The Commission may promulgate additional rules under which it may make available to federal and state agencies, including law-enforcement agencies, records and information otherwise exempt from disclosure, and may enter into agreements with such agencies to receive or exchange information or records subject to nondisclosure and confidentiality provisions.

2. Except as to privileged records, data, and information, the laws of any compacting state pertaining to confidentiality or nondisclosure shall not relieve any compacting state commissioner of the duty to disclose any relevant records, data, or information to the Commission; provided, that disclosure to the Commission shall not be deemed to waive or otherwise affect any confidentiality requirement; and further provided, that, except as otherwise expressly provided in this Compact, the Commission shall not be subject to the compacting state's laws pertaining to confidentiality and nondisclosure with respect to records, data, and information in its possession. Confidential information of the Commission shall remain confidential after such information is provided to any commissioner.

3. The Commission shall monitor compacting states for compliance with duly adopted bylaws, rules, including uniform standards, and operating procedures. The Commission shall notify any noncomplying compacting state in writing of its noncompliance with Commission bylaws, rules, or operating procedures. If a noncomplying compacting state fails to remedy its noncompliance within the time specified in the notice of noncompliance, the compacting state shall be deemed to be in default as set forth in Article XIV.

4. The commissioner of any state in which an insurer is authorized to do business, or is conducting the business of insurance, shall continue to exercise the commissioner's authority to oversee the market regulation of the activities of the insurer in accordance with the provisions of the state's law. The commissioner's enforcement of compliance with the Compact is governed by the following provisions:

A. With respect to the commissioner's market regulation of a product or advertisement that is approved by or certified to the Commission, the content of the product or advertisement shall not constitute a violation of the provisions, standards, or requirements of the Compact except on a final order of the Commission, issued at the request of a commissioner after prior notice to the insurer and an opportunity for a hearing before the Commission.

B. Before a commissioner may bring an action for violation of any provision, standard, or requirement of the Compact relating to the content of an advertisement not approved by or certified to the Commission, the Commission, or an authorized Commission officer or employee, must authorize the action. However, authorization pursuant to this paragraph does not require notice to the insurer, opportunity for a hearing, disclosure of requests for authorization, or disclosure of records of the Commission's action on such requests.

Article IX. Dispute Resolution.

The Commission shall attempt, on the request of a member, to resolve any disputes or other issues that are subject to this Compact and which may arise between two or more compacting states, or between compacting states and non-compacting states, and the Commission shall promulgate an operating procedure providing for resolution of such disputes.

Article X. Product Filing and Approval.

1. Insurers and third-party filers seeking to have a product approved by the Commission shall file the product with, and pay applicable filing fees to, the Commission. Nothing in this Compact shall be construed to restrict or otherwise prevent an insurer from filing its product with the insurance department in any state in which the insurer is licensed to conduct the business of insurance, and such filing shall be subject to the laws of the states where filed.

2. The Commission shall establish appropriate filing and review processes and procedures pursuant to Commission rules and operating procedures. Notwithstanding any provision herein to the contrary, the Commission shall promulgate rules to establish conditions and procedures under which the Commission will provide public access to product filing information. In establishing such rules,

the Commission shall consider the interests of the public in having access to such information, as well as the protection of personal medical and financial information and trade secrets that may be contained in a product filing or supporting information.

3. Any product approved by the Commission may be sold or otherwise issued in those compacting states for which the insurer is legally authorized to do business.

Article XI. Review of Commission Decisions Regarding Filings.

1. Not later than 30 days after the Commission has given notice of a disapproved product or advertisement filed with the Commission, the insurer or third-party filer whose filing was disapproved may appeal the determination to a review panel appointed by the Commission. The Commission shall promulgate rules to establish procedures for appointing such review panels and provide for notice and a hearing. An allegation that the Commission, in disapproving a product or advertisement filed with the Commission, acted arbitrarily, capriciously, or in a manner that is an abuse of discretion or otherwise not in accordance with the law, is subject to judicial review in accordance with Article III, Section 4.

2. The Commission shall have authority to monitor, review, and reconsider products and advertisement subsequent to their filing or approval on a finding that the product does not meet the relevant uniform standard. Where appropriate, the Commission may withdraw or modify its approval after proper notice and hearing, subject to the appeal process in Section 1 of this article.

Article XII. Finance.

1. The Commission shall pay or provide for the payment of the reasonable expenses of its establishment and organization. To fund the cost of its initial operations, the Commission may accept contributions and other forms of funding from the National Association of Insurance Commissioners, compacting states, and other sources. Contributions and other forms of funding from other sources shall be of such a nature that the independence of the Commission concerning the performance of its duties shall not be compromised.

2. The Commission shall collect a filing fee from each insurer and third-party filer filing a product with the Commission to cover the cost of the operations and activities of the Commission and its staff in a total amount sufficient to cover the Commission's annual budget.

3. The Commission's budget for a fiscal year shall not be approved until it has been subject to notice and comment as set forth in Article VII of this Compact.

4. The Commission shall be exempt from all taxation in and by the compacting states.

5. The Commission shall not pledge the credit of any compacting state, except by and with the appropriate legal authority of that compacting state.

6. The Commission shall keep complete and accurate accounts of all its internal receipts, including grants and donations, and disbursements of all funds under its control. The internal financial accounts of the Commission shall be subject to the accounting procedures established under its bylaws. The financial accounts and reports, including the system of internal controls and procedures of the Commission, shall be audited annually by an independent certified public accountant. On the determination of the Commission, but no less frequently than every 3 years, the review of the independent auditor shall include a management and performance audit of the Commission. The Commission shall make an annual report to the governor and legislature of the compacting states, which shall include a report of the independent audit. The Commission's internal accounts shall not be confidential and such materials may be shared with the commissioner of any compacting state on request; provided, however, that any work papers related to any internal or independent audit and any information regarding the privacy of individuals and insurers' proprietary information, including trade secrets, shall remain confidential.

7. No compacting state shall have any claim to or ownership of any property held by or vested in the Commission or to any Commission funds held pursuant to the provisions of this Compact.

Article XIII. Compacting States, Effective Date, and Amendment.

1. Any state is eligible to become a compacting state.

2. The Compact shall become effective and binding on legislative enactment of the Compact into law by two compacting states; provided, that the Commission shall become effective for purposes of adopting uniform standards for, reviewing, and giving approval or disapproval of, products filed with the Commission that satisfy applicable uniform standards only after 26 states are compacting states; or, alternatively, by states representing greater than 40 percent of the premium volume for life insurance, annuity, disability income, and long-term care insurance products, based on records of the NAIC for the prior year. Thereafter, it shall become effective and binding as to any other compacting state on enactment of the Compact into law by that state.

3. Amendments to the Compact may be proposed by the Commission for enactment by the compacting states. No amendment shall become effective and

binding on the Commission and the compacting states unless and until all compacting states enact the amendment into law.

Article XIV. Withdrawal, Default, and Termination.

1. Withdrawal.

A. Once effective, the Compact shall continue in force and remain binding on each and every compacting state; provided, that a compacting state may withdraw from the Compact (withdrawing state) by enacting a statute specifically repealing the statute which enacted the Compact into law.

B. The effective date of withdrawal is the effective date of the repealing statute. However, the withdrawal shall not apply to any product filings approved or self-certified, or any advertisement of such products, on the date the repealing statute becomes effective, except by mutual agreement of the Commission and the withdrawing state unless the approval is rescinded by the withdrawing state as provided in subsection E of this section.

C. The commissioner of the withdrawing state immediately shall notify the management committee in writing on the introduction of legislation repealing this Compact in the withdrawing state.

D. The Commission shall notify the other compacting states of the introduction of such legislation within 10 days after its receipt of notice thereof.

E. The withdrawing state is responsible for all obligations, duties, and liabilities incurred through the effective date of withdrawal, including any obligations, the performance of which extend beyond the effective date of withdrawal, except to the extent those obligations may have been released or relinquished by mutual agreement of the Commission and the withdrawing state. The Commission's approval of products and advertisement prior to the effective date of withdrawal shall continue to be effective and be given full force and effect in the withdrawing state, unless formally rescinded by the withdrawing state in the same manner as provided by the laws of the withdrawing state for the prospective disapproval of products or advertisement previously approved under state law.

F. Reinstatement following withdrawal of any compacting state shall occur on the effective date of the withdrawing state reenacting the Compact.

2. Default.

A. If the Commission determines that any compacting state has at any time defaulted (defaulting state) in the performance of any of its obligations or

responsibilities under the Compact, the bylaws, or duly promulgated rules or operating procedures, then, after notice and a hearing as set forth in the bylaws, all rights, privileges, and benefits conferred by this Compact on the defaulting state shall be suspended from the effective date of default as fixed by the Commission. The grounds for default include the failure of a compacting state to perform its obligations or responsibilities and any other grounds designated in Commission rules. The Commission immediately shall notify the defaulting state in writing of the defaulting state's suspension pending a cure of the default. The Commission shall stipulate the conditions and the time period within which the defaulting state must cure its default. If the defaulting state fails to cure the default within the time period specified by the Commission, the defaulting state shall be terminated from the Compact and all rights, privileges, and benefits conferred by this Compact shall be terminated from the effective date of termination.

B. Product approvals by the Commission or product self-certifications, or any advertisement in connection with such product, that are in force on the effective date of termination shall remain in force in the defaulting state in the same manner as if the defaulting state had withdrawn voluntarily pursuant to Section 1 of this article.

C. Reinstatement following termination of any compacting state requires a reenactment of the Compact.

3. Dissolution of Compact.

A. The Compact dissolves effective on the date of the withdrawal or default of the compacting state which reduces membership in the Compact to one compacting state.

B. On the dissolution of this Compact, the Compact becomes null and void and shall be of no further force or effect, and the business and affairs of the Commission shall be wound up and any surplus funds shall be distributed in accordance with the bylaws.

Article XV. Severability and Construction.

1. The provisions of this Compact shall be severable, and if any phrase, clause, sentence, or provision is deemed unenforceable, the remaining provisions of the Compact shall be enforceable.

2. The provisions of this Compact shall be liberally construed to effectuate its purposes.

Article XVI. Other Laws and Binding Effect of Compact.

1. Other laws.

A. Nothing herein prevents the enforcement of any other law of a compacting state, except as provided in paragraph B of this section.

B. For any product approved by or certified to the Commission, the rules, uniform standards, and any other requirements of the Commission shall constitute the exclusive provisions applicable to the content, approval, and certification of such products. For an advertisement that is subject to the Commission's authority, any rule, uniform standard, or other requirement of the Commission which governs the content of the advertisement shall constitute the exclusive provision that a commissioner may apply to the content of the advertisement. Notwithstanding the foregoing, no action taken by the Commission shall abrogate or restrict: (i) the access of any person to state courts; (ii) remedies available under state law related to breach of contract, tort, or other laws not specifically directed to the content of the product; (iii) state law relating to the construction of insurance contracts; or (iv) the authority of the attorney general of the state, including maintaining any actions or proceedings, as authorized by law.

C. All insurance products filed with individual states shall be subject to the laws of those states.

2. Binding effect of Compact.

A. All lawful actions of the Commission, including all rules and operating procedures promulgated by the Commission, are binding on the compacting states.

B. All agreements between the Commission and the compacting states are binding in accordance with their terms.

C. On the request of a party to a conflict over the meaning or interpretation or Commission actions, and on a majority vote of the compacting states, the Commission may issue advisory opinions regarding the meaning or interpretation in dispute.

D. In the event any provision of this Compact exceeds the constitutional limits imposed on the legislature of any compacting state, the obligations, duties, powers, or jurisdiction sought to be conferred by that provision on the Commission shall be ineffective as to that compacting state, and those obligations, duties, powers, or jurisdiction shall remain in the compacting state and shall be exercised by the agency thereof to which those obligations, duties, powers, or jurisdiction are delegated by law in effect at the time this Compact becomes effective.

§29–102.

The Insurance Commissioner of the Maryland Insurance Administration is hereby appointed as the State of Maryland's representative to the Interstate Insurance Product Regulation Commission.

§30–101.

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

(b) "Reporting insurer" means an insurer that is a member of a holding company that has been designated by the holding company as responsible for submitting a report under § 30–102 of this title on behalf of the insurer and other insurers in the holding company.

(c) "Slave" means an individual:

(1) who had no freedom of action;

(2) whose person and services were wholly under the control of another;

(3) who was in a state of enforced compulsory service to another; and

(4) who could not legally leave enforced compulsory service to another on the individual's own initiative during the individual's lifetime before the end of the slavery era.

(d) "Slaveholder" means:

(1) an owner of a slave;

(2) an owner of a commercial enterprise that used the services of a slave;

(3) an owner of a vessel or other means of transporting slaves; or

(4) a person dealing in the purchase, sale, or financing of the business of slaves and slavery.

(e) "Slaveholder insurance policy" means a policy issued to or for the benefit of a slaveholder to insure the slaveholder against injury to a slave or the death of a slave.

(f) "Slavery era" means years prior to 1865.

§30–102.

(a) On or before October 1, 2011, an insurer authorized to do business in the State shall provide the Commissioner with:

(1) a report of information in the records of the insurer about each slaveholder insurance policy issued in the State by the insurer, or any predecessor of the insurer, during the slavery era; and

(2) a copy of each document in the insurer's records that relates to the information provided under item (1) of this subsection.

(b) A holding company may designate one insurer in the holding company to be a reporting insurer on behalf of the member insurers of the holding company.

(c) On or before January 1, 2010, the Commissioner shall adopt regulations that specify the form and content of the report required under this section.

§30–103.

(a) (1) On or before April 1, 2012, the Commissioner shall issue a report on the information provided to the Commissioner under § 30–102 of this title.

(2) The report required under this section shall:

(i) contain the names of any slaveholders or slaves provided under § 30–102 of this title; and

(ii) include a copy of each document provided to the Commissioner under § 30–102 of this title.

(b) (1) The report required under this section shall be made available to the public.

(2) The Commissioner shall make a copy of the report available on the Web site of the Administration.

(c) The Commissioner shall provide a copy of the report required under this section to the Governor and, in accordance with § 2–1257 of the State Government Article, the General Assembly.

(d) A copy of the report shall be maintained at the Thurgood Marshall Law Library at the University of Maryland School of Law.

§31–101.

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

(a–1) "Application counselor" means an individual who holds an Individual Exchange application counselor certification issued under § 31–113(r) of this subtitle.

(a–2) "Application counselor sponsoring entity" or "sponsoring entity" means an entity designated by the Individual Exchange as a sponsoring entity under § 31–113(r) of this subtitle.

(b) "Board" means the Board of Trustees of the Exchange.

(b–1) "Captive producer" means an insurance producer who:

(1) is licensed in the State and authorized by the Commissioner to sell, solicit, or negotiate health insurance;

(2) receives an authorization and meets the other requirements set forth in § 31–113(n)(2) of this subtitle;

(3) has a current and exclusive appointment with a single carrier; and

(4) receives compensation as a captive producer only from that carrier.

(c) "Carrier" means:

(1) an insurer authorized to sell health insurance;

(2) a nonprofit health service plan;

(3) a health maintenance organization;

(4) a dental plan organization; or

(5) any other entity providing a plan of health insurance, health benefits, or health services authorized under this article or the Affordable Care Act.

(c–1) "Consolidated Services Center" or "CSC" means the consumer assistance call center established in accordance with the requirement to operate a toll–free hotline under § 1311(d)(4) of the Affordable Care Act and § 31–108(b)(5) of this subtitle.

(d) "Coverage level" means a level of coverage, as defined in § 1302 of the Affordable Care Act and as determined in regulations adopted by the Secretary, for a qualified health plan.

(e) (1) "Exchange" means the Maryland Health Benefit Exchange established as a public corporation under § 31–102 of this subtitle.

(2) "Exchange" includes:

(i) the Individual Exchange; and

(ii) the Small Business Health Options Program (SHOP Exchange).

(e–1) (1) "Full–time employee" means, with respect to a calendar month, an employee of a small employer who works, on average, at least 30 hours per week.

(2) "Full–time employee" does not include a seasonal employee as defined in federal law.

(f) "Fund" means the Maryland Health Benefit Exchange Fund established under § 31–107 of this subtitle.

(g) (1) "Health benefit plan" means a policy, contract, certificate, or agreement offered, issued, or delivered by a carrier to an individual or small employer in the State to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services.

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

(i) coverage only for accident or disability insurance or any combination of accident and disability insurance;

(ii) coverage issued as a supplement to liability insurance;

(iii) liability insurance, including general liability insurance and automobile liability insurance;

(iv) workers' compensation or similar insurance;

(v) automobile medical payment insurance;

(vi) credit–only insurance;

(vii) coverage for on–site medical clinics; or

(viii) other similar insurance coverage, specified in federal regulations issued pursuant to the federal Health Insurance Portability and Accountability Act, under which benefits for health care services are secondary or incidental to other insurance benefits.

(3) "Health benefit plan" does not include the following benefits if they are provided under a separate policy, certificate, or contract of insurance, or are otherwise not an integral part of the plan:

(i) limited scope dental or vision benefits;

(ii) benefits for long–term care, nursing home care, home health care, community–based care, or any combination of these benefits; or

(iii) such other similar limited benefits as are specified in federal regulations issued pursuant to the federal Health Insurance Portability and Accountability Act.

(4) "Health benefit plan" does not include the following benefits if the benefits are provided under a separate policy, certificate, or contract of insurance, there is no coordination between the provision of the benefits and any exclusion of benefits under any group health plan maintained by the same plan sponsor, and the benefits are paid with respect to an event without regard to whether the benefits are provided under any group health plan maintained by the same plan sponsor:

(i) coverage only for a specified disease or illness;

(ii) group hospital indemnity or other fixed indemnity insurance, if the benefits are payable in a fixed dollar amount per period of time, such as $100 per day of hospitalization, regardless of the amount of expenses incurred; or

(iii) individual hospital indemnity or other fixed indemnity insurance, if:

1. 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; and

2. 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.".

(5) "Health benefit plan" does not include the following if offered as a separate policy, certificate, or contract of insurance:

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

(ii) coverage supplemental to the coverage provided under Chapter 55 of Title 10, United States Code (Civilian Health and Medical Program of the Uniformed Services (CHAMPUS)); or

(iii) similar supplemental coverage provided to coverage under a group health plan if the coverage qualifies for the exception described in 45 C.F.R. § 146.145(b)(5)(i)(C).

(h) "Health literacy" means the degree to which an individual has the capacity to obtain, process, and understand health information and services in order to make an appropriate health decision.

(i) "Individual Exchange" means the division of the Exchange that serves the individual health insurance market.

(j) "Individual Exchange connector entity" means a community–based organization or other entity or a partnership of entities that:

(1) is authorized by the Individual Exchange under § 31–113(f) of this subtitle; and

(2) employs or engages Individual Exchange navigators to provide the services described in § 31–113(d)(1) of this subtitle.

(k) "Individual Exchange connector entity authorization" means a grant of authority from the Individual Exchange to an Individual Exchange connector entity under § 31–113(f) of this subtitle.

(l) "Individual Exchange navigator" means an individual who:

(1) holds an Individual Exchange navigator certification; and

(2) provides the services described in § 31–113(d)(1) of this subtitle for an Individual Exchange connector entity.

(m) "Individual Exchange navigator certification" means a certificate issued by the Individual Exchange that authorizes an individual to act as an Individual Exchange navigator.

(n) "Insurance producer authorization" means a permit issued by the SHOP Exchange or Individual Exchange to allow an insurance producer to sell qualified plans in the SHOP Exchange or Individual Exchange.

(o) "Managed care organization" has the meaning stated in § 15–101 of the Health – General Article.

(p) "Maryland Health Care Reform Coordinating Council" means the joint executive–legislative council established and expanded by Executive Orders 01.01.2010.07 and 01.01.2011.10.

(p–1) (1) "Minimum essential coverage" means:

(i) Medicare;

(ii) the Maryland Medical Assistance Program;

(iii) the Maryland Children's Health Insurance Program;

(iv) medical coverage under 10 U.S.C. §§ 1071 through 1110b;

(v) a health care program under 38 U.S.C. §§ 1701 through 1788 or 38 U.S.C. §§ 1802 through 1834, as determined by the Secretary of Veterans Affairs in coordination with the Secretary of Health and Human Services and the Secretary of the Treasury;

(vi) a health plan under 22 U.S.C. § 2504(e);

(vii) the Nonappropriated Fund Health Benefits Program of the Department of Defense, established under 10 U.S.C. § 1587;

(viii) coverage under an eligible employer–sponsored plan, as defined in 26 U.S.C. § 5000A;

(ix) coverage under a health plan offered in the individual market in the State;

(x) coverage under a grandfathered health plan; or

(xi) other coverage as the Exchange recognizes, consistent with policy goals of Subtitle 2 of this title.

(2) "Minimum essential coverage" does not include:

(i) health insurance coverage that consists of coverage of excepted benefits described in:

1. § 2791(c)(1) of the Public Health Service Act; or

2. § 2791(c)(2), (3), or (4) of the Public Health Service Act if the benefits are provided under a separate policy, certificate, or contract of insurance;

(ii) a short–term limited duration insurance;

(iii) an association health plan that fails to meet the requirements of the State small group market or, in the case of a plan purchased by sole proprietors, the State individual market; or

(iv) another form of coverage identified by the Exchange that:

1. does not meet the requirements of Title I of the Affordable Care Act; and

2. undermines the stability or increases average premiums in the individual or small group market.

(p–2) "Plan year" has the meaning stated in § 15–1201 of this article.

(q) "Qualified dental plan" means a dental plan certified by the Exchange that provides limited scope dental benefits, as described in § 31–108(b)(2) of this subtitle.

(r) "Qualified employer" means a small employer that elects to make its full–time employees and, at the option of the employer, some or all of its part–time employees eligible for one or more qualified health plans offered through the SHOP Exchange, provided that the employer:

(1) has its principal place of business in the State and elects to provide coverage through the SHOP Exchange to all of its eligible employees, wherever employed; or

(2) elects to provide coverage through the SHOP Exchange to all of its eligible employees who are principally employed in the State.

(s) "Qualified health plan" means a health benefit plan that has been certified by the Exchange to meet the criteria for certification described in § 1311(c) of the Affordable Care Act and § 31–115 of this subtitle.

(t) "Qualified individual" means an individual, including a minor, who at the time of enrollment:

(1) is seeking to enroll in a qualified health plan offered to individuals through the Exchange;

(2) resides in the State;

(3) is not incarcerated, other than incarceration pending disposition of charges; and

(4) is, and reasonably is expected to be for the entire period for which enrollment is sought, a citizen or national of the United States or an alien lawfully present in the United States.

