(2) For those members enrolled in the Plan whose eligibility in the Plan is subject to the requirements of the federal tax credit for health insurance costs under Section 35 of the Internal Revenue Code, the Board shall report on or before December 1, 2003, and annually thereafter, to the Governor, and subject to § 2–1246 of the State Government Article, to the General Assembly on the number of members enrolled in the Plan and the costs to the Plan associated with providing insurance to those members.

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(a) (1) The Board shall establish a standard benefit package to be offered by the Plan.

(2) The Board may exclude from the benefit package:

(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 DEVELOP A MASTER PLAN DOCUMENT THAT SETS FORTH IN DETAIL ALL OF THE TERMS AND CONDITIONS OF THE STANDARD BENEFIT PACKAGE REQUIRED BY SUBSECTION (A)(1) OF THIS SECTION, INCLUDING:

(I) THE BENEFITS PROVIDED IN THE PACKAGE;

(II) ANY EXCLUSIONS FROM COVERAGE;

(III) ANY CONDITIONS REQUIRING PREAUTHORIZATIONS OR UTILIZATION REVIEW AS A CONDITION TO OBTAINING A BENEFIT OR SERVICE;

(IV) ANY CONDITIONS OR LIMITATIONS ON THE SELECTION OF A PRIMARY CARE PROVIDER OR PROVIDER OF SPECIALTY MEDICAL CARE;

(V) ANY COST–SHARING REQUIREMENTS, INCLUDING ANY PREMIUMS, DEDUCTIBLES, COINSURANCE, AND COPAYMENT AMOUNTS FOR WHICH A MEMBER MAY BE RESPONSIBLE; AND