Evidence of Coverage (EOC) Checklist

Single Health Care Service Plan Dental Care

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)

Single Service HMO EOC - General Provisions

Page _____ : Description of covered dental services, applicable copayments and glossary - 28 TAC Section 11.2201

Mandatory EOC Provisions

Complaint and Appeal Procedures

Page _____ : Complaints and appeals - TIC Sections 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

Utilization Review

The provisions below are not required if the dental HMO does not perform utilization review. Any plan that does not perform utilization review should not include terms such as dental necessity, medical necessity, dentally necessary, medically necessary, preauthorization, prior authorization, prior approval, adverse determination, or other terms descriptive of utilization review.

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 if the provider has an exemption for the service, 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 preauthorization expires - TIC Sections 1222.003 - 1222.004 and Section 843.348 (definition of preauthorization)

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

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

Page _____ : Adverse determination - appeal - TIC Section 4201.359

Page _____ : Adverse determination - expedited appeal for denial of emergency care - TIC Section 4201.357

Page _____ : Adverse determination - immediate appeal to independent review organization (IRO) for a life threatening condition - TIC Section 4201.360 and Sections 4201.401 - 4201.457

Continuation of Coverage - group plans only - TIC Sections 1271.301 - 1271.304, and 28 TAC Section 21.5302, and Section 21.5310 - 21.5314

Page _____ : Enrollee must send written notice of election to continue coverage no later than 60 days

Page _____ : 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 _____ : Following the first payment made, payments considered timely if made by the 30th day after the date payment is due

Page _____ : Enrollees not eligible for COBRA are entitled to 9 months Continuation coverage

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

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

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 not previously been denied health benefit plan coverage in underwriting the coverage for which the applicant has applied - individual plansonly - 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)

Genetic Testing - TIC Section 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

Other Mandatory EOC Provisions

Page _____ : Cancellation or termination of contract - group plans only - TIC Section 843.208, and 28 TAC Section 11.506(b)(3)(A) - (C)

Page _____ : Cancellation or termination of contract - individual plans only - TIC 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 _____ : 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 _____ : Grace period - 28 TAC Section 11.506(b)(12)

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

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 _____ : 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.

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)

Page _____ : Premium rate changes - 60-day notice - group plans only - TIC Section 1254.001(a) - (g) and 28 TAC Section 11.506(b)(15)

Page _____ : Premium rate changes - 60-day notice of increase - individual plans only - TIC Section 843.2071

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 _____ : Schedule of benefits - schedule of all health care services that are available to enrollee under the basic, limited, or single service plan must be included, together with any copayments or deductibles and description of where and how to obtain services. An HMO may use a variable copayment or deductible schedule. The schedule must clearly indicate the benefit to which it applies. An HMO may requirecopayments to supplement payment for health care services 28 TAC Section 11.506(b)(2) (A)

Page _____ : Schedule of benefits - deductibles. An HMO may not charge a deductible for in-network services. Except for emergency care and services not available in-network,an HMO 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)

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 _____ : Teledentistry as defined by Section 111.001 of the Occupations Code- TIC Section 1455.001 - 1455.006:

- Must cover teledentistry 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 for a teledentistry service based on the platform used - TIC Section 1455.004(a)(2)(B).
- Deductible, copayment, or coinsurance must be the same as if services were provided through an in-person consultation; a separate deductible or annual lifetime maximum may not apply to teledentistry coverage - TIC Section 1455.004(b), (b-1), and (d).

Additional Mandatory Contractual Provisions - Conversion and Individual EOCs Only

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 Section 21.407

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

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

Additional Mandatory Benefit Standards - Group Agreement Only

Page _____ : Certificate - 28 TAC Section 11.509(1)

Page _____ : Inability to undergo dental treatment - a group agreement may not exclude from coverage an enrollee who is unable to undergo dental treatment in an office setting or under local anesthesia due to a documented physical, mental, or medical reason as determined by the enrollee's physician or treating dentist - large group plans only - 28 TAC Section 11.509(b)(7)

Page _____ : New enrollees - 28 TAC Section 11.509(2)

Page _____ : 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 Section 843.210

Out-of-State Group Agreement

Page _____ : 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 Section 26.5(g) (small groups) and Section 26.301(i) (large groups)

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 _____ : Conversion privilege - group plans only - 28 TAC Section 11.511(4), Section 21.5302 and Section 21.5320 - 21.5322

Page _____ : Coordination of dental benefits - TIC Section 1203.051 - 1203.054, and 28 TAC Section 3.3501- 3.3510, and Section 11.511(1)

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

Minimum Standards - Dental Care Services and Benefits

Page _____ : CDT Codes - codes are not required. But if the EOC uses codes, it must use the current version of the American Dental Association's Current Dental Terminology (CDT) and the dental HMO must certify that the codes referenced in its EOC are as specified in the current version of the CDT - 28 TAC Section 11.2203(a)

Page _____ : Palliative (emergency) treatment of dental pain - a dental HMO may not exclude or limit emergency dental care and services that are necessary to treat dental pain - 28 TAC Section 11.2203(c).

