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CONSUMER CHOICE EVIDENCE OF COVERAGE (EOC) CHECKLIST

Small Employer and Conversion Plans

Every effort has been made to ensure the accuracy of the information in this document. All parties should consult the Texas Insurance Code, the Texas Administrative Code, and other applicable laws.

Important Note

The requirements listed are only summaries. The reader should refer to the actual cited statutes or rules to review the complete provisions listed.

Form Use - *For each listed item, complete the following:*

Page No. field *- enter a form page number reference, or N/A if not applicable.*

Comment box *- enter general comments or form objections. In the drop down box select: No Comments, Comments, or Objection. Text limit: 1200 characters. When you print the form, only the visible text (first three lines) will print.*

To view the full text in a comment box, click on the + icon in the lower right corner of the box and then use the up or down scroll buttons.

Use the last page for additional comments and objections. (Text limit: 4000 characters)

FILING REQUIREMENTS

Page No. ____

HMOs must file the evidence of coverage and related forms, including the member handbook for all plans other than CHIP plans, for approval prior to issuance - TIC §1271.101, and 28 TAC §11.301(4) and §11.501
Chip member handbooks are filed for information - 28 TAC §11.301(5)

Page No. ____

All variable material must be bracketed and include an explanation of variability - 28 TAC §11.505(e)

Page No. ____

Certification of plain language requirements (transmittal checklist) - 28 TAC §3.601, §3.602, §11.505(f) and §26.14(b)

Page No.

Insert Pages - replacement page; may be filed with or subsequent to approval or review of an evidence of coverage or written plan description, including a member handbook - 28 TAC §11.2(b)(22) and §11.505(h) - (j)

Page No.

Matrix Filings - must identify each provision with a unique form number that is sufficient to distinguish it as a matrix filing - 28 TAC §11.2(b)(27) and §11.505(g)

FORMS AND DOCUMENTS TO BE INCLUDED IN FILING

Page No.

Cost Savings Statement - reduction in premium resulting from the differences in coverage and design between the consumer choice health benefit plan and an identical plan providing all state mandated benefits - 28 TAC §21.3543(2)(B)

Page No.

Certification of compliance relating to Offer of State Mandated Plan - 28 TAC §21.3542 and §21.3543(2)(C)

Page No.

Health Carrier Disclosure Form CCP 1 - 28 TAC §21.3530 and §21.3543(2)(A)

Page No.

Rates to be used with a consumer choice health benefit plan - 28 TAC §21.3543(2)(D)

MANDATORY EOC PROVISIONS

Complaint and Appeal Procedures:

Page No. ____

Complaints and appeals - TIC §§843.251 - 843.262 and §1271.054, and 28 TAC §11.506(b)(5)

Page No. ____

A statement that an HMO will not engage in retaliatory action against an enrollee filing a complaint - TIC §843.281

Preauthorization Procedures:

Page No. ____

Preauthorization - Favorable determination of medical necessity - TIC §843.348, and 28 TAC §19.1718(d)

Adverse Determination Procedures - Utilization Review:

Page No. ____

Adverse determination - services provided or proposed are determined not medically necessary or experimental and investigational - TIC §4201.002 and §§4201.304 - 4201.305

Page No. ____

Adverse determination - prescription drugs, if covered:
The denial of a formulary exception request or a step therapy protocol exception request is considered an adverse determination - TIC §1369.056 and §1369.0546(f)
A plan must provide 30 days' notice for a concurrent review prior to discontinuing coverage for a prescription drug or intravenous infusion for which an enrollee is receiving benefits - TIC §4201.304(b)
Step therapy exception requests qualify for an expedited review - TIC §4201.357(a-2) and §4202.003

Page No. ____

Adverse determination - retrospective review - TIC §4201.305

Adverse Determination Appeal Procedures - Utilization Review - TIC §§4201.351 - 4201.3601:

Page No. [ ] Parity - nonquantitative treatment limits. Utilization review criteria and processes must be no more restrictive for mental health and substance use disorder treatment than for medical or surgical treatment - TIC §1355.254

[ ] [ ]