(u) "Qualified plan" means a:

(1) qualified health plan;

(2) qualified dental plan; and

(3) qualified vision plan.

(u–1) "Qualified resident" means an individual, including a minor, regardless of immigration status, who at the time of enrollment:

(1) is seeking to enroll in a qualified plan offered to individuals through the Exchange;

(2) resides in the State;

(3) is not incarcerated, other than incarceration pending disposition of charges; and

(4) is not eligible for the federal premium tax credit, the Maryland Medical Assistance Program, Medicare, the Maryland Children's Health Plan, or employer–sponsored minimum essential coverage.

(v) "Qualified vision plan" means a vision plan certified by the Exchange that provides limited scope vision benefits, as described in § 31–108(b)(3) of this subtitle.

(w) "Secretary" means the Secretary of the federal Department of Health and Human Services.

(x) "SHOP Exchange" means the Small Business Health Options Program authorized under § 31–108(b)(13) of this subtitle.

(y) "SHOP Exchange navigator" means an individual engaged by the SHOP Exchange and authorized by the Commissioner to provide the services described in § 31–112(c)(1) of this subtitle.

(z) "SHOP Exchange navigator license" means a license issued by the Commissioner that authorizes an individual to carry out the functions set forth in § 31–112(c) of this subtitle in the SHOP Exchange.

(aa) (1) "Small employer" means an employer that, during the preceding calendar year, employed an average of not more than 50 employees.

(2) For purposes of this subsection:

(i) all persons treated as a single employer under § 414(b), (c), or (o) of the Internal Revenue Code shall be treated as a single employer;

(ii) an employer and any predecessor employer shall be treated as a single employer;

(iii) the number of employees of an employer shall be determined by adding:

1. the number of full–time employees; and

2. the number of full–time equivalent employees, which shall be calculated for a particular month by dividing the aggregate number of hours of service of employees who are not full–time employees for the month by 120;

(iv) if an employer was not in existence throughout the preceding calendar year, the determination of whether the employer is a small employer shall be based on the average number of employees that the employer is reasonably expected to employ on business days in the current calendar year;

(v) an employer that makes enrollment in qualified health plans available to its employees through the SHOP Exchange, and would cease to be a small employer by reason of an increase in the number of its employees, shall continue to be treated as a small employer for purposes of this subtitle as long as it continuously makes enrollment through the SHOP Exchange available to its employees; and

(vi) to the extent permitted by federal law, an entity that leases employees from a professional employer organization, coemployer, or other organization engaged in employee leasing and that otherwise meets the description in this section shall be treated as a small employer.

(bb) "State benchmark plan" means the health benefit plan designated by the State, under regulations adopted by the Secretary, to serve as the standard for the essential health benefits to be offered by:

(1) qualified health plans inside the Exchange;

(2) individual health benefit plans, except grandfathered health plans, as defined in § 1251 of the Affordable Care Act; and

(3) health benefit plans offered to small employers, except grandfathered health plans, as defined in § 1251 of the Affordable Care Act.

§31–102.

(a) There is a Maryland Health Benefit Exchange.

(b) (1) The Exchange is a body politic and corporate and is an instrumentality of the State.

(2) The Exchange is a public corporation and a unit of State government.

(3) The exercise by the Exchange of its authority under this subtitle is an essential governmental function.

(c) The purposes of the Exchange are to:

(1) reduce the number of uninsured in the State;

(2) facilitate the purchase and sale of qualified health plans in the individual market in the State by providing a transparent marketplace;

(3) assist qualified employers in the State in facilitating the enrollment of their employees in qualified health plans in the small group market in the State and in accessing small business tax credits;

(4) assist individuals in accessing public programs, premium tax credits, and cost–sharing reductions; and

(5) supplement the individual and small group insurance markets outside of the Exchange.

(d) Nothing in this subtitle, and no regulation adopted or other action taken by the Exchange under this subtitle, may be construed to:

(1) preempt or supersede:

(i) the authority of the Commissioner to regulate insurance business in the State; or

(ii) the requirements of the Affordable Care Act;

(2) authorize the Exchange to carry out any function not authorized by the Affordable Care Act; or

(3) authorize the Exchange to offer any products or services except qualified health plans, qualified dental plans, and qualified vision plans.

§31–103.

(a) The Exchange is subject to:

(1) the following provisions of the General Provisions Article:

(i) Title 3 (Open Meetings Act);

(ii) Title 4 (Public Information Act); and

(iii) Title 5 (Maryland Public Ethics Law);

(2) the following provisions of the State Finance and Procurement Article:

(i) Title 3.5, Subtitle 3 (Information Processing), to the extent that the Secretary of Information Technology determines that an information technology project of the Exchange is a major information technology development project;

(ii) Title 12, Subtitle 4 (Policies and Procedures for Exempt Units); and

(iii) Title 14, Subtitle 3 (Minority Business Participation);

(3) the following provisions of the State Government Article:

(i) Title 10, Subtitle 1 (Administrative Procedure Act – Regulations); and

(ii) Title 12 (Immunity and Liability); and

(4) Title 5, Subtitle 3 of the State Personnel and Pensions Article.

(b) The Exchange is not subject to:

(1) taxation by the State or local government;

(2) Title 3.5, Subtitle 3 (Information Processing) of the State Finance and Procurement Article, except to the extent determined by the Secretary of Information Technology under subsection (a)(2)(i) of this section;

(3) Division II of the State Finance and Procurement Article, except as provided in subsection (a)(2)(ii) and (iii) of this section;

(4) Title 10 of the State Government Article, except as provided in subsection (a)(3)(i) of this section;

(5) Division I of the State Personnel and Pensions Article, except as provided in subsection (a)(4) of this section and elsewhere in this title; or

(6) this article, except as provided in subsection (c) of this section and elsewhere in this subtitle.

(c) (1) Except as provided in paragraph (3) of this subsection, to the extent that the Exchange, acting on behalf of a carrier offering a qualified plan in the

Individual Exchange or the SHOP Exchange, is required by law or contract to collect premiums, conduct billing, send required notices, provide required disclosures, or take any other action normally taken by a carrier under this article, the carrier is not liable or subject to regulatory sanction by the Commissioner for the failure of the Exchange to comply with the law or contract in taking an action under this subsection.

(2) (i) Subject to subparagraph (ii) of this paragraph, the Commissioner shall regulate the Exchange in taking an action under this subsection.

(ii) If the Commissioner finds that the Exchange has failed to comply with the law or contract in taking an action under this subsection, the Commissioner:

1. may not impose a fine or an administrative penalty on the Exchange; and

2. may require the Exchange to:

A. make restitution, not to exceed the amount of actual economic damages sustained by the consumer, to a consumer who has sustained actual economic damages because of the failure of the Exchange to comply with the law or contract in taking an action; and

B. make restitution, not to exceed the amount of actual premium, premium subsidies, or cost–sharing subsidies the carrier did not receive, to a carrier that has authorized, provided, or paid for health care services without receiving premium, premium subsidies, or cost–sharing subsidies the carrier otherwise would have received but for the failure of the Exchange to comply with the law or contract in taking an action.

(3) (i) The Exchange and the carrier shall hold a consumer harmless from any adverse consequence that is:

1. related to the consumer's purchase of, or coverage under, a qualified plan; and

2. caused by the failure of the Exchange to comply with the law or contract in taking an action under this subsection.

(ii) Holding the consumer harmless shall include:

1. the extension of deadlines or other accommodations necessary to protect the consumer; and

2. the carrier's authorization of, provision of, or payment for health care services the carrier otherwise would be under an obligation to authorize, provide, or pay for except for the failure of the Exchange to comply with the law or contract in taking an action under this subsection.

(4) The Commissioner, in the Commissioner's role as a member of the Board, may not participate in any matter that involves the alleged failure of the Exchange to comply with the law or contract in taking an action under this subsection if, in the Commissioner's judgment, the Commissioner's participation might create a conflict of interest with respect to the Commissioner's regulatory authority over the Exchange's taking an action under this subsection.

(d) Except as provided in subsection (c) of this section, this section does not:

(1) affect the Commissioner's authority to regulate a carrier under this article; or

(2) limit the authority of the Commissioner to take action against any person with respect to any provision of this article.

§31–104.

(a) There is a Board of Trustees of the Exchange.

(b) The Board consists of the following members:

(1) the Secretary of Health;

(2) the Commissioner;

(3) the Executive Director of the Maryland Health Care Commission; and

(4) the following members appointed by the Governor, with the advice and consent of the Senate:

(i) three members who:

1. represent the interests of employers and individual consumers of products offered by the Exchange; and

2. may have public health research expertise; and

(ii) three members who have demonstrated knowledge and expertise in at least two of the following areas:

1. individual health care coverage;

2. small employer–sponsored health care coverage;

3. health benefit plan administration;

4. health care finance;

5. administration of public or private health care delivery systems;

6. purchasing and facilitating enrollment in health plan coverage, including demonstrated knowledge and expertise about the role of licensed health insurance producers and third–party administrators in connecting employers and individual consumers to health plan coverage; and

7. public health and public health research, including knowledge about the health needs and health disparities among the State's diverse communities.

(c) In making appointments of members under subsection (b)(4) of this section, the Governor shall assure that:

(1) the Board's composition reflects a diversity of expertise;

(2) the Board's composition reflects the gender, racial, and ethnic diversity of the State; and

(3) the geographic areas of the State are represented.

(d) (1) For purposes of this subsection, "affiliation" means:

(i) a financial interest, as defined in § 5–101 of the General Provisions Article;

(ii) a position of governance, including membership on a board of directors, regardless of compensation;

(iii) a relationship through which compensation, as defined in § 5–101 of the General Provisions Article, is received; or

(iv) a relationship for the provision of services as a regulated lobbyist, as defined in § 5–101 of the General Provisions Article.

(2) A member of the Board or of the staff of the Exchange, while serving on the Board or the staff, may not have an affiliation with:

(i) a carrier, an insurance producer, a third–party administrator, a managed care organization, or any other person contracting directly with the Exchange;

(ii) a trade association of carriers, insurance producers, third–party administrators, or managed care organizations; or

(iii) any other association of entities in a position to contract directly with the Exchange.

(e) (1) The term of a member appointed by the Governor is 4 years.

(2) The terms of members appointed by the Governor are staggered as required by the terms provided for members of the Board on June 1, 2011.

(3) At the end of a term, a member continues to serve until a successor is appointed and qualifies.

(4) A member who is appointed after a term has begun serves only for the rest of the term and until a successor is appointed and qualifies.

(f) An appointed member of the Board may not serve more than two consecutive full terms.

(g) The Governor shall designate a chair of the Board.

(h) (1) The Board shall determine the times, places, and frequency of its meetings.

(2) Five members of the Board constitute a quorum.

(3) Action by the Board requires the affirmative vote of at least five members.

(i) A member of the Board is entitled to reimbursement for expenses under the Standard State Travel Regulations, as provided in the State budget.

(j) A member shall:

(1) meet the requirements of this subtitle, the Affordable Care Act, and all applicable State and federal laws and regulations;

(2) serve the public interest of the individuals and qualified employers seeking health care coverage through the Exchange; and

(3) ensure the sound operation and fiscal solvency of the Exchange.

(k) A member of the Board shall perform the member's duties:

(1) in good faith;

(2) in the manner the member reasonably believes to be in the best interests of the Exchange; and

(3) without intentional or reckless disregard of the care an ordinarily prudent person in a like position would use under similar circumstances.

(l) A member of the Board who performs the member's duties in accordance with the standard provided in subsection (k) of this section may not be liable personally for actions taken as a member.

(m) A member of the Board may be removed for incompetence, misconduct, or failure to perform the duties of the position.

(n) (1) (i) A member of the Board shall be subject to the Maryland Public Ethics Law, Title 5, Subtitles 1 through 7 of the General Provisions Article.

(ii) In addition to the disclosure required under Title 5, Subtitle 6 of the General Provisions Article, a member of the Board shall disclose to the Board and to the public any relationship not addressed in the required financial disclosure that the member has with a carrier, insurance producer, third–party administrator, managed care organization, or other entity in an industry involved in matters likely to come before the Board.

(2) On all matters that come before the Board, the member shall:

(i) adhere strictly to the conflict of interest provisions under Title 5, Subtitle 5 of the General Provisions Article relating to restrictions on participation, employment, and financial interests; and

(ii) provide full disclosure to the Board and the public on:

1. any matter that gives rise to a potential conflict of interest; and

2. the manner in which the member will comply with the provisions of Title 5, Subtitle 5 of the General Provisions Article to avoid any conflict of interest or appearance of a conflict of interest.

§31–105.

(a) (1) With the approval of the Governor, the Board shall appoint an Executive Director of the Exchange.

(2) The Executive Director shall serve at the pleasure of the Board.

(3) The Board shall determine the appropriate compensation for the Executive Director.

(b) Under the direction of the Board, the Executive Director shall:

(1) be the chief administrative officer of the Exchange;

(2) direct, administer, and manage the operations of the Exchange; and

(3) perform all duties necessary to comply with and carry out the provisions of this subtitle, other State law and regulations, and the Affordable Care Act.

(c) (1) In accordance with the State budget, the Executive Director may employ and retain a staff for the Exchange.

(2) (i) The Executive Director may set the compensation of an Exchange employee in a position that:

1. is unique to the Exchange;

2. requires specific skills or experience to perform the duties of the position; and

3. does not require the employee to perform functions that are comparable to functions performed in other units of the Executive Branch of State government.

(ii) The Secretary of Budget and Management, in consultation with the Executive Director, shall determine the positions for which the Executive Director may set compensation under subparagraph (i) of this paragraph.

(3) Except as provided in paragraphs (4) and (5) of this subsection, or otherwise by law, the Executive Director's appointment, retention, and removal of staff of the Exchange are not subject to Division I of the State Personnel and Pensions Article.

(4) In hiring staff for functions that must be performed by State personnel under the Affordable Care Act or other applicable federal or State laws, the Executive Director's appointment, retention, and removal of staff shall be in accordance with Division I of the State Personnel and Pensions Article.

(5) In hiring staff for functions that have been and currently are performed by State personnel, the Executive Director's appointment, retention, and removal of staff shall be in accordance with Division I of the State Personnel and Pensions Article.

(6) Except as provided in paragraph (7) of this subsection, staff for all other positions necessary to carry out the purposes of this subtitle shall be positions in the executive service or management service, or special appointments of the skilled service or the professional service in the State Personnel Management System.

(7) The Executive Director may retain as independent contractors, and set compensation for, attorneys, financial consultants, and any other professionals or consultants necessary to carry out the planning, development, and operations of the Exchange and the provisions of this subtitle.

(d) The Executive Director shall determine the classification, grade, and compensation of those positions designated under subsection (c)(2) of this section:

(1) in consultation with the Secretary of Budget and Management;

(2) with the approval of the Board; and

(3) when possible, in accordance with the State pay plan.

(e) (1) With respect to staff of the Exchange designated under subsection (c)(2) of this section, the Executive Director shall submit to the Secretary of Budget and Management, at least 45 days before the effective date of the change, each change to the Exchange's salary plans that involves increases or decreases in salary ranges

other than those associated with routine reclassifications and promotions or general salary increases approved by the General Assembly.

(2) Reportable changes include:

(i) the creation or abolition of classes;

(ii) the regrading of classes from one established range to another; and

(iii) the creation of new pay schedules or ranges.

(3) The Secretary of Budget and Management shall:

(i) review the proposed change; and

(ii) at least 15 days before the effective date of the proposed change:

1. advise the Executive Director whether the change would have an adverse effect on comparable State jobs; and

2. if there would be an adverse effect, recommend an alternative change that would not have an adverse effect on comparable State jobs.

(4) Failure of the Secretary of Budget and Management to respond in a timely manner is deemed to be agreement with the change as submitted.

(f) Except as otherwise provided in this subtitle, an employee or independent contractor of the Exchange is not subject to any law, regulation, or executive order governing State compensation, including furloughs, pay cuts, or any other General Fund cost savings measure.

§31–106.

(a) Subject to any limitations under this subtitle or other applicable law, the Board shall have all powers necessary or convenient to carry out the functions authorized by the Affordable Care Act and consistent with the purposes of the Exchange.

(b) The enumeration of specific powers in this subtitle is not intended to restrict the Board's power to take any lawful action that the Board determines is necessary or convenient to carry out the functions authorized by the Affordable Care Act and consistent with the purposes of the Exchange.

(c) (1) In addition to the powers set forth elsewhere in this subtitle, the Board may:

(i) adopt and alter an official seal;

(ii) sue, be sued, plead, and be impleaded;

(iii) adopt bylaws, rules, and policies;

(iv) subject to paragraph (2) of this subsection, adopt regulations to carry out this subtitle:

1. in accordance with Title 10, Subtitle 1 of the State Government Article; and

2. without conflicting with or preventing application of regulations adopted by the Secretary under Title 1, Subtitle D of the Affordable Care Act;

(v) maintain an office at the place designated by the Board;

(vi) enter into any agreements or contracts and execute the instruments necessary or convenient to manage its own affairs and carry out the purposes of this subtitle;

(vii) apply for and receive grants, contracts, or other public or private funding; and

(viii) do all things necessary or convenient to carry out the powers granted by this subtitle.

(2) Unless waived by the chairs of the committees, at least 30 days before submitting any proposed regulation to the Maryland Register for publication, the Board shall submit the proposed regulation to the Senate Finance Committee and the House Health Committee.

(d) (1) To carry out the purposes of this subtitle or perform any of its functions under this subtitle, the Board may contract or enter into memoranda of understanding with eligible entities, including:

(i) the Maryland Medical Assistance Program;

(ii) the family investment unit of the Department of Human Services;

(iii) insurance producers and third party administrators registered in the State; and

(iv) any other entities that have experience in individual and small group public and private health insurance plans or facilitating enrollment in those plans.

(2) The operations of the Exchange are subject to the provisions of this subtitle whether the operations are performed directly by the Exchange or through an entity under a contract with the Exchange.

(3) The Board shall ensure that any entity under a contract with the Exchange complies with the provisions of this subtitle when performing services that are subject to this subtitle on behalf of the Exchange.

(e) (1) The Board may enter into information–sharing agreements with federal and state agencies, and other state health insurance exchanges, to carry out the provisions of this subtitle.

(2) An information–sharing agreement entered into under paragraph (1) of this subsection shall:

(i) include adequate protections with respect to the confidentiality of information; and

(ii) comply with all State and federal laws and regulations.

(f) (1) The Board, in accordance with Title 12, Subtitle 4 of the State Finance and Procurement Article, shall adopt written policies and procedures governing all procurements of the Exchange.

(2) To the fullest extent practicable, and in a manner that does not impair the Exchange's ability to carry out the purposes of this subtitle, the Board's procurement policies and procedures shall establish an open and transparent process that:

(i) promotes public confidence in the procurements of the Exchange;

(ii) ensures fair and equitable treatment of all persons and entities that participate in the procurement system of the Exchange;

(iii) fosters appropriate competition and provides safeguards for maintaining a procurement system of quality and integrity;

(iv) promotes increased economic efficiency and responsibility on the part of the Exchange;

(v) achieves the maximum benefit from the purchasing power of the Exchange; and

(vi) provides clarity and simplicity in the rules and procedures governing the procurements of the Exchange.

(g) (1) To carry out the purposes of this subtitle, the Board shall:

(i) create and consult with ad hoc advisory committees; and

(ii) appoint to the ad hoc advisory committees representatives of:

1. insurers or health maintenance organizations offering health benefit plans in the State;

2. nonprofit health service plans offering health benefit plans in the State;

3. licensed health insurance producers and advisers;

4. third–party administrators;

5. health care providers, including:

A. hospitals;

B. long–term care facilities;

C. mental health providers;

D. developmental disability providers;

E. substance abuse treatment providers;

F. Federally Qualified Health Centers;

G. physicians;

H. nurses;

I. experts in services and care coordination for criminal and juvenile justice populations;

J. licensed hospice providers; and

K. other health care professionals;

6. managed care organizations;

7. employers, including large, small, and minority–owned employers;

8. public employee unions, including public employee union members who are caseworkers in local departments of social services with direct knowledge of information technology systems used for Medicaid eligibility determination;

9. consumers, including individuals who:

A. reside in lower–income and racial or ethnic minority communities;

B. have chronic diseases or disabilities; or

C. belong to other hard–to–reach or special populations;

10. individuals with knowledge and expertise in advocacy for consumers described in item 9 of this item;

11. public health researchers and other academic experts with knowledge and background relevant to the functions and goals of the Exchange, including knowledge of the health needs and health disparities among the State's diverse communities; and

12. any other stakeholders identified by the Exchange as having knowledge or representing interests relevant to the functions and duties of the Exchange.

(2) In addition to the ad hoc advisory committees created under paragraph (1) of this subsection, the Board, on or before March 15, 2014, shall create a standing advisory committee that:

(i) consists of members who, to the extent practicable:

1. reflect the gender, racial, ethnic, and geographic diversity of the State;

2. constitute a diverse cross–section of stakeholders broadly representative of the individuals and entities described in paragraph (1)(ii) of this subsection; and

3. are appointed by the Board for a term of no more than 3 years in a manner that provides continuity and rotation;

(ii) has a liaison to the Board who is a member of the Board and is appointed by the chair of the Board; and

(iii) is charged with the responsibility of addressing the broad range of policy issues:

1. on which the Board may seek its input and advice; and

2. that may be proposed by the liaison to the Board, in consultation with the standing advisory committee chair and members.

§31–107. ** CONTINGENCY – IN EFFECT – CHAPTER 468 OF 2025 **

(a) There is a Maryland Health Benefit Exchange Fund.

(b) (1) The purpose of the Fund is to:

(i) provide funding for the operation and administration of the Exchange in carrying out the purposes of the Exchange under this subtitle;

(ii) provide funding for the establishment and operation of the State Reinsurance Program authorized under this subtitle;

(iii) provide funding for the Medical Assistance Program and the Senior Prescription Drug Assistance Program;

(iv) provide funding for the establishment and operation of Health Equity Resource Communities under Title 20, Subtitle 14 of the Health – General Article;

(v) provide funding for the establishment and operation of the State–Based Young Adult Health Insurance Subsidies Program authorized under this subtitle; and

(vi) provide funding for the establishment of State–based health insurance subsidies to mitigate the impact of a reduction in federal advance premium tax credits under 26 U.S.C. § 36B(b)(3)(A)(iii).

