**SUBCHAPTER X. PREFERRED AND EXCLUSIVE PROVIDER PLANS**
**DIVISION 1. GENERAL REQUIREMENTS**
**28 TAC §3.3705**

**INTRODUCTION.** The Texas Department of Insurance adopts amendments to 28 TAC Chapter 3, Subchapter X, Division 1, §3.3705, relating to Nature of Communications with Insureds; Readability, Mandatory Disclosure Requirements, and Plan Designations. The amendments are adopted with no changes to the proposed text published in the December 9, 2016, issue of the *Texas Register* (41 TexReg 9693).

**REASONED JUSTIFICATION.** The amendments to §3.3705 are necessary to restore subsections inadvertently omitted from a previous adoption order. In the May 27, 2016, issue of the *Texas Register* (41 TexReg 3832), the department proposed amendments to 28 TAC §3.3705(f) and §3.3708(e). Section 3.3705(a) - (e) and (g) - (q) and the remainder of §3.3708 were specifically proposed as "No change."

On October 14, 2016, the commissioner adopted amendments to 28 TAC §3.3705 and §3.3708, specifically noting three changes to the proposed amendments to §3.3705(f) and three changes to the proposed amendments to §3.3708(3). The order noted that the department was making no further changes to either section.

The adoption order should have included the entirety of §3.3705 and §3.3708 for publication in the *Texas Register*. The unchanged text of §3.3705(g) - (q) should have been copied and pasted into the order after the amended text of subsection (f). Because of a clerical error, only the unchanged text of §3.3705(g) - (l)(2) was pasted in. As a result, the adoption order omitted the unchanged text of §3.3705(l)(3) - (q). The adoption order was published in the October 28, 2016, issue of the *Texas Register* (41 TexReg 8605) with §3.3705(l)(3) - (q) still missing. The omission went unnoticed during the review period the *Texas Register* allows for correction of errors, and the adoption became effective on November 3, 2016.

To correct the error, §3.3705 needs to be amended to restore the inadvertently omitted subsections.

**SUMMARY OF COMMENTS AND AGENCY RESPONSE.**

**Commenters:** The department received three written comments and two oral comments, with one commenter making both written and oral comments. The Center for Public Policy Priorities supported the proposal. The Texas Medical Association supported the proposal, with changes. Two individuals requested a public hearing on behalf of the Texas Society of Anesthesiologists, and generally supported the proposal, with changes.

**Comments in General.**

Two commenters asked for a hearing, stating that out-of-network and balance billing issues needs a public forum—a public hearing or series of public hearings—under the management of a facilitator such as the department, where all parties can voice and share their positions, and parties can work together to formulate solutions. These commenters suggested that some insurers were not complying with department rules and that network directories are not accurate. The second commenter suggested revising the network adequacy portion of the rules. A third commenter suggested changes, but generally strongly supported reinstating the omitted subsections, and suggested changes. A fourth commenter supported reinstating the omitted subsections.

**Agency Response to Comments in General.**

The department appreciates the supportive comments. The department notes that the amendment simply restores text inadvertently omitted from §3.3705 because of a clerical error, and that both the proposal that led to the error and the current proposal informed the public that the department did not intend to change that text. The department does not find it advisable at this point to make changes without subjecting them to the normal notice and comment process. As the first two commenters note, issues of network adequacy, provision of services by out-of-network providers, reimbursement for such services, and balance billing have consumed considerable time and resources from all affected parties, as well as the department and the Legislature. These issues deserve more consideration and discussion than is likely to result from this correction of a clerical error, and they are currently under consideration by the Legislature. Finally, the department notes that compliance with the rules is a different issue than the content of the rules, and the department is addressing the compliance issue elsewhere. The department continues to monitor these issues, as well as the effect of, and compliance with, §3.3705, and will take appropriate action when necessary.

**Comment on §3.3705(l)(3) - (l)(9), (m), and (p).**

Two commenters supported reinstating the omitted text.

