(2) BY AN INSURER OR NONPROFIT HEALTH SERVICE PLAN ON AN EXPENSE-INCURRED BASIS, SHALL BE ACTUARIALLY EQUIVALENT TO AT LEAST THE MINIMUM BENEFITS REQUIRED TO BE OFFERED UNDER ITEM (1) OF THIS SUBSECTION.

(C) EXCLUSIONS, LIMITATIONS, OR ADJUSTMENTS.

(1) SUBJECT TO PARAGRAPH (2) OF THIS SUBSECTION, THE COMMISSION SHALL EXCLUDE OR LIMIT BENEFITS OR ADJUST COST-SHARING ARRANGEMENTS IN THE STANDARD PLAN IF THE AVERAGE RATE FOR THE STANDARD PLAN EXCEEDS 12% OF THE AVERAGE ANNUAL WAGE IN THE STATE.

(2) THE COMMISSION ANNUALLY SHALL DETERMINE THE AVERAGE RATE FOR THE STANDARD PLAN BY USING THE AVERAGE RATE SUBMITTED BY EACH CARRIER THAT OFFERS THE STANDARD PLAN.

(D) CRITERIA FOR ESTABLISHING BENEFITS.

IN ESTABLISHING BENEFITS, THE COMMISSION SHALL JUDGE PREVENTIVE SERVICES, MEDICAL TREATMENTS, PROCEDURES, AND RELATED HEALTH SERVICES BASED ON:

(1) THEIR EFFECTIVENESS IN IMPROVING THE HEALTH STATUS OF INDIVIDUALS;

(2) THEIR IMPACT ON MAINTAINING AND IMPROVING HEALTH AND ON REDUCING THE UNNECESSARY CONSUMPTION OF HEALTH CARE SERVICES; AND

(3) THEIR IMPACT ON THE AFFORDABILITY OF HEALTH CARE COVERAGE.

(E) EXCLUSION OF MANDATED BENEFITS ALLOWED.

THE COMMISSION MAY EXCLUDE:

(1) A HEALTH CARE SERVICE, BENEFIT, COVERAGE, OR REIMBURSEMENT FOR COVERED HEALTH CARE SERVICES THAT IS REQUIRED UNDER THIS ARTICLE OR THE HEALTH - GENERAL ARTICLE TO BE PROVIDED OR OFFERED IN A HEALTH BENEFIT PLAN THAT IS ISSUED OR DELIVERED IN THE STATE BY A CARRIER; OR

(2) REIMBURSEMENT REQUIRED BY STATUTE, BY A HEALTH BENEFIT PLAN FOR A SERVICE WHEN THAT SERVICE IS PERFORMED BY A HEALTH CARE PROVIDER WHO IS LICENSED UNDER THE HEALTH OCCUPATIONS ARTICLE AND WHOSE SCOPE OF PRACTICE INCLUDES THAT SERVICE.

(F) DEDUCTIBLES AND COST-SHARING.

THE STANDARD PLAN SHALL INCLUDE UNIFORM DEDUCTIBLES AND COST-SHARING ASSOCIATED WITH ITS BENEFITS, AS DETERMINED BY THE COMMISSION.

(G) CONSIDERATIONS FOR COST-SHARING.