Consumer Choice Evidence of Coverage (EOC) Checklist
Individual Plans

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

Filing Requirements

Page _____ : 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 Section 1271.101, and 28 TAC Section 11.301(4) and Section 11.501

Note: Chip member handbooks are filed for information - 28 TAC Section 11.301(5)

Page _____ : All variable material must be bracketed and include an explanation of variability - 28 TAC Section 11.505(e)

Page _____ : Certification of plain language requirements (transmittal checklist) - 28 TAC Section 3.601 and Section 3.602 and Section 11.505(f)

Page _____ : 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 Section 11.2(b)(22) and Section 11.505(h) - (j)

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

Forms and Documents to be included in Filing

Page _____ : Certification of compliance relating to Offer of State Mandated Plan - TIC Section 1507.057 and 28 TAC Section 21.3542 and 28 TAC Section 21.3543

Page _____ : Health Carrier Disclosure Form CCP 1 - TIC Section 1507.056 and 28 TAC Section 21.3530

Page _____ : Rates to be used with a consumer choice health benefit plan -TIC Section 1507.058 and 28 TAC Section 21.3543(3)

Mandatory EOC Provisions

Complaint and Appeal Procedures:

Page _____ : Complaints and appeals - TIC Section 843.251 - 843.262 and Section 1271.054, and 28 TAC Section 11.506(b)(5)

Page _____ : A statement that an HMO will not engage in retaliatory action against an enrollee filing a complaint - TIC Section 843.281

Preauthorization Procedures:

Page _____ : Preauthorization - Favorable determination of medical necessity - TIC Section 843.348, and 28 TAC Section 19.1718(d)

Page _____ : A plan may not require preauthorization of a particular service if the provider meets exemption criteria for certain health care services consistent with TIC Chapter 4201, Subchapter N as added by HB 3459

Page _____ : Preauthorization renewal - a plan that requires preauthorization must provide a preauthorization renewal process that permits a renewal request at least 60 days before an existing preauthorization expires - TIC Section 1222.003 - 1222.004 and Section 843.348 (definition of preauthorization)

Page _____ : Web-based access to preauthorization requirements - information about preauthorization requirements must be publicly accessible on the plan's website -TIC Section 843.3481

Adverse Determination Procedures - Utilization Review:

Page _____ : Adverse determination - services provided or proposed are determined not medically necessary or experimental and investigational - TIC Section 4201.002 and Section 4201.304 - 4201.305

Page _____ : 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 Section 1369.056 and Section 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 Section 4201.304(b)
- Step therapy exception requests qualify for an expedited review -TIC Section 4201.357(a-2) and Section 4202.003

Page _____ : Adverse determination - retrospective review - TIC Section 4201.305

Adverse Determination Appeal Procedures - Utilization Review TIC Section 4201.351 - 4201.3601

Page _____ : 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 Section 1355.254

Page _____ : Adverse determination - appeal - TIC Section 4201.359 and Section 1369.056

Page _____ : Adverse determination - expedited appeal for denial of emergency care, continued hospitalization, prescription drugs or intravenous infusions - TIC Section 4201.357

Page _____ : Adverse determination - immediate appeal to independent review organization (IRO) for a life threatening condition, prescription drugs or intravenous infusions -TIC Section 4201.360 - 4201.457

Eligibility and Enrollment Standards:

Page _____ : Eligibility requirements - 28 TAC Section 11.506(b)(8)

Page _____ : Adopted children - 28 TAC Section 11.506(b)(8)(A)(i)

Page _____ : Court-ordered medical and dental child support - TIC Section 1504.001 - 1504.102 and 28 TAC Section 11.506(b)(8)(A)(iv) and Section 21.2001 - 21.2011

Page _____ : Grandchildren - if children are eligible, limiting age for children and grandchildren must be stated in the EOC - TIC Section 1201.062, Section 1271.005(e) and Section 1271.006, and 28 TAC Section 11.506(b)(8)(E)

Page _____ : Handicapped child - a covered disabled child's attainment of limiting age does not operate to terminate the coverage of such child - 28 TAC Section 11.506(b)(17)

Page _____ : Limiting age - subscriber and dependents - 28 TAC Section 11.506(b)(8)(C)

Page _____ : Newborns - 28 TAC Section 11.506(b)(8)(D)

Page _____ : Newly acquired dependents - 28 TAC Section 11.506(b)(8)(B)