**Agency Response to Comment on §3.3705(l)(3) - (l)(9), (m), and (p).**

The department appreciates the supportive comments.

**Comment on §3.3705(n)**.

One commenter strongly supported reinstating the omitted subsection, but suggested generally replacing the words "provider" and "providers" with "physician" and "physicians" to make it clear that preferred facility-based physicians of the same specialty, rather than any other type of provider, must be made available to insureds. A second commenter supported reinstating the omitted subsection.

**Agency Response to Comment on §3.3705(n).**

The department appreciates the supportive comments. The department notes that subsection (n) specifically requires disclosure of a substantial decrease in the availability of preferred facility-based physicians and discusses contracts between insurers and facility-based physician groups. The department doubts that the terminology used in the subsection is subject to misinterpretation, and declines to make the suggested change.

**Comment on §3.3705(o)**.

Four commenters supported reinstating the omitted subsection. One commenter stated the commenter's belief that information regarding insurers' disclosure of their out-of-network payment methodology has never been made public, and noted that the department's recent survey shows discrepancies in "usual and customary" payment methodology. A second commenter questioned whether a Medicare rate could be described as "usual and customary." The second commenter said that the department's recent survey shows a correlation between the use of Medicare rates and complaints.

**Agency Response to Comment on §3.3705(o).**

The department appreciates the supportive comments. As one commenter notes, the department has recently completed and released a survey regarding reimbursement rates for some out-of-network services. The department is closely monitoring payment and compliance issues, but the issues raised in the survey stem from rules other than the one being amended. These are issues that deserve consideration and discussion, and are currently under consideration by the Legislature. The

department continues to monitor these issues, and will take appropriate action when necessary, but does not believe that a response to comments on the reinstatement of the omitted subsection would appropriately address them.

**Comment on §3.3705(q).**

Two commenters supported reinstating the omitted subsection. One commenter suggested that the department: (1) decrease the period a plan may remain non-compliant to 15 days from 30 days in order to limit the potential for insurers to mislead consumers regarding the strength of their hospital networks; (2) require the plan to inform insureds of the loss of AHCN status immediately (after the 15 day period), as well as at the time of renewal; and (3) promptly satisfy all requirements under subsection (p) regarding required disclosures as a Limited Hospital Care Network, which would require updating the insurer's outline of coverage, as well as the cover page of any provider listing describing the network.

**Agency Response to Comment on §3.3705(q).**

The department appreciates the supportive comments. The department notes again that the amendment simply restores text inadvertently omitted from §3.3705 because of a clerical error, and that both the proposal that led to the error and the current proposal informed the public that the department did not intend to change the omitted text. The department continues to monitor the issues raised by the commenter and will take appropriate corrective action when necessary, but does not believe that a response to comments on the reinstatement of this subsection appropriately addresses them.

**STATUTORY AUTHORITY.** These amendments are adopted under Insurance Code §§36.001, 1301.007, and 1301.0042.

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

Insurance Code §1301.007 authorizes the commissioner to adopt rules to implement Insurance Code Chapter 1301 and to ensure reasonable accessibility and availability of preferred provider services to residents of Texas.

Insurance Code §1301.0042 provides that a provision of the Insurance Code or another insurance law of Texas that applies to a preferred provider benefit plan applies to an exclusive provider benefit plan except to the extent that the commissioner determines the provision to be inconsistent with the function and purpose of an exclusive provider benefit plan.

**TEXT.**

**SUBCHAPTER X. PREFERRED AND EXCLUSIVE PROVIDER PLANS**

**DIVISION 1. GENERAL REQUIREMENTS**

**§3.3705. Nature of Communications with Insureds; Readability, Mandatory Disclosure Requirements, and Plan Designations.**

(a) Readability. All health insurance policies, health benefit plan certificates, endorsements, amendments, applications or riders are required to be written in a readable and understandable format that meets the requirements of §3.602 of this chapter (relating to Plain Language Requirements).

