SUBCHAPTER F. Evidence of Coverage
28 TAC §§11.506, 11.508, and 11.511

1. INTRODUCTION. The commissioner of insurance adopts amendments to 28 TAC Chapter 11, Subchapter F, §§11.506, 11.508, and 11.511. The amendments are adopted with nonsubstantive changes to the proposal published in the July 4, 2014, issue of the *Texas Register* (39 TexReg 5081). The amendments are related to the separate adoption of a new 28 TAC Chapter 21, Subchapter SS, and the repeal of 28 TAC Chapter 3, Subchapter F, both published in this issue of the *Texas Register*.

2. REASONED JUSTIFICATION. The repeal of 28 TAC Chapter 3, Subchapter F; its replacement by the proposed new 28 TAC Chapter 21, Subchapter SS; and concurrently proposed amendments to 28 TAC Chapter 11, Subchapter F; are necessary to conform TDI's continuation and conversion rules to statutory changes that have occurred over time, including HB 710, 75th Legislature, Regular Session (1997) and SB 1771, 81st Legislature, Regular Session (2009), and to consolidate the rules for insured and HMO products to enhance consistency in the market to the extent possible. The repealed, amended, and new rules will conserve agency resources by reducing the need for multiple rule projects resulting from future changes in continuation or conversion laws. TDI's original proposal made no changes to §11.506(1) - (5). However, renumbering of other paragraphs of §11.506 requires changes to references to those paragraphs in §11.506(3)(A)(ii), §11.506(3)(B)(i), and §11.506(3)(D)(i) and (ii).

Those changes have been made. Nonsubstantive editorial changes to conform to TDI usage and style guidelines have also been made to the proposed rules.

3. SUMMARY OF COMMENTS AND AGENCY RESPONSE. TDI received no comments on the published proposal for the amendments.

4. STATUTORY AUTHORITY. TDI adopts the amendments under Insurance Code §§36.001, 843.051(b)(3), 1251.008, 1251.251(a), 1251.253, 1251.258, 1251.260, 1271.301(b), 1271.306(c), and 1701.060(a).

Section 36.001 provides that the commissioner may adopt any rules necessary and appropriate to implement the powers and duties of the department under the Insurance Code and other laws of this state.

Section 843.051(b)(3) states, “A health maintenance organization is subject to … Subchapter G, Chapter 1251, and Section 1551.064.”

Section 1251.008 states, “The commissioner may adopt rules necessary to administer this chapter. A rule adopted under this section is subject to notice and hearing as provided by Section 1201.007 for a rule adopted under Chapter 1201.”

Section 1251.251(a) states, “An insurer or group hospital service corporation that issues policies that provide hospital, surgical, or major medical expense insurance coverage or any combination of those coverages on an expense incurred basis shall, as required by this subchapter, provide continuation of group coverage for employees or

members and their eligible dependents, subject to the eligibility provisions prescribed by Section 1251.252."

Section 1251.253 states, "An employee, member, or dependent must provide to the employer or group policyholder a written request for continuation of group coverage not later than the 60th day after the later of: (1) the date the group coverage would otherwise terminate; or (2) the date the individual is given, in a format prescribed by the commissioner, notice by either the employer or the group policyholder of the right to continuation of group coverage."

Section 1251.258 states, "The commissioner by rule shall establish minimum standards for benefits under converted policies issued under this subchapter."

Section 1251.260 states, "(a) An employer that provides to its employees group accident and health insurance coverage that includes a group continuation or conversion privilege on termination of coverage shall give written notice of the continuation or conversion privileges under the policy to each employee or dependent insured under the group and affected by the termination. (b) The commissioner by rule shall establish minimum standards for the notice required by this section."

Section 1271.301(b) states, "A health maintenance organization shall provide a group coverage continuation privilege as required by and subject to the eligibility provisions of this subchapter."

Section 1271.306(c) states, "A conversion contract must meet the minimum standards for services and benefits for conversion contracts. The commissioner shall

adopt rules to prescribe the minimum standards for services and benefits applicable to conversion contracts."

Section 1701.060(a) provides that the commissioner may adopt reasonable rules necessary to implement the purposes of Chapter 1701.

