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# GROUP HEALTH NON-EMPLOYER OR MEMBER ASSOCIATION CHECKLIST

**Every effort has been made to ensure the accuracy of the information in this document. All parties should consult the Texas Insurance Code, the Texas Administrative Code, and other applicable laws.**

## Important Note

**A policy being reviewed against this checklist must also satisfy the "Group Health Product Requirements" checklist.**

***Form Use -*** *For each listed item, complete the following:*

***Page No. field*** *- enter a form page number reference, or N/A if not applicable.*

***First comment box*** *- enter general comments or form objections. In the drop down box select: No Comments, Comments, or Objection.*
*Text size: 1200 characters. When you print the form, only the visible text (first three lines) will print.*
***To view the full text in a comment box, click on the + icon in the lower right corner of the box and then use the up or down scroll buttons.***

***Second comment box labeled Company Response*** *- enter a response if the first box is marked Objection (optional)*

*Use the last two pages of this form for additional comments, objections and responses (text size: 4000 characters).*

## FILING SUBMISSIONS

Page No.

Submission requirements for filings - 28 TAC §§3.1 - 3.8

Company Response

Page No.

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

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Page No.

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

Company Response

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"ABC Association" basis - 28 TAC §3.6(c)(3)

Company Response

## POLICY AND APPLICATION REQUIREMENTS - CONSUMER CHOICE HEALTH BENEFIT PLANS (CCHBP)

This section references requirements specific to CCHBP.

Page No.

Insurer notice on application - TIC §1507.005(a), and 28 TAC §21.3525

Company Response

Page No.

Insurer notice on policy - TIC §1507.005(b), and 28 TAC §21.3526

Company Response

Page No.

Health carrier disclosure - TIC §1507.006, and 28 TAC §21.3530

Company Response

**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 form filing containing any of the referenced terms shall not define the terms more restrictively than referenced in the applicable statute or rule.

Page No.

Emergency Care - TIC §1201.060

Company Response

Page No.

Health Benefit Plan - 28 TAC §21.2702(7)

Company Response

## ASSOCIATION TYPES

According to 28 TAC § 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 §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 to the supervision and control of the Farm Credit Administration of the United States of America, that

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

Page No.

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 §21.2703.

Company Response

## BONA FIDE ASSOCIATION DEFINED: 28 TAC §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 to an individual (including the individual eligible for membership or a dependent of the individual eligible for membership, if dependent coverage is offered), and
- 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 dependents eligible 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 No.

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 for coverage, regardless of health status related factors - 28 TAC §21.2703

Company Response

## 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 "‡".
- Mandates not required by state law, but required by federal law are noted as "‡‡".

Page No.

Amino acid-based elemental formulas - TIC Chapter 1377 ‡

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Page No.

Alternate mental health treatment benefits - TIC Chapter 1355 ‡

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Page No.

Acquired brain injury (forms must include definitions referenced in 28 TAC §21.3102) - TIC Chapter 1352, and 28 TAC §§21.3101 - 21.3105 ‡

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Autism spectrum disorder - TIC §1355.015, and 28 TAC §§21.4401 - 21.4404 ‡

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Cardiovascular disease, certain tests - TIC Chapter 1376 ‡

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Chemical dependency coverage - TIC Chapter 1368 ‡

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

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Colorectal cancer testing - TIC Chapter 1363

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Complications of pregnancy - 28 TAC §21.405(1)

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Dental services - TIC §1360.005 ‡

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Developmental delays, certain therapies - TIC §1367.205 ‡

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Diabetes - TIC Chapter 1358, and 28 TAC §§21.2604 - 21.2607

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Diabetes care guidelines - TIC §§1358.001 - 1358.005 ‡

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Hearing impairment, screening test - TIC §1367.103

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Home health service - TIC Chapter 1351 ‡

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Immunizations - TIC §1367.053 and §1367.054

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In-vitro fertilization procedures - TIC §§1366.001 - 1366.007 ‡

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Mammography benefits - TIC Chapter 1356

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Mandatory benefit notices - 28 TAC §21.2103

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Mastectomy and lymph node dissection, minimum stay - TIC §1357.054 ‡

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Mastectomy, reconstructive surgery - TIC §1357.004 ‡‡

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Maternity, minimum stay - TIC §1366.055 ‡‡

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Mental health benefits - TIC §1355.106 ‡

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Oral contraceptives - 28 TAC §21.404(3) ‡

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Orally administered anticancer medications - TIC §1369.204 ‡

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Osteoporosis detection and prevention - TIC Chapter 1361 ‡

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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 that complies with the minimum screening test coverage requirements under TIC §1370.003(b).

