SUBCHAPTER M. MANDATORY BENEFIT NOTICE REQUIREMENTS
28 TAC §§21.2101 - 21.2103 AND 21.2105 - 21.2107
REPEAL OF §21.2104

INTRODUCTION. The Texas Department of Insurance adopts amendments to 28 TAC §§21.2101 - 21.2103 and 21.2105 - 2107, and the repeal of §21.2104, concerning Mandatory Benefit Notice Requirements. The amendments to §21.2101 and §21.2105 and the repeal of §21.2104 are adopted without changes to the proposed text as published in the May 13, 2016, issue of the *Texas Register* (41 TexReg 3426). Sections 21.2102, 21.2103, 21.2106, and 21.2107 are adopted with non-substantive changes to the proposed text to improve clarity and conform the text to current agency style, such changes being at §§21.2102(2)(D) and 4(B), 21.2103(b)(3), 21.2106(b)(1), and §21.2107.

In response to comment, TDI modified §21.2103(b) to clarify that a form of the notice for any substantially similar language notice must be approved by the commissioner prior to use and forms already being used must be approved by the commissioner by March 1, 2017. In addition, a change is made in §21.2103(a)(5) as proposed to revise a reference to paragraph (4) of the subsection, and changes are made throughout §21.2103(a) to revise references to §21.2306 to follow agency style.

The modification and changes do not introduce new subject matter, create additional costs, or affect persons other than those previously on notice from the proposal.

REASONED JUSTIFICATION. The amendments to §§21.2101 - 21.2103 and 21.2105 - 21.2107, and repeal of §21.2104, are necessary to implement HB 2813, 84th Legislature, Regular Session (2015) and SB 979, 84th Legislature, Regular Session (2015).

HB 2813 amended Insurance Code §1370.002 and §1370.003 to require a health benefit plan to include an annual diagnostic screening test for early detection of ovarian cancer, specifically the CA 125 blood test, as part of its coverage. Section 1370.004 requires that a health benefit plan carrier provide written notice of the coverage required under Chapter 1370.

SB 979 amended Insurance Code §1201.104 to expand one category of individual accident and health insurance policy from "hospital confinement indemnity" to "hospital indemnity or other fixed indemnity." The amendments make conforming changes to the text of Chapter 21, Subchapter M.

Amendments to §21.2101 clarify definitions and remove notice requirements related to date limitations that are no longer relevant.

Amendments to §21.2103(a)(7) require that the mandatory benefit notice include language related to ovarian cancer screening, and clarify that the notice may be modified to omit the references to ovarian cancer and the CA 125 blood test if a plan is not required to provide a benefit for ovarian cancer screening due to the exception in Insurance Code §1370.002(b). Amendments to §21.2103(b) require that any notice that includes "substantially similar language," issued after the effective date of these amendments, must be filed with TDI for review and approval by the commissioner. Amendments to §21.2103(d) remove language relating to compliance prior to the section's effective date because that grandfathering language is no longer necessary. The section includes the requirement relocated from §21.2104, which was repealed, that notices be printed in no less than 10-point type.

Amendments to §21.2105 remove date requirements that are no longer relevant.

Amendments to §21.2106 update the TDI website address and provide for language regarding ovarian cancer to be added to the notice.

Amendments to §21.2107 clarify language and include the requirement relocated from repealed §21.2104, that notices must be printed in no less than 10-point type.

The adopted amendments also include nonsubstantive changes to the the proposed text to conform the text to current agency style.

SUMMARY OF COMMENTS AND AGENCY RESPONSE. TDI received one written comment. The commenter in support of the proposal, with changes, was Texas Association of Health Plans. No hearing was requested or held.

Comment: A commenter requests that §21.2103(b) be amended to remove the requirement that any benefit notices not using the exact prescribed language be filed with TDI for review and approval. The commenter says that such a requirement: (a) is not necessary because the regulations as currently written provide sufficient protection, and (b) creates an unnecessary administrative burden and expense. As an example of the unnecessary administrative burden and expense associated with complying with the amended section, the commenter says that some health plans may modify the prescribed language so that notices may be used in multiple states and must comply with the current

requirements applicable to substantially similar notice language. The commenter also requests that if TDI does pursue a filing requirement, the filing should be on an informational basis rather than requiring approval.