5. TEXT.

§11.506 Mandatory Contractual Provisions: Group, Individual, and Conversion Agreement and Group Certificate

Each enrollee residing in this state is entitled to an evidence of coverage under a health care plan. By agreement between the issuer of the evidence of coverage and the enrollee, the evidence of coverage approved under this subchapter and required by this section may be delivered electronically. Each group, individual, and conversion contract and group certificate must contain the following provisions:

(1) Name, address, and phone number of the HMO--The toll-free number referred to in Insurance Code §521.102, where applicable, must appear on the face page.

(A) The face page of an agreement is the first page that contains any written material.

(B) If the agreements or certificates are in booklet form the first page inside the cover is considered the face page.

(C) The HMO must provide the information regarding the toll-free number referred to in Insurance Code Chapter 521, Subchapter C, in compliance with §1.601 of this title.

(2) Benefits--A schedule of all health care services that are available to enrollees under the basic, limited, or single health care service plan, including any copayments or deductibles and a description of where and how to obtain services. An HMO may use a variable copayment or deductible schedule. The copayment schedule must clearly indicate the benefit to which it applies.

(A) Copayments. An HMO may require copayments to supplement payment for health care services. Each basic service HMO may establish one or more reasonable copayment options. A reasonable copayment option may not exceed 50 percent of the total cost of services provided. A basic service HMO may not impose copayment charges on any enrollee in any calendar year, when the copayments made by the enrollee in that calendar year total 200 percent of the total annual premium cost which is required to be paid by or on behalf of that enrollee. This limitation applies only if the enrollee demonstrates that copayments in that amount have been paid in that year. The HMO must state the copayment in the group, individual or conversion agreement and group certificate.

(B) Deductibles. A deductible must be for a specific dollar amount of the cost of the basic, limited, or single health care service. An HMO may charge a deductible only for services performed out of the HMO’s service area or for services performed by a physician or provider who is not in the HMO’s delivery network.

(C) Immunizations. An HMO may not charge a copayment or deductible for immunizations as described in Insurance Code Chapter 1367, Subchapter B for a child from birth through the date the child is six years of age, except that a small employer health benefit plan, as defined by Insurance Code §1501.002, that covers such immunizations may charge a copayment or deductible.

(3) Cancellation and nonrenewal--A statement specifying the following grounds for cancellation and nonrenewal of coverage and the minimum notice period that will apply.

(A) An HMO may cancel a subscriber in a group and subscriber's enrolled dependents under circumstances described in clauses (i) - (vii) of this subparagraph, so long as the circumstances do not include health status related factors:

(i) For nonpayment of amounts due under the contract, coverage may be canceled after not less than 30 days written notice, except no written notice will be required for failure to pay premium.

(ii) In the case of fraud or intentional misrepresentation of a material fact, except as described in paragraph (13) of this section, coverage may be canceled after not less than 15 days written notice.

(iii) In the case of fraud in the use of services or facilities, coverage may be canceled after not less than 15 days' written notice.

(iv) For failure to meet eligibility requirements other than the requirement that the subscriber reside, live, or work in the service area, coverage may

be canceled immediately, subject to continuation of coverage and conversion privilege provisions, if applicable.

(v) In the case of misconduct detrimental to safe plan operations and the delivery of services, coverage may be canceled immediately.

(vi) For failure of the enrollee and a plan physician to establish a satisfactory patient-physician relationship if it is shown that the HMO has, in good faith, provided the enrollee with the opportunity to select an alternative plan physician, the enrollee is notified in writing at least 30 days in advance that the HMO considers the patient-physician relationship to be unsatisfactory and specifies the changes that are necessary in order to avoid termination, and the enrollee has failed to make such changes, coverage may be canceled at the end of the 30 days.

(vii) Where the subscriber neither resides, lives, or works in the service area of the HMO, or area for which the HMO is authorized to do business, but only if the HMO terminates coverage uniformly without regard to any health status-related factor of enrollees, coverage may be canceled after 30 days' written notice. An HMO may not cancel coverage for a child who is the subject of a medical support order because the child does not reside, live, or work in the service area.

(B) An HMO may cancel a group under circumstances described in clauses (i) - (vi) of this subparagraph:

(i) For nonpayment of premium, all coverage may be canceled at the end of the grace period as described in paragraph (12) of this section.

(ii) In the case of fraud on the part of the group, coverage may be canceled after 15 days' written notice.

(iii) For employer groups, violation of participation or contribution rules, coverage may be canceled in compliance with §26.8(h) and §26.303(j) of this title (relating to Guaranteed Issue; Contribution and Participation Requirements and Coverage Requirements).

