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# Texas Register

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**Proposed Sections** - sections proposed for adoption

**Withdrawn Sections** - sections withdrawn by state agencies from consideration for adoption, or automatically withdrawn by the Texas Register six months after the proposal publication date

**Adopted Sections** - sections adopted following a 30-day public comment period

**Open Meetings** - notices of open meetings

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Specific explanation on the contents of each section can be found on the beginning page of the section The division also publishes cumulative quarterly and annual indexes to aid in researching material published

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In order that readers may cite material more easily, page numbers are now written as citations Example on page 2 in the lower-left hand corner of the page, would be written "18 TexReg 2 issue date," while on the opposite page, page 3, in the lower right-hand corner, would be written "issue date 18 TexReg 3"

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The Titles of the *TAC*, and their respective Title numbers are.

1 Administration
4 Agriculture
7. Banking and Securities
10. Community Development
13. Cultural Resources
16. Economic Regulation
19. Education
22. Examining Boards
25 Health Services
28 Insurance
30 Environmental Quality
31 Natural Resources and Conservation
34. Public Finance
37. Public Safety and Corrections
40 Social Services and Assistance
43 Transportation

**How to Cite** Under the *TAC* scheme, each section is designated by a *TAC* number. For example in the citation 1 TAC §27 15

1 indicates the title under which the agency appears in the *Texas Administrative Code*, *TAC* stands for the *Texas Administrative Code*, §27 15 is the section number of the rule (27 indicates that the section is under Chapter 27 of Title 1, 15 represents the individual section within the chapter)

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TITLE 40 SOCIAL SERVICES AND ASSISTANCE
*Part I. Texas Department of Human Services*
40 TAC §3 704 . . . 950, 1820

The *Table of TAC Titles Affected* is cumulative for each volume of the *Texas Register* (calendar year)

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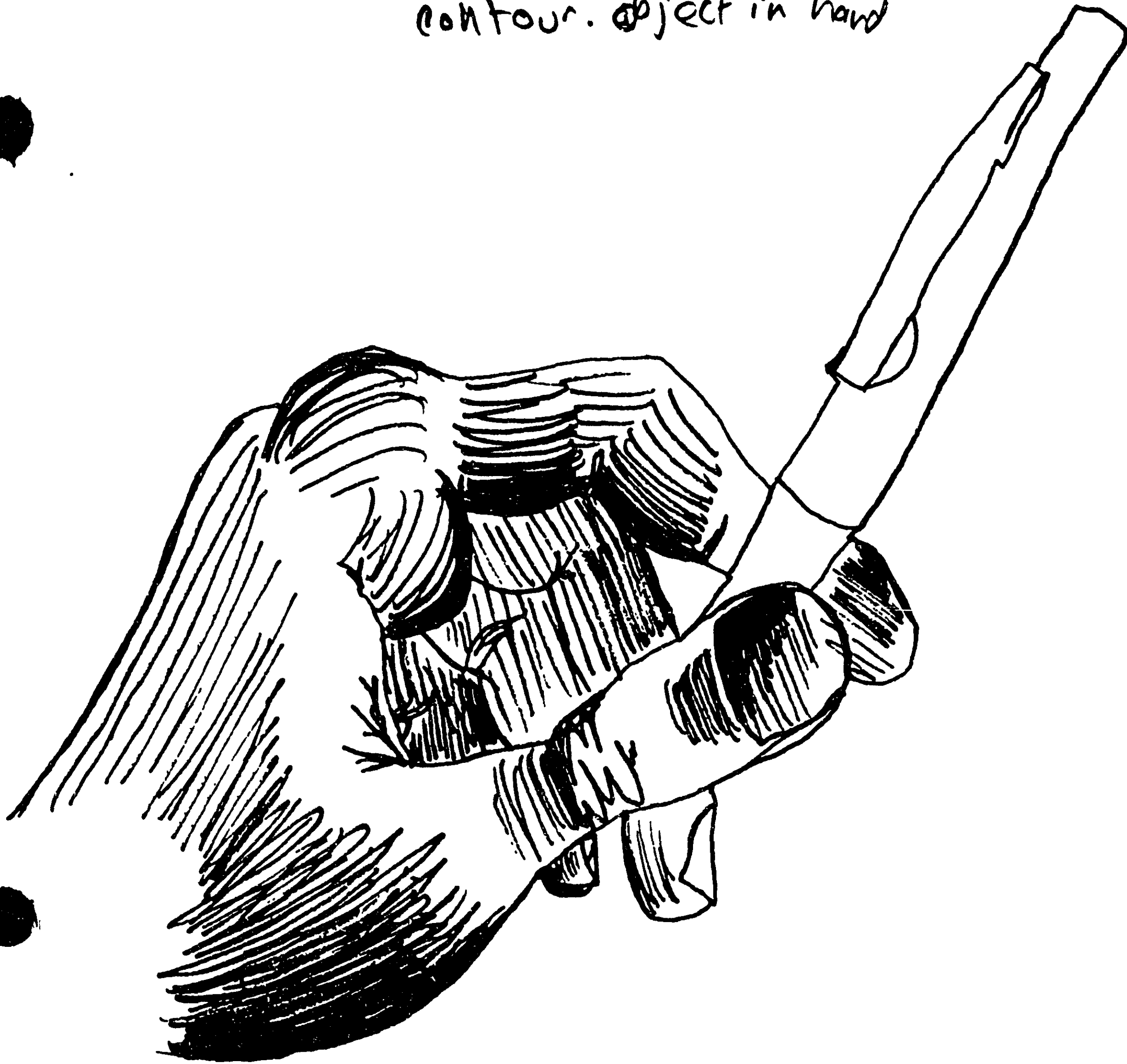


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# Adopted Sections

An agency may take final action on a section 30 days after a proposal has been published in the *Texas Register*. The section becomes effective 20 days after the agency files the correct document with the *Texas Register*, unless a later date is specified or unless a federal statute or regulation requires implementation of the action on shorter notice.

If an agency adopts the section without any changes to the proposed text, only the preamble of the notice and statement of legal authority will be published. If an agency adopts the section with changes to the proposed text, the proposal will be republished with the changes.

## TITLE 28. INSURANCE

## Part I. Texas Department of Insurance

### Chapter 26. Small Employer Health Insurance Regulations

### SMALL EMPLOYER HEALTH INSURANCE REGULATIONS

**• 28 TAC §§26.1-26.27**

*(Editor's Note Due to the size of the following rules and the restriction the Register has on the number of pages per issue, the following will be published in its entirety in Volumes I and II of the December 17, 1993 issue of the Texas Register Volumes III will begin with the other submissions for this issue )*

The State Board of Insurance and the Commissioner of Insurance adopt new §§26.1-26.27. Sections 26 4-26.7 26 9, 26 11, 26.14, 26.16, 26 19 and 26 27, Figures 14, 15, 16, 17, 18, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 31, 34, 36, 37, 38, 39, 40, 41, 42, 43, 46, 47, 50, 51, 52, 53, 54, 56, 58, 59, 61, 62, 63, 64, 68 and 70, are adopted with changes to the proposed text published in the October 29, 1993 issue of the *Texas Register* (18 Tex Reg 7587). Sections 26.1-26 3, 26 8, 26 10, 26.12, 26 13, 26 15, 26.17, 26 18 and 26 20-26 26, and §26.27, Figures I-13, 17, 18, 19, 30, 32, 33, 35, 45, 48, 49, 55, 57, 60, 65, 66, 67, and 69 are adopted without changes to the proposed text and will not be republished

The sections are necessary to implement the Insurance Code, Chapter 26, enacted by the 73rd Legislature in House Bill 2055 The sections also are intended to make certain that the provisions of the Insurance Code, Articles 21 20, 21 21, 21 21-3, and 21 21-5 are adhered to in health benefit plans covered by the Insurance Code, Chapter 26 The amendments to the sections made as a result of comment are explained in the summary of comments and the agency's response to the comments One amendment to §26 19 was made to correct a typographical error Section 26 19(b)()(1)(B) was amended to insert the word "than" which was omitted through typographical error

The sections set out the requirements for compliance with the Insurance Code, Chapter 26, which governs small employer health insurance Section 26 1 describes the purpose of the sections, §26 2 adopts and incorporates certain forms to be used with small employer health plans, §26 3 contains the severability clause, §26.4 defines the words and terms used in the sections, and §26.5 describes the applicability and scope of these sections and the plans to which these sections are applicable (e.g., by type, purchaser, dates of issue, and the changing status of the employer contributing to the plans) Section 26.6 lists the ways in which a carrier becomes a health carrier as described in these sections, outlines the duties of health carriers in connection with these sections under varying circumstances, and sets out the reporting requirement for health carriers to elect whether or not to be a small employer carrier, and to designate geographic areas Section 26 7 outlines the requirement that a small employer carrier must offer to provide coverage to entire groups and sets out the ways in which various members of the groups must be treated, as well as the requirements for enrollment periods, and §26 8 sets forth the way in which the contribution and participation requirements for small employer health benefit plans must be determined Section 26.9 contains requirements and limitations on exclusions, limitations, waiting periods, preexisting conditions and restrictive riders written in connection with small employer health benefit plans. Section 26 10 sets out the requirements for determining the classes of business of small employers for rating purposes Section 26 11 describes the restrictions relating to premium rates and sets forth the requirements for rating manuals and rating methods, as well as the requirements for subsequent changes in rating methods Section 26 12 describes the disclosures which must be given by each small employer carrier and each agent as part of any solicitation and distribution of sales materials relating to small employer health benefit plans Section 26 13 contains the requirements for fair marketing of small employer health benefit plans. Section 26 14 contains the requirements for coverage (the three prescribed plans and the optional plans) which must be offered to small employers; §26.15 contains the requirements for additional coverage which must be offered under certain circumstances Section 26.16 contains the requirements for renewability of coverage and the rules relating to limitations on cancellation; §26 17 describes the circumstances under which a small employer may elect to refuse to renew coverage and the fact that the election will foreclose the carrier from writing small employer health benefit plans in the state or geographic area for a period of five years, the way in which a carrier may reapply to reenter the small employer market after the passage of five years, and the requirements that the carrier give notification of termination of coverage, §26 18 describes the contents of the notice to covered persons of the termination of coverage Section 26.19 describes the requirements for filing policy forms, contracts, certificates and evidences of coverage for health benefit plans in the small employer market, and §26 20 contains the reporting requirements for health carriers subject to the Insurance Code, Chapter 26 Section 26 21 contains the requirements for and limitations on cost containment Section 26 22 sets out the requirements for private purchasing cooperatives and §26 23 contains a description of the powers and duties of the Texas Health Benefits Purchasing Cooperative and private purchasing cooperatives Section 26 24 lists the procedures for the appeals process in connection with the filing and approval requirements of these sections and the mailing address for the reporting requirements found in these sections Section 26 25 states that misrepresentations about the effects of Insurance Code, Chapter 26 will be considered a violation of Insurance code, Articles 21 20 and 21 21, and §26 26 describes the administrative violations and penalties The forms are listed in §26 27 of these sections and printed in the appendix which follows that section Copies of the forms are on file with the Office of the Secretary of State, Texas Register Section. Copies of the forms and complete sets of prototype forms may be obtained from the Texas Department of Insurance, Publications Department, MC 108-5A, P. O Box 149104, Austin, Texas 78714-9104

Comments Relating to Purpose-Section 26 1

Two commenters stated that this provision not only states the purpose of the rules, but includes a statement of legislative intent The commenters indicated that because the legislation did not contain a specific statement of legislative intent, the authority of the department to state in rules the legislative intent of House Bill 2055 is questionable

Agency Response. The agency disagrees with this comment because it is clear from the legislative history and the provisions in the Insurance Code, Chapter 26, that the stated purpose corresponds to what the statute attempts to achieve and the purpose section reflects the agency's purpose in promulgating the rules. No change is necessary.

Comments Relating to Franchise Insurance Policy-Section 26 4

A few commenters requested that the definition of franchise insurance policy be changed to state that the rates for such a policy shall differ from the rate otherwise applicable to individually solicited policies, rather than may

Agency Response The franchise insurance policy definition will remain unchanged from the published definition because the

commenters recommendation would create a loophole allowing companies to charge the same rate (rather than a lower rate) simply to remove the policies from the definition of franchise insurance policy.

Comments Relating to Limited Benefit Definition

Several commenters stated that the proposed definition of limited benefit was not consistent with rules previously adopted by the Board and the intent of other chapters of the Texas Insurance Code. These commenters recommended that the definition be amended to be identical to that defined by previous rules.

Several commenters stated that they believe the current definition creates a loophole through which carriers can market a whole slate of policies to small employers that are exempt from the Insurance Code, Chapter 26. The commenters recommended that the definition be amended to: policies that provide payment of benefits only upon occurrence of certain contingencies, such as cancer, or in a particular setting, in contrast to policies covering all contingencies other than those excluded

Several commenters stated that policies sold to supplement other in-force policies, such as but not limited to CHAMPUS and intensive care, should be added to the list of those plans excluded from Chapter 26. Several commenters stated that they were still uncertain exactly what constitutes a limited benefit policy

Agency Response The agency believes the definition of limited benefit is consistent with legislative intent and accomplishes the purpose of the legislation The agency believes that the definition is specific as being applicable to Chapter 26 provisions only and there is no correlation between these sections and §§ 3.3070-3.3080 which were written under a different statute for a different purpose.

The agency agrees that there should not be a loophole to allow carriers to market policies to small employers and believes that the proposed definition allows only policies with truly limited coverage be exempt from this chapter. It was not the agency's intent to exclude Supplemental coverage such as, but not limited to, CHAMPUS supplements and intensive care from the types of coverages that are not required to comply with Chapter 26 nor do we believe it was the legislature's intent to require supplement coverages to comply with Chapter 26 of the Texas Insurance Code. The definition in §26.4 has been changed to include those coverages.

The agency agrees that there may be some confusion as the true intent of the definition and the beginning of the definition of limited benefit is amended to read as follows: "For purposes of this chapter and the Insurance Code, Chapter 26, only, this term means a policy of accident and sickness insurance:..."

Subsection (A) of the definition of limited benefit is amended to include supplemental coverage as follows

"(A) that provides for payment of benefits only upon the occurrence of certain contingencies, such as cancer or other specified disease, in contrast to policies covering all contingencies other than those excluded, or coverage, including but not limited to CHAMPUS supplements or intensive care, sold to supplement other coverage in force, or"

Comments Relating to Actuary Definition in §26.4.

One commenter suggested that a definition of "actuary" be included in the rules since actuaries are responsible for certifying compliance with the rating provisions.

Agency Response. The agency agrees, and a definition of actuary is included in the rules based on the definition of actuary found in the Insurance Code, Article 1.11a.

Comments Relating to Definitions.

One commenter recommended including a definition of new employee that would provide the employee is commencing employment with the employer for the first time.

Another commenter indicated the definitions of case characteristics, small employer, dependent, and eligible employee should be consistent with the statutes. Another commenter indicated that the definition of "eligible employee" could extend coverage to businesses with more than 50 employees.

A commenter suggested adding reference to Article 26.48 in the definition of small employer health benefit plan to include HMOs in the definition.

Agency Response. The agency believes the recommended definitions would be contrary to provisions in the statute relating to the definition of eligible employee. Also, the rules include a definition of new entrant and eligible employee; therefore, an additional definition is not needed in that area. It should be noted that the recommended definition could serve to remove certain employees from eligibility for coverage.

The agency does not believe it is necessary to include HMOs since there is already a reference to Article 26.42(d) which refers to other plans authorized to be sold; these other plans include HMOs. Also, the definition is taken directly from the statute and should not be changed.

Definitions are consistent with and repetitive of definitions in the statute and therefore no change is necessary.

Comments Relating to Existing Plans.

Several commenters stated that the proposed rule prohibits any change whatsoever to existing plans; there are many routine changes provided by insurers at the request of the employer/employee-these changes would compel those plans to comply with Chapter 26 and the result is that there is really no "grandfathering" of pre-9/1/93 plans.

Commenters listed at least nine transactions which they consider to be routine and that they do not believe should be considered "changes" to the plan, stated that inclusion of existing plans was contrary to legislative intent and was not authorized.

Many commenters indicated that the Insurance Code, Chapter 26 contains no provisions that make the bill applicable to plans in force as of 9/1/93, except Article 26.34 which subjects those plans to rate provisions in Article 26.32 and 26.33. Some commenters suggested language.

Several commenters stated that §26.5(c) describes certain events that will be considered to be changes in the plan, for plans issued prior to 9/1/93 and it includes as a change "excluding one or more of the previously covered employees or dependents from the plan."Individual employees or dependents may voluntarily leave an existing plan for many reasons (such as divorce, death, retirement, resignation, failure to pay premium, etc.) If one covered employee or dependent left the plan after 9/1/93, the plan for all other remaining insureds would have to be modified subject to Chapter 26.

A few commenters expressed uncertainty regarding the application of Chapter 26 to association group business. One commenter believed that employers first purchasing a plan through an association should be able to obtain a plan through a contract issued prior to 9/1/93 even though the employer is purchasing the plan on or after 1/1/94.

Agency Response. Based on the comments received, the agency has changed §26.5 and §26.7, to totally grandfather the existing business issued prior to September 1, 1993. The published sections seemed a fair compromise, but would be difficult to enforce. Employers will have the option of cancelling the plans and getting the plans covered by this chapter with all of their guarantees. There will be a turnover of these existing plans in the normal course of events

The agency agrees that clarification may be needed concerning changes in covered employees, and changes have been made to §26.5 and §26.7, which should remove these concerns Other recommendations concerning changes for purposes of the renewal date will be addressed under that topic.

The Insurance Code, Chapter 26, is applicable to association group business to the extent it involves a small employer. Plans purchased on or after 1/1/94 are subject to the requirements of the statute. Allowing the continued sale of plans that do not comply with the statute would be contrary to the law and defeat the purpose of small employer group health insurance reform

Comments Relating to Existing Plans and Renewal Date Definition.

A commenter suggested that reference to changes in the renewal date definition be excluded.

Several commenters suggested that the words "or deletion" be added after the word "addition" and indicates that there is no reasonable or rational distinction between addition or deletion of employees.

Several commenters had suggested language for changes in the definition, suggested clarification of renewal date for associations, and stated that list billed policies were guaranteed renewable and could not be changed.

One commenter agreed with the definition of renewal date as published.

One commenter suggested language to clarify the definition of "renewal date".

Agency Response. The agency does not agree with the proposed deletion of reference to changes in the definition of renewal date because it is needed to sufficiently define the term.

The agency agrees that the "voluntary" deletion of an employee or dependent, insured under a health benefit plan, should not be considered a change for purposes of determining whether a renewal date has occurred. The agency has changed the definition of "renewal date" in §26.4 to clarify that the deletion of an insured or dependent from a plan would have to be voluntary by the insured employee or due to termination of employment of the employee or retirement or death of the employee or dependent.

The agency also agrees that the definition of renewal date needs the clarifying wording "contract or certificate of coverage" as recommended by the commenter.

Comments Relating to Jurisdiction and Employer Becomes a Small Employer.

A commenter suggested that compliance of a health benefit plan (when an employer becomes a small employer) be required on the later of January 1, 1994, or the date specified for renewal or the policy anniversary date, the commenter also stated this would be consistent with §26 5 (i). A few commenters suggested that consideration be given to making the plan subject to requirements of the statute and rules if the employer remains under 50 eligible employees for a certain length of time. One commenter stated that the regulations would be applied to business originally sold and delivered outside Texas if the employer relocates to Texas and that this will create conflicts in jurisdiction between Texas and the original state where the plan was issued.

Commenters suggested that the date for determination of whether an employer is a small employer be changed to the renewal date, and requested that §26. 5(i) and (j) make the employer responsible for assuring compliance, stated that regulation of out-of-state master policies was a problem as was jurisdiction over out-of-state certificates. One commenter stated a non-small employer was not guaranteed renewable.

Agency Response. To make the provision consistent with §26.5(i), the agency agrees that a change is needed; also, the change is needed due to other changes related to grandfathering of existing business issued prior to 9/1/93. These changes are found in §26.5 and §26.7. A change with respect to small employers based on number of employers is unnecessary because this is covered in the definition of small employer.

Due to changes with respect to the applicability of the rules to existing business issued prior to September 1, 1993, changes are needed to make the provision consistent with other recommended changes. With the change, requirements would apply to business issued between 9/1/93 and 1/1/94 upon the first renewal date following 1/1/94 in cases where the employer becomes a small employer. The change is included in §26.5. The agency does not agree that the employer should be made responsible for assuring compliance.

With respect to out-of-state jurisdiction, the agency agrees, in part, with the comments; however, the Insurance Code, Chapter 26 defines "small employer" in terms of the majority of employees being employed in this state. The agency will delete the words "or certificate" in §26.5 of the published rules to assure that certificates issued outside the state of Texas not be subjected to Texas requirements. Texas has traditionally tried to protect its policyholders who have policies issued outside the state and it is important that this position is maintained This change does not remove the requirement that certificates issued in Texas must comply when the master contract is issued elsewhere.

The agency has changed §26 5(i) to provide that the small employer health benefit plan is subject to the Insurance Code, Chapter 26 and these sections, except when the employer non-renews the plan or enrolls in a different plan.

Comments Relating to Plans Issued Between 91/193 and 1/1/94.

Because §26 5(d) is clearly intended to apply only to health benefit plans issued after 9/1/93 and before 1/1/94, the words "or renewed" in the first line confuse the time period and conflict with the exclusion of pre-9/1/93 issued plans in §26.5(b).

Agency Response The agency agrees and the words "or renewed" are removed from the first sentence in §26.5(d)

Comments Relating to Notice Requirements

A few commenters indicated that requiring carriers to send notice about the three standard plans to existing policyholders could disrupt that coverage and increase the cost to the small employer. A few commenters indicated there could be administrative costs for the notice required. One commenter indicated that the rule requires a second 60-day notice in addition to the 30 day notice required by the Insurance Code, Article 3 51-10 and suggested that the notice requirement coincide with the notice requirement in Article 3 51-10.

Agency Response The agency does not agree with these comments This notice is not disruptive. It simply educates small employers of the availability of other options so that the employer can make a more educated choice among available coverage. Also, it is likely that any administrative costs would be minuscule–carriers will already be contacting the employers concerning renewal of their plans and they could include the notice with any mailing concerning renewal of the plans To minimize the number of notices required and eliminate any additional costs, however, the agency will change §26 5(f) and (g) to provide that the required notices be provided at least 30 days prior to the first renewal date rather than 60 days This will allow carriers to mail the notice required by the rules along with the notice required by statute and should eliminate additional costs.

Comments Relating to Status as Small Employer Carrier.

One commenter suggested clarifying that carriers who elect only to continue to renew business (that may otherwise fall under the Act) not be subject to the guaranteed renewability provisions of the Act. Also, commenters requested that companies with a small number of policies (unintentionally brought under the Act) be given a transition period to see if other arrangements can be made or be allowed to required insured to pay their own premiums.

Agency Response. Other recommended changes to the published rules clarify the applicability to health benefit plans issued prior to 9/1/93; the agency does not recommend any further exception other than the recommended grandfathering of those plans. It should be noted that for rating of health benefit plans issued prior to 9/1/93, the statutes require carriers to fully comply by 9/1/95.

Comments Relating to Geographical Service Areas

A commenter indicated that the statute was intended to affect only those carriers (such as HMOs) with limited geographical service areas and that most carriers do not have territorial limitations within Texas Another commenter indicated that it believed the agency intended the rules to prohibit unfair withdrawal from the market, etc, and redlining The commenter recommended including in §26 6(c) the following language Service areas by zip code shall be defined in a non-discriminatory manner and in compliance with Insurance Code, Article 21.21, §4 and §21.21-5

Agency Response. The proposed rule was not intended to require carriers who do not have geographic service areas to develop and establish such areas. To clarify the requirement, a sentence is added to §26.6(c) that indicates if a carrier has no particular service areas, a statement that the entire state is the geographical service area will be acceptable The agency agrees with the comment on non-discrimination and the suggested language is added to §26 6

Comments Relating to Dependent Coverage

Several commenters stated that HB 2055 does not mandate dependent coverage in every small employer plan, but leaves the option (to the employer) of providing dependent coverage. Commenters further state that the carrier does not have an option, but the employer does, and state that the rule should not go beyond the statute. Other commenters said that it is up to the carrier whether to offer dependent coverage and the rules go beyond the authority granted in the statute, and that the costs to the employer would go up because the employer pays 75%

One commenter supported the proposed rule as published and indicated that requiring the offer of dependent coverage to employees of the small employer is consistent with Article 26 21 and helps to spread the risk and make coverage more broadly available

Agency Response. A reading of the provisions of HB 2055 as a whole seems to indicate that it is intended that dependent coverage be offered to employees of small employers. Because one of the primary purposes of HB 2055 is to increase the availability of coverage, it is appropriate to require that employees of small employers have the option to purchase dependent coverage. This would ensure that coverage is available to a larger number of people, particularly children. Testimony of various individuals before the House Insurance Committee and Senate Economic Development Committee also supports this interpretation of legislative intent. There are many references in the Insurance Code, Chapter 26, to employees and dependents. References can be found in Articles 26.02(7); 26.02(12); 26.13; 26.21(d), (f), (h), (j);(k); 26.23(b); 26.24; and 26.72(a). Article 26.13 specifically provides that the Purchasing Cooperative is established to make health care coverage available to small employers and their eligible employees and eligible employees' dependents. All references lead one to believe that dependent coverage is always available to employees of the small employer.

Article 26.21(j) provides (in part) that any coverage of a newborn child terminates on the 31st day after the date of birth unless dependent children are eligible for coverage. Dependent children would not be eligible for coverage if an employee had dependent children and had decided not to purchase to coverage on those dependent children; otherwise, dependent children would be eligible for coverage.

In addition, Articles 26.45 and 26.47 provide that coverage must be included (in the preventive and primary care benefit plan and the standard health benefit plan respectively) for well-child care; Article 26.47 provides that coverage must be included for childhood immunizations, and vision and hearing tests for children under 19 years of age. These provisions also support the agency's view of the legislative intent to cover dependents.

Since the costs for dependent coverage must be paid for by employees and not the small employers, the comment that small employers costs would increase does not seem to be valid.

To clarify whether dependent coverage is provided, the agency has added language to the policy forms (prototypes.) The language states whether or not dependent coverage is provided; the certificate face pages, referenced in §26.14, will be required to include the dependent coverage election and the explanation in the individual data pages, referenced in §26.14, will be changed to require the same. These changes will still require that dependent coverage be offered to employees of the small employer. The employer is not required to pay for dependent coverage. The employee pays for dependent coverage.

Comments Relating to Clarification.

One commenter stated that in §26.7(1), third line, the comma after "small employer carrier" appears to be inappropriate and should be deleted, and the next word "in" probably should be change to "during" or "during the initial enrollment" for clarification purposes.

Agency Response. The agency does not agree with the recommended change because it could create a major loophole in the requirement; however, changes are made to make the requirements consistent with the grandfathering of existing business issued prior to September 1, 1993, as a result of other comments in §26.5 and §26.7.

Comments Relating to Duty of Agents/Carriers.

A commenter indicated that the provisions of §26.7 impose additional burdens on agents and carriers and would be potentially damaging to all three parties. The commenter further indicated that using the words "reason to believe" to trigger the requirement for an agent to notify the carrier leaves the agent open to litigation or other actions for failure to notify.

Agency Response. The agency agrees that "reason to believe" could be a very difficult provision for agents and carriers and those words are deleted and replaced with the word "knowledge" in §26.7(e).

Comments Relating to Adding Previously Excluded Employees.

Several commenters objected to adding employees previously excluded from health benefit plans to the coverage of the plan. They also indicated that in most cases, the groups would not have been issued coverage if the excluded individuals had to be provided coverage. One commenter said that most states do not require this until the reinsurance mechanism is in place and it could cause financial harm to carriers if required before then. A commenter stated that there is no statutory authority for this requirement and that if it remains, the carrier should at least be allowed to adjust premium rates not subject to the rating requirements. A commenter stated that there was much debate during the 1993 Legislative Session concerning guaranteed issue. The commenter also indicated that Article 26.21(e) requires guaranteed issue of coverage to new entrants in a small employer group, but by virtue of an oversight it is in direct contradiction to the Act's intent.

Agency Response. Due to the comments received and the proposed change to grandfather health benefit plans issued prior to 9/1/93, changes are made to §26.7(l) and (n). The changes delete the applicability of these requirements for plans issued prior to 9/1/93.

This would not eliminate the requirement for plans issued between 9/1/93 and 1/1/94; those plans will have to be in full compliance on their first renewal date following 1/1/94. While carriers could adjust the rates, the resulting rates must comply with provisions of the statute.

The correct cite is Article 26.21(f), which requires guaranteed issue to new entrants in a small employer's health benefit plan;. All plans issued on or after 9/1/93 are subject to this requirement; however, due to the grandfathering of existing business issued prior to 9/1/93, the agency has changed §26.7(j) to make the provisions consistent with the grandfathering of existing business.

Comments Relating to Waivers.

One commenter suggested that the waiver requirement be eliminated or changed. The commenter suggested that the employer is in a better position to administer this requirement and provided suggested language for changes. Another commenter indicated that the waiver requirement could be burdensome and costly to small employers if they are required to maintain the waivers. Another commenter stated that the provisions penalize the carrier for an employer's misdeeds and portions of the rule are unenforceable.

Agency Response. The waiver requirement is designed to protect employees of a small employer and ensure that those employees are not being excluded except at their own election. The waivers are required to be maintained by carriers not small employers. No change is necessary.

Comments Relating to Waiting Periods

A commenter indicated that there is no basis in the statute for treating reductions in waiting periods in such a broad manner.

Agency Response. The agency disagrees with this comment and believes that Article 26.21 and 26.49 provide direction on providing credit toward waiting periods. Furthermore, this requirement will only apply to plans issued on or after 9/1/93 and those plans should not have excluded individuals anyway. No change is necessary.

Comments Relating to Additional Coverage.

A commenter indicated that the section could use clarification and that it was not clear if carriers would have to provide coverage not permitted as part of the prototypes. A commenter stated that the additional coverage that could be added should consist only of the riders that could be added to the three standard plans. A few commenters indicated that Article 26.8(b) seemed to permit employers to select more than one plan (as additional coverage) and expressed doubt that the 90% participation requirement could be met in this situation. A commenter expressed concern over the lack of restrictions in the rules concerning an employee's ability to change plans and indicated that an employee with the lowest cost plan could become severely ill and then change to a richer benefit package. A few commenters indicated that nothing prevents employees from selectively upgrading benefits and such antiselection could make pricing difficult.

Agency Response. Sections 26.15(b) and (c) already address these comments; §26.15(b) specifically excludes life insurance and products from the additional coverage required to provide and §26.15(c) specifically states that a health carrier shall not be required to provide any types of additional coverage that the carrier does not write in the state. Otherwise, the carrier must provide additional coverage with any health benefit plan issued to small employers. An employer could select more than one plan, but a carrier is only required to issue additional coverage (riders or a richer benefit plan) if 40% of the employees elect the same additional coverage, in accordance with Article 26.21(c) A single employee could not generally purchase additional coverage on a guaranteed issue basis, unless 40% of

the eligible employees also elected such additional coverage; however, if an employer negotiated an arrangement where the employer is issued more than one plan, all eligible employees would have to be given an equal opportunity to select from the plans issued. No change is necessary.

Comments Relating to Contribution and Participation Requirements.

A commenter stated that the rules exceed statutory authority and conflict with the statute, by allowing carriers to ignore statutes, authorizing a six month period where the employer fails to meet statutory requirements, and allowing rounding down to meet the participation requirement. Several commenters indicated they believed the 75% contribution and 90% participation requirement only applies to the three standard benefit plans. Two commenters indicated they thought the contribution and participation requirements did not apply to HMOs. A commenter urged we include some flexibility for employers of less than 20 employees. A few commenters stated that the 90% participation level should only be measured specifically at the time of renewal and there should be no six-month failure to meet participation requirements. A few commenters indicated that coverage may be less available due to the 75% contribution and 90% participation requirement and this is contrary to the law.

Agency Response. The agency does not agree with these comments. The rules are authorized under Article 26.04 as well as other statutes that provide the Board and/or Commissioner rule-making authority. The rules do not conflict with the statute but provide clarification for the statutory requirements. The requirements apply to all small employer health benefit plans as defined by statute and rule. These plans include the three standard plans and any other health benefit plan offered to the small employer subject to Article 26. 42(d). Any other health benefit plan is inclusive of HMOs plans. The statute does not distinguish between employees with more or less than 20 employees and the statute is equally applicable to all small employer health benefit plans. The rules do include a provision to round down if the application of 90% is not a whole number. The provision of the rules relating to 90% participation addresses situations where the employers' participation level may fluctuate frequently placing him in and out of the category of small employer. Early comments received on the rules prior to publication indicated a need to address this situation and this rule does that. The agency is hopeful that that coverage will be more available. It should be noted that the requirements for 75% contribution and 90% participation are found in the statute (Article 26.21(b)) enacted by the Legislature. No changes are necessary.

Comments Relating to Enrollment

A few commenters suggested changes in the language of this rule to address situations where the employee may not be eligible for coverage on the date employment begins One commenter questioned whether the rule was in accordance with the statute.

Agency Response. Section 26.7(h)(1) and (3) are being changed to address the concerns expressed by commenters and to assure that new entrants are provided the required enrollment periods.

Comments Relating to Preexisting Conditions.

A commenter suggested that this requirement be deleted or changed so that any determination at time of enrollment would be at the carrier's discretion. The commenter indicated that this is part of some carrier's claim administration. A commenter suggested that the rule be changed to require the enrollee to provided the information within a certain amount of time.

Agency Response. The agency disagrees. No change is necessary. The agency believes it is important to determine, at time of enrollment and issuance of the plan, the applicability of pre-existing condition provisions to the enrollees under the plan. This should help assure prompt payment of claims if carriers already have the information at time of claim. The agency does not agree that the rule should require enrollees to provide all the information needed and within a certain time period. Carriers generally are better equipped to find out the type of information needed to administer the preexisting condition provisions.

Comments Relating to Rating Provisions.

A commenter stated that §26 11(c)(4) appears to go beyond Article 26.36(a) by prohibiting the use of emerging experience to vary the rates of different benefit plans as well as the use of assumptions as to what groups will select different plans. The commenter also indicated that the rule fails to recognize the permitted use of restricted networks when a reduced premium or substantial difference in claim costs result. A commenter indicated that §26.11(c)(6) only provides for carriers to include one separate charge of $5 per month per employee in calculating premiums. The commenter further stated that §26 8(c)(2) allows termination for failure to meet participation requirements. The commenter suggested that carriers be allowed to charge a participation penalty when small employers fail to maintain the participation requirement.

A few commenters stated that the commissioner lacks statutory authority to require prior approval of changes in rating methodology used by small employer carriers to calculate premium rates and that compliance with underwriting and rating requirements is demonstrated by actuarial certification. Three commenters indicated that there is no basis in H. B. 2055 for §26.11(d) relating to establishment of maximum rating factors related to group size.

A commenter suggested changing requirements in §26.11(c)(6) to clarify that the fee applies to only to a covered employee and to consistently use other terms. A commenter indicated the prototype policies should be changed because they imply that rates may change by both policy form and class It was suggested that language be added to include "the same or similar coverage and that the policy provision should specify what rate class is applicable. A commenter suggested that §26.11(a) be changed in the third sentence after the words "is based on," to delete the words "the health carrier's discretion" and insert in their place language relating to objective criteria.

Agency Response. Article 26.36(a) specifically provides that rating factors shall produce premiums for identical groups that differ only by amounts attributable to plan design and that do not reflect differences due to the nature of the groups assumed to select particular health benefit plans, so it would be contrary to statute to allow use of assumptions as to what groups will select. The rule allows differences among base premium rates based solely on reasonable and objective differences in the design and benefits of the plans.

The statute does not provide for charging a participation penalty fee when employers fail to meet participation requirements.

The agency has statutory authority for these sections. Article 26 36 provides for the department to adopt rules to implement the statute and rules to ensure that rating practices are consistent with the purposes of the statute, including rules that ensure that differences in rates charged for each small employer health benefit plan are reasonable and reflect objective differences in plan design. The agency agrees that compliance is demonstrated by actuarial certification; however, TDI must monitor compliance and changes in rating methodology are particularly important to ensure reasonable and objective differences.

As a result of the comments received, however, the agency has revised §26. 11 to remove the prior approval requirements and instead require carriers to file changes in rating methodology 60 days prior to use and provide for the Commissioner to disapprove any such change in rating methodology that fails to comply with requirements of the statute and rules. The use of the disapproval rather than approval process will allow this agency to concentrate on the problems areas and will be less burdensome.

The agency agrees that §26.11(c)(6) should be changed to reference "covered employer" rather than "employee" and "small employer carrier" rather than "small employer health carrier", and this change has been made.

The agency does not believe language or figures need to be changed to include the additional language suggested. Article 26.02(3) requires carriers to base premium rates on classes of business with same or similar coverage. TDI will monitor compliance with the statute.

The agency agrees with the recommendation on removing the carrier discretion language. The statute does not provide for carrier discretion, but requires rates to be determined in a particular manner based on objective criteria. Section 26.11(a) has been changed accordingly.

Comments Relating to Disclosure.

A commenter suggested that §26.12 needed to clarify the meaning of reasonable disclosure because agents will have no way of knowing what a carrier's rating practices are.

Agency Response. The agency does not believe it is necessary to further detail the disclosure required. Furthermore, carriers will have to provide agents with specific rate information as it relates to their health benefit plans for small employers. Rates are not necessarily filed with TDI.

Comments Relating to Fair Marketing

A few commenters indicated that it's not uncommon for agents to have exclusive marketing contracts for certain products or certain associations and that carriers may not want to permit all agents to market small employer plans as provided in §26.13(a). A few commenters stated that the time limits for providing price quotes (within 10 days) and notifying employers of additional needed information (within 5 days) stated in §26.13(c) were too short and 10 should be changed to 20 and 5 should be changed to 10 Also, they indicated it is not clear if the price quote requirements apply to only standard benefit plans or all plans. A few commenters indicated that Article 26 71 required the use of agents but that §26.13(b) and (c) seemed to imply agents were optional A commenter suggested that §26 13(i) be changed to make employers responsible for determining whether the employer's health benefit plan will be subject to the statute A commenter asked for clarification if an HMO must comply with §26.13(b) and (d) A commenter suggested particular language changes in the policy forms (prototypes) concerning rates to limit segregating the market by policy form for rating purposes A commenter stated that it is inappropriate for the Commissioner to have authority to determine whether a small employer carrier has "good cause" to leave the Texas market A commenter requested that §26 13 be changed to delete exclusionary references to HMOs.

Agency Response This provision is from the NAIC Model Regulation and is intended to assure that all small employer health benefit plans are equally marketed and made broadly available. Employers should receive prompt responses and this will help assure that occurs There is no prohibition in the statute for carriers to directly market to small employers The carrier (not the employer) should determine whether or not a health benefit plan is subject to the statute HMO requirements are specifically addressed in these sections

The practice of segregating the market would be subject to the statute and rules and TDI must monitor compliance already

Article 26.22 sets forth conditions under which a small employer carrier is not required to market health benefit plans to small employers. Article 26. 22(e) specifically provides that "if the Commissioner determines" requiring acceptance of small employers would jeopardize the carriers financial condition, the carrier is not required to offer the plans for the period set by the Commissioner

HMOs are not subject to the same requirements as indemnity health carriers since they do not have to offer the three standard plans. Section 26 13 appropriately reflects exceptions provided for under the statute and no change is recommended. No change is made as a result of these comments.

Comments Relating to Filing Requirements.

A commenter objected to the requirement for shell format for SEHPB's and believes it is inappropriate for the department to mandate format changes to previously approved forms.

Agency Response. The agency believes that the shell format requirement must be included in the filing of any small employer health benefit plan not only to streamline the policy form approval process, but also to comply with the proposed conversion rules (§3 3501-3 3512).

A change to clarify the filing requirements is included in §26 19(a).

Comments Relating to Renewability.

A commenter indicated that there appeared to be a conflict with §26 8 of the rules HMOs should be allowed to cancel an individual that fails to maintain the proper patient/physician relationship A commenter asked for the reasons an HMO can terminate/cancel a group A commenter stated that HMOs are usually allowed a 60-day termination without cause and should not be subject to penalties under §26 17

Agency Response The agency disagrees with these comments There is no conflict between the provisions

HMOs normal operation allows this type of cancellation if it is included in the contract

An HMO may cancel or non-renew for the same reasons an indemnity carrier may do so under the prototype plans, cancellation/non-renewal can be due to non-payment of premium, fraud or misrepresentation of material facts, or noncompliance with small employer benefit plan provisions No changes are necessary as a result of these comments

Comments Relating to Filing Requirements

A commenter said that it appears that previously-approved policy forms would be required to be filed and suggested an exemption or a certification process listing the form numbers and approval dates A commenter suggested amending §26 19(c)(12) to include reference to the requirement of filings information relating to Plain Language, Subchapter G

Agency Response Section 26 19(a) does not require a refiling of previously approved forms, however, it should be noted that it is very unlikely that those forms comply with Insurance Code, Chapter 26, and applicable rules New forms or amendments to previously approved forms must be filed to assure compliance The agency agrees that it would be helpful and appropriate to require carriers to file a certification stating which specific previously approved forms the carrier intends to use in the small employer market and therefore §26 19 has been changed to include this requirement

The agency agrees with the comment including the reference to Subchapter G, Plain Language in §26.19(c)(12). The change has been made.

Comments Relating to Reporting Requirements.

A commenter indicated that reporting deadlines in §26 20(b) should be changed to be consistent with existing financial statement reporting requirements because the requested information must come from the same source as the financials. Dates should be (1) May 15, 1994, (2) August 15, 1994, (3) November 15, 1994, and (4) March 15, 1994 Because of the existing financial and tax statement preparation and reporting requirements due on March 1 each year, reporting dates of March 1 in §26 20(e)-(g) should be changed to either March 15 or April 1

A commenter stated that the gross premium reporting requirement deadline of 1/1/94 should be changed to 1/31/94; reporting should only be semi-annual, and rules should detail what is needed in the update. Another commenter stated that quarterly reports should be deleted. Two commenters stated that carriers do not maintain information on zip codes of insured employees and that this would be a costly requirement A commenter indicated that the reporting of numbers of insureds for the various riders would be extremely burdensome. Two commenters recommended deletion of §26 20(b) reporting requirements

Agency Response. The agency believes the dates suggested by one of the commenters (for reporting requirements in §26.20(b) would be acceptable, if it would simplify the process. The dates in §26.20(b) have been changed to correspond to the dates recommended. Section 26 20(f) contains reporting requirements taken directly from the statute, Article 26.07(a), and it would not be appropriate to change a statutory reporting date (March 1) stated in the statute. Other March 1st dates were included to coincide with the statutory date. No change is necessary for those dates

The agency has changed the reporting dates in accordance with another comment, but will not change to a semi-annual report TDI needs to monitor this market closely to determine the effectiveness in the marketplace and to address the need for this type of information The agency has made changes in the reporting requirements of §26 20 to require reporting by zip codes only for the small employer's zip code (not the employees') This should be readily available and will provide necessary information to the agency.