Page _____ : Past denial of coverage - HMO may not consider a determination that the applicant has or has not previously been denied health benefit plan coverage in underwriting the coverage for which the applicant has applied - TIC Section 544.502

Page _____ : Student coverage - termination due to change in student enrollment status -TIC Section 1503.001 - 1503.003, and 28 TAC Section 11.506(b)(18)

Other Mandatory EOC Provisions:

Page _____ : Cancellation or termination of contract - TIC Section 843.208 and Section 1271.307, and 28 TAC Section 11.506(b)(3)(C) - (D)

Page _____ : Conformity with state law - 28 TAC Section 11.506(b)(19)

Page _____ : Consideration - 28 TAC Section 11.507(3)

Page _____ : Continuance of coverage due to change in marital status - 28 TAC Section 11.507(4) and 28 TAC Section 21.407

Page _____Cover page - consumer choice required EOC notice; must be at the beginning of the document in at least 12 point bold type - TIC Section 1507.055

Page _____ : Definitions - 28 TAC Section 11.506(b)(6)

Page _____ : Effective date - 28 TAC Section 11.506(b)(7)

Page _____ : Entire contract, amendments - 28 TAC Section 11.506(b)(10)

Page _____ : Exclusions and limitations - 28 TAC Section 11.506(b)(11)

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

Page _____ : Face page - Toll-Free Notice (English/Spanish) - 28 TAC Section 1.601 and Section 11.506(b)(1)(C)

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

Page _____ : Grace period - 28 TAC Section 11.506(b)(12)

Page _____ : Incontestability - 28 TAC Section 11.506(b)(13)

Page _____ : Mandatory Benefit Notices - 28 TAC Section 21.2103 - 21.2106

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

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

Page _____ : Obstetrician or gynecologist - designation and notice to enrollees - TIC Section 1451.251- 1451.260 and 28 TAC Section 11.506(b)(22)

Page _____ : Chiropractic services - plan may not deny reimbursement for a medically necessary service covered by the plan solely because the service is performed by a chiropractor if the service is within the scope of the chiropractor's license - TIC Section 843.3042

Page _____ : Services provided by pharmacist - plan may not deny reimbursement to a pharmacist for a service performed within the scope of the pharmacist's license that would be covered if provided by physician, advance practice nurse, or physician assistant - TIC Section 1451.1261(d)

Page _____ : Out-of-Network claims; non-network physicians and providers - 28 TAC Section 11.1611.HMO reimbursement for:

- 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.
- Emergency care in a non-network facility.
- 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.
- 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.
- Methodology used to calculate reimbursements - must comply with 28 TAC Section 11.1611(f) and be no less favorable for mental health and substance use disorder benefits than for medical or surgical benefits - TIC Section 1355.254

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

Page _____ : Prohibition on balance billing by medical emergency service providers – extends statutory balance billing protections to services rendered by an out-of-network "emergency medical services provider" as defined by Health and Safety Code Section 773.003(11) and TIC Section 1271.159

Page _____ : Premium rate changes - 60-day notice - TIC Section 843.2071, and 28 TAC Section 11.506(b)(15)

Page _____ : Prescription drug accelerated refills for eye drops - TIC Section 1369.0041(b)

Page _____ : Prescription drug cost sharing - lesser of copayment, allowed amount, or cash price - TIC Section 1369.0041(a)

Page _____ : Prescription insulin cost sharing – cost sharing for insulin that is on the formulary cannot exceed $25 per prescription for a 30-day supply. A formulary must include at least one insulin from each therapeutic class, regardless of the amount or type of insulin needed to fill the enrollee's prescription. - TIC Section 1358.103 and Section 1358.104

Page _____ : Prescription drug synchronization - process for medication synchronization and prorated cost sharing - TIC Section 1369.454 and Section 1369.456

Page _____ : Prescription copay accumulators, credit out of pocket expenses – issuers must credit any third-party payment, financial assistance, discount, product voucher, or other reduction in out-of-pocket made by or behalf of an enrollee, to the enrollee's deductible, copayment, cost-sharing responsibility, or out-of-pocket maximum applicable to prescription drug benefits under the plan. TIC Section 1369.0542

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

Page _____ : Reinstatement - 28 TAC Section 11.507(1)

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

Page _____ : Schedule of benefits - copayments. A Consumer Choice Benefit Plan (CCBP) may impose higher copayment amounts than the limits required by 28 TAC Section 11.506(b)(2)(A). If a CCBP imposes higher copayment amounts, the benefit limitation mustbe reflected on Health Carrier Disclosure Form CCP1 - TIC Section 1507.056 and 28 TAC Section 21.3530

