



# Texas Small Group Business Employer Application

FOR GROUP COVERAGE (2 – 50 ELIGIBLE EMPLOYEES)

\*\* You have the option to choose this Consumer Choice of Benefits Health Insurance Plan or Health Maintenance Organization health care plan that, either in whole or in part, does not provide state-mandated health benefits normally required in accident and sickness insurance policies or evidences of coverage in Texas. This standard health benefit plan may provide a more affordable health insurance policy or health plan for you although, at the same time, it may provide you with fewer health or health plan benefits than those normally included as state-mandated health benefits in Texas. If you choose this standard health benefit plan, please consult with your insurance agent to discover which state-mandated health benefits are excluded in this Policy or evidence of coverage.

Life, Accidental Death & Dismemberment, Disability and Aetna PPO Plan are underwritten by Aetna Life Insurance Company. In-Network Aetna QPOS and POS Plans are underwritten by Aetna Health Inc. Out-of-Network Aetna QPOS and POS Plans are underwritten by Corporate Health Insurance Company. Dental plans are provided or administered by Aetna Dental Inc. and Aetna Life Insurance Company.

Company Name (Legal Name)	DBA/Doing Business As (if applicable)		
Street Address (P.O. Box not acceptable)	City	State	ZIP
Bill Address (If different than above)	City	State	ZIP
Company Contact Person - Title	Phone Number ( )	Fax Number ( )	
E-Mail Address	Federal Tax ID Number	Date Business Established (Mo/Yr):	
Employer Classification <input type="checkbox"/> Corporation <input type="checkbox"/> Non-Profit <input type="checkbox"/> Partnership <input type="checkbox"/> Sole Proprietor <input type="checkbox"/> Other:			SIC Code:

### Medical Coverage Selection

<b>Aetna QPOS Plan**</b> <input type="checkbox"/> Plan _____	<b>Aetna PPO Plan**</b> <input type="checkbox"/> Plan _____
<b>Aetna OA POS Plan**</b> <input type="checkbox"/> Plan _____	<input type="checkbox"/> <b>Aetna Indemnity Plan**</b>
<b>Aetna OA MC Plan**</b> <input type="checkbox"/> Plan _____	<input type="checkbox"/> <b>Medical Out-of-State (OOS) **</b> Plan _____
Is employer, plan sponsor, or a third party funding any of the deductible? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, how much? _____	
<b>NOTE:</b> OA MC 500 plan and QPOS 30 plan are NOT offered under the Consumer Choice of Benefits Health Insurance Plan.	

### Other Coverage Selection

<b>Aetna Dental™ Plans</b> <input type="checkbox"/> Plan _____
<b>Voluntary Dental:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No
Available only to groups with 10 to 50 eligible employees. Orthodontia coverage option for dependent children (not available with Standard Plan Options 1 and 4 and Voluntary Option 1): <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Packaged Dental/Life/Disability</b> <input type="checkbox"/> Plan _____
<b>Dental Out-of-State (OOS)</b> <input type="checkbox"/> Plan _____

### Life, Accidental Death & Dismemberment, & Disability Coverage Selections

Groups with 10 to 50 eligible employees may select one, two, or three options for Life, Accidental Death & Dismemberment, and Disability. If more than one option is selected, describe each class of employees, indicate the amount selected for each class and attach a list of employee names with each class designation. (Limited to 3 classes. The highest option selected can be no more than 5 times the lowest option.)

<b>All Groups - Life</b>	<input type="checkbox"/> \$10,000 <input type="checkbox"/> \$15,000 <input type="checkbox"/> \$20,000 <input type="checkbox"/> \$50,000
<b>All Groups - Life &amp; Disability Packaged Plan</b>	<input type="checkbox"/> Low <input type="checkbox"/> Medium <input type="checkbox"/> High
<b>Additional options for Groups with 10 – 50 eligible employees</b>	<input type="checkbox"/> \$75,000 <input type="checkbox"/> \$100,000 <input type="checkbox"/> \$125,000
<b>Class Description</b>	<b>Class 1</b> _____ <b>Class 2</b> _____ <b>Class 3</b> _____
<b>Optional Dependent Term Life</b>	(Available only to groups with 10 to 50 eligible employees.) <input type="checkbox"/> Yes <input type="checkbox"/> No

Please keep a copy of this application for your records. If the application is accepted by Aetna it becomes part of the issued Group Agreement and/or Group Policy.

