TDI | Texas Department of Insurance

Evidence Of Coverage (EOC) Checklist

Single Health Care Service Plan Vision 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 Section11.2(b)(27) and Section 11.505(g)

Single Service HMO EOC - General Provisions

Page _______ : Description of covered vision 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 vision HMO does not perform utilization review. Anyplan that does not perform utilization review should not include terms such as medical necessity, medically necessary, preauthorization, prior preauthorization, 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 Section 4201.401 - 4201.457

Continuation of Coverage - group plans only - TIC Section 1271.301 - 1271.304, and 28 TAC Section 21.5302, and Sections 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 _______ : 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 - 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 HHMO 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 _______ : Urgent vision care services - may be provided in a physician or provider office or urgent care setting - 28 TAC Section 11.2(54), Section 11.1607(g)(1) and 11.2204(a)

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 ________ : 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 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 1203.001 – 1203.003 and Section 1203.105 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 - Vision Care Services and Benefits

Page ________ : **Emergency services and fees**:

- A vision 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 vision services - 28 TAC Section 11.2204(a). Each single service HMO EOC that covers vision care services and benefits must provide the following as covered primary and preventive vision services:

- Comprehensive eye examination to include medical history;
- Visual acuities, with and without correction (distance and near);
- Cover test at 20 feet and at 16 inches;
- Versions;
- External examination of the eye lids, cornea, conjunctive, pupillary reaction (neurological integrity), and muscle function;
- Binocular measurements for far and near;
- Internal eye examination (ophthalmoscopy);
- Autorefraction/refraction (far point and near point);
- Tonometry (reasonable attempt or equivalent testing if contraindicated);
- Retinoscopy;
- Biomicroscopy;
- Intraocular pressure glaucoma test;
- Slit lamp examination; and
- Urgent care.

Page ________ : Secondary vision services (28 TAC Section 11.2204(b)). Each single service HMO EOC that covers vision care services and benefits may provide the following as covered secondary vision services:

- Contact lens examination;
- Fitting;
- Training;
- Follow-up visits; or
- Eyeglasses.

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 coverageunder 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 vision 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 vision HMO may not exclude vision care services and benefits that are otherwise covered under the plan and are necessary to treat pre-existing vision conditions - 28 TAC Section 11.2202(1)

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

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 Section11.1600(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;
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 optionof 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)