(iv) For employer groups, in compliance with §26.16 and §26.309 of this title (relating to Refusal to Renew and Application to Reenter Small Employer Market and Refusal to Renew and Application to Reenter Large Employer Market), coverage may be canceled upon discontinuance of:

(I) each of its small or large employer coverages; or

(II) a particular type of small or large employer coverage.

(v) Where no enrollee resides, lives, or works in the service area of the HMO, or area for which the HMO is authorized to do business, but only if the coverage is terminated uniformly without regard to any health status-related factor of enrollees, the HMO may cancel the coverage after 30 days written notice.

(vi) If membership of an employer in an association ceases, and if coverage is terminated uniformly without regard to the health status of an enrollee, the HMO may cancel the coverage after 30 days' written notice.

(C) In the case of a material change by the HMO to any provisions required to be disclosed to contract holders or enrollees pursuant to this chapter or

other law, a group or individual contract holder may cancel the contract after not less than 30 days written notice to the HMO.

(D) An HMO may cancel an individual contract under circumstances described in clauses (i) - (vi) of this subparagraph.

(i) For nonpayment of premiums in compliance with the terms of the contract, including any timeliness provisions, coverage may be canceled without written notice, subject to paragraph (12) of this section.

(ii) In the case of fraud or intentional material misrepresentation, except as described in paragraph (13) of this section, the HMO may cancel coverage after not less than 15 days' written notice.

(iii) In the case of fraud in the use of services or facilities, the HMO may cancel coverage after not less than 15 days' written notice.

(iv) Where the subscriber neither resides, lives, or works in the service area of the HMO, or area for which the HMO is authorized to do business, but only if coverage is terminated uniformly without regard to any health status-related factor of enrollees, coverage may be canceled after 30 days' written notice. An HMO may not cancel the coverage for a child who is the subject of a medical support order because the child does not reside, live, or work in the service area.

(v) In case of termination by discontinuance of a particular type of individual coverage by the HMO in that service area, but only if coverage is discontinued uniformly without regard to health status-related factors of enrollees and dependents of enrollees who may become eligible for coverage, the HMO may cancel

coverage after 90 days' written notice, in which case the HMO must offer to each enrollee on a guaranteed-issue basis any other individual basic health care coverage offered by the HMO in that service area.

(vi) In case of termination by discontinuance of all individual basic health care coverage by the HMO in that service area, but only if coverage is discontinued uniformly without regard to health status-related factors of enrollees and dependents of enrollees who may become eligible for coverage, the HMO may cancel coverage after 180 days' written notice to the commissioner and the enrollees, in which case the HMO may not re-enter the individual market in that service area for five years beginning on the date of discontinuance at the last coverage not renewed.

(4) Claim payment procedure--A provision that sets forth the procedure for paying claims, including any time frame for payment of claims that must comply with Insurance Code Chapter 542, Subchapter B and §1271.005 and the applicable rules.

(5) Complaint and appeal procedures--A description of the HMO's complaint and appeal process available to complainants.

(6) Definitions--A provision defining any words in the evidence of coverage that have other than the usual meaning. Definitions must be in alphabetical order.

(7) Effective date--A statement of the effective date requirements of various kinds of enrollees.

(8) Eligibility--A statement of the eligibility requirements for membership, including:

(A) that the subscriber must reside, live, or work in the service area and the legal residence of any enrolled dependents must be the same as the subscriber, or the subscriber must reside, live, or work in the service area and the residence of any enrolled dependents must be:

(i) in the service area with the person having temporary or permanent conservatorship or guardianship of the dependents, including adoptees or children who have become the subject of a suit for adoption by the enrollee, where the subscriber has legal responsibility for the health care of the dependents;

(ii) in the service area under other circumstances where the subscriber is legally responsible for the health care of the dependents;

(iii) in the service area with the subscriber's spouse; or

(iv) anywhere in the United States for a child whose coverage under a plan is required by a medical support order.

(B) the conditions under which dependent enrollees may be added to those originally covered;

(C) any limiting age for subscriber and dependents;

(D) a clear statement regarding the coverage of newborn children:

(i) No evidence of coverage may contain any provision excluding or limiting coverage for a newborn child of the subscriber or the subscriber's spouse.

(ii) Congenital defects must be treated the same as any other illness or injury for which coverage is provided.

(iii) The HMO may require that the subscriber notify the HMO during the initial 31 days after the birth of the child and pay any premium required to continue coverage for the newborn child.

