**Form CCP Figure 1**

**TEXAS DEPARTMENT OF INSURANCE**
**REQUIRED DISCLOSURE NOTICE FOR ALL GROUP 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 |
|---|---|---|
| No Deductible | | X |
| Home Health Visits | X | |
| Rehabilitation Visits | X | |
| In Vitro Fertilization Visits | X | |
| | | |
| | | |
| | | |

* 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 additional information on Consumer Choice Health Benefit Plans, either by visiting the TDI website at www.tdi.texas.gov/consumer/index.html, or by calling 1-800-252-3439.

_____
Signature of Applicant

_____
Name of Applicant

_____
Name of Business (if applicable)

_____
Address

_____ _____ _____
City State Zip

_____
Date

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.