(2) The operation and administration of the Exchange, the State Reinsurance Program, the State–Based Young Adult Health Insurance Subsidies Program, and the Qualified Resident Enrollment Program may include functions delegated by the Exchange to a third party under law or by contract.

(c) The Exchange shall administer the Fund.

(d) (1) The Fund is a special, nonlapsing fund that is not subject to § 7–302 of the State Finance and Procurement Article.

(2) The State Treasurer shall hold the Fund separately, and the Comptroller shall account for the Fund.

(e) The Fund consists of:

(1) any user fees or other assessments collected by the Exchange;

(2) all revenue deposited into the Fund that is received from the distribution of the premium tax under § 6–103.2 of this article;

(3) income from investments made on behalf of the Fund;

(4) interest on deposits or investments of money in the Fund;

(5) money collected by the Board as a result of legal or other actions taken by the Board on behalf of the Exchange or the Fund;

(6) money donated to the Fund;

(7) money awarded to the Fund through grants;

(8) any pass–through funds received from the federal government under a waiver approved under § 1332 of the Affordable Care Act;

(9) any funds designated by the federal government to provide reinsurance to carriers that offer individual health benefit plans in the State;

(10) any funds designated by the State to provide reinsurance to carriers that offer individual health benefit plans in the State;

(11) any funds designated by the State to provide State–based health insurance subsidies to young adults in the State;

(12) any funds designated by the State to provide State–based health insurance subsidies to individuals in the State to mitigate the impact of a reduction in federal advance premium tax credits under 26 U.S.C. § 36B(b)(3)(A)(iii);

(13) any federal funds received in accordance with § 31–121 of this subtitle for the administration of small business tax credits; and

(14) any other money from any other source accepted for the benefit of the Fund.

(f) (1) The Fund may be used only:

(i) 1. for the operation and administration of the Exchange in carrying out the purposes authorized under this subtitle;

2. for the establishment and operation of the State Reinsurance Program; and

3. for appropriations to the Health Equity Resource Community Reserve Fund under § 20–1407 of the Health – General Article;

(ii) in fiscal years 2021 and 2022, for the Medical Assistance Program within the Medical Care Programs Administration of the Maryland Department of Health;

(iii) in fiscal year 2022, for the Senior Prescription Drug Assistance Program established under Title 15, Subtitle 10 of the Health – General Article;

(iv) for the establishment and operation of the State–Based Young Adult Health Insurance Subsidies Program; and

(v) in fiscal years 2026 through 2028, for the establishment of State–based health insurance subsidies to mitigate the impact of a reduction in federal advance premium tax credits under 26 U.S.C. § 36B(b)(3)(A)(iii).

(2) In each of fiscal years 2023 through 2025, the Governor shall:

(i) transfer $15,000,000 to the Health Equity Resource Community Reserve Fund; and

(ii) include the funds transferred in accordance with item (i) of this paragraph in the annual budget bill as an appropriation to the Health Equity Resource Community Reserve Fund under § 20–1407 of the Health – General Article.

(g) (1) The Board shall maintain separate accounts within the Fund for Exchange operations, for the State Reinsurance Program, and for the State–Based Young Adult Health Insurance Subsidies Program.

(2) Accounts within the Fund shall contain the money that is intended to support the purpose for which each account is designated.

(3) Funds received from the distribution of the premium tax under § 6–103.2 of this article shall be placed in the account for Exchange operations and may be used only for the purpose of funding the operation and administration of the Exchange.

(4) The following funds may be used only for the purposes of funding the State Reinsurance Program:

(i) any pass–through funds received from the federal government under a waiver approved under § 1332 of the Affordable Care Act to provide reinsurance to carriers that offer individual health benefit plans in the State;

(ii) any funds designated by the federal government to provide reinsurance to carriers that offer individual health benefit plans in the State; and

(iii) any funds designated by the State to provide reinsurance to carriers that offer individual health benefit plans in the State.

(5) Except as provided in subsection (f) of this section, funds received from the distribution of the assessment under § 6–102.1 of this article may be used only for purposes of funding the State Reinsurance Program and the State–Based Health Insurance Subsidies Program.

(h) (1) Expenditures from the Fund for the purposes authorized by this subtitle may be made only:

(i) with an appropriation from the Fund approved by the General Assembly in the State budget; or

(ii) by the budget amendment procedure provided for in Title 7, Subtitle 2 of the State Finance and Procurement Article.

(2) Notwithstanding § 7–304 of the State Finance and Procurement Article, if the amount of the distribution from the premium tax under § 6–103.2 of this article exceeds in any State fiscal year the actual expenditures incurred for the operation and administration of the Exchange, funds in the Exchange operations account from the premium tax that remain unspent at the end of the State fiscal year shall revert to the General Fund of the State.

(3) If operating expenses of the Exchange may be charged to either State or non–State fund sources, the non–State funds shall be charged before State funds are charged.

(i) (1) The State Treasurer shall invest the money of the Fund in the same manner as other State money may be invested.

(2) Any investment earnings of the Fund shall be credited to the Fund.

(3) Except as provided in subsection (h)(2) of this section, no part of the Fund may revert or be credited to the General Fund or any special fund of the State.

(j) A debt or an obligation of the Fund is not a debt of the State or a pledge of credit of the State.

§31–107. ** CONTINGENCY – NOT IN EFFECT – CHAPTER 468 OF 2025**

(a) There is a Maryland Health Benefit Exchange Fund.

(b) (1) The purpose of the Fund is to:

(i) provide funding for the operation and administration of the Exchange in carrying out the purposes of the Exchange under this subtitle;

(ii) provide funding for the establishment and operation of the State Reinsurance Program authorized under this subtitle;

(iii) provide funding for the Medical Assistance Program and the Senior Prescription Drug Assistance Program;

(iv) provide funding for the establishment and operation of Health Equity Resource Communities under Title 20, Subtitle 14 of the Health – General Article; and

(v) provide funding for the establishment and operation of the State–Based Young Adult Health Insurance Subsidies Program authorized under this subtitle.

(2) The operation and administration of the Exchange, the State Reinsurance Program, the State–Based Young Adult Health Insurance Subsidies Program, and the Qualified Resident Enrollment Program may include functions delegated by the Exchange to a third party under law or by contract.

(c) The Exchange shall administer the Fund.

(d) (1) The Fund is a special, nonlapsing fund that is not subject to § 7–302 of the State Finance and Procurement Article.

(2) The State Treasurer shall hold the Fund separately, and the Comptroller shall account for the Fund.

(e) The Fund consists of:

(1) any user fees or other assessments collected by the Exchange;

(2) all revenue deposited into the Fund that is received from the distribution of the premium tax under § 6–103.2 of this article;

(3) income from investments made on behalf of the Fund;

(4) interest on deposits or investments of money in the Fund;

(5) money collected by the Board as a result of legal or other actions taken by the Board on behalf of the Exchange or the Fund;

(6) money donated to the Fund;

(7) money awarded to the Fund through grants;

(8) any pass–through funds received from the federal government under a waiver approved under § 1332 of the Affordable Care Act;

(9) any funds designated by the federal government to provide reinsurance to carriers that offer individual health benefit plans in the State;

(10) any funds designated by the State to provide reinsurance to carriers that offer individual health benefit plans in the State;

(11) any funds designated by the State to provide State–based health insurance subsidies to young adults in the State;

(12) any federal funds received in accordance with § 31–121 of this subtitle for the administration of small business tax credits; and

(13) any other money from any other source accepted for the benefit of the Fund.

(f) (1) The Fund may be used only:

(i) 1. for the operation and administration of the Exchange in carrying out the purposes authorized under this subtitle;

2. for the establishment and operation of the State Reinsurance Program; and

3. for appropriations to the Health Equity Resource Community Reserve Fund under § 20–1407 of the Health – General Article;

(ii) in fiscal years 2021 and 2022, for the Medical Assistance Program within the Medical Care Programs Administration of the Maryland Department of Health;

(iii) in fiscal year 2022, for the Senior Prescription Drug Assistance Program established under Title 15, Subtitle 10 of the Health – General Article; and

(iv) for the establishment and operation of the State–Based Young Adult Health Insurance Subsidies Program.

(2) In each of fiscal years 2023 through 2025, the Governor shall:

(i) transfer $15,000,000 to the Health Equity Resource Community Reserve Fund; and

(ii) include the funds transferred in accordance with item (i) of this paragraph in the annual budget bill as an appropriation to the Health Equity Resource Community Reserve Fund under § 20–1407 of the Health – General Article.

(g) (1) The Board shall maintain separate accounts within the Fund for Exchange operations, for the State Reinsurance Program, and for the State–Based Young Adult Health Insurance Subsidies Program.

(2) Accounts within the Fund shall contain the money that is intended to support the purpose for which each account is designated.

(3) Funds received from the distribution of the premium tax under § 6–103.2 of this article shall be placed in the account for Exchange operations and may be used only for the purpose of funding the operation and administration of the Exchange.

(4) The following funds may be used only for the purposes of funding the State Reinsurance Program:

(i) any pass–through funds received from the federal government under a waiver approved under § 1332 of the Affordable Care Act to provide reinsurance to carriers that offer individual health benefit plans in the State;

(ii) any funds designated by the federal government to provide reinsurance to carriers that offer individual health benefit plans in the State;

(iii) any funds designated by the State to provide reinsurance to carriers that offer individual health benefit plans in the State; and

(iv) except as provided in subsection (f) of this section, funds received from the distribution of the assessment under § 6–102.1 of this article.

(h) (1) Expenditures from the Fund for the purposes authorized by this subtitle may be made only:

(i) with an appropriation from the Fund approved by the General Assembly in the State budget; or

(ii) by the budget amendment procedure provided for in Title 7, Subtitle 2 of the State Finance and Procurement Article.

(2) Notwithstanding § 7–304 of the State Finance and Procurement Article, if the amount of the distribution from the premium tax under § 6–103.2 of

this article exceeds in any State fiscal year the actual expenditures incurred for the operation and administration of the Exchange, funds in the Exchange operations account from the premium tax that remain unspent at the end of the State fiscal year shall revert to the General Fund of the State.

(3) If operating expenses of the Exchange may be charged to either State or non–State fund sources, the non–State funds shall be charged before State funds are charged.

(i) (1) The State Treasurer shall invest the money of the Fund in the same manner as other State money may be invested.

(2) Any investment earnings of the Fund shall be credited to the Fund.

(3) Except as provided in subsection (h)(2) of this section, no part of the Fund may revert or be credited to the General Fund or any special fund of the State.

(j) A debt or an obligation of the Fund is not a debt of the State or a pledge of credit of the State.

§31–107.1.

(a) The Board shall establish a trust account to hold premium payments accepted from qualified plan enrollees and small employers by the Exchange on behalf of a carrier under contract or other agreement.

(b) The trust account may be used only to hold a premium payment until the Exchange transmits the premium payment to the carrier on whose behalf the Exchange accepted the premium payment.

(c) The Exchange shall maintain separate records of account for each carrier on whose behalf it accepts premium payments.

(d) The payment of a premium by an enrollee or a small employer to the Exchange is deemed to be a payment to the carrier on whose behalf the Exchange accepted the premium payment.

§31–107.2.

(a) (1) For State fiscal year 2015 and for each State fiscal year thereafter, from the funds received from the distribution of the premium tax under §

6–103.2 of this article, the Governor shall provide an appropriation in the State budget adequate to fully fund the operations of the Exchange.

(2) (i) For State fiscal year 2015, the appropriation shall be no less than $10,000,000.

(ii) For State fiscal year 2021, the appropriation shall be $31,500,000.

(iii) For State fiscal year 2022 and each fiscal year thereafter, the appropriation shall be $32,000,000.

(b) Funds allocated from the premium tax under subsection (a) of this section to provide the appropriation to the Exchange may be used only for the purpose of funding the operation and administration of the Exchange.

(c) If, in any State fiscal year, the amount of the allocation from the premium tax is insufficient to meet the actual expenditures incurred for the operation and administration of the Exchange, the Governor may provide an additional appropriation by deficiency appropriation.

(d) Notwithstanding § 7–304 of the State Finance and Procurement Article, funds allocated to the Exchange under this section that remain unspent at the end of a fiscal year shall revert to the General Fund of the State.

§31–108.

(a) On or before January 1, 2014, the functions and operations of the Exchange shall include at a minimum all functions required by § 1311(d)(4) of the Affordable Care Act.

(b) In compliance with § 1311(d)(4) of the Affordable Care Act, the Exchange shall:

(1) make qualified plans available to qualified individuals, qualified residents, and qualified employers;

(2) allow a carrier to offer a qualified dental plan through the Exchange that provides limited scope dental benefits that meet the requirements of § 9832(c)(2)(A) of the Internal Revenue Code, either separately, in conjunction with, or as an endorsement to a qualified health plan, provided that the qualified health plan provides pediatric dental benefits that meet the requirements of § 1302(b)(1)(J) of the Affordable Care Act;

(3) allow a carrier to offer a qualified vision plan through the Exchange that provides limited scope vision benefits that meet the requirements of § 9832(c)(2)(A) of the Internal Revenue Code, either separately, in conjunction with, or as an endorsement to a qualified health plan, provided that the qualified health plan provides pediatric vision benefits that meet the requirements of § 1302(b)(1)(J) of the Affordable Care Act;

(4) consistent with the guidelines developed by the Secretary under § 1311(c) of the Affordable Care Act, implement procedures for the certification, recertification, and decertification of:

(i) health benefit plans as qualified health plans;

(ii) dental plans as qualified dental plans; and

(iii) vision plans as qualified vision plans;

(5) provide for the operation of a toll–free telephone hotline to respond to requests for assistance;

(6) provide for initial, annual, and special enrollment periods, in accordance with guidelines adopted by the Secretary under § 1311(c)(6) of the Affordable Care Act;

(7) maintain a website through which enrollees and prospective enrollees of qualified plans may obtain standardized comparative information on qualified health plans, qualified dental plans, and qualified vision plans;

(8) with respect to each qualified plan offered through the Exchange:

(i) assign a rating to each qualified plan in accordance with the criteria developed by the Secretary under § 1311(c)(3) of the Affordable Care Act and any additional criteria that may be applicable under the laws of the State and regulations adopted by the Exchange under this subtitle; and

(ii) determine each qualified health plan's coverage level in accordance with regulations adopted by the Secretary under § 1302(d)(2)(A) of the Affordable Care Act and any additional regulations adopted by the Exchange under this subtitle;

(9) (i) present qualified plan options offered by the Exchange in a standardized format, including the use of the uniform outline of coverage established under § 2715 of the federal Public Health Service Act; and

(ii) to the extent necessary, modify the standardized format to accommodate differences in qualified health plan, qualified dental plan, and qualified vision plan options;

(10) in accordance with § 1413 of the Affordable Care Act, provide information and make determinations regarding eligibility for the following programs:

(i) the Maryland Medical Assistance Program under Title XIX of the Social Security Act;

(ii) the Maryland Children's Health Program under Title XXI of the Social Security Act; and

(iii) any applicable State or local public health insurance program;

(11) facilitate the enrollment of any individual who the Exchange determines is eligible for a program described in item (10) of this subsection;

(12) establish and make available by electronic means a calculator to determine the actual cost of coverage of a qualified plan offered by the Exchange after application of any premium tax credit under § 36B of the Internal Revenue Code and any cost–sharing reduction under § 1402 of the Affordable Care Act;

(13) in accordance with this subtitle, establish a SHOP Exchange through which qualified employers may access coverage for their employees at specified coverage levels and meet standards for the federal qualified employer tax credit;

(14) implement a certification process for individuals exempt from the individual responsibility requirement and penalty under § 5000A of the Internal Revenue Code on the grounds that:

(i) no affordable qualified health plan that covers the individual is available through the Exchange or the individual's employer; or

(ii) the individual meets other requirements under the Affordable Care Act that make the individual eligible for the exemption;

(15) implement a process for transfer to the United States Secretary of the Treasury the name and taxpayer identification number of each individual who:

(i) is certified as exempt from the individual responsibility requirement;

(ii) is employed but determined eligible for the premium tax credit on the grounds that:

1. the individual's employer does not provide minimum essential coverage; or

2. the employer's coverage is determined to be unaffordable for the individual or does not provide the requisite minimum actuarial value;

(iii) notifies the Exchange under § 1411(b)(4) of the Affordable Care Act that the individual has changed employers; or

(iv) ceases coverage under a qualified health plan during the plan year, together with the date coverage ceased;

(16) provide notice to employers of employees who cease coverage under a qualified health plan during a plan year, together with the date coverage ceased;

(17) conduct processes required by the Secretary and the United States Secretary of the Treasury to determine eligibility for premium tax credits, reduced cost–sharing, and individual responsibility requirement exemptions;

(18) establish a Navigator Program in accordance with § 1311(i) of the Affordable Care Act and this subtitle;

(19) carry out a plan to provide appropriate assistance for consumers seeking to purchase products through the Exchange, including the implementation of:

(i) a navigator program for the SHOP Exchange and a navigator program for the Individual Exchange; and

(ii) the toll–free hotline required under item (5) of this subsection;

(20) carry out a public relations and advertising campaign to promote the Exchange;

(21) conduct outreach and education activities to increase health literacy and to educate consumers about the Exchange and insurance affordability programs that:

(i) include minority populations;

(ii) do not include clinical or individual health information related to a specific health condition; and

(iii) increase participation in the Exchange; and

(22) perform administrative, technological, operational, and reporting functions for Maryland Medical Assistance programs, as requested by the Maryland Department of Health and approved by the Board, to the extent that the performance of the functions aid in the efficient operations of the Exchange and the Maryland Medical Assistance programs.

(c) (1) In carrying out the functions under subsections (a) and (b) of this section, the Exchange shall comply with § 508 of the federal Rehabilitation Act of 1973 and any regulations adopted under § 508 of the Act.

(2) The obligation for the Exchange to comply with § 508 of the federal Rehabilitation Act of 1973 does not affect any other requirements relating to accessibility for persons with disabilities to which the Exchange may be subject under the federal Americans with Disabilities Act of 1990.

(d) If an individual enrolls in another type of minimum essential coverage, neither the Exchange nor a carrier offering qualified health plans through the Exchange may charge the individual a fee or penalty for termination of coverage on the grounds that:

(1) the individual has become newly eligible for that coverage; or

(2) the individual's employer–sponsored coverage has become affordable under the standards of § 36B(c)(2)(C) of the Internal Revenue Code.

(e) The Exchange, through the advisory committees established under § 31–106(g) of this subtitle or through other means, shall consult with and consider the recommendations of the stakeholders represented on the advisory committees in the exercise of its duties under this subtitle.

(f) The Exchange may not make available:

(1) any health benefit plan that is not a qualified health plan;

(2) any dental plan that is not a qualified dental plan; or

(3) any vision plan that is not a qualified vision plan.

(g) The Exchange shall provide the advance directive information sheet developed under § 5–615 of the Health – General Article:

(1) in the Exchange's consumer publications;

(2) on the Exchange's website; and

(3) at the request of an applicant.

(h) (1) The Exchange shall open a special or other enrollment period for an individual who consents to share information through the system implemented in accordance with § 8–109(b)(1) of the Labor and Employment Article.

(2) The enrollment period opened under paragraph (1) of this subsection shall:

(i) apply to qualified health plans offered through the Exchange in the individual market;

(ii) begin on the date the Exchange sends notice to the individual;

(iii) last for a period of time determined by the Exchange and that is at least 30 days; and

(iv) be available to an individual described in paragraph (1) of this subsection and to the individual's dependent as defined in 45 C.F.R. § 155.420.

(3) The Exchange may conduct outreach to an individual described in paragraph (1) of this subsection using methods that include:

(i) written notices;

(ii) contact through telephonic and electronic means; and

(iii) the provision of individualized assistance by insurance agents and brokers, navigators, and Exchange contractors and staff.

§31–109.

(a) Subject to subsection (b) of this section, the Exchange may enter into agreements or memoranda of understanding with another state to:

(1) develop joint or reciprocal certification processes;

(2) develop consistency in qualified plans offered across states; and

(3) coordinate resources for administrative processes necessary to support:

(i) certification of qualified plans; and

(ii) other functions of the Exchange.

(b) Any interstate agreements or memoranda of understanding entered into under subsection (a) of this section shall comply with and advance:

(1) the purposes and requirements of this subtitle and the Affordable Care Act; and

(2) the policies and regulations adopted by the Exchange under this subtitle.

§31–110.

(a) In making qualified plans available to individuals and employers through contracts with carriers, the Exchange first shall seek to:

(1) achieve a robust and stable enrollment in the Exchange; and

(2) decrease the number of State residents without health insurance coverage.

(b) (1) Subject to subsection (e) of this section, the Exchange, with the market impact and leverage attained through a robust and stable enrollment, may use alternative contracting options and active purchasing strategies to increase affordability and quality of care for consumers and lower costs in the health care system overall.

(2) The Exchange's efforts to increase affordability and quality of care and to lower costs may include pursuing key objectives such as higher standards of care, continuity of care, delivery system reforms, health equity, improved patient experience and outcomes, and meaningful cost controls within the health care system.

(c) In employing contracting strategies to implement this section, the Exchange shall consider, on a continuing basis, the need to balance:

(1) the importance of sufficient enrollment and carrier participation to ensure the Exchange's success and long–term viability; and

(2) its progress in achieving the key objectives stated in subsection (b)(2) of this section.

(d) Beginning January 1, 2014, the Exchange:

(1) shall allow any qualified plans that meet the minimum standards established by the Exchange under this subtitle to be offered in the Exchange; and

(2) may exercise its authority under § 31–115(b)(9) of this subtitle to establish minimum standards for qualified plans in addition to those required by the Affordable Care Act.

(e) Subject to subsections (f) and (g) of this section, beginning January 1, 2016, in addition to establishing minimum standards for qualified plans, the Exchange may employ alternative contracting options and active purchasing strategies, including:

(1) competitive bidding;

(2) negotiation with carriers to achieve optimal participation and plan offerings in the Exchange; and

(3) partnering with carriers to promote choice and affordability for individuals and small employers among qualified plans offering high value, patient–centered, team–based care, value–based insurance design, and other high quality and affordable options.

(f) During any year in which the Exchange employs alternative contracting options and active purchasing strategies, the participation requirements set forth in §§ 15–1204.1(b) and 15–1303(b) of this article for carriers in the individual and small group markets outside the Exchange shall be suspended.

