~~AUTOMOBILE INSURANCE FUND UNDER § 243H OF THIS ARTICLE FOR ANY BENEFITS OR PAYMENTS THAT WOULD OTHERWISE BE PAYABLE UNDER UNINSURED MOTORIST COVERAGE.~~

~~(h) The amount of uninsured motorist coverage under a motor vehicle insurance policy may not exceed the amount of the liability coverage under the same policy.~~

~~541A.~~

~~(A) IN THIS SECTION, THE TERMS "HEALTH CARE SERVICE" AND "HEALTH CARE PRACTITIONER" HAVE THE MEANINGS STATED IN THE HEALTH – GENERAL ARTICLE, § 19-1501.~~

~~(B) (1) BEGINNING JULY 1, 1997, WITH RESPECT TO HEALTH CARE SERVICES RELATING TO SOFT TISSUE INJURIES RESULTING FROM A MOTOR VEHICLE ACCIDENT, AN INSURER PROVIDING BENEFITS UNDER § 539 OF THIS SUBTITLE OR PROVIDING COVERAGE UNDER § 541(A) AND (C) OF THIS SUBTITLE MAY NOT BE REQUIRED TO PAY, AND A PERSON PROVIDING SUCH HEALTH CARE SERVICES MAY NOT REQUIRE OR REQUEST, PAYMENT IN EXCESS OF THAT PROVIDED UNDER § 19-1509 OF THE HEALTH – GENERAL ARTICLE.~~

~~(2) IF REIMBURSEMENT FOR A HEALTH CARE SERVICE HAS NOT BEEN ESTABLISHED BY THE SYSTEM ADOPTED UNDER § 19-1509 OF THE HEALTH – GENERAL ARTICLE THE AMOUNT PAYABLE MAY NOT EXCEED 80% OF THE PROVIDER'S USUAL AND CUSTOMARY CHARGE.~~

~~(3) A HEALTH CARE PRACTITIONER SUBJECT TO THIS SECTION MAY NOT BILL THE INSURED OR INJURED PERSON, OR OTHERWISE ATTEMPT TO COLLECT, ANY DIFFERENCE BETWEEN THE AMOUNT PAYABLE UNDER THIS SECTION AND ANY OTHER AMOUNT CHARGED BY THE HEALTH CARE PRACTITIONER.~~

~~(C) (1) BEGINNING JANUARY 1, 1997, ANY INSURER PAYING BENEFITS OR CLAIMS UNDER § 539 OR PROVIDING COVERAGE UNDER § 541 OF THIS ARTICLE MAY CONTRACT WITH A PEER REVIEW ORGANIZATION (PRO) FOR THE PURPOSE OF EVALUATING WHETHER HEALTH CARE SERVICES FOR SOFT TISSUE INJURIES ARE:~~

~~(I) MEDICALLY NECESSARY; AND~~

~~(II) CONFORM TO PROFESSIONAL STANDARDS OF PERFORMANCE.~~

~~(2) AN INSURER'S REFERRAL OF A BILL FOR A HEALTH CARE SERVICE MUST BE MADE TO A PRO WITHIN 90 DAYS OF THE INSURER'S RECEIPT OF THE PRACTITIONER'S BILL, OR MAY BE MADE AT ANY TIME FOR CONTINUING HEALTH CARE SERVICES.~~

~~(3) AN INSURER, PRACTITIONER, OR INSURED MAY REQUEST A RECONSIDERATION BY THE PRO OF THE PRO'S INITIAL DETERMINATION. SUCH A REQUEST FOR RECONSIDERATION MUST BE MADE WITHIN 30 DAYS OF THE PRO'S INITIAL DETERMINATION. IF RECONSIDERATION IS REQUESTED FOR THE HEALTH~~