(b) Disclosure of terms and conditions of the policy. The insurer is required, on request, to provide to a current or prospective group contract holder or a current or prospective insured an accurate written description of the terms and conditions of the policy that allows the current or prospective group contract holder or current or prospective insured to make comparisons and informed decisions before selecting among health care plans. An insurer may utilize its handbook to satisfy this requirement provided that the insurer complies with all requirements set forth in this subsection including the level of disclosure required. The written description must be in a readable and understandable format, by category, and must include a clear, complete, and accurate description of these items in the following order:

(1) a statement that the entity providing the coverage is an insurance company; the name of the insurance company; that, in the case of a preferred provider benefit plan, the insurance contract contains preferred provider benefits; and, in the case of an exclusive provider benefit plan, that the contract only provides benefits for services received from preferred providers, except as otherwise noted in the contract and written description or as otherwise required by law;

(2) a toll free number, unless exempted by statute or rule, and address to enable a current or prospective group contract holder or a current or prospective insured to obtain additional information;

(3) an explanation of the distinction between preferred and nonpreferred providers;

(4) all covered services and benefits, including payment for services of a preferred provider and a nonpreferred provider, and prescription drug coverage, both generic and name brand;

(5) emergency care services and benefits and information on access to after-hours care;

(6) out-of-area services and benefits;

(7) an explanation of the insured's financial responsibility for payment for any premiums, deductibles, copayments, coinsurance or other out-of-pocket expenses for noncovered or nonpreferred services;

(8) any limitations and exclusions, including the existence of any drug formulary limitations, and any limitations regarding preexisting conditions;

(9) any authorization requirements, including preauthorization review, concurrent review, post-service review, and post-payment review; and any penalties or reductions in benefits resulting from the failure to obtain any required authorizations;

(10) provisions for continuity of treatment in the event of termination of a preferred provider's participation in the plan;

(11) a summary of complaint resolution procedures, if any, and a statement that the insurer is prohibited from retaliating against the insured because the insured or another person has filed a complaint on behalf of the insured, or against a physician or provider who, on behalf of the insured, has reasonably filed a complaint against the insurer or appealed a decision of the insurer;

(12) a current list of preferred providers and complete descriptions of the provider networks, including names and locations of physicians and health care providers, and a disclosure of which preferred providers will not accept new patients. Both of these items may be provided electronically, if notice is also provided in the disclosure required by this subsection regarding how a nonelectronic copy may be obtained free of charge;

(13) the service area(s); and

(14) information that is updated at least annually regarding the following network demographics for each service area, if the preferred provider benefit plan is not offered on a statewide service area basis, or for each of the 11 regions specified in §3.3711 of this title (relating to Geographic Regions), if the plan is offered on a statewide service area basis:

(A) the number of insureds in the service area or region;

(B) for each provider area of practice, including at a minimum internal medicine, family/general practice, pediatric practitioner practice, obstetrics and gynecology, anesthesiology, psychiatry, and general surgery, the number of preferred providers, as well as an indication of whether an active access plan pursuant to §3.3709 of this title (relating to Annual Network Adequacy Report; Access Plan) applies to the services furnished by that class of provider in the service area or region and how such access plan may be obtained or viewed, if applicable; and

(C) for hospitals, the number of preferred provider hospitals in the service area or region, as well as an indication of whether an active access plan pursuant to §3.3709 of this title applies to hospital services in that service area or region and how the access plan may be obtained or viewed.

(15) information that is updated at least annually regarding whether any waivers or local market access plans approved pursuant to §3.3707 of this title (relating to Waiver Due to Failure to Contract in Local Markets) apply to the plan and that complies with the following:

(A) if a waiver or a local market access plan applies to facility services or to internal medicine, family or general practice, pediatric practitioner practice, obstetrics and gynecology, anesthesiology, psychiatry, or general surgery services, this must be specifically noted;

(B) the information may be categorized by service area or county if the preferred provider benefit plan is not offered on a statewide service area basis, and, if by county, the aggregate of counties is not more than those within a region; or for each of the 11 regions specified in §3.3711 of this title (relating to Geographic Regions), if the plan is offered on a statewide service area basis; and

(C) the information must identify how to obtain or view the local market access plan.