Comments Relating to Cooperatives.

A commenter indicated that this provision allows carriers or TPAs to provide administrative services to a coop and therefore, allows for possible conflict of interest if a carrier is so contracted The commenter further stated that the rules should include a provision that bars a carrier from assuming this role if it intends to participate in the market or require the carrier to make representations that as the provider of administrative services it will not act in any way to further its conflicting interests as a small employer carrier.

A commenter stated that Article 26.15(a)(2) provides for coops to collect premiums to pay for insurance and premiums for administrative expenses however, Congress in 15 USCA, §13(c) provides it is unlawful for an insurer to pay as compensation to a coop any funds since it is a representative of the opposing party.

A commenter suggested that it might be acceptable for carriers to decline parts of a purchasing cooperative.

A commenter indicated that TDI rules should clarify how TDI intends coops to operate and not simply repeat the statute. A commenter expressed concern that people (who have relatively little, if any, presence in Texas) will come to create coops, and may cut corners, fail to properly pay claims and fail to provide what they agreed to (which will continue to make the whole industry look bad).

Agency Response. The agency agrees with the commenter that such a provision is desirable; however, Article 26.15 does not provide any specific requirement for TDI to adopt rules. Additional review and research is needed concerning the department's role in regulating purchasing cooperatives; therefore, no change is recommended at this time.

The cooperatives develop and adopt their own plans of operation, etc., and it is unlikely that a coop would contract with a carrier that is unwilling to write the entire coop. No changes are recommended

Comments Relating to Misrepresentation of Statute or Rule, §26.25.

Two commenters objected to this provision and indicated there was no basis for it in HB 2055.

Agency Response. Carriers and agents are already subject to Article 21.21, and including such in the rule helps assure that they are aware of the law and rules. No change is needed.

Comments Relating to ERISA.

Commenters suggested that the Employees Retirement Income Security Act (ERISA) might preempt the sections of Insurance Code, Chapter 26 dealing with the 75% contribution requirement and the 90% eligible employees participation requirement for small employer health benefit plans. The comments suggest that an Attorney General's opinion be sought by TDI.

Agency Response. The agency does not believe that an AG's opinion is necessary at this time. We recommend that TDI monitor this situation closely; as specific facts are brought to the department's attention (under which specific employers have ERISA plans and preemption is claimed) the agency may consider seeking an opinion from the appropriate regulatory body when the situation warrants No change is recommended at this time.

Comments Relating to Non-Profit.

The commenters suggested that small employer be further defined to include non-profit and not-for-profit entities.

Agency Response. The statutory definition of "small employer" is repeated in the rules from the statute) and it provides that a small employer is a person that is actively engaged in business and that on at least 50% of its working days during the preceding calendar year, employed at least three but not more than 50 eligible employees, including the employees of an affiliated employer, the majority of whom were employed in the state The agency does not believe a change is warranted as the definitions in the statute are clear.

Comments Relating to Guaranteed Issue.

A few commenters indicated that all references to "guaranteed issue" should be removed from the requirements in the rules, particularly in §26.5, since the Legislature may address this in the next session. One commenter expressed concern that whole groups could be excluded if one employee meets the definition of "sick". Other commenters supported the notice requirements concerning the law and guaranteed issue.

Agency Response. The agency disagrees with this comment-we believe that the notice requirements are simply a means to educate and inform the consumer about existing law and if future law changes, rules will be amended to reflect the amended statute, as necessary. Until September 1, 1995, carriers will not be required to issue coverage to small employers on a guaranteed issue basis as provided under the Insurance Code, Chapter 26. The agency recommends no change in this provision of the rules

Comments Relating to Reinsurance Costs A commenter indicated that reinsurance administrative costs were underestimated

Agency Response. Costs associated with reinsurance contemplated under the Insurance Code, Chapter 26 are costs related to the statute, not the rules Furthermore, the reinsurance system will not be operational until September 1, 1995 and the rules require nothing with respect to reinsurance

Comments Relating to Delay Implementation Two commenters requested that implementation be delayed to provide carriers and agents time to comply.

Agency Response. The agency recommends no changes. The effective dates are set by statute

Comments Relating to Eligible Employee and 90-Day Waiting Period

The definition of eligible employee should correspond to the statute A commenter requested a more detailed definition of eligible employee with respect to the requirement that the employee "usually work at least 30 hours per week" Two commenters asked for a waiting period of six-months. One commenter indicated the rules should be consistent with the statute in this regard

Agency Response No change is needed The statute only permits a maximum waiting period of 90 days and the rule contains the same definitions of eligible employee as the statute

Comments Relating to Boycott

A commenter indicated that not allowing the purchase of other full coverage types of policies would coerce the employer and constitute under federal and state law an improper restraint on the business of insurance. This could cause violation of federal law as to boycott or impediment of commerce.

Agency Response. The Insurance Code, Chapter 26, (enacted under HB 2055) applies to all health benefit plans sold to small employers except those specifically excluded. There is no boycott violation involved. No change is recommended.

Comments Relating to Complexity of Rules.

The statute and rules are extremely complex and may result in additional costs to carriers.

Agency Response. The agency agrees that the rules are complex; this is a result of the legislation which is also complex. The agency has attempted to look at all the issues and minimize complexity to the extent possible.

Comments Relating to Certification Forms.

Commenter suggested that a box for the flesch score for any additional or alternate forms submitted would be helpful. A commenter suggested that Certification Form for Prototype Forms be changed to allow the Actuary or Attorney to sign the certification

Agency Response. The agency agrees and has changed Certification Form (Form Number 2055 Cert Prototypes) to include the Flesch score for the alternate forms.

The agency agrees it would be helpful for the certification forms to be consistent and the signature line on the Certification Form for Prototype Forms is changed to state:

"Signature and Title of Person Certifying (on behalf of named carrier) Chief Executive Officer, Actuary, or Attorney for the named Health Carrier"

Comments Relating to Affordable Health Care

Several commenters stated that the purpose of the bill was to keep coverage provided by chapter 26 affordable and to provide small business access to affordable health insurance Comments were also made that every requirement placed upon carriers will increase the cost of health care benefits and that the legislation was a hard-fought compromise Benefits not specified in this legislation should not be included by agency rule. A commenter stated it is difficult and costly to run a small business and urges agency to stay within parameters of legislation.

Agency Response. The agency agrees with the commenters that the purpose of the legislation was to make coverage provided to small employers more available and affordable For this reason, we have attempted to develop the three benefit packages with this always in mind-in developing the benefits and exclusions, we looked at many policies that we have on file and tried to incorporate provisions most common to those forms. Although we would like to provide richer benefits, we have not done so in order to fulfill the legislative purpose of providing affordable insurance.

Comments Relating to Exclusions.

Many comments were received objecting to various exclusions. Many commenters expressed concerns that the ADA would be violated by these rules and/or the exclusions and would leave disabled persons without equitable coverage. Others suggested that the agency adopt the position that the ADA applies to insurance and adopt a rule that contains a definition of "sound actuarial principles", and define the actuarial standards to be used in connection with these policies prior to the implementation of guaranteed issue.

Other comments were received stating that nothing in the ADA required coverage of any specific treatment, that it has no application to the majority of small employers from the EEOC standpoint, that it does not require treatment of experimental or medically unproved methods of treatment just because the patient is disabled, and nothing in the ADA required coverage for weight reduction, eyeglasses or a face-lift. One comment suggested that for many of the exclusions a phrase should be added to provide that the exclusion would not be effective if the need for the item related to a "disability" under the ADA.

Comments specifically objected to the following exclusions: cosmetic surgery for cosmetic disfigurement, obesity, eyeglasses, contact lenses, hearing aids, orthopedic devices, transplants and transplant services, orthopedic shoes, chelation therapy, transplants, orthotic devices, blood, contraceptive devises, infertility medications, injectable drugs, medical social services, outpatient counseling, bereavement, vocational and marital counseling, injury or illness arising out of employment, personal items which are not medically necessary, dental services except as necessitated by accidental injury, transportation including ambulance services, foot care, prescription drug rider and supplementary accidental injury benefit exclusions, services provided by family members, and TMJ. Other specific exceptions are discussed under specific titles in these comments.

Careful and thoughtful comments were provided on all these exclusions, illustrating the needs for the various treatments or items and indicating that treatment in these areas might well be cost effective. Medical personnel testified in writing or in oral testimony concerning the efficacy of many of these treatments. One commenter stated that coverage for services relating to transplants had been contemplated in the prototype insurance plans presented to the legislature. A comment expressed concern about the effect of the cosmetic surgery exclusion on newborn congenital defects

Comments were also received suggesting modified language for some of these exclusions which the comments stated would either broaden, limit, or clarify the exclusions

Other comments were received which indicated that deleting these exclusions would add to the cost of these policies and noting that affordability was one of the key objectives of the underlying legislation, House Bill 2055. Some comments stated that carriers should be allowed to use any exclusions they wanted to and not be required to use exclusions that they do not currently use, and felt that the comprehensive listing of exclusions and limitations were too limiting and were inconsistent with the legislative intent of HB 2055 to increase access to health insurance coverage. Some comments stated that the exclusions were too broad and that more specific exclusions could be drafted. Some comments stated that exclusions were beyond the statutory authority of the agency to promulgate

Agency Response. At the outset, the agency wishes to make it clear that the exclusions discussed are not exclusions for all health plans and do not impact all insurance written under the Insurance Code. These exclusions apply only to the three benefit plans in the small employer market provided for in Insurance Code, Chapter 26. These three plans were designed by the Legislature to be policies which would cover specific kinds of benefits and would provide low-cost, affordable insurance for small employers, their employees and dependents In order to meet this goal, it has been necessary for the agency to allow exclusions which are customary in the insurance market so that the plans are no richer than those plans The legislature specifically removed statutorily mandated benefits from the small employer market and the agency believes that the exclusions which remain in the prototypes are consistent with the legislative intent to provide low cost insurance to small employers The agency believes that inclusion of the exclusions is within its authority as it is necessary to fully define the benefits as required by the Insurance Code, Chapter 26

The agency does not believe that the rules or the exclusions violate the ADA The agency wishes to make certain that health plans in Texas follow both state and federal law with respect to persons with disabilities. The department will carefully monitor the administration of the health plans covered by these rules to insure that state laws protecting the rights of persons with disabilities are followed The Insurance Code, Articles 21 21-3 and 21 21-5 prohibit discrimination against persons based upon disabilities The Department's rules found in Chapter 21, Subchapter H, also prohibit discriminatory practices. These statutes and regulations apply to policies written under the Insurance Code, Chapter 26

With respect to transplants, the agency believes that removing this exclusion would result in increased costs The agency believes this exclusion to be in accord with legislative intent Riders can be added to the standard benefit plan and benefits for transplants could be added through a rider which would be consistent with standard practice in the marketplace With respect to the exclusion for blood, the agency wishes to clarify that this benefit is covered as a miscellaneous hospital service. The exclusion for blood is solely with respect to the prescription drug rider The agency believes that newborn congenital defects are covered by these plans consistent with Insurance Code, Article 3.70-2E With respect to injectable drugs, the exclusion is only for the prescription drug benefit. It does not affect coverage for injectable drugs provided in conjunction with medical care in a hospital (inpatient or outpatient), other covered facility or a physician's office. No changes are necessary with respect to the exclusions listed in the comments to which this response is made.

Comments Relating to Requested Exclusions.

The agency also received comments which requested exclusions be added. Comments asked for exclusions for failure to make appointment, inpatient custodial care, an exclusion for covering illness not received while covered, and a dietary exclusion.

Agency Response. The agency disagrees that these exclusions are necessary. The services may be medically necessary and should not be excluded. Payment for services due to missed appointments, completing insurance forms and medical records should not be added. These items are a cost of doing business The policies are clear on the illness or injury which is covered by them, and no further exclusion is necessary.

Comments Relating to Exclusions for Services or Treatment in a Government Hospital and Treatment in a Veterans Hospital.

Comments were received expressing concern that these exclusions might require insured persons to pay for services in government-supported and VA hospitals which were actually billed to them.

Agency Response. The agency believes the prototype plans are clear that only service-connected disability treatment in a VA hospital is excluded. With respect to services in a government-supported hospital, the agency has made a change to clarify that services the insured is obligated to pay are not excluded. In Figures 28, 36, 43, 50, 52, 53, 56, 58 and 59, the following language will be included in the government hospital exclusion: "Services or treatment provided in a government hospital, unless there is a legal obligation to pay. This does not exclude coverage for treatment of mental health and mental retardation provided by a tax-supported institution of the State of Texas, including community centers for mental health and mental retardation services, provided charges are regularly and customarily charged to non-indigent patients."

Comments Relating to Abortions.

A large number of comments were received on this issue. Some comments stated that the issue of abortion should be left to the insurer and insured. Other comments supported coverage for all elective abortions due to cost savings and a need for reduction in unwanted and unintended pregnancies Some comments were concerned about the phrase "non-viable fetus" because it was felt that this phrase would allow abortions other than non-elective (therapeutic) abortions. Some comments suggested that citizen participation was not invited and that the decision on abortion had already been made and agreed to by the Governor's office, staff, and special interest groups Many comments were received objecting coverage for abortions under any circumstances and others objected to coverage for abortion except when the life of the mother would be endangered, while others felt coverage should be allowed for all medi-

cally necessary or appropriate abortions.

Agency Response. The exclusion initially proposed was included because the agency staff believed that it was necessary to address this issue in order to describe the benefits as required by the statute. There was no agreement by anyone to ignore citizen input or to provide any specific coverage for abortions. The staff simply believed that this exclusion was necessary to fully explain the benefits available, and therefore proposed such an exclusion. Following the comment period, the agency has decided that in order to fulfill the legislative intent of allowing this decision to be one which is made between the employers and the carriers, changes will be made in the rules in §26.14 to read:

"Exclusions of elective abortions, if any, are to be determined by an agreement between the employer and the small employer carrier and must be included in the Exclusions and Limitations of the policy, certificate and/or outline of coverage." Similar language will be placed in §26.14 to cover HMOs. The prototype plans will be changed to indicate where the exclusion would be placed if the carrier chooses to use one, in Figures 28, 36, 43, 50, 52, 53, 56, 58, 59 and 62 (HMO)

Comments Relating to Attempted Suicide/Intentional Self-Inflicted Injury.

Several commenters objected to elimination of the usual policy exclusion for attempted suicide or self-inflicted injury. Some comments suggested that the exclusion be deleted as it might interfere with mental health service coverage. Other commenters indicated that the exclusion was necessary to control costs and one comment suggested that removal of the exclusion from the Supplementary Accidental Injury Benefit Rider is ridiculous.

Agency Response. The agency believes that health insurance, unlike other kinds of coverage, should be essentially "no-fault". The exclusion will be left out of the prototypes The agency did not intend, however, to remove the exclusion from the Supplementary Accidental Injury Rider, Figure 37, and it will be put into that rider to read as an exclusion for an injury as a result of attempted suicide or intentionally self-inflicted injury. Such injuries are not accidents and should be excluded

Comments Relating to Dependency on or Addition to Tobacco/Smoking Cessation.

Comments were received in support of including such an exclusion on the grounds of reducing costs. Other comments were received concerning the efficacy of those programs, stating that in the long term, these programs would be cost effective in view of the danger smoking presented to life and health. Another commenter felt that the prescription drug rider would require nicotine patches which were quite expensive for very little success

Agency Response. The agency would like to see good smoking cessation programs provided for by these plans. Because there is inadequate information to allow for definitions which would cover good programs, at this time the agency will include an exclusion for these services. The department will seek to get further information on these programs and an appropriately limited benefit may be added to these rules by amendments at a later date. The exclusion will be added to Appendix, §26.17, Figures 28, 29, 36, 43, 50, 51, 52, 56, 58, 59, 61 (HMO).

Comments Relating to Exclusion for Illegal Occupation or Illegal Activity and Participation in a Riot.

Some comments were received stated that the phrase "illegal activity" was preferably to "felonious activity", as used in the exclusions. Other commenters felt there should be no such exclusion as these exclusions were inappropriate in a health policy, while still others felt the exclusion should be included as published.

Agency Response.

The agency believes these exclusion should be included as a cost-reducing measure and as being consistent with the marketplace. Felonious activity will be the phrase used as that more clearly delineates the conduct involved No change is necessary.

Comments Relating to Definitions of Experimental or Investigational Treatments, Off-Label Use of Drugs.

Comments stated that the commenters supported the definitions contained in the draft prior to publication as they believed that these definitions were a reasonable approach to such decisions and should be added to the published prototypes. There were also numerous comments received from organizations, citizens and medical professionals indicating that broad exclusions of these services would result in the inability of persons to get efficacious treatment that would at times actually be cost-effective Some comments suggested various modifications, including those intended to be consistent with either federal guidelines or professional practice guidelines

Agency Response The agency believes that the definitions need to be amended from the published version to be specific so that insureds would know what would and would not be covered. The amended definitions will more closely follow federal practices and help define the benefits section, and result in a more cost-effective and standardized plan, and conforming changes are made to the title of the exclusion The changes will be made to §26 27, Appendix, Figures 26, 28, 29, 34, 36, 41, 42, 43 , 50, 51, 52, 53, 56, 58, 59, and 62 (HMO).

Comments Relating to Clinical Ecology and Environmental Sensitivity.

Some comments stated that this definition and exclusion is often included in group health insurance policies as employers have been reluctant to pay for health benefit payments for some of these services As this is a new field there is little information to make claim determinations Other comments supported removing the exclusion as the treatment is necessary, in the public interest and efficacious.

Agency Response. The agency agrees that there should be no exclusion in this area and will leave the prototype plans as they were published without the exclusion.

Comments Relating to Definition of Medical Necessity.

Comments noted that while cost is an important concern, the appropriateness of care for the patient should be the central consideration of any definition of "medically necessary". Other comments noted that this definition must be precise and advocated that insurers be allowed to use their own and furnished sample language.

Agency Response The language in this definition has been modified in Figures 26, 34, 41, and 62 to provide greater clarity. The change includes physicians who diagnose and refers to licensed practitioners who diagnose or treat the injury or illness.

Comments Relating to Appeals Process in the Definition of Medical Necessity

Some comments objected to any required dispute resolution and stated such a requirement would weaken the acceptance of these plans in the marketplace as it is not a normal or usual provision in health insurance policies. The comments stated that if the process was included the carrier should not be required to pay 90% of the cost Other comments supported the addition of an appeals process and requested further appeals processes in emergency care, reasonable and customary, and experimental definition areas

Agency Response The agency believes there should be a good appeals process provided, but does not believe this appeals process is workable The agency will delete this requirement entirely This area will be revisited after more study and may be addressed in future amendments to these rules The appeals process provision will be deleted from Figures 26, 27, 34, 38, 41 and 42 of §26 27, Appendix

Comments Relating to Home Health Care Services

Several commenters stated they supported the inclusion of Home Health services as defined in the published rules and that the services published are consistent with the legislative intent of both the Insurance Code, Chapter 26, and Chapter 142 of the Health and Safety Code entitled Home and Community Support Services Continuing to allow the delegation of services to unlicensed personnel is less expensive that the cost of benefits provided by nurses and other health care providers

Several commenters requested that the benefits of Home Health be expanded to include "Respite".

The commenters support the inclusion of Home Health Services, and specifically encourage the continued inclusion of services delegated to unlicensed personnel. The commenters recommend that the Home Health Benefit include Respite Services

Commenter encourages consistency with HB 1551, definition of Home Health benefit as home and community support and use of definitions and allowable services as detailed in HB 1551

Several commenters stated that the published version exceeds the legislative intent by including benefits/services that were not listed in the Insurance Code, Chapter 26 or the Insurance Code, Article 3.70-3B and that if the legislature intended for the services that are listed in the Texas Health and Safety Code to be included, the legislature would have said so. Commenters stated that some of the services provided (social services and nutritional services) are not usually considered medically necessary treatment services The commenters also stated that the expansion of services will increase the cost of the plans. These commenters recommended that benefits be restored to the prior draft proposed by department staff One commenter stated that the certification that "hospitalization or confinement in a Skilled Nursing Facility would otherwise be required" in the preventive and primary plan and rider (Figures 27 and 38) did not comply with §26.45(a). They also stated that this would increase cost as services could only be obtained if confined in a hospital or skilled nursing facility.

Agency Response. The agency believes that benefits for Home Health Services in the prototype forms should include only those services specifically listed in of Insurance Code, Article 3.70-3B, §1, as it believes that the legislature intended to include the services actually listed in that statute The only list of services in Article 3 70-3B is that contained in §1.

This change will also make the plans cost effective. The "certification that hospitalization or skilled nursing confinement would otherwise be required" would not result in increased cost as the certification is not time specific. The certification does not require hospitalization or skilled nursing confinement be immediately required

Comments Relating to Rental or Purchase of Durable Medical Equipment

A commenter stated that the published version includes repair and maintenance of purchased equipment, not otherwise provided for under a manufacturer's warranty or purchase agreement. This is a relatively minor item, but may well produce disagreements when equipment is damaged by the user of the equipment Commenters noted that regulations extend coverage to items which were not included in legislation or the rule (repair and maintenance of purchased medical equipment) which will increase the cost of the plans and thwart the intended objective of the legislation-affordable health insurance, and was unauthorized by statute One commenter recommended adding a provision to the benefit that insurers cannot rent or purchase such equipment from entities owned or controlled by the prescribing provider Many commenters noted DME is essential for disabled persons, is cost effective, and this provision adds very little to the overall cost of the plans. One commenter supports the continued inclusion of Durable Medical Equipment (DME) (rental/purchase and repair/maintenance) as a benefit, and suggests that the benefit include rental of DME for as long as is necessary to maintain the insured's health and functioning, rather than discontinuing rental once the rental costs equal the purchase price of specific equipment.

Agency Response. The agency believes that a benefit for rental or purchase of durable medical equipment required for therapeutic use as provided in the published version is an important benefit which should remain in the prototype plans. Repair and maintenance of purchased equipment should remain as a part of the benefit for durable medical equipment based on comments that this is a relatively minor item and that it is relatively inexpensive and will be more cost-effective in the long run than replacing equipment. The agency does not believe that a restriction of entities owned or controlled by a prescribing provider is a matter that should be addressed in these rules and prototype forms No change is necessary

Comments Relating to Preventive and Primary Benefit Plan and Rider.

A commenter stated that Figure 38 should include as a covered service purchase or rental of durable medical equipment and oxygen and the rental of equipment for its administration as such is covered in Figure 27 Commenter also stated that terminology, capitalization and reference should be consistent between the two Figures

Agency Response. The agency agrees Figure 27 and 38 are amended so that terminology, capitalization is consistent and that Figure 38 be amended to include the following covered services· "Rental or purchase price, at Our option, of durable medical equipment required for therapeutic use, including repairs and necessary maintenance of purchased equipment, not otherwise provided for under a manufacturer's warranty or purchase agreement, Oxygen and the rental of equipment for its administration".

Comments Relating to Definitions of Hospital.

Commenter requests flexibility in the definition of "hospital" to permit carriers with special statutory rights to contract with hospitals to use their long-standing definition.

Agency Response The agency believes that consideration should be given to allow flexibility in establishing criteria for hospitals with whom certain carriers contract under special statutory rights (the Insurance Code, Chapter 20)

The agency will add variability to the Definition of Hospital in all prototype plans with explanation in §26 14 that variable is allowed only for additional criteria for purposes of clarification or to accommodate carriers with unique operations and special statutory rights, such as Chapter 20 See agency response The agency believes no change is necessary to provide flexibility

Comments Relating to Definition of Policy Year

Commenter expresses concern that their company's system for claim payments is set up on a calendar-year basis

Agency Response Sections 26 4 , 26 14, and 26 27-Appendix (Figures 26, 34, and 41) allow a "Policy Year" to be a 365-day period that begins on the anniversary of the Policy's Effective Date or a period of one full calendar-year for the carrier to select the definition that is consistent with their practices.

Comments Relating to Definition of Complication of Pregnancy.

Commenter stated definition appears to limit coverage to those circumstances requiring hospital confinement. Suggested hospital confinement requirement be deleted because there could be circumstances which would not require the more expensive hospital confinement and could be treated on an outpatient basis.

Agency Response. The agency believes the definition of Complication of Pregnancy, as defined in Subchapter E, §21.405, is a fair and equitable definition and no change is warranted.

Comments Relating to Prescription Drugs.

A commenter stated that name-brand drugs, at times, are actually cheaper than the generic drugs. The suggestion made was that a clause be added that name-brand drugs would be covered when the name-brand is cheaper than the generic. Another commenter stated that patients who need the appropriate medication for the illness diagnosed should not be penalized by having to pay a higher co-pay because it is a name brand drug, and many new and improved medications do not have a generic equivalent.

Agency Response. The agency agrees and has amended the figures to state; the "Charges for Name Brand Drugs will only be covered if there is no Generic Drug available or if the Physician, Provider, or Other Health Care Practitioner specifically prescribes a Name Brand Drug for the Insured Person and Generic selection is not permitted, or if cost of Name Brand Drug is less than cost of the Generic Drug, and recommends Figures 24, 25, 39, and 40 and amended by adding the following to the Prescription Drug Card Program rider provision· Generic Drug or Name Brand Drug if less than Generic Drug

Comments Relating to Maternity Benefits in In-Hospital Plan.

The commenter asked: Shouldn't maternity benefits be included in the In-Hospital Plan?

Agency Response. The definition of Illness includes pregnancy, therefore, maternity benefits are included in the In-hospital Plan, and no change is needed

Comments· Relating to Standard Benefit Plan-Benefits

Commenter asks if a limit should be used in the Standard Health Benefit Plan for diagnostic exams, laboratory, and x-rays as is provided in the Preventive and Primary Plan.

Agency Response The limitation for diagnostic exams, laboratory and x-rays services is included in the Preventive and Primary Care Benefit Plan and not included in the Standard Health Benefit Plan as required by Chapter 26, the Insurance Code No change is required

Comments Relating to Mental Health and Chemical Dependency Services

A commenter suggests removing all day and visit limits and provide full equality between mental health and physical health coverage. Another commenter asked that because the Standard Health Plan has a $100. limit per outpatient visits for mental health services, this limit also apply to the Preventive and Primary Care benefits.

Agency Response. The agency disagrees These limits are taken directly from the statute, Article 26.45(c)(8) and Article 26.47(8)(A)(B). Therefore, such change would not be warranted. The $100. limit per outpatient visits for mental health services in the Standard Health Plan is taken directly from statute, Article 26.47(8)(B). Since this limit is not set out by statute in the Preventive and Primary Plan, no change is warranted

Comments Relating to PPO.

A commenter stated that every insured should have the right to have their chosen physician provide services covered under the plan as long as the physician is willing to provide the services under the reasonable terms and conditions of the policy. To unduly restrict this right is detrimental to the patient and physician. The PPO rules should apply as it relates to patient and physician rights Another commenter noted that the rules allow a 30% differentiation in reimbursement between preferred and non preferred providers The schedule of benefits allows a 30% difference only when 100% reimbursement is used for the preferred provider. The PPO differential seen most frequently in the marketplace are 80/70, 80/60, 90/70, and 90/60 Only one of these (90/70) is allowed by the prototype and asked why emergency care paid 100%.

Agency Response The agency believes §26.21 of the proposed rule allowing restricted network of providers is in accordance with the Insurance Code, Chapter 26 and therefore no change is necessary. The agency agrees that an additional variable should be added to the reimbursement percentages offered under preferred provider plans. A variable of 80% has been added in the PPO schedules of benefits for the In-Hospital Benefit Plan and the Standard Benefit Plan, Figures 31 and 40 respectively, and a corresponding change has been made in §26.14.

Departmental PPO rules and Figure 48 require emergency care to be paid at the preferred provider level, which is not always 100%.

Comments Relating to Alcohol and Substance Abuse-Waiver.

Commenter stated that Article 26.47A (which allows carriers to offer the preventive and primary plan or the standard plan without providing alcohol and substance abuse to employees if 50% of more employees request waiver and certify in writing that they have undergone alcohol or substance abuse counseling in the last 3 years and the exclusion of coverage would only apply to those employees who so certify) will be difficult if not impossible to administer.

Agency Response. The waiver is required by statute. Figure 49 is a prototype form which may assist carriers in implementing this provision.

Comments Relating to Childhood Immunizations.

A commenter stated that pertussis(whooping cough) should be added to the list of immunizations.

Agency Response The agency agrees Pertussis(DPT) was inadvertently left off the list of immunizations It has now been included See Figure 26

Comments Relating to Deductibles

A commenter asked that the agency limit the use of deductibles for well-child care Many families could not afford it and would not seek the care.

Agency Response The agency disagrees Articles 26 45 and 26 47 are very specific as to when deductibles or for what benefits deductibles can be waived. Well-child care was NOT specified as a benefit for which the deductible could be waived No change will be made

Comments Relating to Child of the Spouse

The commenter states "The proposed regulation conflicts with Article 26 02(7) in that it adds a new category of dependent child, a child of the employees spouse, and the Insurance Code does not require stepchildren to be covered, not even in Article 3 70-2(M)(1)

Agency Response The agency believes a definition of "Child" is needed for clarification of the Insurance Code, Article 26 02(7) Article 3 70-2(M) requires the natural-born or adopted child of the spouse be covered, provided the child resides with the insured person No change will be made

Comments Relating to Adopted Child

Comments stated the general definitions in the rule should conform not only to "HB 2055" but also to Article 3 51-6, §3D(c) and also requested deletion of the language "including a child who the enrollee is seeking to adopt" as being vague and because the child is not a dependent.

Agency Response The Insurance code, Article 3 51-6 and Article 3 70-2(K) were amended by the 73rd Legislative Session to provide that an adopted child is considered the child of an insured if the insured is a party in a suit in which the adoption of the child is sought The rule is clear that the enrollee must be seeking to adopt the child No change is needed

Comments Relating to Newborn Child

Comments requested that the word "covered" be included in §26 9(a)(3) as follows

Any coverage of a newborn child of a covered employee under this subsection terminates on the 31st day ", that §26 14(g)(6)(C) be amended by changing the word "allows" to "provides" and the word "insured" to "covered", and noted that the allowed variable in §26 14(g)(6)(C) appears to conflict with the provisions of §26 9(a)(3) One commenter recommended a change to §26 9 and the corresponding prototype forms relating to the payment of the additional premium within the 30-day period, noting that the period is problematical when the employer/insured billing cycle does not coincide with the 30-day premium payment requirement.

Agency Response. The agency disagrees with the first of these comments The language questioned is clarified by the preceding language of the rule The changes suggested are not needed The agency believes the "31 day" concerns refer to the language regarding a premium charge for the "31 day" coverage in §26 14 and the language regarding receipt of the additional premium not later than the "30th" day after birth in §26 9 There is no conflict as Article 26 21(j) requires that coverage for a newborn be provided for "31 days" and that coverage terminates after the "31 days" unless notification of the birth and any required premium is received not later than the "30th day" after birth The agency agrees with the last comment and a sentence has been added to §26 9 to provide that coverage of the newborn shall not be terminated if the carrier's billing cycle does not coincide with the 30-day requirement until the next billing cycle has occurred and there has been nonpayment of the additional required premium for a period of 30 days after the due date Figures 20 and 21 will be changed accordingly

Comments Relating to Free Look Period

A commenter stated that this provision appears to be optional If so, there is no objection If mandatory, the comment stated there is no statutory authority for the provision It makes sense when used in individual polices but not in group policies, and may lead to litigation and exceeds statutory authority

Agency Response Figures 1-9 are face pages for group policies All nine face pages for group coverage have the 10-day free look provision bracketed, indicating that the language is variable For clarification, staff recommends the following language be added to §26 14(g) the small employer carrier may include or omit the variable provision addressing the free look period

Figures 10-12 are face pages for individual contracts The 10-day free look provision is not bracketed on these forms as the Insurance Code, Article 3 70-3(A)(8), mandates that all individual policies contain a 10-day free look provision, therefore, no change is needed in proposed rule or forms

Comments Relating to Variable Termination Provisions

Commenter questions the variable for termination due to failure to maintain status as a small employer carrier

Agency Response The agency disagrees, and believes the provision is consistent with §26 5 relating to Applicability and Scope, and no change is necessary

Comments Relating to Grace Period

A commenter states its products currently do not provide coverage for expenses incurred during the Grace Period

Agency Response No change is needed in either the rule or the proposed form as Pro-

posed Figure 22, the Group Provisions, reflects that the Grace Period is a variable provision as does the corresponding proposed rule, §26.14(g)(8)(E) and

Proposed Figure 23, the Individual Provisions, does not allow the Grace Period to be variable as it is required by the Insurance Code, Article 3.70-3(A)(3).

Comments Relating to Eligible Employee and Actively-At-Work Requirement.

The prototype policies do not include the requirement of actively-at-work which is generally required in group contracts. This requirement is implicit in HB 2055 in that the bill contains minimum hours of work per week before an employee is considered an eligible employee. Without such requirement it is implied that people who are not full-time employees because of long-term disabilities will be covered when in fact those people cannot satisfy the minimum hours per week requirement by HB 2055.

Agency Response. The agency disagrees The prototype policies and proposed rules include the requirements of the Insurance Code, Chapter 26 with regard to eligible employee Although "actively-at-work" is not used in the prototype policies nor in the Insurance Code, Chapter 26, the requirement that an eligible employee be an employee who works on a full-time basis and who usually works at least 30 hours a week follows the statutory definition and is contained in the Eligibility For Coverage provision of each of the prototype policies. This provision also specifies what the term "eligible employee" does not include The proposed rules define "eligible employee" in §26 4. No change is necessary

Comments Relating to Eligible Employee Provisions.

A comment stated that §26 14(g)(6)(F) should be revised to read The Eligible employees and Dependents provisions under Termination of Insurance allow variables for continued coverage for a covered employee who is on an approved leave of absence for a specified period of time to be inserted if the provision remains. This provision shall be included or omitted as appropriate " This will clarify the applicability of the provision to covered employees only.

Agency Response The agency disagrees The word "covered" does not need to be included in the rule The Termination of Insurance provision of Figure 20 clarifies to whom termination applies and Figures 26, 34 and 41 define employee as "you, the principal insured, hereafter referred to as "you.""

Comments Relating to Preexisting Conditions/Late Enrollees

Commenter believes the optional preexisting condition provisions should include variables for the time period up to 12 months to allow a shorter period of time.

Agency Response. The agency agrees that the provisions for preexisitng condition and late enrollees should provide variability for the time period(s) to allow for shorter periods of time as elected by the small employer carrier

The preexisting conditions and late enrollee provisions in the prototype forms will be marked variable and the following language is added to the preexisting and late enrollee provisions in §26.14 of the rules to describe the variability "The time period[s] is/are variable to allow a shorter period of time if elected by the small employer carrier."

Comments Relating to Claims Process.

Comments stated that the prototype plans merged the provisions of Article 21.55, Prompt Payment of Claims, with the standard provisions required by Article 3.51-6. The mixture of these provisions results in conflicting, confusing statements. Further, Article 21 55 applies only to first-party claims, i.e a claim made by an employee, and it is inapplicable to third- party claims. The prototypes and Article 21.55 conflict with and are preempted by ERISA. Claim payment provisions should adhere to notice requirements in Article 21.21-2, Unfair Claims Settlement Practices Act

Agency Response The agency disagrees The prototype forms include the language contained in Article 21.55 and the required provisions of Article 3 51-6 and/or Article 3 70-3(A), relating to claim filing and claim processing procedures that must be followed by insurers. The Figures in question are not mandated forms that must be used. Carriers may or may not utilize the recommended language/forms

Comments Relating to Payment of Claims.

A comment stated that the plans state that any benefits unpaid at the insured's death will be paid to the insured's beneficiary or, if no beneficiary, to the estate. The term 'beneficiary" is a life insurance term. There is no beneficiary in a health policy. Most carriers pay benefits due a deceased insured to the surviving spouse, and if no spouse, to the estate

Agency Response The agency disagrees. Beneficiary is addressed in Insurance Code, Article 3.70-3(A)(9) and (12), (required provisions for individual health contracts) and Article 3 51-6 § 3, (provisions for group health contract). Additionally the term "beneficiary" is contained in the definitions portion of each of the prototype forms

Comments Relating to Rescission of Coverage.

Several commenters stated carriers should be allowed to rescind coverage for fraud or material misrepresentation and should not have to continue paying claims on such persons until the next renewal date. A suggestion was made that the following language be added to §26.16 A small employer carrier may rescind or refuse to renew the coverage of an eligible employee or dependent for fraud or misrepresentation of a material fact by that individual

Agency Response The agency agrees clarification is needed To address this concern, §26.16(b) is amended to read "The coverage is also subject to any provisions relating to incontestability or time limit on certain defenses"

Comments Relating to Conversion/Continuation.

A commenter stated that the intent of this provision is not clear Suggested deleting the language "Coverage under a conversion or continuation of" and begin the sentence with "All small employer health benefit plans...". Commenter also suggested that the same change be made in the HMO portion of this rule

Agency Response. The agency agrees that the suggested language is needed for the indemnity coverage and it is included in §26 15(d).

Comments Relating to Continuation/Conversion Variable Upon Policy Termination

A commenter states the rule section fails to include the variable explanation for prototype form 2055 COP (Figure 46).

Agency Response. The agency agrees and the following variable explanation is added to §26.14(h)(4)(B)

"The small employer carrier shall include one of the variable provisions for continuation upon policy termination."

Comments Relating to Conversion and Continuation Provision.

A commenter stated that as a result of comments received to the published version of Subchapter F-Group Health Insurance Mandatory Conversion Privilege, §§3.501-3.512, changes are necessary to this section for consistency.

Agency Response. The agency agrees Figure 46 (Form 2055 COP) now reads: "1. the termination of coverage occurred because you failed to pay any required premium or any discontinued group coverage was replaced by similar group coverage within 31 days of the discontinuance, or. . . .".

Comments Relating to COBRA.

Commenters asked that the prototypes mention a COBRA requirement.

Agency Response. The agency does not agree with the recommendation. Since COBRA is a federal law, we believe that it would be inappropriate for us to attempt to develop language addressing requirements that are not regulated by this Department. Furthermore, applicability of COBRA is limited to those employers of 20 or more and would not apply universally to all small employers

The current regulation permits insurers to develop additional provisions as appropriate and needed for inclusion in the prototype policies with approval by the Department. Necessary provisions describing COBRA options as developed and filed by insurers could be included when appropriate.

Comments Relating to Coordination of Benefits.

Commenters objected to requiring individual policies to contain coordination of benefit provisions, and requested the provisions be changed to refer to reduction of benefit rules instead of coordination of benefits and allow the consumer to determine which plan is the primary plan, and to withdraw the form until

such time as the proposed rules for coordination of benefits are adopted. Comments also objected to the "Right to Receive and Release Needed Information" provision, suggested language changes to this provision, and expressed concerns regarding subrogation and coordination of benefits and the term "third party" as used in the rules and concerns that disputes between insurer and third-party or between insurer and insured could result in lapse in benefits and needed services.

Agency Response. The agency believes that a coordination of benefits provision is necessary in all small employer health benefit group or individual. The prototype form is consistent with the rules proposed and authorized under the Insurance Code, Chapter 26 and generally follow the NAIC Model Act and Regulation for Coordination of Benefits. The majority of group carriers already follow the NAIC rules. Staff believes that the provisions for Subrogation and Coordination of Benefits are clear and that the concern expressed regarding lapse in benefits and needed services would be prohibited under the Unfair Claim Settlement Practices Act.

The agency does agree with the comment regarding the "Right to Receive" provision and language will be changed in the provision of the prototype form as follows.

RIGHT TO RECEIVE AND

RELEASE NEEDED INFORMATION

Certain facts are needed to apply these COB rules. We may get material facts from each person claiming benefits and also gather material facts from or give them to any other insurance company or health benefit plan administrator with whom we coordinate benefits See Figure 47.

Comments Specific to HMOS.

Comments Relating to Exclusions (HMO's)

Comments were received stating that the HMO Prototype plans are missing some standard exclusions which are very important because they allow the HMO to provide benefits in a more cost effective manner. As the prototype plans are plans which HMOs are only encouraged to offer in the small employer market, the comment suggests that HMOs should add standard exclusionary language from their existing policy forms to any submitted HMO prototype forms if the department does not include these typical exclusions

Agency Response. The agency disagrees. No change is necessary as the prototypes are consistent with the Insurance Code, Chapter 26. The language in the prototypes is not optional. The agency has, however, changed the HMO prototype plans to incorporate those standard exclusions that are allowed under the indemnity plans to the extent that their inclusion is consistent with standard HMO practice. The changes are in Figures 61 and 62 and include the following exclusions A provision was also added in Figure 62 for HMOs entitled H2d Provision for Required Premium Contribution. Exclusions which were changed:

4. Injury or illness arising out of employment

6. Transportation except for ground ambulance or air services

11. Charges for treatment of experimental or investigational.

12. Elective abortions.

13. Services in connection with treatment for infertility and in-vitro fertilization

20. Services in connection with routine foot care

39. Services for treatment of transplants.

Exclusions which were added

37. Services in connection with act of war or during active service in the armed services.

40 Any medical social services or vocational counseling.

41 Addiction to tobacco Exclusion deleted·

34. Service associated with autopsy

Comments Relating to §26 4 Definition of Premium

A comment was made that language should be added to clarify that payment of a co-payment or deductible is not a charge associated with a premium

Agency Response The agency believes that the rule is clear regarding this matter No change is necessary

Comments Relating to §26 14(H)

Comments stated that the rule should be clarified to address that the percentage payable refers to the percentage payable by the carrier and the rule should be redrafted to delete the reference to $8 00 and $12

Agency Response The agency does not believe that such changes in language are necessary. The deletion of the dollar amounts language would increase the variability of the plans

Comments Relating to Prescription Drug Benefits

A comment states that the prescription drug benefit is overly broad and could result in an HMO being required to cover any prescription a primary care physician writes This will make the coverage less affordable due to the excessive use of this benefit

Agency Response The agency agrees that the benefit as published was overly broad and is changing the language to be consistent with the benefit levels offered in the indemnity rider, in Figure 61

Comments to Plain Language Requirement

A comment stated that compliance with the Plain Language Requirements is costly because it will be costly to reprint contract materials

Agency Response Compliance is required by statute No change is necessary

Comments Relating to Serious Mental Illness

A comment stated that unlimited Serious Mental Illness coverage is prohibitive

Agency Response This coverage is statutory. No change is necessary.