(iv) An HMO may not require that a newborn child receive health care services only from network physicians or providers after the birth if the newborn child is born outside the HMO service area due to an emergency, or born in a non-network facility to a mother who does not have HMO coverage. The HMO may require that the newborn be transferred to a network facility at the HMO's expense and, if applicable, to a network provider when the transfer is medically appropriate, as determined by the newborn's treating physician.

(v) A newborn child of the subscriber or subscriber's spouse is entitled to coverage during the initial 31 days following birth. The HMO must allow an enrollee 31 days after the birth of the child to notify the HMO, either verbally or in writing, of the addition of the newborn as a covered dependent.

(E) A clear statement regarding the coverage of the enrollee's grandchildren up to the age of 25 under the conditions by which the coverage is required by Insurance Code §1201.062 and §1271.006.

(9) Emergency services--A description of how to obtain services in emergency situations including:

(A) what to do in case of an emergency occurring outside or inside the service area;

(B) a statement of any restrictions or limitations on out-of-area services;

(C) a statement that the HMO will provide for any medical screening examination or other evaluation required by state or federal law that is necessary to determine whether an emergency medical condition exists in a hospital emergency facility or comparable facility;

(D) a statement that necessary emergency care services will be provided, including the treatment and stabilization of an emergency medical condition; and

(E) a statement that where stabilization of an emergency condition originated in a hospital emergency facility or comparable facility, as defined in subparagraph (F) of this paragraph, treatment subject to stabilization must be provided to enrollees as approved by the HMO, provided that the HMO must approve or deny coverage of poststabilization care as requested by a treating physician or provider. An HMO must approve or deny the treatment within the time appropriate to the circumstances relating to the delivery of the services and the condition of the patient, but in no case may approval or denial exceed one hour from the time of the request.

(F) For purposes of this paragraph, “comparable facility” includes the following:

(i) any stationary or mobile facility, including, but not limited to, Level V Trauma Facilities and Rural Health Clinics that have licensed or certified personnel and equipment to provide Advanced Cardiac Life Support consistent with American Heart Association and American Trauma Society standards of care;

(ii) for purposes of emergency care related to mental illness, a mental health facility that can provide 24-hour residential and psychiatric services and is:

(I) a facility operated by the Texas Department of State Health Services;

(II) a private mental hospital licensed by the Texas Department of State Health Services;

(III) a community center as defined by Texas Health and Safety Code §534.001;

(IV) a facility operated by a community center or other entity the Texas Department of State Health Services designates to provide mental health services;

(V) an identifiable part of a general hospital in which diagnosis, treatment, and care for persons with mental illness is provided and that is licensed by the Texas Department of State Health Services; or

(VI) a hospital operated by a federal agency.

(10) Entire contract, amendments--A provision stating that the form, applications, if any, and any attachments constitute the entire contract between the

parties and that, to be valid, any change in the form must be approved by an officer of the HMO and attached to the affected form and that no agent has the authority to change the form or waive any of the provisions.

(11) Exclusions and limitations--A provision setting forth any exclusions and limitations on basic, limited, or single health care services.

(12) Grace period--A provision for a grace period of at least 30 days for the payment of any premium falling due after the first premium during which the coverage remains in effect. An HMO may add a charge to the premium for late payments received within the grace period. If an HMO does not receive payment within the 30 days, the HMO may cancel coverage after the 30th day and may hold the terminated members liable for the cost of services received during the grace period, if this requirement is disclosed in the agreement.

(13) Incontestability:

(A) All statements made by the subscriber on the enrollment application are considered representations and not warranties. The statements are considered truthful and made to the best of the subscriber's knowledge and belief. A statement may not be used in a contest to void, cancel, or nonrenew an enrollee's coverage or reduce benefits unless:

(i) it is in a written enrollment application signed by the subscriber; and

(ii) a signed copy of the enrollment application is or has been furnished to the subscriber or the subscriber's personal representative.

(B) An individual contract or group certificate may only be contested because of fraud or intentional misrepresentation of material fact made on the enrollment application. For small employer coverage, the misrepresentation must be other than a misrepresentation related to health status.

(C) For a group contract or certificate, the HMO may increase its premium to the appropriate level if the HMO determines that the subscriber made a material misrepresentation of health status on the application. The HMO must provide the contract holder 31 days' prior written notice of any premium rate change.