Agency Response: TDI disagrees with the commenter and declines to make the requested changes, but has revised the proposed text in order to provide additional time to bring forms into compliance. As adopted, the rule requires that notices that include "substantially similar language" must be filed with TDI for review and approval by the commissioner under Insurance Code Chapters 843 (concerning Health Maintenance Organizations), 1271 (concerning Benefits Provided by Health Maintenance Organizations; Evidence of Coverage; Charges), and 1701 (concerning Policy Forms). Substantially similar notices already in use must be approved for use by March 1, 2017. Although current regulations require that the substantially similar language be readable, clear, and accurately describe certain required information, TDI cannot determine if a notice complies with these requirements unless the notice is filed with TDI for review and approval. The requirement to file and receive commissioner approval ensures that the substantially similar notice protects the rights and interests of Texas consumers to at least the same extent as the corresponding prescribed notice.

SUBCHAPTER M. MANDATORY BENEFIT NOTICE REQUIREMENTS

28 TAC §§21.2101 - 21.2103 AND 21.2105 - 21.2107

STATUTORY AUTHORITY. The amendments are adopted under Insurance Code §§1357.006, 1357.056, 1362.004, 1363.004, 1366.058, 1370.004, 1201.104, and 36.001.

Section 1357.006 requires notice of coverage for mastectomies. Section 1357.056 requires notice of coverage required for hospital stays after mastectomies. Section 1362.004 requires notice of coverage for detection of prostate cancer. Section 1363.004 requires notice of coverage for detection of colorectal cancer. Section 1366.058 requires notice of coverage for maternity, childbirth, and in-home postdelivery care. Section 1370.004 requires notice of coverage for human papillomavirus, ovarian cancer, and cervical cancer screening. Section 1201.104 requires TDI to adopt rules establishing minimum benefit standards for individual accident and health insurance policies. Insurance Code Section 36.001 provides that the commissioner may adopt any rules necessary and appropriate to implement the powers and duties of TDI under the Insurance Code and other laws of the state.

TEXT.

SUBCHAPTER M. MANDATORY BENEFIT NOTICE REQUIREMENTS

§21.2101. Scope. The purpose of this subchapter is:

(1) to require notice to enrollees in a health benefit plan of coverage or benefits for:

(A) prostate cancer examinations;

(B) minimum inpatient stays for maternity and childbirth;

(C) minimum inpatient stays for mastectomy or lymph node dissection;

(D) reconstructive surgery after mastectomy;

(E) certain diagnostic screening tests for early detection of human papillomavirus, ovarian cancer, and cervical cancer; and

(F) certain tests for the detection of colorectal cancer; and

(2) to require notice to individuals who become eligible for certain protections regarding Medicare supplement coverage under §3.3312 of this title (relating to Guaranteed Issue for Eligible Persons).

§21.2102. Definitions. The following words and terms, when used in this subchapter, have the following meanings unless the context clearly indicates otherwise.

(1) Another limited benefit--A plan that provides coverage, singularly or in combination, for benefits for a specifically named disease, accident, or combination of diseases or accidents, including, but not limited to:

(A) heart attack;

(B) stroke;

(C) AIDS; or

(D) travel, farm, or occupational accident.

(2) Carrier--The term includes:

(A) an insurance company, a group hospital service corporation, a fraternal benefit society, a stipulated premium insurance company, a health maintenance organization, a multiple employer welfare arrangement that holds a certificate of authority under Insurance Code Chapter 846,

or an approved nonprofit health corporation that holds a certificate of authority issued by the commissioner under Insurance Code Chapter 844;

(B) for the purposes of paragraph (4)(B) and (F) of this section, a reciprocal exchange operating under Insurance Code Chapter 942;

(C) for purposes of paragraph (4)(E) and (F) of this section, a Lloyds plan operating under Insurance Code Chapter 941; and

(D) for purposes of paragraph (4)(E) of this section, a risk pool created under Local Government Code Chapter 172.

(3) Enrollee--A person enrolled in and entitled to coverage under a health benefit plan, including covered dependents.

