# Group Health Non-Employer or Member Association Checklist

## Use this checklist:

- When reviewing group or group health non-employer or member association insurance policies or products.
- To ensure the product or policy meets requirements as listed in the Texas Insurance Code (TIC), the Texas Administrative Code (TAC), department guidelines, and other laws.
- To enter the page number or reference location in the "Page" field.

## Filing Submissions

Page _____ : Submission requirements for filings - 28 TAC Section 3.1 - 3.8

Page _____ : Policy must be issued to eligible group (must specify specific group on the transmittal checklist) TIC Section 1251.002, and 28 TAC Section 3.6(c)(1) and (2)

Page _____ : Filing issued to a case specific association must include a copy of the association's constitution, bylaws and articles of incorporation - 28 TAC Section 3.6(c)(3)(B)

Page _____ : "ABC Association" basis - 28 TAC Section 3.6(c)(3)

## Policy and Application Requirements - Consumer Choice Health Benefit Plans (CCHBP)

This section references requirements specific to CCHBP.

Page _____ : Insurer notice on application - TIC Section 1507.005(a)

Page _____ : Insurer notice on policy - TIC Section 1507.005(b)

Page _____ : Health carrier disclosure - TIC Section 1507.006

## Definitions

This definition section provides a reference to general terms that may be included in a form filing. The section is not intended to limit or require the inclusion of certain terms in a form filing. A formfiling containing any of the referenced terms shall not define the terms more restrictively than referenced in the applicable statue or rule.

Page _____ : Emergency Care - TIC Section 1201.060

Page _____ : Health Benefit Plan - 28 TAC Section 21.2702(7)

## Association Types

According to 28 TAC Section 21.2703, a health benefit plan issued to an association or a bona fide association is considered a group product and shall comply with the statutes and regulations applicable to coverage and benefits relating to group.

**Association Defined** - 28 TAC Section 21.2702

An association (other than an employer association), including but not limited to a labor union or organizations of such unions, membership corporations organized or holding a certificate of authority under the Texas Non-profit Corporation Act, and cooperatives and corporations subject tothe supervision and control of the Farm Credit Administration of the United States of America, that:

- has a constitution and bylaws;
- has been actively in existence for at least 2 years; and has been formed and maintained in goodfaith for purposes other than for obtaining coverage under a health benefit plan to; and
- covers members for the benefit of persons other than the association or its officers and trustees.

Page _____ : Issuance of Coverage - health carriers that offer health benefit plans to associations that are not bona fide associations may decline, restrict, limit, exclude, or rate-up coverage based upon a member's health status related factors - 28 TAC Section 21.2703

**Bona Fide Association Defined** - 28 TAC Section 21.2702

An association, in addition to meeting the requirements of an association, that:

- has been actively in existence for at least 5 years;
- does not condition membership in the association on any health status-related factor relating toan individual (including the individual eligible for membership or a dependent of the individual eligible for membership, if dependent coverage is offered);
- makes coverage under a health benefit plan offered through the association available to all members, regardless of any health status related factor relating to the members (or dependentseligible for coverage through a member, if dependent coverage is offered); and does not make a health benefit plan offered through the association available
- other than in connection with a member of the association.

Page _____ : Issuance of Coverage - health carriers that issue a health benefit plan to a bona fide association must issue coverage to all members, and dependents of members if dependent coverage is offered, of the bona fide association that apply forcoverage, regardless of health status related factors - 28 TAC Section 21.2703

## Mandated Benefits and Offers

This section provides reference to mandated benefits and offers required to be included in form filings. Mandated benefits are benefits required to be included in form filings, while mandated offers are subject to acceptance by the policyholder.

- Mandates not required for Consumer Choice Health Benefit Plans (CCHBP) are noted with symbol "ǂ".
- Mandates not required by state law but required by federal law are noted as "ǂǂ".