(14) Out-of-network services--Each contract between an HMO and a contract holder must provide that if medically necessary covered services are not available through network physicians or providers, the HMO must, on the request of a network physician or provider, within the time appropriate to the circumstances relating to the delivery of the services and the condition of the patient, but in no event to exceed five business days after receipt of reasonably requested documentation, allow a referral to a non-network physician or provider and must fully reimburse the non-network provider at the usual and customary or an agreed rate.

(A) For purposes of determining whether medically necessary covered services are available through network physicians or providers, the HMO must offer its entire network, rather than limited provider networks within the HMO delivery network.

(B) The HMO may not require the enrollee to change his or her primary care physician or specialist providers to receive medically necessary covered services that are not available within the limited provider network.

(C) Each contract must further provide for a review by a specialist of the same or similar specialty as the type of physician or provider to whom a referral is requested before the HMO may deny a referral.

(15) Schedule of charges--A statement that discloses the HMO's right to change the rate charged with 60 days' written notice under Insurance Code Chapter 1254.

(16) Service area--A description and a map of the service area, with key and scale, that identifies the county, or counties, or portions of counties, to be served, indicating primary care physicians, hospitals, and emergency care sites. A ZIP code map and a provider list may be used to meet the requirement.

(17) Termination due to attaining limiting age--A provision that a child's attainment of a limiting age does not operate to terminate the child's coverage while that child is incapable of self-sustaining employment due to mental retardation or physical disability, and chiefly dependent on the subscriber for support and maintenance. The HMO may require the subscriber to furnish proof of incapacity and dependency within 31 days of the child's attainment of the limiting age and subsequently as required, but not more frequently than annually following the child's attainment of the limiting age.

(18) Termination due to student dependent's change in status--Each group agreement and certificate that conditions dependent coverage for a child twenty-

five years of age or older on the child's being a full-time student at an educational institution must contain a provision complying with Insurance Code Chapter 1503.

(19) Conformity with state law--A provision that if the agreement or certificate contains any provision not in conformity with Insurance Code Chapter 1271 or other applicable laws, it must not be rendered invalid but must be construed and applied as if it were in full compliance with Insurance Code Chapter 1271 and other applicable laws.

(20) Conformity with Medicare supplement minimum standards and long-term care minimum standards--Each group, individual, and conversion agreement and group certificate must comply with Chapter 3, Subchapter T of this title, referred to in this paragraph as Medicare supplement rules, and Chapter 3, Subchapter Y of this title, referred to in this paragraph as long-term care rules, where applicable. If there is a conflict between the Medicare supplement or long-term care rules and the HMO rules, the Medicare supplement or long-term care rules will govern to the exclusion of the conflicting provisions of the HMO rules. Where there is no conflict, an HMO must follow the Medicare supplement and long-term care rules and the HMO rules where applicable.

(21) Nonprimary care physician specialist as primary care physician--A provision that allows enrollees with chronic, disabling, or life threatening illnesses to apply to the HMO's medical director to use a nonprimary care physician specialist as a primary care physician as set out in Insurance Code §1271.201.

(22) Selected obstetrician or gynecologist--Individual, conversion, and group agreements and certificates, except small employer plans as defined by Insurance Code §1501.002, must contain a provision that permits an enrollee to select, in addition to a primary care physician, an obstetrician or gynecologist to provide health care services within the scope of the professional specialty practice of a properly credentialed obstetrician or gynecologist, and subject to the provisions of Insurance Code Chapter 1451, Subchapter F. An HMO must not prevent an enrollee from selecting a family physician, internal medicine physician, or other qualified physician to provide obstetrical or gynecological care.

(A) An HMO must permit an enrollee who selects an obstetrician or gynecologist direct access to the health care services of the selected obstetrician or gynecologist without a referral by the enrollee's primary care physician or prior authorization or precertification from the HMO.

(B) Access to the health care services of an obstetrician or gynecologist includes:

(i) one well-woman examination per year;

(ii) care related to pregnancy;

(iii) care for all active gynecological conditions; and

(iv) diagnosis, treatment, and referral to a specialist within the HMO's network for any disease or condition within the scope of the selected professional practice of a properly credentialed obstetrician or gynecologist, including treatment of medical conditions concerning breasts.

(C) An HMO may require an enrollee who selects an obstetrician or gynecologist to select the obstetrician or gynecologist from within the limited provider network to which the enrollee's primary care physician belongs.