(c) Filing required. A copy of the written description required in subsection (b) of this section must be filed with the department with the initial filing of the preferred provider benefit plan and within 60 days of any material changes being made in the information required in subsection (b) of this section. Submission of listings of preferred providers as required in subsection (b)(12) of this section may be made electronically in a format acceptable to the department or by submitting with the filing the Internet website address at which the department may view the current provider listing. Acceptable formats include Microsoft Word and Excel documents. Electronic submission of the provider listing, if

applicable, must be submitted to the following email address: LifeHealth@tdi.texas.gov. Nonelectronic filings must be submitted to the department at: Life/Health and HMO Intake Team, Mail Code 106-1E, Texas Department of Insurance, P.O. Box 149104, Austin, Texas 78714-9104.

(d) Promotional disclosures required. The preferred provider benefit plan and all promotional, solicitation, and advertising material concerning the preferred provider benefit plan must clearly describe the distinction between preferred and nonpreferred providers. Any illustration of preferred provider benefits must be in close proximity to an equally prominent description of basic benefits, except in the case of an exclusive provider benefit plan.

(e) Internet website disclosures. Insurers that maintain an Internet website providing information regarding the insurer or the health insurance policies offered by the insurer for use by current or prospective insureds or group contract holders must provide:

(1) an Internet-based provider listing for use by current and prospective insureds and group contract holders;

(2) an Internet-based listing of the state regions, counties, or three-digit ZIP Code areas within the insurer's service area(s), indicating as appropriate for each region, county or ZIP Code area, as applicable, that the insurer has:

(A) determined that its network meets the network adequacy requirements of this subchapter; or

(B) determined that its network does not meet the network adequacy requirements of this subchapter; and

(3) an Internet-based listing of the information specified for disclosure in subsection (b) of this section.

(f) Notice of rights under a network plan required. An insurer must include the notice specified in Figure: 28 TAC §3.3705(f)(1) for a preferred provider benefit plan that is not an exclusive provider benefit plan, or Figure: 28 TAC §3.3705(f)(2) for an exclusive provider benefit plan, in all policies, certificates, disclosures of policy terms and conditions provided to comply with subsection (b) of this section, and outlines of coverage in at least 12-point font:

(1) Preferred provider benefit plan notice.

Attached Graphic

**Figure: 28 TAC §3.3705(f)(1)**

**Texas Department of Insurance Notice**

**• You have the right to an adequate network of preferred providers (also known as "network providers"). If you believe that the network is inadequate, you may file a complaint with the Texas Department of Insurance.**

**• You have the right, in most cases, to obtain estimates in advance:**

- **from out-of-network providers of what they will charge for their services; and**
- **from your insurer of what it will pay for the services.**

**• You may obtain a current directory of preferred providers at the following website: [website address to be filled out by the insurer or marked inapplicable if the insurer does not maintain a website providing information regarding the insurer or the health insurance policies offered by the insurer for use by current or prospective insureds or group contract holders] or by calling [to be filled out by the insurer] for assistance in finding available preferred providers.**

**• If you are treated by a provider or facility that is not a preferred provider, you may be billed for anything not paid by the insurer.**

**• If the amount you owe to an out-of-network hospital-based radiologist, anesthesiologist, pathologist, emergency department physician, neonatologist, or assistant surgeon, including the amount unpaid by the administrator or insurer, is greater than $500 (not including your copayment, coinsurance, and deductible responsibilities) for services received in a network hospital, you may be entitled to have the parties participate in a teleconference, and, if the result is not to your satisfaction, in a mandatory mediation at no cost to you. You can learn more about mediation at the Texas Department of Insurance website: www.tdi.texas.gov/consumer/cpmmediation.html.**

**• If directory information is materially inaccurate and you rely on it, you may be entitled to have an out-of-network claim paid at the in-network percentage level of reimbursement and your out-of-pocket expenses counted toward your in-network deductible and out-of-pocket maximum.**

(2) Exclusive provider benefit plan notice.

