**Consumer choice plan disclosure statement**

This health plan does not include the same level of benefits required in other plans.

This [PPO/EPO/HMO] plan is a consumer choice plan. This plan doesn't include the same level of benefits that are in Texas health plans known as state-mandated plans. [This plan does include all health benefits required by the Affordable Care Act.]¹

[The benefits or coverages you are agreeing to on this renewal are different from your current plan.]² [The benefits required by state law have changed since you first received this disclosure.]³ To see all benefits offered by this plan, go to the plan’s “Summary of Benefits and Coverage.”

<table>
<thead>
<tr>
<th>Benefit/coverage: [4]</th>
<th>This plan:</th>
<th>A health plan with required benefits (state-mandated plan):</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Deductible</strong>&lt;br&gt;The amount you pay for care before the plan begins to share the cost.</td>
<td>[Has a deductible.]</td>
<td>[Has no deductibles for in-network care.]</td>
</tr>
<tr>
<td><strong>Out-of-pocket costs</strong>&lt;br&gt;The amount you pay when you receive care, up to an annual limit.]</td>
<td>[Includes out-of-pocket costs that meet federal requirements but may sometimes be more than in a state-mandated plan.]</td>
<td>[A copay must be less than 50% of the total cost of the service. Annual out-of-pocket costs must be capped at 200% of your annual premium cost if you alert the plan.]</td>
</tr>
<tr>
<td><strong>Habilitative and Rehabilitative care</strong>&lt;br&gt;Care that helps you improve skills for daily living.]</td>
<td>[Includes a limit on the number of visits per year for speech therapy, occupational therapy, and physical therapy.]</td>
<td>[Has no limit on the amount of care if it is needed for medical reasons.]</td>
</tr>
<tr>
<td><strong>Autism care</strong>&lt;br&gt;Autism spectrum disorder is a disorder that often affects how a person interacts with others and communicates.]</td>
<td>[Does not cover applied behavioral analysis. Each year, the plan has a limit on the number of sessions for:&lt;br&gt;• Speech therapy.&lt;br&gt;• Occupational therapy.&lt;br&gt;• Physical therapy.]</td>
<td>[Has no limit on the amount of care that is ordered by your doctor.]</td>
</tr>
<tr>
<td><strong>Substance use disorder treatment</strong>&lt;br&gt;Inpatient or outpatient care to treat a substance use disorder.]</td>
<td>[Does not cover any treatment for substance use disorder.]</td>
<td>[Must cover inpatient and outpatient care for substance use disorders in the same way the plan covers medical care to treat other types of health conditions.]</td>
</tr>
</tbody>
</table>
If you want a plan with all required benefits:

We also offer a state-mandated plan that includes all required benefits. [This plan is on Healthcare.gov and may allow you to get help with premiums and out-of-pocket costs.]

[This plan is not on Healthcare.gov and does not allow you to get help with premiums and out-of-pocket costs.]

To learn more about this plan, call [phone number] or visit [website URL].

[By signing your application to enroll in this plan, you acknowledge the following:] [By signing this form, you acknowledge the following:] [When you first bought this consumer choice plan, you agreed to the following statements:]

- I understand the consumer choice plan I am applying for does not provide the same level of coverage required in other Texas health plans (state-mandated plans).
- [I understand if my health changes and this plan does not meet my needs, in most cases I won’t be able to get a new plan until the next open enrollment period.]
- I understand I can get more information about consumer choice plans from the Texas Department of Insurance’s website, www.tdi.texas.gov/consumer/consumerchoice.html, or by calling the Consumer Help Line at 1-800-252-3439.

[Don't sign this document if you don't understand it.
No firme este documento si no lo comprende.]

Print the name of the person applying: __________________________________________

Signature of the person applying: __________________________________________

Date of signature: __________________________________________

Name of business, if applicable: __________________________________________

[Name of insurer or HMO] must give you a copy of this statement upon request.]