- Emergency services and fees - a dental HMO may not limit coverage for emergency services or charge an emergency fee in addition to an emergency care copayment - 28 TAC Section 11.2205(b) and (c).
- 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).
- 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 Section 26.28 (small groups) and Section 26.314 (large groups).

Page _____ : Primary and preventive dental services - 28 TAC Section 11.2203(c). Each single service HMO EOC that covers dental care services and benefits may include an infection control (sterilization) fee and must cover the following primary and preventive services to be provided by a general dentist or hygienist, as applicable:

- Office visit - during and after regularly scheduled hours;

- Oral evaluations;
- X-rays;
- Bitewings;
- Panoramic film;
- Dental prophylaxis - adult and child;
- Topical fluoride treatment for children;
- Dental sealants for children;
- Amalgam fillings - 1, 2, 3 and 4 or more surfaces, primary and permanent, including polishing;
- Anterior resin fillings - 1, 2, 3 and 4 or more surfaces or involving incisal angle, primary and permanent, including polishing;
- Simple oral extractions;
- Surgical incision and drainage of abscess, intra-oral soft tissue; and
- Palliative (emergency) treatment of dental pain, provided that the enrollee may obtain emergency treatment of dental pain in a comparable facility.

Page _____ : Secondary dental services - 28 TAC Section 11.2203(d). Each single service HMO EOC that covers dental care services and benefits may include an infection control (sterilization) fee, and may provide coverage for secondary dental care services and benefits, including:

- Posterior resin restorations, 1, 2, 3 and 4 or more surfaces (to include polishing);
- Crowns and crown recementation;
- Composite resin crowns, anterior-primary;
- Sedative fillings;
- Core buildup, including any pins, and pin retention;
- Pulp cap (direct and indirect);
- Therapeutic pulpotomy;
- Root canal therapy, anterior, bicuspid and molar;
- Gingival curettage;
- Osseous surgery;
- Periodontal scaling and root planning;
- Periodontal maintenance procedures;
- Complete denture (maxillary and mandibular);

- Partial denture (maxillary and mandibular);
- Root removal-exposed roots;
- Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone or section of tooth;
- Removal of impacted tooth (soft tissue and completely bony);
- Tooth re-implantation or stabilization, or both, of accidentally evulsed or displaced tooth or alveolus, or both;
- Alveoplasty;
- Occlusal guard (bruxism appliance); or
- Orthodontia

Page _____ : Supplemental preventive service plans - 28 TAC Section 11.2203(e). A Dental HMO may also offer a Preventive Services Plan as a supplement to a basic health care service plan offered by an affiliate or another carrier, as long as a plan described in 28 TAC Section 11.2203(c), has first been offered to and rejected in writing by the group contract holder. A Preventive Services Plan must include coverage for the following:

- Oral evaluations;
- X-rays;
- Bitewings;
- Panoramic film; and
- Dental prophylaxis - adult and child.

Page _____ : Treatment in progress - EOC must include language that describes coverage for dental treatment in progress - 28 TAC Section 11.2203(b)

Prohibited Practices

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

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 _____ : 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 _____ : 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 Section 544.453

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 _____ : "Lock-In" provisions - a dental HMO may not limit an enrollee's right to terminate their membership before the end of the enrollment year - individual plans only - 28 TAC Section 11.2205(a)

Page _____ : Pre-existing conditions exclusions - a dental HMO may not exclude dental care services and benefits that are otherwise covered under the plan and are necessaryto treat pre-existing dental conditions - 28 TAC Section 11.2202(1)

Page _____ : Waiting period for pre-existing conditions - a dental HMO may not establish a waiting period for coverage of pre-existing dental conditions - 28 TAC Section 11.2202(2)

Point-of-Service (POS) Group Applications and Enrollment Forms

Page _____ : Certification - each HMO offering a dental POS plan must retain a certification that the dental POS plan includes corresponding dental indemnity benefits - 28 TAC Section 11.2206(b)

Page _____ : Disclosure - each dental POS enrollment application must include a disclosure statement in compliance with 28 TAC Section 11.2206(a) and include the following information:

- Disclose the identity of the HMO that provides dental care services, and the identity of the insurance company that provides dental indemnity benefits.
- Explain that to receive benefits under the HMO, enrollee must use only network providers, except for emergency care, and pay copayments specified in the EOC.
- Under the indemnity plan, enrollee may use any provider, but before receiving reimbursement, must meet the required deductible and is responsible for the coinsurance amount specified in the policy or certificate.

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

Written Plan Description Or Member Handbook - 28 TAC Section 11.1600

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

Page _____ : General Requirements:

- 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).
- 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 _____ : 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)