Comments Relating to Benefits: Home Health Visits Requirement.

A comment stated that 40 Home Health visits per contract year is excessive.

Agency Response. This benefit is set by statute for the Standard plan. No change is needed.

Comments Relating to Benefits.

A comment stated that 40 out-patient visits and 90 inpatient days for mental health is excessive.

Agency Response. This benefit level is set by statute for the Standard Plan No change is necessary.

Comments Relating to Deductible.

A comment stated that application of a deductible based on a percent of billed charges is very difficult for an HMO. We recommend HMOs have the option of a $0-$500 deductible on the standard plan with standard co-payments for physician visits.

Agency Response The agency agrees. Allowing a $0 deductible is more beneficial to the consumer, and it will not require HMOs to change their current operations. This change is made in Figure 62.

Comments Relating to Clarity of Rule Regarding and HMO Offering a Plan Which Meets Federal Requirements.

Comments stated that it should be made clear that the type of plan authorized by Article 24 48 does not require an HMO to be federally-qualified as this would penalize an HMO which is seeking but has not received its federal qualification.

Agency Response. The agency believes this is clearly stated in the current rules, and no change is necessary

Comments Relating to Federally Qualified HMO's

Comments were received stating that an HMO should be allowed to offer its current federally-qualified plan and comply with other provisions of federal qualification; the HMO Primary and Preventive Care and HMO Standard plans fail to meet the requirements of a federally-qualified plan, and federally- qualified HMOs should not have to comply with the provisions of HB 2055 except for the benefit plan structure as they are already meeting many of the requirements of House Bill 2055 when they offer a federally-qualified benefit plan.

Agency Response Implicit in this comment is that if an HMO offers a federally-qualified benefit plan, it does not have to comply with the requirements of the Insurance Code, Chapter 26 The agency disagrees with this position There is no apparent statutory intent to exclude federally- qualified HMOs from those regulatory requirements. The 1988 amendments to the Federal HMO Act allow a federally-qualified HMO to offer a plan which does not provide the federally required benefit levels if certain conditions are meet. There is no apparent statutory intent to exclude federally-qualified HMOs from the Insurance

Code, Chapter 26, regulatory requirements, however, HMOs are not required to offer the three plans described in Subchapter E of the Insurance Code, Chapter 26; under the Insurance Code, Article 26.48.

Comments Relating to Emergency Services Outside of the Service Area.

Comments were received stating that the provision for Emergency Care Outside of the Service Area which is contained in the HMO prototype plans is loosely written and could result in HMOs being required to cover services provided outside of the service area for non-emergency care.

Agency Response The agency agrees and the definition will be clarified to more closely reflect standard HMO practice of providing only emergency care outside of the service area

Comments Relating to Important Notice Requirement

A comment was received asking why the HMOs can't use their "regular" important notice language instead of the important notice language contained in the prototype plans?

Agency Response. The Important Notice language referred to is the notice of Toll-Free numbers and complaint numbers which is required by §1.601. The notice in the HMO prototype forms is taken from the regulation and includes optional language The HMOs may continue to use their previously approved documents. No change is necessary.

Comments Relating to Figure 62, HMO Certificate of Coverage.

A comment stated that as not every HMO mandates the selection of Primary Care Physicians, all references to this requirement should be deleted

Agency Response. The agency will change the language which would require an enrollee to choose a primary care physician to variable language which may be included or excluded according to the HMO's standard operations.

Comments Relating to Figures 60 and 61 HMO Schedules of Benefits.

A comment stated that it is unreasonable to expect that you must notify your primary care physician prior to receiving emergency care.

Agency Response. Current language is used in an effort to keep costs down and to alert the enrollee that if they receive care from an out-of-network provider for non-emergency care, they will be responsible for the costs associated with this care The department will monitor the effectiveness of this rule in accomplishing its intended purpose No change is necessary at this time

Comments Relating to Coverage for Spouse of an Individual if Ordered

A comment stated that this is not in the law that I have read and should be removed

Agency Response. The language referred to defines who is not a "late enrollee" and is statutory. No change is necessary

Comments Relating to Late Enrollee.

A comment stated that the regulations do not clearly explain how or when a "late enrollee" is to be covered They should be required to furnish evidence of good health or wait until the next open enrollment period

Agency Response The agency disagrees with this comment, but has made a change to the definition in Figure 62. The regulations state that a person may be enrolled only during initial enrollment, an open enrollment period, or upon meeting the group's eligibility requirements Therefore, a late enrollee could only be enrolled during an open enrollment period or upon meeting the group's eligibility requirements However, as a result of this comment, the agency has made a change to the definition of late enrollee in the HMO/Prototype Plans that is consistent with the statute and regulations

Comments Relating to §26 9A(1)

A comment stated that this rule should include a provision which allows an HMO to limit enrollment due to it's inability to provide services to new enrollees due to existing commitments

Agency Response The agency agrees The prototype plan given to the board was changed to more correctly reflect the statutory definition of late enrollee in Figure 62

The comments made in connection with these sections were made on the basis of issues involved in the sections which often affected more than one section The comments are listed as being against the sections, but were actually for or against particular provisions of the sections as originally published The summary of the comments describes the positions of commenters for and against certain issues

Commenting against

Abortion Rights Action Legal, Advocacy, Incorporated, Aetna Life Insurance Company (Aetna Health Plans), American Cancer Society Texas Division, Inc , American Chambers Life Insurance Company, American Medical Security, American National Insurance Company, American Society of Clinical Oncology (ASCO), Austin Crisis Pregnancy Center, Blue Cross-Blue Shield of Texas, Business Insurance Consumers Association of Texas (BICA), Center for Church Renewal, Chemical Connection, Christ's Church, Coalition of Texans with Disabilities, Coastal Bend Health Plan, Wesner Coke Boyd and Clymer, Combined Underwriters Life Insurance Company, Consumers Union, Consumers Union of the Southwest Regional Office, William P. Daves, Jr and Associates, Inc , Diocese of San Angelo, Disability Policy Consortium, Entrust, FHP of Texas, Inc , Golden Rule Insurance Company, Greater El Paso Chamber of Commerce, Group and Pension Administrators, Inc., The Harvest Life Insurance Company, Kaiser Foundation Health Plan of Texas, Ladies Clinic, League of Women Voters of Texas, Metropolitan Life Insurance Company, Millman and Robertson, Inc , Mutual of Omaha Companies, National Association of Social Workers-Texas Chapter, National Coalition for Cancer Survivorship, National Federation of Independent Business (NFIB), Office of Public Insurance Counsel (OPIC) PacifiCare, PCA Health Plans, PFL Life Insurance Company, Pfizer Pharmaceuticals, Planned Parenthood Center, Professional Benefits Insurance Company, Provident American Insurance Company, Prudential Insurance Company, Reproductive Services of Austin, Resources for Choice, Scott and White Health Plan, Shoal Creek Associates, Small Business United of Texas, Small, Craig and Werkenthin, The Statesman National Life Insurance Company, Summit Medical Group, P A , Texans United for Life, Texas Alliance for the Mentally Ill (TEXAMI), Texas Association of Business), Texas Association of Health Underwriters, Texas Association of Home Care, Texas Association of Life Insurance Officials, Texas Association of Life Underwriters, Texas Catholic Conference, Texas Conservation Coalition, Texas Consumer Association, Texas Credit Union League and Affiliates, Texas Family Planning Association, Texas Health Maintenance Organization Assocaition (THMOA), Texas Legal Reserve Officials Association (TLROA), Texas Life Insurance Association (TLIA), Texas Medical Association (TMA), Texas Physical Therapy Association, Texas Planning Council for Developmental Disabilities, Texas Professional Benefit Administrators Association (TPBAA), Texas Right to Life Committee, Inc , Texas State Board of Medical Examiners, Transport Life Insurance Company, The Travelers, The United Wisconsin Life Insurance, The Traveler's Insurance Company, United Cerebral Palsy of Texas, Inc (UCP), Universe Life, University of Texas, MD Anderson Cancer Center, West Texas Boys Ranch, Women's Injury Network, Wright Insurance and Retirement Services, and numerous individuals and members of the legislature

These sections are adopted under the Insurance Code, Chapter 26, and the Insurance Code, Articles 1 03A, 1.10, 1.33, 21 20, 21 21, 21 21-3, and 21 21-5, and §1 23 of House Bill 1461, 73rd Legislature, Regular Session The Insurance Code, Chapter 26, sets out the requirements for small employer health benefit plans, including but not limited to fair marketing, disclosure, rating, mandated policy provisions, mandates for offering coverage for small employer health carriers, coverage and renewability of the policies, various filing and reporting requirements, cancellation, contribution and participation requirements, exclusions, limitations, preexisting conditions, previous coverage and status of health carriers as small employer health carriers These rules are intended to implement the provisions of that chapter. Insurance code, Article 21 20 prohibits misrepresentation of policies and Article 21 21 contains prohibitions against unfair competition and unfair trade practices and discrimination Article 21 21-3 prohibits discrimination in coverage or rates due to disability and Article 21 21-5 prohibits discrimination in rates or renewals on the grounds of geographical location, disability, sex or age. These rules are intended to address such discrimination in connection with the coverage which is subject to these sections Insurance Code, Article 1 03A sets forth the requirements for rules of general application to be adopted by the commissioner of insurance Article 1.10 authorizes sanctions for violations by licensees

**Article 1.33 sets forth the summary procedures for routine matters. Section 1.23 of House Bill 1461 authorizes the promulgation and approval of rules relating to rates, policy forms and endorsements by the State Board of Insurance.**

*§26.4. Definitions.* The following words and terms, when used in this chapter shall have the following meanings, unless the context clearly indicates otherwise:

Actuary–A qualified actuary who is a member in good standing of the American Academy of Actuaries.

Affiliated employer–A person connected by commonality of ownership with a small employer. The term includes a person that owns a small employer, shares directors with a small employer, or is eligible to file a consolidated tax return with a small employer.

Agent–A person who may act as an agent for the sale of a health benefit plan under a license issued under the Insurance Code, Article 20A. 15 or 20A.15A, or under the Insurance Code, Chapter 21, Subchapter A.

Base premium rate–For each class of business and for a specific rating period, the lowest premium rate that is charged or that could be charged under a rating system for that class of business by the small employer carrier to small employers with similar case characteristics for small employer health benefit plans with the same or similar coverage.

Case characteristics–With respect to a small employer, the geographic area in which that employer's employees reside, the age and gender of the individual employees and their dependents, the appropriate industry classification as determined by the small employer carrier, the number of employees and dependents, and other objective criteria as established by the small employer carrier that are considered by the small employer carrier in setting premium rates for that small employer. The term does not include claim experience, health status, duration of coverage since the date of issuance of a health benefit plan, or whether a covered person is or may become pregnant.

Child–An unmarried natural child of the employee, including a newborn child; adopted child, including a child who the employee is seeking to adopt; natural child or adopted child of the employee's spouse, provided that the child resides with the employee.

Class of business–All small employers or a separate grouping of small employers established under Insurance Code, Chapter 26.

Commissioner–The commissioner of insurance.

Department–The Texas Department of Insurance.

Dependent–A spouse; newborn child; child under the age of 19 years; child who is a full-time student under the age of 23 years and who is financially dependent on the parent; child of any age who is medically certified as disabled and dependent on the parent; and any person who must be covered under the Insurance Code, Article 3.51-6, §3D or §3E or the Insurance Code, Article 3.70-2(L).

Eligible employee–An employee who works on a full-time basis and who usually works at least 30 hours a week. The term includes a sole proprietor, a partner, and an independent contractor, if the sole proprietor, partner, or independent contractor is included as an employee under a health benefit plan of a small employer. The term does not include: an employee who works on a part-time, temporary, or substitute basis or an employee who is covered under another health benefit plan or an employee welfare benefit plan that provides health benefits and that is established in accordance with the Employee Retirement Income Security Act of 1974 (29 U.S.C., §1001, et seq.).

Franchise insurance policy–An individual health benefit plan under which a number of individual policies are offered to a selected group of a small employer. The rates for such a policy may differ from the rate applicable to individually solicited policies of the same type and may differ from the rate applicable to individuals of essentially the same class

HMO–A health maintenance organization subject to Insurance Code, Chapter 26A

Health benefit plan–A group, blanket, or franchise insurance policy, a certificate issued under a group policy, a group hospital service contract, or a group subscriber contract or evidence of coverage issued by a health maintenance organization that provides benefits for health care services The term does not include the plans or coverage excluded under Insurance Code, Article 26.02(9)(A-P), as follows.

(A) accident-only insurance coverage;

(B) credit insurance coverage;

(C) disability insurance coverage,

(D) specified disease coverage or other limited benefit policies;

(E) coverage of Medicare services under a federal contract;

(F) Medicare supplement and Medicare Select policies regulated in accordance with federal law,

(G) long-term care insurance coverage;

(H) coverage limited to dental care;

(I) coverage limited to care of vision;

(J) coverage provided by a single-service health maintenance organization;

(K) insurance coverage issued as a supplement to liability insurance;

(L) insurance coverage arising out of a workers' compensation system or similar statutory system,

(M) automobile medical payment insurance coverage;

(N) jointly managed trusts authorized under 29 U.S.C. §141 et seq. that contain a plan of benefits for employees that is negotiated in a collective bargaining agreement governing wages, hours, and working conditions of the employees that is authorized under 29 U.S.C §157,

(O) hospital confinement indemnity coverage, or

(P) reinsurance contracts issued on a stop-loss, quota-share, or similar basis

Health carrier–Any entity authorized under the Insurance Code or another insurance law of this state that provides health insurance or health benefits in this state including an insurance company, a group hospital service corporation under the Insurance Code, Chapter 20, a health maintenance organization under the Texas Health Maintenance Organization Act (Insurance Code, Chapter 20A), and a stipulated premium company under the Insurance Code, Chapter 22;

Index rate–For each class of business as to a rating period for small employers with similar case characteristics, the arithmetic average of the applicable base premium rate and corresponding highest premium rate

Late enrollee–An eligible employee or dependent who requests enrollment in a small employer's health benefit plan after the expiration of the initial enrollment period established under the terms of the first plan for which that employee or dependent was eligible through the small employer An eligible employee or dependent

is not a late enrollee if:

(A) the individual:

(i) was covered under another employer health benefit plan at the time the individual was eligible to enroll;

(ii) declines in writing, at the time of initial eligibility, stating that coverage under another employer health benefit plan was the reason for declining enrollment;

(iii) has lost coverage under another employer health benefit plan as a result of the termination of employment, the termination of the other plan's coverage, the death of a spouse, or divorce; and

(iv) requests enrollment not later than the 31st day after the date on which coverage under another employer health benefit plan terminates;

(B) the individual is employed by an employer who offers multiple health benefit plans and the individual elects a different health benefit plan during an open enrollment period; or

(C) a court has ordered coverage to be provided for a spouse or minor child under a covered employee's plan and request for enrollment is made not later than the 31st day after issuance of the date on which the court order is issued.

Limited benefit policy-For purposes of this chapter and the Insurance Code, Chapter 26, only, this term means a policy of accident and sickness insurance:

(A) that provides for payment of benefits only upon the occurrence of certain contingencies, such as cancer or other specified disease, in contrast to policies covering all contingencies other than those excluded, or coverage, including but not limited to CHAMPUS supplements or intensive care, sold to supplement other coverage in force; or

(B) that provides only the type of coverage set forth in §3.3071 of this title (relating to Minimum Standards for Basic Hospital Expense Coverage), §3.3072 of this title (relating to Minimum Standards for Basic Medical Surgical Expense Coverage); or §3.3075 of this title (relating to Minimum Standards for Disability Income Protection Coverage), where the policy fails to meet the minimum standards as provided in those sections; and

(C) A policy will not be deemed to be a limited benefit policy:

(i) solely due to a deductible in excess of the minimum standard provided in §3.3071(4) of this title (relating to Minimum Standards for Basic Hospital Expense Coverage); or

(ii) if it provides any coverage or benefit in addition to or other than the coverage and benefits set out respectively in §§3.3071, 3.3072, or 3.3075.

New entrant-An eligible employee, or the dependent of an eligible employee, who becomes part of a small employer group after the initial period for enrollment in a health benefit plan. After the initial enrollment period, this includes any employee or dependent who becomes eligible for coverage and who is not a late enrollee.

New business premium rate-For each class of business as to a rating period, the lowest premium rate that is charged or offered or that could be charged or offered by the small employer carrier to small employers with similar case characteristics for newly-issued small employer health benefit plans that provide the same or similar coverage.

Person-An individual, corporation, partnership, association, or other private legal entity.

Policy year-For purposes of the Insurance Code, Chapter 26, and this chapter, a 365-day period that begins on the policy's effective date or a period of one full calendar-year, under a health benefit plan providing coverage to small employers and their employees, as defined in the policy. Small employer carriers must use the same definition of policy year in all small employer health benefit plans.

Preexisting condition provision-A provision that denies, excludes, or limits coverage as to a disease or condition for a specified period after the effective date of coverage.

Premium-All amounts paid by a small employer and eligible employees as a condition of receiving coverage from a small employer carrier, including any fees or other contributions associated with a health benefit plan.

Rating period-A calendar period for which premium rates established by a small employer carrier are assumed to be in effect.

Renewal date-For each small employer's health benefit plan, the earlier of the date (if any) specified in such plan (contract) for renewal; the policy anniversary date; or the date on which the small employer's plan is changed. A change in the premium rate due solely to the addition or deletion of an employee or dependent if the deletion is due to a request by the employee, death or retirement of the employee or dependent, termination of employment of the employee, or because a dependent is no longer eligible; is not considered a renewal date. For association or multiple employer trusts group health benefit plans, small employer carriers may use the date specified for renewal or the policy anniversary date, of either the master contract or the contract or certificate of coverage of each small employer in the association or trust, in determining the renewal date. Small employer carriers must use the same method of determining renewal dates for all small employer health benefit plans.

Risk characteristic-The health status, claims experience, duration of coverage, or any similar characteristic related to the health status or experience of a small employer group or of any member of a small employer group.

Risk load-The percentage above the applicable base premium rate that is charged by a small employer carrier to a small employer to reflect the risk characteristics of the small employer group.

Small employer-A person that is actively engaged in business and that, on at least 50% of its working days during the preceding calendar year, employed at least three but not more than 50 eligible employees, including the employees of an affiliated employer, the majority of whom were employed in this state.

Small employer carrier-A health carrier, to the extent that that health carrier is offering, delivering, issuing for delivery, or renewing health benefit plans subject to the Insurance Code, Chapter 26, under Article 26.06(a).

Small employer health benefit plan-The preventive and primary care benefit plan, the in-hospital benefit plan, or the standard health benefit plan described by the Insurance Code, Chapter 26, Subchapter E, or any other health benefit plan offered to a small employer under the Insurance Code, Article 26.42(d).

Standard benefit plans-The preventive and primary care benefit plan, the in-hospital benefit plan and the standard health benefit plan required to be offered by health carriers, excluding HMOs, under the Insurance Code, Chapter 26, Subchapter E. For HMOs, the standard benefit plans means the preventive and primary care benefit plan and the standard health benefit plan that may be offered by an HMO, as provided under Insurance Code, Chapter 26, Subchapter E.

Waiting period-A period of time, established by a small employer, during which a new employee is not eligible for coverage and which cannot exceed 90 days from the first day of employment.

*§26.5. Applicability and Scope.*

(a) Except as otherwise provided in this chapter, this chapter shall apply to any health benefit plan providing health care benefits covering three or more eligible employees of a small employer, whether pro-

vided on a group or individual franchise basis, regardless of whether the policy was issued in this State, if the plan:

(1) meets one or more of the conditions listed in subparagraphs (A) -(C) of this paragraph and the Insurance Code, Article 26.06(a)(1)-(3):

(A) a portion of the premium or benefits is paid by or on behalf of small employers;

(B) a covered individual is reimbursed, whether through wage adjustments or otherwise, by or on behalf of a small employer for a portion of the premium; or

(C) the health plan is treated by the employer or by a covered individual as part of a plan or program for the purposes of 26 U.S.C., §106 or §162;

(2) is issued on or after September 1, 1993.

(b) Health benefit plans issued prior to September 1, 1993, to small employers and/or employees of a small employer, including franchise insurance policies, shall not be required to be amended to comply with the provisions of the Insurance Code, Chapter 26, and this chapter; except that a premium rate for a rating period may only exceed the ranges set forth in the Insurance Code, Article 26.32 and 26.33, until September 1, 1995, and such rate shall be calculated, as provided in the Insurance Code, Article 26.34

(c) While franchise insurance policies issued prior to September 1, 1993, to small employers and/or their employees do not have to comply with the provisions of the Insurance Code, Chapter 26, and this chapter, other than the provisions relating to rates referred to in subsection (b) of this section; policies written for individuals after that date must comply with the provisions of the Insurance Code, Chapter 26, and this chapter, even if the employer has an existing franchise policy.

(d) Health benefit plans issued to small employers and their employees on or after September 1, 1993, and prior to January 1, 1994:

(1) that are specifically offered, marketed, represented, issued, or delivered as "small employer health benefit plans" during this time-frame shall comply with all provisions of the Insurance Code, Chapter 26, when issued or renewed, and shall be amended to comply with all provisions of this chapter no later than January 1, 1994;

(2) that are not specifically offered, marketed, represented, issued or delivered as "small employer health benefit plans" during this time frame shall be amended to comply with all provisions of Insurance Code, Chapter 26, and this chapter, on the first renewal date occurring on or after January 1, 1994.

(e) Health benefit plans that are offered, marketed, represented, issued, or delivered for issue to small employers and their employees, on and after January 1, 1994 shall comply with all provisions of the Insurance Code, Chapter 26, and this chapter beginning January 1, 1994.

(f) If a health carrier continues to provide coverage to small employers and their employees under existing health benefit plans and elects not to continue to offer, deliver or issue for delivery, health benefit plans to small employers and their employees, the health carrier will only be considered a small employer carrier for purposes of renewing such existing plans. In this case, the health carrier shall notify the small employer of certain information. The notice shall be provided at least 30 days prior to the first renewal date occurring on or after January 1, 1994, except for renewal dates occurring prior to March 1, 1994, and for those renewal dates, the notice shall be given as soon as possible before the renewal date. The notice shall state that:

(1) the health carrier (the current health carrier of the small employer's employee health benefit plans) has elected not to continue to offer new health benefit plans in the small employer market; and

(2) other health benefit plans may be available to the small employer through other small employer carriers and that such other plans should be compared against existing plans to determine which plan is more beneficial.

(g) If a health carrier continues to provide coverage to small employers and their employees under existing health benefit plans and elects to continue to offer, issue, and issue for delivery, health benefit plans to small employers and their employees, the health carrier shall notify the small employer of certain information. The notice shall be provided at least 30 days prior to the first renewal date occurring on or after January 1, 1994, except for renewal dates occurring prior to March 1, 1994, and for those renewal dates, the notice shall be given as soon as possible before the renewal date. The notice shall:

(1) offer the small employer the option of continuing the existing health benefit plan or plans or purchasing new small employer benefit plans in accordance with the Insurance Code, Chapter 26, and this chapter; and

(2) provide notice that such other plans should be compared against existing plans to determine which plan is more beneficial.

(h) The provisions of the Insurance Code, Chapter 26, and this chapter shall apply to a health benefit plan provided to a small employer or to the employees of a small employer without regard to whether the health benefit plan is offered under or provided through a group policy or trust arrangement of any size sponsored by an association or discretionary group.

(i) If a small employer or the employees of a small employer are issued a health benefit plan under the provisions of the Insurance Code, Chapter 26, and this chapter, and the small employer subsequently employs more than 50 eligible employees or less than three eligible employees, the provisions of the Insurance Code, Chapter 26 and this chapter shall continue to apply to that particular health plan. A health carrier providing coverage to such an employer shall, within 60 days of becoming aware that the employer has more than 50 eligible employees or less than three eligible employees, but not later than the first renewal date occurring after the small employer has ceased to be a small employer, notify the employer that the protections provided under the Insurance Code, Chapter 26, and this chapter shall cease to apply to the employer, if such employer fails to renew its current health benefit plans or elects to enroll in a different health benefit plan.

(j) If a health benefit plan is issued on or after September 1, 1993 to an employer that is not a small employer as defined in the Insurance Code, Chapter 26, but subsequently the employer becomes a small employer, the provisions of the Insurance Code, Chapter 26, and this chapter shall apply to the health benefit plan on the first renewal date on or after January 1, 1994. An employer may become a small employer due to several reasons, including, but not limited to, the loss or change of work status of one or more employees, or the employer has moved to this state from another state and has a health benefit plan that was issued in the other state. The health carrier providing a health benefit plan to such an employer:

(1) shall not be considered to have elected to offer, issue or issue for delivery health benefit plans to small employers under the provisions of the Insurance Code, Chapter 26, and this chapter, solely because the health carrier continues to provide coverage under the health benefit plan to the employer and employees of the employer; however, for purposes of such existing health benefit plans, the health carrier will be considered a small employer carrier; and

(2) shall, within 60 days of becoming aware that the employer has 50 or

fewer eligible employees, notify the small employer of the options that will be available to the small employer under the Insurance Code, Chapter 26, and this chapter, including the small employer's option to purchase a small employer health benefit plan from the employer's current health carrier, if the carrier is offering such coverage, or from any small employer carrier willing to accept the group.

(k) If a small employer has employees in more than one state, the provisions of the Insurance Code, Chapter 26, and this chapter shall apply to a health benefit plan issued to the small employer if:

(1) the majority of eligible employees of such small employer are employed in this state on the issue date or renewal date; or

(2) the primary business location of the small employer is in this state on the issue date or renewal date and no state contains a majority of the eligible employees of the small employer.

*§26.6. Status of Health Carriers as Small Employer Carriers and Geographic Service Area.*

(a) No later than December 15, 1993, each health carrier providing health benefit plans in this state shall make a filing with the commissioner indicating whether the health carrier will or will not offer, renew, issue or issue for delivery, health benefit plans to small employers in this state as defined in the Insurance Code, Chapter 26, and this chapter. The required filing shall include certification form (Form Number 2055 CERT SEHC STATUS) completed according to the carrier's status and shall at least provide a statement to the effect of one of the following:

(1) The health carrier intends to offer, renew, issue, and issue for delivery health benefit plans to small employers and their employees and therefore will operate in accordance with the Insurance Code, Chapter 26, and this chapter; or

(2) The health carrier does not intend to offer, issue, or issue for delivery, health benefit plans to small employers and their employees; however, the health carrier intends to renew health benefit plans issued prior to January 1, 1994. With respect to plans issued between September 1, 1993, and January 1, 1994, the health carrier intends to comply with Chapter 26, and this chapter, as applicable; or

(3) The health carrier does not intend to offer, issue or issue for delivery, health benefit plans to small employers and their employees in the State of Texas and intends to nonrenew all health benefit plans issued to small employers in Texas.

(4) The health carrier has no health benefit plans issued to small employers or to employees of a small employer, which are in force on or after September 1, 1993, and the health carrier does not intend to offer, issue or issue for delivery health benefit plans to small employers.

(b) After December 15, 1993, if a health carrier chooses to change its election under subsection (a)(1), (2), or (4) of this section, the health carrier shall notify the commissioner of its new election at least 30 days prior to the date the health carrier intends to begin operations under the new election. This notification shall be made on Form Number 2055 CERT SEHC STATUS.

(c) Upon election to become a small employer carrier, the health carrier shall establish geographic service areas within which the health carrier reasonably anticipates it will have the capacity to deliver services adequately to small employers in each established geographic service area. The geographic service areas shall be defined in terms of counties or zip codes, to the extent possible, and shall be submitted in conjunction with any filing of a small employer health benefit plan. If the service area cannot be defined by counties or zip code, a map which clearly shows the geographic service areas is required to be submitted in conjunction with the filing of the small employer health benefit plan. Service areas by zip code shall be defined in a nondiscriminatory manner and in compliance with the Insurance Code, Article 21.21, §4 and Article 21.21-5. If the geographic area of the carrier is the entire state, the carrier shall define the service area as the state of Texas and no other definition is necessary.

(d) Health carriers providing coverage under any health benefit plans issued to small employers and/or their employees, whether on a group or franchise basis, shall be considered small employer carriers for purposes of such plans, and shall comply with all provisions of the Insurance Code, Chapter 26, and this chapter, as applicable.

(e) A health carrier that continues to provide coverage pursuant to subsection (a)(2) of this section shall not be eligible to participate in the reinsurance program established under the Insurance Code, Chapter 26.

*§26.7. Requirement to Insure Entire Groups.*

(a) A small employer carrier that offers coverage to a small employer and its employees shall offer to provide coverage to each eligible employee and to each dependent of an eligible employee. Except as provided in subsection (b) of this section, the small employer carrier shall provide the same health benefit plan to each such employee and dependent.

(b) If elected by the small employer, a small employer carrier may offer the eligible employees of a small employer the option of choosing among one or more health benefit plans, provided that each eligible employee may choose any of the plans offered. If at least 40% of eligible employees elect additional coverage, as provided in §26.15 of this title (relating to Additional Coverage), each eligible employee shall have the option to choose such additional coverage. Except as provided in the Insurance Code, Article 26.21 and Article 26.49 (with respect to exclusions for preexisting conditions), the choice among benefit plans may not be limited, restricted or conditioned based upon the risk characteristics of the eligible employees or their dependents.

(c) A small employer carrier may require each small employer that applies for coverage, as part of the application process, to provide a complete list of eligible employees and dependents of eligible employees as defined in Insurance Code, Article 26.02. If the small employer carrier requires such list, then the carrier may also require the small employer to provide appropriate supporting documentation (such as a W-2 Summary Wage and Tax Form) to verify the information required under this subsection.

(d) A small employer carrier shall secure a waiver with respect to each eligible employee and each dependent of such an eligible employee who declines an offer of coverage under a health benefit plan provided to a small employer. Waivers shall be maintained by the small employer carrier for a period of six years. The waiver shall be signed by the eligible employee (on behalf of such employee or the dependent of such employee) and shall certify that the individual who declined coverage was informed of the availability of coverage under the health benefit plan. The waiver form shall:

(1) require that the reason for declining coverage be stated on the form;

(2) include a written warning of the penalties imposed on late enrollees; and

(3) include a statement that the eligible employee and dependents were not induced or pressured by the small employer, agent, or health carrier, into declining coverage, but elected of their own accord to decline such coverage.

(e) A small employer carrier shall not provide coverage to a small employer or the employees of such employer if the health carrier, or an agent for such health carrier, has knowledge that the small employer has induced or pressured an eligible employee (or dependent of an eligible employee) to decline coverage due to the indi-

vidual's risk characteristics.

(f) An agent shall notify a small employer carrier, prior to submitting an application for coverage with the health carrier on behalf of a small employer or employee of a small employer, of any circumstances that would indicate that the small employer has induced or pressured an eligible employee (or dependent of an eligible employee) to decline coverage due to the individual's risk characteristics.

(g) New entrants in a health benefit plan issued to a small employer group on or after September 1, 1993, shall be offered an opportunity to enroll in the health benefit plan currently held by such employer group or shall be offered an opportunity to enroll in the health benefit plan if the plan is provided through an individual franchise policy or more than one plan is available. If a small employer carrier has offered more than one health benefit plan to eligible employees of a small employer group pursuant to subsection (b) of this section, or if 40% of the eligible employees of the small employer group have elected to receive additional coverage under §26. 15 of this chapter (relating to Additional Coverage), the new entrant shall be offered the same choice of health benefit plans as the other employees (members) in the group. A new entrant that does not exercise the opportunity to enroll in the health benefit plan within the period provided by the small employer carrier may be treated as a late enrollee by the health carrier, provided that the period provided to enroll in the health benefit plan complies with subsection (h) of this section.

(h) Periods provided for enrollment in and application for any health benefit plan provided to a small employer group shall comply with the following:

(1) the enrollment period extends at least 30 days after the date the new entrant begins employment or if the waiting period exceeds 30 days, the date the new entrant becomes eligible for coverage;

(2) the new entrant is notified of his or her opportunity to enroll at least 30 days in advance of the last date enrollment is permitted; and

(3) a period of at least 31 days following the date of employment, or following the date the new entrant is eligible for coverage, is provided during which the new entrant's application for coverage may be submitted.

(i) A small employer carrier shall not apply a waiting period, elimination period, or other similar limitation of coverage (other than an exclusion for preexisting medical conditions consistent with the Insurance Code, Article 26.21 and Article 26.49) with respect to a new entrant, that is longer than 90 days. Any waiting period applied to a new entrant, shall be based on the waiting period established by the small employer.

(j) New entrants in a health plan issued to a small employer group on or after September 1, 1993, shall be accepted for coverage by the small employer carrier without any restrictions or limitations on coverage related to the risk characteristics of the employees or their dependents, except that a health carrier may exclude coverage for preexisting medical conditions, to the extent allowed under the Insurance Code, Article 26.21 and Article 26.49

(k) A small employer carrier may assess a risk load to the premium rate associated with a new entrant, consistent with the requirements of the Insurance Code, Chapter 26, Subchapter D, and this chapter. The risk load shall be the same risk-load charged to the small employer group immediately prior to acceptance of the new entrant into the group.

(l) In the case of an eligible employee (or dependent of an eligible employee) who was excluded from coverage, not eligible for coverage, or denied coverage by a small employer carrier, in the process of providing a health benefit plan to an eligible small employer (as defined in the Insurance Code, Chapter 26, and this chapter), the small employer carrier shall provide an opportunity for the eligible employee (or dependent(s) of such eligible employee) to enroll in the health benefit plan issued to the small employer or the employees of the small employer on the first renewal date occurring on or after January 1, 1994, if the plan was issued between September 1, 1993, and January 1, 1994.

(m) A small employer carrier may require an individual who requests enrollment under this section to sign a statement indicating that such individual sought coverage under the group contract or franchise policy (other than as a late enrollee) and that the coverage was not offered or provided to the individual.

(n) The opportunity to enroll shall meet the following requirements:

(1) The opportunity to enroll under this section shall comply with subsection (h) of this section, and shall begin on the first renewal date occurring on or after January 1, 1994, if the plan was issued between September 1, 1993, and January 1, 1994.

(2) Eligible employees and dependents of eligible employees who are provided an opportunity to enroll pursuant to this section shall be treated as new entrants. Premium rates related to such individuals shall be set in accordance with subsection (j) of this section.

(3) The terms of coverage offered to an individual described in subsection (l) of this section may exclude coverage for preexisting medical conditions only if the health benefit plan currently held by the small employer contains such an exclusion, provided that the exclusion period shall be reduced by the number of days between the date the individual was excluded or denied coverage and the date coverage is provided to the individual pursuant to this subsection

(4) A small employer carrier shall provide written notice at least 45 days prior to the opportunity to enroll provided in this section, or if less than 45 days are available, within five working days after determination that subsections (g)-(m) of this section apply to each small employer insured under a health benefit plan offered by such health carrier. The notice shall clearly describe the rights granted under subsections (g)-(m) of this section to employees and dependents who were previously excluded from, not eligible for, or denied coverage and the process for enrollment of such individuals in the employer's health benefit plan.

*§26.9. Exclusions, Limitations, Waiting Periods, and Pre-existing Conditions and Restrictive Riders.*

(a) All health benefit plans that provide coverage for small employers and their employees as defined in the Insurance Code, Article 26.02(21) and §26 4 of this title (relating to Definitions) shall comply with the following requirements All such plans issued to small employers on or after January 1, 1994 shall comply with these provisions; plans issued between September 1, 1993, and January 1, 1994, shall be amended to comply with these provisions on the first renewal date after January 1, 1994.

(1) A small employer carrier shall not exclude any eligible employee or dependent (including a late enrollee, who would otherwise be covered under a small employer's health benefit plan), except to the extent permitted under the Insurance Code, Article 26.21(g)

(2) A small employer carrier shall not limit or exclude (by use of rider, amendment or other provision of the plan, applicable to a specific individual) coverage by type of illness, treatment, medical condition, or accident, except for preexisting conditions or diseases, as permitted under the Insurance Code, Article 26.49

(3) A small employer health benefit plan may not limit or exclude initial coverage of a newborn child of a covered employee. Any coverage of a newborn child of an employee under this subsection terminates on the 31st day after the date of the

birth of the child unless:

(A) dependent children are eligible for coverage; and

(B) notification of the birth and any required additional premium are received by the small employer carrier not later than the 30th day after the date of birth. A small employer carrier shall not terminate coverage of a newborn child if such carrier's billing cycle does not coincide with this 30 day premium payment requirement, until the next billing cycle has occurred and there has been non-payment of the additional required premium, within 30 days of the due date of such premium.

(4) A late enrollee may be excluded from coverage for 18 months from the date of application or may be subject to a 12-month preexisting condition provision as described by the Insurance Code, Article 26.49(b), (c), (d) and (e). If both a period of exclusion from coverage and a preexisting condition provision are applicable to a late enrollee, the combined period of exclusion may not exceed 18 months from the date of the late application.

(5) A preexisting condition provision in a small employer health benefit plan may not apply to coverage for a disease or condition other than a disease or condition:

(A) for which medical advice, diagnosis, care, or treatment was recommended or received during the six months before the effective date of coverage; or

(B) that would have caused an ordinary, prudent person to seek medical advice, diagnosis, care, or treatment during the six months before the effective date of coverage.

(6) A preexisting condition provision in a small employer health benefit plan shall not apply to an individual who was continuously covered for a minimum period of 12 months by a health benefit plan that was in effect up to a date not more than 60 days before the effective date of coverage under the small employer health benefit plan.

(7) In determining whether a preexisting condition provision applies to an individual covered by a small employer health benefit plan, the small employer carrier shall credit the time the individual was covered under a previous health benefit plan if the previous coverage was in effect at any time during the 12 months preceding the effective date of coverage under a small employer health benefit plan. If the previous coverage was issued by a health maintenance organization, any waiting period that applied before that coverage became effective also shall be credited against the preexisting condition provision period.

(8) A small employer may establish a waiting period, that cannot exceed 90 days from the first day of employment, during which a new employee is not eligible for coverage.

(9) A preexisting condition provision in a small employer health benefit plan may exclude coverage for a pregnancy existing on the effective date of the coverage, except as provided by paragraph (6) of this subsection.

(b) In order to determine if preexisting conditions as defined in the Insurance Code, Article 26.02(16) exist, a small employer carrier shall ascertain the source of previous or existing coverage of each eligible employee and each dependent of an eligible employee at the time such employee or dependent initially enrolls into the health benefit plan provided by the small employer carrier. The small employer carrier shall have the responsibility to contact the source of such previous or existing coverage to resolve any questions about the benefits or limitations related to such previous or existing coverage.

*§26.11. Restrictions Relating to Premium Rates.*

(a) A small employer carrier shall develop a separate rate manual for each class of business. Base premium rates and new business premium rates charged to small employers by the small employer carrier shall be computed solely from the applicable rate manual developed pursuant to this subsection. To the extent that a portion of the premium rates charged by a small employer carrier is based on objective criteria established by the small employer carrier consistent with the criteria set out in the Insurance Code, Articles 26. 02(5) and 26.36, the manual shall specify the criteria and factors considered by the health carrier in exercising such discretion.

(b) A small employer carrier shall not modify the rating method used in the rate manual for a class of business until the change has been filed with the department for 60 days. The small employer carrier shall ensure that the rating method used is actuarially sound and appropriate to assure compliance with the Insurance Code, Chapter 26, and this chapter, and that differences in rates charged for each small employer health benefit plan are reasonable and reflect objective differences in plan design. The commissioner may disapprove a change to the rating method that does not meet these requirements.

(1) A small employer health carrier may modify the rating method for a class of business only with prior approval of the commissioner. A small employer health carrier requesting to change the rating method for a class of business shall make a filing with the commissioner at least 60 days prior to the proposed date of the change. The filing shall contain at least the following information:

(A) the reasons the change in rating method is being requested;

(B) a complete description of each of the proposed modifications to the rating method;

(C) a description of how the change in rating method would affect the premium rates currently charged to small employers in the class of business, including an estimate from a qualified actuary of the number of groups or individuals and a description of the types of groups or individuals whose premium rates may change by more than 10% due to the proposed change in rating method (not including general increases in premium rates applicable to all small employers in a health benefit plan);

(D) a certification from a qualified actuary that the new rating method would be based on objective and credible data and would be actuarially sound and appropriate; and

(E) a certification from a qualified actuary that the proposed change in rating method would not produce premium rates for small employers that would be in violation of the Insurance Code, Chapter 26, Subchapter D.

(2) For the purpose of this section a change in rating method shall mean:

(A) a change in the number of case characteristics used by a small employer carrier to determine premium rates for health benefit plans in a class of business;

(B) a change in the manner or procedures by which insureds are assigned into categories for the purpose of applying a case characteristic to determine premium rates for health benefit plans in a class of business;

(C) a change in the method of allocating expenses among health benefit plans in a class of business; or

(D) a change in a rating fac-

tor with respect to any case characteristic if the change would produce a change in premium for any small employer that exceeds 10%. For the purpose of this paragraph, a change in a rating factor shall mean the cumulative change with respect to such factor considered over a 12 month period. If a small employer carrier changes rating factors with respect to more than one case characteristic in a 12 month period, the health carrier shall consider the cumulative effect of all such changes in applying the 10% test under this paragraph.

(c) Each rate manual developed pursuant to subsection (a) of this section shall specify the case characteristics and rate factors to be applied by the small employer carrier in establishing premium rates for the class of business.

(1) A small employer carrier may not use case characteristics other than those specified in the Insurance Code, Article 26.36(c), without the prior approval of the commissioner. A small employer carrier seeking such an approval shall make a filing with the commissioner for a change in rating method under subsection (b) of this section.

(2) A small employer carrier shall use the same case characteristics in establishing premium rates for each health benefit plan in a class of business and shall apply them in the same manner in establishing premium rates for each such health benefit plan. Case characteristics may include the employer's industry classification consistent with the Insurance Code, Article 26.33(c). Case characteristics shall be applied without regard to the risk characteristics of a small employer.

(3) The rate manual developed pursuant to subsection (a) shall clearly illustrate the relationship among the base premium rates charged for each health benefit plan in the class of business. If the new business premium rate is different than the base premium rate for a health benefit plan, the rate manual shall illustrate the difference.

