Sec. 1362.001. APPLICABILITY OF CHAPTER. This chapter applies only to a health benefit plan that:

(1) provides benefits for medical or surgical expenses incurred as a result of a health condition, accident, or sickness, including:

   (A) an individual, group, blanket, or franchise insurance policy or insurance agreement, a group hospital service contract, or an individual or group evidence of coverage that is offered by:

      (i) an insurance company;

      (ii) a group hospital service corporation operating under Chapter 842;

      (iii) a fraternal benefit society operating under Chapter 885;

      (iv) a stipulated premium company operating under Chapter 884; or

      (v) a health maintenance organization operating under Chapter 843; and

   (B) to the extent permitted by the Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1001 et seq.), a health benefit plan that is offered by:

      (i) a multiple employer welfare arrangement as defined by Section 3 of that Act; or

      (ii) another analogous benefit arrangement;

(2) is offered by:

   (A) an approved nonprofit health corporation that holds a certificate of authority under Chapter 844; or

   (B) an entity not authorized under this code or another insurance law of this state that contracts directly for health care services on a risk-sharing basis, including a capitation basis; or
(3) provides health and accident coverage through a risk pool created under Chapter 172, Local Government Code, notwithstanding Section 172.014, Local Government Code, or any other law.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1362.002. EXCEPTION. This chapter does not apply to:

(1) a health benefit plan that provides coverage:

(A) only for a specified disease or for another limited benefit;

(B) only for accidental death or dismemberment;

(C) for wages or payments in lieu of wages for a period during which an employee is absent from work because of sickness or injury;

(D) as a supplement to a liability insurance policy; or

(E) only for indemnity for hospital confinement;

(2) a small employer health benefit plan written under Chapter 1501;

(3) a Medicare supplemental policy as defined by Section 1882(g)(1), Social Security Act (42 U.S.C. Section 1395ss);

(4) a workers' compensation insurance policy;

(5) medical payment insurance coverage provided under a motor vehicle insurance policy; or

(6) a long-term care insurance policy, including a nursing home fixed indemnity policy, unless the commissioner determines that the policy provides benefit coverage so comprehensive that the policy is a health benefit plan as described by Section 1362.001.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1362.003. COVERAGE REQUIRED. (a) A health benefit plan that provides coverage for diagnostic medical procedures must provide to each male enrolled in the plan coverage for expenses for an annual medically recognized diagnostic examination for the detection of prostate cancer.

(b) Coverage required under this section includes at a
minimum:

(1) a physical examination for the detection of prostate cancer; and

(2) a prostate-specific antigen test used for the detection of prostate cancer for each male who:

(A) is at least 50 years of age and is asymptomatic; or

(B) is at least 40 years of age and has a family history of prostate cancer or another prostate cancer risk factor.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1362.004. NOTICE OF COVERAGE. (a) A health benefit plan issuer shall provide to each individual enrolled in the plan written notice of the coverage required under this chapter.

(b) The notice must be provided in accordance with rules adopted by the commissioner.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1362.005. RULES. The commissioner shall adopt rules necessary to administer this chapter.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.