(g) Before employing an alternative contracting option or active purchasing strategy, the Exchange:

(1) on or after December 1, but not later than the first day of the next regular session of the General Assembly, shall submit to the Senate Finance

Committee and the House Health Committee, in accordance with § 2–1257 of the State Government Article, a plan for the use of the alternative contracting option or active purchasing strategy, including an analysis of:

(i) the objectives to be achieved through use of the alternative contracting option or active purchasing strategy; and

(ii) the impact on the insurance markets inside and outside the Exchange and on consumers; and

(2) shall allow the committees to have 90 days for review and comment.

§31–111.

(a) The SHOP Exchange:

(1) shall be a separate insurance market within the Exchange for small employers; and

(2) may not be merged with the individual market of the Individual Exchange.

(b) The SHOP Exchange shall be designed to balance:

(1) the viability of the SHOP Exchange as an alternative for qualified employers and their employees who have not been able historically to access and afford insurance in the small group market;

(2) the need for stability and predictability in employers' health insurance costs incurred on behalf of their employees;

(3) the desirability of providing employees with a meaningful choice among high–quality and affordable health benefit plans; and

(4) the need to facilitate continuity of care for employees who change employers or health benefit plans.

(c) The SHOP Exchange shall allow qualified employers to:

(1) as required by regulations adopted by the Secretary under the Affordable Care Act, designate a coverage level within which their employees may choose any qualified health plan; or

(2) designate a carrier or an insurance holding company system, as defined in § 7–101 of this article, and a menu of qualified health plans offered by the carrier or the insurance holding company system in the SHOP Exchange from which their employees may choose.

(d) In addition to the options set forth in subsection (c) of this section, the SHOP Exchange also may allow qualified employers to designate one or more qualified dental plans and qualified vision plans to be made available to their employees.

(e) (1) A qualified employer is not required to contribute to the qualified plan premiums of its employees.

(2) (i) If a qualified employer chooses to contribute to the qualified plan premiums of its employees, the qualified employer shall:

1. select a reference plan on which the contributions will be based; and

2. make a contribution that is:

A. a fixed percentage of the premium of the reference plan, based on the coverage level selected by the member and the member's job classification, if otherwise permissible; or

B. a dollar amount that ensures that all of the qualified employer's employees with the same coverage level and job classification would pay the same amount if they purchased the reference plan.

(ii) A reference plan selected under subparagraph (i)1 of this paragraph:

1. under the employer choice model, shall be a qualified plan that is:

A. offered by the carrier or insurance holding company system selected by the qualified employer; and

B. among the qualified plans of the carrier or insurance holding company system selected by the qualified employer; or

2. under the employee choice model, shall be a qualified plan offered by any carrier at the metal level selected by the qualified employer.

(f) On or after January 1, 2016, in order to continue to promote the SHOP Exchange's principles of accessibility, choice, affordability, and sustainability, and as it obtains more data on adverse selection, cost, enrollment, and other factors, the SHOP Exchange:

(1) may reassess and modify the manner in which the SHOP Exchange allows qualified employers to offer, and their employees to choose, qualified health plans and coverage levels;

(2) in reassessing employer and employee choice, may consider options which would promote the additional objective of increasing the portability of employees' health insurance as employees move from employer to employer or transition in and out of employment; and

(3) shall implement any modification of offerings and choice through regulations adopted by the SHOP Exchange.

§31–112.

(a) There is a navigator program for the SHOP Exchange.

(b) The navigator program for the SHOP Exchange shall focus outreach efforts and provide health insurance enrollment and eligibility services to small employers that do not offer health insurance to their employees.

(c) (1) To carry out its purpose and in compliance with the Affordable Care Act, the SHOP Exchange navigator program, with respect only to qualified plans offered in the SHOP Exchange, shall provide comprehensive consumer assistance services, including:

(i) conducting education and outreach to small employers;

(ii) distributing information about the SHOP Exchange, including information about:

1. options with respect to employer and employee choice;

2. procedures for enrolling in qualified plans; and

3. the availability of applicable tax credits;

(iii) facilitating:

1. qualified plan selection, based on the needs of the employee;

2. application processes;

3. enrollment;

4. renewals; and

5. disenrollment;

(iv) conducting eligibility determinations and redeterminations for tax credits;

(v) providing referrals to appropriate agencies, including the Attorney General's Health Education and Advocacy Unit and the Administration, for applicants and enrollees with grievances, complaints, or questions;

(vi) providing all information and services in a manner that is culturally and linguistically appropriate and ensures accessibility for individuals with disabilities; and

(vii) providing ongoing support with respect to the functions set forth in this section, including eligibility and enrollment and disenrollment in and renewal of qualified plans offered in the SHOP Exchange.

(2) A SHOP Exchange navigator:

(i) shall hold a SHOP Exchange navigator license issued under subsection (d) of this section;

(ii) may not be required to hold an insurance producer license;

(iii) shall be engaged by and receive compensation only through the SHOP Exchange;

(iv) may not receive compensation from or otherwise be affiliated with a carrier, an insurance producer, a third–party administrator, or any other person connected to the insurance industry; and

(v) shall complete and comply with any ongoing requirements of the training program established under subsection (h) of this section.

(3) With respect to the insurance market outside the Exchange, a SHOP Exchange navigator:

(i) may not provide any information or services related to health benefit plans or other products not offered in the Exchange, except for general information about the insurance market outside the Exchange, which shall be limited to the information provided in a consumer education document developed by the Exchange and the Commissioner;

(ii) shall refer any inquiries about health benefit plans or other products not offered in the Exchange to:

1. any resources that may be maintained by the Exchange; or

2. carriers and licensed insurance producers;

(iii) may not seek to replace any health benefit plan already offered by a small employer unless the small employer is eligible for a federal tax credit available only through the SHOP Exchange; and

(iv) shall refer to the Individual Exchange navigator program any inquiries about information or services related to:

1. qualified plans offered in the Individual Exchange; or

2. the Maryland Medical Assistance Program and the Maryland Children's Health Program.

(d) (1) The Commissioner shall issue a SHOP Exchange navigator license to each applicant who meets the requirements of this subsection.

(2) To qualify for a SHOP Exchange navigator license, an applicant:

(i) shall be of good character and trustworthy;

(ii) shall be at least 18 years old;

(iii) shall pass a written examination given by the Commissioner under this subsection; and

(iv) may not have committed any act that the Commissioner finds would warrant suspension or revocation of a license under subsection (e) of this section.

(3) The Commissioner shall adopt regulations that govern:

(i) the scope, type, conduct, frequency, and assessment of the written examination required for a license;

(ii) the experience required for an individual applicant to be eligible to take the written examination; and

(iii) the reinstatement of an expired license.

(e) (1) The Commissioner may deny, suspend, revoke, or refuse to renew or reinstate a SHOP Exchange navigator license after notice and opportunity for a hearing under §§ 2–210 through 2–214 of this article, if the licensee:

(i) has willfully violated this article or any regulation adopted under this article;

(ii) has intentionally misrepresented or concealed a material fact in the application for the license;

(iii) has obtained the license by misrepresentation, concealment, or other fraud;

(iv) has engaged in fraudulent or dishonest practices in conducting activities under the license;

(v) has misappropriated, converted, or unlawfully withheld money in conducting activities under the license;

(vi) has failed or refused to pay over on demand money that belongs to a person entitled to the money;

(vii) has willfully and materially misrepresented the provisions of a qualified plan;

(viii) has been convicted of a felony, a crime of moral turpitude, or any criminal offense involving dishonesty or breach of trust;

(ix) has failed an examination required by this article or regulations adopted under this article;

(x) has forged another's name on an application for a qualified plan or on any other document in conducting activities under the license;

(xi) has otherwise shown a lack of trustworthiness or competence to act as a SHOP Exchange navigator; or

(xii) has willfully failed to comply with or violated a proper order or subpoena of the Commissioner.

(2) Instead of or in addition to suspending or revoking a license, the Commissioner may:

(i) impose a penalty of not less than $100 but not exceeding $500 for each violation of this article; and

(ii) require that restitution be made to any person who has suffered financial injury because of a violation of this article.

(3) If the Commissioner suspends a SHOP Exchange navigator license, the Commissioner may require the individual to pass an examination and file a new application before the suspension is lifted.

(4) The penalties available to the Commissioner under this subsection shall be in addition to any criminal or civil penalties imposed for fraud or other misconduct under any other State or federal law.

(5) The Commissioner shall notify the SHOP Exchange of any decision affecting the license of a SHOP Exchange navigator or any sanction imposed on a SHOP Exchange navigator under this subsection.

(6) The Commissioner, in the Commissioner's role as a member of the Board, may not participate in any matter that involves the SHOP Exchange's navigator program if, in the Commissioner's judgment, the Commissioner's participation might create a conflict of interest with respect to the Commissioner's regulatory authority over the SHOP Exchange's navigator program.

(7) A carrier is not responsible for the activities and conduct of a SHOP Exchange navigator.

(f) (1) The SHOP Exchange shall establish and administer an insurance producer authorization program.

(2) Under the program, the SHOP Exchange shall:

(i) provide an authorization to sell qualified plans to a licensed insurance producer who meets the requirements in subsection (g) of this section; and

(ii) require renewal of an authorization every 2 years.

(3) (i) Subject to the contested case hearing provisions of Title 10, Subtitle 2 of the State Government Article, the SHOP Exchange may suspend, revoke, or refuse to renew an authorization for good cause, which shall include a finding that the insurance producer holding the authorization has committed any act described in subsection (e)(1) of this section with respect to the authorization.

(ii) The SHOP Exchange shall notify the Commissioner of any decision affecting the status of an insurance producer's authorization.

(4) The SHOP Exchange, in consultation with the Commissioner, shall adopt regulations to carry out this subsection.

(g) (1) Subject to the requirements in paragraph (2) of this subsection, an insurance producer who is licensed in the State and authorized by the Commissioner to sell, solicit, or negotiate health insurance may sell any qualified plan offered in the SHOP Exchange without being separately licensed as a SHOP Exchange navigator.

(2) To sell qualified plans in the SHOP Exchange, an insurance producer shall:

(i) register and apply for an authorization from the SHOP Exchange;

(ii) complete and comply with any ongoing requirements of the training program established under subsection (h) of this section; and

(iii) in providing assistance to a small employer seeking information about offering health insurance, inform the small employer of:

1. all qualified health plans available to employees in the SHOP Exchange; and

2. all options available to the small employer in the SHOP Exchange for offering qualified health plans to employees.

(3) An insurance producer:

(i) may not be compensated by the SHOP Exchange for the sale of a qualified plan offered in the SHOP Exchange; and

(ii) shall be compensated directly by a carrier.

(h) (1) The SHOP Exchange, with the approval of the Commissioner and in consultation with stakeholders, shall develop, implement, and, as appropriate, update training programs for:

(i) SHOP Exchange navigators;

(ii) licensed insurance producers who seek authorization to sell qualified plans in the SHOP Exchange; and

(iii) Consolidated Services Center employees required to hold a SHOP Exchange enrollment permit.

(2) The training programs shall:

(i) impart the skills and expertise necessary to perform functions specific to the SHOP Exchange, such as making tax credit eligibility determinations; and

(ii) enable the SHOP Exchange's navigator program and the Consolidated Services Center to provide robust protection of consumers and adherence to high quality assurance standards.

§31–113.

(a) (1) There is a navigator program for the Individual Exchange.

(2) The navigator program for the Individual Exchange shall be:

(i) administered by the Individual Exchange; and

(ii) regulated by the Commissioner.

(3) In administering the navigator program, the Individual Exchange shall consult with the Commissioner and the Maryland Department of Health to ensure consistency and compliance with all laws, regulations, and policies governing:

(i) the sale, solicitation, and negotiation of health insurance; and

(ii) the Maryland Medical Assistance Program and the Maryland Children's Health Program.

(4) In regulating the navigator program, the Commissioner shall enter into one or more memoranda of understanding with the Exchange and the Maryland Department of Health to facilitate enforcement of this section.

(5) The Commissioner may require the Individual Exchange to:

(i) make available to the Commissioner all records, documents, data, and other information relating to the navigator program, including the authorization of Individual Exchange connector entities and the certification of Individual Exchange navigators; and

(ii) submit a corrective plan to take appropriate action to address any problems or deficiencies identified by the Commissioner in the Individual Exchange connector entity authorization process or the Individual Exchange navigator certification process.

(6) The Commissioner, in the Commissioner's role as a member of the Board, may not participate in any matter that involves the Individual Exchange's navigator program if, in the Commissioner's judgment, the Commissioner's participation might create a conflict of interest with respect to the Commissioner's regulatory authority over the Individual Exchange's navigator program.

(b) The navigator program for the Individual Exchange shall:

(1) focus outreach efforts and services on individuals without health insurance coverage;

(2) use Individual Exchange connector entities that:

(i) have expertise in working with vulnerable and hard–to–reach populations; and

(ii) conduct outreach and provide enrollment support for these populations; and

(3) enable the Individual Exchange to:

(i) comply with the Affordable Care Act by providing seamless entry into the Maryland Medical Assistance Program, the Maryland Children's Health Program, and qualified plans;

(ii) assist individuals who, due to former incarceration or other circumstances, transition between the types of coverage described in item (i) of this item or have lapsed enrollment; and

(iii) meet consumer needs and demands for health insurance coverage while maintaining high standards of quality assurance and consumer protection.

(c) To carry out its purposes and in compliance with the Affordable Care Act, the Individual Exchange navigator program, with respect only to the Maryland Medical Assistance Program, the Maryland Children's Health Program, and qualified plans offered in the Exchange, shall provide comprehensive consumer assistance services, including:

(1) conducting education and outreach to individuals;

(2) distributing information about:

(i) the Individual Exchange, including eligibility requirements for applicable federal premium subsidies and cost–sharing assistance;

(ii) eligibility requirements for the Maryland Medical Assistance Program and the Maryland Children's Health Program; and

(iii) procedures for enrolling in the Maryland Medical Assistance Program, the Maryland Children's Health Program, or qualified plans offered in the Individual Exchange;

(3) with respect to qualified plans, facilitating:

(i) plan selection, based on the needs of the individual seeking to enroll;

(ii) assessment of tax implications and premium and cost–sharing requirements; and

(iii) application, enrollment, renewal, and disenrollment processes;

(4) facilitating eligibility determinations for the Maryland Medical Assistance Program and the Maryland Children's Health Program, selection of managed care organizations, and application, enrollment, and disenrollment processes;

(5) conducting eligibility determinations and redeterminations for premium subsidies and cost–sharing assistance;

(6) providing referrals to appropriate agencies, including the Attorney General's Health Education and Advocacy Unit and the Administration, for applicants and enrollees with grievances, complaints, questions, or the need for other social services;

(7) providing all information and services in a manner that is culturally and linguistically appropriate and ensures accessibility for individuals with disabilities; and

(8) providing ongoing support with respect to issues relating to eligibility, enrollment, renewal, and disenrollment in the Maryland Medical Assistance Program, the Maryland Children's Health Program, and qualified plans offered in the Individual Exchange.

(d) (1) The consumer assistance services described in subsection (c) of this section that must be provided by an Individual Exchange navigator are those services that involve the sale, solicitation, and negotiation of qualified plans offered in the Individual Exchange, including:

(i) examining or offering to examine a qualified plan for the purpose of giving, or offering to give, advice or information about the terms, conditions, benefits, coverage, or premium of a qualified plan;

(ii) facilitating:

1. qualified plan selection;

2. the application of premium tax subsidies to selected qualified health plans;

3. plan application, enrollment, renewal, and disenrollment processes; and

(iii) providing ongoing support with respect to issues relating to qualified plan enrollment, application of premium tax subsidies, renewal, and disenrollment.

(2) The consumer assistance services described in subsection (c) of this section that do not have to be provided by an Individual Exchange navigator are:

(i) conducting general education and outreach;

(ii) facilitating eligibility determinations and redeterminations for premium tax subsidies, the Maryland Medical Assistance Program, and the Maryland Children's Health Program; and

(iii) facilitating and providing ongoing support with respect to the selection of managed care organizations, application processes, enrollment, and disenrollment for the Maryland Medical Assistance Program and the Maryland Children's Health Program.

(e) (1) The Exchange may authorize an Individual Exchange connector entity to provide consumer assistance services that:

(i) are required to be provided by an Individual Exchange navigator; or

(ii) subject to paragraph (2)(iii) of this subsection, result in a consumer's enrollment in the Maryland Medical Assistance Program or the Maryland Children's Health Program.

(2) The Exchange:

(i) may limit the authorization of an Individual Exchange connector entity to the provision of a subset of services, depending on the needs of the Individual Exchange navigator program and the capacity of the Individual Exchange connector entity, provided that the navigator program overall provides the totality of services required by the Affordable Care Act and this subtitle;

(ii) pursuant to contractual agreement, may require an Individual Exchange connector entity to provide education, outreach, and other consumer assistance services in addition to the services provided under the Individual Exchange connector entity's authorization in order to achieve all of the objectives of the navigator program; and

(iii) may not authorize an Individual Exchange connector entity to provide services that result in a consumer's enrollment in the Maryland Medical Assistance Program or the Maryland Children's Health Program without the approval of the Maryland Department of Health.

(f) An Individual Exchange connector entity:

(1) shall obtain authorization from the Individual Exchange to provide services that:

(i) are required to be provided by an Individual Exchange navigator; or

(ii) result in a consumer's enrollment in the Maryland Medical Assistance Program or the Maryland Children's Health Program;

(2) may provide:

(i) those services that are within the scope of the Individual Exchange connector entity's authorization; and

(ii) any other consumer assistance services that:

1. are not required to be provided by an Individual Exchange navigator; or

2. do not require authorization under this subsection;

(3) to the extent the scope of its authorization includes services that must be provided by an Individual Exchange navigator, shall provide those services only through Individual Exchange navigators;

(4) in addition to the services it may provide under its authorization, may employ or engage other individuals to conduct:

(i) consumer education and outreach; and

(ii) determinations of eligibility for premium subsidies and cost–sharing assistance, the Maryland Medical Assistance Program, and the Maryland Children's Health Program;

(5) may employ or engage individuals to perform activities that:

(i) are executive, administrative, managerial, or clerical; and

(ii) relate only indirectly to services that must be provided by an Individual Exchange navigator or result in a consumer's enrollment in the Maryland Medical Assistance Program or the Maryland Children's Health Program;

(6) shall comply with all State and federal laws, regulations, and policies governing the Maryland Medical Assistance Program and the Maryland Children's Health Program;

(7) may not receive any compensation, directly or indirectly:

(i) from a carrier, an insurance producer, or a third–party administrator in connection with the enrollment of a qualified individual in a qualified health plan; or

(ii) from any managed care organization that participates in the Maryland Medical Assistance Program in connection with the enrollment of an individual in the Maryland Medical Assistance Program or the Maryland Children's Health Program; and

(8) with respect to the insurance market outside the Exchange:

(i) may not provide any information or services related to health benefit plans or other products not offered in the Exchange, except for general information about the insurance market outside the Exchange, which shall be limited to the information provided in a consumer education document developed by the Exchange and the Commissioner;

(ii) shall refer any inquiries about health benefit plans or other products not offered in the Exchange to:

1. any resources that may be maintained by the Exchange; or

2. carriers and licensed insurance producers; and

(iii) on contact with an individual who acknowledges having existing health insurance coverage obtained through an insurance producer, shall refer the individual back to the insurance producer for information and services unless:

1. the individual is eligible for but has not obtained a federal premium subsidy and cost–sharing assistance available only through the Individual Exchange;

2. the insurance producer is not authorized to sell qualified plans in the Individual Exchange; or

3. the individual would prefer not to seek further assistance from the individual's insurance producer.

(g) (1) The Commissioner may suspend or revoke an Individual Exchange connector entity authorization after notice and opportunity for a hearing

under §§ 2–210 through 2–214 of this article if the Individual Exchange connector entity:

(i) has willfully violated this article or any regulation adopted under this article;

(ii) has engaged in fraudulent or dishonest practices in conducting activities under the Individual Exchange connector entity authorization;

(iii) has had any professional license or certification suspended or revoked for a fraudulent or dishonest practice;

(iv) has been convicted of a felony, a crime of moral turpitude, or any criminal offense involving dishonesty or breach of trust; or

(v) has willfully failed to comply with or violated a proper order or subpoena of the Commissioner.

(2) Instead of or in addition to suspending or revoking an Individual Exchange connector entity authorization, the Commissioner may:

(i) impose a penalty of not less than $100 but not exceeding $500 for each violation of this article; and

(ii) require that restitution be made to any person who has suffered financial injury because of the Individual Exchange connector entity's violation of this article.

(3) The penalties available to the Commissioner under this subsection shall be in addition to any criminal or civil penalties imposed for fraud or other misconduct under any other State or federal law.

(4) The Commissioner shall notify the Individual Exchange of any decision affecting the authorization of an Individual Exchange connector entity or any sanction imposed on an Individual Exchange connector entity under this subsection.

(5) A carrier is not responsible for the activities and conduct of Individual Exchange connector entities.

(h) An Individual Exchange navigator:

(1) shall hold an Individual Exchange navigator certification issued under subsection (j) of this section;

(2) may provide consumer assistance services that are required to be provided by an Individual Exchange navigator under subsection (d)(1) of this section;

(3) may not be required to hold an insurance producer or adviser license;

(4) shall be employed or engaged by an Individual Exchange connector entity or by the Exchange;

(5) shall receive compensation only through the Individual Exchange or an Individual Exchange connector entity and not from a carrier or an insurance producer;

(6) may not receive any compensation, directly or indirectly:

(i) from a carrier, an insurance producer, or a third–party administrator in connection with the enrollment of a qualified individual in a qualified health plan; or

(ii) from a managed care organization that participates in the Maryland Medical Assistance Program in connection with the enrollment of an individual in the Maryland Medical Assistance Program or the Maryland Children's Health Program;

(7) with respect to the insurance market outside the Exchange, is subject to the same requirements applicable to Individual Exchange connector entities as set forth in subsection (f)(8) of this section; and

(8) shall comply with all State and federal laws, regulations, and policies governing the Maryland Medical Assistance Program and the Maryland Children's Health Program.

(i) The Exchange:

(1) shall establish and administer a process for Individual Exchange navigator certification and the issuance of Consolidated Services Center employee Individual Exchange enrollment permits;

(2) in consultation with the Commissioner and the Maryland Department of Health, shall adopt regulations to implement this subsection; and

(3) may implement the process for Individual Exchange navigator certification and the issuance of Consolidated Services Center employee Individual

Exchange enrollment permits with the assistance of the Commissioner and the Maryland Department of Health, in accordance with one or more memoranda of understanding.