Page No. [ ] Adverse determination - appeal - TIC §4201.359 and §1369.056

[ ] [ ]

Page No. [ ] Adverse determination - expedited appeal for denial of emergency care, continued hospitalization, prescription drugs or intravenous infusions - TIC §4201.357

[ ] [ ]

Page No. [ ] Adverse determination - immediate appeal to independent review organization (IRO) for a life threatening condition, prescription drugs or intravenous infusions - TIC §§4201.360 - 4201.457

[ ] [ ]

Continuation of Coverage - TIC §§1271.301 - 1271.304, and 28 TAC §21.5302, §§21.5310 - 21.5314 and §26.14(a):

Page No. [ ] Enrollee must send written notice of election to continue coverage no later than 60 days

[ ] [ ]

Page No. [ ] Enrollee shall make payment no later than 45 days after the initial election for coverage and on the due date of each month thereafter

[ ] [ ]

Page No. [ ] Following the first payment made, payments considered timely if made by the 30th day after the date payment is due

[ ] [ ]

Page No. [ ] Enrollees not eligible for COBRA are entitled to 9 months Continuation coverage

[ ] [ ]

Page No.

Enrollees eligible for COBRA, entitled to continuation of coverage for an additional 6 months

Eligibility and Enrollment Standards:

Page No.

Eligibility requirements - 28 TAC §11.506(b)(8)

Page No.

Adopted children - TIC §1501.608, and 28 TAC §11.506(b)(8)(A)(i), §26.9(a)(5) - (8)

Page No.

Affiliation period - imposed by HMO (cannot exceed 60 days for enrollees and 90 days for late enrollees) - TIC §1501.104, and 28 TAC §26.9(a)(9) and (16) - (18)

Page No.

Court-ordered medical and dental child support - TIC §1501.008(c)(3) and §§1504.001 - 1504.102, and 28 TAC §11.506(b)(8)(A)(iv) and §§21.2001 - 21.2011

Page No.

Dependent Coverage - must offer dependent coverage to each eligible employee - 28 TAC §26.14(c)

Page No.

Grandchildren - limiting age for children and grandchildren must be stated in the EOC - TIC §1201.062, §1271.005(e) and §1271.006, and 28 TAC §11.506(b)(8)(E)

Page No.

Handicapped child - a covered disabled child's attainment of limiting age does not operate to terminate the coverage of such child - TIC §1501.002(2)(C), and 28 TAC §11.506(b)(17)

Page No.

Late enrollment and late enrollee exceptions - TIC §1501.008 and §1501.156, and 28 TAC §26.4(29) and §26.9

Page No.

Limiting age - subscriber and dependents - 28 TAC §11.506(b)(8)(C)

Page No.

New enrollees - special enrollment in accordance with 45 C.F.R. 146.117 (HIPAA) - 28 TAC §11.509(2)

Page No.

Newborns - TIC §1501.002(2)(B) and §1501.157, and 28 TAC §11.506(b)(8)(D) and §26.9(a)(4)

Page No.

Newly acquired dependents - 28 TAC §11.506(b)(8)(B)

Page No.

Open enrollment - TIC §1501.606, and 28 TAC §26.7(h)(4)

Page No.

Participation criteria - determined by HMO - TIC §1501.154, §1501.155, and §1501.203

Page No.

Student coverage - termination due to change in student enrollment status - TIC §1501.002(2) and §§1503.001 - 1503.003, and 28 TAC §11.506(b)(18)

Page No.

Waiting period - determined by the employer for new employees - TIC §1501.002(17), §1501.105 and §1501.156
Note: Eligible Employee does not include employees within their waiting or affiliation period for percentage of participation requirements - 28 TAC §26.8(b)

Other Mandatory EOC Provisions:

Page No.

Cancellation or termination of contract - TIC §843.208 and §1501.108, and 28 TAC §11.506(b)(3)(A) - (C) and §26.15 group plans

Page No.

Conformity with state law - 28 TAC §11.506(b)(19)

Page No.

Cover page - consumer choice required EOC notice; must be at the beginning of the document in at least 12 point bold type - 28 TAC §21.3528

Page No.