Attached Graphic

**Figure: 28 TAC §3.3705(f)(2)**

**Texas Department of Insurance Notice**

**• An exclusive provider benefit plan provides no benefits for services you receive from out-of-network providers, with specific exceptions as described in your policy and below.**

**• You have the right to an adequate network of preferred providers (known as "network providers").**

- **If you believe that the network is inadequate, you may file a complaint with the Texas Department of Insurance.**

**• If your insurer approves a referral for out-of-network services because no preferred provider is available, or if you have received out-of-network emergency care, your insurer must, in most cases, resolve the nonpreferred provider's bill so that you only have to pay any applicable coinsurance, copay, and deductible amounts.**

**• You may obtain a current directory of preferred providers at the following website: [website address to be filled out by the insurer or marked inapplicable if the insurer does not maintain an Internet website providing information regarding the insurer or the health insurance policies offered by the insurer for use by current or prospective insureds or group contract holders] or by calling [to be filled out by the insurer] for assistance in finding available preferred providers. If you relied on materially inaccurate directory information, you may be entitled to have an out-of-network claim paid at the in-network level of benefits.**

(g) Untrue or misleading information prohibited. No insurer, or agent or representative of an insurer, may cause or permit the use or distribution of information which is untrue or misleading.

(h) Disclosure concerning access to preferred provider listing. The insurer must provide notice to all insureds at least annually describing how the insured may access a current listing of all preferred providers on a cost-free basis. The notice must include, at a minimum, information concerning how to obtain a nonelectronic copy of the listing and a telephone number through which insureds may obtain assistance during regular business hours to find available preferred providers.

(i) Required updates of available provider listings. The insurer must ensure that it updates all electronic or nonelectronic listings of preferred providers made available to insureds at least every three months.

(j) Annual provision of provider listing required in certain cases. If no Internet-based preferred provider listing or other method of identifying current preferred providers is maintained for use by insureds, the insurer must distribute a current preferred provider listing to all insureds no less than

annually by mail, or by an alternative method of delivery if an alternative method is agreed to by the insured, group policyholder on behalf of the group, or certificate holder.

(k) Reliance on provider listing in certain cases. A claim for services rendered by a nonpreferred provider must be paid in the same manner as if no preferred provider had been available under §3.3708(b) - (d) of this title (relating to Payment of Certain Basic Benefit Claims and Related Disclosures) and §3.3725(d) - (f) of this title (relating to Payment of Certain Out-of-Network Claims), as applicable, if an insured demonstrates that:

(1) in obtaining services, the insured reasonably relied upon a statement that a physician or provider was a preferred provider as specified in:

(A) a provider listing; or

(B) provider information on the insurer's website;

(2) the provider listing or website information was obtained from the insurer, the insurer's website, or the website of a third party designated by the insurer to provide such information for use by its insureds;

(3) the provider listing or website information was obtained not more than 30 days prior to the date of services; and

(4) the provider listing or website information obtained indicates that the provider is a preferred provider within the insurer's network.

(l) Additional listing-specific disclosure requirements. In all preferred provider listings, including any Internet-based postings of information made available by the insurer to provide information to insureds about preferred providers, the insurer must comply with the requirements in paragraphs (1) - (9) of this subsection.

(1) The provider information must include a method for insureds to identify those hospitals that have contractually agreed with the insurer to facilitate the usage of preferred providers as specified in subparagraphs (A) and (B) of this paragraph.

(A) The hospital will exercise good faith efforts to accommodate requests from insureds to utilize preferred providers.