Page _____ : Amino acid-based elemental formulas - TIC Chapter 1377 ǂ

Page _____ : Mental or emotional illness or disorder (inpatient hospital alternative treatment facility) - Mandated Offer -TIC Section 1355.101 - 1355.106 ǂ

Page _____ : Acquired brain injury (if definitions included they must comply with 28 TAC Section 21.3102) - TIC Chapter 1352, and 28 TAC Section 21.3101 - 21.3105 ǂ

Page _____ : Autism spectrum disorder - TIC Section 1355.015 ǂ

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, certain tests - TIC Chapter 1376 ǂ

Page _____ : Chemical dependency coverage - TIC Chapter 1368 ǂ

Page _____ : Clinical trials, routine care for participants (may not exclude routine patient care costs for enrollees participating in certain clinical trials) - TIC Chapter 1379

Page _____ : Colorectal cancer testing – All colorectal cancer exams, preventive services, and lab tests with an "A" or "B" grade from the USPSTF must be covered starting at age 45, with no cost-sharing for in-network care. A follow-up colonoscopy must also be covered with no cost-sharing if the results of the initial colonoscopy, test, or procedure are abnormal. - TIC Chapter 1363

Page _____ : Complications of pregnancy - 28 TAC Section 21.405(1)

Page _____ : Dental services - TIC Section 1360.005 ǂ

Page _____ : Developmental delays, certain therapies - TIC Section 1367.205 ǂ

Page _____ : Diabetes - TIC Chapter 1358, and 28 TAC Section 21.2604 - 21.2607

Page _____ : Diabetes care guidelines - TIC Section 1358.001 - 1358.005 ‡

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 nonemergency 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. TIC Section 1366.104

Page _____ : Hearing impairment, screening test - TIC Section 1367.103

Page _____ : Hearing aid or cochlear implant and related services and supplies, for children that are 18 years of age or younger - TIC Section 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 _____ : Home health service - TIC Chapter 1351 ‡

Page _____ : Immunizations - TIC Section 1367.053 and Section 1367.054

Page _____ : In-vitro fertilization procedures - TIC Section 1366.001 - 1366.007 ‡

Page _____ : Mammography 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 or and 3D (breast tomosynthesis) mammography, ultrasound imaging, or magnetic resonance imaging (MRI). Coverage for a diagnostic imaging must be no less favorable than coverage for a screening mammogram. - TIC Chapter 1356

**Note**: To the extent that this creates first-dollar coverage that would disqualify a plan from being Health Savings Account (HSA) - eligible, flexibility is permitted under TIC Chapter 1653.

Page _____ : Mandatory benefit notices - 28 TAC Section 21.2103

Page _____ : Mastectomy and lymph node dissection, minimum stay - TIC Section 1357.054 ‡

Page _____ : Mastectomy, reconstructive surgery - TIC Section 1357.004 ‡‡

Page _____ : Maternity, minimum stay - TIC Section 1366.055 ‡‡

Page _____ : Mental health coverage must include - inpatient and outpatient benefits for Serious Mental Illness, including inpatient care in a psychiatric day treatment facility and treatment in a residential treatment center for children and adolescentsor a crisis stabilization unit, as an alternative to inpatient hospital treatment -TIC Section 1355.001 - 1355.004, Section 1355.051 - 1355.054, Section 1355.101 - 1355.104.

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

Page _____ : Oral contraceptives - 28 TAC Section 21.404(4) ‡

Page _____ : Orally administered anticancer medications - TIC Section 1369.204 ‡

Page _____ : Osteoporosis detection and prevention - TIC Chapter 1361 ‡

Page _____ : Ovarian cancer testing and screening- 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 a pap smear, FDA-approved HPV test, CA-125 blood test, or any other FDA-approved test for ovarian cancer that complies with the minimum screening test coverage requirements under - TIC Section 1370.003(b).

Page _____ : Phenylketonuria (PKU) - TIC Chapter 1359

Page _____ : Prescription contraceptive drugs and devices and related services - TIC Section 1369.101 - 1369.109 ‡

**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 same 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 _____ : Prescription copay accumulators, credit out of pocket expenses - Issuers and Pharmacy Benefit Managers must credit any third-party payment, financial assistance, discount, product voucher, or other reduction in out-of-pocket made by or on behalf of an enrollee, to the enrollee's deductible, copayment, cost-sharing responsibility, or out-of-pocket maximum applicable to health benefits under the plan. TIC Section 1369.0542

Page _____ : Prescription drug coverage (off label drug use) (Large Employer) TIC Section 1369.001 - 1369.005 ‡

Page _____ : Prescription drug coverage formulary continuation and modification only at renewal - TIC Section 1369.0541, Section 1369.055, and 28 TAC Section 21.3022

Page _____ : Prescription drug formulary disclosure and formulary information provided by toll-free number" - TIC Section 1369.054