(4) Health Benefit Plan--Subject to subparagraphs (A), (B), (C), (D), (E), and (F) of this paragraph, a plan that is offered by a carrier and provides benefits for medical or surgical expenses incurred as a result of a health condition, accident, or sickness, including an individual, group, blanket, or franchise insurance policy or insurance agreement; a group hospital service contract; an individual or group evidence of coverage; or any similar coverage document. The term does not include a plan that provides coverage only for accidental death or dismemberment, disability income, supplement to liability insurance, Medicare supplement, workers' compensation, medical payment insurance issued as a part of a motor vehicle insurance policy, or a long-term care policy.

(A) For the inpatient mastectomy coverage notice required by §21.2103(a)(1) of this title (relating to Mandatory Benefit Notices), the definition of health benefit plan includes a plan that provides coverage only for a specific disease or condition for the treatment of breast cancer or for hospitalization. The term does not include a small employer health benefit plan issued under Insurance Code Chapter 1501, Subchapters A - H (concerning Health Insurance Portability and Availability Act).

(B) For the reconstructive surgery after mastectomy notices required by §21.2103(a)(2) of this title, the definition of health benefit plan does not include:

(i) a plan that provides coverage for a specified disease or another limited benefit, except for cancer;

(ii) a plan that provides only credit insurance;

(iii) a plan that provides coverage only for dental or vision care; or

(iv) a plan that provides coverage only for hospital indemnity or other fixed indemnity.

(C) For the prostate cancer examination notice required by §21.2103(a)(3) of this title, the definition of health benefit plan does not include:

(i) a small employer health benefit plan written under Insurance Code Chapter 1501, Subchapters A - H;

(ii) a plan that provides coverage only for a specified disease or another limited benefit; or

(iii) a plan that provides coverage only for hospital indemnity or other fixed indemnity.

(D) For the inpatient maternity and childbirth coverage notice required by §21.2103(a)(4) and (5) of this title, the definition of health benefit plan does not include:

(i) a plan that provides only credit insurance;

(ii) a plan that provides coverage only for a specified disease or another limited benefit;

(iii) a plan that provides coverage only for dental or vision care; or

(iv) a plan that provides coverage only for hospital indemnity or other fixed indemnity.

(E) For the detection of colorectal cancer screening coverage notice required by §21.2103(a)(6) of this title, the definition of health benefit plan does not include:

(i) a small employer health benefit plan written under Insurance Code Chapter 1501, Subchapters A - H;

(ii) a plan that provides coverage only for a specified disease or another limited benefit; or

(iii) a plan that provides coverage only for hospital indemnity or other fixed indemnity.

(F) For the detection of human papillomavirus and cervical cancer screening notice required by §21.2103(a)(7) of this title, the definition of health benefit plan includes a small employer health benefit plan written under Insurance Code Chapter 1501, but does not include:

(i) a plan that provides coverage only for a specified disease or another limited benefit, other than a plan that provides benefits for cancer treatment or similar services;

(ii) a plan that provides coverage only for dental or vision care;

(iii) a plan that provides coverage only for indemnity or for hospital indemnity or other fixed indemnity;

(iv) a credit insurance policy; or

(v) a limited benefit policy that does not provide coverage for physical examinations or wellness exams.

(5) Primary Enrollee--For group coverage, the covered member or employee of the group. For individual coverage, the person first named on the application or enrollment form.

§21.2103. Mandatory Benefit Notices.

(a) Prescribed mandatory benefit notices consist of the following:

(1) For a health benefit plan that provides coverage or benefits for the treatment of breast cancer, a carrier must issue a notice that includes the language provided in Figure 1 of §21.2106(b) of this title (relating to Forms).

(2) For a health benefit plan that provides coverage or benefits for a mastectomy, a carrier must issue:

(A) an enrollment notice that includes the language provided in Figure 2 of §21.2106(b) of this title; and

(B) an annual notice that includes either:

(i) the language provided in Figure 3 §21.2106(b) of this title; or

(ii) the language provided in Figure 2 §21.2106(b) of this title.

(3) For a health benefit plan that provides coverage or benefits for diagnostic medical procedures, a carrier must issue a notice that includes the language provided in Figure 4 §21.2106(b) of this title.

(4) For a health benefit plan that provides coverage or benefits for maternity, including benefits for childbirth, a carrier must issue a notice that includes the language provided in Figure 5 §21.2106(b) of this title.

