

**TEXAS DEPARTMENT OF INSURANCE REQUIRED DISCLOSURE NOTICE
FOR SMALL EMPLOYER GROUP OPEN ACCESS HMO CONSUMER CHOICE BENEFIT PLANS ISSUED IN
TEXAS**

As required by 28 TAC §21.3530, I have been informed that the Consumer Choice Standard Benefit Plan that I am purchasing does not include all state mandated health insurance benefits. I understand that the following benefits are provided at a reduced level from what is mandated, or are excluded completely from the plan:

Mandated Benefit Description	Benefit Reduced	Benefit Excluded
<p>BASIC HEALTH SERVICES - Section 843.002 and Section 11.2(b)(9), Title 28, Texas Administrative Code – Each evidence of coverage providing basic health care services shall provide the following basic health care services when they are provided by network physicians or providers: Outpatient services, including: primary care and specialist physician services; outpatient services by other providers; diagnostic services, including laboratory, imaging and radiologic services; therapeutic radiology services; prenatal services, if maternity benefits are covered; outpatient rehabilitation therapies including physical therapy, speech therapy and occupational therapy; home health services, as prescribed or directed by the responsible physician or other authority designated by the HMO; periodic health examinations for adults as required in the Insurance Code §1271.153; well-child care from birth as required in the Insurance Code §1271.154; cancer screenings as required in the Insurance Code Chapter 1356 relating to mammography; cancer screenings as required in the Insurance Code Chapter 1362 relating to screening for prostate cancer; eye and ear examinations for children through age 17, to determine the need for vision and hearing correction in accordance with established medical guidelines; and 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 emergency services as required by the Insurance Code §1271.155.</p> <p>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. 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. Outpatient hospital services, including treatment services; ambulatory surgery services; diagnostic services, including laboratory, radiology, and imaging services; rehabilitation therapy; and radiation therapy.</p>	<p>All plan services and supplies include benefit maximums and limitations.</p>	
<p>REHABILITATION SERVICES Article 20A.09(a)(4), Texas Insurance Code Section 11.508(a)(4)(C), Subchapter F, Title 28, Texas Administrative Code - Any EOC that provides benefits for rehabilitation services and therapies must provide those services that in the opinion of a physician, are medically necessary and may not be denied, limited or terminated. For a physically disabled person, treatment goals may include maintenance of functioning or prevention of or slowing of further deterioration.</p>	<p>Physical Therapy and Occupational Therapy limited to 20 visits per member per calendar year combined. Speech Therapy limited to 20 visits per member per calendar year.</p>	
<p>IN VITRO FERTILIZATION Article 3.51-6, Section 3A, Texas Insurance Code Section 11.510(1), Subchapter F, Title 28, Texas Administrative Code Unless rejected in writing by the group contract holder, any EOC providing coverage for pregnancy-related procedures must offer and make available coverage for</p>		<p>Not offered; not covered.</p>