**Domestic Partner Option**

Please indicate whether you will provide Domestic Partner coverage to your employees:  
 Yes, include Domestic Partner coverage for my employees       No, decline Domestic Partner coverage for my employees

**Effective Date**      Actual effective date will be assigned by Aetna.

Requested effective date (may be the 1st or 15th of the month only): \_\_\_\_\_

**Group Ownership Information – OPTIONAL**

(This information is designed for the purposes of data collection and will not be used for underwriting.)

Check one or both if applicable:  
 Woman Owned Business       Minority Owned Business (indicate status below):  
     African American or Black     Hispanic or Latino     Asian     Other \_\_\_\_\_

**Employer Contribution(s)**

Coverage	Medical	Dental	Employee Life	Dependent Life	Disability
Employer's Minimum Contribution for Employee	%	%	%	NA	%

**Section 125 Plan**

Does the group have a flex plan under Section 125 of the Internal Revenue Service code?     Yes     No

**Employee Eligibility**

Work Location (list by state)	Number of Employees			
	Full-time (based on number of minimum hours allowed by state law)	Part-time	COBRA or State Continues	Other (i.e., temporary, substitute, seasonal)

Total number of employees: \_\_\_\_\_  
 Is your group subject to COBRA? (20 or more total employees during at least 50% of the working days in the previous calendar year)  
 Yes     No  
 Total number of independent contractors compensated via a 1099-Misc tax form applying for coverage: \_\_\_\_\_  
 (Requires Underwriting approval and additional documentation.)  
 Total number of employees eligible for coverage (must usually work at least 30 hours per week): \_\_\_\_\_  
 Total number of employees waiving Aetna health benefits but covered through their spouse's health benefit plan: \_\_\_\_\_  
 Total number of employees waiving Aetna health benefits coverage without coverage elsewhere: \_\_\_\_\_  
 Total number of employees covered under another health benefit plan offered by the employer: \_\_\_\_\_  
 Are Union employees excluded for eligibility purposes?     Yes     No  
 If Yes, how many union employees are to be excluded? \_\_\_\_\_  
 Eligibility date will be the 1st of the policy month following the waiting period.  
 Waiting period for all employees:     0 months     1 month     2 months     90 days  
 Is the group waiving the waiting period at initial enrollment?     Yes     No  
 Are you currently a client company of a Professional Employer Organization (PEO)?     Yes     No

**Prior Carrier Information**

	Health	Dental	Life	Disability
Is this group transferring from another group carrier?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, provide Carrier Name				
Effective Date of Coverage				
Proposed Termination Date				
Is this total replacement?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
If prior carrier Aetna, provide Group/Control Number				
Prior Carrier Deductible				
Dental Only – Prior coverage included, check all that apply:		<input type="checkbox"/> Major Services <input type="checkbox"/> Orthodontia		

**Workers' Compensation Information**

Aetna's coverage is not occupational in nature and, consequently, it is not a substitute for Workers' Compensation coverage.  
 Name of current Workers' Compensation carrier: \_\_\_\_\_      Renewal Date: \_\_\_\_\_  
 Is Workers' Compensation coverage provided on all employees?       Yes     No  
 If not, please attach a list of all employees enrolling that are NOT covered by Workers' Compensation or similar legislation (including title).

## Medical Information

Is any person to be covered unable to work due to illness or injury?  Yes  No

Is any person unable to perform the normal duties of another person in the same employment class of the same age and sex?  Yes  No

If Yes is answered to either question, attach a sheet with the names of the individual(s), dates and degree of recovery.

## Texas Notice of Election or Rejection of Optional Medical Benefits

If medical coverage **has not been** selected or a Value Plan (Consumer Choice of Benefits Health Insurance Plan) **has been** selected, this section does not apply.

Texas law requires that the following optional benefits be offered to applicants having employees who are located in Texas. If elected, coverage will be provided to all employees covered under a Texas contract except as otherwise noted. Additional medical premium will be required for each option selected.