(5) If the health benefit plan described in paragraph (4) of this subsection includes benefits or coverage for in-home postdelivery care, the following language, or substantially similar language, must be inserted immediately before the "Prohibitions" portion of the notice language in Figure 5 §21.2106(b) of this title: "Since we provide in-home postdelivery care, we are not required to provide the minimum number of hours outlined above unless (a) the mother's or child's physician determines the inpatient care is medically necessary, or (b) the mother requests the inpatient stay."

(6) For a health benefit plan that provides coverage or benefits for medical screening procedures, a carrier must issue a notice that includes the language provided in Figure 6 §21.2106(b) of this title.

(7) For a health benefit plan that provides coverage or benefits for medical screening procedures, a carrier must issue a notice that includes the language provided in Figure 7 §21.2106(b) of this title. If a plan is not required to provide a benefit for ovarian cancer screening due to the exception in Insurance Code §1370.002(b) (concerning Exceptions), the notice may be modified to omit the references to ovarian cancer and the CA 125 blood test.

(b) Instead of the prescribed notices outlined in subsection (a) of this section, a carrier may opt to provide notices with substantially similar language rather than the notices contained in §21.2106(b) of this title. A form that includes substantially similar language under this subsection must be filed for review and approval by the commissioner prior to use, in accordance with Insurance Code Chapters 843 (concerning Health Maintenance Organizations), 1271 (concerning Benefits Provided by Health Maintenance Organizations; Evidence of Coverage; Charges), and 1701 (concerning Policy Forms), except that a form already in use may not be used after March 1, 2017, unless approved by the commissioner. The substantially similar language must be in a readable and understandable format, and must include a clear, complete, and accurate description of these items in the following order:

(1) a heading in bold print and all capital letters indicating the information in the notice relates to mandated benefits;

(2) a statement that the notice is being provided to advise the enrollee of the appropriate coverage or benefits, including the carrier's complete licensed name;

(3) a heading in bold print describing the coverage or benefits being provided; for example, Examinations for Detection of Prostate Cancer;

(4) a description of the coverage or benefits for which the notice is being provided;

(5) for a carrier who issues a health benefit plan that provides coverage or benefits for a mastectomy, the following requirements apply:

(A) the enrollment notice required by subsection (a)(2)(A) of this section must disclose that the coverage or benefits must be provided in a manner determined to be appropriate, in consultation with the attending physician and the enrollee, and state the specific deductibles, copayments, and coinsurance, which may not be greater than the deductibles, copayments, and coinsurance applicable to other benefits under the health benefit plan; and

(B) the annual notice required by subsection (a)(2)(B) of this section must, at a minimum, describe that the health benefit plan provides coverage or benefits for reconstructive surgery after mastectomy, surgery and reconstruction of the other breast for symmetry, prostheses, and treatment of complications resulting from a mastectomy (including lymphedema);

(6) for the notice required by subsection (a)(1), (2)(A), and (4) of this section, the heading "Prohibitions" in bold, followed by a summary of the prohibited acts by a carrier in providing the coverage or benefits for which the notice is being provided; and

(7) a statement identifying the carrier, and providing a phone number and address to which an enrollee may direct questions regarding the coverage or benefits for which the notice is being provided.

(c) If a health benefit plan provides coverage or benefits of more than one of the required notices described in subsection (a) of this section, the carrier may combine the language of the required notices into one notice.

(d) The notices must be printed in no less than 10-point type.

§21.2105. Delivery of Mandatory Benefit Notices.

(a) The notices required by §21.2103(a)(1), (3), and (4) of this title (relating to Mandatory Benefit Notices) must be issued to enrollees of a health benefit plan within 60 days of the plan's issuance or renewal.

(1) Except as specified in paragraph (5) of this subsection, a carrier must deliver the notices to enrollees through the U.S. Postal Service or, as permitted by state law, electronically.

(2) The notice may be delivered with other health benefit plan documents within 60 days of the plan's issuance or renewal. For example, the notice may be delivered with the policy, certificate, evidence of coverage, or the enrollment or insurance card.

(3) If the notices are provided to the primary enrollee's last known address, the requirements of this section are satisfied with respect to all enrollees residing at that address.