(j) (1) The Exchange shall issue an Individual Exchange navigator certification to each applicant who meets the requirements of this subsection.

(2) To qualify for an Individual Exchange navigator certification, an applicant:

(i) shall be of good character and trustworthy;

(ii) shall be at least 18 years old;

(iii) shall complete, and comply with any ongoing requirements of, the training program established under subsection (k) of this section; and

(iv) shall comply with all applicable requirements of the Maryland Department of Health.

(3) A certification shall expire 2 years after the date it is issued unless it is renewed.

(k) (1) The Exchange, with the approval of the Commissioner and in consultation with the Maryland Department of Health, the Health Education and Advocacy Unit of the Office of the Attorney General, and stakeholders, shall develop, implement, and, as appropriate, update a training program for the certification of Individual Exchange navigators and the issuance of Individual Exchange enrollment permits for Consolidated Services Center employees.

(2) The training program shall:

(i) provide Individual Exchange navigators and Consolidated Services Center employees with the full range of skills, knowledge, and expertise necessary to meet the consumer assistance, eligibility, enrollment, renewal, and disenrollment needs of individuals:

1. eligible for the Maryland Medical Assistance Program and the Maryland Children's Health Program; or

2. seeking qualified plans offered in the Individual Exchange;

(ii) enable the navigator program for the Individual Exchange and the Exchange's Consolidated Services Center to provide robust protection of consumers and adherence to high quality assurance standards; and

(iii) enable the Individual Exchange to ensure that, with respect to Individual Exchange navigators and Consolidated Services Center employees who offer any form of assistance to individuals regarding the Maryland Medical Assistance Program or the Maryland Children's Health Program, the Individual Exchange navigator certification program and Consolidated Services Center shall comply with all requirements of the Maryland Department of Health.

(3) The Individual Exchange, in consultation with the Maryland Department of Health and with the approval of the Commissioner, shall adopt regulations that govern:

(i) the scope, type, conduct, frequency, and assessment of the training required for an Individual Exchange navigator certification;

(ii) the experience requirements, if any, for an individual applicant to be eligible to participate in the training program; and

(iii) the reinstatement of an expired Individual Exchange navigator certification or the reactivation of an inactive Individual Exchange navigator certification.

(l) (1) The Commissioner may suspend or revoke an Individual Exchange navigator certification after notice and opportunity for a hearing under §§ 2–210 through 2–214 of this article if the certified Individual Exchange navigator:

(i) has willfully violated this article or any regulation adopted under this article;

(ii) has intentionally misrepresented or concealed a material fact in the application for the Individual Exchange navigator certification;

(iii) has obtained the Individual Exchange navigator certification by misrepresentation, concealment, or other fraud;

(iv) has engaged in fraudulent or dishonest practices in conducting activities under the Individual Exchange navigator certification;

(v) has misappropriated, converted, or unlawfully withheld money in conducting activities under the Individual Exchange navigator certification;

(vi) has failed or refused to pay over on demand money that belongs to a person entitled to the money;

(vii) has willfully and materially misrepresented the provisions of a qualified plan;

(viii) has been convicted of a felony, a crime of moral turpitude, or any criminal offense involving dishonesty or breach of trust;

(ix) has failed an examination required by this article or regulations adopted under this article;

(x) has forged another's name on an application for a qualified plan or on any other document in conducting activities under the Individual Exchange navigator certification;

(xi) has otherwise shown a lack of trustworthiness or competence to act as an Individual Exchange navigator; or

(xii) has willfully failed to comply with or violated a proper order or subpoena of the Commissioner.

(2) Instead of or in addition to suspending or revoking a certification, the Commissioner may:

(i) impose a penalty of not less than $100 but not exceeding $500 for each violation of this article; and

(ii) require that restitution be made to any person who has suffered financial injury because of a violation of this article.

(3) The penalties available to the Commissioner under this subsection shall be in addition to any criminal or civil penalties imposed for fraud or other misconduct under any other State or federal law.

(4) The Commissioner shall notify the Individual Exchange and the Individual Exchange connector entity for which the Individual Exchange navigator works of any decision affecting the certification of an Individual Exchange navigator or any sanction imposed on an Individual Exchange navigator under this subsection.

(5) A carrier is not responsible for the activities and conduct of Individual Exchange navigators.

(m) (1) The Exchange shall establish and administer an insurance producer authorization process for the Individual Exchange.

(2) Under the process, the Exchange shall:

(i) provide an authorization to sell qualified plans to a licensed insurance producer who meets the requirements in subsection (n) of this section; and

(ii) require renewal of an authorization every 2 years.

(3) (i) Subject to the contested case hearing provisions of Title 10, Subtitle 2 of the State Government Article, the Exchange may suspend, revoke, or refuse to renew an authorization for good cause, which shall include a finding that the insurance producer holding the authorization has committed any act described in subsection (l)(1) of this section with respect to the authorization.

(ii) The Individual Exchange shall notify the Commissioner of any decision affecting the status of an insurance producer's authorization.

(4) The Individual Exchange, with the approval of the Commissioner, shall adopt regulations to carry out this subsection.

(n) (1) Subject to the requirements in paragraph (2) of this subsection, an insurance producer who is licensed in the State and authorized by the Commissioner to sell, solicit, or negotiate health insurance may sell any qualified plan offered in the Individual Exchange without being separately certified as an Individual Exchange navigator.

(2) To sell qualified plans in the Individual Exchange, an insurance producer shall:

(i) register and apply for an authorization from the Exchange;

(ii) complete and comply with any ongoing requirements of the training program established under subsection (o) of this section; and

(iii) refer individuals seeking insurance who may be eligible for the Maryland Medical Assistance Program or the Maryland Children's Health Program to the navigator program for the Individual Exchange.

(3) An insurance producer:

(i) may not be compensated by the Individual Exchange for the sale of a qualified plan offered in the Individual Exchange; and

(ii) shall be compensated directly by a carrier.

(o) (1) The Exchange shall develop, implement, and, as appropriate, update a training program for insurance producers who sell qualified plans in the Individual Exchange.

(2) The training program shall:

(i) impart the skills and expertise necessary to perform functions specific to the Individual Exchange, such as making premium assistance eligibility determinations;

(ii) enable the Exchange to provide robust protection of consumers and adherence to high quality assurance standards;

(iii) impart the skills and expertise necessary to facilitate appropriate referrals of individuals and their dependents to the Maryland Medical Assistance Program, the Maryland Children's Health Program, the appropriate Individual Exchange connector entity, an independent insurance producer, or the Consolidated Services Center; and

(iv) be approved by the Commissioner.

(p) (1) Subject to paragraphs (2) through (7) of this subsection, until January 1, 2017, a captive producer, without being separately certified as an Individual Exchange navigator, may enroll, in a qualified plan offered in the Individual Exchange by the carrier from which the captive producer has an exclusive appointment:

(i) an individual who:

1. is currently enrolled in one of the carrier's nongroup plans; and

2. except as provided in paragraph (2) of this subsection, does not have an insurance producer of record in connection with the carrier's nongroup plan; or

(ii) an individual who:

1. initiates contact with the captive producer or the carrier for the purpose of requesting assistance or inquiring about the carrier's plans; and

2. except as provided in paragraph (2) of this subsection, does not acknowledge having an insurance producer in connection with any existing insurance coverage.

(2) (i) If an individual under paragraph (1) of this subsection has an insurance producer, a captive producer shall refer the individual back to the insurance producer, together with any available contact information, for information and services, unless:

1. the individual is eligible for, but has not obtained a federal premium subsidy and cost–sharing assistance, and the insurance producer is not authorized to sell qualified plans in the Individual Exchange; or

2. the individual would prefer not to seek further assistance from the individual's insurance producer.

(ii) If a captive producer is not aware of an insurance producer of record, the captive producer shall disclose to an individual under paragraph (1) of this subsection that there may be an insurance producer of record in connection with an existing policy.

(3) (i) A carrier and its captive producers, in offering information and assistance to the carrier's current enrollees regarding qualified plans offered in the Individual Exchange:

1. shall comply with fair marketing standards developed jointly by the Exchange and the Commissioner;

2. may not employ marketing practices or offer information and assistance only to certain enrollees in a manner that will have the effect of enrolling a disproportionate number of the carrier's enrollees with significant health needs in qualified plans offered in the Individual Exchange; and

3. shall act in the best interest of the individual to whom the carrier and its captive producers provide assistance.

(ii) A carrier shall provide to the Exchange, and update as needed, a list of its current captive producers.

(4) Before providing an individual under paragraph (1) of this subsection any information or assistance with respect to qualified plans offered in the Individual Exchange, a captive producer in a manner prescribed under fair marketing standards established by the Commissioner and the Exchange, shall:

(i) disclose to the individual that:

1. the captive producer is employed by the carrier and able to provide information about and sell only qualified plans offered by the carrier; and

2. the Individual Exchange offers other qualified plans, sold by other carriers, that may meet the individual's needs;

(ii) on the individual's request:

1. refer the individual for further assistance to an independent insurance producer, the appropriate Individual Exchange connector entity, or the Consolidated Services Center; and

2. provide, through mail or electronic communication, written information about the Individual Exchange, the connector program, and the Consolidated Services Center; and

(iii) document that the captive producer has provided the required disclosures and the individual has acknowledged that the individual:

1. understands the disclosures;

2. does not want to be referred to an independent insurance producer, an Individual Exchange connector entity, or the Consolidated Services Center; and

3. wants to receive information and assistance from the captive producer.

(5) A record of the documentation required under paragraph (4)(iii) of this subsection shall be:

(i) retained by a captive producer for at least 3 years;

(ii) subject to the Commissioner's review in a market conduct examination; and

(iii) provided to the Exchange on a quarterly basis.

(6) With respect to any health benefit plans or other products offered in the Individual Exchange or the insurance market outside the Individual Exchange by carriers other than the carrier with which the captive producer has an exclusive appointment, a captive producer:

(i) may not provide any information or services related to health benefit plans or other products not offered by the captive producer's carrier; and

(ii) shall refer any inquiries about health benefit plans or other products not offered by the captive producer's carrier to:

1. any resources that may be maintained by the Exchange; or

2. a licensed independent insurance producer.

(7) If a carrier or a captive producer fails to comply with the requirements of this subsection, the Exchange may:

(i) suspend, revoke, or refuse to renew the captive producer's authorization under subsection (m)(3) of this section; and

(ii) impose sanctions against the carrier under § 31–115(j) of this subtitle.

(q) Nothing in this section shall prohibit a community–based organization or a unit of State or local government from providing the consumer assistance services described in subsection (c) of this section that are not required to be provided by an Individual Exchange navigator, if the entity providing the services and its employees do not:

(1) receive any compensation, directly or indirectly, from a carrier, an insurance producer, or a third–party administrator in connection with the enrollment of a qualified individual in a qualified health plan;

(2) receive any compensation, directly or indirectly, from a managed care organization that participates in the Maryland Medical Assistance Program or the Maryland Children's Health Program; and

(3) identify themselves to the public as Individual Exchange connector entities or Individual Exchange navigators.

(r) (1) To the extent and in the manner permitted or required by federal law or regulation governing application counselors and other Exchange consumer assistance personnel, subject to paragraph (2) of this subsection, and depending on its needs and resources, the Exchange may:

(i) designate as an application counselor sponsoring entity under this subsection a community–based organization, health care provider, unit of State or local government, or other entity; and

(ii) certify as an application counselor any agent, employee, or volunteer of an application counselor sponsoring entity who meets the requirements for Individual Exchange navigator certification under this section.

(2) An application counselor sponsoring entity and an application counselor authorized to provide services under this subsection:

(i) may not be compensated by the Exchange;

(ii) may not impose a fee on individuals to whom they are authorized to provide services under this section for the services;

(iii) shall disclose to the Exchange and to individuals to whom they provide services any relationships they have with:

1. a carrier, an insurance producer, or a third–party administrator; or

2. a managed care organization that participates in the Maryland Medical Assistance Program and the Maryland Children's Health Program;

(iv) shall act in the best interest of the individuals for whom they are authorized to provide services; and

(v) may not be compensated by a carrier, insurance producer, or third–party administrator for their enrollment services.

(3) An application counselor is subject to all requirements, restrictions, conflict of interest rules, and oversight applicable to:

(i) Individual Exchange connector entities and Individual Exchange navigators under this subsection and any other relevant State or federal laws; and

(ii) application counselors under federal law or regulation.

(4) The Exchange, in consultation with the Commissioner and the Maryland Department of Health, may:

(i) establish requirements for a sponsoring entity; and

(ii) adopt regulations to carry out this subsection.

§31–113.1.

(a) In accordance with the requirement to operate a toll–free hotline under § 1311(d)(4) of the Affordable Care Act and § 31–108(b)(5) of this subtitle, the Exchange may establish a Consolidated Services Center.

(b) (1) The CSC may employ individuals to assist the SHOP Exchange.

(2) A CSC employee authorized to assist the SHOP Exchange:

(i) may provide the services set forth in § 31–112(c)(1) of this subtitle, but may not initiate contact with a small employer for the purpose of soliciting the small employer to provide qualified plans offered by the SHOP Exchange to its employees;

(ii) shall hold a SHOP Exchange enrollment permit;

(iii) is not a SHOP Exchange navigator and may not hold a SHOP Exchange navigator license;

(iv) may not be required to hold an insurance producer license; and

(v) shall comply with the limitations set forth in § 31–112(c)(3) of this subtitle.

(3) (i) The Commissioner shall issue a SHOP Exchange enrollment permit to each applicant who meets the requirements of this paragraph.

(ii) To qualify for a SHOP Exchange enrollment permit, an applicant:

1. shall be of good character and trustworthy;

2. shall be at least 18 years old;

3. shall pass the written examination given by the Commissioner to applicants for a SHOP navigator license under § 31–112(d)(2)(iii) of this subtitle;

4. shall be engaged by, and receive compensation only through, the CSC;

5. may not receive compensation from or otherwise be affiliated with a carrier, an insurance producer, a third–party administrator, or any other person connected to the insurance industry; and

6. shall complete, and comply with any ongoing requirements of, the training program established under § 31–112(h) of this subtitle.

(4) The Commissioner's duties and authority under § 31–112(d)(3) and (e) of this subtitle shall apply to CSC employees who hold a SHOP Exchange enrollment permit issued under this subsection.

(c) (1) The CSC may employ individuals to assist the Individual Exchange.

(2) A CSC employee authorized to assist the Individual Exchange:

(i) may provide the services set forth in § 31–113(d) of this subtitle, but may not initiate contact with an individual for the purpose of soliciting the individual to enroll in a qualified plan offered by the Individual Exchange;

(ii) shall hold an Individual Exchange enrollment permit;

(iii) is not an Individual Exchange navigator and may not hold an Individual Exchange navigator certification;

(iv) may not be required to hold an insurance producer or adviser license;

(v) with respect to the insurance market outside the Exchange, shall comply with § 31–113(f)(8) of this subtitle;

(vi) shall inquire whether an individual has health insurance obtained through an insurance producer and, if so, shall refer the individual to the insurance producer for information and services unless:

1. the individual is eligible for, but has not obtained a federal premium subsidy and cost–sharing assistance, and the insurance producer is not authorized to sell qualified plans in the Individual Exchange; or

2. the individual would prefer not to seek further assistance from the individual's insurance producer; and

(vii) shall comply with all State and federal laws, regulations, and policies governing the Maryland Medical Assistance Program and the Maryland Children's Health Program.

(3) (i) The Exchange shall issue an Individual Exchange enrollment permit to each applicant who meets the requirements of this paragraph.

(ii) To qualify for an Individual Exchange enrollment permit, an applicant:

1. shall be of good character and trustworthy;

2. shall be at least 18 years old;

3. shall be engaged by, and receive compensation only through, the CSC;

4. may not receive any compensation, directly or indirectly, from:

A. a carrier, an insurance producer, or a third–party administrator in connection with the enrollment of a qualified individual in a qualified health plan; or

B. a managed care organization that participates in the Maryland Medical Assistance Program in connection with the enrollment of an individual in the Maryland Medical Assistance Program or the Maryland Children's Health Program; and

5. shall complete, and comply with any ongoing requirements of, the training program established under § 31–113(k) of this subtitle.

(4) The Commissioner's duties and authority under § 31–113(l) of this subtitle shall apply to CSC employees who hold an Individual Exchange enrollment permit issued under this subsection.

(d) The Exchange, the CSC, and CSC employees shall assist the Health Education and Advocacy Unit of the Office of the Attorney General in carrying out its duties to assist consumers under Title 13, Subtitle 4A of the Commercial Law Article and Title 15, Subtitles 10A and 10D of this article.

§31–114.

(a) Nothing in this subtitle requires the Maryland Medical Assistance Program or the Maryland Children's Health Program to provide any specific financial support to the Individual Exchange for the services provided by an Individual Exchange navigator or an Individual Exchange connector entity.

(b) The financing arrangements between the Individual Exchange, the Maryland Medical Assistance Program, and the Maryland Children's Health Program shall be governed by a memorandum of agreement between the Exchange and the Maryland Department of Health.

§31–115.

(a) The Exchange shall certify:

(1) health benefit plans as qualified health plans;

(2) dental plans as qualified dental plans, which may be offered by carriers as:

(i) stand–alone dental plans; or

(ii) dental plans sold in conjunction with or as an endorsement to qualified health plans;

(3) vision plans as qualified vision plans, which may be offered by carriers as:

(i) stand–alone vision plans; or

(ii) vision plans sold in conjunction with or as an endorsement to qualified health plans; and

(4) stand–alone dental plans for sale outside the Exchange.

(b) To be certified as a qualified health plan, a health benefit plan shall:

(1) provide the essential health benefits required under § 1302(a) of the Affordable Care Act and § 31–116 of this subtitle;

(2) obtain prior approval of premium rates and contract language from the Commissioner;

(3) except as provided in subsection (d) of this section, provide at least a bronze level of coverage, as defined in the Affordable Care Act and determined by the Exchange under § 31–108(b)(8)(ii) of this subtitle;

(4) (i) ensure that its cost–sharing requirements do not exceed the limits established under § 1302(c)(1) of the Affordable Care Act; and

(ii) if the health benefit plan is offered through the SHOP Exchange, ensure that the health benefit plan's deductible does not exceed the limits established under § 1302(c)(2) of the Affordable Care Act;

(5) be offered by a carrier that:

(i) is licensed and in good standing to offer health insurance coverage in the State;

(ii) offers in each Exchange, the Individual and the SHOP, in which the carrier participates, at least one qualified health plan:

1. at a bronze level of coverage;

2. at a silver level of coverage; and

3. at a gold level of coverage;

(iii) if the carrier participates in the Individual Exchange and offers any health benefit plan in the individual market outside the Exchange, offers at least one qualified health plan at the silver level and one at the gold level in the individual market outside the Exchange;

(iv) if the carrier participates in the SHOP Exchange and offers any health benefit plan in the small group market outside the SHOP Exchange, offers at least one qualified health plan at the silver level and one at the gold level in the small group market outside the SHOP Exchange;

(v) charges the same premium rate for each qualified health plan regardless of whether the qualified health plan is offered through the Exchange, through an insurance producer outside the Exchange, or directly from a carrier;

(vi) does not charge any cancellation fees or penalties in violation of § 31–108(d) of this subtitle; and

(vii) complies with the regulations adopted by the Secretary under § 1311(d) of the Affordable Care Act and by the Exchange under § 31–106(c)(1)(iv) of this subtitle;

(6) meet the requirements for certification established under the regulations adopted by:

(i) the Secretary under § 1311(c)(1) of the Affordable Care Act, including minimum standards for marketing practices, network adequacy, essential community providers in underserved areas, accreditation, quality improvement, uniform enrollment forms and descriptions of coverage, and information on quality measures for health plan performance; and

(ii) the Exchange under § 31–106(c)(1)(iv) of this subtitle;

(7) be in the interest of qualified individuals, qualified residents, and qualified employers, as determined by the Exchange;

(8) provide any other benefits as may be required by the Commissioner under any applicable State law or regulation; and

(9) meet any other requirements established by the Exchange under this subtitle, including:

(i) transition of care language in contracts as determined appropriate by the Exchange to ensure care continuity and reduce duplication and costs of care;

(ii) criteria that encourage and support qualified plans in facilitating cross–border enrollment; and

(iii) demonstrating compliance with the federal Mental Health Parity and Addiction Equity Act of 2008.

(c) The Exchange may determine whether a carrier may elect to offer coverage for nonessential vision benefits in either the SHOP Exchange or Individual Exchange.

(d) A qualified health plan is not required to provide at least a bronze level of coverage under subsection (b)(3) of this section if the qualified health plan:

(1) meets the requirements and is certified as a qualified catastrophic plan as provided under the Affordable Care Act; and

(2) will be offered only to individuals eligible for catastrophic coverage.

(e) A health benefit plan may not be denied certification:

(1) solely on the grounds that the health benefit plan is a fee–for–service plan;

(2) through the imposition of premium price controls by the Exchange; or

(3) solely on the grounds that the health benefit plan provides treatments necessary to prevent patients' deaths in circumstances the Exchange determines are inappropriate or too costly.

(f) In addition to other rate filing requirements that may be applicable under this article, each carrier seeking certification of a health benefit plan shall:

(1) (i) submit to the Exchange notice of any premium increase before implementation of the increase; and

(ii) post the increase on the carrier's website;

(2) submit to the Exchange, the Secretary, and the Commissioner, and make available to the public, in plain language as required under § 1311(e)(3)(b) of the Affordable Care Act, accurate and timely disclosure of:

(i) claims payment policies and practices;

(ii) financial disclosures;

(iii) data on enrollment, disenrollment, number of claims denied, and rating practices;

(iv) information on cost–sharing and payments with respect to out–of–network coverage;

(v) information on enrollee and participant rights under Title I of the Affordable Care Act; and

(vi) any other information as determined appropriate by the Secretary and the Exchange; and

(3) make available information about costs an individual would incur under the individual's health benefit plan for services provided by a participating health care provider, including cost–sharing requirements such as deductibles, co–payments, and coinsurance, in a manner determined by the Exchange.

(g) (1) Except as provided in paragraphs (2) through (5) of this subsection, the requirements applicable to qualified health plans under this subtitle also shall apply to qualified dental plans to the extent relevant, whether offered in conjunction with or as an endorsement to qualified health plans or as stand–alone dental plans.

(2) A carrier offering a qualified dental plan shall be licensed to offer dental coverage but need not be licensed to offer other health benefits.

