INSURANCE CODE

TITLE 8. HEALTH INSURANCE AND OTHER HEALTH COVERAGES

SUBTITLE F. PHYSICIANS AND HEALTH CARE PROVIDERS

CHAPTER 1451. ACCESS TO CERTAIN PRACTITIONERS AND FACILITIES

SUBCHAPTER A. GENERAL PROVISIONS

The following section was amended by the 89th Legislature. Pending publication of the current statutes, see H.B. 2038, 89th Legislature, Regular Session, for amendments affecting the following section.

Sec. 1451.001. DEFINITIONS; HEALTH CARE PRACTITIONERS. In this chapter:

(1) "Acupuncturist" means an individual licensed to practice acupuncture by the Texas State Board of Medical Examiners.

(2) "Advanced practice nurse" means an individual licensed by the Texas Board of Nursing as a registered nurse and recognized by that board as an advanced practice nurse.

(3) "Audiologist" means an individual licensed to practice audiology by the Texas Department of Licensing and Regulation.

(4) "Chemical dependency counselor" means an individual licensed by the Texas Commission on Alcohol and Drug Abuse.

(5) "Chiropractor" means an individual licensed by the Texas Board of Chiropractic Examiners.

(6) "Dentist" means an individual licensed to practice dentistry by the State Board of Dental Examiners.

(7) "Dietitian" means an individual licensed by the Texas Department of Licensing and Regulation under Chapter 701, Occupations Code.

(8) "Hearing instrument fitter and dispenser" means an individual licensed by the Texas Department of Licensing and Regulation under Chapter 402, Occupations Code.

(9) "Licensed clinical social worker" means an individual licensed as a clinical social worker under Chapter 505, Occupations Code.

(10) "Licensed professional counselor" means an individual licensed under Chapter 503, Occupations Code.

(11) "Marriage and family therapist" means an individual licensed under Chapter 502, Occupations Code.

(12) "Occupational therapist" means an individual licensed as an occupational therapist by the Texas Board of Occupational Therapy Examiners.

(13) "Optometrist" means an individual licensed to practice optometry by the Texas Optometry Board.

(13-a) "Pharmacist" means an individual licensed to practice pharmacy by the Texas State Board of Pharmacy.

(14) "Physical therapist" means an individual licensed as a physical therapist by the Texas Board of Physical Therapy Examiners.

(15) "Physician" means an individual licensed to practice medicine by the Texas State Board of Medical Examiners. The term includes a doctor of osteopathic medicine.

(16) "Physician assistant" means an individual licensed by the Texas State Board of Physician Assistant Examiners.

(17) "Podiatrist" means an individual licensed to practice podiatry by the Texas Department of Licensing and Regulation.

(18) "Psychological associate" means an individual licensed as a psychological associate by the Texas Behavioral Health Executive Council.

(19) "Psychologist" means an individual licensed as a psychologist by the Texas Behavioral Health Executive Council.

(20) "Speech-language pathologist" means an individual licensed to practice speech-language pathology by the Texas Department of Licensing and Regulation.

(21) "Surgical assistant" means an individual licensed as a surgical assistant by the Texas State Board of Medical Examiners.

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

Amended by:

Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.041(a), eff. September 1, 2005.

Acts 2007, 80th Leg., R.S., Ch. 889 (H.B. 2426), Sec. 71, eff. September 1, 2007.

Acts 2017, 85th Leg., R.S., Ch. 324 (S.B. 1488), Sec. 10.002, eff. September 1, 2017.

Acts 2019, 86th Leg., R.S., Ch. 281 (H.B. 1757), Sec. 1, eff. September 1, 2019.

Acts 2019, 86th Leg., R.S., Ch. 467 (H.B. 4170), Sec. 19.015, eff. September 1, 2019.

Acts 2019, 86th Leg., R.S., Ch. 768 (H.B. 1501), Sec. 3.006, eff. September 1, 2019.

SUBCHAPTER B. DESIGNATION OF PRACTITIONERS UNDER ACCIDENT AND HEALTH INSURANCE POLICY

Sec. 1451.051. APPLICABILITY OF SUBCHAPTER. (a) This subchapter applies to an accident and health insurance policy, including an individual, blanket, or group policy.

(b) This subchapter applies to an accident and health insurance policy issued by a stipulated premium company subject to Chapter 884.

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

Sec. 1451.052. APPLICABILITY OF GENERAL PROVISIONS OF OTHER LAW. The provisions of Chapter 1201, including provisions relating to the applicability, purpose, and enforcement of that chapter, the construction of policies under that chapter, rulemaking under that chapter, and definitions of terms applicable in that chapter, apply to this subchapter.

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

Sec. 1451.053. PRACTITIONER DESIGNATION. (a) An accident and health insurance policy may not make a benefit contingent on treatment or examination by one or more particular health care practitioners listed in Section 1451.001 unless the policy contains a provision that designates the practitioners whom the insurer will and will not recognize.

(b) The insurer may include the provision anywhere in the

policy or in an endorsement attached to the policy.

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

Sec. 1451.054. TERMS USED TO DESIGNATE HEALTH CARE PRACTITIONERS. A provision of an accident and health insurance policy that designates the health care practitioners whom the insurer will and will not recognize must use the terms defined by Section 1451.001 with the meanings assigned by that section.

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

SUBCHAPTER C. SELECTION OF PRACTITIONERS

Sec. 1451.101. DEFINITIONS. In this subchapter:

(1) "Health insurance policy" means a policy, contract, or agreement described by Section 1451.102.

(2) "Insured" means an individual who is issued, is a party to, or is a beneficiary under a health insurance policy.

(3) "Insurer" means an insurer, association, or organization described by Section 1451.102.

(4) "Nurse first assistant" has the meaning assigned by Section 301.1525, Occupations Code.