Definitions - 28 TAC §11.506(b)(6)

Page No.

Effective date - 28 TAC §11.506(b)(7)

Page No.

Entire contract, amendments - 28 TAC §11.506(b)(10)

Page No.

Exclusions and limitations - 28 TAC §11.506(b)(11)

Page No.

Face page - HMO name, address, website address, telephone number, and toll-free telephone number - TIC §521.102, and 28 TAC §11.506(b)(1)

Page No.

Face page - Toll-Free Notice (English/Spanish) - 28 TAC §1.601 and §11.506(b)(1)(C)

Page No.

Face page - Workers' Compensation (WC) Insurance Disclosure - sale of substitutes to WC Insurance, if applicable - 28 TAC §§5.6302 and 11.511(3)

Page No.

Facility-based physicians and balance billing - required statement - TIC §1456.003, and 28 TAC §11.506(b)(2)(C)

Page No.

Grace period - 28 TAC §11.506(b)(12)

Page No.

Incontestability - 28 TAC §11.506(b)(13)

Page No.

Mandatory Benefit Notices - 28 TAC §§21.2103 - 21.2106

Page No.

Mandatory Disclosure Requirements - Notice of rights must be included in all evidence of coverages, certificates, disclosures of plan terms, and member handbooks - 28 TAC §11.1612(c)

Page No. [ ]

Medicare Supplement and Long-Term Care - conformity with minimum standards, if applicable - 28 TAC §11.506(b)(20)

[ ] [ ]

Page No. [ ]

Out-of-Network claims; non-network physicians and providers - 28 TAC §11.1611
HMO reimbursement for:
(a) Services by a non-network facility-based physician in a network facility, or situations where no choice of a network physician or provider was given;
(b) Emergency care in a non-network facility;
(c) Referral to a non-network physician or provider if medically necessary covered services, other than emergency care, are not available through a network physician or provider; referrals must be approved within five business days;
(d) An HMO reimbursing a non-network physician or provider providing services as provided under subsections (a) - (c) must hold the enrollee harmless for any amounts beyond the copayment or other out-of-pocket amounts the enrollee would have paid for services from a contracted physician or provider.
(e) An HMO must issue payment to the non-network physician or provider at the usual and customary rate or at a rate agreed to by the HMO and the non-network physician or provider;
(f) Methodology used to calculate reimbursements - must comply with 28 TAC §11.1611(f) and be no less favorable for mental health and substance use disorder benefits than for medical or surgical benefits - TIC §1355.254

[ ] [ ]

Page No. [ ]

Out-of-network services - when covered medically necessary services are not available through network physicians or providers - TIC §1271.055, and 28 TAC §11.506(b)(14) and §11.508(a)

[ ] [ ]

Page No. [ ]

Premiums - Group contract holder is liable for an enrollee's premiums from the time the enrollee is no longer part of the group eligible for coverage under the contract until the end of the month in which the contract holder notifies the HMO that the enrollee is no longer part of the group eligible for coverage by the contract. The enrollee remains covered by the contract until the end of that period - TIC §843.210, and 28 TAC §11.506(b)(12)(B) and §§21.4001 - 21.4003

[ ] [ ]

Page No. [ ]

Premium rate changes - 60-day notice - TIC §1254.001(a) - (g), and 28 TAC §11.506(b)(15)

[ ] [ ]

Page No.

Prescription drug synchronization - process for medication synchronization and prorated cost sharing - TIC §1369.454 and §1369.456

Page No.

Prompt payment of enrollee claims - TIC §§542.051- 542.061 and §1271.005(c), and 28 TAC §11.506(b)(4)

Page No.

Service area - description and map; a ZIP code map and a provider list may meet this requirement - 28 TAC §11.506(b)(16)

Page No.

Schedule of benefits - copayments. A Consumer Choice Benefit Plan (CCBP) may impose higher copayment amounts than the limits required by 28 TAC §11.506(b)(2)(A).
If a CCBP imposes higher copayment amounts, the benefit limitation must be reflected on Health Carrier Disclosure Form CCP 1 - 28 TAC §21.3530

Page No.