(4) If a covered spouse or dependent's last known address is different than the primary enrollee, separate notices are required to be provided to the spouse or the dependent at the spouse's or dependent's last known address.

(5) For group health benefit plans, the notice may be provided to the group master contract holder for distribution to enrollees if the carrier has an agreement with the group master contract holder that the notice will be delivered within 60 days of the plan's issuance or renewal; however, TDI will hold the carrier responsible for ensuring that notice is provided to the enrollees.

(b) The notices required by §21.2103(a)(2) of this title must be issued to enrollees of a health benefit plan and be provided according to the following paragraphs:

(1) the enrollment notice required by §21.2103(a)(2)(A) of this title must be issued to each enrollee upon enrollment in the health benefit plan;

(2) the annual notice required by §21.2103(a)(2)(B) of this title must be issued to each enrollee annually; and

(3) notwithstanding §21.2103(a)(2) of this title, a carrier may elect to issue the enrollment notice required by §21.2103(a)(2)(A) of this title to satisfy the annual notice requirements set forth in §21.2103(a)(2)(B) of this title.

§21.2106. Forms.

(a) The forms identified in §21.2103 of this title (relating to Mandatory Benefit Notices) are included in subsection (b) of this section in their entirety. The forms can be obtained from the Texas Department of Insurance, P.O. Box 149104, Austin, Texas 78714-9104, or from the TDI website, www.tdi.texas.gov.

(b) The forms referenced in this chapter are:

(1) Figure Number 1: Form Number 349 Mastectomy:

Figure: 28 TAC §21.2106(b)(1)

NOTICE OF CERTAIN MANDATORY BENEFITS

This notice is to advise you of certain coverage and/or benefits provided by your contract with [name of carrier].

Mastectomy or Lymph Node Dissection

Minimum Inpatient Stay: If due to treatment of breast cancer, any person covered by this plan has either a mastectomy or a lymph node dissection, this plan will provide coverage for inpatient care for a minimum of:

(a) 48 hours following a mastectomy, and

(b) 24 hours following a lymph node dissection.

The minimum number of inpatient hours is not required if the covered person receiving the treatment and the attending physician determine that a shorter period of inpatient care is appropriate.

Prohibitions: We may not (a) deny any covered person eligibility or continued eligibility or fail to renew this plan solely to avoid providing the minimum inpatient hours; (b) provide money payments or rebates to encourage any covered person to accept less than the minimum inpatient hours; (c) reduce or limit the amount paid to the attending physician, or otherwise penalize the physician, because the physician required a covered person to receive the minimum inpatient hours; or (d) provide financial or other incentives to the attending physician to encourage the physician to provide care that is less than the minimum hours.

If any person covered by this plan has questions concerning the above, please call [name of carrier] at [customer service or related department phone number], or write us at [carrier's customer service or related department address].

Form Number 349 Mastectomy

(2) Figure Number 2: Form Number 1764 Reconstructive Surgery After Mastectomy-Enrollment:

Figure: 28 TAC §21.2106(b)(2)

NOTICE OF CERTAIN MANDATORY BENEFITS

This notice is to advise you of certain coverage and/or benefits provided by your contract with [name of carrier].

Coverage and/or Benefits for Reconstructive Surgery After Mastectomy-Enrollment

Coverage and/or benefits are provided to each covered person for reconstructive surgery after mastectomy, including:

(a) all stages of the reconstruction of the breast on which mastectomy has been performed;

(b) surgery and reconstruction of the other breast to achieve a symmetrical appearance; and

(c) prostheses and treatment of physical complications, including lymphedemas, at all stages of mastectomy.

The coverage and/or benefits must be provided in a manner determined to be appropriate in consultation with the covered person and the attending physician.

[Include any specific deductibles, copayments, and/or coinsurance applicable to the coverage and/or benefits, which may not be greater than the deductibles, copayments and/or coinsurance applicable to other coverage and/or benefits under the health benefit plan.]

Prohibitions: We may not (a) offer the covered person a financial incentive to forego breast reconstruction or waive the coverage and/or benefits shown above; (b) condition, limit, or deny any covered person's eligibility or continued eligibility to enroll in the plan or fail to renew this plan solely to avoid providing the coverage and/or benefits shown above; or (c) reduce or limit the amount paid to the physician or provider, nor otherwise penalize, or provide a financial incentive to induce the physician or provider to provide care to a covered person in a manner inconsistent with the coverage and/or benefits shown above.