(4) Differences among base premium rates for health benefit plans shall be based solely on the reasonable and objective differences in the design and benefits of the health benefit plans and shall not be based in any way on the actual or expected health status or claims experience of the small employer groups that choose or are expected to choose a particular health benefit plan. A small employer carrier shall apply case characteristics and rate factors within a class of business in a manner that assures that premium differences among health benefit plans for identical small employer groups vary only due to reasonable and objective differences in the design and benefits of the health benefit plans and are not due to the actual or expected health status or claims experience of the small employer groups that choose or are expected to choose a particular health benefit plan.

(5) Each rate manual developed pursuant to subsection (a) of this section shall provide for premium rates to be developed in a two step process. In the first step, a base premium rate shall be developed for the small employer group without regard to any risk characteristics of the group. In the second step, the resulting base premium rate may be adjusted by a risk load, subject to the provisions of the Insurance Code, Chapter 26, Subchapter D, to reflect the risk characteristics of the group.

(6) Except as provided in this subsection, a premium charged to a small employer for a health benefit plan shall not include a separate application fee, underwriting fee, or any other separate fee or charge. A small employer carrier may charge a separate fee with respect to a health benefit plan (but only one fee with respect to such plan) provided the fee is no more than $5.00 per month per covered employee and is applied in a uniform manner to each health benefit plan in a class of business.

(7) A small employer carrier shall allocate administrative expenses to the small employer health benefit plans on no less favorable of a basis than expenses are allocated to other health benefit plans in the class of business. The rate manual developed pursuant to subsection (a) of this section shall describe the method of allocating administrative expenses to the health benefit plans in the class of business for which the manual was developed.

(8) Each rate manual developed pursuant to subsection (a) of this section shall be maintained by the health carrier for a period of 6 years. Updates and changes to the manual shall be maintained with the manual.

(9) Each rate manual and the rating practices of a small employer carrier shall comply with any applicable rules.

(d) If group size is used as a case characteristic by a small employer carrier, the highest rate-factor associated with a group size classification shall not exceed the lowest rate-factor associated with such a classification by more than 20%.

(e) The restrictions related to changes in premium rates in Insurance Code, Article 26.33 and Article 26.34, shall be applied as follows:

(1) A small employer carrier shall revise its rate manuals each rating period to reflect changes in base premium rates and changes in new business premium rates.

(2) If, for any health benefit plan with respect to any rating period, the percentage change in the new business premium rate is less than or the same as the percentage change in the base premium rate, the change in the new business premium rate shall be deemed to be the change in the base premium rate for the purposes of the Insurance Code, Article 26.33 and Article 26.34.

(3) If, for any health benefit plan with respect to any rating period, the percentage change in the new business premium rate exceeds the percentage change in the base premium rate, the health benefit plan shall be considered a health benefit plan into which the small employer carrier is no longer enrolling new small employers for the purposes of Insurance Code, Article 26.33 and Article 26.34.

(4) If, for any rating period, the change in the new business premium rate for a health benefit plan differs from the change in the new business premium rate for any other health benefit plan in the same class of business by more than 20%, the health carrier shall make a filing with the commissioner containing a complete explanation of how the respective changes in new business premium rates were established and the reason for the difference. The filing shall be made at least 60 days prior to the beginning of the rating period when the change would be applicable. The filing is for the purpose of allowing the commissioner to determine whether the methodology used is actuarially sound and appropriate to insure compliance with the Insurance Code, Chapter 26.

(5) A small employer carrier shall keep on file for a period of at least six years the calculations used to determine the change in base premium rates and new business premium rates for each health benefit plan for each rating period.

(f) Changes in premium rates and revised premium rates shall comply with the following:

(1) Except as provided in subsection (e) of this section, a change in premium rate for a small employer shall produce a revised premium rate that is no more than the base premium rate for the small employer (as shown in the rate manual as revised for the rating period), multiplied by one plus the sum of:

(A) the risk load applicable to the small employer during the previous rating period; and

(B) )15% (prorated for periods of less than one year).

(2) In the case of a health benefit plan into which a small employer carrier

is no longer enrolling new small employers, a change in premium rate for a small employer shall produce a revised premium rate that is no more than the base premium rate for the small employer (given its present composition and as shown in the rate manual in effect for the small employer at the beginning of the previous rating period), multiplied by one plus the lesser of:

(A) the change in the base rate; or

(B) the percentage change in the new business premium for the most similar health benefit plan into which the small employer carrier is enrolling new small employers, multiplied by one plus the sum of:

(i) The risk load applicable to the small employer during the previous rating period; and

(ii) 15% (prorated for periods of less than one year).

(3) In the case of a health benefit plan described in the Insurance Code, Article 26.33(c), if the current premium rate for the health benefit plan exceeds the ranges set forth in the Insurance Code, Article 26.32(b), the formulae set forth in paragraphs (1) and (2) of this subsection will be applied as if the 15% adjustment provided in paragraphs (1)(B)(ii) and (2) (C)(ii) of this subsection were a 0% adjustment.

(4) Notwithstanding the provisions of paragraphs (1) and (2) of this subsection, a change in premium rate for a small employer shall not produce a revised premium rate that would exceed the limitations on rates provided in the Insurance Code, Article 26.32(c).

(g) HMOs shall follow the rating requirements set out in this section for the prototype benefit plans authorized by the Insurance Code, Article 26.42 and this chapter. HMOs offering any state-approved, federally-qualified plan described in the Insurance Code, Article 26.48 and §26.14 of this title (relating to Coverage) shall establish premium rates for those plans in accordance with formulas or schedules of charges filed with the department under the procedures set forth in the Insurance Code, Article 20A.09(b) and Chapter 11, Subchapter H, of this title (relating to Schedule of Charges).

*§26.14. Coverage.*

(a) Every small employer carrier, except HMOs, shall as a condition of transacting business in this state with small employers, offer to small employers at least three standard benefit plans, including the preventive and primary care benefit plan, the in-hospital benefit plan, and the standard health benefit plan, as provided under Insurance Code, Articles 26. 42-26.49.

(b) In addition to the three standard benefit plans required to be offered to small employers as provided in the Insurance Code, Chapter 26, small employer carriers may, subject to the provisions of the Insurance Code, Article 26. 42(d) and this chapter, offer other health benefit plans to small employers, as provided in the Insurance Code, Article 26.42(d). Such other health benefit plans shall comply with all provisions of Chapter 26 and this chapter, except that provisions defining the specific benefits required under the three required standard benefit plans are not applicable. The Insurance Code, Article 26.06(c) does not apply to a health benefit plan offered to a small employer as provided under Insurance Code, Article 26.42(d).

(c) Instead of the standard benefit plans described by this chapter, a health maintenance organization may offer a state-approved health benefit plan that complies with the requirements of Title XI, Public Health Service Act (42 U.S.C., §300e et seq.) and rules adopted under that Act. An HMO may also offer two of the three prototype plans described in the Insurance Code, Article 26.45 and Article 26.47; including the Preventive and Primary Care Benefit Plan and the Standard Health Benefit Plan. HMOs may not offer the In-Hospital Benefit Plan, as that plan does not comply with either state or federal law regarding the operation of HMOs.

(d) All small employer health benefit plans provided by a small employer carrier other than an HMO shall provide an option for conversion/continuation which complies with all provisions of Subchapter F of Chapter 3 of this title (relating to Group Health Insurance Mandatory Conversion Privilege). An HMO shall provide coverage for conversion or continuation of any small employer health benefit plan which complies with the requirements of §11.506(7) or (8) of this title (relating to Mandatory Provisions: Group and Non-Group Agreement and Group Certificate).

(e) Each health benefit plan, certificate, policy, rider, or application used by health carriers to provide coverage to small employers and their employees shall comply with the Insurance Code, Article 26.43; be written in plain language; and meet the requirements of Chapter 3, Subchapter G, of this title (relating to Plain Language Requirements). Requirements for use of plain language are not applicable to a health benefit plan group master policy or a policy application or enrollment form for a health benefit plan group master policy.

(f) Every small employer carrier providing health benefit plans to small employers is required to offer dependent coverage. Dependent coverage may be paid for by the employer, the employee, or both.

(g) This section contains requirements for optional prototype policy forms. The policy forms described in this subsection are adopted by reference to complete a prototype policy and/or certificate when combined with the required prescribed benefit prototype policy forms outlined in this section. The prototype policy forms have been developed to facilitate implementation of the Insurance Code, Chapter 26, and to streamline the policy approval process. Small employer carriers are encouraged to use all of the prototype policy forms as described in this subsection to expedite the approval process. Each form has a unique form number appearing in the lower left-hand corner and small employer carriers may use one or any number of the prototype forms. Alternate language, except for variables indicated by brackets, must be filed for review and approval under a different form number using 2055 as part of the form number. Additional filing requirements are outlined in Section 26.19 of this title (relating to Filing Requirements).

(1) This paragraph describes policy face pages.

(A) The group policy face pages are described in this subparagraph. These prototype policies provide for the entire contract to include any applications, the certificate of insurance and any attached riders. If the small employer carrier elects to use policies other than the prototype forms, this shell format shall be used with any small employer health benefit plan. Each policy face page, whether or not the prototype form is used, shall include the small employer carrier name and address; policyholder name (and industry, if issued on a multiple-employer trustee basis); policy number; policy effective date; provision for the entire contract to include applications, the certificate of insurance and any attached riders; workers' compensation disclaimer notice; description of the policy in bold type as the Group Small Employer Preventive and Primary Care Benefit Plan, the Group Small Employer In-Hospital Benefit Plan or the Group Small Employer Standard Health Benefit Plan; and the form number. and Primary Care Benefit Plan, the Group Small Employer In-Hospital Benefit Plan or the Group Small Employer Standard Health Plan; and the form number. The small employer carrier may include or omit the variable provision addressing the free look period. The Group Policy Face Pages for the prototype policies include a:

(i) Group Small Employer Preventive and Primary Care Benefit Plan (Form Number 2055 SE.PP) for a single-employer policy.

(ii) Group Small Employer In-Hospital Benefit Plan (Form Number 2055 SE.IH) for a single-employer policy.

(iii) Group Small Employer Standard Health Benefit Plan (Form Number 2055 SE.STD) for a single-employer policy.

(iv) Group Small Employer Preventive and Primary Care Benefit Plan (Form Number 2055 MET.PP) for a multiple-employer trustee policy.

(v) Group Small Employer In-Hospital Benefit Plan (Form Number 2055 MET.IH) for a multiple employer trustee policy.

(vi) Group Small Employer Standard Health Benefit Plan (Form Number 2055 MET.STD) for a multiple-employer trustee policy.

(vii) Group Small Employer Preventive and Primary Care Benefit Plan (Form Number 2055 ASSN.PP) for an association policy.

(viii) Group Small Employer In-Hospital Benefit Plan (Form Number 2055 ASSN.IH) for an association policy.

(ix) Group' Small Employer Standard Health Benefit Plan (Form Number 2055 ASSN.STD) for an association policy.

(B) The individual policy face pages are described in this subparagraph. These prototype policies provide for the entire contract to include the application and any attached papers. If the small employer carrier elects to use policies other than the prototype forms, this shell format shall be used with any small employer health benefit plan. All policy face pages, whether or not the prototype form is used, shall include the small employer carrier name and address; renewal statement; right to change premium rates statement; Policyholder (Employee) name and address; policy number; the policy effective date; provision for the entire contract to include the application and any attached papers; right to examine policy provision; workers' compensation disclaimer notice; description of the policy in bold type as the Individual Small Employer Preventive and Primary Care Benefit Plan, the Individual Small Employer In-Hospital Benefit Plan, or the Individual Small Employer Standard Health Benefit Plan; and the form number. These prototype policies require the plans to be issued on a guaranteed renewable for life or attainment of the maximum benefits, if any, basis. If the prototype policy forms are not used, a small employer carrier shall issue small employer health benefit plans on a guaranteed renewable for life or attainment of maximum benefits basis; or on a guaranteed renewable basis with the only reasons for termination being those set out in the Insurance Code, Articles 26.23 and 26.24A, and shall include a conversion provision which provides conversion options required under of Chapter 3, Subchapter F, of this title (relating to Group Health Insurance Mandatory Conversion Privilege). The Individual Policy Face Pages include the following:

(i) Individual Small Employer Preventive and Primary Care Benefit Plan (Form Number 2055 ISE.PP).

(ii) Individual Small Employer In-Hospital Benefit Plan (Form Number 2055 ISE.IH).

(iii) Individual Small Employer Standard Health Benefit Plan (Form Number 2055 ISE.STD).

(2) The Notice of Toll-Free Telephone Numbers and Information and Complaint Procedures form (Form Number TOLLFREE) for group and individual policies are described in this paragraph. This prototype form contains the language prescribed in §1.601 of this title (relating to Notice of Toll-Free Telephone Numbers and Information and Complaint Procedures) and shall be attached as the second or third page of the policy and the certificate of insurance. The variable provisions are optional only to the extent outlined in §1.601.

(3) The group certificate of insurance face page is described in this paragraph. Each certificate of insurance face page, whether or not the prototype form is used, shall include the small employer carrier name and address; the certification provision; a provision that the certificate face page, all attached provisions and any riders shall constitute the entire certificate of insurance; the workers' compensation disclaimer notice; a description of the plan in bold type as the Small Employer Preventive and Primary Care Benefit Plan, the Small Employer In-Hospital Benefit Plan or the Small Employer Standard Health Benefit Plan; and the form number. The identification information (Employee name, ID Number, Certificate Effective Date, Policyholder name, Policy Number, Policy Effective Date, Dependent Coverage) is variable to the extent that small employer carriers may include all of the information in the certificate of insurance by any appropriate method, such as an insert or as a sticker on the face page or schedule of benefits or printed on the face page as provided in the prototype form. The Dependent Coverage information is variable for small employer carriers to insert a dependent coverage election. The variable replacement provision is an optional provision which carriers may include as provided in the prototype form or carriers may alter the language in any appropriate manner or may elect to omit the provision in its entirety. The Group Certificate of Insurance Face Pages include the following:

(A) Certificate of Insurance Face Page for the Group Small Employer Preventive and Primary Care Benefit Plan (Form Number 2055 CERT.PP).

(B) Certificate of Insurance Face Page for the Group Small Employer In-Hospital Benefit Plan (Form Number 2055 CERT.IH).

(C) Certificate of Insurance Face Page for the Group Small Employer Standard Health Benefit Plan (Form Number 2055 CERT.STD).

(4) The data page for individual policies (Form Number 2055 DP) is described in this paragraph. The Premium, Premium Mode, Policy Fee and Dependent Coverage information shall be included in the policy whether or not the prototype Data Page is used. The Dependent Coverage information is variable for small employer carriers to insert dependent coverage election. The Policy Fee provision shall be omitted if there is no policy fee. The information on this Data Page may be included by any appropriate method, such as an insert as provided by the prototype form, or as a sticker on the face page or the schedule of benefits page or printed on the face page or schedule of benefits page.

(5) The table of contents for group policies (Form Number 2055 TCG) and table of contents for individual policies (Form Number 2055 TCI) are described in this paragraph. The variable items shall be included or omitted as appropriate for the policy or certificate and page numbers shall be renumbered accordingly. If the prototype Table of Contents is not used, the format and order shall be the same as provided in the prototype.

(6) The General Provisions form for group policies (Form Number 2055 GGP) may be used with all group small employer health benefit plans. If the prototype General Provisions form is not used, each general provision with same or similar language shall be included in each policy/certificate. Variable language for the General Provisions form are described in the following subparagraphs:

(A) The definition of an Eligible Employee under the Eligibility for Coverage (Employee Coverage) provision shall add that an "Eligible Employee also includes an employee of an Employer member of an association" when the policy is to be issued to an association.

(B) The Initial Enrollment for New Eligible Employees provision under Effective Dates allows a variable for a waiting period which is to be included if the small employer requires a waiting period or omitted if not applicable. The length of time for the waiting period is also variable to allow flexibility for small employers to elect a period of time not to exceed 90 days.

(C) The Newborn Children provision under Effective Dates allows a variable to be included if the small employer carrier requires a premium to be charged for the 31 day period of coverage if the insured person elects not to continue coverage for the newborn child. If no premium will be charged, this provision shall be omitted.

(D) The Late Enrollees provision under Effective Dates shall include one of the four variable provisions to reflect the date on which a late enrollee will be eligible for coverage. The time periods are variable to allow a shorter period of time, if elected by the small employer carrier.

(E) The Preexisting Conditions provision is variable only to the extent that it may be omitted in its entirety if the small employer carrier elects not to impose a limitation for preexisting conditions. If a preexisting condition limitation applies, this provision shall be included in its entirety. The time period is variable to allow a shorter period of time if elected by the small employer carrier.

(F) The Eligible Employees and Dependents provisions under Termination of Insurance allow variables for continued coverage for an employee who is on an approved leave of absence for a specified period of time to be inserted if the provision remains. This provision shall be included or omitted as appropriate.

(G) The Eligible Employees and Dependents provisions under Termination of Insurance allow variables for coverage to end on either "the date the Employer terminates participation in the Trust" which may be included when the policy is to be issued to a multiple employer trust; or "the date the Employer member terminates membership in the Association" which may be included when the policy is to be issued to an association.

(H) The Policyholder and Company provision under Termination of Insurance provides alternate provisions for termination by the Employer as Policyholder; termination by the Association as Policyholder; termination of participation by an Employer (member) under an Association policy, or termination of participation by an Employer under a Multiple Employer Trust policy. Provisions shall be included appropriately for a single employer policy, an association policy or a multiple employer trust policy.

(I) The Policyholder and Company provision under Termination of Insurance allows a variable to be included for the exception to non-payment of premiums if a grace period is provided. If a grace period is not provided, the variable "Coverage will end at the end of the last period for which premium payment has been made to Us" shall be included. A variable is allowed to be included if the small employer carrier will terminate the employer's plan for failure to maintain the required minimum participation requirements. A variable is allowed to be included if the small employer carrier will terminate the employer's plan due to failure of the employer to maintain status as a small employer, as described in §26.5 of this title (relating to Applicability and Scope).

(7) The General Provisions for individual policies (Form Number 2055 IGP) may be used with all individual small employer health benefit plans. If the prototype General Provisions form is not used, each general provision with same or similar language shall be included in each policy. Variable provisions for the General Provisions form include the following:

(A) The Initial Enrollment for New Eligible Employees provision under Effective Dates allows a variable for a waiting period which is to be included if the small employer requires a waiting period or omitted if not applicable. The length of time for the waiting period is also variable to allow flexibility for small employers to elect a period of time not to exceed 90 days.

(B) The Newborn Children provision under Effective Dates provides a variable to be included if the small employer carrier requires a premium to be charged for the 31 day period of coverage if the insured person elects not to continue coverage for the newborn child. If no premium will be charged, this provision shall be omitted.

(C) The Late Enrollees provision under Effective Dates shall include one of the four variable provisions to reflect the date on which a late enrollee will be eligible for coverage. The time periods are variable to allow a shorter period of time if elected by the small employer carrier.

(D) The Preexisting Conditions provision is variable only to the extent that it may be omitted in its entirety if the small employer carrier elects not to impose a limitation for preexisting conditions. If a preexisting condition limitation applies, this provision shall be included in its entirety. The time period is variable to allow a shorter period of time if elected by the small employer carrier.

(8) The Group Provisions form (Form Number 2055 GRP) may be used with all group small employer health benefit plans. If the prototype Group Provisions form is not used, each provision with the same or similar language shall be included in each policy/certificate. Variable provisions for the Group Provisions form include the following:

(A) A variable is provided in the Payment of Premiums provision for the mode of premium to be inserted.

(B) The Representations provision under Time Limit on Certain Defenses shall provide that statements made by the "Policyholder or" Employer shall be considered representations and not warranties and that the "Policyholder or" Employer shall be provided a copy of any statements used to contest coverage when policies are to be issued to a multiple employer trust or to an association.

(C) The Time Limit on Certain Defenses provision allows a variable for Preexisting Conditions only to the extent that it may be omitted in its entirety if the small employer carrier elects not to impose a limitation for preexisting conditions. If a preexisting condition limitation applies, this provision shall be included in its entirety. The time period is variable to allow a shorter period of time, if elected by the small employer carrier.

(D) The Payment to Assignee provision under Payment of Claims is variable only to the extent that Chapter 20 companies may substitute this provision for the alternate Assignment provision.

(E) The Grace Period provision is a variable to be included when a grace period is provided for the specified number of days as determined by the small employer carrier.

(F) Dividends, Subrogation, and Right to Recovery/Clerical Error provisions may be included, omitted, or modified by the small employer carrier. Right to Recovery/Clerical Error provisions shall be

considered one provision for purposes of variability and both provisions shall be either included or omitted.

(9) The Individual Provisions form (Form Number 2055 IRP) may be used with all individual small employer health benefit plans. If the Individual Provisions prototype form is not used, a provision with the same or similar language shall be used in each policy. Variable provisions for the Individual Provisions form include the following:

(A) The Time Limit on Certain Defenses provision allows a variable for Preexisting Conditions only to the extent that it may be omitted in its entirety if the small employer carrier elects not to impose a limitation for preexisting conditions. If a preexisting condition limitation applies, this provision shall be included in its entirety. The time period is variable to allow a shorter period of time, if elected by the small employer carrier.

(B) The Payment to Assignee provision under Payment of Claims is variable only to the extent that Chapter 20 companies may substitute this provision for the Assignment provision.

(C) The Cancellation, Dividends, Misstatement of Age, Right to Recovery, Subrogation, and Unpaid Premiums provisions may be included, omitted or modified by the small employer carrier.

(h) Prescribed benefits are discussed in this subsection. No policy, subscriber contract, or certificate shall be issued or delivered for issue in this state to a small employer by a small employer carrier as a Preventive and Primary Care Benefit Plan, an In-Hospital Benefit Plan or a Standard Health Benefit Plan unless such policy, subscriber contract, or certificate contains the prescribed benefit provisions outlined in paragraphs (1)-(4) of this subsection.

(1) The Preventive and Primary Care Benefit Plan is discussed in this paragraph. The following forms shall be included in this plan as prescribed. Variable language in the prescribed forms is indicated by brackets.

(A) The Schedule of Benefits (Non-PPO Plan) for the Preventive and Primary Care Benefit Plan (Form Number 2055 SCH.PP) shall be in the language and format prescribed. This Schedule of Benefits shall be used when the plan does not include preferred provider (PPO) benefits.

(i) Variable amounts of $100 or $250 for the Policy Year Deductible are allowed to be elected by the small employer carrier or offered as an option to the small employer.

(ii) The optional Prescription Drug Benefit Rider shall be included on the Schedule of Benefits when provided. This optional rider is allowed to be included with the Preventive and Primary Care Benefit Plan. The prescription drug benefit shall be provided at a Percentage Payable of at least 50%, but may be provided at a greater Percentage Payable. The small employer carrier may elect to provide the prescription drug benefit through a prescription drug card program with a deductible not to exceed $8.00 per prescription or refill for a generic drug, or name brand drug if less than the generic drug, and $12 per prescription or refill for a name brand drug

(B) The Schedule of Benefits (PPO Plan) for the Preventive and Primary Care Benefit Plan (Form Number 2055 SCHPO.PP) shall be in the language and format prescribed. This Schedule of Benefits shall be used when the plan includes preferred provider (PPO) benefits.

(i) The terms "Policy Year Deductible", "Non-Preferred Provider Policy Year Deductible" and "Preferred Provider Policy Year Deductible" are variable to allow the same policy year deductible to apply to both preferred and nonpreferred provider options or to allow a "Non-Preferred Provider Policy Year Deductible" and a "Preferred Provider Policy Year Deductible" if different deductibles will apply. A "Per Visit Deductible" may be used in lieu of a Preferred Provider Policy Year Deductible. The deductible may be waived for either option.

(ii) A variable amount of $100 or $250 for the Policy Year Deductible or the Non-Preferred Provider Policy Year Deductible may be elected by the small employer carrier or the small employer. The Preferred Provider Policy Year Deductible may be any lesser amount.

(iii) A Per Visit Deductible of $10 or $15 may be included for the preferred provider option except for the Preventive Care Benefit.

(iv) A variable Percentage Payable of 90% or 100% when preferred providers are utilized shall be determined by the small employer carrier or offered as an option to the small employer. The Percentage Payable for the Preventive Care Benefit is not variable and shall be 100%.

(v) The optional Prescription Drug Benefit Rider shall be included on the Schedule of Benefits when provided. This optional rider is allowed to be included with the Preventive and Primary Care Benefit Plan. The prescription drug benefit shall be provided at a Percentage Payable of at least 50%, but may be provided at a greater Percentage Payable. The small employer carrier may elect to provide the prescription drug benefit through a prescription drug card program with a deductible not to exceed $8.00 per prescription or refill for a generic drug, or name brand drug if less than the generic drug, and $12.00 per prescription or refill for a name brand drug.

(C) The Policy Definitions for the Preventive and Primary Care Benefit Plan (Form Number 2055 DEF.PP) shall be in the language and format prescribed.

(i) The term and definition "Certificate of Insurance" is variable to be included or omitted as appropriate.

(ii) The terms and definitions for "Contracting Facility" and "Noncontracting Facility" are variable for Chapter 20 companies only and neither provision shall be included by other than Chapter 20 companies.

(iii) The term and definition of "Employer" provide a variable to include an Employer member of an association when a policy is to be issued to an association.

(iv) The term and definition of "Hospital" is variable only to allow for additional criteria for purposes of clarification or to accommodate carriers with unique operations and special statutory rights, such as Chapter 20 companies.

(v) The term and definition of "Policyholder" shall be included in the Policy Definitions as appropriate to define the Policyholder as the Employer, the Trustee of a Multiple Employer Trust or the Association.

(vi) The alternate definitions for the term "Policy Year" are included to allow the small employer to select the definition that is consistent with the carrier's and employer's practices. The definition, as selected, shall be included in the policy/certificate.

(vii) The term and definition of "Preexisting Condition" is variable only to the extent that it may be omitted in its entirety if the small employer carrier elects not to impose a limitation for preexisting conditions. If a preexisting condition limitation applies, this provision shall be included in its entirety.

(D) The Benefits Provided for the Preventive and Primary Care Benefit Plan (Form Number 2055 BEN.PP) shall be in the language and format prescribed.

(E) The Exclusions and

Limitations for the Preventive and Primary Care Benefit Plan (Form Number 2055 EXC.PP) shall be in the language and format prescribed. Exclusions of elective abortions, if any, are to be determined by an agreement between the employer and the small employer carrier and must be included in the Exclusions and Limitations of the policy, certificate and/or outline of coverage. Other variable exclusions are allowed to be included by Chapter 20 companies only.

(F) The Prescription Drug Benefit Rider (Form Number 2055 PDR), if elected, shall be in the language and format prescribed. This optional rider is allowed with the Preventive and Primary Care Benefit Plan. The variable 50% may be changed to provide a greater percentage payable under this rider.

(2) This paragraph discusses the in-hospital benefit plan. The following forms shall be included in this plan as prescribed. Variable language in the prescribed forms is indicated by brackets.

(A) The Schedule of Benefits (Non-PPO Plan) for the In-Hospital Benefit Plan (Form Number 2055 SCH.IH) shall be in the language and format prescribed. This Schedule of Benefits shall be used when the plan does not include preferred provider (PPO) benefits.

(i) A variable amount of $100 or $250 for the Hospital Deductible Per One Period of Hospital Confinement may be selected by the small employer carrier or offered as an option to the small employer.

(ii) A variable amount of $2,000 or $5,000 per individual for the Policy Year Copayment Maximum may be selected by the small employer carrier or offered as an option to the small employer.

(iii) The optional Supplementary Accidental Injury Benefit shall be included on the Schedule of Benefits, when elected. This optional rider is allowed with the In-Hospital Benefit Plan.

(B) The Schedule of Benefits (PPO Plan) for the In-Hospital Benefit Plan (Form Number 2055 SCHPO.IH) shall be in the language and format prescribed. This Schedule of Benefits shall be used when the plan includes preferred provider (PPO) benefits.

(i) The terms "Hospital Deductible Per One Period of Hospital Confinement", "Hospital Preferred Provider Deductible Per One Period of Hospital Confinement" and "Hospital Non-Preferred Provider Deductible Per One Period of Hospital Confinement" are variable to allow the same hospital deductible per confinement to apply to both preferred and non-preferred options or to allow a Hospital Preferred Provider Deductible Per One Period of Hospital Confinement and a Hospital Non-Preferred Provider Deductible Per One Period of Hospital Confinement if different deductibles will apply. The deductible may be waived for either option.

(ii) A variable amount of $100 or $250 for the Hospital Deductible Per One Period of Hospital Confinement or the Hospital Non-Preferred Provider Deductible Per One Period of Hospital Confinement may be elected by the small employer carrier or offered as an option to the small employer.

(iii) A variable amount of $2,000 or $5,000 per individual for the Policy Year Copayment Maximum may be elected by the small employer carrier or offered as an option to the small employer. A combination of preferred provider and non-preferred provider amounts for the Policy Year Copayment Maximum may be provided.

(iv) A variable Percentage Payable of 80%, 90% or 100% for the Inpatient Hospital Expense Benefit and Outpatient Follow-Up Care Benefit and a variable Percentage Payable of 70% or 80% for Mental Illness or Chemical Dependency Benefits when preferred providers are utilized shall be determined by the small employer carrier or offered as an option to the small employer.

(v) A variable Percentage Payable of 70% or 80% for the Inpatient Hospital Expense Benefit and Outpatient Follow-Up Care Benefit when non-preferred providers are utilized shall be determined by the small employer carrier or offered as an option to the small employer.

(vi) The optional Supplementary Accidental Injury Benefit shall be reflected on the Schedule of Benefits, when the optional rider is elected with the In-Hospital Benefit Plan.

(C) The Schedule of Benefits (Non-PPO Plan) for the Preventive and Primary Care Benefit Rider (Form Number 2055 SCH.PPR) shall be added to the In-Hospital Benefit Plan, when elected, in the language and format prescribed. This Schedule of Benefits shall be used when the plan does not include preferred provider (PPO) benefits. Variable amounts of $100 or $250 for the Policy Year Deductible may be elected by the small employer carrier or offered as an option to the small employer.

(D) The Schedule of Benefits (PPO Plan) for the Preventive and Primary Care Benefit Rider (Form Number 2055 SCHPO.PPR) shall be added to the In-Hospital Benefit Plan, when elected, in the language and format prescribed. This Schedule of Benefits shall be used when the plan includes preferred provider (PPO) benefits.

(i) The terms "Policy Year Deductible", "Non-Preferred Provider Policy Year Deductible" and "Preferred Provider Policy Year Deductible" are variable to allow the same policy year deductible to apply to both preferred and non-preferred provider options or to allow a "Non-Preferred Provider Policy Year Deductible" and a "Preferred Provider Policy Year Deductible" if different deductibles will apply. A "Per Visit Deductible" may be used in lieu of a Preferred Provider Policy Year Deductible. The deductible may be waived for either option.

(ii) A variable amount of $100 or $250 for the Policy Year Deductible or the Non-Preferred Provider Policy Year Deductible may be elected by the small employer carrier or offered as an option to the small employer. The Preferred Provider Policy Year Deductible may be any lesser amount.

(iii) A Per Visit Deductible of $10 or $15 may be included for the preferred provider option except for the Preventive Care Benefit.

(iv) A variable Percentage Payable of 90% or 100% when preferred providers are utilized shall be determined by the small employer carrier or offered as an option to the small employer. The Percentage Payable for the Preventive Care Benefit is not variable and shall be 100%.

(E) The Policy Definitions for the In-Hospital Benefit Plan (Form Number 2055 DEF.IH) shall be in the language and format prescribed.

(i) The term and definition "Certificate of Insurance" is variable to be included or omitted as appropriate.

(ii) The terms and definitions for "Contracting Facility" and "Noncontracting Facility" are variable to be included by Chapter 20 companies only and neither provision shall be included by other than Chapter 20 companies.

(iii) The term and definition of "Employer" provide a variable to include an Employer member of an association when a policy is to be issued to an Association.

(iv) The term and definition of "Hospital" is variable only to allow for additional criteria for purposes of clarification or to accommodate carriers with unique operations and special statutory

rights, such as Chapter 20 companies.

(v) The term "One Period of Hospital Confinement" provides a variable number of days of 90, 120, 150, or 180 to be included as elected by the small employer carrier or the small employer to determine one period of hospital confinement.

(vi) The term and definition of "Policyholder" shall be included in the Policy Definitions as appropriate to define the Policyholder as the Employer, the Trustee of a Multiple Employer Trust or the Association.

(vii) The alternate definitions for the term "Policy Year" are included to allow the small employer carrier to select the definition that is consistent with the carrier's and employer's practices. The definition, as selected, shall be included in the policy/certificate.

(viii) The term and definition of "Preexisting Condition" is variable only to the extent that it may be omitted in its entirety if the small employer carrier elects not to impose a limitation for preexisting conditions. If a preexisting condition limitation applies, this provision shall be included in its entirety.

(F) The Benefits Provided for the In-Hospital Benefit Plan (Form Number 2055 BEN.IH) shall be in the language and format prescribed. The Individual Policy Year Copayment Maximum amount of $2,000 or $5,000 elected shall be inserted in this provision.

(G) The Exclusions and Limitations for the In-Hospital Benefit Plan (Form Number 2055 EXC.IH) shall be in the language and format prescribed. Exclusions of elective abortions, if any, are to be determined by an agreement between the employer and the small employer carrier and must be included in the exclusions and limitations of the policy, certificate and/or outline of coverage. Other variable exclusions are allowed to be included by Chapter 20 companies only.

(H) The Supplementary Accidental Injury Benefit Rider for the In-Hospital Benefit Plan (Form Number 2055 ACCR) shall be in the language and format prescribed. This optional rider is allowed with the In-Hospital Benefit Plan.

(I) The Preventive and Primary Care Benefit Rider (Form Number 2055 PPR) added to the In-Hospital Benefit Plan shall be in the language and format prescribed. This optional rider is allowed with the In-Hospital Benefit Plan.

(3) The standard health benefit plan is discussed in this paragraph. The following forms shall be included in this plan as prescribed. Variable language in the prescribed forms is indicated by brackets.

(A) The Schedule of Benefits (Non-PPO Plan) for the Standard Health Benefit Plan (Form Number 2055 SCH.STD) shall be in the language and format prescribed. This Schedule of Benefits shall be used when the plan does not include preferred provider (PPO) benefits.

(i) A variable amount of $250 or $500 for the Policy Year Deductible may be elected by the small employer carrier or offered as an option to the small employer.

(ii) A variable amount of $2,000 per individual or $5,000 per individual for the Policy Year Copayment Maximum may be elected by the small employer carrier or offered as an option to the small employer.

(iii) A variable amount of $6,000 per family or $15,000 per family for the Policy Year Copayment Maximum may be elected by the small employer carrier or offered as an option to the small employer.

(iv) The variable limitation of a lifetime maximum of three separate series of treatment for each insured person for Chemical Dependency benefits shall be reflected when the small employer carrier elects to include this limitation.

(v) The Prescription Drug Benefit is variable only to the extent that the Percentage Payable may be greater than 50% or the small employer carrier may elect to provide the prescription drug benefit through a prescription drug card program with a deductible not to exceed $8.00 per prescription or refill for a generic drug, or name brand drug if less than the generic drug, and $12 per prescription or refill for a name brand drug.

(vi) All benefits added by riders shall be reflected on the Schedule of Benefits.

(B) The Schedule of Benefits (PPO Plan) for the Standard Health Benefit Plan (Form Number 2055 SCHPO.STD). This Schedule of Benefits shall be used when the plan includes preferred provider (PPO) benefits.

(i) The terms "Policy Year Deductible", "Non-Preferred Provider Policy Year Deductible" and "Preferred Provider Policy Year Deductible" are variable to allow the same policy year deductible to apply to both preferred and non-preferred provider options or to allow a "Non-Preferred Provider Policy Year Deductible" and a "Preferred Provider Policy Year Deductible" if different deductibles will apply. A "Per Visit Deductible" may be used in lieu of any policy year deductible. The deductible may be waived for either option.

(ii) A variable amount of $250 or $500 for the Policy Year Deductible or the Non-Preferred Provider Policy Year Deductible may be elected by the small employer carrier or offered as an option to the small employer. The Preferred Provider Policy Year Deductible may be any lesser amount.

(iii) A Per Visit Deductible of $10 or $15 is allowed except for the Preventive Care Benefit.

(iv) A variable amount of $2,000 per individual or $5,000 per individual for the Policy Year Copayment Maximum may be elected by the small employer carrier or offered as an option to the small employer. The preferred provider and non-preferred provider amounts may be combined for the Policy Year Copayment Maximum.

(v) A variable amount of $6,000 per family or $15,000 per family for the Policy Year Copayment Maximum may be elected by the small employer carrier or the small employer. The preferred provider and non-preferred provider amounts may be combined for the Policy Year Copayment Maximum.

(vi) A variable Percentage Payable of 80%, 90% or 100% when preferred providers are utilized shall be determined by the small employer carrier. The Percentage Payable for the Preventive Care Benefit is not variable and shall be 100% with no deductible.

(vii) A variable Percentage Payable of 70% or 80% when non-preferred providers are utilized shall be determined by the small employer carrier. The Percentage Payable for Preventive Care Benefits is not variable and shall be at 100% with no deductible.

(viii) The variable limitation of a lifetime maximum of three separate series of treatments for each insured person for Chemical Dependency benefits shall be reflected when the small employer carrier elects to include this limitation.

(ix) The Prescription Drug Benefit is variable only to the extent that the Percentage Payable may be greater than 50% or the small employer carrier may elect to provide the prescription drug benefit through a prescription drug card program with a deductible not to exceed $8.00 per prescription or refill for a generic drug, or name brand drug if less than the generic drug, and $12 per prescription or refill for a name brand drug.

(x) Any benefits added by riders shall be reflected on the Schedule of Benefits.

(C) The Policy Definitions for the Standard Health Benefit Plan (Form Number 2055 DEF.STD) shall be in the language and format prescribed.

(i) The term and definition "Certificate of Insurance" is variable to be included or omitted as appropriate.

(ii) The terms and definitions for "Contracting Facility" and "Noncontracting Facility" are variables to be included by Chapter 20 companies only and neither provision shall be used by other than Chapter 20 companies.

(iii) The term and definition of "Employer" provides a variable to include an Employer member of an association when a policy is to be issued to an Association.

(iv) The term and definition of "Hospital" is variable only to allow for additional criteria for purposes of clarification or to accommodate carriers with unique operations and special statutory rights, such as Chapter 20 companies.

(v) The term and definition of "Policyholder" shall be included in the Policy Definitions as appropriate to define the Policyholder as the Employer, the Trustee of a Multiple Employer Trust or the Association.

(vi) The alternate definitions for the term "Policy Year" are included to allow the small employer carrier to select the definition that is consistent with the carrier's and employer's practices. The definition, as selected, shall be included in the policy/certificate.

(vii) The term and definition of "Preexisting Condition" is variable only to the extent that it may be omitted in its entirety if the small employer carrier elects not to impose a limitation for preexisting conditions. If a preexisting condition limitation applies, the provision shall be included in its entirety.

(D) The Benefits Provided for the Standard Health Benefit Plan (Form Number 2055 BEN.STD) shall be in the language and format prescribed.

(i) The Individual Policy Year Copayment Maximum amount elected shall be inserted in this provision.

(ii) The Family Policy Year Copayment Maximum elected shall be inserted in this provision.

(E) The Exclusions and Limitations for the Standard Health Benefit Plan (Form Number 2055 EXC.STD) shall be in the language and format prescribed. Exclusions of elective abortions, if any, are to be determined by an agreement between the employer and the small employer carrier and must be included in the exclusions and limitaitons of the policy, certificate and/or outline of coverage. Other variable exclusions may be included by Chapter 20 companies only.

(F) The Alternate Benefits for Chemical Dependency (Form Number 2055 ACD), if elected by the small employer carrier, shall be attached to the policy, subscriber contract, and certificate and shall be in the language and format prescribed.

(4) Forms common to more than one health benefit plan are described in subparagraphs (A) through (D) and shall be included with the benefit provisions of each plan as specified.

(A) Alternate Cost Containment Provisions for Large Case Management and Second Opinion Requirements (Form Number 2055 ACC) are provided as optional provisions for all plans. Small employer carriers may use these provisions or modification of these provisions. Other alternate cost containment provisions, including precertification, pre-authorization, case management and utilization review may be used.

(B) The Continuation/Conversion Provisions (Form Number 2055 COP) shall be included with all group plans. This form shall be in the language and format prescribed. The small employer carrier shall include one of the variable provisions for continuation upon policy termination.

(C) The Coordination of Benefits (Form Number 2055 COB) shall be included with all plans. This form shall be in the language and format prescribed. The variable insert language "This provision will only apply for the duration of your employment with the Employer" is required to be included in the individual policies.

(D) The Preferred Provider Provisions (PPO) (Form Number 2055 PPO) shall be included with all plans when preferred provider options are included. This form shall be in the language and format prescribed. Additional provisions may be added as necessary to disclose preferred provider information.

(i) Variable provisions are allowed for the definition of service area to be in terms of counties, zip codes, in terms of a 50-mile radius from the employee's principal place of employment unless there are no providers located within the 50 mile radius, or the service area may be described in a specific document to be referenced in the policy/certificate provision. Service areas by zip codes shall be defined in a non-discriminatory manner and in compliance with the Insurance Code, Articles 21.21, §4 and 21.21-5. Service area definitions and descriptions shall be filed with the form filings. The small employer carrier shall obtain approval for any definition of the service area by counties or zip codes where the grouping of counties or zip codes exceed a 50-mile radius from the principal place of employment or for a different definition of a service area.

(ii) Except as provided in §26.21 of this title (relating to Cost Containment), preferred provider arrangements shall comply with Chapter 3, Subchapter X, of this title (relating to Preferred Provider Plans).

(E) The Chemical Dependency Benefit Waiver Rider (Form Number 2055 CDW) shall be in the language and format prescribed. The Rider may be included with the Preventive and Primary Care Benefit Plan or the Standard Health Benefit Plan when at least 50% of the employees waive alcohol and substance abuse benefits in writing, and indicate in writing that they have undergone treatment or counseling for alcoholism or substance abuse within the last three years. The rider shall apply only to those employees who have waived these benefits in writing as noted in this subparagraph. Small employer carriers shall comply with the provisions of the Insurance Code, Article 26.47A, before the above waiver is attached to a policy, subscriber contract and certificate. The small employer carrier shall obtain in writing a waiver of alcohol and substance abuse benefits by at least 50% of the employees and the employees shall indicate in writing that they have undergone alcoholism or substance abuse treatment or counseling within the last three years.