(3) A qualified dental plan shall:

(i) be limited to dental and oral health benefits, without substantial duplication of other benefits typically offered by health benefit plans without dental coverage; and

(ii) include at a minimum:

1. the essential pediatric dental benefits required by the Secretary under § 1302(b)(1)(j) of the Affordable Care Act; and

2. other dental benefits required by the Secretary or the Exchange.

(4) (i) The Exchange may determine:

1. the manner in which carriers must disclose the price of oral and dental benefits and, to the extent relevant, medical benefits, when offered:

A. to the extent permitted by the Exchange, in a qualified health plan;

B. in conjunction with or as an endorsement to a qualified health plan; or

C. as a stand–alone plan; and

2. when a carrier offers a qualified dental plan in conjunction with a qualified health plan, whether the carrier also must make the qualified health plan, the qualified dental plan, or both qualified plans available on a stand–alone basis.

(ii) In determining the manner in which carriers must offer and disclose the price of medical, oral, and dental benefits under this paragraph, the Exchange shall balance the objectives of transparency and affordability for consumers.

(5) The Exchange may:

(i) exempt qualified dental plans from a requirement applicable to qualified health plans under this subtitle to the extent the Exchange determines the requirement is not relevant to qualified dental plans; and

(ii) establish additional requirements for qualified dental plans in conjunction with its establishment of additional requirements for qualified health plans under subsection (b)(9) of this section.

(h) (1) Except as provided in paragraphs (2) through (5) of this subsection, the requirements applicable to qualified health plans under this subtitle also shall apply to qualified vision plans to the extent relevant, whether offered in conjunction with or as an endorsement to qualified health plans or as stand–alone vision plans.

(2) A carrier offering a qualified vision plan shall be licensed to offer vision coverage but need not be licensed to offer other health benefits.

(3) A qualified vision plan shall:

(i) be limited to vision and eye health benefits, without substantial duplication of other benefits typically offered by health benefit plans without vision coverage; and

(ii) include at a minimum:

1. the essential pediatric vision benefits required by the Secretary under § 1302(b)(1)(j) of the Affordable Care Act; or

2. other vision benefits required by the Secretary or the Exchange.

(4) (i) The Exchange may determine:

1. the manner in which carriers must disclose the price of vision benefits and, to the extent relevant, medical benefits, when offered:

A. to the extent permitted by the Exchange, in a qualified health plan;

B. in conjunction with or as an endorsement to a qualified health plan; or

C. as a stand–alone plan; and

2. when a carrier offers a qualified vision plan in conjunction with a qualified health plan, whether the carrier also must make the qualified health plan, the qualified vision plan, or both qualified plans available on a stand–alone basis.

(ii) In determining the manner in which carriers must offer and disclose the price of medical and vision benefits under this paragraph, the Exchange shall balance the objectives of transparency and affordability for consumers.

(5) The Exchange may:

(i) exempt qualified vision plans from a requirement applicable to qualified health plans under this subtitle to the extent the Exchange determines the requirement is not relevant to qualified vision plans; and

(ii) establish additional requirements for qualified vision plans in conjunction with its establishment of additional requirements for qualified health plans under subsection (b)(9) of this section.

(i) A managed care organization may not be required to offer a qualified plan in the Exchange.

(j) (1) Subject to the contested case hearing provisions of Title 10, Subtitle 2 of the State Government Article, and subsection (e) of this section, and except as provided in subsection (k)(2) of this section, the Exchange may deny certification to a health benefit plan, a dental plan, or a vision plan, or suspend or revoke the certification of a qualified plan, based on a finding that the health benefit plan, dental plan, vision plan, or qualified plan does not satisfy requirements or has otherwise violated standards for certification that are:

(i) established under the regulations and interim policies adopted by the Exchange to carry out this subtitle; and

(ii) not otherwise under the regulatory and enforcement authority of the Commissioner.

(2) Certification requirements shall include providing data and meeting standards related to:

(i) enrollment;

(ii) essential community providers;

(iii) complaints and grievances involving the Exchange;

(iv) network adequacy;

(v) quality;

(vi) transparency;

(vii) race, ethnicity, language, interpreter need, and cultural competency (RELICC);

(viii) plan service area, including demographics;

(ix) accreditation; and

(x) complying with fair marketing standards developed jointly by the Exchange and the Commissioner.

(3) Instead of or in addition to denying, suspending, or revoking certification, the Exchange may impose other remedies or take other actions, including:

(i) taking corrective action to remedy a violation of or failure to comply with standards for certification; and

(ii) imposing a penalty not exceeding $5,000 for each violation of or failure to comply with standards for certification.

(4) In determining the amount of a penalty under paragraph (3)(ii) of this subsection, the Exchange shall consider:

(i) the type, severity, and duration of the violation;

(ii) whether the plan or carrier knew or should have known of the violation;

(iii) the extent to which the plan or carrier has a history of violations; and

(iv) whether the plan or carrier corrected the violation as soon as they knew or should have known of the violation.

(5) The penalties available to the Exchange under this subsection shall be in addition to any criminal or civil penalties imposed for fraud or other violation under any other State or federal law.

(6) (i) A carrier or plan, under Title 10, Subtitle 2 of the State Government Article and the Exchange's appeals and grievance process may:

1. appeal an order or decision issued by the Exchange under this section; and

2. request a hearing.

(ii) A demand for a hearing stays a decision or order of the Exchange pending the hearing, and a final order of the Exchange resulting from it, if the Exchange receives the demand:

1. before the effective date of the order; or

2. within 10 days after the order is served.

(iii) If a petition for judicial review is filed with the appropriate court under Title 10, Subtitle 2 of the State Government Article, the court has jurisdiction over the case and shall determine whether the filing operates as a stay of the order from which the appeal is taken.

(k) (1) To be certified for sale outside the Exchange, a stand–alone dental plan shall be reviewed and approved by the Administration as meeting appropriate requirements, including:

(i) covering the State benchmark pediatric dental essential health benefits;

(ii) complying with annual limits and lifetime limits applicable to essential health benefits;

(iii) complying with annual limits on cost sharing applicable to stand–alone dental plans under 45 C.F.R. § 156.150; and

(iv) meeting the same actuarial value requirement for the pediatric dental essential health benefits that is required for a qualified dental plan.

(2) Subject to the contested case hearing provisions of Title 10, Subtitle 2 of the State Government Article, the Exchange may deny, suspend, or revoke the certification of a stand–alone dental plan for sale outside the Exchange if the stand–alone dental plan does not satisfy the requirements of paragraph (1) of this subsection.

(l) Any certification standards established under subsection (j) of this section related to network adequacy or network directory accuracy:

(1) shall be consistent with the provisions of § 15–112 of this article; and

(2) may not be implemented until January 1, 2019.

§31–116.

(a) The essential health benefits required under § 1302(a) of the Affordable Care Act:

(1) shall be the benefits in the State benchmark plan, selected in accordance with this section; and

(2) notwithstanding any other benefits mandated by State law, shall be the benefits required in:

(i) subject to subsection (f) of this section, all individual health benefit plans and health benefit plans offered to small employers, except for grandfathered health plans, as defined in the Affordable Care Act, offered outside the Exchange; and

(ii) all qualified health plans offered in the Exchange.

(b) In selecting the State benchmark plan, the State seeks to:

(1) balance comprehensiveness of benefits with plan affordability to promote optimal access to care for all residents of the State;

(2) accommodate to the extent practicable the diverse health needs across the diverse populations within the State; and

(3) ensure the benefit of input from the stakeholders and the public.

(c) (1) The State benchmark plan, for 2017 and until the Secretary requires that a new benchmark plan be selected, shall be selected by the Commissioner, in consultation with the Exchange:

(i) based on enrollment for the first quarter of 2014, from the largest health plan by enrollment in any of the three largest small group insurance products by enrollment in the State's small group market; and

(ii) through an open, transparent, and inclusive process, which shall include at least one public hearing and an opportunity for public comment.

(2) In selecting the State benchmark plan, the Commissioner, in consultation with the Exchange, may exclude, consistent with applicable federal regulations:

(i) a health care service, benefit, coverage, or reimbursement for covered health care services that is required under this article or the Health – General Article to be provided or offered in a health benefit plan that is issued or delivered in the State by a carrier; or

(ii) reimbursement required by statute, by a health benefit plan for a service when that service is performed by a health care provider who is licensed under the Health Occupations Article and whose scope of practice includes that service.

(d) In selecting the State benchmark plan, the Commissioner, in consultation with the Exchange, shall:

(1) select a plan that complies with all requirements of this subtitle and the Affordable Care Act, the federal Mental Health Parity and Addiction Equity Act of 2008, and any other federal laws, regulations, policies, or guidance applicable to state benchmark plans and essential health benefits;

(2) for individual health benefit plans, require that the health benefit plans include any mandated benefits that were required in individual health benefit

plans before December 31, 2011, if the benefits are not included in the selected benchmark plan; and

(3) if the selected state benchmark plan does not comply with any federal benefit requirement, supplement the required benefits, to the extent permitted by federal law, with benefits similar to those chosen by the Maryland Health Care Reform Coordinating Council in 2012.

(e) Within 10 days after selecting the State benchmark plan, the Commissioner shall submit a report, in accordance with § 2–1257 of the State Government Article, to the Senate Finance Committee and the House Health and Government Operations Committee advising the Committees of the Commissioner's selection and the process used in making the selection.

(f) (1) (i) In this subsection the following words have the meanings indicated.

(ii) "Exchange certified stand–alone dental plan" means a stand–alone dental plan that has been certified by the Exchange for sale outside the Exchange under § 31–115 of this subtitle.

(iii) "Purchaser" means:

1. with respect to an individual health benefit plan, the individual applying for coverage; and

2. with respect to a small group health benefit plan, the employer applying for coverage.

(2) To the extent permitted under federal law, a health benefit plan offered outside the Exchange to individuals or small employers is not required to provide pediatric dental essential health benefits if:

(i) at the time the carrier offers the health benefit plan, the carrier discloses in a form approved by the Commissioner that the health benefit plan does not provide the full range of pediatric dental essential health benefits; and

(ii) the carrier is reasonably assured that the enrollee has obtained full coverage of pediatric dental essential health benefits through an Exchange certified stand–alone dental plan.

(3) A carrier shall:

(i) disclose to a potential purchaser, for those health benefit plans sold outside the Exchange that do not provide the pediatric dental essential health benefits, that the plan does not include the pediatric dental essential health benefits; and

(ii) for those health benefit plans sold outside the Exchange that do not provide the pediatric dental essential health benefits, include on its application completed by a purchaser the following:

"Have you obtained stand–alone dental coverage that provides pediatric dental essential health benefits through a Maryland Health Benefit Exchange certified stand–alone dental plan offered outside the Maryland Health Benefit Exchange?

Yes ____ No ____

If you answered "Yes", please provide the name of the company issuing the stand–alone dental coverage.

If you answered "No", you will be issued a health benefit plan that includes the pediatric dental essential health benefits."

(4) The Administration shall place on its website a list of the Exchange certified stand–alone dental plans in the State.

§31–117.

(a) The Exchange, in consultation with the Commissioner and as approved by the Board, shall establish and implement a State Reinsurance Program:

(1) to provide reinsurance to carriers that offer individual health benefit plans in the State;

(2) that meets the requirements of a waiver approved under § 1332 of the Affordable Care Act; and

(3) that is consistent with State and federal law.

(b) The State Reinsurance Program shall be designed to mitigate the impact of high–risk individuals on rates in the individual insurance market inside and outside the Exchange.

(c) (1) Based on available funds, the Exchange, in consultation with the Commissioner and as approved by the Board, shall establish reinsurance payment parameters for calendar year 2019 and each subsequent calendar year that include:

(i) an attachment point;

(ii) a coinsurance rate; and

(iii) a coinsurance cap.

(2) The Exchange, in consultation with the Commissioner and as approved by the Board, may alter the parameters established in accordance with paragraph (1) of this subsection as necessary to secure federal approval for a waiver submitted in accordance with § 31–117.1(a) of this subtitle.

(d) Beginning January 1, 2019, funding for reinsurance in the individual market through the State Reinsurance Program may be made by using:

(1) any pass–through funds received from the federal government under a waiver approved under § 1332 of the Affordable Care Act;

(2) any funds designated by the federal government to provide reinsurance to carriers that offer individual health benefit plans in the State; and

(3) any funds designated by the State to provide reinsurance to carriers that offer individual health benefit plans in the State.

(e) The implementation of a State Reinsurance Program for reinsurance in the individual market shall be contingent on approval from the U.S. Secretary of Health and Human Services and the U.S. Secretary of the Treasury of a State Innovation Waiver application under § 1332 of the Affordable Care Act.

(f) On or before January 1, 2019, the Exchange shall adopt regulations implementing the provisions of this section.

§31–117.1.

(a) As soon as practicable but not later than July 1, 2018, the Exchange, in consultation with the Commissioner and as approved by the Board, shall submit a State Innovation Waiver application under § 1332 of the Affordable Care Act to establish a program for reinsurance and seek federal pass–through funding.

(b) On or before December 31, 2018, the Commissioner may waive any notification or other requirements that apply to a carrier under this article in calendar year 2018 due to the implementation of a waiver approved under § 1332 of the Affordable Care Act.

§31–118.

(a) Beginning January 1, 2014, subject to subsections (b) and (c) of this section, the Exchange may:

(1) impose user fees, licensing or other regulatory fees, or other assessments that do not exceed reasonable projections regarding the amount necessary to support the operations of the Exchange under this subtitle; or

(2) otherwise generate funding necessary to support its operations under this subtitle.

(b) Any fees, assessments, or other funding mechanisms shall be imposed or implemented, to the maximum extent possible, in a manner that is transparent and broad–based.

(c) Before imposing or altering any fee or assessment established by law, the Exchange shall adopt regulations that specify:

(1) the persons subject to the fee or assessment;

(2) the amount of the fee or assessment; and

(3) the manner in which the fee or assessment will be collected.

(d) Funds collected through any fees, assessments, or other funding mechanisms:

(1) shall be deposited in the Fund;

(2) shall be used only for the purposes authorized under this subtitle; and

(3) may not be used for staff retreats, promotional giveaways, excessive executive compensation, or promotion of federal or State legislative and regulatory actions.

(e) The Exchange may not impose fees or assessments authorized under this section in a manner that would provide a competitive disadvantage to health benefit plans operating outside of the Exchange.

(f) The Exchange shall maintain a website on which it shall publish:

(1) the average amounts of any fees, assessments, or other payments required by the Exchange;

(2) the administrative costs of the Exchange; and

(3) the amount of funds known to be lost through waste, fraud, and abuse.

§31–119.

(a) The Exchange shall be administered in a manner designed to:

(1) prevent discrimination on the basis of race, color, national origin, disability, age, sex, gender identity, or sexual orientation;

(2) streamline enrollment and other processes to minimize expenses and achieve maximum efficiency;

(3) prevent waste, fraud, and abuse; and

(4) promote financial integrity.

(b) (1) The Exchange shall establish a full–scale fraud, waste, and abuse detection and prevention program designed to:

(i) ensure the Exchange's compliance with federal and State laws for the detection and prevention of fraud, waste, and abuse, including whistleblower and confidentiality protections and federal anti–kickback prohibitions; and

(ii) promote transparency, credibility, and trust on the part of the public in the integrity of its operations.

(2) The fraud, waste, and abuse detection and prevention program shall:

(i) establish a framework for internal controls;

(ii) identify control cycles;

(iii) conduct risk assessments;

(iv) document processes; and

(v) implement controls.

(3) The Exchange:

(i) shall, in accordance with § 2–1257 of the State Government Article, submit its plan for the fraud, waste, and abuse detection and prevention program to the Senate Finance Committee and the House Health and Government Operations Committee; and

(ii) shall allow the committees 60 days for review and comment before establishing the program.

(c) The Exchange shall keep an accurate accounting of all its activities, expenditures, and receipts.

(d) (1) On or before December 1 of each year, the Board shall forward to the Secretary, the Governor, and, in accordance with § 2–1257 of the State Government Article, the General Assembly, a report on the activities, expenditures, and receipts of the Exchange.

(2) The report shall:

(i) be in the standardized format required by the Secretary;

(ii) include data regarding:

1. health plan participation, ratings, coverage, price, quality improvement measures, and benefits;

2. consumer choice, participation, and satisfaction information to the extent the information is available;

3. financial integrity, fee assessments, and status of the Fund; and

4. any other appropriate metrics related to the operation of the Exchange that may be used to evaluate Exchange performance, assure transparency, and facilitate research and analysis;

(iii) assess and, to the extent feasible and permitted by law, include data to identify disparities related to gender, race, ethnicity, geographic location, language, disability, gender identity, sexual orientation, or other attributes of special populations; and

(iv) include information on its fraud, waste, and abuse detection and prevention program.

(e) (1) The Board shall cooperate fully with any investigation into the affairs of the Exchange, including making available for examination the records of the Exchange, conducted by:

(i) the Secretary under the Secretary's authority under the Affordable Care Act; and

(ii) the Commissioner under the Commissioner's authority under this article.

(2) The Commissioner may adopt regulations establishing the minimum length of time for which, and the manner in which, the Exchange is required to maintain records of insurance transactions conducted by the Exchange.

§31–120.

(a) (1) In this section the following words have the meanings indicated.

(2) "Central Repository" means the Criminal Justice Information System Central Repository of the Department of Public Safety and Correctional Services.

(3) "Contractor" means an individual who:

(i) is not a State employee with a position in the State Personnel Management System; and

(ii) performs work functions for the Exchange in accordance with the terms of a written agreement.

(b) The purpose of this section is to authorize the Exchange to perform a criminal background check, including a State and national criminal history records check, to determine the suitability of a contractor to access confidential or sensitive federal tax information in accordance with federal laws and regulations.

(c) For any contractor who has or may obtain access to federal tax information that is considered confidential or sensitive under federal or State law or regulation, the Exchange may:

(1) require the contractor to provide information necessary to perform a criminal background check including, for at least the immediately preceding 5–year period, the contractor's:

(i) address history; and

(ii) employment and education history, including the names and addresses of all previous employers and schools attended;

(2) request a State and national criminal history records check on the contractor from the Central Repository;

(3) as part of the application for a criminal history records check, collect from the contractor and submit to the Central Repository:

(i) two complete sets of the contractor's legible fingerprints taken in a format approved by the Director of the Central Repository and the Director of the Federal Bureau of Investigation;

(ii) the fee authorized under § 10–221(b)(7) of the Criminal Procedure Article for access to Maryland criminal history records;

(iii) the mandatory processing fee required by the Federal Bureau of Investigation for a national criminal history records check; and

(iv) any other documents or fees required by the Central Repository for completion of a criminal history records check; and

(4) conduct a reinvestigation within 10 years after the date of the previous background investigation for each contractor with access to federal tax information.

(d) In accordance with §§ 10–201 through 10–229 of the Criminal Procedure Article, the Central Repository shall forward to the contractor and the Exchange the contractor's criminal history record information.

(e) Information obtained from the Central Repository under this section:

(1) is confidential;

(2) may not be redisseminated except as allowed by federal or State law or regulation; and

(3) may be used only for the purposes authorized under this section.

(f) A contractor who is the subject of a criminal history records check under this section may contest the criminal history record information issued by the Central Repository as provided in § 10–223 of the Criminal Procedure Article.

(g) If criminal history record information is reported to the Central Repository after the date of the initial criminal history records check, the Central Repository shall provide to the Exchange and the contractor revised criminal history record information on the contractor.

(h) A contractor who refuses to comply with or fails the criminal history records check under this section may not perform work functions for the Exchange that require access to federal tax information.

(i) The Board may adopt regulations, guidelines, and policies to carry out this section.

(j) This section does not limit the authority of the Exchange to perform a background investigation or request a criminal history records check for personnel in accordance with §§ 7–103 and 7–104 of the State Personnel and Pensions Article.

§31–121.

(a) The Exchange, in consultation with the Commissioner and as approved by the Board, may submit a State Innovation Waiver application under § 1332 of the Affordable Care Act to allow the State to administer the federal Small Business Health Care Tax Credit to small businesses for monthly premium payments.

(b) Before applying for a State Innovation Waiver under subsection (a) of this section, the Exchange shall determine whether the State needs to apply for a State Innovation Waiver in order to distribute the federal Small Business Health Care Tax Credit on a monthly basis to eligible employers enrolling in the SHOP Exchange.

§31–122.

(a) In this section, "Program" means the State–Based Young Adult Health Insurance Subsidies Program.

(b) (1) Subject to paragraph (2) of this subsection, the Exchange, in consultation with the Commissioner and as approved by the Board, may establish and implement a State–Based Young Adult Health Insurance Subsidies Program to provide subsidies to young adults for the purchase of health benefit plans in the individual health insurance market.

(2) The Exchange may not implement the Program for calendar years in which funds from the distribution of the assessment under § 6–102.1 of this article are not available.

(c) The Program required under this section shall be designed to:

(1) reduce the amount that young adults pay for health benefit plans in the individual health insurance market; and

(2) target young adults who are not directly impacted by the State Reinsurance Program.

(d) (1) For each calendar year, the Exchange, in consultation with the Commissioner and as approved by the Board, shall establish subsidy eligibility and payment parameters for the Program.

(2) In determining the subsidy eligibility and payment parameters required under paragraph (1) of this subsection, the Exchange shall consider:

(i) young adults at least 18 years old and under the age of 41 years; and

(ii) income groups between 133% and 400% of the federal poverty level.

(e) (1) Subject to available funds and paragraph (2) of this subsection, in each fiscal year, the Exchange may designate funds from the Fund to be used for the Program so that annual subsidies may be provided to young adults who meet the subsidy eligibility and payment parameters established under subsection (d) of this section.

(2) (i) For each of calendar years 2024 and 2025, the funds designated under paragraph (1) of this subsection may not exceed $20,000,000 plus any unspent funds designated for subsidies for young adults in a previous calendar year.

(ii) For calendar year 2026 and each calendar year thereafter, the Exchange, in consultation with the Commissioner, may designate funds from the Fund to provide annual subsidies to young adults who meet the subsidy eligibility and payment parameters established under subsection (d) of this section.

(f) The Exchange shall adopt regulations implementing the provisions of this section.

(g) The Exchange shall adopt regulations to provide a subsidy to cover 100% of the cost of the premium for young adults who have a 0% expected contribution under the subsidy eligibility parameters established under subsection (d) of this section.