Page _____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 Section 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 – TIC Section 1507.056 and 28 TAC Section 21.3530

Page _____ : 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 Section 1355.254

Page _____ : Specialist as primary care physician - TIC Section 1271.201 - 1271.203, and 28 TAC 11.506(b)(21)

Page _____ : Ten days to examine agreement - 28 TAC Section 11.507(2)

Optional EOC Provisions

Page _____ : Arbitration (voluntary) - *mandatory binding arbitration provisions are prohibited* 28 TAC Section 11.511(5) and Texas Civil Practice and Remedies Code Chapter 171

Page _____ : Coordination of benefits - plans may coordinate benefits only if the agreement includes provisions consistent with TIC Section 1203.001 - 1203.003, and 28 TAC Section 3.3501 - 3.3510, and Section 11.511(1)

Page _____ : Coordination of vision and eye care benefits – requires coordination of benefits for health benefit plans and standalone vision plans. Sets specific requirements for coordinating benefits as primary and secondary issuers. Prohibits a health benefit plan or vision benefit plan from excluding or reducing payment of benefits based on the existence of another plan. TIC Section 1203.105

Page _____ : Point of Service and POS riders - TIC Section 843.107, Section 843.108 and Section 1273.001 -1273.004, and 28 TAC Section 11.2501 - 11.2503, Section 21.2901 and Section 21.2902

Page _____ : Subrogation - 28 TAC Section 11.511(2), and Civil Practice and Remedies Code Chapter 140

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 _____ : Definition of "Basic Health Care Services" - TIC Section 843.002(2), and 28 TAC Section 11.2(b)(6) and Section 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 _____ : Emergency services, including emergency transport. 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 - TIC Section 843.002(7) and Section 1271.155, and 28 TAC Section 11.506(b)(9) and Section 11.508(a)(1)(J)

Note: Out-of-network emergency services must be paid at the usual and customary rate or at an agreed upon rate - 28 TAC Section 11.1611(b)

Page _____ : Inpatient services - 28 TAC Section 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; and
- X-ray services.

Page _____ : 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 careservices - 28 TAC Section 11.506(b)(25) and Section 11.508(a)(3)

Page _____ : Outpatient hospital services - 28 TAC Section 11.508(a)(4). Including:

- Ambulatory surgery services;
- Diagnostic services, including laboratory, radiology and imaging services;
- Rehabilitation and radiation therapy; and
- Treatment services.

Page _____ : Outpatient mental health services - in parity with medical surgical benefits TIC Section 1355.254, and 28 TAC Section 11.508(a)(1)(I)

Page _____ : Outpatient services - 28 TAC Section 11.508(a)(1). Including:

- Home health services;
- Prenatal services (if maternity benefit covered);
- Primary care - TIC Section 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; and
- Therapeutic radiology services.

Page _____ : Preventative health services - 28 TAC Section 11.508(a)(1)(H). Including:

- Adult cancer screenings - prostate and colorectal cancer as required by TIC Chapter 1362, TIC Chapter 1363, and TIC Section 1363.003;
- Cancer screenings - mammography as required by TIC Sections 1356.001 - 1356.005;
- Eye and ear exams for children through age 17;
- Periodic adult health examinations as required by TIC Section 1271.153;
- Immunizations for children as required by TIC Sections 1367.051 – Section 1367.054; and
- Well-childcare from birth including the cost of administration and the cost of the newborn screening test kit as required by TIC Section 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 Section 21.3530.

Page _____ : Acquired brain injury - TIC Sections 1352.001 – Section 1352.008, and 28 TAC Section 21.3101 - 21.3107- required by federal law

Page _____ : Amino acid-based formulas for diagnosis and treatment of certain diseases or disorders -TIC Sections 1377.001 – 1377.052 - required by federal law

Page _____ : Biomarker testing – requires coverage of biomarker testing (only when testing provides clinical utility) for diagnosis, treatment, appropriate management, or ongoing monitoring of an enrollee's disease or condition to guide treatment based on medical and scientific evidence the test supports. Must provide coverage in a manner that limits disruption in care, including limiting the number of biopsies and biospecimen samples. TIC Section 1372.003

Page _____ : 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 Sections 1376.001 – 1376.003, and 28 TAC Section 21.4301 - required by federal law