(5) Applications are discussed in this paragraph. Small employer carriers may use any appropriate application, enrollment, or participation agreement forms.

(6) The outline of coverage is discussed in this paragraph. No individual small employer health benefit plan, subject to the Insurance Code, Chapter 26, may be delivered or issued for delivery in this state unless an appropriate Outline of Coverage, as prescribed in the Insurance Code, Article 3.70-1(G) and §3.3090 of this title (relating to Outline of Coverage Generally), §3.3092 of this title (relating to Format, Content and Readability for Outline of Coverage), and §3.3093 of this title (relating to Prescribed

Outlines of Coverage), or this paragraph is also issued. If the prototype forms are not used, small employer carriers must follow instructions outlined in §§3.3090, 3.3092, and 3.3093, as applicable.

(A) The Outline of Coverage for the Small Employer Preventive and Primary Care Benefit Plan (Non-PPO) (Form Number 2055 OC.PP) is discussed in this subparagraph. The variables in the Benefits and Exclusions and Limitations provisions correspond to the variables described for the Schedule of Benefits and Exclusions and Limitations in subparagraphs (1)(A) and (E) of this subsection.

(B) The optional insert to the Outline of Coverage shall be included when the Prescription Drug Rider (Form Number 2055 OC.PDR) is elected. The Prescription Drug Rider is allowed to be added to the Preventive and Primary Care Benefit Plan (Non-PPO and PPO). The variables in the Benefits provision correspond to the variables described for the Schedule of Benefits in paragraph (1)(A) of this subsection.

(C) The Outline of Coverage for the Small Employer Preventive and Primary Care Benefit Plan (PPO), (Form Number 2055 OCPO.PP) is discussed in this subparagraph. The variables in the Benefits and Exclusions and Limitations provisions correspond to the variables described for the Schedule of Benefits in paragraphs (1)(B) and (E) of this subsection.

(D) The Outline of Coverage for the Small Employer In-Hospital Benefit Plan (Non-PPO) (Form Number 2055 OC.IH) is discussed in this subparagraph. The variables in the Benefits and Exclusions and Limitations provisions correspond to the variables described for the Schedule of Benefits and Exclusions and Limitations in paragraph (2)(A) and (G) of this subsection.

(E) Optional insert to the Outline of Coverage shall be included when the Supplementary Accidental Injury Benefit (Form Number 2055 OC.ACCR) is elected. The Supplementary Accidental Injury Benefit is allowed to be added to the In-Hospital Benefit Plan (Non-PPO and PPO).

(F) Optional insert to the Outline of Coverage shall be included when the Preventive and Primary Care Benefit Rider (Form Number 2055 OC.PPR) is elected. The Preventive and Primary Care Benefit Rider is allowed to be added to the In-Hospital Benefit Plan (Non-PPO). The variables in the Benefits provision correspond to the variables described for the Schedule of Benefits in paragraph (2)(C) of this subsection.

(G) The Outline of Coverage for the Small Employer In-Hospital Benefit Plan (PPO) (Form Number 2055 OCPO.IH) is discussed in this paragraph. The variables in the Benefits and Exclusions and Limitations provisions correspond to the variables described for the Schedule of Benefits and Exclusions and Limitations in paragraph (2)(B) and (E) of this subsection.

(H) Optional insert to the Outline of Coverage shall be included when the Preventive and Primary Care Benefit Rider (Form Number 2055 OCPO.PPR) is elected. The Preventive and Primary Care Benefit Rider is allowed to be added to the In-Hospital Benefit Plan (PPO). The variables in the Benefits provision correspond to the variables described for the Schedule of Benefits in paragraph (2)(D) of this subsection.

(I) The Outline of Coverage for the Small Employer Standard Health Benefit Plan (Non-PPO) (Form Number 2055 OC.STD) is discussed in this subparagraph. The variables in the Benefits and Exclusions and Limitations provisions correspond to the variables described for the Schedule of Benefits and Exclusions and Limitations in paragraph (3)(A) and (E) of this subsection.

(J) The Outline of Coverage for the Small Employer Standard Health Benefit Plan (PPO) (Form Number 2055 OCPO.STD) is discussed in this subparagraph. The variables in the Benefits and Exclusions and Limitations provisions correspond to the variables described for the Schedule of Benefits and Exclusions and Limitations in sub paragraphs (3)(B) and (E) of this subsection.

(j) The HMO forms are discussed in this subsection.

(1) Pototype contracts/certificates of coverage and benefit plans have been developed to facilitate implementation of the Insurance Code, Chapter 26, and to streamline the contract approval process. The required benefit language is provided in the prototype Primary and Preventive Health Benefit Plan (Form Number 2055 HMO-PP), and the Standard Health Benefit Plan (Form Number 2055 HMO-STAN). The optional standard provision language is provided in the prototypc contract/certificate of coverage (Form Number 2055 HMO-CONT). Variable material in these forms is denoted in brackets. HMOs may use various options within the bracketed material. Exclusions of elective abortions, if any, are to be determined by an agreement between the employer and the small employer carrier and must be in the contract/certificate of coverage at Exclusions.

(2) The prototype contracts/certificates of coverage provide for the entire contract to include any applications, certificate of coverage and any attached riders.

(3) If the HMO elects to be a small employer carrier and offers a health benefit plan other than the two prototype benefit plans; that plan must be a state-approved health benefit plan that complies with the requirements of Title XI, Public Health Service Act (42 U.S.C., §300, et seq.) and the rules adopted under the act. The following content format shall be used:

A. CONTRACT FACE PAGE This page shall contain the name, address and telephone numbers (800 number, if applicable) of the health maintenance organization. The prototype contract shall be entitled:

**Texas Small Employer Group Health Benefit Plan Contract/Certificate of Coverage**

The attached benefit plan shall be entitled one of the following:

1. Preventive and Primary Care Benefit Plan, or

2. Standard Health Benefit Plan

B. TOLL-FREE NUMBER PAGE This form must contain the language prescribed in §1.601 of Chapter 1 of this title (relating to Notice of Toll-free Telephone Numbers and Information and Complaint Procedures) and shall be attached as the first, second or third page of the contract.

C. CONTRACT PROVISIONS At a minimum, the contract must contain the following provisions:

1. Face Page
2. Benefits
3. Cancellation
4. Claim filing procedure
5. Complaint procedure
6. Conformity with state law
7. Continuation of coverage for certain dependents
8. Conversion privilege
9. Coordination of Benefits
10. Definitions
11. Effective date
12. Eligibility
13. Emergency services
14. Entire contract provision
15. Exclusions and limitations

16. Grace period
17. Incontestability
18. Schedule of charges
19. Service area
20. Subrogation
21. Termination

D. RIDERS Riders allowing for additional benefits may be attached to the state approved health benefit plan. The Preventive and Primary Care Benefit Plan may allow the attachment of a prescription drug rider only. The Standard Health Benefit Plan may allow the attachment of unlimited riders.

*§26.16. Renewability of Coverage and Cancellation.*

(a) Except as provided by the Insurance Code, Article 26.24, a small employer carrier shall renew any small employer health benefit plan for any covered small employer at the option of the small employer, except for:

(1) nonpayment of a premium as required by the terms of the plan;

(2) fraud or misrepresentation of a material fact by the small employer;

(3) noncompliance with small employer health benefit plan provisions. Such provisions may address requirements such as the level of contribution and participation and failure of an employer to maintain status as a small employer subject to requirements of this chapter. Noncompliance with a small employer health benefit plan with respect to an HMO also includes those items set forth in §11.506(4)(A) of this title (relating to Mandatory Provisions: Group and Non-Group Agreement and Group Certificate).

(b) A small employer carrier may refuse to renew the coverage of an eligible employee or dependent for fraud or misrepresentation of a material fact by that individual. The coverage is also subject to any policy or contractual provisions relating to incontestability or time limits on certain defenses.

(c) A small employer carrier may not cancel a small employer health benefit plan except for the reasons specified for refusal to renew under the Insurance Code, Article 26.23(a) and subsections (a) and (b) of this section. A small employer carrier may not cancel the coverage of an eligible employee or dependent except for the reasons specified for refusal to renew under the Insurance Code, Article 26.23(b) and subsections (a) and (b) of this section.

(d) Standard benefit plans, provided through an individual policy, shall be guaranteed renewable for life or until maximum benefits have been paid. Other small employer health benefit plans, provided through individual policies, shall be guaranteed renewable for life or until maximum benefits have been paid, or may be guaranteed renewable with the only reasons for termination being those set out in the Insurance Code, Articles 26.23 and 26.24, and this chapter, provided that such plans shall include a conversion provision which provides comparable benefits to those required under Chapter 3, Subchapter F of this title (relating to Group Health Insurance Mandatory Conversion Privilege). All other health benefit plans issued to small employers shall be renewed at the option of the small employer, but may provide for termination in accordance with the Insurance Code, Chapter 26, and this chapter.

*§26.19. Filing Requirements.*

(a) Each health carrier shall file each form, including, but not limited to, each policy, contract, certificate, agreement, evidence of coverage, endorsement, amendment, enrollment form, and application, that will be used to provide a health benefit plan in the small employer market, with the department in accordance with the Insurance Code, Article 3.42 and Chapter 3, Subchapter A, of this title (relating to Requirements for Filing of Policy Forms, Riders, Amendments, and Endorsements for Life, Accident and Health Insurance and Annuities), or the Insurance Code, Article 20A.09 and §11.301(4) of this title (relating to Filing Requirements) or §11.302(6) of this title (relating to Service Area Expansion Requests), as applicable, except as provided in subsection (b) of this section. A health carrier desiring to use existing forms to provide a health benefit plan in the small employer market shall file a certification stating which previously approved forms the health carrier intends to use in that market. The form provided at Figure 69 of these sections (Form 2055 CERT ANN) may be used for this purpose. The previously approved forms should be listed in Provision E of that form. The certification shall be forwarded to the department as soon as reasonably possible after January 1, 1994.

(b) The following certification forms providing information relating to prototype policy forms, marketing in the small employer market and/or other markets, and geographic service areas, shall accompany each health benefit plan form filing submitted for use in the small employer market.

(1) A geographic service area certification (Form Number 2055 CERT GEOG) shall be submitted by each health carrier providing health benefit plans to small employers and shall define the geographic service areas within which the small employer carrier will operate as a small employer carrier.

(A) This certification form must accompany each health benefit plan form filing initially submitted for use in the small employer market.

(B) After the initial filings of health benefit plans intended for use in the small employer market have been approved, this certification form will only be due annually, no later than March 1 of each calendar year; however, if the geographic service areas change at anytime, a new certification form defining the new service areas will be due no later than 30 days prior to the change.

(2) A prototype certification form (Form Number 2055 CERT PROTOTYPES/MRKT) shall accompany each policy form filing and/or certification filing. The certification form shall:

(A) state whether the carrier plans to use prototype policy forms;

(B) specify the prototype forms, if any, that the health carrier plans to use in the small employer market; and

(C) specify, describe and explain any variance contained in the forms being filed from the provisions contained in the prototype forms. If a health carrier, other than an HMO, utilizes the prototype forms and only uses variations permitted in the prescribed and/or adopted forms, the certification with the description of the variations will suffice and policy forms will not be required to be submitted for review and approval. Approval of the use of the prototype forms based on the certification and the description of the variations, will be communicated via an approval letter.

(D) define the market in which the form will be used, such as, for use only in the small employer market or in all employer markets or other markets. The certification form shall also specify whether the carrier will be marketing the form in geographic services areas previously submitted or will be marketing in new geographic service areas. If marketing in new geographic service areas, the filing shall include the certification (Form Number 2055 CERT GEOG) which defines the new geographic service areas.

(c) Each health carrier, other than an HMO, shall use a policy shell format for any group or individual health benefit plan form used to provide a health benefit plan in the small employer market. To expedite the review and approval process, all group and individual health benefit plan form fil-

ings (excluding HMO filings which are covered in subsection (d) of this section) shall be submitted as follows:

(1) a group policy face page or individual policy face page, as applicable;

(2) the group certificate page or individual data page, as applicable;

(3) the toll free number and complaint notice page, as required by Chapter 1, Subchapter E, of this title (relating to Notice of Policyholder Complaint Procedure);

(4) the table of contents;

(5) insert pages for the general provisions;

(6) insert pages for the required provisions and any optional provisions, if elected and as applicable;

(7) for the standard benefit forms, which include the Preventive and Primary Care Benefit Plan, the In-Hospital Benefit Plan, and the Standard Health Benefit Plan, an insert of the required benefits section that includes the schedule of benefits, definitions, benefits provided, alternate cost containment and preferred provider provisions, if any, exclusions and limitations, continuation/conversion provisions, coordination of benefits, and riders;

(8) for small employer health benefit plans that are not one of the standard benefit forms, an insert page for the benefits section of the health benefit plan, including, but not limited to, schedule of benefits, definitions, benefits provided, alternate cost containment and preferred provider provisions, if any, exclusions and limitations, continuation/conversion provisions, coordination of benefits, and riders.

(9) insert pages for any amendments, applications, enrollment forms, or other form filings which comprise part of the contract;

(10) insert pages for any additional forms required under Chapter 3, Subchapter F, of this title (relating to Group Health Insurance Mandatory Conversion Privilege);

(11) insert pages for any required Outline of Coverage for individual products;

(12) any additional form filings and documentation as outlined in Chapter 3, Subchapter A of this title (relating to Requirements for Filing of Policy Forms, Riders, Amendments and Endorsements for Life, Accident and Health Insurance and Annuities) and Chapter 3, Subchapter G of this title (relating to Plain Language Requirements for Health Benefit Policies);

(13) the certifications required under this section and any other rating information required under §26.10 of this title (relating to Establishment of Classes of Business) and §26.11 of this chapter (relating to Restrictions Relating to Premium Rates); and

(14) the rate schedule applicable to any individual health benefit plan, as required by §3.3(d) of this title (relating to Specific Additional Submission Requirements);

(d) In addition to subsections (a) and (b) of this section, the following provisions apply to each health carrier that is an HMO. The HMO shall submit health benefit plan forms for use in the small employer market in accordance with the following:

(1) Any HMO group or individual agreement shall address and include all required provisions of the Insurance Code, Chapter 26. Such agreement shall be in compliance with any other applicable provisions of the Insurance Code. In addition, the agreement shall comply with the provisions of Subchapter F of Chapter 11 of this title (relating to Evidence of Coverage) where those provisions are not in conflict with Insurance Code, Chapter 26.

(2) The filing shall include any alternate page(s) to the agreement or the schedule of benefits and any alternate schedule(s) of benefit.

(3) The filing shall include any additional riders, amendments, applications, enrollment forms, or other forms and any other required documentation outlined in Chapter 11, Subchapter F, of this title (relating to Evidence of Coverage).

(4) The filing shall include any applicable requirements of of Chapter 11, Subchapter D, of this title (relating to Regulatory Requirements for an HMO Subsequent to Issuance of a Certificate of Authority), and of Chapter 11, Subchapter F, of this title (relating to Evidence of Coverage).

(5) The filing shall include any rider forms that will be used with health benefit plans offered to small employers. The rider forms, if developed subsequent to approval of the agreement, shall be submitted with an explanation of the market in which the forms will be used. All rider forms shall comply with the Insurance Code, Article 20A.09 and applicable provisions of Chapter 11, Subchapter D, of this title (relating to Regulatory Requirements for an HMO Subsequent to Issuance of a Certificate of Authority ) and of Chapter 11, Subchapter F, of this title (relating to Evidence of Coverage).

*§26 27 Appendix.* The forms adopted and incorporated in §26.2 (relating to Forms adopted and Incorporated by Reference) are included in the Appendix to these sections. The following index refers to the form number, its description, and the figure number in the appendix.

*(Editor's Note The forms are being published on the following pages.)*

**This agency hereby certifies that the rule as adopted has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.**

Issued in Austin, Texas, on December 9, 1993.

TRD-9000428 Linda K. von Quintus-Dorn
Chief Clerk
Texas Department of Insurance

Effective date: December 30, 1993

Proposal publication date: October 29, 1993

For further information, please call: (512) 463-6327

Name: Dallas Martin
Grade: 2
School: Barton Hills Elementary, Travis ISD

| FORM NUMBER | FIGURE NO. | DESCRIPTION |
|---|---|---|
| 2055 SE.PP | 1 | Group Policy Face Page - Preventive and Primary Care Benefit Plan (single employer) |
| 2055 SE.IH | 2 | Group Policy Face Page - In-Hospital Benefit Plan (single employer) |
| 2055 SE.STD | 3 | Group Policy Face Page - Standard Health Benefit Plan (single employer) |
| 2055 MET.PP | 4 | Group Policy Face Page - Preventive and Primary Care Benefit Plan (MET) |
| 2055 MET.IH | 5 | Group Policy Face Page - In-Hospital Benefit Plan (MET) |
| 2055 MET.STD | 6 | Group Policy Face Page - Standard Health Benefit Plan (MET) |
| 2055 ASSN.PP | 7 | Group Policy Face Page - Preventive and Primary Care Benefit Plan (Association) |
| 2055 ASSN.IH | 8 | Group Policy Face Page - In-Hospital Benefit Plan (Association) |
| 2055 ASSN.STD | 9 | Group Policy Face Page - Standard Health Benefit Plan (Association) |

| | | |
|---|---|---|
| 2055 ISE.PP | 10 | Individual Policy Face Page - Preventive and Primary Care Benefit Plan |
| 2055 ISE.IH | 11 | Individual Policy Face Page - In-Hospital Benefit Plan |
| 2055 ISE.STD | 12 | Individual Policy Face Page - Standard Health Benefit Plan |
| TOLLFREE | 13 | Notice of Toll-Free Telephone Numbers and Information and Complaint Procedures |
| 2055 CERT.PP | 14 | Group Certificate Face Page - Preventive and Primary Care Benefit Plan |
| 2055 CERT.IH | 15 | Group Certificate Face Page - In-Hospital Benefit Plan |
| 2055 CERT.STD | 16 | Group Certificate Face Page - Standard Health Benefit Plan |
| 2055 DP | 17 | Individual Data Page |
| 2055 TCG | 18 | Group Table of Contents |
| 2055 TCI | 19 | Individual Table of Contents |
| 2055 GGP | 20 | Group General Provisions |
| 2055 IGP | 21 | Individual General Provision |
| 2055 GRP | 22 | Group Provisions |
| 2055 IRP | 23 | Individual Provisions |
| 2055 SCH.PP | 24 | Schedule of Benefits (Non-PPO) Preventive and Primary Care Benefit Plan |
| 2055 SCHPO.PP | 25 | Schedule of Benefits (PPO) Preventive and Primary Care Benefit Plan |
| 2055 DEF.PP | 26 | Policy Definitions - Preventive and Primary Care Benefit Plan |

| | | |
|---|---|---|
| 2055 BEN.PP | 27 | Benefits Provided - Preventive and Primary Care Benefit Plan |
| 2055 EXC.PP | 28 | Exclusions and Limitations Preventive and Primary Care Benefit Plan |
| 2055 PDR | 29 | Prescription Drug Benefit Rider Preventive and Primary Care Benefit Plan |
| 2055 SCH.IH | 30 | Schedule of Benefits (Non-PPO) In-Hospital Benefit Plan |
| 2055 SCHPO.IH | 31 | Schedule of Benefits (PPO) In-Hospital Benefit Plan |
| 2055 SCH.PPR | 32 | Schedule of Benefits for the Preventive and Primary Care Benefit Rider (Non-PPO) In-Hospital Benefit Plan |
| 2055 SCHPO.PPR | 33 | Schedule of Benefits for the Preventive and Primary Care Benefit Rider (PPO) In-Hospital Benefit Plan |
| 2055 DEF.IH | 34 | Policy Definitions In-Hospital Benefit Plan |
| 2055 BEN.IH | 35 | Benefits Provided In-Hospital Benefit Plan |
| 2055 EXC.IH | 36 | Exclusions and Limitations In-Hospital Benefit Plan |
| 2055 ACCR | 37 | Supplementary Accidental Injury Benefit Rider In-Hospital Benefit Plan |
| 2055 PPR | 38 | Preventive and Primary Care Benefit Rider In-Hospital Benefit Plan |

| | | |
|---|---|---|
| 2055 SCH.STD | 39 | Schedule of Benefits (Non-PPO) Standard Health Benefit Plan |
| 2055 SCHPO.STD | 40 | Schedule of Benefits (PPO) Standard Health Benefit Plan |
| 2055 DEF.STD | 41 | Policy Definitions Standard Health Benefit Plan |
| 2055 BEN.STD | 42 | Benefits Provided Standard Health Benefit Plan |
| 2055 EXC.STD | 43 | Exclusions and Limitations Standard Health Benefit Plan |
| 2055 ACD | 44 | Alternate Benefits for Chemical Dependency Standard Health Benefit Plan |
| 2055 ACC | 45 | Alternate Cost Containment Provisions (all plans) |
| 2055 COP | 46 | Continuations/Conversion Provisions (group plans) |
| 2055 COB | 47 | Coordination of Benefits (all plans) |
| 2055 PPO | 48 | Preferred Provider Provisions (all plans) |
| 2055 CDW | 49 | Chemical Dependency Benefit Waiver Rider Preventive and Primary Care Benefit Plan/Standard Health Benefit Plan |
| 2055 OC.PP | 50 | Outline of Coverage Individual Preventive and Primary Care Benefit Plan (Non-PPO) |
| 2055 OC.PDR | 51 | Outline of Coverage Insert - Prescription Drug Rider Preventive and Primary Care Benefit Plan (Non-PPO) |

| | | |
|---|---|---|
| 2055 OCPO.PP | 52 | Outline of Coverage Individual Preventive and Primary Care Benefit Plan (PPO) |
| 2055 OC.IH | 53 | Outline of Coverage Individual In-Hospital Benefit Plan (Non-PPO) |
| 2055 OC.ACCR | 54 | Outline of Coverage insert Supplementary Accidental Injury Benefit Rider In-Hospital Benefit Plan (Non-PPO and PPO) |
| 2055 OC.PPR | 55 | Outline of Coverage insert Preventive and Primary Care Benefit Rider In-Hospital Benefit Plan (Non-PPO) |
| 2055 OCPO.IH | 56 | Outline of Coverage Individual In-Hospital Benefit Plan (PPO) |
| 2055 OCPO.PPR | 57 | Outline of Coverage Insert Preventive and Primary Care Benefit Rider In-Hospital Benefit Plan (PPO) |
| 2055 OC.STD | 58 | Outline of Coverage Individual Standard Health Benefit Plan (Non-PPO) |
| 2055 OCPO.STD | 59 | Outline of Coverage Individual Standard Health Benefit Plan (PPO) |
| 2055 HMO-PP | 60 | Small Group Primary and Preventive Benefit Plan. Includes required benefit language for HMOs. |
| 2055 HMO-STAN | 61 | Small Group Standard Health Benefit Plan. Includes required benefit language for HMOs. |

| | | |
|---|---|---|
| 2055 HMO-CONT | 62 | Texas Small Employer Group Health Benefit Plan Contract and Certificate of Coverage. Includes optional standard provision language for HMOs. |
| 2055 CERT SEHC STATUS | 63 | Certification form status of health carriers as small employer carriers |
| 2055 CERT PROTOTYPES/MRKT | 64 | Certification form specifying prototypes forms, if any, health carrier plans to use in small employer market and whether for use only in small employer markets or all employer markets or otherwise |
| 2055 CERT GEOG | 65 | Certification form defining (on an annual basis or upon change) geographic service areas within which small employers will operate as a small employer carrier |
| 2055 CERT ACTUARIAL | 66 | Actuarial Certification form providing required actuarial certification on an annual basis |
| 2055 CERT COOP | 67 | Annual filing for private purchasing coops |
| 2055 CERT GROSS PREM | 68 | Report of gross premiums |
| 2055 CERT ANN LIST-OTHER/SEHBP | 69 | Certification form listing, on an annual basis, small employer health benefit plans and other plans (sold to small employers) not subject to Insurance Code, Chapter 26 |
| 2055 CERT DATA | 70 | Form listing information on small employer health plans insured by small employer carriers |

# LIST OF PROTOTYPE POLICY FORMS AND FORM NUMBERS FOR EACH PLAN

Group Preventive and Primary Care Benefit Plan
Group In-Hospital Benefit Plan
Group Standard Health Benefit Plan

Individual Preventive and Primary Care Benefit Plan
Individual In-Hospital Benefit Plan
Individual Standard Health Benefit Plan

## GROUP PREVENTIVE AND PRIMARY CARE BENEFIT PLAN

| Prototype Form Number | Form Description |
|---|---|
| 2055 SE.PP | Policy Face Page (Employer) |
| 2055 MET.PP | Policy Face Page (MET) |
| 2055 ASSN.PP | Policy Face Page (Association) |
| TOLLFREE | Tollfree Number & Information |
| 2055 CERT.PP | Certificate Face Page |
| TOLLFREE | Tollfree Number & Information |
| 2055 TCG | Table of Contents |
| 2055 GGP | Geheral Provisions |
| 2055 GRP | Group Provisions |
| 2055 SCH.PP | Schedule of Benefits (Non-PPO) |
| 2055 SCHPO.PP | Schedule of Benefits (PPO) |
| 2055 DEF.PP | Policy Definitions |
| 2055 BEN.PP | Benefits Provided |
| 2055 ACC | Alternate Cost Containment |
| 2055 PPO | Preferred Provider Provisions |
| 2055 EXC.PP | Exclusions and Limitations |
| 2055 COP | Continuation/ Conversion |
| 2055 COB | Coordination of Benefits |
| 2055 PDR | Prescription Drug Rider |
| 2055 CDW | Chemical Dependency Benefit Waiver Rider |

## GROUP IN-HOSPITAL BENEFIT PLAN

| Prototype Form Number | Form Description |
|---|---|
| 2055 SE.IH | Policy Face Page (Employer) |
| 2055 MET.IH | Policy Face Page (MET) |
| 2055 ASSN.IH | Policy Face Page (Association) |
| TOLLFREE | Tollfree Number & Information |
| 2055 CERT.IH | Certificate Face Page |
| TOLLFREE | Tollfree Number & Information |
| 2055 TCG | Table of Contents |
| 2055 GGP | General Provisions |
| 2055 GRP | Group Provisions |
| 2055 SCH.IH | Schedule of Benefits (Non-PPO) |
| 2055 SCHPO.IH | Schedule of Benefits (PPO) |
| 2055 SCH.PPR | Schedule of Benefits - Preventive & Primary Care Rider (Non-PPO) |
| 2055 SCHPO.PPR | Schedule of Benefits - Preventive & Primary Care Rider (PPO) |
| 2055 DEF.IH | Policy Definitions |
| 2055 BEN.IH | Benefits Provided |
| 2055 ACC | Alternate Cost Containment |
| 2055 PPO | Preferred Provider Provisions |
| 2055 EXC.IH | Exclusions and Limitations |
| 2055 COP | Continuation/ Conversion |
| 2055 COB | Coordination of Benefits |
| 2055 PPR | Preventive and Primary Care Rider |
| 2055 ACCR | Supplementary Accidental Injury Benefit Rider |

**GROUP STANDARD HEALTH BENEFIT PLAN**

| Prototype Form Number | Form Description |
|---|---|
| 2055 SE.STD | Policy Face Page (Employer) |
| 2055 MET.STD | Policy Face Page (MET) |
| 2055 ASSN.STD | Policy Face Page (Association) |
| TOLLFREE | Tollfree Number & Information |
| 2055 CERT.STD | Certificate Face Page |
| TOLLFREE | Tollfree Number & Information |
| 2055 TCG | Table of Contents |
| 2055 GGP | General Provisions |
| 2055 GRP | Group Provisions |
| 2055 SCH.STD | Schedule of Benefits (Non-PPO) |
| 2055 SCHPO.STD | Schedule of Benefits (PPO) |
| 2055 DEF.STD | Policy Definitions |
| 2055 BEN.STD | Benefits Provided |
| 2055 ACC | Alternate Cost Containment |
| 2055 PPO | Preferred Provider Provisions |
| 2055 EXC.STD | Exclusions and Limitations |
| 2055 COP | Continuation/Conversion |
| 2055 COB | Coordination of Benefits |
| 2055 CDW | Chemical Dependency Benefit Waiver Rider |
| 2055 ACD | Alternate Benefits for Chemical Dependency |

## INDIVIDUAL PREVENTIVE AND PRIMARY CARE BENEFIT PLAN

| Prototype Form Number | Form Description |
|---|---|
| 2055 ISE.PP | Policy Face Page |
| TOLLFREE | Tollfree Number & Information |
| 2055 DP | Individual Data Page |
| 2055 TCI | Table of Contents |
| 2055 IGP | General Provisions |
| 2055 IRP | Individual Provisions |
| 2055 SCH.PP | Schedule of Benefits (Non-PPO) |
| 2055 SCHPO.PP | Schedule of Benefits (PPO) |
| 2055 DEF.PP | Policy Definitions |
| 2055 BEN.PP | Benefits Provided |
| 2055 ACC | Alternate Cost Containment |
| 2055 PPO | Preferred Provider Provisions |
| 2055 EXC.PP | Exclusions and Limitations |
| 2055 COB | Coordination of Benefits |
| 2055 PDR | Prescription Drug Rider |
| 2055 CDW | Chemical Dependency Benefit Waiver Rider |
| 2055 OC.PP | Outline of Coverage (Non-PPO) |
| 2055 OC.PDR | Insert to the Outline of Coverage (Non-PPO and PPO) for the Prescription Drug Rider |
| 2055 OCPO.PP | Outline of Coverage (PPO) |

## INDIVIDUAL IN-HOSPITAL BENEFIT PLAN

| Prototype Form Number | Form Description |
|---|---|
| 2055 ISE.IH | Policy Face Page |
| TOLLFREE | Tollfree Number & Information |
| 2055 DP | Individual Data Page |
| 2055 TCI | Table of Contents |
| 2055 IGP | General Provisions |
| 2055 IRP | Individual Provisions |
| 2055 SCH.IH | Schedule of Benefits (Non-PPO) |
| 2055 SCHPO.IH | Schedule of Benefits (PPO) |
| 2055 SCH.PPR | Schedule of Benefits - Preventive & Primary Care Rider (Non-PPO) |
| 2055 SCHPO.PPR | Schedule of Benefits - Preventive & Primary Care Rider (PPO) |
| 2055 DEF.IH | Policy Definitions |
| 2055 BEN.IH | Benefits Provided |
| 2055 ACC | Alternate Cost Containment |
| 2055 PPO | Preferred Provider Provisions |
| 2055 EXC.IH | Exclusions and Limitations |
| 2055 COB | Coordination of Benefits |
| 2055 PPR | Preventive & Primary Care Rider |
| 2055 ACCR | Supplementary Accidental Injury Rider |
| 2055 OC.IH | Outline of Coverage (Non-PPO) |
| 2055 OC.ACCR | Insert to the Outline of Coverage (Non-PPO & PPO) - Supplementary Accidental Injury Rider |
| 2055 OC.PPR | Insert to Outline of Coverage (Non-PPO)-Preventive & Primary Care Benefit Rider |
| 2055 OCPO.IH | Outline of Coverage (PPO) |
| 2055 OCPO.PPR | Insert to the Outline of Coverage (PPO) Preventive & Primary Care Rider(PPO) |

**INDIVIDUAL STANDARD HEALTH BENEFIT PLAN**

| Prototype Form Number | Form Description |
|---|---|
| 2055 ISE.STD | Policy Face Page |
| TOLLFREE | Tollfree Number & Information |
| 2055 DP | Individual Data Page |
| 2055 TCI | Table of Contents |
| 2055 IGP | General Provisions |
| 2055 IRP | Individual Provisions |
| 2055 SCH.STD | Schedule of Benefits (Non-PPO) |
| 2055 SCHPO.STD | Schedule of Benefits (PPO) |
| 2055 DEF.STD | Policy Definitions |
| 2055 BEN.STD | Benefits Provided |
| 2055 ACC | Alternate Cost Containment |
| 2055 PPO | Preferred Provider Provisions |
| 2055 EXC.STD | Exclusions and Limitations |
| 2055 COB | Coordination of Benefits |
| 2055 CDW | Chemical Dependency Benefit Waiver Rider |
| 2055 ACD | Alternate Benefits for Chemical Dependency |
| 2055 OC.STD | Outline of Coverage (Non-PPO) |
| 2055 OCPO.STD | Outline of Coverage (PPO) |

# OPTIONAL PROTOTYPE POLICY FORMS

Policy Face Pages
Toll Free Telephone No. and Information Notice
Certificate Face Pages
Individual Data Page
Group/Individual Table of Contents
Group/Individual General Provisions
Individual/Group Provisions

[ABC SMALL EMPLOYER CARRIER]
[ADDRESS]

# CERTIFICATE OF INSURANCE

[EMPLOYEE: [XXXXX]
ID NUMBER: [XXX]
CERTIFICATE EFFECTIVE DATE: [XXXXXX]

POLICYHOLDER: [XXXXXXXXXXXXX]
POLICY NUMBER: [XXX]
POLICY EFFECTIVE DATE: [XXXXXX]
DEPENDENT COVERAGE: [YES/NO]

We certify that coverage is provided for each Insured Person in accordance with the terms of the Group Insurance Policy.

This page, all attached provisions, and any riders will constitute the entire Certificate of Insurance.

[This Certificate of Insurance replaces any previous certificate issued to you for the coverage described in the Certificate. All benefits are subject in every way to the entire Group Insurance Policy which includes this Certificate of Insurance.]

**THE INSURANCE POLICY UNDER WHICH THIS CERTIFICATE IS ISSUED IS NOT A POLICY OF WORKERS' COMPENSATION INSURANCE. YOU SHOULD CONSULT YOUR EMPLOYER TO DETERMINE WHETHER OR NOT YOUR EMPLOYER IS A SUBSCRIBER TO THE WORKER'S COMPENSATION SYSTEM.**

**Small Employer Preventive and Primary Care Benefit Plan**

**2055 CERT.PP**

12/09/93

Figure 15

(ABC SMALL EMPLOYER CARRIER)
(ADDRESS)

**CERTIFICATE OF INSURANCE**

[EMPLOYEE: [XXXXXXX]
ID NUMBER: [XXXXXX]
CERTIFICATE EFFECTIVE DATE: [XXXXXX]

POLICYHOLDER: [XXXXXXXXXX]
POLICY NUMBER: [XXX]
POLICY EFFECTIVE DATE: [XXXXXX]
DEPENDENT COVERAGE: [YES/NO]

We certify that coverage is provided for each Insured Person in accordance with the terms of the Group Insurance Policy.

This page, all attached provisions, and any riders will constitute the entire Certificate of Insurance.

[This Certificate of Insurance replaces any previous Certificate issued to you for the coverage described in the Certificate. All benefits are subject in every way to the entire Group Insurance Policy which includes this Certificate of Insurance.]

**THE INSURANCE POLICY UNDER WHICH THIS CERTIFICATE IS ISSUED IS NOT A POLICY OF WORKERS' COMPENSATION INSURANCE. YOU SHOULD CONSULT YOUR EMPLOYER TO DETERMINE WHETHER OR NOT YOUR EMPLOYER IS A SUBSCRIBER TO THE WORKERS' COMPENSATION SYSTEM.**

**Small Employer In-Hospital Benefit Plan**

**2055 CERT.IH**

12/09/93

Figure 16

(ABC SMALL EMPLOYER CARRIER)
(ADDRESS)

## CERTIFICATE OF INSURANCE

[EMPLOYEE: [XXXXXXXX]
ID NUMBER: [XXX]
CERTIFICATE EFFECTIVE DATE: [XXXXXX]

POLICYHOLDER: [XXXXXXXXXXXX]
POLICY NUMBER: [XXX]
POLICY EFFECTIVE DATE: [XXXXXX]
DEPENDENT COVERAGE: [YES/NO]

We certify that coverage is provided for each Insured Person in accordance with the terms of the Group Insurance Policy.

This page, all attached provisions, and any riders will constitute the entire Certificate of Insurance.

[This Certificate of Insurance replaces any previous Certificate issued to you for the coverage described in the Certificate. All benefits are subject in every way to the entire Group Insurance Policy which includes this Certificate of Insurance.]

**THE INSURANCE POLICY UNDER WHICH THIS CERTIFICATE IS ISSUED IS NOT A POLICY OF WORKERS' COMPENSATION INSURANCE. YOU SHOULD CONSULT YOUR EMPLOYER TO DETERMINE WHETHER OR NOT YOUR EMPLOYER IS A SUBSCRIBER TO THE WORKER'S COMPENSATION SYSTEM.**

**Small Employer Standard Health Benefit Plan**

**2055 CERT.STD**

12/09/93

Figure 17

[ABC SMALL EMPLOYER CARRIER]
[ADDRESS]

DATA PAGE

PREMIUM: [XXXX]

PREMIUM MODE: [MONTHLY]

DEPENDENT COVERAGE: [YES/NO]
[DEPENDENT'S NAME]

[POLICY FEE: _____]

2055 DP

12/09/93

## TABLE OF CONTENTS

Toll Free Information Notice

General Provisions
- Eligibility For Coverage
- Effective Dates
- [Preexisting Conditions]
- Termination Of Insurance

Group Provisions
- Payment of Premiums
- Time Limit On Certain Defenses
- The Contract Between You And Us
- Misstatement Of Age
- The Claims Process
- Time Of Payment Of Claims
- Payment Of Claims
- Physical Examinations And Autopsy
- Legal Actions
- Extension Of Benefits
- [Dividends]
- [Grace Period]
- [Right To Recovery/Clerical Error]
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Schedule Of Benefits (Non PPO or PPO)
Policy Definitions
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Coordination of Benefits
[Riders As Allowed By Chapter 26, TIC]

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Figure 20

## GENERAL PROVISIONS

### ELIGIBILITY FOR COVERAGE

**Employee Coverage:**

You are an Eligible Employee if you:

1. work on a full time basis; and
2. usually work at least 30 hours a week

Eligible Employee includes a sole proprietor, a partner, and an independent contractor, if the sole proprietor, partner or independent contractor is included as an Employee under a Health Benefit Plan of the Employer. [Eligible Employee also includes an Employee of an Employer member of an association.] The term does not include:

1. an Employee who works on a part-time, temporary or substitute basis; or
2. an Employee who is covered under:
   a. another Health Benefit Plan; or
   b. an employee welfare benefit plan that provides health benefits and that is established in accordance with Employee Retirement Income Security Act of 1974.

**Dependent Coverage:**

Eligible Dependents are:

1. your spouse;
2. a Child under the age of 19 years;
3. a Child who is a full-time student under the age of 23 years and who is financially dependent on the parent;
4. a Child of any age who is medically certified as disabled and dependent on the parent; and
5. a grandchild who is dependent on the Employee for federal income tax purposes.

The marital status of the Employee and the other parent shall not be used in determining the Dependents or Beneficiary.

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If both husband and wife are Employees of the Employer, such Employees shall not be eligible for coverage as a Dependent under the Policy. Each must be covered as an Employee.

If both husband and wife are Employees, only one is eligible for Dependent coverage.

## EFFECTIVE DATES

### Eligible Employees:

In order for an Eligible Employee's coverage to take effect, the Eligible Employee must submit written enrollment for coverage for himself and any Dependents. The Effective Date of coverage under the Policy is the date shown in the Certificate of Insurance issued to the Insured Person.

Any person covered by a previous group health plan of the Employer on the day prior to the Policy Effective Date, including any person who has continued group coverage under applicable federal or state law, is eligible on the Policy Effective Date.

Coverage under the Policy shall become effective on the Policy Effective Date for all existing Eligible Employees and Dependents upon completion of an application and election of coverage. This includes any Eligible Employee or Dependent who is confined in a Hospital or other institution. If the Policy is replacing a discontinued group health plan, coverage for an Eligible Employee or Dependent may be delayed only until the expiration of any applicable extension of benefits provided by the previous group health plan.

### Initial Enrollment for New Eligible Employees:

If We receive your application or enrollment form within 31 days of your date of employment, your coverage will become effective on the first day of the month following the date that written application for coverage for you and any Dependents is received [and any Waiting Period has been satisfied. The **Waiting Period** is the length of time that you must be continuously employed before your coverage may become effective under the Policy. The Waiting Period under the Policy is [90] days from the first date of employment].

If you do not enroll within 31 days of your employment date, coverage will become effective in accordance with the provisions for Late Enrollees.

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Dependents:

If you have eligible Dependents on the date your coverage begins, your Dependents' coverage will begin on your Certificate Effective Date if:

1. you enroll your Dependent for coverage on or before your Effective Date; and
2. you pay the appropriate premium.

If you have Dependents who are not enrolled on the date your coverage begins and you subsequently apply for Dependent coverage, coverage for your Dependent(s) will become effective in accordance with the provision for Late Enrollees.

Newly Acquired Dependents:

If you acquire new eligible Dependents after the date your coverage begins, coverage for your Dependent will become effective in accordance with the following provisions:

Newborn Children

Coverage will be automatic for the first 31 days following the birth of your newborn Child. To continue coverage beyond 31 days, you must notify Us within 30 days of birth and pay the required premium within that 30 day period or a period consistent with Our next billing cycle. If you notify Us after that 30 day period, your newborn Child will become effective in accordance with the provisions for Late Enrollees. [If you decide not to continue coverage for your Dependent Child beyond the 31 day period, premium will be charged for the 31 days coverage was in force.]

Court Ordered Coverage for a Dependent

If a court has ordered you to provide coverage for a spouse or minor Child, coverage will be automatic for the first 31 days following the date on which the court order is issued. To continue coverage beyond 31 days, you must notify Us and pay the required premium within that 31 day period. If you notify Us after that 31 day period, your Dependent will become effective in accordance with the provisions for Late Enrollees.

Other Dependents

Written enrollment must be received within 31 days of the date that a spouse or Child first qualifies as an eligible Dependent. Coverage will become effective on the first day of the month following the date that application for coverage is received. If application is not made within the initial 31 days, then your Dependent's coverage will become effective in accordance with the provisions for Late Enrollees.

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If you have coverage for your spouse and existing children or coverage for existing children only, coverage for any additional children will become effective as of the date they become your Dependent provided that enrollment for coverage is made within 31 days of eligibility.

If you ask that your Dependent be insured again after having canceled his or her coverage while your Dependent was still entitled to coverage, your Dependent's coverage will become effective in accordance with the provisions for Late Enrollees.

In no event will your Dependent's coverage become effective for coverage prior to your Certificate Effective Date.

