(3) 15 DAYS AFTER NOTICE OF THE CHANGE AND THE EFFECTIVE DATE OF CHANGE IS:

(I) SENT TO:

1. EACH MEMBER OF THE PLAN; OR

2. IF DEPENDENTS ARE INCLUDED IN THE COVERAGE, TO THE FAMILY UNIT; AND

(II) POSTED ON THE PLAN WEBSITE.

(F) ON OR BEFORE SEPTEMBER 1 OF EACH YEAR, IN ACCORDANCE WITH § 2–1246 OF THE STATE GOVERNMENT ARTICLE, THE BOARD SHALL REPORT TO THE HOUSE HEALTH AND GOVERNMENT OPERATIONS COMMITTEE AND THE SENATE FINANCE COMMITTEE ON:

(1) THE CURRENT STANDARD BENEFIT PACKAGE OFFERED BY THE PLAN; AND

(2) ANY CHANGES TO THE STANDARD BENEFIT PACKAGE IMPLEMENTED DURING THE IMMEDIATELY PRECEDING FISCAL YEAR.

(G) (1) IF THERE IS A CONFLICT BETWEEN A PROVISION OF THE MASTER PLAN DOCUMENT AND A PROVISION OF THE CERTIFICATE OF COVERAGE, THE PROVISION THAT IS MOST BENEFICIAL TO THE MEMBER SHALL CONTROL.

(2) NOTWITHSTANDING THE TERMS AND CONDITIONS OF THE STANDARD BENEFIT PACKAGE, THE MASTER PLAN DOCUMENT, OR THE CERTIFICATE OF COVERAGE, THE PLAN SHALL COMPLY WITH THE TERMS OF ANY WRITTEN REPRESENTATION OR AUTHORIZATION OF COVERAGE MADE BY OR ON BEHALF OF THE PLAN TO THE EXTENT THAT A MEMBER HAS INCURRED COSTS FOR HEALTH CARE SERVICES IN REASONABLE RELIANCE ON THE WRITTEN REPRESENTATION OR AUTHORIZATION.

[(b)](H) (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.