### 1. In Vitro Fertilization Coverage

Coverage includes expenses incurred by the subscriber or the subscriber's covered spouse for outpatient in vitro fertilization procedures subject to the provisions of the Texas Insurance Code.

Applicant accepts the optional In Vitro Fertilization benefit.

Applicant rejects the optional In Vitro Fertilization benefit.

### 2. Additional Speech and Hearing Impairment Coverage

The optional coverage would include benefits for the necessary care and treatment of loss or impairment of speech or hearing. Such coverage will not be less favorable than coverage under the plan for physical illness generally, subject to the same durational limits, dollar limits, deductibles and coinsurance factors that may apply.

Applicant accepts the optional Speech and Hearing Impairment benefit.

Applicant rejects the optional Speech and Hearing Impairment benefit.

In rejecting coverage, I understand that it will not be provided at a future date unless I request it at policy renewal.

Signature \_\_\_\_\_ Title \_\_\_\_\_ Date \_\_\_\_\_

### 3. Additional Coverage for Serious Mental Illness

Additional coverage offered for the treatment of "serious mental illness." A "serious mental illness" is defined as:

- Schizophrenia;
- Paranoid and other psychotic disorders;
- Bipolar disorders (hypomanic, manic, depressive and mixed);
- Major depressive disorders (single episode or recurrent);
- Schizo-affective disorders (bipolar or depressive);
- Obsessive-compulsive disorders; and
- Depression in childhood and adolescence.

Applicant accepts the optional Serious Mental Illness benefit.

Applicant rejects the optional Serious Mental Illness benefit.

## Texas Notice of Election or Rejection of Optional Dental Benefits

To provide flexibility to covered persons, dental coverage can be obtained through either the Dental Plan Coverage (DPC Plan), offered by Aetna Dental Inc., or the Comprehensive Dental Expense Coverage plan (Point of Service Plan), offered by Aetna Life Insurance Company. The Point of Service Plan (POS Plan) provides out-of-network coverage for covered dental expenses and includes deductible and coinsurance percentage provisions. This plan must be offered to every customer who purchases a DMO plan and has 25 or more employees. If dental coverage has not been selected or the group does not meet the criteria indicated above, this section does not apply.

If any covered services or supplies are performed or received from a Member Dental Provider or a Member Specialty Dental Provider, benefits will be considered to have been paid for such services and supplies under the DPC Plan. The covered person will be responsible for the payment of the copayment amounts specified in the Certificate of Coverage describing his/her DPC Plan.

Except for Emergency Care, if any covered services or supplies are performed or received from a Non-Member Dental Provider, benefits will be considered to have been paid for such services and supplies under the POS Plan. The covered person will be responsible for the payment of the deductible and coinsurance percentage amounts specified in the Certificate of Coverage describing his/her POS Plan.

All the terms and conditions of the plan under which the services or supplies are provided will apply.

If you live and work outside of the Service Area, you will not be eligible for the DPC Plan Coverage.

Additional dental premium will be required if the Point of Service Option is accepted.

Applicant accepts the Point of Service Option.

Applicant rejects the Point of Service Option.

Signature \_\_\_\_\_ Title \_\_\_\_\_ Date \_\_\_\_\_

## Signature Section

### APPLICABLE TO ALL COVERAGES

The Applicant agrees that at no time shall any employee be permitted or required to contribute for non-contributory coverage; or, unless the change is approved in writing by an authorized representative of Aetna, to make contributions for contributory coverage at a rate higher than the initial contribution rate applicable for the employee's then current coverage. It is agreed that no coverage shall become effective as to any person who is not then a full-time employee, regularly performing the duties of his or her occupation (except for health-related factors and subject to applicable HIPAA requirements for health coverage), unless otherwise specifically provided in the plan documents (which consist of the Group Policy and/or Group Agreement). All statements herein shall be deemed representations and not warranties.

The Applicant acknowledges that it has selected this plan based upon written information provided by Aetna and that no broker, agent or consultant is authorized to modify the terms of the offer or to agree to changes. All material terms of plan coverage are set forth in the plan documents. Applicant agrees to make payroll and other records directly related to employee's coverage under the Group Agreement or Group Policy available to Aetna for inspection, at Aetna's expense, at Applicant's office, during regular business hours, upon reasonable advance request. This provision shall survive termination of the Group Agreement or Group Policy.