If any person covered by this plan has questions concerning the above, please call [name of carrier] at [customer service or related department phone number], or write us at [carrier's customer service or related department address].

Form Number 1764 Reconstructive Surgery After Mastectomy-Enrollment

(3) Figure Number 3: Form Number 1764 Reconstructive Surgery After Mastectomy-Annual:

Figure: 28 TAC §21.2106(b)(3)

NOTICE OF CERTAIN MANDATORY BENEFITS

This notice is to advise you of certain coverage and/or benefits provided by your contract with [name of carrier].

Coverage and/or Benefits for Reconstructive Surgery After Mastectomy-Annual

Your contract, as required by the federal Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including reconstruction and surgery to achieve symmetry

between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedema).

If any person covered by this plan has questions concerning the above, please call [name of carrier] at [customer service or related department phone number], or write us at [carrier's customer service or related department address].

Form Number 1764 Reconstructive Surgery After Mastectomy-Annual

(4) Figure Number 4: Form Number 258 Prostate:

Figure: 28 TAC §21.2106(b)(4)

NOTICE OF CERTAIN MANDATORY BENEFITS

This notice is to advise you of certain coverage and/or benefits provided by your contract with [name of carrier].

Examinations for Detection of Prostate Cancer

Benefits are provided for each covered male for an annual medically recognized diagnostic examination for the detection of prostate cancer. Benefits include:

(a) a physical examination for the detection of prostate cancer; and
(b) a prostate-specific antigen test for each covered male who is
(1) at least 50 years of age; or
(2) at least 40 years of age with a family history of prostate cancer or other prostate cancer risk factor.

If any person covered by this plan has questions concerning the above, please call [name of carrier] at [customer service or related department phone number], or write us at [carrier's customer service or related department address].

Form Number 258 Prostate

(5) Figure Number 5: Form Number 102 Maternity:

Figure: 28 TAC §21.2106(b)(5)

NOTICE OF CERTAIN MANDATORY BENEFITS

This notice is to advise you of certain coverage and/or benefits provided by your contract with [name of carrier].

Inpatient Stay following Birth of a Child

For each person covered for maternity/childbirth benefits, we will provide inpatient care for the mother and her newborn child in a health care facility for a minimum of:

(a) 48 hours following an uncomplicated vaginal delivery, and

(b) 96 hours following an uncomplicated delivery by cesarean section.

This benefit does not require a covered female who is eligible for maternity/childbirth benefits to (a) give birth in a hospital or other health care facility or (b) remain in a hospital or other health care facility for the minimum number of hours following birth of the child.

If a covered mother or her newborn child is discharged before the 48 or 96 hours has expired, we will provide coverage for postdelivery care. Postdelivery care includes parent education, assistance and training in breast-feeding and bottle-feeding and the performance of any necessary and appropriate clinical tests. Care will be provided by a physician, registered nurse or other appropriate licensed health care provider, and the mother will have the option of receiving the care at her home, the health care provider's office or a health care facility.

[*In-home postdelivery care language, if applicable, is to be inserted here.*]

Prohibitions. We may not (a) modify the terms of this coverage based on any covered person requesting less than the minimum coverage required; (b) offer the mother financial incentives or other compensation for waiver of the minimum number of hours required; (c) refuse to accept a physician's recommendation for a specified period of inpatient care made in consultation with the mother if the period recommended by the physician does not exceed guidelines for prenatal care developed by nationally recognized professional associations of obstetricians and gynecologists or pediatricians; (d) reduce payments or reimbursements below the usual and customary rate; or (f) penalize a physician for recommending inpatient care for the mother and/or the newborn child.

If any person covered by this plan has questions concerning the above, please call [name of carrier] at [customer service or related department phone number], or write us at [carrier's customer service or related department address].

Form Number 102 Maternity

(6) Figure Number 6: Form Number 1467 Colorectal Cancer Screening:

Figure: 28 TAC §21.2106(b)(6)

NOTICE OF CERTAIN MANDATORY BENEFITS

This notice is to advise you of certain coverage and/or benefits provided by your contract with [name of carrier].