(D) An HMO may require a selected obstetrician or gynecologist to forward information concerning the medical care of the patient to the primary care physician. However, the HMO must not impose any penalty, financial or otherwise, on the obstetrician or gynecologist by the HMO for failure to provide this information if the obstetrician or gynecologist has made a reasonable and good faith effort to provide the information to the primary care physician.

(E) An HMO may limit an enrollee in the plan to self-referral to one participating obstetrician and gynecologist for both gynecological care and obstetrical care. The limitation must not affect the right of the enrollee to select the physician who provides that care.

(F) An HMO must include in its enrollment form a space in which an enrollee may select an obstetrician or gynecologist as set forth in Insurance Code Chapter 1451, Subchapter F. The enrollment form must specify that the enrollee is not required to select an obstetrician or gynecologist, but may instead receive obstetrical or gynecological services from her primary care physician or primary care provider. The enrollee must have the right at all times to select or change a selected obstetrician or gynecologist. An HMO may limit an enrollee's request to change an obstetrician or gynecologist to no more than four changes in any 12-month period.

(G) An enrollee who elects to receive obstetrical or gynecological services from a primary care physician (i.e., a family physician, internal medicine physician, or other qualified physician) must adhere to the HMO's standard referral protocol when accessing other specialty obstetrical or gynecological services.

(23) Diagnosis of Alzheimer's disease--An HMO that provides for the treatment of Alzheimer's disease must provide that a clinical diagnosis of Alzheimer's disease under Insurance Code Chapter 1354 by a physician licensed in this state satisfies any requirement for demonstrable proof of organic disease.

(24) Drug Formulary--A group agreement and certificate, except small employer plans as defined by Insurance Code §1501.002, that covers prescription drugs and uses one or more formularies must comply with Insurance Code Chapter 1369, Subchapter B and Chapter 21, Subchapter V of this title.

(25) Inpatient care by non primary care physician--If an HMO or limited provider network provides for an enrollee's care by a physician other than the enrollee's primary care physician while the enrollee is in an inpatient facility (e.g., hospital or skilled nursing facility), a provision that on admission to the inpatient facility a physician other than the primary care physician may direct and oversee the enrollee's care.

§11.508 Mandatory Benefit Standards: Group, Individual, and Conversion Agreements

(a) Each evidence of coverage providing basic health care services must provide the following basic health care services when they are provided by network physicians or providers, or by non-network physicians and providers as set out in §11.506(9) or (14) of this title;

(1) Outpatient services, including the following:

(A) primary care and specialist physician services;

(B) outpatient services by other providers;

(C) diagnostic services, including laboratory, imaging, and radiologic services;

(D) therapeutic radiology services;

(E) prenatal services, if maternity benefits are covered;

(F) outpatient rehabilitation therapies including physical therapy, speech therapy, and occupational therapy;

(G) home health services, as prescribed or directed by the responsible physician or other authority designated by the HMO;

(H) preventive services, including:

(i) periodic health examinations for adults as required by Insurance Code §1271.153;

(ii) immunizations for children as required by Insurance Code §1367.053;

(iii) well-child care from birth as required by Insurance Code §1271.154;

(iv) cancer screenings as required by Insurance Code Chapter 1356 relating to mammography;

(v) cancer screenings as required by Insurance Code Chapter 1362 relating to screening for prostate cancer;

(vi) cancer screenings as required by Insurance Code Chapter 1363 relating to screening for colorectal cancer;

(vii) eye and ear examinations for children through age 17, to determine the need for vision and hearing correction complying with established medical guidelines; and

(viii) immunizations for adults under the United States Department of Health and Human Services Centers for Disease Control Recommended Adult Immunization Schedule by Age Group and Medical Conditions, or its successor.

(I) no less than 20 outpatient mental health visits per enrollee per year as may be necessary and appropriate for short-term evaluative or crisis stabilization services, which must have the same cost-sharing and benefit maximum provisions as any physical health services; and

(J) emergency services as required by Insurance Code §1271.155.

(2) Inpatient hospital services, including room and board, general nursing care, meals and special diets when medically necessary, use of operating room and related facilities, use of intensive care unit and services, X-ray services, laboratory and other diagnostic tests, drugs, medications, biologicals, anesthesia and oxygen services, special duty nursing when medically necessary, radiation therapy, inhalation therapy,

administration of whole blood and blood plasma, and short-term rehabilitation therapy services in the acute hospital setting.