*continued on back*

## Signature Section (Continued)

Applicant has selected, in accordance with applicable state law, the plan to be offered to Applicant's employees and Applicant has solely determined any/all health plan options for the Applicant's employees and the contribution amounts.

Information on agent's compensation is available from your agent or at Aetna.com.

The plan documents will determine the contractual provisions, including procedures, exclusions and limitations relating to the plan and will govern in the event they conflict with any benefits comparison, summary or other description of the plan.

Applicant agrees to deliver, or otherwise make available to enrollees, all Aetna paper or online member documents and other plan-related materials upon request by Aetna.

Any person who, with intent to defraud or knowing that he/she is facilitating a fraud, submits an application or a statement of claim containing false or deceptive statement may be committing insurance fraud, which is a crime subject to civil and criminal penalties.

All data that may have a bearing on coverage or premiums will be open for Aetna to inspect while the Group Agreement or Group Policy is in force. The availability of a plan or program may vary by geographic service area. Some benefits are subject to limitations or maximums.

### APPLICABLE TO LIFE INSURANCE COVERAGE ONLY

In accordance with current IRS regulations and the 1986 Tax Reform Act, a life insurance position schedule may be deemed discriminatory and result in imputed income tax to certain employees and possibly an excise tax to employers. Employers should consult with legal counsel prior to electing a position schedule. Aetna disclaims any responsibility if the employer elects such a position schedule and it is later deemed discriminatory.

### APPLICABLE TO HEALTH AND DENTAL COVERAGE ONLY

Participating physicians, hospitals and other health care providers are independent contractors and are neither agents nor employees of Aetna. Aetna does not provide health or dental care services and, therefore, cannot guarantee any results or outcome.

I hereby apply for the coverage(s) indicated above. I certify that all information provided in this application is accurate and complete.

I understand that this application will form a part of the Group Agreement or Group Policy issued by Aetna (a sample of which may be available on request), and by my signature below I agree to be bound by the terms and conditions of that Group Agreement or Group Policy. I understand that Aetna may choose not to accept this application at its sole discretion subject to Texas small employer laws.

**JOINDER AGREEMENT - REQUEST FOR PARTICIPATION** (For life, disability, accidental death and dismemberment, out-of-state medical and out-of-state dental employee benefits): The undersigned employer agrees to the establishment of an insurance trust fund ("Fund") for the purposes of implementing a Trust Agreement ("Agreement"), and to the designation of the Chase Manhattan Bank Delaware, Wilmington, DE, as "Trustee" for the Fund and Agreement. The undersigned, as a Participating Employer in the Industry Trust corresponding to the standard industry classification ("SIC") code selected above: 1) agrees to be bound by the terms of the Agreement and the policy issued to the Trustee (including any amendments); 2) requests coverage for its eligible employees under the policy (subject to applicable underwriting requirements) as of the effective date requested or as of the date of approval of the Employer for participation under the Agreement, whichever is later, and continue as long as the Employer remains actively in business; and 3) agrees to make the required contributions to the Fund; in the event of default, it will be liable to the insurer for such unpaid contributions for the coverage period, and such insurer will terminate coverage. The insurer may also terminate coverage as of the date the group fails to meet minimum underwriting requirements in effect on that date. In addition, the Participating Employer, in accordance with ERISA Title I Section 503, designates Aetna Life Insurance Company ("Aetna") as the Named Fiduciary under the Plan, with complete discretionary authority pursuant to all applicable state and Federal laws, to review all denied claims for benefits under the Plan, and to construe disputed/doubtful Plan terms. Aetna shall be deemed to have properly exercised such authority unless it has abused its discretion by acting arbitrarily and capriciously.

Signed at (Location): \_\_\_\_\_  
City, State \_\_\_\_\_ Applicant (Company Name) \_\_\_\_\_  
By: \_\_\_\_\_  
Authorized Applicant Signature \_\_\_\_\_ Official Title \_\_\_\_\_  
\_\_\_\_\_ Date \_\_\_\_\_  
Witness \_\_\_\_\_

## Agent/Broker Certification

I hereby certify that I am not aware of any information not disclosed in this application by the client which may have bearing on this risk. I hereby certify that I have advised the client not to terminate any existing coverage until receiving written notice from Aetna that the coverage being applied for by this application is accepted.