Schedule of benefits - deductibles. A Consumer Choice Benefit Plan (CCBP) may charge a deductible for in-network services. Except for emergency care and services not available in-network, a CCBP may charge an out-of-network deductible for services performed out of the HMO's service area or for services performed by an out-of-network physician or provider. A deductible must be for a specific dollar amount of the service cost - 28 TAC §11.506(b)(2)(B)
If a CCBP charges a deductible for in-network services, the benefit limitation must be reflected on Health Carrier Disclosure Form CCP 1 - 28 TAC §21.3530

Page No.

Schedule of benefits - parity. Quantitative and nonquantitative treatment limits, including visit limits, cost sharing, and other financial requirements must be no more restrictive for mental health and substance use disorder benefits than for medical or surgical benefits - TIC §1355.254

Page No. Specialist as primary care physician - TIC §§1271.201 - 1271.203, and 28 TAC §11.506(b)(21)

OPTIONAL EOC PROVISIONS

Page No. Arbitration (voluntary) - *mandatory binding arbitration provisions are prohibited* - 28 TAC §11.511(5) and Texas Civil Practice and Remedies Code Chapter 171

Page No. Coordination of Benefits - plans may coordinate benefits only if the agreement includes provisions consistent with TIC §§1203.001 - 1203.003, and 28 TAC §§3.3501 - 3.3510, and §11.511(1)

Page No. Conversion Privilege - 28 TAC §11.511(4), §21.5302 and §§21.5320 - 21.5322 and §26.14(a)

Page No. Point of Service and POS Riders - TIC §843.107, §843.108, and §§1273.001 - 1273.004, and 28 TAC §§11.2501 - 11.2503, §§21.2901 and 21.2902

Page No. Subrogation - 28 TAC §11.511(2), and Civil Practice and Remedies Code Chapter 140

OPTIONAL PROVISIONS - GROUP AGREEMENTS ONLY

Page No. Employer offer - 100% premium coverage - TIC §1501.153(a-1)

MANDATORY PROVISIONS - GROUP AGREEMENTS ONLY

Page No. ☐ Certificate - 28 TAC §11.509(1)

☐ ☐

Page No. ☐ New enrollees - 28 TAC §11.509(2)

☐ ☐

BASIC HEALTH CARE SERVICES - MANDATORY COVERAGE

A Consumer Choice Benefit Plan must cover the following basic health care services but may impose time and cost limits as permitted by TIC Chapter 1507, Subchapter B.

Page No. ☐ Definition of "Basic Health Care Services" - TIC §843.002(2), and 28 TAC §11.2(b)(6) and §11.508(a)
Note: An HMO must provide basic health care services when they are provided by network physicians or providers, or by non-network physicians and providers.

☐ ☐

Page No. ☐ Emergency services, including emergency transport - TIC §843.002(7) and §1271.155, and 28 TAC §11.506(b)(9), §11.508(a)(1)(J)
Notes:
Out-of-network emergency services must be paid at the usual and customary rate or at an agreed upon rate - 28 TAC §11.1611(b)
An HMO may not exclude health care services, supplies, or drugs provided for medical emergencies outside the plan service area, including outside of the United States - 28 TAC §26.28

☐ ☐

Page No.

Inpatient services - 28 TAC §11.508(a)(2)
Including:
Administration of whole blood and blood plasma
Anesthesia and oxygen services
Drugs, medications and biologicals
General nursing care
Inhalation therapy
Laboratory and other diagnostic tests
Meals and special diets when medically necessary
Private duty nursing when medically necessary
Radiation therapy
Room and board
Short-term rehabilitation therapy services in the acute hospital setting
Use of intensive care unit and services
Use of operating room and related facilities
Whole blood including cost of blood, blood plasma, and blood plasma expanders that are not replaced by or for the enrollee
X-ray services

Page No.

Inpatient physician care services - including services performed, prescribed, or supervised by physicians or other health professionals, including diagnostic, therapeutic, medical, surgical, preventive, referral, and consultative health care services - 28 TAC §11.506(b)(25) and §11.508(a)(3)

Page No.