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 _____ : Prostate testing - TIC Chapter 1362

Page _____ : Prostate testing, Texas Public Schools Employees Group Insurance Act – TIC Section 1575.159

Page _____ : Prosthetic devices, orthotic devices, and related services - TIC Chapter 1371 ‡

Page _____ : Reconstructive surgery for craniofacial abnormalities (Large Employer) - TIC Section 1367.153

Page _____ : Serious mental illness, Local Governments - TIC Section 1355.151

Page _____ : Serious mental illness, Texas Employee Uniform Group Insurance Benefits - TIC Section 1551.205

Page _____ : Serious mental illness, Texas State College and University Employees Uniform Insurance Benefits Act - TIC Section 1601.109

Page _____ : Speech and hearing - TIC Chapter 1365 ‡

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 a year or if the drug is added to the plan's drug formulary. TIC 1369.0547

Page _____ : Step therapy exception - drugs for stage-four metastatic cancer are not subject to step-therapy or fail first attempts if approved by the United States Food and Drug Administration TIC Section 1369.213 , as added by HB1584

Page _____ : Temporomandibular joint (TMJ) benefits - TIC Section 1360.004 ‡

Page _____ : Telehealth and telemedicine medical services - TIC Section 1455.001 - 1455.006 and defined by Section 111.001 of the Occupation Code:

- Must cover telemedicine or telehealth services provided by a preferred or contracted provider on the same basis and to the same extend 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 telemedicine or telehealth servicebased 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 orlifetime maximum may not apply to telemedicine, telehealth, or teledentistry coverage - TIC Section 1455.004(b), (b-1), and (d)

## Provisions Specific to Preferred and Exclusive Provide Plans

This section provides reference to provisions applicable to health benefit plans that contain preferred and exclusive provider plans.

Page _____ : Acupuncturist - TIC Section 1301.0515

Page _____ : Balance billing prohibition notice - TIC Section 1301.010

Page _____ : Balancing billing by medical emergency service providers prohibited- Extends statutory balance billing protections to services rendered by an out-of-network "emergency medical services provider" as defined by Health and Safety Code §773.003(11). TIC Section 1271.159

Page _____ : Continuity of care - TIC Section 1301.153 and Section 1301.154

Page _____ : Contracting requirements - TIC Section 1301.051 - 1301.066, Section 1301.201 -1301.202,and 28 TAC Section 3.3703

Page _____ : Disclosure notice - TIC Section 1301.158

Page _____ : Definitions - TIC Section 1301.001, and 28 TAC Section 3.3702

Page _____ : Emergency care - TIC Section 1301.155, and 28 TAC Section 3.3704

Page _____ : Emergency care reimbursement and balance billing (out-of-network provider) - TIC Section 1301.0053, 28 TAC Section 3.3725 (EPO), and Section 1301.155 (PPO)

Page _____ : Hospitalist - TIC Section 1301.063

Page _____ : Mandatory written disclosures and notices - the written disclosure must follow the order of requirements provided in the rule (insurer may utilize its handbook to satisfy the disclosure requirements) - TIC Section 1301.157 - 1301.160, and 28 TAC Section 3.3705(a) - (q)

**Note:** for Figure 28 TAC Section 3.3705(f)(1): An assistant surgeon is a type of facility-based physician - TIC Section 1456.001(3)

Page _____ : Provider Directories Disclosure Requirements- 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 _____ : Obligation to continue premium payment and coverage after notice of lost group eligibility 28 TAC Section 21.4001 - 21.4003

Page _____ : Out-of-network facility-based provider, reimbursement, and balance billing - TIC Section 1301.164

Page _____ : Out-of-network diagnostic imaging and laboratory service provider, eimbursement, and balance billing – TIC Section 1301.165

Page _____ : Podiatrist - TIC Section 1301.062

Page _____ : Preauthorization of medical and health care services - TIC Section 1301.135

Page _____ : Preauthorization renewal - before the expiration of an existing preauthorization, if the health benefit plan receives a request to renew, it must review the request and issue a determination - TIC Section 1222.0003 -1222.0004 and Section 1301.001 (definition of preauthorization)

Page _____ : Preferred and exclusive provider benefit plans - TIC Chapter 1301, and 28 TAC Section 3.3701 - 3.3706