Agent/Broker Name: \_\_\_\_\_ Aetna Agent Number/Tax ID/SSN: \_\_\_\_\_  
Agency Name: \_\_\_\_\_ % of Credit: \_\_\_\_\_  
Phone Number: (\_\_\_\_\_) \_\_\_\_\_ Fax Number: (\_\_\_\_\_) \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_  
Signature: \_\_\_\_\_ Date: \_\_\_\_\_ E-Mail Address: \_\_\_\_\_

Agent/Broker Name: \_\_\_\_\_ Aetna Agent Number/Tax ID/SSN: \_\_\_\_\_  
Agency Name: \_\_\_\_\_ % of Credit: \_\_\_\_\_  
Phone Number: (\_\_\_\_\_) \_\_\_\_\_ Fax Number: (\_\_\_\_\_) \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_  
Signature: \_\_\_\_\_ Date: \_\_\_\_\_ E-Mail Address: \_\_\_\_\_

General Agent Name: \_\_\_\_\_ Aetna Agent Number/ID Number: \_\_\_\_\_  
Phone Number: (\_\_\_\_\_) \_\_\_\_\_ Fax Number: (\_\_\_\_\_) \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_  
Signature: \_\_\_\_\_ Date: \_\_\_\_\_ E-Mail Address: \_\_\_\_\_

**For Aetna Use Only** Group Number \_\_\_\_\_ Control Number \_\_\_\_\_ SCD \_\_\_\_\_ Effective Date \_\_\_\_\_

**Form CCP Figure 1**

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

As required by 28 TAC §21.3530, I have been informed that the Consumer Choice Standard Benefit Plan that I am purchasing does not include all state mandated health insurance benefits. I understand that purchase of this plan may limit future coverage options in the event that plan participant's health changes and needed benefits are not covered under the consumer choice health benefit plan. I understand that the following benefits are provided at a reduced level from what is mandated, or are excluded completely from the plan:

Mandated Benefit Description	Benefit Reduced	Benefit Excluded
<p><b>IN VITRO FERTILIZATION Article 3.51-6, Section 3A, Texas Insurance Code</b> Unless rejected in writing by the group policyholder, benefits for in-vitro fertilization must be provided to the same extent as benefits provided for other pregnancy-related procedures subject to certain requirements.</p>		Not offered; not covered.
<p><b>MENTAL HEALTH Article 3.70-2(F), Texas Insurance Code</b> The insurer must offer and the group policyholder shall have the right to reject benefits for mental or emotional illness.</p>	The base medical plan provides coverage for both serious and non-serious mental illness, limited to 14 days inpatient and 20 visits outpatient per member per year.	
<p><b>SERIOUS MENTAL ILLNESS Article 3.51-14, Texas Insurance Code</b> Small employer carriers must offer to small employers coverage for serious mental illness that complies with the following: (a) coverage for 45 days of inpatient treatment, and 60 visits for outpatient treatment, including group and individual outpatient treatment in each calendar year; (b) the coverage may NOT include a lifetime limit on the number of days of inpatient treatment or the number of outpatient visits covered under the policy; and (c) the coverage must include the same amount limits, and deductibles and coinsurance factors for serious mental illness as for physical illness.</p>	The base medical plan provides coverage for both serious and non-serious mental illness, limited to 14 days inpatient and 20 visits outpatient per member per year.	Additional benefits not offered or covered
<p><b>SPEECH AND HEARING - Article 3.70-2(G), Texas Insurance Code</b> Unless rejected by the group policyholder or an alternative level of benefits is negotiated, benefits must be provided for the necessary care and treatment of loss or impairment of speech or hearing that are not less favorable than for physical illness generally. (See also "Hearing Screening for Children" under section for Mandated Benefits).</p>	Outpatient Speech therapy limited to 20 visits per year.	Additional benefits not covered or offered.
<p><b>AUTISM SPECTRUM DISORDER - Section 1355.015, Texas Insurance Code</b> At a minimum, a health benefit plan must provide coverage as provided by this section to an enrollee older than two years of age and younger than six years of age who is diagnosed with autism spectrum disorder. If an enrollee who is being treated for autism spectrum disorder becomes six years of age or older and continues to need treatment, this subsection does not preclude coverage of treatment and services described in the law.</p>		Not covered
<p><b>PREFERRED PROVIDER FREEDOM OF CHOICE - limitations or restrictions on coinsurance imposed by § 3.3704(a)(6) of this title (relating to Freedom of Choice: Availability of Preferred Providers)</b></p>	The difference in coinsurance amounts in some plans may exceed 30% between preferred and non-preferred tiers.	