Outpatient hospital services - 28 TAC §11.508(a)(4)
Including:
Ambulatory surgery services
Diagnostic services, including laboratory, radiology and imaging services
Rehabilitation and radiation therapy
Treatment services

Page No.

Outpatient mental health services - in parity with medical surgical benefits - TIC §1355.254, and 28 TAC §11.508(a)(1)(I) and §§21.2401 - 21.2407

Page No.

Outpatient services - 28 TAC §11.508(a)(1)
Including:
Home health services
Prenatal services (if maternity benefit covered)
Primary care - TIC §843.203
Outpatient diagnostic services, including laboratory, radiology and imaging services
Outpatient rehabilitation therapies (including physical, speech and occupational therapy)
Outpatient services by other providers
Specialist services
Therapeutic radiology services

Page No.

Preventive health services - 28 TAC §11.508(a)(1)(H)
Including:
Adult immunizations
Cancer screenings - mammography as required by TIC §§1356.001 - 1356.005
Eye and ear exams for children through age 17
Periodic adult health examinations as required by TIC §1271.153
Well-child care from birth as required by TIC §1271.154

ADDITIONAL REQUIRED BENEFITS AND CONTRACT PROVISIONS - OTHER THAN BASIC HEALTH CARE SERVICES

This section provides reference to additional benefits and contract provisions required by Texas statutes and rules. A Consumer Choice Benefit Plan (CCBP) may limit the benefits as to time and cost. The applicability for a CCBP is designated as follows:

- Benefits that are required by federal law, are noted with "required by federal law."
- Benefits that a CCBP may exclude under TIC Chapter 1507, Subchapter B, are noted with "CCBP may exclude."

If a CCBP excludes any of the following benefits, the benefit exclusion or limitation must be reflected on Health Carrier Disclosure Form CCP 1 - 28 TAC §21.3530

Page No.

Acquired brain injury - TIC §§1352.001 - 1352.008, and 28 TAC §§21.3101 - 21.3107 - required by federal law

Page No.

Amino acid-based formulas for diagnosis and treatment of certain diseases or disorders - TIC §§1377.001 - 1377.052 - required by federal law

Page No.

Cardiovascular disease - atherosclerosis and abnormal artery structure screening for diabetic enrollees and certain enrollees who have a documented medical risk of developing coronary heart disease - TIC §§1376.001 - 1376.003, and 28 TAC §21.4301 - required by federal law

Page No.

Autism Spectrum Disorder - TIC §1355.015, and 28 TAC §§21.4401 - 21.4404 - required by federal law

Page No.

Birth of child and post delivery care - minimum inpatient hospital stay if the plan includes maternity benefits - TIC §§1366.051 - 1366.059, and 28 TAC §11.508(b)(2) - required by federal law

Page No.

Annual diagnostic medical examinations and tests for each woman 18 years of age or older for the early detection of ovarian cancer and cervical cancer that complies with the minimum screening test coverage requirements under TIC §1370.003(b) - cervical cancer screening required by federal law

Page No.

Chemical dependency - TIC §§1368.001 - 1368.008, and 28 TAC §§3.8001 - 3.8030 and §11.509(3) - required by federal law

Page No.

Complications of pregnancy - 28 TAC §21.405(1) - required by federal law

Page No.

Continuity of treatment by treating physician or provider of enrollee with a “special circumstance” and termination notice - TIC §843.309 and §843.362

Page No.

Contraceptive drugs and devices and related services - TIC §§1369.101 - 1369.108, and 28 TAC §21.404(3) - required by federal law
Note: Plans may extend religious accommodations as required by Court.

Page No.

Drug formulary (if drugs are covered) - TIC §1355.254 and §§1369.051 - 1369.056, and 28 TAC §11.506(b)(24) and §§21.3020 - 21.3030

Page No.

Drug coverage continuation (if drugs are covered) - if an approved or covered drug is removed from the drug formulary before the plan renewal date, HMO must continue to offer the drug at the contracted benefit level and until the plan's renewal date - TIC §1369.055

Page No.