Late Enrollees:

**Late Enrollee** means any Eligible Employee or Dependent who requests enrollment in the Employer's Health Benefit Plan after the expiration of the Initial Enrollment Period. **Initial Enrollment Period** is the defined time frame for enrollment outlined in the above Effective Dates provision or otherwise in effect at the time of your employment date.

[A Late Enrollee is eligible for coverage the first day of the policy month following [18] months from the date of application. The date of application shall be the date the application is received by Us. The Preexisting Condition limitation shall be inapplicable to a Late Enrollee.]

[A Late Enrollee is eligible for coverage the first day of the policy month following the receipt of the application by Us. A Late Enrollee is subject to a [12] month Preexisting Condition limitation beginning on the Effective Date of coverage.]

[A Late Enrollee is eligible for coverage the first day of the policy month following six months from the date of application. The date of application shall be the date the application is received by Us. A Late Enrollee is subject to a [12] month Preexisting Condition limitation beginning on the Effective Date of coverage.]

[A Late Enrollee is eligible for coverage the first day of the policy month following [12] months from the date of application.]

**Exceptions to Late Enrollee Provisions:**

The Employee or Dependent will not be considered a Late Enrollee, if the Employee or Dependent did not enroll for coverage within the Initial Enrollment Period and:

1. was covered under another Employer Health Benefit Plan during the Initial Enrollment Period; and

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2. declined coverage under this Policy in writing on the basis of the coverage under another Employer Health Benefit Plan; and
3. coverage under the other Health Benefit Plan is terminating due to termination of the plan, termination of employment, death of a spouse, or divorce.

The Employee or Dependent must enroll within 31 days after the date that coverage ends under another Employer Health Benefit Plan. If enrollment is not requested within this 31 days, coverage for the Employee or Dependent will become effective in accordance with the provisions for Late Enrollees.

**[PREEXISTING CONDITIONS**

**Benefits for Eligible Expenses incurred for treatment of a Preexisting Condition will not be paid for a period of [12] months from the Insured Person's Effective Date of coverage.**

The Preexisting Condition limitation shall not apply to an Insured Person who was continuously covered for a minimum of [12] months by a Health Benefit Plan that was in effect up to a date not more than 60 days before the Effective Date of coverage under the Policy.

Credit shall be given for the time the Insured Person was covered under a previous Health Benefit Plan if the previous Health Benefit Plan was in effect at any time during the [12] months before the Effective Date of coverage under the Policy.]

**TERMINATION OF INSURANCE**

**<u>Eligible Employees</u>:**

Your coverage will end on the earlier of:

1. the first day of the month after the date you no longer meet the definition of an Eligible Employee including termination of employment. [However, when you are on approved leave of absence, coverage may be continued for up to [1 year], if premiums continue to be paid to Us by you or on your behalf];
2. the end of the last period for which premium payment has been made to Us, [subject to the Grace Period provision of the Policy];
3. the date the Policy terminates;
4. the date any Lifetime Maximum Benefits have been exhausted;
5. the date of fraud or misrepresentation of a material fact by you, except as indicated in the Time Limit on Certain Defenses provision.

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[6. the date the Employer terminates participation in the trust.]
[6. the date the Employer terminates membership in the association.]

**Dependents:**

Your Dependent's coverage will end on the earlier of:

1. the date your Dependent no longer meets the definition of Dependent, as defined in the Policy;
2. the end of the period for which premium payment has been made to Us, [subject to the Grace Period provision of the Policy];
3. the date the Policy terminates;
4. the date your coverage terminates (unless due to exhaustion of any Lifetime Maximum Benefits available for you);
5. the date any Lifetime Maximum Benefits have been exhausted;
6. the date of fraud or misrepresentation of a material fact by the Dependent, except as indicated in the Time Limit on Certain Defenses provision.

[7. the date the Employer terminates participation in the Trust.]
[7. the date the Employer terminates membership in the Association.]

**Policyholder and Company:**

The coverage of all Insured Persons shall terminate if the Policy is terminated.

[The policy may be terminated by the Employer on any premium due date. The Employer must request cancellation in writing at least 30 days in advance.]

[The policy may be terminated by the Association on any premium due date. The Association must request cancellation in writing at least 30 days in advance.]

[The Employer may terminate participation under the Policy on any premium due date. The Employer must request cancellation in writing at least 30 days in advance.]

[The Employer (Member) may terminate participation under the Policy on any premium due date. The Employer (Member) must request cancellation at least 30 days in advance.]

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The Policy may be terminated by Us:

1. for non-payment of premiums [, except for the Grace Period provision]. [Coverage will end at the end of the last period for which premium payment has been made to Us];

2. on any premium due date for any of the following reasons. We must give the Employer written notice of cancellation at least 30 days in advance if termination is due to:

   a. fraud or misrepresentation of a material fact by the [Policyholder or] Employer, except as indicated the in Time Limit on Certain Defenses provision;
   b. failure to maintain the required minimum premium contribution;
   c. failure to provide required information or documentation related to the Employer Health Benefit Plan upon request.
   [d. failure to maintain the required minimum participation requirements];
   [e. failure to maintain status as an Employer as defined in the Policy Definition provision.]

3. on any premium due date if We are also canceling all Small Employer Health Benefit Plans in the state or in a geographic service area. We must give the Employer written notice of cancellation:

   a. at least 180 days in advance and
   b. again at least 30 days in advance.

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## GENERAL PROVISIONS

**GUARANTEED RENEWABLE:** We will renew this Policy for any Policyholder's life or payment of maximum benefits, if any. We will renew this Policy each time We receive the correct premium before the end of the Grace Period. If you leave your Employer, you will be required to pay the entire premium in order to keep the Policy in force. Additionally, if your Employer elects to no longer pay premiums, you may keep this Policy in force by paying the required premium. While this Policy is in force, We cannot change the benefits without your consent.

**RATES:** We may change the premium rates for this Policy from time to time. Such change shall be made for all policies of this form in a particular class as determined by Us. No premium change may be made on an individual basis.

**ELIGIBILITY FOR COVERAGE**

**Employee Coverage:** You are an Eligible Employee if you:

1. work on a full time basis; and
2. usually work at least 30 hours a week.

Eligible Employee includes a sole proprietor, a partner, and an independent contractor, if the sole proprietor, partner or independent contractor is included as an Employee under a Health Benefit Plan of the Employer. The term does not include:

1. an Employee who works on a part-time, temporary or substitute basis; or
2. an Employee who is covered under:
   a. another Health Benefit Plan; or
   b. an employee welfare benefit plan that provides health benefits and that is established in accordance with Employee Retirement Income Security Act of 1974.

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**Dependent Coverage**: Eligible Dependents are:

1. your spouse;
2. a Child under the age of 19 years;
3. a Child who is a full-time student under the age of 23 years and who is financially dependent on the parent;
4. a Child of any age who is medically certified as disabled and dependent on the parent; and
5. a grandchild who is dependent on the Employee for federal income tax purposes.

The marital status of the Employee and the other parent shall not be used in determining the Dependents or Beneficiary.

If both husband and wife are Employees of the Employer, such Employees shall not be eligible for coverage as a Dependent under the Policy. Each must be covered as an Employee.

If both husband and wife are Employees, only one is eligible to include children under this Policy.

## EFFECTIVE DATES

**Eligible Employees**:

In order for an Eligible Employee's coverage to take effect, the Eligible Employee must submit written application for coverage for himself and any Dependents. The Effective Date of coverage under this Policy is the date shown on the face page of the Policy.

Any person covered by a previous health plan of the Employer on the day prior to the Policy Effective Date, including any person who has continued group coverage under applicable federal or state law, is eligible on the Policy Effective Date.

Coverage under this Policy shall become effective on the Policy Effective Date for all existing Eligible Employees and Dependents upon completion of an application and election of coverage. This includes any Eligible Employee or Dependent who is confined in a Hospital or other institution. If the Policy is replacing coverage under a discontinued health plan, coverage for an Eligible Employee or Dependent may be delayed only until the expiration of any applicable extension of benefits provided by the previous health plan.

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## Initial Enrollment For New Eligible Employees:

If you apply for coverage within 31 days of your date of employment, your coverage will become effective on the first day of the month following the date that written application for coverage for you and any Dependents is received [and any Waiting Period has been satisfied. The **Waiting Period** is the length of time that you must be continuously employed before your coverage may become effective under the Policy. The Waiting Period under this Policy is [90] days from the first date of employment].

If you do not enroll within 31 days of your employment date, coverage will become effective in accordance with the provisions for Late Enrollees.

## Dependents:

If you have eligible Dependents on the date your coverage begins, your Dependents' coverage will begin on your Effective Date if:

1. you apply for Dependent coverage on or before your Effective Date; and
2. you pay the appropriate premium.

If you have Dependents who are not covered on the date your coverage begins and you subsequently apply for Dependent coverage, coverage for your Dependents will become effective in accordance with the provision for Late Enrollees.

## Newly Acquired Eligible Dependents:

If you acquire new Dependents after the date your coverage begins, coverage for your Dependents will become effective in accordance with the following provisions:

## Newborn Children:

Coverage will be automatic for the first 31 days following the birth of your newborn Child. To continue coverage beyond 31 days, you must notify Us within 30 days of birth and pay the required premium within that 30 day period or a period consistent with Our next billing cycle. If you notify Us after that 30 day period, your newborn Child will become effective in accordance with the provisions for Late Enrollees. [If you decide not to continue coverage for your Dependent Child beyond the 31 day period, premium will be charged for the 31 days coverage was in force.]

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## Court Ordered Coverage for a Dependent:

If a court has ordered you to provide coverage for a spouse or minor Child, coverage will be automatic for the first 31 days following the date on which the court order is issued. To continue coverage beyond 31 days, you must notify Us and pay the required premium within that 31 day period. If you notify Us after that 31 day period, your Dependent's coverage will become effective in accordance with the provisions for Late Enrollees.

## Other Dependents:

Written application must be received within 31 days of the date that a spouse or Child first qualifies as an eligible Dependent. Coverage will become effective on the first day of the month following the date that application for coverage is received. If application is not made within the initial 31 days, then your Dependent's coverage will become effective in accordance with the provisions for Late Enrollees.

If you have coverage for your spouse and existing children or coverage for existing children only, coverage for any additional children will become effective as of the date they become your Dependent provided that application for coverage is made within 31 days of eligibility.

If you ask that your Dependent be insured again after having canceled his or her coverage while your Dependent was still entitled to coverage, your Dependent's coverage will become effective in accordance with the provisions for Late Enrollees.

In no event will your Dependent's coverage become effective for coverage prior to your Effective Date.

## Late Enrollees:

**Late Enrollee** means any Eligible Employee or Dependent who requests coverage in the Employer's Health Benefit Plan after the expiration of the Initial Enrollment Period. **Initial Enrollment Period** is the defined time frame for enrollment outlined in the above Effective Dates provision or otherwise in effect at the time of your employment date.

[A Late Enrollee is eligible for coverage the first day of the policy month following [18] months from the date of application. The date of application shall be the date the application is received by Us. The Preexisting Condition limitation shall be inapplicable to a Late Enrollee.]

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[A Late Enrollee is eligible for coverage the first day of the policy month following the receipt of the application by Us. A Late Enrollee is subject to a [12] month Preexisting Condition limitation beginning on the Effective Date of coverage.]

[A Late Enrollee is eligible for coverage the first day of the policy month following six months from the date of application. The date of application shall be the date the application is received by Us. A Late Enrollee is subject to a [12] month Preexisting Condition limitation beginning on the effective date of coverage.]

[A Late Enrollee is eligible for coverage the first day of the policy month following [12] months from the date of application.]

**Exceptions to Late Enrollee Provisions:**

The Employee or Dependent will not be considered a Late Enrollee, if the Employee or Dependent did not apply for coverage within the Initial Enrollment Period and:

1. was covered under another Employer Health Benefit Plan during the Initial Enrollment Period; and
2. declined coverage under this Policy in writing on the basis of the coverage under another Employer Health Benefit Plan; and
3. coverage under the other Health Benefit Plan is terminating due termination of the plan, termination of employment, death of a spouse, or divorce.

The Employee or Dependent must apply within 31 days after the date coverage ends under another Employer Health Benefit Plan. If application is not requested within this 31 days, coverage for the Employee or Dependent will become effective in accordance with the provisions for Late Enrollees.

**[PREEXISTING CONDITIONS**

Benefits for Eligible Expenses incurred for treatment of a Preexisting Condition will not be paid for a period of [12] months from the Insured Person's Effective Date of coverage.

The Preexisting Condition limitation shall not apply to an Insured Person who was continuously covered for a minimum of [12] months by a Health Benefit Plan that was in effect up to a date not more than 60 days before the effective date of coverage under this Policy.

Credit shall be given for the time the Insured Person was covered under a previous Health Benefit Plan if the previous Health Benefit Plan was in effect at any time during the [12] months before the Effective Date of coverage under this Policy.]

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## TERMINATION OF INSURANCE

**Eligible Employees:**

Your coverage will end on the earlier of:

1. the end of the last period for which premium payment has been made to Us, subject to the Grace Period provision of this Policy;
2. the date the Lifetime Maximum Benefits, if any, have been exhausted;
3. the date of fraud or misrepresentation of a material fact by you except as indicated in the Time Limit on Certain Defenses provision.

**Dependents:**

Your Dependent's coverage will end on the earlier of:

1. the date your coverage terminates (unless due to exhaustion of any Lifetime Maximum Benefits available to you);
2. the end of the period for which premium payment has been made to Us, subject to the Grace Period provision of this policy;
3. the date your Dependent no longer meets the definition of Dependent, as defined in the Policy;
4. the date Lifetime Maximum Benefits, if any, have been exhausted for the Dependent;
5. the date of fraud or misrepresentation of a material fact by the Dependent except as indicated in the Time Limit on Certain Defenses provision.

**Company:**

The Policy may be terminated by Us for non-payment of premiums, except as set out in the Grace Period provision of this Policy.

**CONVERSION:**

Any Dependent insured under this Policy whose coverage terminates because the Dependent no longer meets the definition of a Dependent shall be eligible for continuous coverage under a conversion policy with similar benefits at attained age then issued by Us. Written request for conversion together with payment of the first premium must be made within 31 days after such Dependent's coverage under this Policy has terminated.

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## GROUP PROVISIONS

**PAYMENT OF PREMIUMS:** Premiums are payable in advance. Premiums must be paid [monthly] including any contributions you must make. We may change the premium rates from time to time. We must give the Employer written notice of any premium rate change at least 31 days prior to the change. No premium rate change may be made on an individual basis.

**TIME LIMIT ON CERTAIN DEFENSES:**

**Representations:** All statements made by the [Policyholder or] Employer shall be considered representations and not warranties. We must provide the [Policyholder or] Employer with a copy of any statements used to contest coverage. All statements made by you shall be considered representations and not warranties. We must provide you or your Beneficiary with a copy of any statements used to contest coverage.

**Misstatements on the application:** After 2 years from the Policy Effective Date, we will not contest the validity of the Policy. After two years from your Certificate Effective Date, no misstatements on your application may be used to:

1. void this coverage, or
2. deny any claim for loss incurred or disability that starts after the 2 year period.

The above does not apply to fraudulent misstatements.

**[Pre-Existing Conditions:** After [one year] from the Certificate Effective Date, We will not reduce or deny any claim under the Policy because an Illness or Injury existed before the Certificate Effective Date.]

**THE CONTRACT BETWEEN YOU AND US**

**Entire contract and changes:** The entire contract between the Policyholder and Us is as stated in the Policy. No change in the Policy will be effective until approved by one of Our officers. This approval must be noted on or attached to the Policy. No agent may change the Policy or waive any of its provisions.

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## THE CLAIMS PROCESS

1. Within 20 days after you receive Covered Services, or as soon as reasonably possible, you or someone on your behalf, must notify Us in writing of your claim.

2. Within 15 days after We receive your written notice of claim, We must:

   a. acknowledge receipt of the claim;
   b. begin any investigation of the claim;
   c. specify the information you must provide to file proof of loss. (We can request additional information during the investigation, if necessary); and
   d. send you any forms We require for filing proof of loss. If We do not send you the forms within this time period, you can file proof of loss by giving Us a letter describing the occurrence, the nature and the extent of your claim. You must give Us this letter within the time period for filing proof of loss.

3. Within 90 days after you receive Covered Services, you must send Us written proof of loss. If it is not reasonably possible to give Us written proof in the time required, We will not reduce or deny your claim for being late if the proof is filed as soon as reasonably possible. Unless the Insured Person is not legally capable, the required proof must always be given to Us no later than one year from the date otherwise required.

4. Within 15 business days after We receive all the information required to secure final proof of loss, We must:

   a. give you written notice that your claim or part of your claim has been accepted and pay benefits within five business days after We notify you of Our acceptance; or
   b. give you written notice that your claim has been rejected and tell you the reason(s) for the rejection; or
   c. give you written notice if We need more time to make Our decision and the reasons We need additional time. However, We must notify you of Our final decision within 45 days.

5. If payment of the claim or part of the claim requires the performance of an act by you, We will pay within five business days after the date you perform the act.

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**TIME OF PAYMENT OF CLAIMS**: We will pay benefits for any loss covered by the policy within 60 days upon receipt of written proof of loss.

**PAYMENT OF CLAIMS:**

Payment to You, Your Beneficiary, Your Estate: Benefits will be paid to you. Any benefits that are unpaid at your death will be paid either to the Beneficiary or to your estate if no Beneficiary is named.

If benefits are payable to your estate or to You or to a Beneficiary who cannot execute a valid release, We may pay benefits up to $1,000 to someone related to you or a Beneficiary by blood or marriage whom We deem to be equitably entitled to such benefits. We will be discharged to the extent of any such payments made by Us in good faith.

[Payment to Assignee: We will recognize any assignment made under the policy, if:

1. it is duly executed on a form acceptable to Us; and
2. a copy is on file with Us.

We assume no responsibility for the validity or effect of an assignment.]

**[For Chapter 20 Companies Only:**
**Assignment:** The rights and benefits of this Policy may not be assigned at any time.]

Payment to a Managing Conservator: Benefits paid on behalf of a covered Dependent Child may be paid to a person who is not the Employee, if an order issued by a court of competent jurisdiction in this or any other state names such person the managing conservator of the Child.

To be entitled to receive benefits, a managing conservator of a Child must submit to Us with the claim form, written notice that such person is the managing conservator of the Child on whose behalf the claim is made and submit a certified copy of a court order establishing the person as managing conservator. This will not apply in the case of any unpaid medical bill for which a valid assignment of benefits has been exercised or to claims submitted by the Employee where the Employee has paid any portion of a medical bill that would be covered under the terms of the Policy.

Payment to the Texas Department of Human Services: When services are paid for or rendered by the Texas Department of Human Services on behalf of You or a Dependent, payment for the services will be made directly

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to the Texas Department of Human Services. In the case of a Dependent Child, when services are paid or rendered by the Texas Department of Human Services on behalf of such Dependent Child, payment for the services will be made directly to the Texas Department of Human Services if:

1. the parent who is an Employee is:

   a. a possessory conservator of the Child under an order issued by a court in this state or is not entitled to possession of or;
   b. access to the Child; and is required by court order or court-approved agreement to pay child support;

2. the Texas Department of Human Services is paying benefits on behalf of the Child under Chapter 31 or Chapter 32, Human Resources Code; and

3. We are notified through an attachment to the claim for insurance benefits when the claim is first submitted to us that the benefits must be paid directly to the Texas Department of Human Services.

**PHYSICAL EXAMINATIONS AND AUTOPSY:** We have the right to require a medical examination, at reasonable intervals, or an autopsy, where not prohibited by law, when a claim is made. If an examination or autopsy is required, you will not have to pay for it.

**LEGAL ACTIONS:** You cannot sue on any claim before 60 days after written proof of loss has been given as required. You cannot sue on any claim after 3 years from the time written proof of loss is required to be given.

**EXTENSION OF BENEFITS:** If an Insured Person is Totally Disabled on the date of termination of the Policy, coverage will be extended. Benefits will continue to be paid under the terms of the Policy for Eligible Expenses due to the disabling condition. Extension of benefits will continue until the earlier of: a) the date payment of the maximum benefits occurs, b) the date the Insured Person ceases to be Totally Disabled, or c) the end of 90 days following the date of termination. This Extension of Benefits is not applicable if the policy is replaced by another carrier providing substantially equivalent or greater benefit.

Totally Disability or Totally Disabled means:

1. As applied to an Employee, the complete inability of the Employee to perform all of the substantial and material duties and functions of his occupation and any other gainful occupation in which the Employee earns substantially the same compensation earned prior to disability;

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2. As applied to a Dependent, confinement as a bed patient in a Hospital.

Except as provided here, no benefits are payable for expenses incurred after the date of any termination of coverage. For information about the right to continue or convert coverage, refer to the Continuation/Conversion provision.

[**GRACE PERIOD:** There is a 31 day Grace Period allowed for the payment of each premium after the first premium. During this period coverage will remain in force. If the premium is not paid during the Grace Period, coverage will terminate at the end of the Grace Period. This is called a lapse.]

[**DIVIDENDS:** The Policy is a participating Policy. This means that the Policy will receive its share of any divisible surplus as determined each year by Us. This share will be credited as a dividend and paid to the Employer. Payment of any dividend directly to the Employer discharges Us from all liability for the payment of dividends].

**MISSTATEMENT OF AGE:** If the age of an Insured Person has been misstated and if the amount of premium is based on age, an adjustment of premiums shall be made based on the Insured Person's true age.

If age is a factor in determining eligibility or amount of insurance and there has been a misstatement of age, the insurance coverages or amounts of benefits, or both, shall be adjusted in accordance with the Insured Person's true age. Any such misstatement of age shall neither continue insurance otherwise validly terminated nor terminate insurance otherwise validly in force.

[**RIGHT TO RECOVERY/CLERICAL ERROR:**

1. If We make benefit payments in excess of the benefits payable under the provisions of the Policy, We have the right to recover such excess from any persons to, or for, or with respect to whom, such payments were made.]

2. Clerical error by the policyholder will not end coverage or continue coverage that has ceased. In the event of such error, a premium adjustment will be made. However, such adjustment will not be made beyond the preceding renewal date of the Plan.]

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**[SUBROGATION:** When We pay benefits under the Policy and it is determined that a negligent third party is liable for the same expenses, We have the right to subrogate from the monies payable from the negligent third party equal to the amount We have paid for such expenses. The Insured hereby agrees to reimburse Us from any monies recovered from a negligent third party as a result of a judgment against, settlement with or otherwise paid by the third party. The Insured Person agrees to take action against the third party, furnish all information and provide assistance to Us regarding the action taken, and execute and deliver all documents and information necessary for Us to enforce our rights of subrogation.]

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## INDIVIDUAL PROVISIONS

### THE CONTRACT BETWEEN YOU AND US:

**Entire contract and changes:** The entire contract between You and Us is as stated in this Policy, your application and any attached papers. No change in this Policy will be effective until approved by one of Our officers. This approval must be noted on or attached to this Policy. No agent may change this Policy or waive any of its provisions.

### TIME LIMIT ON CERTAIN DEFENSES:

**Misstatements on your application:** After 2 years from the Policy's Effective Date no misstatements in your application may be used to:

1. void this Policy, or
2. deny any claim for loss incurred or disability that starts after the 2 year period.

This does not apply to fraudulent misstatements.

**[Pre-existing Conditions:** After [one year] from your Effective Date, We will not reduce or deny any claim under this Policy because an Illness or Injury existed before your Effective Date.]

**GRACE PERIOD:** There is a 31 day Grace Period allowed for the payment of each premium after the first premium. During this period the Policy will remain in force. If the premium is not paid during the Grace Period, the Policy will terminate at the end of the Grace Period. This is called a lapse.

### HOW TO PUT THIS POLICY BACK IN FORCE:

**Reinstatement:** Once the Policy lapses, We may or may not put it back in force (reinstate) at Our option. Our acceptance of a late premium without requiring an application for reinstatement will reinstate the Policy.

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If We require an application for reinstatement, You will be given a conditional receipt for the premium. If We approve the application, the Policy will be reinstated on the approval date. If We do not give you prior written notice of our disapproval, the Policy will be reinstated on the 45th day after the date of the conditional receipt.

After reinstatement, this Policy will cover only losses that result from an Injury sustained after the date of reinstatement or an Illness that begins more than 10 days after such date. In all other respects your rights and Our rights will stay the same, subject to any provisions that are endorsed on or attached to this Policy at the time of reinstatement. You will be charged up to 60 days of past due premiums.

**THE CLAIMS PROCESS:**

1. Within 20 days after you receive Covered Services, or as soon as reasonably possible, you or someone on your behalf, must notify Us in writing of your claim.

2. Within 15 days after We receive your written notice of claim, We must:

   a. acknowledge receipt of the claim;
   b. begin any investigation of the claim;
   c. specify the information you must provide to file proof of loss. (We can request additional information during the investigation, if necessary); and
   d. send you any forms We require for filing proof of loss. If We do not send you the forms within this time period, you can file proof of loss by giving Us a letter describing the occurrence, the nature and the extent of your claim. You must give Us this letter within the time period for filing proof of loss.

3. Within 90 days after you receive Covered Services, you must send Us written proof of loss. If it is not reasonably possible to give Us written proof in the time required, We will not reduce or deny your claim for being late if the proof is filed as soon as reasonably possible. Unless the Insured Person is not legally capable, the required proof must always be given to Us no later than one year from the date otherwise required.

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4. Within 15 business days after We receive all the information required to secure final proof of loss, We must:

   a. give you written notice that your claim or part of your claim has been accepted and pay benefits within five business days after We notify you of Our acceptance; or
   b. give you written notice that your claim has been rejected and tell you the reason(s) for the rejection; or
   c. give you written notice if We need more time to make Our decision and the reasons We need additional time. However, We must notify you of Our final decision within 45 days.

5. If payment of the claim or part of the claim requires the performance of an act by you, We will pay within five business days after the date you perform the act.

**TIME OF PAYMENT OF CLAIMS:** We will pay benefits for any loss covered by this Policy immediately upon receipt of written proof of loss.

**PAYMENT OF CLAIMS:**

**Payment to You, Your Beneficiary, Your Estate:** Benefits will be paid to You. Any benefits that are unpaid at your death will be paid either to the Beneficiary or to your estate, if no Beneficiary is named.

If benefits are payable to your estate or to You or to a Beneficiary who cannot give a valid release, we may pay benefits up to $1,000 to someone related to You or a Beneficiary by blood or marriage whom We deem to be equitably entitled to such benefits. We will be discharged to the extent of any such payments made by Us in good faith.

[**Payment to Assignee:** We will recognize any assignment made under the policy, if:

1. it is duly executed on a form acceptable to Us; and
2. a copy is on file with Us.

We assume no responsibility for the validity or effect of an assignment.]

[**For Chapter 20 Companies Only: Assignment:** The rights and benefits of the Policy may not be assigned at any time.]

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**Payment to the Texas Department of Human Services:** When services are paid for or rendered by the Texas Department of Human Services on behalf of You or a Dependent, payment for the services will be made directly to the Texas Department of Human Services. In the case of a Dependent Child, when services are paid or rendered by the Texas Department of Human Services on behalf of such Dependent Child, payment for the services will be made directly to the Texas Department of Human Services if:

1. the parent who is an Employee is:
   a. a possessory conservator of the Child under an order issued by a court in this state or
   b. is not entitled to possession of or access to the Child and is required by court order or court-approved agreement to pay child support;
2. the Texas Department of Human Services is paying benefits on behalf of the Child under Chapter 31 or Chapter 32, Human Resources Code; and
3. We are notified through an attachment to the claim for insurance benefits when the claim is first submitted to us that the benefits must be paid directly to the Texas Department of Human Services.

**PHYSICAL EXAMINATIONS AND AUTOPSY:** We have the right to require a medical examination, at reasonable intervals, or an autopsy, where not prohibited by law, when a claim is made. If an examination or autopsy is required, you will not have to pay for it.

**LEGAL ACTIONS:** You cannot sue on any claim before 60 days after written proof of loss has been given as required. You cannot sue on any claim after 3 years from the time written proof of loss is required to be given.

**CHANGE OF BENEFICIARY:** Unless you have named an irrevocable Beneficiary, you have the right to change the Beneficiary, make or change assignment of benefits or change any part of your Policy.

**PAYMENT OF PREMIUMS:** The premium mode shown on the Data Page shows how often premiums are to be paid. After the first premium, each premium is due at the end of the period of which the prior premium was paid.

**EXTENSION OF BENEFITS:** Termination of this Policy will not affect the payment of benefits for any continuous loss that began while the Policy was in force. Benefits will continue to be paid under the terms of the Policy limited to

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the duration of the Policy benefit period, payment of the maximum benefits or a time period of not less than three months. Except as provided here, no benefits are payable for expenses incurred after the date of any termination of coverage.

**SPOUSE, THE INSURED**: In the event you should die while this Policy is in force, your spouse, if insured under this Policy, will become the Policyholder.

[**CANCELLATION:** You may cancel this Policy at any time by sending Us written notice. Your Policy will be canceled as of the date of the next premium is due. The cancellation will not affect the payment of benefits for any continuous loss that began prior to the effective date of the cancellation.]

[**DIVIDENDS:** This Policy is a participating Policy. This means that the Policy will receive its share of any divisible surplus as determined each year by Us. This share will be credited as a dividend and paid to you. Payment of any dividend directly to you the Insured Person discharges Us from all liability for the payment of dividends.]

[**MISSTATEMENT OF AGE:** Your age may have been misstated in your application. If so, We will pay the benefits that your premiums would have purchased at your true age. If the Policy would not have become effective at your true age, We will be liable only for a refund of all premiums paid.]

[**RIGHT TO RECOVERY:** If We make benefit payments in excess of the benefits payable under the provisions of this Policy, We have the right to recover such excess from any persons to, or for, or with respect to whom, such payments were made.]

[**SUBROGATION**: When We pay benefits under this Policy and it is determined that a negligent third party is liable for the same expenses, We have the right to subrogate from the monies payable from the negligent third party equal to the amount We have paid for such expenses. The Insured Person hereby agrees to reimburse Us from any monies recovered from a negligent third party as a result of a judgment against, settlement with or otherwise paid by the third party. The Insured Person agrees to take action against the third party, furnish all information and provide assistance to Us regarding the action taken, and execute and deliver all documents and information necessary for Us to enforce Your rights of subrogation.]

[**UNPAID PREMIUMS:** When We pay a claim, We will deduct any premium and unpaid from the claim payment.]

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# PROTOTYPE FORMS FOR PRESCRIBED BENEFITS

## Preventive and Primary Care Benefit Plan

Schedules of Benefits (Non-PPO and PPO)
Policy Definitions
Benefits Provided
Exclusions and Limitations
Prescription Drug Benefit Rider

## In-Hospital Benefit Plan

Schedules of Benefits (Non-PPO and PPO)
Policy Definitions
Benefits Provided
Exclusions and Limitations
Supplementary Accidental Injury Benefit Rider
Preventive and Primary Care Benefit Rider

## Standard Health Benefit Plan

Schedules of Benefits (Non-PPO and PPO)
Policy Definitions
Benefits Provided
Exclusions and Limitations
Alternate Benefits for Chemical Dependency

## Forms Common to More Than One Plan

Alternate Cost Containment Provisions
Continuation/Conversion
Coordination of Benefits
Preferred Provider Provisions
Chemical Dependency Benefit Waiver Rider

## Outlines of Coverage

# PREVENTIVE AND PRIMARY CARE BENEFIT PLAN

Figure 24

**SCHEDULE OF BENEFITS**
**PREVENTIVE AND PRIMARY CARE BENEFIT PLAN**
**(Non-PPO Plan)**

| | |
|---|---|
| Policy Year Deductible | [$100] [$250] |
| Policy Year Copayment Maximum | $1,000 per individual<br>$3,000 per family |
| Policy Year Maximum Benefit | $15,000 per individual |
| Lifetime Maximum Benefit | unlimited |

| COVERED SERVICES | PERCENTAGE PAYABLE |
|---|---|
| Inpatient Hospital Expense Benefit<br>Subject to the Policy Year Deductible and limited to Maximum of 5 days per Policy Year | 80% |
| Outpatient Expense<br>Subject to Policy Year Deductible<br>(includes outpatient Hospital, outpatient clinic or office visits for treatment of an Illness or Injury) | 80% |
| Diagnostic Exams, Labs and X-rays<br>Subject to Policy Year Deductible and limited to Maximum of $5,000 per Policy Year | 80% |
| Chemical Dependency Benefits***<br>Subject to Policy Year Deductible<br>Inpatient Hospital Expense limited to Maximum of 5 days per Policy Year<br>Outpatient Expense limited to Maximum of 40 visits per Policy Year | 80% |

*** Unless waiver attached

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| | |
|---|---|
| Mental Health Services<br>Subject to Policy Year Deductible<br>Inpatient Hospital Expense limited to Maximum of 5 days per Policy Year<br>Outpatient Expense limited to Maximum of 40 visits per Policy Year | 80% |
| Emergency Care Benefit<br>Subject to Policy Year Deductible | 80% |
| Maternity Benefit<br>Subject to Policy Year Deductible | 80% |
| Preventive Care Benefit<br>Policy Year Deductible and Copayment waived. Includes Childhood Immunizations, pap tests, Low-Dose Mammography for female insureds age 35 and over, colo-rectal screening, prostate cancer screening, and vision/hearing testing for children under the age of 19. | 100% |
| Well Child Care<br>Subject to Policy Year Deductible<br>(except for services covered under the Preventive Care Benefit) | 80% |
| Annual Physical Examination<br>Subject to Policy Year Deductible<br>(except for services covered under the Preventive Care Benefit) | 80% |
| Home Health Benefit<br>Subject to the Policy Year Deductible and limited to Maximum of 40 visits per Policy Year | 80% |
| Therapy Benefit<br>Subject to the Policy Year Deductible and limited to Maximum of 40 visits per Policy Year for physical, occupational and/or speech therapy<br>(includes diagnostic services) | 80% |

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| [Prescription Drug Benefit Rider<br>Subject to the Policy Year Deductible] | [50%] |
|---|---|

or

[Prescription Drug Card Program Rider
Plan pays 100% after the Deductible

| Deductible | |
|---|---|
| Generic drug or Name Brand drug if less than Generic drug -- | [$8] per prescription or refill |
| Name Brand Drug -- | [$12] per prescription or refill] |

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Figure 25

## SCHEDULE OF BENEFITS
## PREVENTIVE AND PRIMARY CARE BENEFIT PLAN
## (PPO)

| | |
|---|---|
| [Policy Year Deductible or Non-Preferred Provider Policy Year Deductible] | [$250] [$100] |
| [Preferred Provider Policy Year Deductible] | [ ] |
| [Per Visit Deductible] | [ $10 ] [ $15 ] |
| Policy Year Copayment Maximum | $1000 per individual<br>$3000 per family<br>[Preferred Provider and Non-Preferred Provider Combined] |
| Policy Year Maximum Benefit | $ 15,000 |
| Lifetime Maximum Benefit | unlimited |

| COVERED SERVICES | PERCENTAGE PAYABLE PPO | PERCENTAGE PAYABLE NON-PPO |
|---|---|---|
| Inpatient Hospital Expense Benefit | [100%] [90% ] | 80% |
| Limited to Maximum of 5 days per Policy Year | [Subject to Policy Year Deductible]<br>or<br>[Subject to Preferred Provider Deductible]<br>or<br>[Subject to Per Visit Deductible]<br>or<br>[Deductible waived] | [Subject to Policy Year Deductible]<br>or<br>Subject to Non-Preferred Provider Deductible]<br>or<br>[Deductible Waived] |
| Outpatient Expense | [100%] [90%] | 80% |
| (includes outpatient Hospital, outpatient clinic or office visits for treatment of an Illness or Injury) | [Subject to Policy Year Deductible]<br>or<br>[Subject to Preferred Provider Deductible]<br>or<br>[Subject to Per Visit Deductible]<br>or<br>[Deductible waived] | [Subject to Policy Year Deductible]<br>or<br>[Subject to Non-Preferred Provider Deductible]<br>or<br>[Deductible waived] |

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| | | |
|---|---|---|
| Diagnostic Exams, Labs and X-rays | [100%] [90%] | 80% |
| Limited to Maximum of $5,000 per Policy Year | [Subject to Policy Year Deductible]<br>or<br>[Subject to Preferred Provider Deductible]<br>or<br>[Subject to Per Visit Deductible]<br>or<br>[Deductible waived] | [Subject to Policy Year Deductible]<br>or<br>[Subject to Non-Preferred Provider Deductible]<br>or<br>[Deductible waived] |
| Chemical Dependency Benefits*** | [100%] [90%] | 80% |
| Inpatient Hospital Expense limited to Maximum of 5 days per Policy Year<br><br>Outpatient Expense limited to Maximum of 40 visits per Policy Year | [Subject to Policy Year Deductible]<br>or<br>[Subject to Preferred Provider Deductible]<br>or<br>[Subject to Per Visit Deductible]<br>or<br>[Deductible waived] | [Subject to Policy Year Deductible]<br>or<br>[Subject to Non-Preferred Provider Deductible]<br>or<br>[Deductible waived] |
| Mental Health Services | [100%] [90%] | 80% |
| Inpatient Hospital Expense limited to Maximum of 5 days per Policy Year<br><br>Outpatient Expense limited to Maximum of 40 visits per Policy Year | [Subject to Policy Year Deductible]<br>or<br>[Subject to Preferred Provider Deductible]<br>or<br>[Subject to Per Visit Deductible]<br>or<br>[Deductible waived] | [Subject to Policy Year Deductible]<br>or<br>[Subject to Non-Preferred Provider Deductible]<br>or<br>[Deductible waived] |
| Emergency Care Benefit | [100% ] [90%] | [100% ] [90%] |
| | [Subject to Policy Year Deductible]<br>or<br>[Subject to Preferred Provider Deductible]<br>or<br>[Subject to Per Visit Deductible]<br>or<br>[Deductible waived] | [Subject to Policy Year Deductible]<br>or<br>[Subject to Preferred Provider Deductible]<br>or<br>[Subject to Per Visit Deductible]<br>or<br>[Deductible waived] |

*** Unless waiver attached

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| | | |
|---|---|---|
| Maternity Benefit | [100%] [90%] | 80% |
| | [Subject to Policy Year Deductible]<br>or<br>[Subject to Preferred Provider Deductible]<br>or<br>[Subject to Per Visit Deductible]<br>or<br>[Deductible waived] | [Subject to Policy Year Deductible]<br>or<br>[Subject to Non-Preferred Provider Deductible]<br>or<br>[Deductible waived] |
| Preventive Care Benefit | 100% | 100% |
| Policy Year Deductible waived. Includes Childhood Immunizations, pap tests, Low-Dose Mammography for female insureds age 35 and over, colo-rectal screening, prostate cancer screening, and vision/hearing testing for children under the age of 19. | No Deductible | No Deductible |
| Well Child Care | [100%] [90%] | 80% |
| (except for services covered under the Preventive Care Benefit) | [Subject to Policy Year Deductible]<br>or<br>[Subject to Preferred Provider Deductible]<br>or<br>[Subject to Per Visit Deductible]<br>or<br>[Deductible waived] | [Subject to Policy Year Deductible]<br>or<br>[Subject to Non-Preferred Provider Deductible]<br>or<br>[Deductible waived] |
| Annual Physical Examination | [100%] [90%] | 80% |
| (except for services covered under the Preventive Care Benefit) | [Subject to Policy Year Deductible]<br>or<br>[Subject to Preferred Provider Deductible]<br>or<br>[Subject to Per Visit Deductible]<br>or<br>[Deductible waived] | [Subject to Policy Year Deductible]<br>or<br>[Subject to Non-Preferred Provider Deductible]<br>or<br>[Deductible waived] |

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| | | |
|---|---|---|
| Home Health Benefit | [100%] [90%] | 80% |
| Limited to Maximum of 40 visits per Policy Year | [Subject to Policy Year Deductible]<br>or<br>[Subject to Preferred Provider Deductible]<br>or<br>[Deductible waived] | [Subject to Policy Year Deductible]<br>or<br>[Subject to Non-Preferred Provider Deductible]<br>or<br>[Deductible waived] |
| Therapy Benefit | [100%] [90%] | 80% |
| Limited to Maximum of 40 visits per Policy Year for physical, occupational and/or speech therapy<br><br>(includes diagnostic services) | [Subject to Policy Year Deductible]<br>or<br>[Subject to Preferred Provider Deductible]<br>or<br>[Subject to Per Visit Deductible]<br>or<br>[Deductible waived] | [Subject to Policy Year Deductible]<br>or<br>[Subject to Non-Preferred Provider Deductible]<br>or<br>[Deductible waived] |

[PRESCRIPTION DRUG CARD PROGRAM
Plan pays 100% after Deductible

Deductible

| | |
|---|---|
| Generic drug or Name Brand drug if less than Generic drug - | [$ 8] per prescription or refill |
| Name Brand drug - | [$12] per prescription or refill] |

or

[PRESCRIPTION DRUG BENEFIT
Percentage Payable [50%]
Subject to the Policy Year Deductible]

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## POLICY DEFINITIONS
## PREVENTIVE AND PRIMARY CARE BENEFIT PLAN

**Affiliated Employer** means a person connected by commonality of ownership with a small employer. The term includes a person that owns a small employer, shares directors with a small employer, or is eligible to file a consolidated tax return with a small employer.

**Ambulatory Surgical Center** means an appropriately licensed institution or facility, either free-standing or as part of a Hospital, with permanent facilities equipped and operated for the primary purpose of performing surgical procedures and to which a patient is admitted and discharged from within a twenty-four (24) hour period.

**Beneficiary** means the person you designate to receive any unassigned benefits that are paid after your death.

[**Certificate of Insurance** means the individual certificate issued to the Insured Person which describes the coverage provided by the Policy.]

**Chemical Dependency** means the abuse of or psychological or physical dependence on or addiction to alcohol or a controlled substance.

**Chemical Dependency Treatment Center** means a facility which provides a program for the treatment of Chemical Dependency pursuant to a written treatment plan approved and monitored by a Physician and which facility is also:

1. affiliated with a Hospital under a contractual agreement with an established system for patient referral; or
2. accredited as such a facility by the Joint Commission on Accreditation of Hospitals; or
3. licensed as a chemical dependency treatment program by the Texas Commission on Alcohol or Drug Abuse; or
4. licensed, certified, or approved as a chemical dependency treatment program or center by any other state agency having legal authority to so license, certify, or approve.

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**Child** means the unmarried:

1. natural Child of the Insured Person including a newborn Child;
2. adopted Child including a Child who the Insured Person is seeking to adopt;
3. natural Child or adopted Child of the Insured Person's spouse provided the Child resides with the Insured Person.