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Phenylketonuria (PKU) - TIC Chapter 1359

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Prescription contraceptive drugs or devices - TIC §§1369.101 - 1369.109 ‡

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Prescription drug coverage (off label drug use) (Large Employer) - TIC §§1369.001 - 1369.005 ‡

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Prescription drug formulary continuation - TIC §1369.055 ‡

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Prescription drug formulary disclosure - TIC §1369.054 ‡

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Page No.

Prescription drug formulary - Provider Directories and Member Handbooks: requirements for formulary information on internet website, formulary disclosure, and formulary information provided by toll-free telephone number - TIC §§1369.0542 - 1369.0544 ‡

*Note - LHL reviews directories and handbooks only if member language is included; otherwise reviewed by MCQA. Refer to TIC §1301.158 Information Concerning Preferred Providers (PPO) for member handbook requirements. Refer to 28 TAC §3.3705(b) if the handbook includes the PPO/EPO disclosures specified in §3.3705(b)*

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Prescription drug - modification of drug coverage under plan - TIC §1369.0541 ‡

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Prostate testing - TIC Chapter 1362

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Prostate testing, Texas Public Schools Employees Group Insurance Act - TIC §1575.159

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

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Reconstructive surgery for craniofacial abnormalities (Large Employer) - TIC §1367.153

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Serious mental illness - TIC Chapter 1355

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Serious mental illness, Local Governments - TIC §1355.151

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Serious mental illness, Texas Employee Uniform Group Insurance Benefits - TIC §1551.205

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Serious mental illness, Texas State College and University Employees Uniform Insurance Benefits Act - TIC §1601.109

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Speech and hearing - TIC Chapter 1365 ‡

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Telehealth services - TIC Chapter 1455 ‡

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Telemedicine medical services - TIC Chapter 1455 ‡

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Temporomandibular joint (TMJ) benefits - TIC §1360.004 ‡

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**PROVISIONS SPECIFIC TO PREFERRED AND EXCLUSIVE PROVIDER PLANS**

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

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Acupuncturist - TIC §1301.0515

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Continuity of care - TIC §1301.153 and §1301.154

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Contracting requirements - TIC §§1301.051 - 1301.066, §1301.201, and §1301.202, and 28 TAC §3.3703

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Disclosure notice - TIC §1301.158

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Definitions - TIC §1301.001, and 28 TAC §3.3702

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Emergency care - TIC §1301.155, and 28 TAC §3.3704

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Hospitalist - TIC §1301.063

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Page No.

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 §§1301.157 - 1301.160, and 28 TAC §3.3705(a) - (q)

Note for Figure 28 TAC §3.3705(f)(1): Change the referenced amount $1,000 to read $500, and add a reference to Assistant Surgeons as a type of facility-based physician (refer to 5th bullet, first sentence) - TIC §1456.001(3) and §1456.004(c) as amended by Senate Bill 481, 84th Legislative Session

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Obligation to continue premium payment and coverage after notice of lost group eligibility - 28 TAC §§21.4001 - 21.4003

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Podiatrist - TIC §1301.062

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Preauthorization of medical and health care services - TIC §1301.135

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Preferred and exclusive provider benefit plans - TIC Chapter 1301, and 28 TAC §§3.3701 - 3.3706

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Restrictions on payment and reimbursement - TIC §1301.056

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Service area - TIC §1301.001(10)

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Transmission - enrollee eligibility status - TIC §1274.002

Company Response

## 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 beginning after 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 not required to reduce pre-existing condition limitations by creditable coverage.

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Creditable coverage - TIC §1205.004, and 28 TAC §21.1101(5)

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Certification of coverage - TIC §1205.002, and 28 TAC §§21.1101 - 21.1110

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Pre-existing condition - TIC §1251.108

Company Response

## 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 bona fide association.
- The health carrier must obtain acceptance from the policyholder and each covered member prior to any changes to the issued policy/certificate, unless the change is due to state or federal law.
- Note: Guaranteed renewable - §2742 of the federal Public Health Services Act as added by the Health Insurance Portability and Availability Act (HIPAA) and 45 Code of Federal Regulation §148.122.

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Guaranteed renewability of association and bona fide association health benefit plans - 28 TAC §21.2704(a)

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Guaranteed renewability of association member's coverage - 28 TAC §21.2704(b) and (c)

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Discontinuance of association health benefit plan(s) - 28 TAC §21.2704(d)(1)

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Withdraw from association market - 28 TAC §21.2704(d)(2)

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**PAYMENT OF BENEFITS**

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Assignment of dental benefits - TIC §1451.206

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Assignment of health care benefit payments - TIC §1204.053

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

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Hospital owned or controlled by state or local government - TIC §1204.001 and §1204.002

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Payment of benefits - TIC §1251.005

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Prompt payment of claims - TIC §§542.051 - 542.061

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Tax supported institutions - TIC §1355.202

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Texas Medical Assistance Act - TIC §1204.201

Company Response

## 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.

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Notice of determination - TIC §§4201.301 - 4201.304, and 28 TAC §19.1709

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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 §4201.303(b) and (c)

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Appeal of adverse determination - TIC §§4201.351 - 4201.360, and 28 TAC §19.1711

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## SUBROGATION

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

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## CONTINUATION

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Continuation or conversion - TIC §1251.117

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Continuation - TIC §§1251.251 - 1251.260

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Continuation (six month period following COBRA) - TIC §1251.255(a)(1)(B)

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Continuation (nine month period without COBRA) - TIC §1251.255(a)(1)(A)

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Continuation and conversion notice requirement - TIC §1251.260, and 28 TAC §21.5311 and §21.5321

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**Continuation and conversion privilege - 28 TAC Chapter 21, Subchapter SS**:
- offer of continuation is required
- offer of conversion is optional

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Group continuation provisions - 28 TAC §§21.5310 - 21.5314

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Group conversion provisions - 28 TAC §§21.5320 - 21.5322

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Continuation for certain dependents - TIC §§1251.301 - 1251.310

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Extension of benefits - TIC §1252.102

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Continuation during labor dispute - TIC §§1253.051 - 1253.060

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## GENERAL POLICY PROVISIONS

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Designation of practitioners - TIC §1451.001 and §1451.053

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Guaranty Fund disclosure document - TIC §463.114 and §463.451

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Identification cards for pharmacy benefits (Large Employer) - TIC §§1369.151 - 1369.153

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Notice of policyholder complaint procedures - TIC §521.005

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## PROHIBITED PRACTICES

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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 §1301.0057

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AIDS - 28 TAC §21.704

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AIDS/HIV prohibition on contract renegotiations - TIC §1253.001

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AIDS/HIV prohibits cancellation - TIC §§1364.051 - 1364.053

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AIDS/HIV prohibits exclusion - TIC §1551.205, §1601.109, and §§1364.001 - 1364.004 ‡

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Alzheimer's disease - TIC §1354.001 and §1354.002

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Certification by podiatrist - TIC §1451.351

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Confidentiality of individual's status as a victim of family violence - TIC §544.154

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Coverage limitations due to history of fibrocystic breast conditions - TIC §§544.201 - 544.204

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Dental preferred provider plans prohibited - TIC §1301.002

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Discrimination in rates or renewal (victims of family violence) - TIC §§544.151 - 544.158

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Discrimination in rates - TIC §§544.002 - 544.004

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Discrimination against optometrist or ophthalmologist - TIC §1451.153 ‡

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Exclusion of coverage for premature births with use of waiting periods - 28 TAC §21.405(3)

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

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HIV, nondiscriminatory testing for - 28 TAC §21.705

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HIV, testing by insurers - TIC Chapter 545

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Higher premium for child subject to medical support order prohibited - 28 TAC §21.2004(e)

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Illegal pricing practices - TIC Chapter 552

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Individual's status as victim of family violence - TIC §544.153

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Minimum inpatient care and post-delivery care following childbirth - TIC §1366.057

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Orthodontic coverage exclusion - 28 TAC §3.3601

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Parity in mental health benefits (Large Employer) - 28 TAC §21.2403

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Physical or mental impairment - 28 TAC §21.702

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Policy may not specify service provider - TIC §1251.006

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Preauthorization penalty maximum 50 percent or $500 - TIC §1701.055(a)(2)

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Retaliation against preferred provider - TIC §§1301.066 - 1301.068, and §1301.161

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Service area restrictions regarding child subject to medical support order - 28 TAC §21.2010

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

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Unauthorized use of DEA numbers - Health and Safety Code §481.003

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Unfair discrimination - TIC §§544.051 - 544.054

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Unfair discrimination, refuse to enroll or renew due to exposure to asbestos or silica - TIC §§544.451 - 544.453

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Unfair discrimination, refuse to enroll - TIC §1206.003

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Unfair discrimination, sex or marital status - 28 TAC §§21.401 - 21.409

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Unlimited exemption from seizure under process - TIC §§1108.051 - 1108.053

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Use of genetic information - TIC §§546.051 - 546.053

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Variation of rates, group size (Small Employer) - 28 TAC §26.11(d)

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Withdrawals for premium payments - TIC §550.002

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## GENERAL INFORMATION

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Burden of proof and pleading of insurer - TIC Chapter 554

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Out-of-state group accident and health coverage - TIC §1251.451

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Texas laws govern policies - TIC Article 21.42

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***See next pages for additional comments or objections and space for additional responses, if any.***

**Additional Comments or Objections**:

**Additional Company Responses**:

Company Response