Drug coverage modification (if drugs are covered) - 60-day notice for modification of drug coverage - TIC §1369.0541

Page No.

Hearing aid or cochlear implant and related services and supplies, if medically necessary, for children that are 18 years of age or younger - TIC §§1367.251 - 1367.253

Page No.

Mammography - including 2D and 3D (breast tomosynthesis) for women age 35 and older on an annual basis - TIC Chapter 1356

Page No.

Mastectomy - breast reconstruction - TIC §§1357.001 - 1357.007, and 28 TAC §11.508(b)(1) - required by federal law

Page No.

Mental health coverage - a small employer plan must offer treatment for Serious Mental Illness.

If included in the plan, must include inpatient and outpatient benefits for Serious Mental Illness, including inpatient care in a psychiatric day treatment facility and treatment in a residential treatment center for children and adolescents or a crisis stabilization unit, as an alternative to inpatient hospital treatment - TIC §§1355.001 - 1355.004, §§1355.051 - 1355.054, §§1355.101 - 1355.104

Coverage must be in parity with and subject to the same terms and conditions applicable to coverage for medical and surgical benefits - TIC §§1355.251 - 1355.257, and 28 TAC §§21.2401 - 21.2407

Page No.

Orally administered anticancer medications - TIC §§1369.201 - 1369.204 - CCBP may exclude

Page No.

Osteoporosis - TIC §§1361.001 - 1361.003 - required by federal law

Page No.

Pharmacy benefits (if drugs are covered) - 28 TAC §11.1605 - CCBP may include higher copayment amounts

Page No.

Phenylketonuria (PKU) or other heritable disease dietary formulas - TIC §§1359.001 - 1359.003 and 28 TAC §11.509(6)

Page No.

Prosthetics, orthotics, and professional fitting services equivalent to that provided by the federal Medicare program - TIC §§1371.001 - 1371.005 - required by federal law

Page No.

Rehabilitation services and therapies - TIC §1271.156 - CCBP may impose time or cost limits

Page No.

Routine costs and clinical trials - routine patient care costs to an enrollee in connection with certain clinical trials - TIC §§1379.001 - 1379.056

Page No.

Urgent care - 28 TAC §11.1607(g)

OPTIONAL BENEFITS

An HMO may limit these optional health services as to time and cost - 28 TAC §11.512

Page No. [ ]

Including - 28 TAC §11.512(1) - (14):
Corrective appliances and artificial aids
Cosmetic surgery
Care for military service - connected disabilities
Care for conditions that state or local law requires be treated in a public facility
Dental services
Vision care
Custodial or domiciliary care
Experimental and investigational medical, surgical, or other experimental or investigational health care procedures
Personal or comfort items and private rooms, unless medically necessary during inpatient hospitalization
Durable medical equipment for home use (such as wheelchairs, surgical beds, ventilators, or dialysis machines)
Infertility medical services, including gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), and outpatient infertility drugs
Reversal of voluntary sterilization
Prescribed drugs and medicines incident to outpatient care, and
Noninsurance benefits provided that HMO complies with 28 TAC Chapter 21, Subchapter NN (relating to Noninsurance Benefits and Features)

[ ] [ ]

Wellness Benefits - TIC §843.151 and §1501.107, and 28 TAC §§21.4701 - 21.4708
Applies to any evidence of coverage that provides health care services, with respect to a plan that establishes premium discounts, rebates or reductions in otherwise applicable copayments, or any combination of these incentives, in return for participation in programs designed to promote disease prevention, wellness, and health.