**Childhood Immunizations** means a test for tuberculosis, immunization and re-immunization against diphtheria, pertussis, tetanus, poliomyelitis, *Haemophilus influenzae type b,* measles, mumps, rubella, and hepatitis B.

**Complication of Pregnancy** means:

1. conditions, requiring Hospital confinement (when the pregnancy is not terminated), whose diagnoses are distinct from pregnancy but are adversely affected by pregnancy, including but not limited to, acute nephritis, nephrosis, cardiac decompensation, missed abortion, and similar medical and surgical conditions of comparable severity, but shall not include false labor, occasional spotting, Physician prescribed rest during the period of pregnancy, morning sickness, hyperemesis gravidarum, pre-eclampsia and similar conditions associated with the management of a difficult pregnancy but not constituting a nosologically distinct Complication of Pregnancy; and
2. non-elective cesarean section, termination of ectopic pregnancy, and spontaneous termination of pregnancy, occurring during a period of gestation in which a viable birth is not possible.

**[For Chapter 20 Companies only:**
**Contracting Facility** means a Hospital, a Facility Other Provider or any other facility that We have a written contract with to provide care, services or supplies that are covered by the Policy. A Contracting Facility also means a Hospital or Facility Other Provider located outside of Texas, that another insurance company has a contract with that allows us to use its facilities.]

**Cosmetic Surgery** means surgery that is primarily for the purpose of improving appearance and does not, other than incidentally, correct or improve a functional impairment.

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**Dependent** means:

1. a spouse;
2. a newborn Child;
3. a Child under the age of 19 years;
4. a Child who is a full-time student under the age of 23 years and who is financially dependent upon the parent;
5. a Child of any age who is medically certified as disabled and dependent on the parent;
6. an adopted Child,
7. a grandchild who is your dependent for federal income tax purposes.

**Educational** means that the primary purpose of the service or supply is to provide the Insured Person with any of the following: training in the activities of daily living; instruction in scholastic skills such as reading and writing; preparation for an occupation; or treatment for learning disabilities.

"Training in the activities of daily living does not include training directly related to treatment of Illness or Injury that resulted in a loss of a previously demonstrated ability to perform those activities.

**Employee** means you, the principal insured, hereafter referred to as "you".

**Employer** means an individual, corporation, partnership, association, or other private legal entity that is actively engaged in business and that on at least 50 percent of its working days during the preceding calendar year, employed at least three but not more than 50 Eligible Employees, including the Employees of an Affiliated Employer, the majority of whom were employed in this state. [Employer includes Employer members of an association that meets the criteria defined above.]

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**Experimental or Investigational** means We determine that one or more of the following is true:

1. The service or supply is under study or in a clinical trial to evaluate its toxicity, safety or efficacy for a particular diagnosis or set of indications. Clinical trials include but are not limited to phase I, II and III clinical trials.
2. The prevailing opinion within the appropriate specialty of the United States medical profession is that the service or supply needs further evaluation for the particular diagnosis or set of indications before it is used outside clinical trials or other research settings.

   We will determine if this item 2. is true based on:

   a. Published reports in authoritative medical literature; and
   b. Regulations, reports, publications and evaluations issued by government agencies such as the Agency for Health Care Policy and Research, the National Institutes of Health, and the FDA.

3. In the case of a drug, a device or other supply that is subject to FDA approval:

   a. It does not have FDA approval; or
   b. It has FDA approval only under its Treatment Investigational New Drug regulation or a similar regulation; or

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c. It has FDA approval, but it is being used for an indication or at a dosage that is not an accepted off-label use. Unlabled uses of FDA-approved drugs are not considered Experimental or Investigational if they are determined to be:

i) included in one or more of the following medical compendia: The American Medical Association Drug Evaluations, The American Hospital Formulary Service Drug Information, The United States Pharmacopeia Information and other authoritative compendia as identified from time to time by the Secretary of Health and Human Services, or

ii) can be established based on supportive clinical evidence in peer-reviewed medical publications.

4. The provider's institutional review board acknowledges that the use of the service or supply is Experimental or Investigtional and subject to that board's approval.

5. Research protocols indicate that the service or supply is Experimental or Investigational. This item 5. applies for protocols used by the Insured Person's provider as well as for protocols used by other providers studying substantially the same service or supply.

**Generic** means drugs not protected by a trademark registration.

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**Health Benefit Plan** means a group, blanket, or franchise insurance policy, a certificate issued under a group policy, a group hospital service contract, or a group subscriber contract or evidence of coverage issued by a health maintenance organization that provides benefits for health care services. The term does not include:

1. accident-only, credit or disability insurance coverages;
2. specified disease coverage or other limited benefit policies;
3. coverage of Medicare services under a federal contract;
4. Medicare Supplement and Medicare Select policies regulated in accordance with federal law;
5. long-term care, dental care, or vision care coverages;
6. coverage provide by a single service health maintenance organization;
7. insurance coverage issued as a supplement to liability insurance;
8. insurance coverage arising out of a workers' compensation system or similar statutory system;
9. automobile medical payment insurance coverage;
10. jointly managed trusts authorized under 29 U.S.C. Section 141 et seq. that contain a plan of benefits for employees that is negotiated in a collective bargaining agreement governing wages, hours, and working conditions of the employees that is authorized under 29 U.S.C. Section 157;
11. hospital confinement indemnity coverage; or
12. reinsurance contracts issued on a stop-loss, quota-share, or similar basis.

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[**Hospital** means:

1. a facility that
    a. is licensed as a Hospital and operated pursuant to law;
    b. is primarily engaged in providing or operating either on its premises or in facilities available to the Hospital on a contractual prearranged basis and under the supervision of a staff of one or more duly licensed Physicians, medical diagnostic and major surgery facilities for the medical care and treatment of sick or injured persons on an inpatient basis for which a charge is made;
    c. provides 24-hour nursing service by or under the supervision of a registered graduate professional nurse (R.N.);
    d. maintains and operates a minimum of five beds;
    e. has x-ray and laboratory facilities either on the premises or available on a contractual prearranged basis;
    f. maintains permanent medical history records; or
2. a facility that
    a. is accredited by the Joint Commission on Accreditation of Healthcare Organizations and
    b. offers medical therapeutic, and psychiatric care for the treatment of Chemical Dependency.

The major surgery facility requirement is hereby waived for facilities that specialize in treating the mentally ill.

Hospital does not mean convalescent, nursing, rest or extended care facilities or facilities operated exclusively for treatment of the aged, whether such facilities are operated as a separate institution or as a section of an institution operated as a Hospital.]

**Illness** means sickness, disease, pregnancy, or Complications of Pregnancy that are first manifested after the Effective Date of insurance and while the Policy is in force.

**Injury or Accidental Injury** means accidental bodily Injury sustained by an Insured Person that is the direct cause of the loss independent of disease, bodily infirmity or any other cause and occurs while the Policy is in force.

**Insured Person** means you and/or your Dependents, if insured under the Policy.

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**Low-Dose Mammography** means the X-ray examination of the breast using equipment dedicated specifically for mammography including the X-ray tube, filter, compression device, screens, films, and cassettes, with an average radiation exposure delivery of less than one rad mid breast, with two views for each breast.

**Medically Necessary** means the Covered Services prescribed by your Physician, Provider, or Other Health Care Practitioner to diagnose or treat an Injury or Illness and is known to be safe and effective by the majority of licensed practitioners to diagnose or treat that Injury or Illness. Such services must be:

1. Performed in the least costly setting available where the services and treatments can be safely and appropriately provided;
2. Not provided primarily for the convenience of you, your Physician, or the facility providing the service;
3. Consistent with professionally recognized standards of care with respect to quality, frequency and duration;
4. Not primarily Educational, Experimental or Investigative; and
5. Consistent with your symptoms, diagnosis or treatment.

**[For Chapter 20 Companies Only:**
**Noncontracting Facility** means a Hospital, a Facility Other Provider or any other facility that We do not have a written contact with.]

**Physician** means a duly licensed Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O.) other than an Insured Person or a person related to the Insured Person, who is practicing within the scope of his or her license.

**[Policyholder** means the Employer.]
**[Policyholder** means the Association.]
**[Policyholder** means the Trustee of a Multiple Employer Trust.]

**[Policy Year** means a 365 day period that begins on the Policy's Effective Date.]
**[Policy Year** means a period of one full calendar year.]

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[**Preexisting Condition** means a disease or condition:

1. for which medical advice, diagnosis, care or treatment was recommended or received during the six months before the Effective Date of coverage; or
2. that would have caused an ordinary, prudent person to seek medical advice, diagnosis, care or treatment during the six months before the Effective Date of coverage

In addition, Preexisting Condition also includes any pregnancy existing on the Effective Date.]

**Provider or Other Health Care Practitioner** means a duly licensed or certified practitioner of the healing arts including, but not limited to, a Physician's assistant or an advanced nurse practitioner, who is acting within the scope of said license or certificate.

**Reasonable and Customary** means the usual charge made by a group, entity, or person who renders or furnishes Covered Services, treatments or supplies; provided the charge is not in excess of the general level of charges made by others who render or furnish the same or similar services, treatments or supplies to persons:

1. who reside in the same geographical area; and
2. whose Illness or Injury is comparable in nature and severity.

You may provide your own estimate of the Reasonable & Customary charge by surveying providers in your area and request that We reconsider Our determination.

**Schedule of Benefits** means the benefit schedule set forth in the Policy or Certificate.

**Serious Mental Illness** means:

1. schizophrenia;
2. paranoid and other psychotic disorders;
3. bipolar disorders (mixed, manic and depressive);
4. major depressive disorders (single episode or recurrent); and
5. schizo-affective disorders (bipolar or depressive).

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Figure 27

## BENEFITS PROVIDED
### Preventive and Primary Care Benefit Plan

If you or your Dependent incur expense for Covered Services while covered under the Policy, We will pay a percentage of that Eligible Expense after the Deductible is satisfied. We will pay up to the Maximums for each Insured Person. The Percentage Payable, Deductible, and Maximums are shown in the Schedule of Benefits.

**Deductible** means the amount of Eligible Expenses shown in the Schedule of Benefits for each Insured Person for which We will pay no benefits during each Policy Year.

**Copayment** means, after the Deductible has been met, the amount you must pay for Eligible Expenses under the Policy. Copayment does not include any services or charges which are not covered under the Policy, the Deductible, or Covered Services under any attached rider.

The **Individual Policy Year Copayment Maximum** for an Insured Person is $1,000. After the Copayments for an Insured Person equal $1,000 in one Policy Year, the Percentage Payable will increase to 100% for the remainder of that Policy Year.

The **Family Policy Year Copayment Maximum** for Insured Persons within one family is $3,000. If Copayments for you and your Dependents equal $3,000 in one Policy Year, the Percentage Payable for those Insured Persons within that family will increase to 100% for the remainder of the Policy Year. No Insured Person will be required to satisfy more than the Individual Policy Year Copayment Maximum.

**Policy Year Maximum** means the maximum benefit payable per Insured Person in a Policy Year.

**Lifetime Maximum** means the maximum benefit payable per Insured Person's lifetime.

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**Eligible Expenses** are charges for Covered Services to the extent that they are:

1. not in excess of the Reasonable and Customary charge for the treatment, service, or supply and

    a. Medically Necessary for the diagnosis or treatment of an Illness or Injury; or
    b. covered preventive care services; and

2. covered by the Policy.

Covered Services are:

1. Inpatient Hospital services for up to five days per policy year for:

    a. Daily room and board and general nursing services in an amount equal to the average semi-private room rate. Charges made by a Hospital for a private room will be considered an Eligible Expense in the amount not greater than the average semi-private room rate;
    b. Confinement in an intensive care or cardiac care unit to a maximum of three times the average semi-private room rate;
    c. Miscellaneous hospital services and supplies including, but not limited to, operating room, recovery room, surgical dressings, casts, splints, trusses, braces, initial artificial limbs or eyes, blood when not replaced and its administration.

2. Hospital outpatient services including surgical services and supplies provided by an Ambulatory Surgical Center or Hospital outpatient facility.

3. Services by Physicians, Providers or Other Health Care Practitioners for diagnosis, treatment and surgery of an Illness or Injury.

4. Physician services for an operation or the repair of a dislocation or fracture.

5. Assistant surgery fee (not to exceed 25% of the primary surgeon's fee for any one assistant) when the procedure requires an assistant surgeon(s) due to medical necessity.

6. anesthesia and its administration.

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7. Physical therapy performed by a qualified licensed physical therapist, occupational therapy performed by a qualified licensed occupational therapist, or speech-language therapy performed by a qualified licensed speech-language pathologist.

   Covered Services include outpatient diagnostic services and outpatient treatment visits. A Policy Year maximum of 40 outpatient treatment visits will be provided for any physical therapy, occupational therapy and/or speech therapy.

8. Emergency Care services including:

   a. inpatient Hospital services;
   b. outpatient Hospital services;
   c. professional ground or air ambulance services for transportation to nearest Hospital equipped to treat the Illness or Injury;
   d. Physician services for an operation, or the repair of a dislocation or fracture; including the services of an assisting surgeon;
   e. anesthesia and its administration; and
   f. services for medical care provided by a Physician, Provider or Other Health Care Practitioner (if not included in d).

   **Emergency Care** means bona fide emergency services provided after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in:

   1. placing the Insured Person's health in serious jeopardy;
   2. serious impairment to bodily functions; or
   3. serious dysfunction of any bodily organ or part.

9. Diagnostic examinations, lab and x-rays services including imaging services, pathology, radiology, and the related interpretations up to a Policy Year maximum benefit of $5,000.

10. Maternity-related care, including prenatal, delivery, postnatal care, high-risk pregnancy care, and Complications of Pregnancy and the initial well child expenses of a newborn Child.

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11. Home health care services under a plan of care established, approved in writing, and reviewed at least every two months by the attending Physician and certified by the attending Physician that hospitalization or confinement in a Skilled Nursing Facility would otherwise be required. Services include:

    a. skilled nursing by a registered nurse or licensed vocational nurse under the supervision of at least one registered nurse and at least one Physician;
    b. physical, occupational, speech, or respiratory therapy;
    c. service of a home health aide under the supervision of a registered nurse; and
    d. the furnishing of medical equipment and medical supplies other than drugs and medicines.

    The comprehensive limitations listed in the Policy will apply to home health care services. In addition, comprehensive covered charges will not include charges for:

    a. services or supplies not included in the home health care plan;
    b. services of any person who normally lives in your home is a member of the Insured Person's Immediate Family (you, your spouse, your parent, brother or sister;
    c. custodial care (services or supplies provided to assist a person in daily living...e.g., meals and personal grooming); or
    d. transportation services.

    Covered home health care services are limited to a maximum of 40 visits per Policy Year. A visit by a nurse or therapist will be considered one visit, four hours of home health aide service is considered one visit, and each four hours or portion of that period for additional home health aide service is considered one visit.

    We may waive the Policy Year limit on home health services if the waiver will result in less expensive treatment and the Insured Person and the Insured Person's Physician agree to an alternate plan of care. Any benefits paid under this provision will continue to be subject to the other maximums shown in the Schedule of Benefits.

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12. Mental Health Services (including Serious Mental Illness) for:

  a. outpatient evaluation;
  b. crisis intervention; and
  c. services for treatment.

  Benefits will be limited to:

  a. eligible inpatient Hospital services for up to five (5) days per Policy Year; and
  b. outpatient services limited to 40 visits per Policy Year.

13. Evaluation and treatment for Chemical Dependency limited to:

  a. eligible inpatient services in a Hospital or a Chemical Dependency Treatment Center for up to five days per Policy Year including:

    1. room and board; and
    2. miscellaneous services and supplies, and

  b. outpatient treatment for a maximum of 40 visits per Policy Year.

14. Well child care including but not limited to:

  a. ophthalmologic examination for infants at risk for eye problems;
  b. child health supervision services by, or supervised by, a Physician at the following intervals: birth, 2 months, 4 months, 6 months, 9 months, 12 months, 18 months, 2 years, and annually thereafter;

  Covered child health supervision services include:

    1. history;
    2. physical examination;
    3. developmental assessment;
    4. anticipatory guidance;
    5. appropriate Childhood Immunizations;
    6. laboratory testing;
    7. hearing and vision screening.

  Charges for Childhood Immunizations will be payable at 100% of the Reasonable and Customary charges and the Deductible and Copayment will be waived. Remaining covered well child care services will be payable as shown on the Schedule of Benefits.

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In addition, Covered Services will include annual vision and hearing testing for any covered Child under the age of 19. Eligible Expenses will be payable at 100% of the Reasonable and Customary charges and the Deductible and Copayment will be waived.

15. Rental or purchase price, at Our option, of durable medical equipment required for therapeutic use, including repairs and necessary maintenance of purchased equipment, not otherwise provided for under a manufacturer's warranty or purchase agreement;

16. Oxygen and the rental of equipment for its administration;

17. One annual physical examination. Services include:

    a. history;
    b. physical examination;
    c. laboratory and x-rays including pap tests, colo-rectal screening, and prostate cancer screening.

    Eligible Expenses for pap tests, colo-rectal screening, and prostate cancer screening will be payable at 100% of the Reasonable and Customary charges and the Deductible and Copayment will be waived. Remaining Covered Services included in an annual physical examination will be payable as shown on the Schedule of Benefits.

    In addition, Covered Services will include one annual screening by Low-Dose Mammography for any female insured age 35 and over. Eligible Expenses will be payable at 100% of the Reasonable and Customary charge and the Deductible and Copayment will be waived.

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Figure 28

## EXCLUSIONS AND LIMITATIONS
## PREVENTIVE AND PRIMARY CARE BENEFIT PLAN

The Policy does not cover expenses incurred resulting from:

a. Any service or supply which is not Medically Necessary.

b. Charges for treatment, services and supplies that are Experimental or Investigational in nature.

c. Any expense which is in excess of the Reasonable and Customary charges.

d. Any charge for services or supplies that is not within the scope of authorized practice of the institution or person rendering the services or supplies.

e. Any treatment provided by any Immediate Family Member (you, your spouse, your parent, brother, or sister) or provided by your Employer.

f. Any loss, expense or charge resulting from the Insured.Person's participation in a riot or inciting a riot.

g. Any loss to which a contributing cause was the Insured Person's being engaged in an illegal occupation or felonious activity.

h. Any act of war, declared or undeclared.

i. Or during active service in the Armed Forces or auxiliary units. Upon receipt of written request, a prorata refund of premiums will be provided for the period an Insured Person is in the military service on full-time active duty.

j. Injury or Illness arising out of employment for wage or profit.

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k. Reversal of sterilization, or medical care or surgery to change gender.

l. [Insert language, if applicable, regarding elective abortion.]

m. Cosmetic Surgery, unless due to an Accidental Injury or Illness occurring while covered under the Policy, to reconstructive surgery following covered surgery, or to repair a congenital defect of a newborn Child. Surgery performed to treat a mental, emotional or nervous disorder through change in appearance is considered Cosmetic Surgery for purposes of this exclusion.

n. Any services or supplies provided for reduction of obesity or weight, including surgical procedures, even if the Insured Person has other health conditions which might be helped by a reduction of obesity or weight.

o. Charges incurred outside the United States if the Insured Person traveled to the location for the purposes of receiving medical services, drugs or supplies.

p. Care received in Veterans Administration hospitals for service connected disabilities.

q. Services or treatment provided in a government hospital unless there is a legal obligation to pay. This does not exclude coverage for treatment of mental health and mental retardation provided by a tax supported institution of the State of Texas, including community centers for mental health and mental retardation services, provided charges are regularly and customarily charged to non-indigent patients.

r. Services or treatment for which the Insured Person is not legally required to pay.

s. Personal items such as TV, admitting kits, cots for family members, guest meals and other items which are not Medically Necessary.

t. Any dental services or supplies except as necessitated by Accidental Injury. Covered Services must be provided within 12 months of the date of Injury. Injuries caused by chewing or biting down are excluded.

u. Eyeglasses, contact lenses, hearing aids or the examination for prescription or fitting (unless otherwise covered under a preventive care benefit).

v. Any service or supply to eliminate or reduce a dependency on or addiction to tobacco.

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w. Charges for prescription drugs or pharmaceuticals except when a covered service provided by a Hospital or Ambulatory Surgical Center or if Prescription Drug Benefit Rider is attached.

x. Any service or supply associated with an autopsy or postmortem examination unless requested by Us.

y. Private duty nursing services, except for covered home health care services.

z. Any service or supply in connection with the diagnosis or treatment of infertility and any form or attempt of artificial fertilization or implantation, including artificial insemination, in-vitro fertilization, and gamete intra-fallopian transfer.

aa. Any service or supply in connection with any transplant.

bb. Any arch supports; orthopedic shoes; or support hose; or similar type devices/appliances regardless of intended use.

cc. Room and board charges incurred during a Hospital admission for diagnostic or evaluation procedures unless the tests could not have been performed on an outpatient basis without adversely affecting the Insured Person's physical condition or the quality of medical care provided.

dd. Transportation, except for local ground ambulance service or air ambulance service to nearest Hospital equipped to treat the Illness or Injury as needed for Emergency Care.

ee. Any service or supply for the diagnosis or treatment of temporomandibular joint dysfunction, unless due to Accidental Injury occurring while covered under the Polic

ff. Any service or supply received by an Insured Person as a result of or in connection with a court order, unless otherwise a Covered Service.

gg. Any service or supply in connection with routine foot care, including the removal of warts, corns, or calluses, the cutting and trimming of toenails, or foot care for flat feet, fallen arches and chronic foot strain in the absence of severe systemic disease.

hh. Any medical social services or vocational counseling.

ii. Any services or supplies provided as, or in conjunction with, chelation therapy, except for treatment of acute metal poisoning.

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**[For Chapter 20 companies only:**

jj. Any services or supplies furnished by a Noncontracting Facility, except for treatment of emergencies.

kk. Any services or supplies furnished by a Contracting Facility if that Facility has not been approved by us to provide those services or supplies.]

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# PRESCRIPTION DRUG BENEFIT RIDER

This rider is made a part of the Policy/Certificate to which it is attached. The rider is subject to all provisions, terms, definitions and limitations of the Policy which are not in conflict with the provisions of this rider.

## DEFINITIONS:

**Generic** means a drug not protected by a registered trademark.

**Name Brand** means a drug protected by a registered trademark.

## BENEFITS:

[Fifty percent (50%)] of the following prescription expenses are paid when dispensed by a licensed pharmacist for use by you or your Dependent, while covered under this rider:

1. Drugs and medicines, which by law, can only be obtained with a Physician's written prescription;
2. Injectable insulin prescribed by a Physician;
3. Formulas necessary for the treatment of Phenylketonuria or other heritable diseases when ordered by a Physician;
4. Oral contraceptives, regardless of their intended use.

Copayment for covered prescription expenses do not help satisfy any Policy Year Copayment Maximum.

Charges for Name Brand drugs will only be covered if there is no Generic drug available or if the Physician, Provider or Other Health Care Practitioner specifically prescribes a Name Brand drug for the Insured Person and Generic selection is not permitted or if cost of Name Brand drug is less than cost of the Generic drug.

## EXCLUSIONS:

To the extent there is not a conflict, the limitations and exclusions of the Policy apply to this rider. In addition to the limitations and exclusions of the Policy, the following limitations and exclusions apply:

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We will not pay benefits for any of the following:

1. Drugs or medications which can be lawfully obtained without a Physician's prescription, except insulin;

2. Any charge incurred for the administration of prescription drugs or injectable insulin by a Physician, Provider or Other Health Care Practitioner;

3. Drugs and substances which are Experimental or Investigational in nature;

4. Drugs taken or given while you or your Dependent are confined on an inpatient or outpatient basis in a Hospital, extended care facility, nursing home or similar institution that has a facility for providing drugs;

5. Refill of a prescription for more than the number of times specified by the Physician; or refill dispensed after one year from the order of the Physician;

6. Any quantity of drugs or medicines dispensed which, when taken according to the direction of the Physician, exceed a 34-day supply or 100 unit dose, whichever is greater;

7. Vitamins, prescription vitamins (except prenatal prescription vitamins), dietary supplements (except for Phenylketonuria or other heritable diseases), cosmetic, health and beauty aids;

8. Charges for drugs in excess of the Reasonable & Customary charges in the area where the drugs are dispensed;

9. Therapeutic devices or appliances including hypodermic needles or syringes, support garments and other non-medical items regardless of their intended use;

10. Rogaine when prescribed for hair loss;

11. Retin-A, except when used to treat acne in persons age 25 and under;

12. Smoking cessation products;

13. Blood and blood plasma;

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14. Appetite suppressants or any other drugs prescribed for weight loss;

15. Contraceptive devices, infertility medications, and injectable drugs, except insulin;

16. Biological sera;

17. Drugs or medications prescribed for an Injury or Illness arising out of employment;

18. Drugs or medications furnished by any government organization or agency unless there is an unconditional legal obligation on the part of the Insured Person to pay such expense, except Medicaid.

The benefits under this rider will be provided in consideration of the payment of the premium for this rider.

**TERMINATION:**

This Rider will terminate upon the earlier of:

1. The date the Policy terminates; or

2. On the first premium due date following Our receipt of the Insured Person's written request that this Rider be terminated.

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# IN-HOSPITAL BENEFIT PLAN

Figure 31

**SCHEDULE OF BENEFITS**
**IN-HOSPITAL BENEFIT PLAN**
**(PPO Plan)**

| | |
|---|---|
| [Hospital Deductible Per One Period of Hospital Confinement or Hospital Non-Preferred Provider Deductible Per One Period of Hospital Confinement] | [$100] [$250] |
| [Hospital Preferred Provider Deductible Per One Period of Hospital Confinement] | [ ] |
| Policy Year Copayment Maximum | [$ 2,000] [$5,000] (per individual) [Preferred Provider and Non-Preferred Provider Combined] |
| Policy Year Maximum Benefit | $ 100,000 (per individual) |
| Lifetime Maximum Benefit | $1,000,000 (per individual) |

| COVERED SERVICES | PERCENTAGE PAYABLE PPO | PERCENTAGE PAYABLE NON-PPO |
|---|---|---|
| Inpatient Hospital Expense Benefit | [100%] [90%] [80%] | [80%] [70%] |
| | [Subject to Hospital Deductible] or [Hospital Deductible per confinement waived when confined in Preferred Provider hospital] or [Subject to Hospital Preferred Provider Deductible] | [Subject to Hospital Deductible] or [Subject to Hospital Non-Preferred Provider Deductible] or [Deductible waived] |

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| | | |
|---|---|---|
| Mental Illness or Chemical Dependency | [80%] [70%] | 50% |
| | [Subject to Hospital Deductible] or [Hospital Deductible per confinement waived when confined in Preferred Provider Hospital] or [Subject to Hospital Preferred Provider Deductible] | [Subject to Hospital Deductible] or [Subject to Hospital Preferred Provider Deductible] or [Deductible waived] |
| Outpatient Follow-up Care (Eligible Expenses limited to 90 days after the date of discharge) | [100%] [90%] [80%] | [80%] [70%] |

[Supplementary Accidental Injury Benefit Rider $ 500

(Eligible Expenses must be incurred within 90 days of the Injury) ]

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# POLICY DEFINITIONS
# IN-HOSPITAL BENEFIT PLAN

**Affiliated Employer** means a person connected by commonality of ownership with a small employer. The term includes a person that owns a small employer, shares directors with a small employer, or is eligible to file a consolidated tax return with a small employer.

**Beneficiary** means the person you designate to receive any unassigned benefits that are paid after your death.

[**Certificate of Insurance** means the individual certificate issued to the Insured Person which describes the coverage provided by the Policy.]

**Chemical Dependency** means the abuse of or psychological or physical dependence on or addiction to alcohol or a controlled substance.

**Child** means the unmarried:

1. natural Child of the Insured Person including a newborn Child;
2. adopted Child including a Child who the Insured Person is seeking to adopt;
3. natural Child or adopted Child of the Insured Person's spouse provided the Child resides with the Insured Person.

**Complication of Pregnancy** means:

1. conditions, requiring Hospital confinement (when the pregnancy is not terminated), whose diagnoses are distinct from pregnancy but are adversely affected by pregnancy, including but not limited to, acute nephritis, nephrosis, cardiac decompensation, missed abortion, and similar medical and surgical conditions of comparable severity, but shall not include false labor, occasional spotting, Physician prescribed rest during the period of pregnancy, morning sickness, hyperemesis gravidarum, pre-eclampsia and similar conditions associated with the management of a difficult pregnancy but not constituting a nosologically distinct complication of pregnancy; and
2. non-elective cesarean section, termination of ectopic pregnancy, and spontaneous termination of pregnancy, occurring during a period of gestation in which a viable birth is not possible.

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**Confinement or Confined** means admission or admitted as a registered bed-patient in a Hospital upon the advice of a Physician.

[**For Chapter 20 Companies only:**
**Contracting Facility** means a Hospital, a Facility Other Provider or any other facility that We have a written contract with to provide care, services or supplies that are covered by the Policy. A Contracting Facility also means a Hospital or Facility Other Provider located outside of Texas, that another insurance company has a contract with that allows us to use its facilities.]

**Cosmetic Surgery** means surgery that is primarily for the purpose of improving appearance and does not, other than incidentally, correct or improve a functional impairment.

**Dependent** means:

1. a spouse;
2. a newborn Child;
3. a Child under the age of 19 years;
4. a Child who is a full-time student under the age of 23 years and who is financially dependent upon the parent;
5. a Child of any age who is medically certified as disabled and dependent on the parent;
6. an adopted Child,
7. a grandchild who is your dependent for federal income tax purposes

**Educational** means that the primary purpose of the service or supply is to provide the Insured Person with any of the following:

1. training in the activities of daily living;
2. instruction in scholastic skills such as reading and writing;
3. preparation for an occupation; or
4. treatment for learning disabilities.

"Training in the activities of daily living" does not include training directly related to treatment of Illness or Injury that resulted in a loss of a previously demonstrated ability to perform those activities.

In addition, in the case of a Hospital stay, charges will be considered "Educational" to the extent that We determine them to be allocable to the scholastic education or vocational training of the Insured Person.

**Employee** means you, the principal insured, hereafter referred to as "you".

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**Employer** means an individual, corporation, partnership, association, or other private legal entity that is actively engaged in business and that on at least 50 percent of its working days during the preceding calendar year, employed at least three but not more than 50 eligible employees, including the employees of an Affiliated Employer, the majority of whom were employed in this state. [Employer includes Employer Members of an Association that meets the criteria defined above.]

**Experimental or Investigational** means We determine that one or more of the following is true:

1. The service or supply is under study or in a clinical trial to evaluate its toxicity, safety or efficacy for a particular diagnosis or set of indications. Clinical trials include but are not limited to phase I, II and III clinical trials.
2. The prevailing opinion within the appropriate specialty of the United States medical profession is that the service or supply needs further evaluation for the particular diagnosis or set of indications before it is used outside clinical trials or other research settings.

   We will determine if this item 2. is true based on:

   a. Published reports in authoritative medical literature; and
   b. Regulations, reports, publications and evaluations issued by government agencies such as the Agency for Health Care Policy and Research, the National Institutes of Health, and the FDA.

3. In the case of a drug, a device or other supply that is subject to FDA approval:

   a. It does not have FDA approval; or
   b. It has FDA approval only under its Treatment Investigational New Drug regulation or a similar regulation; or
   c. It has FDA approval, but it is being used for an indication or at a dosage that is not an accepted off-label use. Unlabled uses of FDA-approved drugs are not considered Experimental or Investigational if they are determined to be:
      i) included in one or more of the following medical compendia: The American Medical Association Drug Evaluations, The American Hospital Formulary Service Drug Information, The United States Pharmacopoeia Information and other authoritative compendia as identified from time to time by the Secretary of Health and Human Services, or
      ii) can be established based on supportive clinical evidence in peer-reviewed medical publications.

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4. The provider's institutional review board acknowledges that the use of the service or supply is Experimental or Investigtional and subject to that board's approval.

5. Research protocols indicate that the service or supply is Experimental or Investigational. This item 5. applies for protocols used by the Insured Person's provider as well as for protocols used by other providers studying substantially the same service or supply.

**Health Benefit Plan** means a group, blanket, or franchise insurance policy, a certificate issued under a group policy, a group hospital service contract, or a group subscriber contract or evidence of coverage issued by a health maintenance organization that provides benefits for health care services. The term does not include:

1. accident-only, credit or disability insurance coverages;
2. specified disease coverage or other limited benefit policies;
3. coverage of Medicare services under a federal contract;
4. Medicare Supplement and Medicare Select policies regulated in accordance with federal law;
5. long-term care, dental care, or vision care coverages;
6. coverage provided by a single service health maintenance organization;
7. insurance coverage issued as a supplement to liability insurance;
8. insurance coverage arising out of a workers' compensation system or similar statutory system;
9. automobile medical payment insurance coverage;
10. jointly managed trusts authorized under 29 U.S.C. Section 141 et seq. that contain a plan of benefits for employees that is negotiated in a collective bargaining agreement governing wages, hours, and working conditions of the employees that is authorized under 29 U.S.C. Section 157;
11. hospital confinement indemnity coverage; or
12. reinsurance contracts issued on a stop-loss, quota-share, or similar basis.

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[**Hospital** means:

1. a facility that
   a. is licensed as a Hospital and operated pursuant to law;
   b. is primarily engaged in providing or operating either on its premises or in facilities available to the Hospital on a contractual prearranged basis and under the supervision of a staff of one or more duly licensed Physicians, medical diagnostic and major surgery facilities for the medical care and treatment of sick or injured persons on an inpatient basis for which a charge is made;
   c. provides 24-hour nursing service by or under the supervision of a registered graduate professional nurse (R.N.);
   d. maintains and operates a minimum of five beds;
   e. has x-ray and laboratory facilities either on the premises or available on a contractual prearranged basis;
   f. maintains permanent medical history records; or
2. a facility that
   a. is accredited by the Joint Commission on Accreditation and
   b. offers medical therapeutic, and psychiatric care for the treatment of Chemical Dependency.

The major surgery facility requirement is hereby waived for facilities that specialize in treating the mentally ill.

Hospital does not mean convalescent, nursing, rest or extended care facilities or facilities operated exclusively for treatment of the aged, whether such facilities are operated as a separate institution or as a section of an institution operated as a Hospital.]

**Illness** means sickness, disease, pregnancy or Complications of Pregnancy that are first manifested after the Effective Date of insurance and while the Policy is in force.

**Injury or Accidental Injury** means accidental bodily injury sustained by an Insured Person that is the direct cause of the loss independent of disease, bodily infirmity or any other cause and occurs while you are an Insured Person.

**Insured Person** means you and/or your Dependents, if insured under the Policy.

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**Medically Necessary** means the Covered Services prescribed by your Physician, Provider, or Other Health Care Practitioner to diagnose or treat an Injury or Illness and is known to be safe and effective by the majority of licensed practitioners who diagnose or treat that Injury or Illness. Such services must be:

1. performed in the least costly setting available where the services and treatments can be safely and appropriately provided;
2. not provided primarily for the convenience of you, your Physician, or the facility providing the service;
3. consistent with professionally recognized standards of care with respect to quality, frequency and duration;
4. not primarily Educational, Experimental or Investigative; and
5. consistent with your symptoms, diagnosis or treatment.

**[For Chapter 20 Companies only:**
**Noncontracting Facility** means a Hospital, a Facility Other Provider or any other facility that We do not have a written contact with.]

**One Period of Hospital Confinement** means confinement within a Hospital as a resident bed patient for the treatment of an Injury or Sickness. All periods of Hospital confinement due to the same or related causes, not separated by [90], [120], [150], [180] days shall be considered One Period of Hospital Confinement.

**Physician** means a duly licensed Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O.) who is practicing within the scope of his or her license.

**[Policyholder** means the Employer.]
**[Policyholder** means the Association.]
**[Policyholder** means the Trustee of a Multiple Employee Trust.]

**[Policy Year** means a 365 day period that begins on the Policy's Effective Date.
**[Policy Year** means a period of one full calendar year.]

**[Preexisting Condition** means a disease or condition:

1. for which medical advice, diagnosis, care or treatment was recommended or received during the six months before the effective date of coverage; or
2. that would have caused an ordinary, prudent person to seek medical advice, diagnosis, care or treatment during the six months before the effective date of coverage.

In addition, a Preexisting Condition will include any pregnancy existing on the Effective Date.]

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**Provider or Other Health Care Practitioner** means a duly licensed or certified practitioner of the healing arts, including but not limited to a physician's assistant or an advanced nurse practitioner, who is acting within the scope of said license or certificate.

**Reasonable and Customary** means the usual charge made by a group, entity, or person who renders or furnishes Covered Services, treatments or supplies; provided the charge is not in excess of the general level of charges made by others who render or furnish the same or similar services, treatments or supplies to persons:

1. who reside in the same geographical area; and
2. whose Illness or Injury is comparable in nature and severity.

You may provide your own estimate of the Reasonable and Customary charge by surveying providers in your area and request that We reconsider Our determination.

**Schedule of Benefits** means the benefit schedule set forth in the Policy or Certificate.

12/09/93

## EXCLUSIONS AND LIMITATIONS
## IN-HOSPITAL BENEFIT PLAN

The Policy does not cover expenses incurred resulting from:

a. Any service or supply which is not Medically Necessary.

b. Charges for treatment, services and supplies that are Experimental or Investigational in nature.

c. Any expense which is in excess of the Reasonable and Customary charges.

d. Any charge for services or supplies that is not within the scope of authorized practice of the institution or person rendering the services or supplies.

e. Reversal of sterilization, or medical care or surgery to change gender.

f. [Insert language, if applicable, regarding elective abortion.]

g. Any loss, expense or charge resulting from the Insured Person's active participation in a riot or inciting a riot.

h. Any loss to which a contributing cause was the Insured Person's being engaged in an illegal occupation or felonious activity.

i. Any treatment provided by an Immediate Family Member (you, your spouse, your parent, brother or sister) or provided by the Employer.

j. Any act of war, declared or undeclared.

k. Or during active service in the Armed Forces or auxiliary units. Upon receipt of written request, a prorata refund of premiums will be provided for the period an Insured Person is in the military service on full-time active duty.

l. Injury or Illness arising out of employment for wage or profit.

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m. Cosmetic Surgery, unless due to an Accidental Injury or Illness occurring while covered under the Policy, to reconstructive surgery following covered surgery, or to repair a congenital defect of a newborn Child. Surgery performed to treat a mental, emotional or nervous disorder through change in appearance is considered a Cosmetic Surgery for purposes of this exclusion.

n. Any services or supplies provided for reduction of obesity or weight, including surgical procedures, even if the Insured Person has other health conditions which might be helped by a reduction of obesity or weight.

o. Charges incurred outside the United States if the Insured Person traveled to the location for the purposes of receiving medical services, drugs or supplies.

p. Care received in Veterans Administration Hospitals for service connected disabilities.

q. Services or treatment provided in a government hospital unless there is a legal obligation to pay. This does not exclude coverage for the treatment of mental health and mental retardation provided by a tax supported institution of the State of Texas, including community centers for mental health and mental retardation services, provided charges are regularly and customarily charged to non-indigent patients.

r. Services or treatment for which the Insured Person is not legally required to pay.

s. Personal items such as TV, admitting kits, cots for family members, guest meals and other items which are not Medically Necessary.

t. Any dental services or supplies except as necessitated by Accidental Injury. Covered Services must be provided within 12 months of the date of Injury. Injuries caused by chewing or biting down are excluded.

u. Eyeglasses, contact lenses, hearing aids or the examination for prescription or fitting (unless otherwise covered under a preventive care benefit).

v. Any service or supply to eliminate or reduce a dependency on or addiction to tobacco.

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w. Charges for prescription drugs or pharmaceuticals except when provided as an inpatient in a Hospital.

x. Any service or supply associated with an autopsy or postmortem examination unless requested by Us.

y. Any service or supply in connection with the diagnosis or treatment of infertility and any form or attempt of artificial fertilization or implantation, including artificial insemination, in-vitro fertilization, and gamete intra-fallopian transfer.

z. Any service or supply in connection with any transplant.

aa. Any arch supports; orthopedic shoes; or support hose; or similar type devices/appliances regardless of intended use.

bb. Room and board charges incurred during a Hospital admission for diagnostic or evaluation procedures unless the tests could not have been performed on an outpatient basis without adversely affecting the Insured Person's physical condition or the quality of medical care provided.

cc. Transportation including ambulance services.

dd. Any service or supply for the diagnosis or treatment of temporomandibular joint dysfunction, unless due to Accidental Injury occurring while covered under the Policy.

ee. Any service or supply received by an Insured Person as a result of or in connection with a court order, unless otherwise a Covered Service.

ff. Any service or supply in connection with routine foot care including the removal of warts, corns, or calluses, the cutting and trimming of toenails, or foot care for flat feet, fallen arches and chronic foot strain in the absence of severe septemic disease.

gg. Any medical social service or vocational counseling.

hh. Any services or supplies provided as, or in conjunction with, chelation therapy, except for treatment of acute metal poisoning.

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**[For Chapter 20 companies only:**

ii. Any services or supplies furnished by a Noncontracting Facility, except for treatment of emergencies.

jj. Any services or supplies furnished by a Contracting Facility if that Facility has not been approved by us to provide those services or supplies.]

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# [SUPPLEMENTARY ACCIDENTAL INJURY BENEFIT RIDER

**Supplementary Accidental Injury Benefit:**

A Supplementary Accidental Injury Benefit will be provided if:

1. an Insured Person has an Accidental Injury while covered under the Policy; and
2. the Covered Services are incurred within 90 days from the date of the Accidental Injury.

Benefits provided are the Reasonable and Customary charges for the necessary care and treatment of the Injury, not to exceed the Supplementary Accidental Injury Benefit shown in the Schedule of Benefits. Any Eligible Expenses paid under this section will not be considered under any other section of the Policy.

**Exclusions:** To the extent there is not a conflict, the limitations and exclusions of the Policy apply to this rider. In addition to the limitations and exclusions of the Policy, the following limitations and exclusions apply.

No coverage will be provided for:

1. Expenses incurred as a result of Illness;
2. An Injury occurring before the Insured Person is covered;
3. Participation in a riot, civil commotion, civil disobedience, or unlawful assembly;
4. Any loss due to Accidental Injury resulting from an Insured Person's racing a motorized vehicle, either as a professional or an amateur;
5. An Injury as a result of attempted suicide or intentionally self-inflicted Injury;
6. An Injury arising out of employment for wage or profit;
7. Accidental Injury resulting from piloting or riding in an aircraft of any type, except as a fare paying passenger on a regularly scheduled flight on a commercial airline;

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8. Any loss sustained due to Accidental Injury as the result of an Insured Person's being intoxicated, or under the influence of any narcotic unless administered on the advice of a Physician;

9. Charges incurred for accidents in which an Insured Person is engaged in sky diving, bungee jumping, parachuting, hang gliding, operating or a passenger on any motor driven All Terrain Vehicle which is being operated primarily for support, racing or exhibition purposes. An All Terrain Vehicle is any motor propelled vehicle primarily designed for use in areas not designed as streets or highways intended for public vehicular traffic.