Page _____ : Preferred provider benefit plan out-of-pocket expense credits- An issuer must credit toward an insured's deductible and annual maximum out-of-pocket medically necessary expenses an insured pays directly to any physician or health care provider. An issuer must (1) establish procedures for the insured to claim credit; (2) identify necessary documentation to support a claim for credit; and (3) make the procedure and necessary documentation information readily accessible on the insured's website. TIC Section 1301.140

Page _____ : Restrictions on payment and reimbursement - TIC Section 1301.056

Page _____ : Service area - TIC Section 1301.001(10)

Page _____ : Transmission - enrollee eligibility status - TIC Section 1274.002

Page _____ : Web-based access to preauthorization requirements – Information about preauthorization requirements must be publicly accessible on the plan's website - TIC Section 1301.1351

## Short-Term Limited Duration Plans

Page _____ : Definition of short-term limited duration insurance – TIC Section 1509.001 and 26 CFR Section 54.9801-2, health insurance coverage that:

- has an expiration date specified in the contract that is less than 12 months afterthe original effective date of the contract and, taking into account renewals or extensions, has a duration of no longer than 36 months in total; and displays prominently in the contract and in any application, materials provided in connection with enrollment in such coverage in at least 14-point type the language in the following Notice, with any additional information required by applicable state law:
- This coverage is not required to comply with certain federal market requirements for health insurance, principally those contained in the Affordable Care Act. Be sure to check your policy carefully to make sure youare aware of any exclusions or limitations regarding coverage of preexisting conditions or health benefits (such as hospitalization, emergency services, maternity care, preventive care, prescription drugs, and mental health and substance use disorder services). Your policy might also have lifetime and/ or annual dollar limits on health benefits. If this coverage expires or you lose eligibility for this coverage, you might have to wait until an open enrollment period to get other health insurance coverage.

Page _____ : Health carrier disclosure - TIC Section 1507.006 and 28 TAC Section 21.3530

Page _____ : Disclosure form - A disclosure form in at least 14-point type must be provided with any short-term limited-duration policy or application - TIC Section 1509.002

Page _____ : Renewability - guaranteed renewability provisions do not apply, but any right to renew coverage must be clearly disclosed -28 TAC Section 3.3050

## Pre-existing Conditions and Creditable Coverage

This section provides reference to pre-existing condition provisions that may be contained in a health benefits plan. In addition, this section defines creditable coverage and how it should be applied.

**General Requirements:**

- A pre-existing condition provision may not apply to a loss incurred or disability beginningafter the earlier of:

  (1) the end of 12 consecutive months during which the insured has not received medical advice or treatment: or

(2) the second anniversary of the effective date of the insured's coverage.

- A pre-existing condition provision may only apply to a disease or condition in which the insured received medical advice or treatment during the 12 months before the effective date of coverage.
- Non-employer or Member Association Health Benefit Plans are creditable coverage but are notrequired to reduce pre-existing condition limitations by creditable coverage.

Page _____ : Creditable coverage - TIC Section 1205.004, and 28 TAC Section 21.1101(5)

Page _____ : Certification of coverage - TIC Section 1205.002, and 28 TAC Section 21.1101 21.1110

Page _____ : Pre-existing condition - TIC Section 1251.108

## Renewability

This section provides reference to mandatory guaranteed renewability provisions for health benefit plans issued to members of an Association or Bona Fide Association.

**General Requirements:**

- The health carrier must renew the health benefit plan at the option of the association or bonafide association.
- The health carrier must obtain acceptance from the policyholder and each covered member priorto any changes to the issued policy/certificate unless the change is due to state or federal law.

**Note**: Guaranteed renewable – Section 2742 of the federal Public Health Services Act as added by theHealth Insurance Portability and Availability Act (HIPAA) and 45 Code of Federal Regulation Section 148.122.

