(3) AN ELECTION SHALL BE MADE ON A FORM AND IN A MANNER REQUIRED BY THE COMMISSIONER.

758.

(A) THE ACTUARIAL VALUE OF BENEFITS PROVIDED UNDER INDIVIDUAL HEALTH INSURANCE COVERAGE SHALL BE CALCULATED BASED ON A STANDARDIZED POPULATION AND A SET OF STANDARDIZED UTILIZATION AND COST FACTORS.

(B) A CARRIER SHALL SUBMIT ANY INFORMATION THE COMMISSIONER MAY REQUIRE TO SUPPORT AND JUSTIFY THE CARRIER'S CALCULATIONS OF ACTUARIAL VALUES.

759.

(A) SUBJECT TO SUBSECTIONS (C) AND (G) OF THIS SECTION, A CARRIER SHALL ISSUE THE INDIVIDUAL HEALTH BENEFIT PLAN ELECTED UNDER § 756 OR § 757(A)(1) OF THIS SUBTITLE TO ANY ELIGIBLE INDIVIDUAL.

(B) (1) A CARRIER MAY NOT LIMIT COVERAGE UNDER ANY INDIVIDUAL HEALTH BENEFIT PLAN ISSUED TO AN ELIGIBLE INDIVIDUAL UNDER A PREEXISTING CONDITION PROVISION.

(2) A CARRIER MAY IMPOSE A PREEXISTING CONDITION PROVISION ON AN INDIVIDUAL WHO HAS HAD A PERIOD OF AT LEAST 63 DAYS DURING ALL OF WHICH THE INDIVIDUAL WAS NOT COVERED UNDER ANY CREDITABLE COVERAGE AND WHO WOULD OTHERWISE HAVE BEEN AN ELIGIBLE INDIVIDUAL.

(C) A CARRIER MAY REFUSE TO ISSUE AN INDIVIDUAL HEALTH BENEFIT PLAN TO AN ELIGIBLE INDIVIDUAL, IF THE CARRIER DEMONSTRATES TO THE SATISFACTION OF THE COMMISSIONER THAT:

(1) IT DOES NOT HAVE THE POLICYHOLDER SURPLUS NECESSARY TO UNDERWRITE ADDITIONAL COVERAGE; AND

(2) IT IS APPLYING THIS SECTION UNIFORMLY TO ALL INDIVIDUALS IN THE INDIVIDUAL MARKET IN THIS STATE WITHOUT REGARD TO:

(I) ANY HEALTH STATUS-RELATED FACTOR; AND

(II) WHETHER THE INDIVIDUALS ARE ELIGIBLE INDIVIDUALS.

(D) A CARRIER THAT DENIES INDIVIDUAL HEALTH INSURANCE COVERAGE UNDER SUBSECTION (C) OF THIS SECTION MAY NOT OFFER COVERAGE IN THE INDIVIDUAL MARKET UNTIL THE LATER OF:

(1) A PERIOD OF 180 DAYS AFTER THE DATE THE COVERAGE IS DENIED; OR

(2) UNTIL THE CARRIER HAS DEMONSTRATED, TO THE COMMISSIONER'S SATISFACTION THAT THE CARRIER HAS SUFFICIENT POLICYHOLDER SURPLUS TO UNDERWRITE ADDITIONAL COVERAGE.