**Termination:**

This Rider will terminate upon the earlier of:

1. The date the Policy terminates; or

2. On the first premium due date following Our receipt of the Insured Person's written request that this Rider be terminated.

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# [ PREVENTIVE AND PRIMARY CARE BENEFIT RIDER

This rider is made a part of the [Policy/Certificate] to which it is attached. The rider is subject to all provisions, terms, definitions, exclusions and limitations of the Policy which are not in conflict with the provisions of this rider.

**DEFINITIONS:**

**Ambulatory Surgical Center** means an appropriately licensed institution or facility, either free-standing or as part of a Hospital, with permanent facilities equipped and operated for the primary purpose of performing surgical procedures and to which a patient is admitted to and discharged from with a twenty-four (24) hour period.

**Childhood Immunizations** means a test for tuberculosis, immunization and re-immunization against diphtheria, pertussis, tetanus, poliomyelitis, Haemophilus influenzae type b, measles, mumps, rubella, and hepatitis B.

**Emergency Care** means bona fide emergency services provided after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in:

1. placing the patient's health in serious jeopardy;
2. serious impairment to bodily functions; or
3. serious dysfunction of any bodily organ or part.

**Low-Dose Mammography** means the X-ray examination of the breast using equipment dedicated specifically for mammography including the X-ray tube, filter, compression device, screens, films and cassettes, with an average radiation exposure delivery of less than one rad mid breast, with two view for each breast.

**Serious Mental Illness** means:

1. schizophrenia;
2. paranoid and other psychotic disorders;
3. bipolar disorders (mixed, manic and depressive);
4. major depressive disorders (single episode or recurrent); and
5. schizo-affective disorders (bipolar or depressive).

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**BENEFITS PROVIDED:**

If you or your Dependent incur expense for Covered Services, We will pay a percentage of that Eligible Expense after the Deductible is satisfied. We will pay up to the Maximums for each Insured Person. The Percentage Payable, Deductible, and Maximums are shown in the Schedule of Benefits. Such charges are payable only to the extent that they do not duplicate charges included under any other Eligible Expense provisions of the Policy. This rider will not duplicate benefits for Covered Services that are paid under the Policy.

**Deductible** means the amount of Eligible Expenses shown in the Schedule of Benefits for each Insured Person for which We will pay no benefits during each Policy Year.

**Copayment** means, after the Deductible has been met, the amount you must pay for Eligible Expenses under the Policy. Copayment does not include any services or charges which are not covered under the Rider, or the Deductible.

The **Individual Policy Year Copayment Maximum** for an Insured Person is $1,000. After the Copayments for an Insured Person equal $1,000 in one Policy Year, the Percentage Payable will increase to 100% for the remainder of that Policy Year.

The **Family Policy Year Copayment Maximum** for Insured Persons within one family is $3,000. If Copayments for you and your Dependents equal $3,000 in one Policy Year, the Percentage Payable for those Insured Persons within that family will increase to 100% for the remainder of the Policy Year. No Insured Person will be required to satisfy more than the Individual Policy Year Copayment Maximum.

**Policy Year Maximum** means the maximum benefit payable per Insured Person in a Policy Year.

**Lifetime Maximum** means the maximum benefit payable per Insured Person's lifetime.

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**Eligible Expenses** are charges for Covered Services to the extent that they are:

1. not in excess of the Reasonable and Customary charge for the treatment, service or supply and:
   a. Medically Necessary for the diagnosis or treatment of an Illness or Injury; or
   b. covered preventive care services; and
2. covered by this rider.

Covered Services are:

1. Hospital outpatient services including surgical services and supplies provided by an Ambulatory Surgical Center or Hospital outpatient facility.

2. Services by Physicians, Providers, or Other Healthcare Practitioners for diagnosis or treatment of an Illness or Injury in an outpatient clinic or office.

3. Physical therapy performed by a qualified licensed physical therapist, occupational therapy performed by a qualified licensed occupational therapist, or speech-language therapy performed by a qualified licensed speech-language pathologist.

   Covered Services include outpatient diagnostic services and outpatient treatment visits. A Policy Year Maximum of 40 outpatient treatment visits will be provided for any physical therapy, occupational therapy and/or speech therapy.

4. Emergency Care services including:
   a. outpatient Hospital services;
   b. professional ground or air ambulance services for transportation to nearest Hospital equipped to treat the Illness or Injury;
   c. Physician services for an operation, or the repair of a dislocation or fracture; including the services of an assisting surgeon;
   d. anesthesia and its administration; and
   e. services for medical care provided by a Physician, Provider or Other Health Care Practitioner (if not included in c.).

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5. Diagnostic examinations, lab and x-rays services including imaging services, pathology, radiology, and the related interpretations up to a Policy Year maximum benefit of $5,000.

6. Maternity-related care, including prenatal, delivery, postnatal care, high-risk pregnancy care, and Complications of Pregnancy, and the initial well child expenses of a newborn Child.

7. Home health care services under a plan of care established, approved in writing, and reviewed at least every two months by the attending Physician and certified by the attending Physician that hospitalization or confinement in a Skilled Nursing Facility would otherwise be required. Services include:

   a. skilled nursing by a registered nurse or licensed vocational nurse under the supervision of at least one registered nurse and at least one Physician;
   b. physical, occupational, speech, or respiratory therapy;
   c. service of a home health aide under the supervision of a registered nurse; and;
   d. the furnishing of medical equipment and medical supplies other than drugs and medicines.

   The comprehensive limitations listed in the Policy will apply to home health care services. In addition, comprehensive covered charges will not include charges for:

   a. services or supplies not included in the home health care plan;
   b. services of any person who normally lives in your home is a member of the Insured Person's Immediate Family (you, your spouse, your parent, brother or sister);
   c. custodial care (services or supplies provided to assist a person in daily living...e.g., meals and personal grooming); or
   d. transportation services.

   Covered home health care services are limited to a maximum of 40 visits per Policy Year. A visit by a nurse or therapist will be considered one visit, four hours of home health aide service is considered one visit, and each four hours or portion of that period for additional home health aide service is considered one visit.

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We may waive the Policy Year limit on home health services if the waiver will result in less expensive treatment and the Insured Person and the Insured Person's Physician agree to an alternate plan of care. Any benefits paid under this provision will continue to be subject to the other maximums shown in the Schedule of Benefits.

8. Mental health services (including Serious Mental Illness) for:

   a. outpatient evaluation;
   b. crisis intervention; and
   c. services for treatment.

   Benefits will be limited to outpatient services limited to 40 visits per Policy Year.

9. Evaluation and treatment for Chemical Dependency limited to outpatient treatment for a maximum of 40 visits per Policy Year.

10. Well child care including but not limited to:

    a. ophthalmologic examination for infants at risk for eye problems;

    b. child health supervision services by, or supervised by, a Physician at the following intervals: birth, 2 months, 4 months, 6 months, 9 months, 12 months, 18 months, 2 years, and annually thereafter;

       covered child health supervision services include:
       1. history;
       2. physical examination;
       3. developmental assessment;
       4. anticipatory guidance;
       5. appropriate Childhood Immunizations;
       6. laboratory testing;
       7. hearing and vision screening.

    Charges for Childhood Immunizations will be payable at 100% of the Reasonable and Customary charges and the Deductible and Copayment will be waived. Remaining covered well child care services will be payable as shown on the Schedule of Benefits.

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In addition, Covered Services will include annual vision and hearing testing for any covered Child under the age of 19. Eligible Expenses will be payable at 100% of the Reasonable and Customary charges and the Deductible and Copayment will be waived.

11. Rental or purchase price, at Our option, of durable medical equipment required for therapeutic use, including repairs and necessary maintenance of purchased equipment, not otherwise provided for under a manufacturer's warranty of purchase agreement;

12. Oxygen and rental of equipment for its administration;

13. One annual physical examination. Services include:

    a. history;
    b. physical examination;
    c. laboratory and x-rays including pap tests, colo-rectal screening, and prostate cancer screening.

    Eligible Expenses for pap tests, colo-rectal screening, and prostate cancer screening will be payable at 100% of the Reasonable and Customary charges and the Deductible and Copayment will be waived. Remaining Covered Services included in an annual physical examination will be payable as shown on the Schedule of Benefits.

    In addition, Covered Services will include one annual screening by Low-Dose Mammography for any female insured age 35 and over. Eligible Expense will be payable at 100% of the Reasonable and Customary charge and the Deductible and Copayment will be waived.

**EXCLUSIONS:**

To the extent there is not a conflict, the Exclusions & Limitations of the Policy apply to this rider. In addition to the Exclusions & Limitations of the Policy, the following Exclusion & Limitation applies:

Charges for prescription drugs or pharmaceuticals except when a Covered Service provided by a Hospital or Ambulatory Surgical Center.

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**TERMINATION:**

This rider will terminate upon the earlier of

1. the date the Policy terminates; or

2. the first premium due date following Our receipt of the Insured Person's written request that this rider be terminated.

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# STANDARD HEALTH BENEFIT PLAN

# SCHEDULE OF BENEFITS
# STANDARD HEALTH BENEFIT PLAN
# (Non-PPO Plan)

| | |
|---|---|
| Policy Year Deductible | [$250] [$500] |
| Policy Year Copayment Maximum | [$2000] [$5000] per individual<br>[$6000] [$15,000] per family |
| Policy Year Maximum Benefit | $250,000 (per individual) |
| Lifetime Maximum Benefit | $1,000,000 (per individual) |

| COVERED SERVICES | PERCENTAGE PAYABLE |
|---|---|
| Inpatient and Outpatient Hospitals<br>Subject to Policy Year Deductible | 80% |
| Skilled Nursing Benefit<br>Subject to Policy Year Deductible and Policy Year Maximum of $10,000 | 80% |
| Hospice Benefit<br>Subject to Policy Year Deductible and Lifetime Maximum amount of $10,000 | 80% |
| Maternity Benefit<br>Subject to Policy Year Deductible | 80% |
| Outpatient Expense Benefit<br>Subject to Policy Year Deductible<br>(includes outpatient clinic or office visits for treatment of an Illness or Injury) | 80% |

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| | |
|---|---|
| Mental Health Services Benefit<br>Subject to Policy Year Deductible | 80% |
| Inpatient Hospital Expense | Maximum of 90 days per Policy Year* |
| Residential Treatment Center or Crisis Stabilization Unit or Psychiatric Day Treatment Facility | Maximum of 180 days per Policy Year** |
| Outpatient Expense | Maximum of 40 visits per Policy Year and $100 per visit |
| Chemical Dependency Benefits***<br>(same as any other Illness) | 80% |
| Subject to Policy Year Deductible | |
| [Limited to a Lifetime Maximum of three separate series of treatment for each Insured Person.] | |
| Serious Mental Illness Benefit<br>(same as any other Illness) | 80% |
| Subject to Policy Year Deductible | |
| Diagnostic Exams, Labs and X-rays<br>Subject to Policy Year Deductible | 80% |
| Preventive Care Benefit<br>Policy Year Deductible and Copayment waived. Includes Childhood Immunizations, pap tests, Low-Dose Mammography for female insureds age 35 and over, colo-rectal screening, prostate cancer screening, and vision/hearing testing for children under age of 19. | 100% |

* Subject to reduction for days treatment is received in Residential Treatment Center, Crisis Stabilization Unit or Psychiatric Day Treatment Facility

** Subject to reduction for days treatment is received under the Inpatient Hospital Expense Benefit

*** Unless waiver attached

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| | |
|---|---|
| Well Child Care Benefit<br>(except for Childhood Immunizations)<br>Subject to Policy Year Deductible | 80% |
| Annual Physical Examination Benefit<br>Subject to Policy Year Deductible<br>(except for services covered under the Preventive Care Benefit) | 80% |
| Therapy Benefit<br>Subject to Policy Year Deductible and limited to Maximum of $10,000 per Policy Year for physical, occupational and speech therapy | 80% |
| Home Health Benefit<br>Subject to Policy Year Deductible and limited to $10,000 per Policy Year | 80% |

| | |
|---|---|
| [Prescription Drug Benefit<br>Subject to Policy Year Deductible] | [50%] |

or

[Prescription Drug Card Program
Plan pays 100% after the Deductible

| | |
|---|---|
| Deductible | |
| Generic drug or Name Brand drug if less than Generic drug-- | [$8] per prescription or refill |
| Name Brand drug -- | [$12] per prescription or refill] |

[Additional benefits added by riders]

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## SCHEDULE OF BENEFITS
## STANDARD HEALTH BENEFIT PLAN
## (PPO PLAN)

| | |
|---|---|
| [Policy Year Deductible or Non-Preferred Provider Policy Year Deductible] | [$250] [$500] |
| [Preferred Provider Policy Year Deductible] | [ ] |
| [Per Visit Deductible] | [$ 10 ] [$ 15 ] |
| Policy Year Copayment Maximum | [$2,000] [$5,000] per individual<br>[$6,000] [$15,000] per family<br>[Preferred Provider and Non-Preferred Provider Combined] |
| Policy Year Maximum Benefit | $ 250,000 (per individual) |
| Lifetime Maximum Benefit | $1,000,000 (per individual) |

| COVERED SERVICES | PERCENTAGE PAYABLE PPO | PERCENTAGE PAYABLE NON-PPO |
|---|---|---|
| Inpatient and Outpatient Hospitals | [100%] [90% ] [80%] | [80%] [70%] |
| | [Subject to Policy Year Deductible]<br>or<br>[Subject to Preferred Provider Deductible]<br>or<br>[Subject to Per Visit Deductible]<br>or<br>[Deductible Waived] | [Subject to Policy Year Deductible]<br>or<br>[Subject to Non-Preferred Provider Deductible]<br>or<br>[Subject to Per Visit Deductible]<br>or<br>[Deductible Waived] |
| Skilled Nursing Benefit | [100%] [90%] [80%] | [80%] [70%] |
| Subject to Policy Year Maximum of $10,000 | [Subject to Policy Year Deductible]<br>or<br>[Subject to Preferred Provider Deductible]<br>or<br>[Deductible Waived | [Subject to Policy Year Deductible]<br>or<br>[Subject to Non-Preferred Provider Deductible]<br>or<br>[Deductible Waived] |

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| | PPO | NON-PPO |
|---|---|---|
| Hospice Benefit<br><br>Lifetime Maximum amount of $10,000 | [100%] [90%] [80%]<br><br>[Subject to Policy Year Deductible]<br>or<br>[Subject to Preferred Provider Deductible]<br>or<br>[Deductible Waived] | [80%] [70%]<br><br>[Subject to Policy Year Deductible]<br>or<br>[Subject to Non-Preferred Provider Deductible]<br>or<br>[Deductible Waived] |
| Maternity Benefit | [100%][90%] [80%]<br><br>[Subject to Policy Year Deductible]<br>or<br>[Subject to Preferred Provider Deductible]<br>or<br>[Subject to Per Visit Deductible]<br>or<br>[Deductible Waived] | [80%] [70%]<br><br>[Subject to Policy Year Deductible]<br>or<br>[Subject to Non-Preferred Provider Deductible]<br>or<br>[Subject to Per Visit Deductible]<br>or<br>[Deductible Waived] |
| Outpatient Expense Benefit (includes outpatient clinic or office visits for treatment of an Illness or Injury) | [100%] [90%] [80%]<br><br>[Subject to Policy Year Deductible]<br>or<br>[Subject to Preferred Provider Deductible]<br>or<br>[Subject to Per Visit Deductible]<br>or<br>[Deductible Waived] | [80%] [70%]<br><br>[Subject to Policy Year Deductible]<br>or<br>[Subject to Non-Preferred Provider Deductible]<br>or<br>[Subject to Per Visit Deductible]<br>or<br>[Deductible Waived] |
| Mental Health Services Benefit | [100%] [90%] [80%]<br><br>[Subject to Policy Year Deductible]<br>or<br>[Subject to Preferred Provider Deductible]<br>or<br>[Subject to Per Visit Deductible]<br>or<br>[Deductible Waived] | [80%] [70%]<br><br>[Subject to Policy Year Deductible]<br>or<br>[Subject to Non-Preferred Provider Deductible]<br>or<br>[Subject to Per Visit Deductible]<br>or<br>[Deductible Waived] |

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| | PPO | NON-PPO |
|---|---|---|
| Inpatient Hospital Expense | maximum of 90 days per Policy Year * | maximum of 90 days per Policy Year |
| Residential Treatment Center or Crisis Stabilization Unit or Psychiatric Day Treatment Facility | maximum of 180 days per Policy Year ** | maximum of 180 days per Policy Year |
| Outpatient Expense | maximum of 40 visits per Policy Year and $100 per visit | maximum of 40 visits per Policy Year and $100 per visit |
| Chemical Dependency Benefits *** (same as any other Illness)<br><br>[Limited to Lifetime Maximum of three separate series of treatment for each Insured Person.] | 100%] [90%] [80%]<br><br>[Subject to Policy Year Deductible]<br>or<br>[Subject to Preferred Provider Deductible]<br>or<br>[Subject to Per Visit Deductible]<br>or<br>[Deductible Waived] | [80 %] [70%]<br><br>[Subject to Policy Year Deductible]<br>or<br>[Subject to Non-Preferred Provider Deductible]<br>or<br>[Subject to Per Visit Deductible]<br>or<br>[Deductible Waived] |
| Serious Mental Illness Benefit (same as any other Illness) | [100%] [90%] [80%]<br><br>[Subject to Policy Year Deductible]<br>or<br>[Subject to Preferred Provider Deductible]<br>or<br>[Subject to Per Visit Deductible]<br>or<br>[Deductible Waived] | [80] [70%]<br><br>[Subject to Policy Year Deductible]<br>or<br>[Subject to Non-Preferred Provi[illegible] Deductible]<br>or<br>[Subject to Per Visit Deductible]<br>or<br>[Deductible Waived] |
| Diagnostic Exams, Labs and X-rays | [100%] [90%] [80%]<br><br>[Subject to Policy Year Deductible]<br>or<br>[Subject to Preferred Provider Deductible]<br>or<br>[Deductible Waived] | [80%] [70%]<br><br>[Subject to Policy Year Deductible]<br>or<br>[Subject to Non-Preferred Provider Deductible]<br>or<br>[Deductible Waived] |

* Subject to reduction for days treatment is received in Residential Treatment Center, Crisis Stabilization Unit or Psychiatric Day Treatment Facility

** Subject to reduction for days treatment is received under the Mental Inpatient Hospital Expense Benefits

*** Unless waiver attached

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| | PPO | NON-PPO |
|---|---|---|
| Preventive Care Benefit<br>Policy Year Deductible and Copayment waived.<br>(Includes Childhood Immunizations pap tests, Low-Dose Mammography for female insureds age 35 and over, colo-rectal screening, prostate cancer screening, and vision/ hearing testing for children under age of 19. | 100%<br>No Deductible | 100%<br>No Deductible |
| Well Child Care Benefit<br>(except for Childhood Immunizations) | [100%] [90%] [80%]<br><br>[Subject to Policy Year Deductible]<br>or<br>[Subject to Preferred Provider Deductible]<br>or<br>[Subject to Per Visit Deductible]<br>or<br>[Deductible Waived] | [80%] [70%<br><br>[Subject to Policy Year Deductible]<br>or<br>[Subject to Non-Preferred Provider Deductible]<br>or<br>[Subject to Per Visit Deductible]<br>or<br>[Deductible Waived] |
| Annual Physical Examination Benefit<br>(except for services covered under the Preventive Care Benefit) | [100%] [90%] [80%]<br><br>[Subject to Policy Year Deductible]<br>or<br>[Subject to Preferred Provider Deductible]<br>or<br>[Subject to Per Visit Deductible]<br>or<br>[Deductible Waived] | [80%] [70%]<br><br>[Subject to Policy Year Deductible]<br>or<br>[Subject to Non-Preferred Provider]<br>or<br>[Subject to Per Visit Deductible]<br>or<br>[Deductible Waived] |
| Therapy Benefit<br>Limited to Maximum of $10,000 per Policy Year for physical, occupational and speech therapy | [100%] [90%] [80%]<br>[Subject to Policy Year Deductible]<br>or<br>[Subject to Preferred Provider Deductible]<br>or<br>[Subject to Per Visit Deductible]<br>or<br>[Deductible Waived] | [80%] [70%]<br>[Subject to Policy Year Deductible]<br>or<br>[Subject to Non-Preferred Provider Deductible]<br>or<br>[Subject to Per Visit Deductible]<br>or<br>[Deductible Waived] |

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| | PPO | NON-PPO |
|---|---|---|
| Home Health Benefit<br>Limited to $10,000 per Policy Year | [100%] [90%] [80%]<br>[Subject to Policy Year Deductible]<br>or<br>[Subject to Preferred Provider Deductible]<br>or<br>[Deductible Waived] | [80%] [70%]<br>[Subject to Policy Year Deductible]<br>or<br>[Subject to Non-Preferred Provid[illegible] Deductible]<br>or<br>[Deductible Waived] |

[PRESCRIPTION DRUG CARD PROGRAM
Plan pays 100% after Deductible

Deductible
Generic drug or Name
Brand drug if less than
Generic drug - [$ 8] per prescription or refill
Name Brand drug - [$12] per prescription or refill]

or

[PRESCRIPTION DRUG BENEFIT
Percentage Payable [50%]
Subject to the Policy Year Deductible]

[Schedule for Covered Services added by riders]

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# POLICY DEFINITIONS
# STANDARD BENEFIT PLAN

**Affiliated Employer** means a person connected by commonality of ownership with a small employer. The term includes a person that owns a small employer, shares directors with a small employer, or is eligible to file a consolidated tax return with a small employer.

**Ambulatory Surgical Center** means an appropriately licensed institution or facility, either free-standing or as part of a Hospital, with permanent facilities equipped and operated for the primary purpose of performing surgical procedures and to which a patient is admitted and discharged from within a twenty-four (24) hour period.

**Beneficiary** means the person you designate to receive any unassigned benefits that are paid after your death.

[**Certificate of Insurance** means the individual certificate issued to the Insured Person which describes the coverage provided by the Policy.]

**Chemical Dependency** means the abuse of or psychological or physical dependence on or addiction to alcohol or a controlled substance.

**Chemical Dependency Treatment Center** means a facility which provides a program for the treatment of Chemical Dependency pursuant to a written treatment plan approved and monitored by a Physician and which facility is also:

1. affiliated with a Hospital under a contractual agreement with an established system for patient referral; or
2. accredited as such a facility by the Joint Commission on Accreditation of Hospitals; or
3. licensed as a chemical dependency treatment program by the Texas Commission on Alcohol or Drug Abuse; or
4. licensed, certified, or approved as a chemical dependency treatment program or center by any other state agency having legal authority to so license, certify, or approve.

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**Child** means the unmarried:

1. natural Child of the Insured Person including a newborn Child;
2. adopted Child including a Child who the Insured Person is seeking to adopt;
3. natural Child or adopted Child of the Insured Person's spouse provided the Child resides with the Insured Person.

**Childhood Immunizations** means a test for tuberculosis, immunization and re-immunization against diphtheria, pertussis, tetanus, poliomyelitis, *Haemophilus influenzae type b,* measles, mumps, rubella, and hepatitis B.

**Complication of Pregnancy** mean:

1. conditions, requiring hospital confinement (when the pregnancy is not terminated), whose diagnoses are distinct from pregnancy but are adversely affected by pregnancy, including but not limited to, acute nephritis, nephrosis, cardiac decompensation, missed abortion, and similar medical and surgical conditions of comparable severity, but shall not include false labor, occasional spotting, Physician prescribed rest during the period of pregnancy, morning sickness, hyperemesis gravidarum, pre-eclampsia and similar conditions associated with the management of a difficult pregnancy but not constituting a nosologically distinct complication of pregnancy; and
2. non-elective cesarean section, termination of ectopic pregnancy, and spontaneous termination of pregnancy, occurring during a period of gestation in which a viable birth is not possible.

**[For Chapter 20 companies only:**
**Contracting Facility** means a Hospital, a Facility Other Provider or any other facility that We have a written contract with to provide care, services or supplies that are covered by the Policy. A Contracting Facility also means a Hospital or Facility Other Provider located outside of Texas, that another insurance company has a contract with that allows us to use its facilities.

**Cosmetic Surgery** means surgery that is primarily for the purpose of improving appearance and does not, other than incidentally, correct or improve a functional impairment.

**Crisis Stabilization Unit** means a 24-hour residential program, appropriately licensed or certified as a Crisis Stabilization Unit or Facility, that provides intensive supervision and highly structured activities to persons who are demonstrating an acute demonstrable psychiatric crisis of moderate to severe proportions.

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**Dependent** means:

1. a spouse;
2. a newborn Child;
3. a Child under the age of 19 years;
4. a Child who is a full-time student under the age of 23 years and who is financially dependent upon the parent;
5. a Child of any age who is medically certified as disabled and dependent on the parent;
6. an adopted Child,
7. a grandchild who is your dependent for federal income tax purposes

**Educational** means that the primary purpose of the service or supply is to provide the Insured Person with any of the following:

1. training in the activities of daily living;
2. instruction in scholastic skills such as reading and writing;
3. preparation for an occupation;
4. or treatment for learning disabilities.

"Training in the activities of daily living does not include training directly related to treatment of Illness or Injury that resulted in a loss of a previously demonstrated ability to perform those activities.

**Emergency Care** means bona fide emergency services provided after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in (1) placing the patient's health in serious jeopardy; (2) serious impairment to bodily functions; or (3) serious dysfunction of any bodily organ or part.

**Employee** means you, the principal insured, hereafter referred to as "you".

**Employer** means an individual, corporation, partnership, association, or other private legal entity that is actively engaged in business and that on at least 50 percent of its working days during the preceding calendar year, employed at least three but not more than 50 Eligible Employees, including the employees of an affiliated employer, the majority of whom were employed in this state. [Employer includes Employer Members of an Association that meets the criteria defined above.]

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**Experimental or Investigational** means We determine that one or more of the following is true:

1. The service or supply is under study or in a clinical trial to evaluate its toxicity, safety or efficacy for a particular diagnosis or set of indications. Clinical trials include but are not limited to phase I, II and III clinical trials.
2. The prevailing opinion within the appropriate specialty of the United States medical profession is that the service or supply needs further evaluation for the particular diagnosis or set of indications before it is used outside clinical trials or other research settings.

   We will determine if this item 2. is true based on:

   a. Published reports in authoritative medical literature; and
   b. Regulations, reports, publications and evaluations issued by government agencies such as the Agency for Health Care Policy and Research, the National Institutes of Health, and the FDA.

3. In the case of a drug, a device or other supply that is subject to FDA approval:

   a. It does not have FDA approval; or
   b. It has FDA approval only under its Treatment Investigational New Drug regulation or a similar regulation; or

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c. It has FDA approval, but it is being used for an indication or at a dosage that is not an accepted off-label use. Unlabled uses of FDA-approved durgs are not considered Experimental or Investigational if they are determined to be:

i) included in one or more of the following medical compendia: The American Medical Association Drug Evaluations, The American Hospital Formulary Service Drug Information, The United States Pharmacopoeia Information and other authoritative compendia as identified from time to time by the Secretary of Health and Human Services, or

ii) In addition, the medical appropriateness of unlabled uses not included in the compendia can be established based on supportive clinical evidence in peer-reviewed medical publications.

4. The provider's institutional review board acknowledges that the use of the service or supply is Experimental or Investigtional and subject to that board's approval.

5. Research protocols indicate that the service or supply is Experimental or Investigational. This item 5. applies for protocols used by the Insured Person's provider as well as for protocols used by other providers studying substantially the same service or supply.

**Generic** means drugs not protected by a trademark registration.

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**Health Benefit Plan** means a group, blanket, or franchise insurance policy, a certificate issued under a group policy, a group hospital service contract, or a group subscriber contract or evidence of coverage issued by a health maintenance organization that provides benefits for health care services. The term does not include:

1. accident-only, credit or disability insurance coverages;
2. specified disease coverage or other limited benefit policies;
3. coverage of Medicare services under a federal contract;
4. Medicare Supplement and Medicare Select policies regulated in accordance with federal law;
5. long-term care, dental care, or vision care coverages;
6. coverage provide by a single service health maintenance organization;
7. insurance coverage issued as a supplement to liability insurance;
8. insurance coverage arising out of a workers' compensation system or similar statutory system;
9. automobile medical payment insurance coverage;
10. jointly managed trusts authorized under 29 U.S.C. Section 141 et seq. that contain a plan of benefits for employees that is negotiated in a collective bargaining agreement governing wages, hours, and working conditions of the employees that is authorized under 29 U.S.C. Section 157;
11. hospital confinement indemnity coverage; or
12. reinsurance contracts issued on a stop-loss, quota-share, or similar basis.

**Hospice Care Facility** means a facility whose primary purpose is to provide to terminally ill persons medical and support services for symptom management and pain relief, that is licensed and operated according to the laws of the state in which it is located.

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[**Hospital** means

1. a facility that
    a. is licensed as a Hospital and operated pursuant to law;
    b. is primarily engaged in providing or operating either on its premises or in facilities available to the Hospital on a contractual prearranged basis and under the supervision of a staff of one or more duly licensed Physicians, medical diagnostic and major surgery facilities for the medical care and treatment of sick or injured persons on an inpatient basis for which a charge is made;
    c. provides 24-hour nursing service by or under the supervision of a registered graduate professional nurse (R.N.);
    d. maintains and operates a minimum of five beds;
    e. has x-ray and laboratory facilities either on the premises or available on a contractual prearranged basis;
    f. maintains permanent medical history records; or
2. a facility that
    a. is accredited by the Joint Commission on Accreditation of Healthcare Organization; and
    b. offers medical therapeutic, and psychiatric care for the treatment of Chemical Dependency.

The major surgery facility requirement is hereby waived for facilities that specialize in treating the mentally ill.

Hospital does not mean convalescent, nursing, rest or extended care facilities or facilities operated exclusively for treatment of the aged, whether such facilities are operated as a separate institution or as a section of an institution operated as a Hospital.]

**Illness** means sickness, disease, pregnancy or Complications of Pregnancy that are first manifested after the Effective Date of insurance and while the Policy is in force.

**Injury or Accidental Injury** means accidental bodily injury sustained by an Insured Person that is the direct cause of the loss independent of disease, bodily infirmity or any other cause and occurs while you are an Insured Person.

**Insured Person** means you and/or your Dependents, if insured under the Policy.

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**Low-Dose Mammography** means the X-ray examination of the breast using equipment dedicated specifically for mammography including the X-ray tube, filter, compression device, screens, films, and cassettes, with an average radiation exposure delivery of less than one rad mid breast, with two views for each breast.

**Medically Necessary** means the Covered Services prescribed by your Physician, Provider, or Other Health Care Practitioner to diagnose or treat an Injury or Illness and is known to be safe and effective by the majority of licensed practitioners who diagnose or treat that Injury or Illness. Such services must be:

1. Performed in the least costly setting available where the services and treatments can be safely and appropriately provided;
2. Not provided primarily for the convenience of you, your Physician, or the facility providing the service;
3. Consistent with professionally recognized standards of care with respect to quality, frequency and duration;
4. Not primarily Educational, Experimental or Investigative; and
5. Consistent with your symptoms, diagnosis or treatment.

**Name Brand** means a drug protected by trademark registration.

**[For Chapter 20 companies only:**
**Noncontracting Facility** means a Hospital, a Facility Other Provider or any other facility that We do not have a written contact with.]

**Physician** means a duly licensed Doctor of Medicine (MD.) or Doctor of Osteopathy (DO.) who is practicing within the scope of his or her license.

**[Policy Year** means a 365 day period that begins on the anniversary of the Policy's Effective Date.]
**[Policy Year** means a period of one full calendar year.]

**[Policyholder:**
[Policyholder means the Employer.]
[Policyholder means the Association.]
[Policyholder means the Trustee of a Multiple Employer Trust.]

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[**Preexisting Condition** means a disease or condition

1. for which medical advice, diagnosis, care or treatment was recommended or received during the six months before the effective date of coverage; or
2. that would have caused an ordinary, prudent person to seek medical advice, diagnosis, care or treatment during the six months before the effective date of coverage.

In addition, a Preexisting Condition will include any pregnancy existing on the Effective Date.]

**Provider or Other Health Care Practitioner** means a duly licensed or certified practitioner of the healing arts including, but not limited to, a Physician's assistant or an advanced nurse practitioner, who is acting within the scope of said license or certificate.

**Psychiatric Day Treatment Facility** means a mental health facility that provides treatment for individuals suffering from acute, mental and nervous disorders in a structured psychiatric program utilizing individualized treatment plans with specific attainable goals and objectives appropriate both to the patient and the treatment modality of the program and that is clinically supervised by a doctor of medicine who is certified in psychiatry by the American Board of Psychiatry and Neurology.

**Reasonable and Customary** means the usual charge made by a group, entity, or person who renders or furnishes Covered Services, treatments or supplies; provided the charge is not in excess of the general level of charges made by others who render or furnish the same or similar services, treatments or supplies to persons:

1. who reside in the same geographical area; and
2. whose Illness or Injury is comparable in nature and severity.

You may provide your own estimate of the Reasonable & Customary charge by surveying providers in your area and request that We reconsider our determination.

**Residential Treatment Center for Children and Adolescents** means a child-care institution that provides residential care and treatment for emotionally disturbed children and adolescents and that is accredited as a residential treatment center by the Council on Accreditation, the Joint Commission on Accreditation of Hospitals, or the American Association of Psychiatric Services for Children.

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**Schedule of Benefits** means the benefit schedule set forth in the Policy or Certificate.

**Serious Mental Illness** means

1. schizophrenia;
2. paranoid and other psychotic disorders;
3. bipolar disorders (mixed, manic and depressive);
4. major depressive disorders (single episode or recurrent); and
5. schizo-affective disorders (bipolar or depressive).

**Skilled Nursing Facility** means a facility that is operated pursuant to law and is primarily engaged in providing, in addition to room and board accommodations, skilled nursing care under the supervision of a duly licensed Physician. It must provide continuous, 24-hour-a-day nursing service by or under the supervision of a registered graduate professional nurse (RN.); and maintain a daily medical record of each patient. A Skilled Nursing Facility is not, except by incident, a rest home, a home for the care if the aged, or engaged in the care and treatment of chemical or alcohol dependence.

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# BENEFITS PROVIDED
# STANDARD HEALTH BENEFIT PLAN

If you or your Dependent incur expense for Covered Services while covered under the Policy, We will pay a percentage of that Eligible Expense after the Deductible is satisfied. We will pay up to the Maximums for each Insured Person. The Percentage Payable, Deductible, and Maximums are shown in the Schedule of Benefits.

**Deductible** means the amount of Eligible Expenses shown in the Schedule of Benefits for each Insured Person for which We will pay no benefits during each Policy Year.

**Copayment** means, after the Deductible has been met, the amount you must pay for Eligible Expenses under the Policy. Copayment does not include any services or charges which are not covered under the Policy, the Deductible or Covered Services under any attached rider.

The **Individual Policy Year Copayment Maximum** for an Insured Person is [$2,000] [$5,000]. After the Copayments for an Insured Person equal [$2,000] [$5,000] in one Policy Year, the Percentage Payable will increase to 100% for the remainder of that Policy Year.

The **Family Policy Year Copayment Maximum** for Insured Persons within one family is [$6,000] [$15,000]. If Copayments for you and your Dependents equal [$6,000] [$15,000] in one Policy Year, the Percentage Payable for those Insured Persons within that family will increase to 100% for the remainder of the Policy Year. No Insured Person will be required to satisfy more than the Individual Policy Year Copayment Maximum.

**Policy Year Maximum** means the maximum benefit payable per Insured Person in a Policy Year.

**Lifetime Maximum** means the maximum benefit payable per Insured Person's lifetime.

**Eligible Expenses** are charges for Covered Services to the extent that they are:

1. not in excess of the Reasonable and Customary charge for the treatment, service or supply, and

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a. Medically Necessary for the diagnosis or treatment of an Illness or Injury; or
b. covered preventive care services; and

2. covered by the Policy.

**Covered Services and Supplies are:**

1. services by Physicians, Providers or Other Health Care Practitioners for diagnosis, treatment, and surgery of an Illness or Injury.

2. daily Hospital room, board and general nursing services equal to the average semi-private room rate. Charges made by a Hospital for a private room will be considered an Eligible Expense in the amount not greater than the average semi-private room rate.

3. confinement in an intensive care or cardiac care unit to a maximum of three times the average semi-private room rate.

4. miscellaneous Hospital services and supplies including, but not limited to operating room, recovery room, surgical dressings, casts, splints, trusses, braces, and initial artificial limbs or eyes, blood when not replaced and its administration.

5. anesthesia and its administration.

6. assistant surgery fee (not to exceed 25% of the primary surgeon's fee for any one assistant) when the procedure requires an assistant surgeon(s) due to medical necessity.

7. professional ground or air ambulance services for transportation to the nearest Hospital equipped to treat the Injury or Illness as needed for Emergency Care.

8. outpatient services made by a Hospital or other emergency care facility for Emergency Care.

9. surgical services and supplies provided by an Ambulatory Surgical Center or Hospital outpatient facility.

10. oxygen and the rental of equipment for its administration.

11. rental or purchase, at out option, of durable medical equipment required for therapeutic use, including repairs and necessary

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maintenance of purchased equipment, not otherwise provided for under a manufacturer's warranty or purchase agreement.

12. inpatient and outpatient radiation therapy, inhalation therapy, and chemotherapy.

13. inpatient and outpatient X-ray and laboratory services, including imaging services, pathology, radiology, and the interpretation thereof.

14. services for the necessary care and treatment of Chemical Dependency, payable on the same basis as any other Illness. Necessary care or treatment in a Chemical Dependency Treatment Center will be considered as if it were care or treatment in a Hospital. [However, coverage for Chemical Dependency is limited to a Lifetime Maximum of three separate series of treatment for each Insured Person.]

15. maternity related care, including prenatal, delivery, and postnatal care, high risk pregnancy care, and Complications of Pregnancy and the initial well child expenses of a newborn child.

16. Well child care including but not limited to:

    a. Ophthalmologic examination for infants at risk for eye problems;
    b. Charges for child health supervision services by or supervised by a physician at the following intervals: birth, 2 months, 4 months, 6 months, 9 months, 12 months, 18 months, 2 years, and annually thereafter;
    c. Covered child health supervision services include:

        1. history;
        2. physical examination;
        3. developmental assessment;
        4. anticipatory guidance;
        5. appropriate childhood immunizations;
        6. laboratory testing;
        7. hearing and vision screening.

Charges for Childhood Immunizations will be payable at 100% of the Reasonable and Customary charges and the Deductible and Copayment will be waived. Remaining covered well child care expenses will be payable as shown in the Schedule of Benefits.

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In addition, Covered Services will include annual vision and hearing testing for any covered child under the age of 19. Charges will be payable at 100% of the Reasonable and Customary charges. The Deductible and Copayment will be waived.

17. one annual physical examination. Services include:

    a. history;
    b. physical examination;
    c. laboratory and x-rays including pap tests, colo-rectal screening, and prostate cancer screening.

    Charges for pap tests, colo-rectal screening, and prostate cancer screening will be payable at 100% of the Reasonable and Customary charges and the Deductible and Copayment will be waived. Remaining Covered Services included in an annual physical examination will be payable as shown on the Schedule of Benefits.

    In addition, Covered Services will include one Low-dose Mammography for any female insured age 35 and over. Charges will be payable at 100% of the Reasonable and Customary charges and the Deductible and Copayment will be waived.

18. physical therapy performed by a qualified licensed physical therapist, occupational therapy performed by a qualified licensed occupational therapist, or speech-language therapy performed by a qualified licensed speech language pathologist, subject to a maximum benefit of $10,000 per Policy Year.

19. services for only the following tissue transplants and replacements: Cornea, prosthetic tissue and joints, vein or artery graft, heart valve, and plantable prosthetic lens in connection with cataracts.

20. room, board, and other services in a Skilled Nursing Facility provided the confinement is certified by a Physician as necessary for recovery from an Illness or Injury and in lieu of Hospital confinement. Covered charges are subject to a maximum benefit of $10,000 per Policy Year.

21. hospice care provided by a licensed Hospice Care Facility for any Insured Person who, in the opinion of the attending Physician, has no reasonable prospect of cure and is expected to live no longer than six months. Covered charges are subject to a Maximum Lifetime benefit of $10,000.

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22. inpatient and outpatient mental health services. Covered expenses include:

   a. Inpatient mental health services, limited to a maximum of 90 days per Policy Year.
   b. Psychiatric day treatment under the direction and continued medical supervision of a doctor of medicine, or a doctor of osteopathy in a Psychiatric Day Treatment Facility that provides organizational structure and individualized treatment plans separate from an inpatient program. Any benefits provided shall be determined as if necessary care and treatment in a Psychiatric Day Treatment Facility were inpatient care and treatment in a Hospital, and each full day of treatment in a Psychiatric Day Treatment Facility shall be considered equal to one-half of one day of treatment of mental or emotional illness or disorder in a Hospital for the purposes of determining benefit maximums. An attending Physician must certify that such treatment is in lieu of hospitalization.
   c. Treatment in a Crisis Stabilization Unit or a Residential Treatment Center for Children and Adolescents. Benefits are payable only if an Insured Person has a mental illness which substantially impairs thought, perception of reality, emotional process, or judgment or grossly impairs behavior as manifested by recent disturbed behavior and which would otherwise necessitate confinement in a Hospital. Each two days of treatment in a Crisis Stabilization Unit or a Residential Treatment Center for Children and Adolescents will be considered equal to one day of treatment in a Hospital.
   d. Outpatient mental health services, limited to a maximum of 40 outpatient visits per Policy Year, subject to a maximum benefit of $100 for each visit.

23. treatment of Serious Mental Illness, including inpatient and outpatient evaluation, crisis intervention and services for treatment. These services are paid as any other Illness. Services for treatment in a Psychiatric Day Treatment Facility, Crisis Stabilization Unit or in a Residential Treatment Center for Children and Adolescents are paid as described in 21(b) and (c), but will not be limited by number of days.

24. home health services under a plan of care established, approved in writing, and reviewed at least every two months by the attending Physician and certified by the attending Physician that

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