(3) 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 care services.

(4) Outpatient hospital services, including treatment services; ambulatory surgery services; diagnostic services, including laboratory, radiology, and imaging services; rehabilitation therapy; and radiation therapy.

(b) In addition to the basic health care services in subsection (a) of this section, each evidence of coverage must include coverage for services as follows:

(1) breast reconstruction as required by federal law if the plan provides coverage for mastectomy. Breast reconstruction is subject to the same deductible or copayment applicable to mastectomy. Breast reconstruction may not be denied because the mastectomy occurred prior to the effective date of coverage;

(2) prenatal services, delivery, and postdelivery care for an enrollee and her newborn child as required by federal law, if the plan provides maternity benefits; and

(3) diabetes self-management training, equipment, and supplies as required in Insurance Code Chapter 1358, Subchapter B.

(c) Benefits described in this section that do not apply to small employer plans are not required to be included in those plans.

(d) A state-mandated health benefit plan defined in §11.2(b) of this title must provide coverage for the basic health care services as described in subsection (a) of this section, as well as all state-mandated benefits as described in §§21.3516 - 21.3518 of this title, and must provide the services without limitation as to time and cost, other than those limitations specifically prescribed in this subchapter.

(e) Nothing in this title requires an HMO, physician, or provider to recommend, offer advice concerning, pay for, provide, assist in, perform, arrange, or participate in providing or performing any health care service that violates its religious convictions. An HMO that limits or denies health care services under this subsection must set out such limitations in its evidence of coverage.

§11.511 Optional Provisions

Group, individual, and conversion certificates may contain optional provisions, including, but not limited to, the following:

(1) Coordination of benefits. Plans may contain a provision that the value of any benefits or services provided by the HMO may be coordinated with any other type of insurance plan or coverage under governmental programs so no more than 100 percent of eligible expenses incurred is paid. The coordination of benefits provision applies to the plan when an enrollee has health care coverage under more than one plan. This provision will only apply for the duration of the enrollee’s coverage in a plan.

(A) If benefits are covered by more than one plan, any plan or plans that do not have a coordination of benefits provision are primary.

(B) Group plans issued or renewed on or before March 25, 2014, may not coordinate benefits with any type of individual or conversion plan.

(C) Group plans issued or renewed on or after March 25, 2014, may coordinate benefits with other plans subject to the requirements of Insurance Code Chapter 1203 and Chapter 3, Subchapter V of this title.

(2) Subrogation. A provision that the HMO receives any rights of recovery allowed by Texas law acquired by an enrollee against any person or organization for negligence or any willful act resulting in illness or injury covered by HMO benefits, but only to the extent of the cost to the HMO of providing the covered services. On receiving the services from the HMO, the enrollee is considered to have assigned the rights of recovery to the HMO and to have agreed to give the HMO any reasonable help required to secure the recovery. The provision may include a statement that the HMO may recover its share of attorney's fees and court costs only if the HMO aids in the collection of damages from a third party.

(3) Sale of substitutes to Workers' Compensation Insurance. If the HMO chooses to market a product that provides coverage for on-the-job injuries or illness, it must comply with §5.6302 of this title.

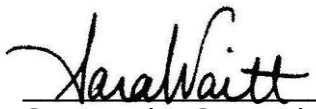
(4) Conversion privilege. Group agreements and certificates for an HMO may, at the HMO's option, contain a conversion privilege. If the HMO elects to offer a conversion privilege, it must provide that, on termination of coverage, each enrollee who resides, lives, or works in the service area who has been covered under the group contract for a period of at least three months, or in the case of a court-ordered

dependent, lives outside the service area, but within the United States, has the right to convert within 31 days to a conversion agreement without presenting evidence of insurability. A single service or limited service HMO must offer a conversion contract without requiring evidence of insurability. Charges for individuals must comply with §11.704 of this title.

(5) Arbitration. A statement of any required arbitration procedure. If enrollee complaints and grievances are resolved through a specified arbitration agreement, the arbitration must be conducted under Texas Civil Practice and Remedies Code Chapter 171.

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

Issued in Austin, Texas, on October 24, 2014.



Sara Waitt, General Counsel
Texas Department of Insurance

The commissioner adopts the amendments to 28 TAC Chapter 11, Subchapter F,

§§11.506, 11.508, and 11.511.

Julia Rathgeber
Commissioner of Insurance

Commissioner's Order No. **3611**