Mandated Benefit Description	Benefit Reduced	Benefit Excluded
outpatient expenses that may arise from in-vitro fertilization procedures to the same extent as the benefits provided for other pregnancy-related procedures		
MENTAL & EMOTIONAL ILLNESS Article 3.70-2(F), Texas Insurance Code Section 11.510(3), Subchapter F, Title 28, Texas Administrative Code An HMO must offer, and the group contract holder shall have the right to reject, benefits for treatment of mental or emotional illness or disorder in a hospital or in a psychiatric day treatment facility. The group EOC holder may select an alternative level of coverage if the HMO offers such coverage.	The base medical plan provides coverage for both serious and non-serious mental illness, limited to 14 days inpatient and 20 visits outpatient per member per year.	Additional benefits not offered or covered
PSYCHIATRIC DAY TREATMENT FACILITY Article 3.70-2(F), Texas Insurance Code Sections 11.509(5) & 11.510(3), Subchapter F, Title 28, Texas Administrative Code An EOC that provides benefits for treatment of mental illness in a hospital must include benefits for treatment in a psychiatric day treatment facility. Determination of EOC benefits and benefit maximums will consider each full day of treatment in a psychiatric day treatment facility equal to one-half day of treatment in a hospital or in-patient program. On rejection of mandated benefits the HMO must offer and the policyholder can select an alternative level of benefits, however, any negotiated benefits must include benefits for treatment in a psychiatric day treatment facility equal to at least one-half of that provided for treatment in hospital facilities.	Limited to 14 days per member per calendar year.	
SERIOUS MENTAL ILLNESS Article 3.51-14, Texas Insurance Code Section 11.509(5), Subchapter F, Title 28, Texas Administrative Code - An HMO issuing coverage to a small employer must offer, and the small employer shall have the right to reject, coverage for serious mental illness that complies with the following requirements: (a) coverage for 45 days of inpatient treatment, and 60 visits for outpatient treatment, including group and individual outpatient treatment coverage, for serious mental illness in each calendar year; (b) the coverage may NOT include a lifetime limit on the number of days of inpatient treatment or the number of outpatient visits covered under the plan; and (c) the coverage must include the same amount limits, and deductibles for serious mental illness as for physical illness.	The base medical plan provides coverage for both serious and non-serious mental illness, limited to 14 days inpatient and 20 visits outpatient per member per year.	Additional benefits not offered or covered
SPEECH AND HEARING - Article 3.70-2(G), Texas Insurance Code Unless rejected by the group policyholder or an alternative level of benefits is negotiated, benefits must be provided for the necessary care and treatment of loss or impairment of speech or hearing that are not less favorable than for physical illness generally.	Speech therapy limited to 20 visits per year.	Additional benefits not offered or covered
AUTISM SPECTRUM DISORDER - Section 1355.015, Texas Insurance Code At a minimum, a health benefit plan must provide coverage as provided by this section to an enrollee older than two years of age and younger than 10 years of age who is diagnosed with autism spectrum disorder. If an enrollee who is being treated for autism spectrum disorder becomes six years of age or older and continues to need treatment, this subsection does not preclude coverage of treatment and services described in the law.		Not covered
COPAYMENTS -- Section 11.506(2)(B), Subchapter F, Title 28, Texas Administrative Code: 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 two hundred percent of the total annual premium cost which is required to be paid by or on behalf of that enrollee.	For some services and supplies, this plan may include cost-sharing that exceeds the limits imposed by the law.	
DEDUCTIBLES - Section 11.506(2)(B), Subchapter F, Title 28, Texas Administrative Code: A deductible shall be for a specific dollar amount of the cost of the basic, limited, or single health care service. An HMO shall only charge a deductible 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.	This plan includes deductibles. Please see the COC for further information.	

* Note: if additional space is needed, the carrier may add additional lines, or may continue the list on a subsequent page, but must clearly note that an additional page is attached.

This HMO Consumer Choice Health Benefit Plan may include requirements and/or restrictions on deductibles, coinsurance, copayments, or annual or lifetime maximum benefit amounts that differ from other HMO plans. I understand that I may obtain from the Department of Insurance a consumer brochure with more information on Consumer Choice Health Benefit Plans, either by visiting the TDI website at www.tdi.state.tx.us/consumer/indexc.html, or by calling 1-800-252-3439.

By signing this document I affirm that I was offered a benefit plan that contains the state mandated health insurance benefits and that I have elected to purchase this Consumer Choice Benefit Plan.

_____		_____	
Signature of Applicant		Name of Applicant	
_____		_____	
Name of Business (if applicable)		Date	
_____		_____	
_____	_____	_____	_____
Address	City	State	Zip

Note: This form must be retained by the carrier issuing the policy and must be provided to the Commissioner of Insurance upon request. **You have the right to a copy of this written disclosure statement free of charge.** A new form must be completed upon each subsequent renewal of this policy.