(B) In those instances in which a particular facility-based physician or physician group is assigned at least 48 hours prior to services being rendered, the hospital will provide the insured with information that is:

(i) furnished at least 24 hours prior to services being rendered; and

(ii) sufficient to enable the insured to identify the physician or physician group with enough specificity to permit the insured to determine, along with preferred provider listings made available by the insurer, whether the assigned facility-based physician or physician group is a preferred provider.

(2) The provider information must include a method for insureds to identify, for each preferred provider hospital, the percentage of the total dollar amount of claims filed with the insurer by or on behalf of facility-based physicians that are not under contract with the insurer. The information must be available by class of facility-based physician, including radiologists, anesthesiologists, pathologists, emergency department physicians, and neonatologists.

(3) In determining the percentages specified in paragraph (2) of this subsection, an insurer may consider claims filed in a 12-month period designated by the insurer ending not more than 12 months before the date the information specified in paragraph (2) of this subsection is provided to the insured.

(4) The provider information must indicate whether each preferred provider is accepting new patients.

(5) The provider information must provide a method by which insureds may notify the insurer of inaccurate information in the listing, with specific reference to:

(A) information about the provider's contract status; and

(B) whether the provider is accepting new patients.

(6) The provider information must provide a method by which insureds may identify preferred provider facility-based physicians able to provide services at preferred provider facilities.

(7) The provider information must be provided in at least 10 point font.

(8) The provider information must specifically identify those facilities at which the insurer has no contracts with a class of facility-based provider, specifying the applicable provider class.

(9) The provider information must be dated.

(m) Annual policyholder notice concerning use of a local market access plan. An insurer operating a preferred provider benefit plan that relies on a local market access plan as specified in §3.3707 of this title (relating to Waiver Due to Failure to Contract in Local Markets) must provide notice

of this fact to each individual and group policyholder participating in the plan at policy issuance and at least 30 days prior to renewal of an existing policy. The notice must include:

(1) a link to any webpage listing of regions, counties, or ZIP codes made available pursuant to subsection (e)(2) of this section;

(2) information on how to obtain or view any local market access plan or plans the insurer uses; and

(3) a link to the department's website where the department posts information relevant to the grant of waivers.

(n) Disclosure of substantial decrease in the availability of certain preferred providers. An insurer is required to provide notice as specified in this subsection of a substantial decrease in the availability of preferred facility-based physicians at a preferred provider facility.

(1) A decrease is substantial if:

(A) the contract between the insurer and any facility-based physician group that comprises 75 percent or more of the preferred providers for that specialty at the facility terminates; or

(B) the contract between the facility and any facility-based physician group that comprises 75 percent or more of the preferred providers for that specialty at the facility terminates, and the insurer receives notice as required under §3.3703(a)(26) of this title (relating to Contracting Requirements).

(2) Notwithstanding paragraph (1) of this subsection, no notice of a substantial decrease is required if the requirements specified in either subparagraph (A) or (B) of this paragraph are met:

(A) alternative preferred providers of the same specialty as the physician group that terminates a contract as specified in paragraph (1) of this subsection are made available to insureds at the facility so the percentage level of preferred providers of that specialty at the facility is returned to a level equal to or greater than the percentage level that was available prior to the substantial decrease; or

(B) the insurer provides to the department, by e-mail to mcqa@tdi.texas.gov, a certification of the insurer's determination that the termination of the provider contract has not caused the preferred provider service delivery network for any plan supported by the network to be noncompliant with the adequacy standards specified in §3.3704 of this title (relating to Freedom of Choice; Availability of Preferred Providers), as those standards apply to the applicable provider specialty.

(3) An insurer must prominently post notice of any contract termination specified in paragraph (1)(A) or (B) of this subsection and the resulting decrease in availability of preferred providers on the portion of the insurer's website where its provider listing is available to insureds.