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

Page _____ : 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; including pap smear; FDA-approved HPV test; CA-125 blood test, or any other FDA-approved test for ovarian cancer. - TIC Section 1370.003(b) - cervical cancer screening required by federal law

Page _____ : Complications of pregnancy - 28 TAC Section 21.405(1) - required by federal law

Page _____ : Continuity of treatment by treating physician or provider of enrollee with a"special circumstance" and termination notice - TIC Section 843.309 and Section 843.362

Page _____ : Contraceptive drugs and devices and related services - TIC Sections 1369.101-1369.108, and 28 TAC Section 21.404(3) - required by federal law

Note: Plans may extend religious accommodations as required by federal law

Page _____ : Prescription contraceptive drugs – an enrollee may obtain: (1) a three-month supply of the covered prescription contraceptive drug at one time the first time the enrollee obtains the drug; and (2) a 12-month supply of the covered prescription contraceptive drug at one time each subsequent time the enrollee obtains the drug (regardless of whether the enrollee was enrolled in the plan the first time they obtained the drug). Limits an enrollee to only one 12-month supply during each 12-month period. TIC Section 1369.1031

Page _____ : Craniofacial abnormalities - TIC Sections 1367.151 – 1367.153 and 28 TAC Section11.509(5)
Page _____ : Diabetes care - self-management training, equipment and supplies - TIC Sections 1358.051 – 1358.056 and 28 TAC Section 11.508(b)(3) and Sections 21.2601 – 21.2606

Page _____: Emergency refills of insulin and insulin related equipment – emergency refills of diabetes equipment or diabetes supplies without prescribing practitioner authorization, must be covered in the same manner as a non-emergency refill. – TIC Section 1358.054(a-1)

Page _____ : Fertility preservation services – requires coverage for standard fertility preservation services provided to a covered person receiving cancer treatment. Treatment includes surgery, chemotherapy, or radiation the American Society of Clinical Oncology or American Society for Reproductive Medicine has established may directly or indirectly cause impaired fertility. "Fertility preservation does not include storage of the unfertilized genetic materials. TIC Section 1366.104

Page _____ : Drug formulary (if drugs are covered) - TIC Section 1355.254 and Section 1369.051 - 1369.056, and 28 TAC Section 11.506(b)(24) and Sections 21.3020 - 21.3023

Page _____ : 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 Section 1369.055

Page _____ : Drug coverage modification (if drugs are covered) - 60-day notice for modification of drug coverage - TIC Section 1369.0541

Page _____ : Drug formulary (if drugs are covered) - Provider Directories and Member Handbooks: requirements for formulary information on internet website, formulary disclosure, and formulary information provided by toll-free telephone number - TIC Sections 1369.078 – 1369.080 and 28 TAC Section 21.3030 – Section 21.3031

Page _____ : Prescription drug disclosure requirements for health care provider directories – directories and internet websites must display facility-based physicians, health care providers, and list provider types under separate headings. Issuers are not required to list a physician or health care provider who is employed by the facility. TIC Section 1451.504

Page _____ : Prescription drug disclosure requirements – disclose information in real time about only drug formularies (including alternative formularies), cost-sharing information (including information based on the patient's preferred dispensing retail or mail-order pharmacy), and applicable utilization management requirements - TIC Section 1369.094

Page _____ : Prescription drug coverage for autoimmune diseases and blood disorders – an issuer may not require an enrollee to receive more than one prior authorization annually for prescription drugs prescribed to treat an autoimmune disease, hemophilia, or Von Willebrand disease. TIC Section 1369.654

Page _____ : Hearing test for newborns and necessary follow-up care - TIC Sections 1367.101 – 1367.104 – required by federal law

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

Page _____ : Hearing aid coverage for adults and children – a health benefit plan that provides coverage for hearing aids may not deny an enrollee's claim for a hearing aid solely on the basis that the price of the hearing aid is more than the benefit available under the health benefit plan. TIC Section 1365.053

Page _____ : Mammography benefits and other breast imaging benefits - both annual screening for women aged 35 and older and diagnostic imaging for women of any age must be covered, including 2D and 3D (breast tomosynthesis) mammography, ultrasound imaging or magnetic resonance imaging (MRI). Coverage for diagnostic imaging must be no less favorable than coverage for a screening mammogram. - TIC Chapter 1356

Page _____ : Mastectomy - breast reconstruction - TIC Sections 1357.001 - 1357.007, and 28 TAC Section 11.508(b)(1) - required by federal law

Page _____ : Mastectomy - minimum hospital stay - TIC Sections 1357.051 - 1357.057 - required by federal law

Page _____ : Mental health parity - mental health conditions and substance use disorders -TIC Sections 1355.251 - 1355.257

Note: An HMO must provide benefits and coverage under the same terms and conditions applicable to the plan's medical and surgical benefits and coverage.