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

**Form CCP Figure 1**

I understand that I may obtain from the Department of Insurance a consumer brochure with more information on Consumer Choice Health Benefit Plans, either by visiting the TDI website at [www.tdi.state.tx.us/consumer/indexc.html](http://www.tdi.state.tx.us/consumer/indexc.html), or by calling 1-800-252-3439.

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

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

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

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

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

Mandated Benefit Description	Benefit Reduced	Benefit Excluded
<p><b>BASIC HEALTH SERVICES</b> - Section 843.002 and Section 11.2(b)(9), Title 28, Texas Administrative Code – Each evidence of coverage providing basic health care services shall provide the following basic health care services when they are provided by network physicians or providers: Outpatient services, including: primary care and specialist physician services; outpatient services by other providers; diagnostic services, including laboratory, imaging and radiologic services; therapeutic radiology services; prenatal services, if maternity benefits are covered; outpatient rehabilitation therapies including physical therapy, speech therapy and occupational therapy; home health services, as prescribed or directed by the responsible physician or other authority designated by the HMO; periodic health examinations for adults as required in the Insurance Code §1271.153; well-child care from birth as required in the Insurance Code §1271.154; cancer screenings as required in the Insurance Code Chapter 1356 relating to mammography; cancer screenings as required in the Insurance Code Chapter 1362 relating to screening for prostate cancer; eye and ear examinations for children through age 17, to determine the need for vision and hearing correction in accordance with established medical guidelines; and no less than 20 outpatient mental health visits per enrollee per year as may be necessary and appropriate for short-term evaluative or crisis stabilization services, which must have the same cost-sharing and benefit maximum provisions as any physical health services; and emergency services as required by the Insurance Code §1271.155.</p> <p>Inpatient hospital services, including room and board, general nursing care, meals and special diets when medically necessary, use of operating room and related facilities, use of intensive care unit and services, x-ray services, laboratory and other diagnostic tests, drugs, medications, biologicals, anesthesia and oxygen services, special duty nursing when medically necessary, radiation therapy, inhalation therapy, administration of whole blood and blood plasma, and short-term rehabilitation therapy services in the acute hospital setting. Inpatient physician care services, including services performed, prescribed, or supervised by physicians or other health professionals including diagnostic, therapeutic, medical, surgical, preventive, referral and consultative health care services. Outpatient hospital services, including treatment services; ambulatory surgery services; diagnostic services, including laboratory, radiology, and imaging services; rehabilitation therapy; and radiation therapy.</p>	<p>All plan services and supplies include benefit maximums and limitations.</p>	
<p><b>REHABILITATION SERVICES</b> Article 20A.09(a)(4), Texas Insurance Code Section 11.508(a)(4)(C), Subchapter F, Title 28, Texas Administrative Code - Any EOC that provides benefits for rehabilitation services and therapies must provide those services that in the opinion of a physician, are medically necessary and may not be denied, limited or terminated. For a physically disabled person, treatment goals may include maintenance of functioning or prevention of or slowing of further deterioration.</p>	<p>Physical Therapy and Occupational Therapy limited to 20 visits per member per calendar year combined. Speech Therapy limited to 20 visits per member per calendar year.</p>	
<p><b>IN VITRO FERTILIZATION</b> Article 3.51-6, Section 3A, Texas Insurance Code Section 11.510(1), Subchapter F, Title 28, Texas Administrative Code Unless rejected in writing by the group contract holder, any EOC providing coverage for pregnancy-related procedures must offer and make available coverage for</p>		<p>Not offered; not covered.</p>