Page _____ : Guaranteed renewability of association and bona fide association health benefit plans - 28 TAC Section 21.2704(a)

Page _____ : Guaranteed renewability of association member's coverage -28 TAC Section 21.2704(b) and (c)

Page _____ : Discontinuance of association health benefit plan(s) - 28 TAC Section 21.2704(d)(1)

Page _____ : Withdraw from association market - 28 TAC Section 21.2704(d)(2)

## Payment of Benefits

Page _____ : Assignment of dental benefits –TIC Section 1451.206

Page _____ : Assignment of health care benefit payments - TIC Section 1204.053

Page _____ : Eligibility for benefits, Alzheimer's disease - TIC Chapter 1354

Page _____ : Hospital owned or controlled by state or local government - TIC Section 1204.001 and Section 1204.002

Page _____ : Payment of benefits - TIC Section 1251.005

Page _____ : Prompt payment of claims - TIC Section 542.051 - 542.061

Page _____ : Tax supported institutions - TIC Section 1355.202

Page _____ : Texas Medical Assistance Act - TIC Section 1204.201

Page _____ : Parity for mental health and substance use disorder benefits (MH/SUD) - Quantitative and nonquantitative treatment limits, including visit limits, cost sharing, and other financial requirements (including methodology used to calculate reimbursements) must be no more restrictive for MH/SUD than for medical or surgical benefits - TIC Section 1355.254

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

## Utilization Review

This section provides reference to provisions applicable to health benefit plans that include language related to utilization review.

- Utilization review provisions are not required; if included, the language must comply with the referenced statutes.
- A health benefit plan may not include language that imposes a specific time limit in which the covered person must file an appeal. The statute does not reflect a specific time limit.

Page _____ : Adverse determination means and includes: - services provided or proposed thatare determined not medically necessary or experimental and investigational - TIC Section 4201.002(1) and 28 TAC Section 19.1703(b)(1):

- if prescription drugs are covered, the refusal of a health benefit plan issuer to provide benefits for a prescription drug not included on the drug formulary andthe enrollee's physician has determined that the drug is medically necessary - TIC Section 1369.056

- if prescription drugs are covered, the denial of a step-therapy protocol exception request - TIC Section 1369.0546

Page _____ : Notice of determination - TIC Section 4201.301 - 4201.304, and 28 TAC Section 19.1709

Page _____ : An adverse determination must include a description of the enrollee's right to an immediate review by an Independent Review Organization (IRO), and of the procedures to obtain that review, for life threatening conditions and for a denial of prescription drugs or intravenous infusions - TIC Section 4201.303(b) and (c)

Page _____ : Appeal of adverse determination - TIC Section 4201.351 - 4201.360 and 28 TAC Section 19.1711

## Subrogation

Page _____ : Contractual subrogation rights of payers of certain benefits - Civil Practice and Remedies Code Chapter 140

## Continuation

Page _____ : Continuation or conversion - TIC Section 1251.117

Page _____ : Continuation - TIC Section 1251.251 - 1251.260

Page _____ : Continuation (six-month period following COBRA) - TIC Section 1251.255(a)(1)(B)

Page _____ : Continuation (nine-month period without COBRA) - TIC Section 1251.255(a)(1)(A)

Page _____ : Continuation and conversion notice requirement - TIC Section 1251.260, and 28 TAC Section 21.5311 and Section 21.5321

**Continuation and conversion privilege** - 28 TAC Chapter 21, Subchapter SS:

- offer of continuation is required
- offer of conversion is optional

Page _____ : Group continuation provisions - 28 TAC Section 21.5310 - 21.5314

Page _____ : Group conversion provisions - 28 TAC Section 21.5320 - 21.5322

Page _____ : Continuation for certain dependents - TIC Section 1251.301 - 1251.310

Page _____ : Extension of benefits - TIC Section 1252.102

Page _____ : Continuation during labor dispute - TIC Section 1253.051 - 1253.060

## General Policy Provisions

Page _____ : Designation of practitioners - TIC Section 1451.001 and Section 1451.053

Page _____ : Guaranty Fund disclosure document - TIC Section 463.114 and Section 463.451

Page _____ : Identification cards for pharmacy benefits (Large Employer) - TIC  Section 1369.151 - 1369.153

Page _____ : Newborn screening test - The cost of administration and the cost of the newborn screening test kit as required by TIC Section 1367.003

Page _____ : Notice of policyholder complaint procedures - TIC Section 521.005

Page _____ : Refusal to reimburse solely on services provided by a chiropractor, acting in the scope of a his/her license, is prohibited - TIC Section 1301.0516

Page _____ : Refusal to reimburse solely on services provided by a pharmacist, acting in the scope of his/her license, is prohibited - TIC Section 1451.001(13-a), Section 1451.1261(d), and Section 1451.128

## Prohibited Practices

Page _____ : Access to Out-of-Network Providers - an insurer may not terminate, or threaten to terminate, an insured's participation in a preferred provider benefit plan solely because the insured uses an out-of-network provider - TIC Section 1301.0057

