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Relevant Maryland Laws and Regulations

Advisory Note

The statutes and regulations provided on PICD's website are updated annually, as needed. PICD has provided a summary in parenthesis after some code & regulatory sections to assist consumers in identifying areas of interest.

a. For Statutes – https://mgaleg.maryland.gov/mgawebsite/Laws/Statutes

b. For Regulations – http://www.dsd.state.md.us/COMAR/comarhome.html

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SECTION I: MARYLAND CLAIM SETTLEMENT LAWS

a. Maryland Code, Insurance Article.Title 27.Unfair Trade Practices and Other Prohibited Practices.Subtitle 3.Unfair Claim Settlement Practices.

b. Website Link to COMAR 31.15.07, Unfair Trade Practices

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§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.

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§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.

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§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.

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§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;

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(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.

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§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 make restitution to each claimant who has suffered actual economic damage because of the violation.

(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.

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(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.

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§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.

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COMAR 31.15.07, Unfair Trade Practices – click HERE

.01. Scope.

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.03. Unfair Claim Settlement Practices.

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SECTION II: MARYLAND LAW HOMEOWNER'S INSURANCE NOTICES & COVERAGE

a. Maryland Code, Insurance Article.Title 19. Property and Casualty Insurance.Subtitle 2.Homeowners Insurance Policies

b. Website link to COMAR 31.15.07, Unfair Trade Practices

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§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.

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§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.

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§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.

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§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.

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§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.

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(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.

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§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.

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(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.

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§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.

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§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.

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(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.

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§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.

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§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

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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.

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§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:

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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.

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§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.

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(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.

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§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.

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§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.

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(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.

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§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.

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§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:

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(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.

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§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.

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§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.

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31.08.05 Addition, Reduction, or Elimination in Coverage Notice Requirement

31.08.12 Temporary Moratoriums and Weather Events

31.08.13 Application of a Percentage Deductible in the Case of a Hurricane

31.08.14 Coverage for Loss Caused by Water That Backs Up Through Sewers or Drains

31.08.15 Underwriting Period

31.08.16 Notice of Amount of Renewal and Expiring Policy Premiums

31.08.18 Homeowner's Insurance Notice

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SECTION III:
MARYLAND LAWS
PREMIUMS, RATINGS, & NON-RENEWAL/CANCELLATION OF INSURANCE

a. Maryland Code, Insurance Article –Various titles and subtitles

b. Maryland Code, Insurance Article, Title 27. Unfair Trade Practices and Other Prohibited Practices.Subtitle 6.Cancellations, Nonrenewal, Premium Increases, and Reductions in Coverage

c. Website link to COMAR 31.15.10.Homeowner's Insurance and Private Passenger Motor Vehicle Insurance—Standards for Cancellation and Nonrenewal

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§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.

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§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.

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§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.

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(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.

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§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.

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§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

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provider's profession may be offered and priced separately from a policy issued or delivered under subsection (a) of this section.

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§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.

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§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;

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(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) This section does not prohibit an insurer from:

(1) paying commissions or other compensation to licensed insurance producers;

(2) 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:

(i) 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

(ii) the insurance producer receiving the commission has agreed to the specific level of commission to be paid on the policy; or

(3) allowing or returning to its participating policyholders, members, or subscribers lawful dividends, savings, or unabsorbed premium deposits.

§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

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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 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 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 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.

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(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 not exceeding:

(i) $100 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) $250 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.

(2) 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 $250 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) 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.

(4) 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.

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(5) 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.

(6) 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 paragraph (4) or (5) of this subsection for each policy or certificate of coverage; and

(ii) only one policy fee may be charged under paragraph (1) or (2) of this subsection for each policy or certificate of coverage.

(7) (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.

(8) 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;

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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.

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(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

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(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.

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§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;

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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

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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.

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(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.

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(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 military 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 military 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 military 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.

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(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.

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(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.

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§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.

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(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.

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§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.

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§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.

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§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.

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(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.

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§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.

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(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.

§27–604.

(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.

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§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.

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§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

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(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.

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§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.

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.01. Definitions.

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SECTION IV:

LACK OF GOOD FAITH ACTIONS

a. Insurance Article, Title 27. Unfair Trade Practices and Other Prohibited Practices.Subtitle10. Property and Casualty Insurance–First-Party Claims. §27-1001. Actions under§3-1701of the Courts Article (procedure for lack of good faith actions)

b. Courts and Judicial Proceedings Article §3-1701

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§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.

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(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:

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(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.

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(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.

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(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.

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§3–1701.

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

(2) "Casualty insurance" has the meaning stated in § 1–101 of the Insurance Article.

(3) "Commercial insurance" has the meaning stated in § 27–601 of the Insurance Article.

(4) (i) "Disability insurance" means insurance that 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.

(ii) "Disability insurance" does not include payment for medical expenses, dismemberment, or accidental death.

(5) "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.

(6) "Insurer" has the meaning stated in § 1–101 of the Insurance Article.

(7) "Property insurance" has the meaning stated in § 1–101 of the Insurance Article.

(b) This subtitle applies only to first–party claims under property and casualty insurance policies or individual disability insurance policies issued, sold, or delivered in the State.

(c) (1) Except as provided in paragraph (2) of this subsection, a party may not file an action under this subtitle before the date of a final decision under § 27–1001 of the Insurance Article.

(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 this article;

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(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) This section applies only in a civil action:

(1) (i) To determine the coverage that exists under the insurer's insurance policy; or

(ii) To determine the extent to which the insured is entitled to receive payment from the insurer for a covered loss;

(2) That alleges that the insurer failed to act in good faith; and

(3) That seeks, in addition to the actual damages under the policy, to recover expenses and litigation costs, and interest on those expenses or costs, under subsection (e) of this section.

(e) Notwithstanding any other provision of law, if the trier of fact in an action under this section finds in favor of the insured and finds that the insurer failed to act in good faith, the insured may recover from the insurer:

(1) Actual damages, which actual damages may not exceed the limits of the applicable policy;

(2) Expenses and litigation costs incurred by the insured in an action under this section or under § 27–1001 of the Insurance Article or both, including reasonable attorney's fees; and

(3) Interest on all actual damages, expenses, and litigation costs incurred by the insured, computed:

(i) At the rate allowed under § 11–107(a) of this article; and

(ii) From the date on which the insured's claim would have been paid if the insurer acted in good faith.

(f) 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.

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(g) The amount of attorney's fees recovered from an insurer under subsection (e) of this section may not exceed one–third of the actual damages recovered.

(h) The clerk of the court shall file a copy of the verdict or any other final disposition of an action under this section with the Maryland Insurance Administration.

(i) This section does not limit the right of any person to maintain a civil action for damages or other remedies otherwise available under any other provision of law.

(j) If a party to the proceeding elects to have the case tried by a jury in accordance with the Maryland Rules, the case shall be tried by a jury.

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