Page No. [ ]

Participatory Wellness Programs: a program with participation as sole basis for reward eligibility and that contains no condition for obtaining a reward premised on an individual satisfying a standard associated with a health factor, program must be made available to all individuals eligible for coverage under the plan - 28 TAC §21.4706(a) and (b)

[ ] [ ]

Page No. [ ]

Activity-only Wellness Programs: a health-contingent program that requires an individual to perform or complete an activity related to a health factor in order to obtain rewards, but does not require the individual to attain or maintain a specific health outcome - 28 TAC §21.4707(a) and (b)

[ ] [ ]

Page No. **Outcome-Based Wellness Programs:** a program that requires an individual to attain or maintain a specific health outcome in order to obtain a reward - 28 TAC §21.4708(a) and (b)

BENEFITS THAT MAY BE OFFERED

This section provides reference to benefits that a Consumer Choice Benefit Plan (CCBP) may offer under the cited Texas statutes and rules, or may exclude under TIC Chapter 1507, Subchapter B.

If a CCBP does not offer any of the following benefits, the benefit exclusion or limitation must be reflected on Health Carrier Disclosure Form CCP 1 - 28 TAC §21.3530

Page No. Emotional illness or disorder (inpatient hospital alternative treatment facility) - TIC §§1355.101 - 1355.106

Page No. In-vitro fertilization procedures - TIC §§1366.001 - 1366.006

Page No. Speech and hearing - TIC §§1365.001 - 1365.004

COVERAGE STANDARDS

Page No. Alzheimer's disease, if applicable - TIC §1354.001 and §1354.002, and 28 TAC §11.506(b)(23)

Page No. Discrimination - general prohibitions applicable to HMOs - TIC §§544.001 - 544.054

Page No. Fibrocystic breast conditions - TIC §§544.201 - 544.204

Page No. Victims of family violence - TIC §§544.151 - 544.158

Genetic Testing - TIC §§546.001 - 546.152:

Page No. Notice to enrollee - TIC §546.051(a)(1)

Page No. Consent required (including consent from mother for testing in utero) - TIC §546.051(a)(3), §546.051(b) and §546.053(b)(1)

Page No. Information to enrollee of test results - TIC §546.051(b)(1)-(2) and §546.101

Page No. Inducement prohibited (to buy insurance or to induce abortion) - TIC §546.051(c) and §546.053(b)(2)

Page No. Improper use of test results prohibited - TIC §546.052

Out-of-State Group Agreement:

Page No. [ ]

An HMO issuing a group certificate covering a Texas resident is responsible for ensuring that the certificate complies with applicable Texas insurance laws and rules, including mandated benefits, regardless of whether the group agreement underlying the certificate was issued outside of Texas - 28 TAC §26.5(g)

[ ] [ ]

ENROLLMENT FORM AND APPLICATION

Page No. [ ]

Consumer choice required notice - 28 TAC §21.3527

[ ] [ ]

Page No. [ ]

COBRA and State Continuation - TIC §§1271.301 - 1271.305, and §1501.159, and 28 TAC §21.5302 and §§21.5310 - 21.5314

[ ] [ ]

Page No. [ ]

Disability affecting the enrollee's ability to communicate or read - 28 TAC §11.1602

[ ] [ ]

Page No. [ ]

Primary language other than English - 28 TAC §11.1602

[ ] [ ]

CONVERSION CONTRACTS ONLY

Page No. [ ] Consideration - 28 TAC §11.507(3)

[ ] [ ]

Page No. [ ] Continuance of coverage due to change in marital status - 28 TAC §11.507(4)

[ ] [ ]

Page No. [ ] Conversion privilege - may offer - TIC §1271.306 and §1271.307, and 28 TAC §11.511(4), §21.5302 and §§21.5320 - 21.5322

[ ] [ ]

Page No. [ ] Reinstatement - 28 TAC §11.507(1)

[ ] [ ]

Page No. [ ] Ten days to examine agreement - 28 TAC §11.507(2)

[ ] [ ]

ELECTRONIC COMMUNICATION

Page No. [ ] Written communication may be delivered by electronic means if the party consented to electronic delivery and has not withdrawn consent. A regulated entity must provide
- a statement informing the party about the right or option to receive written communication in paper form, the right to withdraw consent, and any conditions or consequences imposed if consent is withdrawn; and
- information about how to withdraw consent and how to update information needed to contact the party electronically - TIC §35.004(c)(1) and (2)

[ ] [ ]