(4) Notice of any contract termination specified in paragraph (1)(A) or (B) of this subsection and of the decrease in availability of providers must be maintained on the insurer's website until the earlier of:

(A) the date on which adequate preferred providers of the same specialty become available to insureds at the facility at the percentage level specified in paragraph (2)(A) of this subsection;

(B) six months from the date that the insurer initially posts the notice; or

(C) the date on which the insurer provides to the department, by e-mail to mcqa@tdi.texas.gov, a certification as specified in paragraph (2)(B) of this subsection indicating the insurer's determination that the termination of provider contract does not cause non-compliance with adequacy standards.

(5) An insurer must post notice as specified in paragraph (3) of this subsection and update its Internet-based preferred provider listing as soon as practicable and in no case later than two business days after:

(A) the effective date of the contract termination as specified in paragraph (1)(A) of this subsection; or

(B) the later of:

(i) the date on which an insurer receives notice of a contract termination as specified in paragraph (1)(B) of this subsection; or

(ii) the effective date of the contract termination as specified in paragraph (1)(B) of this subsection.

(o) Disclosures concerning reimbursement of out-of-network services. An insurer must make disclosures in all insurance policies, certificates, and outlines of coverage concerning the reimbursement of out-of-network services as specified in this subsection.

(1) An insurer must disclose how reimbursements of nonpreferred providers will be determined.

(2) Except in an exclusive provider benefit plan, if an insurer reimburses nonpreferred providers based directly or indirectly on data regarding usual, customary, or reasonable charges by providers, the insurer must disclose the source of the data, how the data is used in determining reimbursements, and the existence of any reduction that will be applied in determining the reimbursement to nonpreferred providers.

(3) Except in an exclusive provider benefit plan, if an insurer bases reimbursement of nonpreferred providers on any amount other than full billed charges, the insurer must:

(A) disclose that the insurer's reimbursement of claims for nonpreferred providers may be less than the billed charge for the service;

(B) disclose that the insured may be liable to the nonpreferred provider for any amounts not paid by the insurer;

(C) provide a description of the methodology by which the reimbursement amount for nonpreferred providers is calculated; and

(D) provide to insureds a method to obtain a real time estimate of the amount of reimbursement that will be paid to a nonpreferred provider for a particular service.

(p) Plan designations. A preferred provider benefit plan that utilizes a preferred provider service delivery network that complies with the network adequacy requirements for hospitals under §3.3704 of this title without reliance on an access plan may be designated by the insurer as having an "Approved Hospital Care Network" (AHCN). If a preferred provider benefit plan utilizes a preferred provider service delivery network that does not comply with the network adequacy requirements for hospitals specified in §3.3704 of this title, the insurer is required to disclose that the plan has a "Limited Hospital Care Network":

(1) on the insurer's outline of coverage; and

(2) on the cover page of any provider listing describing the network.

(q) Loss of status as an AHCN. If a preferred provider benefit plan designated as an AHCN under subsection (p) of this section no longer complies with the network adequacy requirements for hospitals under §3.3704 of this title and does not correct such noncompliant status within 30 days of becoming noncompliant, the insurer must:

(1) notify the department in writing concerning such change in status at Filings Intake Division, Mail Code 106-1E, Texas Department of Insurance, P.O. Box 149104, Austin, Texas, 78714-9104;

(2) cease marketing the plan as an AHCN; and

(3) inform all insureds of such change of status at the time of renewal.

**CERTIFICATION.** This agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

Issued at Austin, Texas, on April 25, 2017.

Norma Garcia
General Counsel
Texas Department of Insurance

The Texas Department of Insurance adopts the amendments to 28 TAC Chapter 3, Subchapter X, Division 1, §3.3705, relating to Nature of Communications with Insureds; Readability, Mandatory Disclosure Requirements, and Plan Designations.

Kevin Brady
Deputy Commissioner For Agency Affairs
Texas Department of Insurance
Delegation Order 4506

COMMISSIONER'S ORDER NO. **2017-5045**