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
IN VITRO FERTILIZATION Article 3.51-6, Section 3A, Texas Insurance Code 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.		Not offered; not covered.
MENTAL HEALTH Article 3.70-2(F), Texas Insurance Code The insurer must offer and the group policyholder shall have the right to reject benefits for mental or emotional 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.	
SERIOUS MENTAL ILLNESS Article 3.51-14, Texas Insurance Code 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.	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
SPEECH AND HEARING - 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. (See also "Hearing Screening for Children" under section for Mandated Benefits).	Outpatient Speech therapy limited to 20 visits per year.	Additional benefits not covered or offered.
AUTISM SPECTRUM DISORDER - 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 10 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
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)	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.

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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, 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.