PROHIBITED PRACTICES

Page No. ____ Discretionary clause prohibited - an evidence of coverage may not include a discretionary clause - TIC §1271.057, and 28 TAC §3.1202 and §3.1203

Page No. ____ Asbestos - HMO may not reject, deny, limit, cancel, refuse to renew, increase the premiums for, or otherwise adversely affect the person's eligibility for or coverage under the contract based on the fact that enrollee has been exposed to asbestos fibers or silica or has filed a claim governed by Civil Practice and Remedies Code Chapter 90 and TIC §544.453

Page No. ____ HIV/AIDS - HMO may not exclude or deny coverage for HIV, AIDS or HIV-related illness - TIC §§1364.001 - 1364.101

WRITTEN PLAN DESCRIPTION OR MEMBER HANDBOOK - 28 TAC §11.1600:

Note: Written plan descriptions or member handbooks must appear in the exact order required by 28 TAC §11.1600.

Page No. ____ General Requirements:

The written plan description may be delivered electronically - 28 TAC §11.1600(a)

An HMO may use its member handbook to satisfy the requirements of the written plan description - 28 TAC §11.1600(c)

An HMO offering a Children's Health Insurance Program (CHIP) must file its member handbook with the approval letter from the Texas Health and Human Services Commission (HHSC) - 28 TAC §11.1600(d)

An HMO that maintains a website must list the information on its website - TIC §843.2015 and §1456.003, and 28 TAC §§11.1600(b)-(g) and (j)

Page No.

The written or electronic plan description must include clear, complete, and accurate information in the exact order listed - 28 TAC §11.1600(b):

(1) a statement that the entity providing the coverage is an HMO;
(2) a toll-free number and address for obtaining additional information, including physician and provider information;
(3) a description of all covered services and benefits, including the options, if any, for prescription drug coverage, both generic and brand name, and how to access formulary information, consistent with §21.3031;
(4) a description of emergency care services and benefits, including coverage for out-of-area emergency care services and information on access to after-hours care;
(5) a description of out-of-area services and benefits, if any;
(6) a statement concerning facility-based physicians and balance billing - as provided in TIC §1456.003;
(7) an explanation of enrollee financial responsibility;
(8) a description of any limitations or exclusions, including any drug formulary limitations;
(9) a description of any prior authorization requirements, including limitations or restrictions; a summary of approval procedures for referrals, requirements for preauthorization review, concurrent review, post service review, post payment review, and consequences for failure to obtain required authorizations;
(10) a provision for continuity of treatment in the event of the termination of a primary care physician or dentist;
(11) a summary of the HMO's complaint and appeal procedures, including the availability of the independent review process, and a statement that the HMO is prohibited from retaliating against a physician or provider because he or she has, on behalf of the enrollee, filed a complaint against the HMO or appealed a decision of the HMO;
(12) a current list of physicians and providers, including behavioral health providers and substance abuse treatment providers, if applicable, with information about the network, including the information required by §11.1612 (relating to Mandatory Disclosure Requirements), together with a link to the online directory;
(13) a description of the service area;
(14) an explanation of the point-of-service coverage when the HMO product includes point-of-service (POS) coverage, including when such coverage is provided by an insurer, or when the product is explicitly marketed with the option of purchasing POS coverage.

Page No.

Required notice for access to a limited provider network, if applicable - 28 TAC §11.1600(e)

Page No.

Required notice for unlimited access to obstetrical or gynecological care, if applicable - 28 TAC §11.1600(f)

Page No. [ ] Separate listing of any limited provider networks within the HMO's service area and an alphabetical listing of all physicians and providers, including specialists, available in each limited provider network - 28 TAC §11.1600(g)

[ ] [ ]

Page No. [ ] Notice to contact the HMO on receipt of a bill for covered services from any physician or provider, including a facility-based physician or other health care practitioner, and information how to contact the HMO - 28 TAC §11.1600(h)

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Page No. [ ] Disclosure that upon admission to an inpatient facility, a physician other than the primary care physician may direct and oversee the care, if applicable - 28 TAC §11.1600(i)

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See next page for additional comments or objections, if any.

Additional Comments or Objections: