

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

**1. INTRODUCTION.** The Texas Department of Insurance proposes amendments to 28 TAC Chapter 11, Subchapter F, concerning Evidence of Coverage. These proposed amendments; the new 28 TAC Chapter 21, Subchapter SS; and the concurrent repeal of 28 TAC Chapter 3, Subchapter F and 28 TAC Chapter 11, Subchapter F are necessary to conform the department's rules to statutory changes, including changes made by HB 710, 75th Legislature, Regular Session (1997); SB 1771, 81st Legislature, Regular Session (2009); and Senate Bill 1367, Act of June 14, 2013, 83rd Legislature, Regular Session, (2011), and to consolidate the continuation and conversion rules for insured and HMO products. The 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. Other nonsubstantive changes to existing rules text will conform them to current agency style and usage guidelines.

TDI proposes to replace the repealed 28 TAC Chapter 3, Subchapter F and the concurrently deleted text in 28 TAC Chapter 11, Subchapter F with the proposed new 28 TAC Chapter 21, Subchapter SS.

The proposed amendments to §11.506 delete requirements in §11.506(6), which are being moved to the proposed new 28 TAC Chapter 21, Subchapter SS; redesignate subparts of the rule to compensate for deleted material; and make nonsubstantive changes to conform to agency style and usage guidelines.

The proposed amendments to §11.508 correct references to parts of §11.506 to conform to amendments to that section, and make nonsubstantive changes to conform the section to agency style and usage guidelines.

The proposed amendments to §11.511 amend language in §11.511(1)(B) on coordination of benefits which is inconsistent with §3.3504 in the newly adopted Chapter 3, Subchapter V, concerning Coordination of Benefits; delete language in §11.511(4) referring to the Texas Health Insurance Pool made obsolete by Senate Bill 1367, Act of June 14, 2013, 83rd Legislature, Regular Session; redesignate parts of the rule to compensate for deleted material; and make nonsubstantive changes to conform the section to agency style and usage guidelines.

**2. FISCAL NOTE.** Jan Graeber, director and chief actuary, Rate and Form Review Office in the Life, Accident, and Health Section, has determined that for each year of the first five years the proposed sections will be in effect, there will be no fiscal impact to state and local governments as a result of the enforcement or administration of the proposal. There will be no measurable effect on local employment or the local economy as a result of the proposal.

**3. PUBLIC BENEFIT AND COST NOTE.** Ms. Graeber has also determined that for each year of the first five years the proposed sections are in effect, the public benefit anticipated as a result of the proposal is a more compact and consistent body of rules covering insured and HMO products and conformity of the rules to changes in related

statutes. There is no anticipated cost to persons required to comply with the proposal because it is a repeal of current requirements.

#### **4. ECONOMIC IMPACT STATEMENT AND REGULATORY FLEXIBILITY ANALYSIS**

**FOR SMALL AND MICRO BUSINESSES.** As required by Government Code §2006.002, the department has determined that the proposed amendments will not have an adverse economic impact on small and micro businesses. As a result, the department is not required to prepare a regulatory flexibility analysis.

**5. TAKINGS IMPACT ASSESSMENT.** The department has determined that no private real property interests are affected by this proposal and that this proposal does not restrict or limit an owner's right to property that would otherwise exist in the absence of government action and so does not constitute a taking or require a takings impact assessment under the Government Code §2007.043.

**6. REQUEST FOR PUBLIC COMMENT.** If you wish to comment or request a hearing on this proposal, you must do so in writing no later than 5 p.m. Central time, on August 4, 2014. Send your written comments or hearing request by email to [chiefclerk@tdi.texas.gov](mailto:chiefclerk@tdi.texas.gov), or by mail to Sara Waitt, General Counsel, Mail Code 113-2A, Texas Department of Insurance, P.O. Box 149104, Austin, Texas 78714-9104. A hearing request must be on a separate page from any written comments. You must simultaneously submit an additional copy of the comments or hearing request either by email to [hlcomments@tdi.texas.gov](mailto:hlcomments@tdi.texas.gov), or by mail to Jan Graeber, Director and Chief

Actuary, Rate and Form Review Office, Mail Code 107-2A, Texas Department of Insurance, P.O. Box 149104, Austin, Texas 78714-9104.

**7. STATUTORY AUTHORITY.** The department proposes the amendments under Insurance Code §§36.001, 843.051(b)(3), 1251.008, 1251.251, 1251.253, 1251.258, 1251.260, 1271.301(b), 1271.306(c), and 1701.060(a), as well as Senate Bill 1367, Act of June 14, 2013, 83rd Legislature, Regular Session.

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, “(b) A health maintenance organization is subject to (3) 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 states, “(a) 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.

Senate Bill 1367, Act of June 14, 2013, 83rd Legislature, Regular Session,  
terminates coverage offered by the Texas Health Insurance Pool, making obsolete any  
reference to giving notice of the coverage being available.

**8. CROSS REFERENCE TO STATUTE.** The following statutes are affected by this  
proposal:

Insurance Code Chapter 1251

Insurance Code Chapter 1271

Insurance Code Chapter 1701

**9. TEXT.**

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

**§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) – (5) (No change).

~~[(6) Continuation of coverage--Group agreements must contain a provision providing for mandatory continuation of coverage for enrollees who were continuously covered under a group certificate for three months prior to termination of the group coverage, or newborn or newly adopted children of enrollees with three months prior continuous coverage, that is no less favorable than provided by the Insurance Code Chapter 1271 Subchapter G.]~~

~~[(A) An enrollee shall have the option to continue coverage as provided for by the Insurance Code Chapter 1271 Subchapter G upon completion of any continuation of coverage provided under The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) (Public Law Number 99-272, 100 stat. 222) and any amendments thereto.]~~

~~[(B) A dependent, upon completion of any continuation of coverage provided under the Insurance Code Chapter 1251 Subchapter G, shall have the privilege to continue coverage for the six months prescribed by the Insurance Code Chapter 1271 Subchapter G.]~~

~~[(C) If an HMO offers conversion coverage, it must be offered to the enrollee not less than 30 days prior to the expiration of the COBRA or the Insurance Code Chapter 1251 Subchapter G continuation coverage period.]~~

~~[(D) A basic service HMO shall notify the enrollee not less than 30 days before the end of the six months from the date continuation under the Insurance Code Chapter 1271 Subchapter G was elected that the enrollee may be eligible for coverage under the Texas Health Insurance Risk Pool, as provided under the Insurance Code Chapter 1506, and shall provide the address and toll-free number of the pool.]~~

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

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

(8)~~(9)~~ 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~~such 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~~such dependents;

(ii) in the service area under other circumstances where the subscriber is legally responsible for the health care of ~~the~~such 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~~[shall]~~ 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~~[such]~~ 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~~[shall]~~ 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 under which ~~the~~~~[such]~~ coverage is required by ~~the~~ Insurance Code §1201.062 and §1271.006.

~~(9)~~~~(40)~~ 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 ~~[such]~~ stabilization ~~must~~~~[shall]~~ be provided to enrollees as approved by the HMO, provided that the HMO ~~must~~~~[is required to]~~ approve or deny coverage of poststabilization care as requested by a treating physician or provider. An HMO ~~must~~~~[shall]~~ approve or deny ~~the~~~~[such]~~ 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~~shall 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 which have licensed ~~and~~/or certified personnel and equipment to provide Advanced Cardiac Life Support ~~[(ACLS)]~~ consistent with American Heart Association ~~[(AHA)]~~ and American Trauma Society ~~[(ATS)]~~ 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 ~~[that]~~ 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 the 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)~~(44)~~ 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)~~(42)~~ Exclusions and limitations--A provision setting forth any exclusions and limitations on basic, limited, or single health care services.

(12)~~(43)~~ 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~~[A]~~ charge ~~[may be added]~~ to the premium ~~[by the HMO]~~ for late payments received within the grace period. If an HMO does not receive payment ~~[is not received]~~ within the 30 days, the HMO may cancel coverage ~~[may be cancelled]~~ after the 30th day and may hold the terminated members ~~[may be held]~~ liable for the cost of services received during the grace period, if this requirement is disclosed in the agreement.

(13)~~(44)~~ Incontestability:

(A) All statements made by the subscriber on the enrollment application are~~[shall be]~~ considered representations and not warranties. The statements are considered ~~[to be]~~ truthful and ~~[are]~~ made to the best of the subscriber's

knowledge and belief. A statement may not be used in a contest to void, cancel, or non  
[-]renew 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. [~~A group certificate may only be contested because of fraud or  
intentional misrepresentation of material fact on the enrollment application.~~] For small  
employer coverage, the misrepresentation must[~~shall~~] 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)[~~(15)~~] 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[~~upon~~] 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~~shall 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~~shall offer its entire network, rather than limited provider networks within the HMO delivery network.

(B) The HMO ~~may~~shall 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)~~(16) Schedule of charges--A statement that discloses the HMO's right to change the rate charged with 60 days' written notice ~~under~~pursuant to the Insurance Code Chapter 1254.

~~(16)~~(17) Service area--A description and a map of the service area, with key and scale, which ~~must~~shall identify the county, or counties, or portions thereof, 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)~~(18) 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 ~~[of the child]~~ while that child is incapable of self-sustaining employment due to mental retardation or physical disability, and chiefly dependent ~~on~~upon the subscriber for support and maintenance. The HMO may require the subscriber to furnish proof of

~~[such]~~ 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 ~~[such]~~ limiting age.

~~(18)~~~~(19)~~ 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~~~~[shall]~~ contain a provision complying with~~[in accordance with the]~~ Insurance Code Chapter 1503.

~~(19)~~~~(20)~~ Conformity with state law--A provision that if the agreement or certificate contains any provision not in conformity with ~~[the]~~ Insurance Code Chapter 1271 or other applicable laws it ~~must~~~~[shall]~~ not be rendered invalid but ~~must~~~~[shall]~~ be construed and applied as if it were in full compliance with ~~[the]~~ Insurance Code Chapter 1271 and other applicable laws.

~~(20)~~~~(21)~~ 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 (relating to Minimum Standards for Medicare Supplement Policies), referred to in this paragraph as Medicare supplement rules, and Chapter 3, Subchapter Y of this title (relating to Standards for Long-Term Care Insurance Coverage Under Individual and Group Policies), referred to in this paragraph as long-term care rules, where applicable. If there is a conflict between the Medicare supplement rules ~~[and]~~or the long-term care rules and the HMO rules, the Medicare supplement rules or long-term care rules will~~[shall]~~ govern to the exclusion of the conflicting provisions of the HMO rules. Where

there is no conflict, an HMO must~~[shall]~~ follow ~~[both]~~ the Medicare supplement rules, ~~[and/or]~~ the long-term care rules, and the HMO rules where applicable.

~~(21)~~~~(22)~~) 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 utilize a nonprimary care physician specialist as a primary care physician as set out~~[forth]~~ in ~~[the]~~ Insurance Code §1271.201.

~~(22)~~~~(23)~~) Selected obstetrician or gynecologist--Individual, conversion, and group agreements and certificates, except small employer plans as defined by ~~[the]~~ 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 ~~[the]~~ Insurance Code Chapter 1451 Subchapter F. An HMO must~~[shall]~~ not preclude an enrollee from selecting a family physician, internal medicine physician, or other qualified physician to provide obstetrical or gynecological care.

(A) An HMO must~~[shall]~~ 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) The access to 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~~[shall]~~ not impose any penalty, financial or otherwise, on~~[upon]~~ 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. Such limitation must~~[shall]~~ not affect the right of the enrollee to select the physician who provides that care.

(F) An HMO must~~[shall]~~ include in its enrollment form a space in which an enrollee may select an obstetrician or gynecologist as set forth in ~~[the]~~ 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~~~~Such~~ enrollee must~~shall~~ 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~~that~~ 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~~shall~~ adhere to the HMO's standard referral protocol when accessing other specialty obstetrical or gynecological services.

~~(23)~~~~(24)~~ 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 by a physician licensed in this state under~~pursuant to the~~ Insurance Code Chapter 1354 will~~shall~~ satisfy any requirement for demonstrable proof of organic disease.

~~(24)~~~~(25)~~ Drug Formulary--A group agreement and certificate, except small employer plans as defined by ~~the~~ Insurance Code §1501.002, that covers prescription drugs and uses one or more formularies must comply with ~~the~~ Insurance Code Chapter 1369, Subchapter B and Chapter 21, Subchapter V of this title (relating to Pharmacy Benefits).

~~(25)~~~~(26)~~ Inpatient care by non primary~~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~~~~upon~~ 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 ~~shall~~~~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~~~~forth~~ in §11.506~~(9)~~~~(10)~~ or ~~(14)~~~~(15)~~ of this title (relating to Mandatory Contractual Provisions: Group, Individual and Conversion Agreement and Group Certificate):

(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 in [the] Insurance Code §1271.153;
- (ii) immunizations for children as required in [the] Insurance Code §1367.053;
- (iii) well-child care from birth as required in [the] Insurance Code §1271.154;
- (iv) cancer screenings as required in [the] Insurance Code Chapter 1356 relating to mammography;
- (v) cancer screenings as required in [the] Insurance Code Chapter 1362 relating to screening for prostate cancer;
- (vi) cancer screenings as required in [the] 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 in accord~~[accordance]~~ with established medical guidelines; and
- (viii) immunizations for adults under~~[in accordance with]~~ 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.
- (l) 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 ~~the~~ 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~~shall~~ 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 ~~[the]~~ Insurance Code Chapter 1358, Subchapter B.

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

(d) A state-mandated health benefit plan defined in §11.2(b) of this title (relating to Definitions) must~~shall~~ 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 (relating to State-mandated Health Benefits in Individual HMO Plans, State-mandated Health Benefits in Small Employer HMO Plans, and State-mandated Health Benefits in Large Employer HMO Plans), 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~~shall require~~ 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~~shall~~ set out~~forth~~ 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. ~~[Group plans]~~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 ~~[group]~~insurance plan or coverage under governmental programs so no more than 100% 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 ~~[group]~~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 (relating to Coordination of Benefits).~~[Requirements of the Insurance Code Chapter 1203 and §§3.3501 – 3.3511 of this title (relating to Group Coordination of Benefits) relating to coordination of benefits by insurers should be followed by HMOs that include a coordination of benefits provision in their plan.]~~

(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~~[such]~~ covered services. On~~[Upon]~~ receiving the~~[such]~~ services from the HMO, the enrollee is

considered to have assigned ~~the~~<sup>[such]</sup> 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~~<sup>[which]</sup> provides coverage for on-the-job injuries or illness, it ~~must~~<sup>[shall]</sup> comply with §5.6302 of this title (relating to Sale of Substitutes to Workers' Compensation Insurance).

(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~~<sup>[upon]</sup> 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. ~~[If a basic service HMO does not offer each enrollee a conversion contract, the HMO shall provide written notice of the availability of coverage through the Texas Health Insurance Risk Pool.]~~ A single service or limited service HMO ~~must~~<sup>[shall]</sup> offer a conversion contract without requiring evidence of insurability. Charges for individuals must ~~comply with~~<sup>[be in accordance with]</sup> §11.704 of this title (relating to Charges for Individuals).

(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~~pursuant to the Texas Arbitration Act, Texas Civil Practice and Remedies Code Chapter 171.~~[\$171.001, et seq.]~~

**10. CERTIFICATION.** This agency certifies that legal counsel has reviewed the proposal and found it to be within the agency's legal authority to adopt.

Issued at Austin, Texas, on June 17, 2014



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Sara Waitt  
General Counsel  
Texas Department of Insurance