Coverage for Tests for Detection of Colorectal Cancer

Benefits are provided, for each person enrolled in the plan who is 50 years of age or older and at normal risk for developing colon cancer, for expenses incurred in conducting a medically recognized screening examination for the detection of colorectal cancer. Benefits include the covered person's choice of:

(a) a fecal occult blood test performed annually and a flexible sigmoidoscopy performed every five years, or

(b) a colonoscopy performed every 10 years.

If any person covered by this plan has questions concerning the above, please call [name of carrier] at [customer service or related department phone number], or write us at [carrier's customer service or related department address].

Form Number 1467 Colorectal Cancer Screening

(7) Figure Number 7: Form Number LHL391 Human Papillomavirus, Ovarian Cancer, and Cervical Cancer Screening:

Figure: 28 TAC §21.2106(b)(7)

NOTICE OF CERTAIN MANDATORY BENEFITS

This notice is to advise you of certain coverage or benefits provided by your contract with (name of carrier).

Coverage of Tests for Detection of Human Papillomavirus, Ovarian Cancer, and Cervical Cancer

Coverage is provided for each woman enrolled in the plan who is 18 years of age or older for expenses incurred for an annual, medically recognized diagnostic examination for the early detection of ovarian and cervical cancer. Coverage required under this section includes a CA 125 blood test and, at a minimum, a conventional Pap smear screening or a screening using liquid-based cytology methods, as approved by the FDA, alone or in combination with a test approved by the FDA for the detection of the human papillomavirus.

§21.2107. Right to Medicare Supplement Coverage Notice.

(a) At the time of an event described in §3.3312(b) of this title (relating to Guaranteed Issue for Eligible Persons) that causes an individual to lose coverage or benefits due to the termination of a contract, agreement, policy, or plan, the entity, as defined in §3.3312 of this title, must:

(1) notify the individual of his or her rights under §3.3312(a), (c), (d), and (e) of this title, and the obligations of issuers of Medicare supplement policies under §3.3312(a) of this title; and

(2) communicate this notice at the same time as the notification of termination.

(b) At the time of an event described in §3.3312(b) of this title that causes an individual to cease enrollment under a contract, agreement, policy, or plan, the entity, as defined in §3.3312 of this title, that offers the contract or agreement, regardless of the basis for the cessation of enrollment or the licensed third-party administrator of the plan, must:

(1) notify the individual of his or her rights under §3.3312(a), (c), (d), and (e) of this title, and of the obligations of issuers of Medicare supplement policies under §3.3312(a) of this title; and

(2) communicate this notice within 10 working days of the entity's receipt of notification of disenrollment.

(c) The notices must be printed in no less than 10-point type.

SUBCHAPTER M. MANDATORY BENEFIT NOTICE REQUIREMENTS

REPEAL OF §21.2104

STATUTORY AUTHORITY. The repeal is adopted under Insurance Code §§1357.006, 1357.056, 1362.004, 1363.004, 1366.058, 1370.004, 1201.104, and 36.001.

Section 1357.006 requires notice of coverage for mastectomies. Section 1357.056 requires notice of coverage required for hospital stays after mastectomies. Section 1362.004 requires notice of coverage for detection of prostate cancer. Section 1363.004 requires notice of coverage for detection of colorectal cancer. Section 1366.058 requires notice of coverage for maternity, childbirth, and in-home postdelivery care. Section 1370.004 requires notice of coverage for human papillomavirus, ovarian cancer, and cervical cancer screening. Section 1201.104 requires TDI to adopt rules establishing

minimum benefit standards for individual accident and health insurance policies. Section 36.001 provides that the commissioner may adopt any rules necessary and appropriate to implement the powers and duties of TDI under the Insurance Code and other laws of the state.

TEXT.

SUBCHAPTER M. MANDATORY BENEFIT NOTICE REQUIREMENTS

§21.2104. Print Size of Notices.

CERTIFICATION. This agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

Issued at Austin, Texas, on September 23, 2016.

Norma Garcia
General Counsel
Texas Department of Insurance

The commissioner adopts amendments to 28 TAC §§21.2101 - 21.203 and 21.2105 - 21.2107 and the repeal of 28 TAC §21.2104.

David C. Mattax
Commissioner of Insurance

COMMISSIONER'S ORDER NO. **2016-4722**