Mandated Benefit Description	Benefit Reduced	Benefit Excluded
outpatient expenses that may arise from in-vitro fertilization procedures to the same extent as the benefits provided for other pregnancy-related procedures		
<b>MENTAL &amp; EMOTIONAL ILLNESS</b> Article 3.70-2(F), Texas Insurance Code Section 11.510(3), Subchapter F, Title 28, Texas Administrative Code An HMO must offer, and the group contract holder shall have the right to reject, benefits for treatment of mental or emotional illness or disorder in a hospital or in a psychiatric day treatment facility. The group EOC holder may select an alternative level of coverage if the HMO offers such coverage.	The base medical plan provides coverage for both serious and non-serious mental illness, limited to 14 days inpatient and 20 visits outpatient per member per year.	Additional benefits not offered or covered
<b>PSYCHIATRIC DAY TREATMENT FACILITY</b> Article 3.70-2(F), Texas Insurance Code Sections 11.509(5) & 11.510(3), Subchapter F, Title 28, Texas Administrative Code An EOC that provides benefits for treatment of mental illness in a hospital must include benefits for treatment in a psychiatric day treatment facility. Determination of EOC benefits and benefit maximums will consider each full day of treatment in a psychiatric day treatment facility equal to one-half day of treatment in a hospital or in-patient program. On rejection of mandated benefits the HMO must offer and the policyholder can select an alternative level of benefits, however, any negotiated benefits must include benefits for treatment in a psychiatric day treatment facility equal to at least one-half of that provided for treatment in hospital facilities.	Limited to 14 days per member per calendar year.	
<b>SERIOUS MENTAL ILLNESS</b> Article 3.51-14, Texas Insurance Code Section 11.509(5), Subchapter F, Title 28, Texas Administrative Code - An HMO issuing coverage to a small employer must offer, and the small employer shall have the right to reject, coverage for serious mental illness that complies with the following requirements: (a) coverage for 45 days of inpatient treatment, and 60 visits for outpatient treatment, including group and individual outpatient treatment coverage, for serious mental illness in each calendar year; (b) the coverage may NOT include a lifetime limit on the number of days of inpatient treatment or the number of outpatient visits covered under the plan; and (c) the coverage must include the same amount limits, and deductibles for serious mental illness as for physical illness.	The base medical plan provides coverage for both serious and non-serious mental illness, limited to 14 days inpatient and 20 visits outpatient per member per year.	Additional benefits not offered or covered
<b>SPEECH AND HEARING</b> - Article 3.70-2(G), Texas Insurance Code Unless rejected by the group policyholder or an alternative level of benefits is negotiated, benefits must be provided for the necessary care and treatment of loss or impairment of speech or hearing that are not less favorable than for physical illness generally.	Speech therapy limited to 20 visits per year.	Additional benefits not offered or covered
<b>AUTISM SPECTRUM DISORDER</b> - Section 1355.015, Texas Insurance Code At a minimum, a health benefit plan must provide coverage as provided by this section to an enrollee older than two years of age and younger than six years of age who is diagnosed with autism spectrum disorder. If an enrollee who is being treated for autism spectrum disorder becomes six years of age or older and continues to need treatment, this subsection does not preclude coverage of treatment and services described in the law.		Not covered
<b>COPAYMENTS</b> -- Section 11.506(2)(B), Subchapter F, Title 28, Texas Administrative Code: A reasonable copayment option may not exceed 50 percent of the total cost of services provided. A basic service HMO may not impose copayment charges on any enrollee in any calendar year, when the copayments made by the enrollee in that calendar year total two hundred percent of the total annual premium cost which is required to be paid by or on behalf of that enrollee.	For some services and supplies, this plan may include cost-sharing that exceeds the limits imposed by the law.	
<b>DEDUCTIBLES</b> - Section 11.506(2)(B), Subchapter F, Title 28, Texas Administrative Code: A deductible shall be for a specific dollar amount of the cost of the basic, limited, or single health care service. An HMO shall only charge a deductible for services performed out of the HMO's service area or for services performed by a physician or provider who is not in the HMO's delivery network.	This plan includes deductibles. Please see the COC for further information.	

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

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

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

<hr/>		<hr/>	
Signature of Applicant		Name of Applicant	
<hr/>		<hr/>	
Name of Business (if applicable)		Date	
<hr/>		<hr/>	
Address	City	State	Zip

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