(h) (1) The Exchange shall track on a monthly basis expenditures on subsidies provided under the Program, including:

(i) the average number of young adults receiving subsidies under the Program; and

(ii) the average subsidy amount received by young adults under the Program.

(2) The Exchange shall track:

(i) the impact the Program has on rates in the individual insurance market; and

(ii) the impact of covering 100% of the cost of premiums for qualified participants on effectuation rates and termination for nonpayment rates.

(3) The information tracked by the Exchange under paragraphs (1) and (2) of this subsection shall be:

(i) posted on the website of the Exchange; and

(ii) included in the annual report required under § 31–119(d) of this subtitle.

§31–123.

(a) On or before July 1, 2025, the Exchange, in consultation with the Commissioner and as approved by the Board, shall submit a State Innovation Waiver application amendment under § 1332 of the Affordable Care Act to establish a Qualified Resident Enrollment Program and, if available, seek federal pass–through funding resulting from the implementation of a Qualified Resident Enrollment Program.

(b) On or before December 31, 2025, the Commissioner may waive any notification or other requirements that apply to a carrier under this article in calendar year 2025 due to the implementation of a waiver approved under § 1332 of the Affordable Care Act.

§31–124.

(a) The Exchange, in consultation with the Commissioner and as approved by the Board, shall establish and implement a Qualified Resident Enrollment Program:

(1) to facilitate the enrollment of qualified residents in qualified plans;

(2) that, as necessary, meets the requirements of a waiver approved under § 1332 of the Affordable Care Act; and

(3) that is consistent with federal and State law.

(b) The Qualified Resident Enrollment Program shall allow qualified residents to purchase qualified plans on the Individual Exchange.

(c) (1) The implementation of the Qualified Resident Enrollment Program shall be contingent on approval from the U.S. Secretary of Health and Human Services and the U.S. Secretary of the Treasury of a State Innovation Waiver application amendment under § 1332 of the Affordable Care Act.

(2) Within 6 months before a fiscal year in which the Exchange implements the Qualified Resident Enrollment Program, the Exchange shall submit a report to the General Assembly, in accordance with § 2–1257 of the State Government Article, on its plan to implement the Program, including:

(i) the amount and source of the funding for the Program;

(ii) the parameters of the Program;

(iii) the number of individuals anticipated to participate in the Program;

(iv) the amount of premiums anticipated to be paid by participants under the Program; and

(v) if the General Assembly authorizes funding to subsidize premiums under the Program, the parameters of the subsidies.

(d) On or before January 1, 2026, the Exchange shall adopt regulations to carry out this section.

§31–125. ** CONTINGENCY – IN EFFECT – CHAPTER 468 OF 2025 **

(a) In this section, "Program" means the State–Based Health Insurance Subsidies Program.

(b) The Exchange, in consultation with the Commissioner and as approved by the Board, shall establish and implement a State–Based Health Insurance Subsidies Program to provide subsidies to individuals for the purchase of health benefit plans in the individual health insurance market.

(c) The Program required under this section shall be designed to:

(1) maintain affordability for individuals purchasing health benefit plans through the Exchange; and

(2) target individuals who experience an increase in the applicable percentages established under 26 U.S.C. § 36B(b)(3)(A)(iii) for premiums based on household income in calendar years 2026 and 2027, as compared to the applicable percentages in place for calendar year 2025.

(d) Subject to available funds, for calendar years 2026 and 2027, the Exchange, in consultation with the Commissioner and as approved by the Board, shall establish subsidy eligibility and payment parameters for the Program that:

(1) mitigate a reduction in advance premium tax credits because of changes in the applicable percentages described in subsection (c)(2) of this section;

(2) maximize enrollment in the individual market;

(3) take into consideration State funds needed to ensure the State Reinsurance Program continues to provide market stability through calendar year 2028; and

(4) take into consideration uncertainties in enrollment in the Maryland Medical Assistance Program, the individual market, and the small group market due to changes in State and federal regulation and funding.

(e) In fiscal years 2026 through 2028, the Exchange may designate funds from the Fund to be used for the Program.

(f) The Exchange shall adopt regulations to carry out this section.

(g) (1) The Exchange shall track on a monthly basis expenditures on subsidies provided under the Program, including:

(i) the average number of individuals receiving subsidies under the Program;

(ii) the average subsidy amount received by individuals under the Program; and

(iii) the impact the Program has on rates in the individual insurance market.

(2) The information tracked by the Exchange under paragraph (1) of this subsection shall be:

(i) posted on the website of the Exchange; and

(ii) included in the annual report required under § 31–119(d) of this subtitle.

§31–126.

The Maryland Health Benefit Exchange shall promote access to health insurance for child care professionals by:

(1) partnering with:

(i) the State Department of Education;

(ii) prekindergarten provider hubs, as defined in § 7–1A–01 of the Education Article;

(iii) child care associations; and

(iv) relevant nonprofit organizations;

(2) helping child care professionals obtain health insurance through the Maryland Health Benefit Exchange or Medicaid;

(3) assisting child care professionals who lose Medicaid coverage with finding alternative health insurance options;

(4) helping ensure health plan options meet the budgets and health insurance coverage needs of child care professionals and child care employers;

(5) providing informational resources, including flyers, webinars, in–person events, and other outreach materials targeted to the child care provider community; and

(6) assessing current levels of health care access across the child care community by conducting a survey:

(i) developed in consultation with the State Department of Education and relevant nonprofit organizations; and

(ii) with a particular emphasis on providers who accept child care scholarship vouchers.

§31–201.

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

(b) "Advisory Workgroup" means the Maryland Easy Enrollment Health Insurance Program Advisory Workgroup established under § 31–203 of this subtitle.

(c) "Cost–sharing reduction" means a reduction described in § 1402(c) of the Affordable Care Act.

(d) "Department" means the Maryland Department of Health.

(e) "Insurance affordability program" means:

(1) the Maryland Medical Assistance Program;

(2) the Maryland Children's Health Program;

(3) premium tax credits; or

(4) cost–sharing reductions.

(f) "Modified adjusted gross income" has the meaning stated in 42 U.S.C. § 1395r(i)(4)(A).

(g) "Poverty line" has the meaning stated in 42 U.S.C. § 1397jj(c)(5).

(h) "Premium tax credits" means the tax credits described in § 36B of the Internal Revenue Code.

(i) "Proactively contact" means an attempt by the Exchange or the Department to reach an uninsured individual by:

(1) making multiple attempts to contact the uninsured individual as requested on a State income tax return in accordance with § 2–115(b)(2) of the Tax – General Article;

(2) if the attempts described in item (1) of this subsection do not successfully reach the uninsured individual or if no specific methods for contacting the uninsured individual were requested, making multiple attempts to contact the uninsured individual through telephonic and electronic means; and

(3) if the attempts described in items (1) and (2) of this subsection do not successfully reach the uninsured individual to obtain the requested information, sending paper forms or notices to the uninsured individual by mail.

(j) "Program" means the Maryland Easy Enrollment Health Insurance Program established under § 31–202 of this subtitle.

(k) "Uninsured individual" means an individual under the age of 65 years who is identified through a State income tax return under § 2–115 of the Tax – General Article as not having minimum essential coverage.

§31–202.

(a) There is a Maryland Easy Enrollment Health Insurance Program.

(b) The purposes of the Program are to:

(1) establish a State–based reporting system to provide information about the health insurance status of State residents through the use of State income tax returns to identify uninsured individuals and determine whether an uninsured individual is interested in obtaining minimum essential coverage;

(2) determine whether an uninsured individual who is interested in obtaining minimum essential coverage qualifies for an insurance affordability program;

(3) proactively contact an uninsured individual who is interested in obtaining minimum essential coverage to assist in enrolling the uninsured individual in an insurance affordability program and minimum essential coverage; and

(4) maximize enrollment of eligible uninsured individuals in insurance affordability programs and minimum essential coverage to improve access to care and reduce insurance costs for all residents of the State.

(c) (1) The Exchange, the Department, and the Comptroller shall develop and implement systems, policies, and practices that encourage, facilitate, and streamline determination of eligibility for insurance affordability programs and enrollment in minimum essential coverage to achieve the purposes of the Program.

(2) Except as provided in § 2–115(d) of the Tax – General Article, the systems, policies, and practices shall be:

(i) operational on or before January 1, 2020; and

(ii) available for use by residents of the State when filing a State income tax return for taxable years that begin after December 31, 2018.

(d) To facilitate the most efficient implementation of the Program, the Exchange, the Comptroller, and the Department may:

(1) enter into agreements;

(2) adopt regulations;

(3) adopt guidelines;

(4) establish accounts;

(5) conduct trainings;

(6) provide public information;

(7) educate tax preparers; and

(8) take any other steps as may be necessary to accomplish the purpose of the Program.

§31–203.

(a) The Exchange shall establish a Maryland Easy Enrollment Health Insurance Program Advisory Workgroup to provide ongoing advice regarding the implementation of the Program.

(b) The Advisory Workgroup shall include representation from:

(1) the Office of the Comptroller;

(2) consumer groups;

(3) employers;

(4) insurers;

(5) health care providers;

(6) navigators or other consumer assisters;

(7) insurance brokers or agents;

(8) labor organizations;

(9) income tax preparers;

(10) national policy experts; and

(11) any other organizations or groups selected by the Exchange.

(c) The Advisory Workgroup shall meet at least once every 6 months.

(d) This section may not be construed to prevent the Exchange from convening other formal or informal working or advisory groups to facilitate the implementation of the Program.

§31–204.

(a) The Exchange or the Department, as applicable, shall determine eligibility for insurance affordability programs as soon as possible after an individual files a State income tax return on which the individual chose a checkoff box described in § 2–115(c)(3) of the Tax – General Article indicating that an uninsured individual may be interested in obtaining minimum essential coverage.

(b) (1) To the maximum extent practicable, the Exchange or the Department, as applicable, shall verify an uninsured individual's eligibility for an insurance affordability program:

(i) with information on a State income tax return and other data from third–party data sources, including data described in § 1413 of the

Affordable Care Act or available under § 2–115(b)(2) of the Tax – General Article; and

(ii) without requesting additional information or attestations from the uninsured individual.

(2) If additional attestations or documentation from the uninsured individual are required to establish eligibility for an insurance affordability program, the Exchange or the Department, as applicable, shall take steps to limit the burden on the uninsured individual, including:

(i) proactively contacting the individual who filed the tax return or the uninsured individual;

(ii) recording, by telephonic or electronic means, attestations and documentation provided by the individual who filed the tax return or the uninsured individual; and

(iii) if the attestations or documentation required to determine eligibility are not obtained using the steps described in items (i) and (ii) of this paragraph, facilitating the selection of an authorized representative for the uninsured individual.

(c) (1) Before determining eligibility of an uninsured individual for an insurance affordability program, the Exchange or the Department, as applicable, shall attempt to verify the citizenship status of the uninsured individual and each household member listed on the State income tax return, based on the information available from the return and reliable third–party sources of citizenship data.

(2) If the process described in paragraph (1) of this subsection does not confirm that the uninsured individual and each household member listed on the State income tax return is a United States citizen, the Exchange and the Department may not seek additional verification or take other steps to determine eligibility for or enroll the uninsured individual in an insurance affordability program until the uninsured individual provides affirmative consent using forms and procedures approved by the Exchange.

(3) The affirmative consent required under paragraph (2) of this subsection may be satisfied through the procedures described in 42 U.S.C. § 1320b–7(d).

(4) If citizenship is not verified and affirmative consent is not provided in accordance with paragraph (2) of this subsection, the Exchange and the

Department may not take any further steps to determine an uninsured individual's eligibility for or enroll an uninsured individual in an insurance affordability program.

§31–205.

(a) The Exchange or the Department, as applicable, shall make a determination of eligibility, in accordance with § 31–204 of this subtitle, for the Maryland Medical Assistance Program and, if applicable, the Maryland Children's Health Program under this section, before determining eligibility for any other insurance affordability program.

(b) (1) If an uninsured individual is determined to be eligible for the Maryland Medical Assistance Program or the Maryland Children's Health Program, the procedures described in this subsection and guidelines established by the Exchange, in consultation with the Department, to implement this subsection shall apply.

(2) If an uninsured individual fails to select a managed care organization plan within a period of time established by the Exchange, the Department shall assign the uninsured individual to and promptly enroll the uninsured individual in a managed care organization plan.

(3) Before the Department assigns an uninsured individual to a managed care organization plan, the uninsured individual shall receive:

(i) advance notice;

(ii) an opportunity to select another managed care organization plan within the period of time established by the Exchange; and

(iii) an opportunity to opt out of coverage.

§31–206.

(a) If an uninsured individual is not determined to be eligible for the Maryland Medical Assistance Program or the Maryland Children's Health Program under § 31–205 of this subtitle, the Exchange shall determine, in accordance with § 31–204 of this subtitle, whether the uninsured individual is eligible for premium tax credits or cost–sharing reductions as determined under this section.

(b) (1) A special or other enrollment period for the individual market shall begin on the date an income tax return is filed by or on behalf of an uninsured individual that includes the choice described in § 2–115(c)(3) of the Tax – General Article, if the return is filed on or before the date specified by the Exchange.

(2) The enrollment period described in this subsection shall last for a period of time determined by the Exchange before the start of the calendar year that may not be shorter than 14 days.

(c) (1) Information about the enrollment period described in subsection (b) of this section shall be communicated to the public and affected individuals through measures that may include language in the instructions for the State individual income tax return, if inclusion of the language is approved by the Comptroller.

(2) The Exchange is authorized to conduct outreach to individuals described in paragraph (1) of this subsection, using methods that may include written notices and the provision of individualized assistance by insurance agents and brokers, navigators, tax preparers, and Exchange contractors and staff.

(3) Notwithstanding any other provision of this article, the Exchange may compensate an entity for outreach described in paragraph (2) of this subsection in a manner that reflects, in whole or in part, the number of uninsured individuals enrolled under this section and § 31–204 of this subtitle by that entity.

§31–207.

(a) The Exchange shall develop a detailed set of data privacy and data security safeguards to govern the conveyance, storage, and utilization of data under the Program.

(b) The safeguards developed under subsection (a) of this section shall ensure that the conveyance, storage, and utilization of data under the Program comply with applicable requirements of federal and State law.

§32–101.

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

(b) "Carrier" means:

(1) an insurer;

(2) a nonprofit health service plan;

(3) a health maintenance organization; or

(4) a dental plan organization.

(c) "Insurance group" means, for the purpose of conducting an ORSA, those carriers and affiliates that are included within an insurance holding company system as defined in § 7–101 of this article.

(d) "NAIC" means the National Association of Insurance Commissioners.

(e) "Own Risk and Solvency Assessment" or "ORSA" means a confidential internal assessment, appropriate to the nature, scale, and complexity of a carrier or insurance group, that the carrier or insurance group conducts, of the material and relevant risks associated with the carrier's or insurance group's current business plan and the sufficiency of capital resources to support those risks.

(f) "ORSA Guidance Manual" means the current version of the Own Risk and Solvency Assessment Guidance Manual developed and adopted by the National Association of Insurance Commissioners.

(g) "ORSA–related information" means any document, material, or other information related to an ORSA, an ORSA Summary Report, or a risk management framework of a carrier or insurance group.

(h) "ORSA Summary Report" means a confidential high–level summary of the ORSA of a carrier or insurance group.

(i) "Supervisory college" has the meaning stated in § 2–209.1 of this article.

§32–102.

(a) The purposes of this title are to:

(1) require a carrier or insurance group to maintain a risk management framework and complete an ORSA;

(2) set the requirements for filing an ORSA Summary Report with the Commissioner; and

(3) provide for the confidential treatment of the ORSA, the ORSA Summary Report, and other ORSA–related information.

(b) This title applies to all carriers domiciled in the State that are not exempt under § 32–106 of this title.

§32–103.

(a) Each carrier subject to this title shall maintain a risk management framework for identifying, assessing, monitoring, managing, and reporting its material and relevant risks.

(b) A carrier may satisfy this requirement if the insurance group of which the carrier is a member maintains a risk management framework that applies to the operations of the carrier.

§32–104.

(a) Subject to § 32–106 of this title, a carrier, or the insurance group of which the carrier is a member, shall regularly conduct an ORSA consistent with the process outlined in the ORSA Guidance Manual.

(b) The ORSA shall be conducted:

(1) regularly, but not less than once each year; and

(2) at any time when there is a significant change to the risk profile of the carrier or the insurance group of which the carrier is a member.

§32–105.

(a) On request of the Commissioner, but not more than once each year, a carrier shall submit to the Commissioner an ORSA Summary Report or a combination of reports that together contain the information described in the ORSA Guidance Manual, applicable to the carrier or the insurance group of which the carrier is a member.

(b) Notwithstanding any request from the Commissioner, if the carrier is a member of an insurance group, the carrier shall submit the report required by this section if the Commissioner is the lead state commissioner of the insurance group as determined by the procedures in the Financial Analysis Handbook adopted by the NAIC.

(c) The carrier shall:

(1) determine the most appropriate date of the filing based on the carrier's internal strategic planning processes; and

(2) notify the Commissioner of the anticipated date of the filing.

(d) The carrier's or insurance group's chief risk officer or other executive with responsibility for the oversight of the carrier's enterprise risk management

process shall sign the report and attest to the best of that individual's belief and knowledge that:

(1) the carrier applies the enterprise risk management process described in the ORSA Summary Report; and

(2) a copy of the report has been provided to the carrier's board of directors or the appropriate committee of the board.

(e) A carrier may comply with subsection (a) of this section by providing the most recent and substantially similar report that the carrier or another member of an insurance group of which the carrier is a member provided to the commissioner of another state or to a supervisor or regulator of a foreign jurisdiction if that report provides information that is comparable to the information described in the ORSA Guidance Manual.

(f) Any report that is provided under subsection (e) of this section in a language other than English must be accompanied by a translation of that report into English.

§32–106.

(a) A carrier is exempt from the requirements of this title if:

(1) the carrier has annual direct written and unaffiliated assumed premium less than $500,000,000, including international direct and assumed premium but excluding premiums reinsured with the Federal Crop Insurance Corporation and Federal Flood Program; and

(2) the insurance group of which the carrier is a member has annual direct written and unaffiliated assumed premium less than $1,000,000,000, including international direct and assumed premium but excluding premiums reinsured with the Federal Crop Insurance Corporation and Federal Flood Program.

(b) (1) If a carrier qualifies for exemption under subsection (a)(1) of this section, but the insurance group of which the carrier is a member does not qualify for exemption under subsection (a)(2) of this section, then the ORSA Summary Report that is required under § 32–105 of this title shall include every carrier within the insurance group.

(2) The ORSA Summary Report requirement under paragraph (1) of this subsection may be satisfied by submitting more than one ORSA Summary Report for any combination of carriers if the combination of reports includes every carrier within the insurance group.

(c) If a carrier does not qualify for exemption under subsection (a)(1) of this section, but the insurance group of which it is a member qualifies for exemption under subsection (a)(2) of this section, then the only ORSA Summary Report required under § 32–105 of this title is the report that applies to that carrier.

(d) (1) A carrier that does not qualify for exemption under subsection (a) of this section may apply to the Commissioner for a waiver from the requirements of this title based on unique circumstances.

(2) If the carrier applying for a waiver is part of an insurance group with carriers domiciled in more than one state, the Commissioner shall contact the lead state commissioner and other domiciliary commissioners in considering whether to grant the carrier's request for a waiver.

(3) In deciding whether to grant the carrier's request for a waiver, the Commissioner may consider:

(i) the type and volume of business written;

(ii) ownership and organizational structure; and

(iii) any other factor the Commissioner considers relevant to the carrier or insurance group of which the carrier is a member.

(e) Notwithstanding the exemptions provided for in this section, the Commissioner may require that a carrier:

(1) maintain a risk management framework, conduct an ORSA, and file an ORSA Summary Report based on unique circumstances, including the type and volume of business written, ownership and organizational structure, federal agency requests, and international supervisor requests; or

(2) maintain a risk management framework, conduct an ORSA, and file an ORSA Summary Report if the carrier:

(i) has risk–based capital at a company action level event as set forth in § 4–305 of this article;

(ii) meets one or more of the standards of a carrier deemed to be in financially hazardous condition as described in § 9–102 of this article; or

(iii) otherwise exhibits qualities of a troubled carrier as determined by the Commissioner.

(f) If a carrier that qualifies for an exemption under subsection (a) of this section subsequently no longer qualifies for that exemption due to changes in premium as reflected in the carrier's most recent annual statement or in the most recent annual statements of the carriers within the insurance group of which the carrier is a member, the carrier shall have 1 year following the year the threshold is exceeded to comply with this title.

§32–107.

(a) The ORSA Summary Report shall be prepared consistent with the ORSA Guidance Manual.

(b) Documentation and supporting information for the ORSA Summary Report shall be maintained and made available on examination or request of the Commissioner.

(c) (1) The Commissioner shall review the ORSA Summary Report.

(2) The Commissioner shall make any requests for additional information using procedures similar to those currently used in the analysis and examination of multi–state or global carriers and insurance groups.

(d) The ORSA Summary Report shall include a short summary of material changes and updates to the ORSA Summary Report since the prior year.

(e) The Commissioner may retain, at the carrier's expense, third–party consultants, including attorneys, actuaries, accountants, and other experts not otherwise a part of the Administration's staff as may be reasonably necessary to assist the Administration in reviewing the carrier's risk management framework, ORSA, ORSA Summary Report, or compliance with this title.

§32–108.

(a) (1) ORSA–related information, including the ORSA Summary Report, in the possession or control of the Commissioner that is obtained by, created by, or disclosed to the Commissioner or any other person under this title:

(i) is confidential and privileged;

(ii) is not subject to Title 4 of the General Provisions Article;

(iii) is not subject to subpoena; and

(iv) is not subject to discovery or admissible as evidence in any civil action.

(2) Except as provided in subsections (b) and (d) of this section, the Commissioner may not otherwise make ORSA–related information public without prior written consent of the carrier to which it pertains.

(b) The Commissioner may use ORSA–related information in the furtherance of any regulatory or legal action brought as part of the duties of the Commissioner.

(c) The Commissioner, and any person who receives ORSA–related information, through examination or otherwise, while acting under the authority of the Commissioner or with whom ORSA–related information is shared under this title, may not be allowed or required to testify in any private civil action concerning any ORSA–related information that is subject to subsection (a) of this section.

(d) In order to assist in the performance of the Commissioner's regulatory duties, the Commissioner:

(1) may, on request, share ORSA–related information, including confidential and privileged ORSA–related information that is subject to subsection (a) of this section, with:

(i) other state, federal, and international financial regulatory agencies, including members of any supervisory college;

(ii) the NAIC; and

(iii) any third–party consultants the Commissioner designates.