Page _____ : Off-label drugs - TIC Sections 1369.001 – Section 1369.004, and 28 TAC Section 21.3010 and Section 21.3011 -CCBP may exclude

Page _____ : Orally administered anticancer medications - TIC Sections 1369.201 – 1369.204 – CCBP may exclude

Page _____ : Step therapy exception - drug for stage-four metastatic cancer are not subject to step-therapy or failed first attempts if approved by the United States Food and Drug Administration - TIC Section 1369.213

Page _____ : Step therapy protocols for serious mental illness (SMI) – an issuer that provides coverage for prescription drugs to treat serious mental illness may not require that the enrollee fail to respond to more than one different drug or prove a history of failure of more than one different drug (excluding generic or pharmaceutical equivalent) before the issuer provides coverage. Subject to exception requests, step therapy protocols may be implemented for generic or pharmaceutical equivalents once per year or if the drug is added to the plan's drug formulary. TIC Section 1369.0547

Page _____ : Pharmacy benefits (if drugs are covered) - 28 TAC Section 11.1605 - CCBP may include higher copayment amounts

Page _____ : Prosthetics, orthotics, and professional fitting services equivalent to that provided by the federal Medicare program - TIC Sections 1371.001 – 1371.005 - required by federal law

Page _____ : Rehabilitation services and therapies - TIC Section 1271.156 - CCBP may impose time or cost limits

Page _____ : Routine costs and clinical trials - routine patient care costs to an enrollee in connection with certain clinical trials - TIC Sections 1379.001 – 1379.056

Page _____ : Telehealth, and telemedicine medical services, as defined by Section 111.001 of the Occupations Code - TIC Sections 1455.001 – 1455.006:

- Must cover telemedicine, or telehealth services provided by a preferred or contracted provider on the same basis and to the same extent that the plan covers the service in an in-person setting. - TIC Section 1455.004(a)(1)
- May not exclude benefits solely because the covered health care service or procedure is not provided through an in-person consultation - TIC Section 1455.004(a)(2)(A)
- May not limit, deny, or reduce coverage or for a telemedicine. or telehealth service based on the platform used - TIC Section 1455.004(a)(1)(B)
- Deductible, copayment or coinsurance must be the same as if services were provided through an in-person consultation; a separate deductible or annual or lifetime maximum may not apply to telemedicine, or telehealth coverage - TIC Section 1455.004(b), (b-1), and (d)

Page _____ : Urgent care - 28 TAC Section 11.1607(g)

Optional Benefits

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

Page _____ : Including - 28 TAC Section 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 Section 843.151 and Section 1501.107, and 28 TAC Sections 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 _____ : **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 Section 21.4706(a) and (b)

Page _____ : **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 Section 21.4707(a) and (b)

Page _____ : **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 Section 21.4708(a) and (b)

Benefits That May Be Offered

This section provides 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 the following benefit, the benefit exclusion or limitation must bereflected on Health Carrier Disclosure Form CCP 1 - 28 TAC Section 21.3530.

Page _____ : Certain therapies for children with developmental delays - rehabilitative and habilitative therapies - TIC Sections 1367.201 - 1367.206

Coverage Standards

Page _____ : Alzheimer's disease, if applicable - TIC Section 1354.001 and Section 1354.002, and 28 TAC Section 11.506(b)(23)

Page _____ : Discrimination - general prohibitions applicable to HMOs - TIC Sections 544.001-544.054

Page _____ : Fibrocystic breast conditions - TIC Sections 544.201 - 544.204

Page _____ : Maternity discrimination prohibited - underwriting - 28 TAC Section 21.404(6)

Page _____ : Victims of family violence - TIC Sections 544.151 - 544.158

Genetic Testing

TIC Sections 546.001 - 546.152

Page _____ : Notice to enrollee - TIC Section 546.051(a)(1)

Page _____ : Consent required (including consent from mother for testing in utero) - TIC Section 546.051(a)(3), Section 546.051(b) and Section 546.053(b)(1)

Page _____ : Information to enrollee of test results - TIC Section 546.051(b)(1)-(2) and Section 546.101

