

(i) a health care service, benefit, coverage, or reimbursement for covered health care services that is required under this article or the Health – General Article to be provided or offered in a health benefit plan that is issued or delivered in the State by a carrier; or

(ii) reimbursement required by statute, by a health benefit plan for a service when that service is performed by a health care provider who is licensed under the Health Occupations Article and whose scope of practice includes that service.

(b) (1) The Board shall establish a premium rate for Plan coverage subject to review and approval by the Commissioner.

(2) The premium rate may vary on the basis of family composition.

(3) If the Board determines that a standard risk rate would create market dislocation, the Board may adjust the premium rate based on member age.

(4) The Board may charge different premiums based on the benefit package delivery system **OR COST-SHARING ARRANGEMENT** when more than one benefit package delivery system **OR COST-SHARING ARRANGEMENT** is offered.

(c) (1) The Board shall determine a standard risk rate by considering the premium rates charged by carriers in the State for coverage comparable to that of the Plan.

(2) The premium rate for Plan coverage:

(i) may not be less than 110% of the standard risk rate established under paragraph (1) of this subsection; and

(ii) may not exceed 200% of the standard risk rate.

(3) Premium rates shall be reasonably calculated to encourage enrollment in the Plan.

(4) The Board may subsidize premiums, deductibles, and other policy expenses, based on a member's income.

(D) (1) NOTWITHSTANDING THE PROVISIONS OF SUBSECTION (B) OF THIS SECTION, IF THE BOARD HAS IMPLEMENTED A PREEXISTING CONDITION LIMITATION, THE BOARD MAY OFFER MEMBERS AN OPTIONAL ENDORSEMENT TO REMOVE THE PREEXISTING CONDITION LIMITATION.