Page _____ : AIDS - 28 TAC Section 21.704

Page _____ : AIDS/HIV prohibition on contract renegotiations - TIC Section 1253.001

Page _____ : AIDS/HIV prohibits cancellation - TIC Section 1364.051 - 1364.053

Page _____ : AIDS/HIV prohibits exclusion - TIC Section 1551.205, Section 1601.109, and Section 1364.001 -1364.004 ‡

Page _____ : Alzheimer's disease - TIC Section 1354.001 and Section 1354.002

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 of the patient and providers attestation statement addressing increased risk; (3) charging an additional fee or higher cost based on enrollees choice of pharmacy or because the drug was not dispensed by a network pharmacy. TIC Section 1369.764

Page _____ : Certification by podiatrist - TIC Section 1451.351

Page _____ : Confidentiality of individual's status as a victim of family violence - TIC Section 544.154

Page _____ : Cost-sharing requirements for prescription insulin - 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 – Section 1358.104

Page _____ : Coverage limitations due to history of fibrocystic breast conditions - TIC Section 544.201 - 544.204

Page _____ : Dental preferred provider plans prohibited - TIC Section 1301.002

Page _____ : Discrimination in rates or renewal (victims of family violence) – TIC Section 544.151 - 544.158

Page _____ : Discrimination in rates - TIC Section 544.002 - 544.004

Page _____ : Discrimination against optometrist or ophthalmologist - TIC Section 1451.153 ‡

Page _____ : Exclusion of coverage for premature births with use of waiting periods 28 TAC Section 21.405(3)

Page _____ : Exclusion of coverage for riot and terrorism, must be limited to participation - TIC Section 1701.055(a)(2)

Page _____ : HIV, nondiscriminatory testing for - 28 TAC Section 21.705

Page _____ : HIV, testing by insurers - TIC Chapter 545

Page _____ : Higher premium for child subject to medical support order prohibited - 28 TAC Section 21.2004(e)

Page _____ : Illegal pricing practices - TIC Chapter 552

Page _____ : Individual's status as victim of family violence - TIC Section 544.153

Page _____ : Minimum inpatient care and post-delivery care following childbirth - TIC Section 1366.057

Page _____ : Orthodontic coverage exclusion - 28 TAC Section 3.3601

Page _____ : Parity in mental health benefits (Large Employer) - 28 TAC Section 21.2403

Page _____ : Pharmacy and durable medical equipment (DME) provider freedom of choice – A plan of pharmacy benefit manager (PBM) 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 Sections 1369.553, 1369.554, and 1369.555.

Page _____ : Physical or mental impairment - 28 TAC Section 21.702

Page _____ : Policy may not specify service provider - TIC Section 1251.006

Page _____ : Preauthorization penalty maximum 50 percent or $500 - TIC Section 1701.055(a)(2)

Page_____ : Prohibition on forced organ harvesting - 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. An issuer may not cover any 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. TIC Section 1380.003

Page _____ : Retaliation against preferred provider - TIC Section 1301.066 - 1301.068, and Section 1301.161

Page _____ : Service area restrictions regarding child subject to medical support order – 28 TAC Section 21.2010

Page _____ : Speech and hearing services cannot be based on cause - TIC Chapter 1365

Page _____ : Unauthorized use of DEA numbers - Health and Safety Code Section 481.003

Page _____ : Unfair discrimination - TIC Section 544.051 - 544.054

Page _____ : Unfair discrimination, refuse to enroll or renew due to exposure to asbestos or silica - TIC Sections 544.451 - 544.453

Page _____ : Unfair discrimination, refuse to enroll - TIC Sections 1206.003

Page _____ : Unfair discrimination, sex or marital status - 28 TAC Sections 21.401 - 21.409

Page _____ : Unlimited exemption from seizure under process -TIC Sections 1108.051 - 1108.053

Page _____ : Use of genetic information - TIC Sections 546.051 - 546.053

Page _____ : Variation of rates, group size (Small Employer) - 28 TAC Section 26.11(d)

Page _____ : Withdrawals for premium payments - TIC Section 550.002

## General Information

Page _____ : Burden of proof and pleading of insurer - TIC Chapter 554

Page _____ : Out-of-state group accident and health coverage - TIC Section 1251.451

Page _____ : Texas laws govern policies - TIC Article 21.42