Page _____ : Inducement prohibited (to buy insurance or to induce abortion) - TIC Section 546.051(c) and Section 546.053(b)(2)

Page _____ : Improper use of test results prohibited - TIC Section 546.052

Enrollment Form and Application

Page _____ : Consumer choice required notice - TIC Section 1507.055(a)

Page _____ : Disability affecting the enrollee's ability to communicate or read - 28 TAC Section 11.1602

Page _____ : Obstetrician or gynecologist selection - 28 TAC Section 11.506(b)(22)(F)

Page _____ : Primary language other than English - 28 TAC Section 11.1602

Electronic Communication - TIC Section 35.004(c)(1) and (2) and Section 35.0041

Page _____ : Electronic communication - allows issuers to conduct business electronically: (1) by seeking out prior affirmative consent; or (2) if the issuer provides notice of intent to conduct business electronically and the party does not opt out. Further describes either method is subject to disclosure requirements set out in TIC Section 35.004. In addition, (1) the party must have a right to withdraw consent; or (2) in the case affirmative consent was not obtained, the party requests written communication be delivered in nonelectronic form. TIC Section 35.003

Prohibited Practices

Page _____ : Discretionary clause prohibited - an evidence of coverage may not include a discretionary clause - TIC Section 1271.057, and 28 TAC Section 3.1202 and Section 3.1203

Page _____ : Pharmacy and durable equipment (DME) provider – A plan of pharmacy benefit manager may not transfer patient or prescriber prescription information for a commercial purpose or require or induce an enrollee to use an affiliated pharmacy or DME provider through oral or written communication or methods such as offering reduced cost sharing. – TIC Section 1369.553, Section 1369.544, and Section 1369.555

Page _____ : May not charge an additional fee to the payee for issuing payment by paper check instead of by electronic payment method - Business and Commerce Code Chapter 116

Page _____ : A company may not require a customer to provide any documentation certifying the customer's COVID-19 vaccination or post-transmission recovery in order to obtain health insurance coverage or otherwise receive service from the company – Health and Safety Code Section 161.0085(c), as added by SB 968 (87R)

Page _____ : Use of forced organ harvesting prohibited – An issuer may not cover a transplant or post-transplant care if the transplant was performed in China or another country known to have participated in forced organ harvesting. Also, an issuer may not cover a transplant for which the organ to be transplanted was procured by sale or donation originating in China or another country known to have participated in forced organ harvesting; in addition, this prohibition against coverage extends to coverage for post-transplant care. TIC Section 1380.003

Page _____ : Certain limitations on coverage of clinician-administered drugs (white-bagging) prohibited – an issuer is prohibited from: (1) requiring dispensing by certain pharmacies or network pharmacies; (2) limiting network providers to bill for or be reimbursed under pharmacy benefits instead of medical benefits without informed consent to the patient and provider's attestation statement addressing increased risk; (3) charging an additional fee or higher cost based on enrollee's choice of pharmacy or because the drug was not dispensed by a network pharmacy. TIC Section 1369.764

Page _____ : An HMO may not limit, cancel, refuse to renew, deny coverage, or vary an individual's rate, because of the individual's political affiliation or expression – TIC Section 544.602 as added by HB 3433

Page _____ : 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 the Texas Civil Practice and Remedies Code Chapter 90 and TIC Section 544.453

Written Plan Description or Member Handbook

28 TAC Section 11.1600

Page _____The written plan description may be delivered electronically - 28 TAC Section 11.1600(a).

- An HMO may use its member handbook to satisfy the requirements of the written plan description - 28 TAC Section 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 Section 11.1600(d); and
- An HMO that maintains a website must list the information on its website - TIC Section 843.2015 and Section 1456.003, and 28 TAC Section 11.1600(b)-(g) and (j)

Page _____ : The written or electronic plan description must include clear, complete, and accurate information in the exact order listed - 28 TAC Section 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 28 TAC Section 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 Section 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 28 TAC Section 11.1612 (relating to Mandatory Disclosure Requirements), together with a link to the online directory;
13. a description of the service area; and
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 _____ : Required notice for access to a limited provider network, if applicable - 28 TAC Section 11.1600(e)

Page _____ : Required notice for unlimited access to obstetrical or gynecological care, if applicable – 28 TAC Section 11.1600(f)

Page _____ : 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 Section 11.1600(g)

Page _____ : 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 Section 11.1600(h)

Page _____ : 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 Section 11.1600(i)