(2) The Commissioner may share ORSA–related information under paragraph (1) of this subsection if the recipient:

(i) agrees in writing to maintain the confidentiality and privileged status of the ORSA–related information; and

(ii) verifies in writing that it has the legal authority to maintain the confidentiality of the ORSA–related information.

(e) (1) The Commissioner may receive ORSA–related information from:

(i) other state, federal, and international financial regulatory agencies, including members of any supervisory college; and

(ii) the NAIC.

(2) The Commissioner shall maintain as confidential and privileged any ORSA–related information received under paragraph (1) of this subsection that the Commissioner receives with notice or the understanding that it is confidential or privileged under the laws of the jurisdiction that is the source of the ORSA–related information.

(f) (1) The Commissioner shall enter into a written agreement with the NAIC or a third–party consultant governing the sharing and use of information provided under this title, consistent with this section.

(2) The agreement required under paragraph (1) of this subsection shall:

(i) specify procedures and protocols regarding the confidentiality and security of ORSA–related information shared with the NAIC or a third–party consultant under this title, including procedures and protocols for sharing by the NAIC with other state regulators from states in which the insurance group has domiciled carriers;

(ii) specify that the recipient agrees in writing to maintain the confidentiality and privileged status of the ORSA–related information and has verified in writing the legal authority to maintain the confidentiality;

(iii) specify that ownership of the ORSA–related information shared under this title remains with the Commissioner and that the use of the ORSA–related information by the NAIC or a third–party consultant is subject to the direction of the Commissioner;

(iv) prohibit the NAIC or a third–party consultant from storing the ORSA–related information shared under this title in a permanent database after the underlying analysis is completed;

(v) require prompt notice to be given to a carrier whose confidential ORSA–related information in the possession of the NAIC or a third–party consultant under this title is subject to a request or subpoena for disclosure or production;

(vi) require the NAIC or a third–party consultant to consent to intervention by a carrier in any judicial or administrative action in which the NAIC or a third–party consultant may be required to disclose confidential ORSA–related

information about the carrier shared with the NAIC or a third–party consultant under this title; and

(vii) in the case of an agreement involving a third–party consultant, provide:

1. that the third–party consultant shall be under the direction and control of the Commissioner and act in a purely advisory capacity;

2. that the third–party consultant is subject to the same confidentiality standards and requirements as the Commissioner;

3. that the third–party consultant shall verify to the Commissioner, with notice to the carrier, that the third–party consultant:

A. is free of any conflict of interest;

B. has internal procedures in place to ensure that it remains free of any conflict of interest; and

C. will comply with the confidentiality standards and requirements of this article;

4. that, before using a carrier's ORSA–related information in a manner inconsistent with the agreement with the Commissioner or sharing the carrier's ORSA–related information with a person other than the Commissioner, the third–party consultant shall obtain written consent of the carrier; and

5. for written notification to the carrier.

(g) (1) The sharing of ORSA–related information and documents by the Commissioner under this title may not constitute a delegation of regulatory authority or rulemaking.

(2) The Commissioner is solely responsible for the administration, execution, and enforcement of this title.

(h) A waiver of any applicable privilege or claim of confidentiality in ORSA–related information may not occur as a result of disclosure of the ORSA–related information to the Commissioner under this section or as a result of sharing the ORSA–related information as authorized under this title.

(i) ORSA–related information in the possession or control of the NAIC or a third–party consultant under this title:

(1) is confidential and privileged;

(2) is not subject to Title 4 of the General Provisions Article;

(3) is not subject to subpoena; and

(4) is not subject to discovery or admissible in evidence in any civil action.

§32–109.

(a) Subject to § 2–210 of this article, a carrier that, without just cause, fails to timely file an ORSA Summary Report as required by this title is subject to a penalty of $200 for each day the violation continues, up to a maximum of $25,000.

(b) The Commissioner may reduce the penalty under subsection (a) of this section if the carrier demonstrates to the Commissioner that the imposition of the penalty would constitute a financial hardship to the carrier.

(c) This section does not limit the authority of the Commissioner to take any other action authorized by this article.

§32–110.

The Commissioner may adopt regulations consistent with this title.

§33–101.

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

(b) "Authorized individual" means an individual:

(1) known to and screened by the carrier; and

(2) for whom the carrier has determined it to be necessary and appropriate that the individual have access to the nonpublic information held by the carrier and its information systems.

(c) (1) "Carrier" means:

(i) an authorized insurer;

(ii) a nonprofit health service plan;

(iii) a health maintenance organization;

(iv) a dental organization;

(v) a managed general agent; or

(vi) a third–party administrator.

(2) "Carrier" does not include:

(i) a purchasing group or a risk retention group chartered and licensed in a state other than this State; or

(ii) a person that is acting as an assuming insurer that is domiciled in another state or jurisdiction.

(d) "Consumer" means an individual, including an applicant, a policyholder, an insured, a beneficiary, a claimant, and a certificate holder, who is a resident of the State and whose nonpublic information is in a carrier's possession, custody, or control.

(e) (1) "Cybersecurity event" means an event resulting in unauthorized access to, or disruption or misuse of, an information system or nonpublic information stored on an information system.

(2) "Cybersecurity event" does not include:

(i) the unauthorized acquisition of encrypted nonpublic information if the encryption, process, or key is not also acquired, released, or used without authorization; or

(ii) an event with regard to which the carrier has reasonably determined that the nonpublic information accessed by an unauthorized person has not been and will not be used or released and has been returned or destroyed.

(f) "Encrypted" means the transformation of data into a form which results in a low probability of assigning meaning without the use of a protective process or key.

(g) "Information security program" means the administrative, technical, and physical safeguards that a carrier uses to access, collect, distribute, process, protect, store, use, transmit, dispose of, or otherwise handle nonpublic information.

(h) (1) "Information system" means a discrete set of electronic information resources organized for the collection, processing, maintenance, use, sharing, dissemination, or disposition of electronic information.

(2) "Information system" includes industrial or process control systems, telephone switching and private branch exchange systems, environmental control systems, and other specialized systems.

(i) "Multifactor authentication" means authentication through verification of at least two of the following types of authentication factors:

(1) knowledge factors, such as a password;

(2) possession factors, such as a token or text message on a mobile phone; or

(3) inherence factors, such as a biometric characteristic.

(j) "Nonpublic information" means information that is not publicly available information and is:

(1) business–related information of a carrier the tampering with which, or unauthorized disclosure, access, or use of which, would cause a material adverse impact to the business, operations, or security of the carrier;

(2) information concerning a consumer that, because of name, number, personal mark, or other identifier, can be used to identify the consumer, in combination with one or more of the following data elements:

(i) Social Security number;

(ii) driver's license number or nondriver identification card number;

(iii) account, credit, or debit card number;

(iv) a security code, an access code, or a password that would allow access to a consumer's financial account; or

(v) biometric records; or

(3) information or data, except age or gender, in any form or medium created by or derived from a health care provider or a consumer that can be used to identify a particular consumer and that relates to:

(i) the past, present, or future physical, mental, or behavioral health or condition of a consumer or a member of the consumer's family;

(ii) the provision of health care to a consumer; or

(iii) payment for the provision of health care to a consumer.

(k) "Publicly available information" means information that a carrier has a reasonable basis to believe is lawfully made available to the general public from:

(1) (i) federal, State, or local government records;

(ii) widely distributed media; or

(iii) disclosures to the general public that are required to be made by federal, State, or local law; and

(2) steps taken by the carrier to determine:

(i) that the information is of the type that is available to the general public; and

(ii) whether a consumer can direct that the information be made unavailable to the general public and, if so, that the consumer has not done so.

(l) "Risk assessment" means the risk assessment that a carrier is required to conduct under § 33–103(c) of this title.

(m) "Third–party service provider" means a person, other than a carrier, that contracts with a carrier to maintain, process, store, or is otherwise authorized access to nonpublic information through its provision of services to the carrier.

§33–102.

(a) The purpose of this title is to establish standards for:

(1) data security; and

(2) the investigation of and notification to the Commissioner of a cybersecurity event applicable to carriers.

(b) This title may not be construed to:

(1) create or imply a private cause of action for violation of its provisions; or

(2) curtail a private cause of action which would otherwise exist in the absence of this title.

(c) Compliance with this title does not relieve a carrier from a duty to comply with any other requirements of federal law or Title 14 of the Commercial Law Article relating to the protection and privacy of personal information.

§33–103.

(a) (1) Each carrier shall develop, implement, and maintain a comprehensive written information security program based on the carrier's risk assessment.

(2) The information security program shall contain administrative, technical, and physical safeguards for the protection of nonpublic information and the carrier's information system.

(3) A carrier's information security program shall be commensurate with:

(i) the size and complexity of the carrier;

(ii) the nature and scope of the carrier's activities, including its use of third–party service providers; and

(iii) the sensitivity of the nonpublic information used by the carrier or in the carrier's possession, custody, or control.

(b) A carrier's information security program shall be designed to:

(1) protect the security and confidentiality of nonpublic information and the security of the information system;

(2) protect against threats or hazards to the security or integrity of nonpublic information and the information system;

(3) protect against unauthorized access to or use of nonpublic information and minimize the likelihood of harm to a consumer; and

(4) define and periodically reevaluate a schedule for retention of nonpublic information and a mechanism for its destruction when no longer needed.

(c) Each carrier shall:

(1) designate one or more employees, an affiliate, or an outside vendor designated to act on behalf of the carrier who is responsible for the information security program;

(2) identify reasonably foreseeable internal or external threats that could result in unauthorized access, transmission, disclosure, misuse, alteration, or destruction of nonpublic information, including the security of information systems and nonpublic information that are accessible to, or held by, third–party service providers;

(3) assess the likelihood and potential damage of the threats described under item (2) of this subsection, taking into consideration the sensitivity of the nonpublic information;

(4) assess the sufficiency of policies, procedures, information systems, and other safeguards in place to manage the threats described under item (2) of this subsection, including consideration of threats in each relevant area of the carrier's operations, such as:

(i) employee training and management;

(ii) information systems, including network and software design, as well as information classification, governance, processing, storage, transmission, and disposal; and

(iii) detecting, preventing, and responding to attacks, intrusions, or other system failures;

(5) implement information safeguards to manage the threats identified in its ongoing assessment; and

(6) at least annually, assess the effectiveness of the key controls, systems, and procedures of the safeguards.

(d) Based on its risk assessment, a carrier shall:

(1) design its information security program to mitigate the identified risks, commensurate with the size and complexity of the carrier's activities, including

its use of third–party service providers, and the sensitivity of the nonpublic information used by the carrier or in the carrier's possession, custody, or control; and

(2) determine which of the following security measures are appropriate and implement the appropriate security measures:

(i) placement of access controls on information systems, including controls to authenticate and allow access only to authorized individuals to protect against the unauthorized acquisition of nonpublic information;

(ii) identification and management of the data, personnel, devices, systems, and facilities that enable the organization to achieve business purposes in accordance with their relative importance to business objectives and the organization's risk strategy;

(iii) restriction of access at physical locations containing nonpublic information to authorized individuals only;

(iv) protection, by encryption or other appropriate means, of all nonpublic information:

1. during transmission over an external network; and

2. stored on a laptop computer or other portable computing or storage device or media;

(v) adoption of secure development practices for in–house developed applications used by the carrier and procedures for evaluating, assessing, or testing the security of externally developed applications used by the carrier;

(vi) modification of the information system in accordance with the carrier's information security program;

(vii) use of effective controls, which may include multifactor authentication procedures for an individual accessing nonpublic information;

(viii) regular testing and monitoring of systems and procedures to detect actual and attempted attacks on, or intrusions into, information systems;

(ix) inclusion of audit trails within the information security program designed to:

1. detect and respond to cybersecurity events; and

2. reconstruct material financial transactions sufficient to support normal operations and obligations of the carrier;

(x) implementation of measures to protect against destruction, loss, or damage of nonpublic information due to environmental hazards, such as fire and water damage or other catastrophes or technological failures; and

(xi) development, implementation, and maintenance of procedures for the secure disposal of nonpublic information in any format.

(e) A carrier's enterprise risk management process shall include cybersecurity risks.

(f) Each carrier shall:

(1) stay informed regarding emerging threats or vulnerabilities and use reasonable security measures when sharing information relative to the character of the sharing and the type of information shared; and

(2) provide its personnel with cybersecurity awareness training that is updated as necessary to reflect risks identified by the carrier in the risk assessment.

(g) (1) If a carrier has a board of directors, the board or an appropriate committee of the board shall, at a minimum:

(i) require the carrier's executive management or its delegates to develop, implement, and maintain the carrier's information security program; and

(ii) require the carrier's executive management or its delegates to report in writing, at least annually, the following information:

1. the overall status of the information security program and the carrier's compliance with this title; and

2. material matters related to the information security program, addressing issues such as risk assessment, risk management and control decisions, third–party service provider arrangements, results of testing, cybersecurity events or violations and management's responses thereto, and recommendations for changes in the information security program.

(2) If executive management of a carrier delegates any of the responsibilities under this section, the executive management shall:

(i) oversee the development, implementation, and maintenance of the carrier's information security program prepared by the delegates; and

(ii) receive a report from the delegates that complies with the requirements for the report to the board of directors under paragraph (1) of this subsection.

(h) A carrier shall require a third–party service provider to implement appropriate administrative, technical, and physical measures to protect and secure the information systems and nonpublic information that are accessible to or held by the third–party service provider.

(i) (1) Each carrier shall establish a written incident response plan designed to promptly respond to, and recover from, any cybersecurity event that compromises the confidentiality, integrity, or availability of nonpublic information in its possession, the carrier's information systems, or the continuing functionality of any aspect of the carrier's business or operations.

(2) The incident response plan shall address the following areas:

(i) the internal process for responding to a cybersecurity event;

(ii) the goals of the incident response plan;

(iii) the definition of clear roles, responsibilities, and levels of decision–making authority;

(iv) external and internal communications and information sharing;

(v) identification of requirements for the remediation of identified weaknesses in information systems and associated controls;

(vi) documentation and reporting regarding cybersecurity events and related incident response activities; and

(vii) the evaluation and revision, as necessary, of the incident response plan following a cybersecurity event.

(j) (1) Except as provided in subsection (k) of this section, on or before April 15 each year, each carrier shall submit to the Commissioner a written

statement certifying that the carrier is in compliance with the requirements set forth in this section.

(2) Each carrier shall maintain for examination by the Commissioner all records, schedules, and data supporting this certificate for a period of 5 years.

(k) A carrier that is not domiciled in the State is exempt from the provisions of subsection (j)(1) of this section if the carrier:

(1) (i) is domiciled in another United States insuring jurisdiction that has adopted a law or regulation that is substantially similar to this section;

(ii) is subject to that law or regulation;

(iii) is required to file a certification of compliance with its domestic regulator under that law or regulation; and

(iv) actually files the required certification with its domestic regulator; or

(2) (i) is a member of an insurance holding company system, as defined in § 7–101 of this article; and

(ii) has implemented and is subject to an information security program that has been approved and is maintained by another carrier within the same insurance holding company system that meets all of the criteria set forth in item (1) of this subsection.

§33–104.

(a) If a carrier learns that a cybersecurity event has or may have occurred, the carrier or an outside vendor or service provider designated to act on behalf of the carrier shall conduct a prompt investigation.

(b) During the investigation, the carrier or an outside vendor or service provider designated to act on behalf of the carrier, shall, at a minimum:

(1) determine as much of the following information as possible:

(i) whether a cybersecurity event has occurred;

(ii) the nature and scope of the cybersecurity event; and

(iii) identification of nonpublic information that may have been involved in the cybersecurity event; and

(2) perform or oversee reasonable measures to restore the security of the information systems compromised in the cybersecurity event to prevent further unauthorized acquisition, release, or use of nonpublic information in the carrier's possession, custody, or control.

(c) If a carrier learns that a cybersecurity event has or may have occurred in a system maintained by a third–party service provider, the carrier shall complete the steps listed in subsection (b) of this section or confirm and document that the third–party service provider has completed those steps.

(d) A carrier shall:

(1) maintain records concerning all cybersecurity events for a period of at least 5 years from the date of the cybersecurity event; and

(2) produce the records on demand of the Commissioner.

§33–105.

(a) A carrier shall notify the Commissioner as promptly as possible but in no event later than 3 business days from a determination that a cybersecurity event has occurred when either of the following criteria has been met:

(1) (i) the State is the carrier's state of domicile; and

(ii) the cybersecurity event has a reasonable likelihood of harming a consumer residing in the State or any material part of the normal operations of the carrier; or

(2) the carrier reasonably believes that the nonpublic information involved is of 250 or more consumers residing in the State and either of the following circumstances is present:

(i) a cybersecurity event impacting the carrier has occurred for which notice must be provided to a government body, self–regulatory agency, or any other supervisory body under state or federal law; or

(ii) a cybersecurity event has occurred that has a reasonable likelihood of materially harming:

1. a consumer residing in the State; or

2. a material part of the normal operation of the carrier.

(b) The carrier shall provide as much of the following information as reasonably possible:

(1) the date of the cybersecurity event;

(2) a description of how the information was exposed, lost, stolen, or breached, including the specific roles and responsibilities of third–party service providers, if any;

(3) how the cybersecurity event was discovered;

(4) whether any lost, stolen, or breached information has been recovered and, if so, how this was done;

(5) the identity of the source of the cybersecurity event;

(6) whether the carrier has filed a police report or has notified a regulatory, government, or law enforcement agency and, if so, when the notification was provided;

(7) a description of the specific types of information acquired without authorization and, more specifically, particular data elements, such as types of medical information, types of financial information, or types of information allowing identification of the consumer;

(8) the period during which the information system was compromised by the cybersecurity event;

(9) the number of total consumers in the State affected by the cybersecurity event, with the carrier providing:

(i) the best estimate of this number in its initial report to the Commissioner; and

(ii) an updated estimate of this number in each subsequent report to the Commissioner in accordance with this section;

(10) the results of any internal review:

(i) identifying a lapse in either automated controls or internal procedures; or

(ii) confirming that all automated controls or internal procedures were followed;

(11) a copy of the carrier's privacy policy and a statement outlining the steps the carrier will take to investigate and notify consumers affected by the cybersecurity event; and

(12) the name of a contact person who is both familiar with the cybersecurity event and authorized to act for the carrier.

(c) A carrier shall provide the information required under this section in electronic form as directed by the Commissioner.

(d) A carrier shall have a continuing obligation to update and supplement initial and subsequent notifications to the Commissioner concerning the cybersecurity event.

(e) A carrier shall comply with § 14–3504 of the Commercial Law Article, as applicable, and provide a copy of the notice sent to consumers under that section to the Commissioner.

(f) If a managed care organization conducts an investigation as required by the Maryland Department of Health in accordance with the managed care organization's contract with the Maryland Department of Health and determines that a cybersecurity event has occurred, the managed care organization shall provide to the Commissioner copies of all notices and reports provided to the Maryland Department of Health at the same time and in the same manner that the managed care organization provides the notices and reports to the Maryland Department of Health.

§33–106.

(a) A carrier that is subject to, governed by, and compliant with the privacy, security, and breach notification rules issued by the U.S. Department of Health and Human Services, 45 C.F.R. Parts 160 and 164, established under the Health Insurance Portability and Accountability Act of 1996, and the Health Information Technology for Economic and Clinical Health Act, and that maintains nonpublic information in the same manner as protected health information:

(1) shall be deemed to be in compliance with §§ 33–103 and 33–104 of this title; and

(2) must comply with § 33–105(a) through (d) of this title.

(b) A carrier that is subject to, governed by, and in compliance with § 33–103 of this title shall be deemed to be in compliance with §§ 14–3502 and 14–3503 of the Commercial Law Article.

§33–107.

(a) (1) Documents, materials, and other information in the control or possession of the Commissioner that are furnished by a carrier or an employee or agent thereof acting on behalf of the carrier under § 33–103(j) or § 33–105(b)(2) through (5), (8), (10), and (11) of this title or that are obtained by the Commissioner in an investigation or examination under this section or from a managed care organization in accordance with § 33–105(f) of this title:

(i) are confidential by law and privileged;

(ii) are not subject to the Maryland Public Information Act;

(iii) are not subject to subpoena; and

(iv) are not subject to discovery or admissible in evidence in a private civil action.

(2) The Commissioner is authorized to use the documents, materials, and other information in the furtherance of a regulatory or legal action brought as a part of the Commissioner's duties.

(b) The Commissioner and any person who received documents, materials, or other information while acting under the authority of the Commissioner may not be allowed or required to testify in a private civil action concerning confidential documents, materials, or other information subject to subsection (a) of this section.

(c) The Commissioner may:

(1) if the recipient agrees to maintain the confidentiality and privileged status of the documents, materials, or other information, share documents, materials, or other information, including the confidential and privileged documents, materials, or other information subject to subsection (a) of this section, with:

(i) other state, federal, and international regulatory agencies;

(ii) the National Association of Insurance Commissioners, its affiliates, or subsidiaries; and

(iii) state, federal, and international law enforcement authorities, provided that the recipient agrees to maintain the confidentiality and privileged status of the document, material, or other information;

(2) receive documents, materials, or other information, including otherwise confidential and privileged documents, materials, or other information, from:

(i) the National Association of Insurance Commissioners, its affiliates, or subsidiaries; and

(ii) regulatory and law enforcement officials of other foreign or domestic jurisdictions;

(3) share documents, materials, or other information subject to subsection (a) of this section with a third–party consultant or vendor, if the consultant agrees in writing to maintain the confidentiality and privileged status of the document, material, or other information; and

(4) enter into agreements governing sharing and use of information consistent with this subsection.

(d) The Commissioner shall maintain as confidential or privileged any document, material, or other information received under subsection (c)(2) of this section with notice or the understanding that it is confidential or privileged under the laws of the jurisdiction that is the source of the document, material, or other information.

(e) A waiver of an applicable privilege or claim of confidentiality in the documents, materials, or other information may not occur as a result of disclosure to the Commissioner under this section or as a result of sharing as authorized in subsection (c) of this section.

(f) This section does not prohibit the Commissioner from releasing final, adjudicated actions that are open to public inspection.

§33–108.

In addition to any other sanction to which a carrier may be subject, a carrier that violates a provision of this title is subject to a penalty of not less than $100 but not more than $125,000 for each violation of this title.

§33–109.

The Commissioner may adopt regulations consistent with this title.