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

Sec. 1451.102. APPLICABILITY OF SUBCHAPTER. Except as provided by this subchapter, this subchapter applies only to an individual, group, blanket, or franchise insurance policy, insurance agreement, or group hospital service contract that provides health benefits, accident benefits, or health and accident benefits for medical or surgical expenses incurred as a result of an accident or sickness and that is delivered, issued for delivery, or renewed in this state by any incorporated or unincorporated insurance company, association, or organization, including:

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

(2) a general casualty company operating under Chapter 861;

(3) a life, health, and accident insurance company

operating under Chapter 841 or 982;

(4) a Lloyd's plan operating under Chapter 941;

(5) a local mutual aid association operating under Chapter 886;

(6) a mutual insurance company writing insurance other than life insurance operating under Chapter 883;

(7) a mutual life insurance company operating under Chapter 882;

(8) a reciprocal exchange operating under Chapter 942;

(9) a statewide mutual assessment company, mutual assessment company, or mutual assessment life, health, and accident association operating under Chapter 881 or 887; and

(10) a stipulated premium company operating under Chapter 884.

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

Sec. 1451.103. CONFLICTING PROVISIONS VOID. (a) A provision of a health insurance policy that conflicts with this subchapter is void to the extent of the conflict.

(b) The presence in a health insurance policy of a provision void under Subsection (a) does not affect the validity of other policy provisions.

(c) An insurer shall bring each approved policy form that contains a provision that conflicts with this subchapter into compliance with this subchapter by use of:

(1) a rider or endorsement approved by the commissioner; or

(2) a new or revised policy form approved by the commissioner.

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

Sec. 1451.104. NONDISCRIMINATORY PAYMENT OR REIMBURSEMENT; EXCEPTION. (a) An insurer may not classify, differentiate, or discriminate between scheduled services or procedures provided by a health care practitioner selected under this subchapter and performed in the scope of that practitioner's license and the same services or procedures provided by another type of health care

practitioner whose services or procedures are covered by a health insurance policy, in regard to:

(1) the payment schedule or payment provisions of the policy; or

(2) the amount or manner of payment or reimbursement under the policy.

(b) An insurer may not deny payment or reimbursement for services or procedures in accordance with the policy payment schedule or payment provisions solely because the services or procedures were performed by a health care practitioner selected under this subchapter.

(c) Notwithstanding Subsection (a), a health insurance policy may provide for a different amount of payment or reimbursement for scheduled services or procedures performed by an advanced practice nurse, nurse first assistant, licensed surgical assistant, or physician assistant if the methodology used to compute the amount is the same as the methodology used to compute the amount of payment or reimbursement when the services or procedures are provided by a physician.

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

Sec. 1451.105. SELECTION OF ACUPUNCTURIST. An insured may select an acupuncturist to provide the services or procedures scheduled in the health insurance policy that are within the scope of the acupuncturist's license.

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

Sec. 1451.106. SELECTION OF ADVANCED PRACTICE NURSE. An insured may select an advanced practice nurse to provide the services scheduled in the health insurance policy that are within the scope of the nurse's license.

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

Sec. 1451.107. SELECTION OF AUDIOLOGIST. An insured may select an audiologist to measure hearing to determine the presence or extent of the insured's hearing loss or provide aural rehabilitation services to the insured if the insured has a hearing

loss and the services or procedures are scheduled in the health insurance policy.

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

Sec. 1451.108. SELECTION OF CHEMICAL DEPENDENCY COUNSELOR. An insured may select a chemical dependency counselor to provide services or procedures scheduled in the health insurance policy that are within the scope of the counselor's license.

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

Sec. 1451.109. SELECTION OF CHIROPRACTOR. (a) An insured may select a chiropractor to provide the medical or surgical services or procedures scheduled in the health insurance policy that are within the scope of the chiropractor's license.

(b) If physical modalities and procedures are covered services under a health insurance policy and within the scope of the license of a chiropractor and one or more other type of practitioner, a health insurance policy issuer may not:

(1) deny payment or reimbursement for physical modalities and procedures provided by a chiropractor if:

(A) the chiropractor provides the modalities and procedures in strict compliance with state law; and

(B) the health insurance policy issuer allows payment or reimbursement for the same physical modalities and procedures performed by another type of practitioner that an insured may select under this subchapter;

(2) make payment or reimbursement for particular covered physical modalities and procedures within the scope of a chiropractor's license contingent on treatment or examination by a practitioner that is not a chiropractor; or

(3) establish other limitations on the provision of covered physical modalities and procedures that would prohibit an insured from seeking the covered physical modalities and procedures from a chiropractor to the same extent that the insured may obtain covered physical modalities and procedures from another type of practitioner.

(c) Nothing in this section requires a health insurance

policy issuer to cover particular services or affects the ability of a health insurance policy issuer to determine whether specific procedures for which payment or reimbursement is requested are medically necessary.

(d) This section does not apply to:

(1) workers' compensation insurance coverage as defined by Section 401.011, Labor Code;

(2) a self-insured employee welfare benefit plan subject to the Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1001 et seq.);

(3) the child health plan program under Chapter 62, Health and Safety Code, or the health benefits plan for children under Chapter 63, Health and Safety Code; or

(4) a Medicaid managed care program operated under Chapter 540 or 540A, Government Code, as applicable, or a Medicaid program operated under Chapter 32, Human Resources Code.

(e) A health insurance policy issuer that violates this section is subject to an administrative penalty as provided by Chapter 84 of not more than $1,000 for each claim that remains unpaid in violation of this section. Each day the violation continues constitutes a separate violation.

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

Amended by:

Acts 2011, 82nd Leg., 1st C.S., Ch. 7 (S.B. 7), Sec. 11.01, eff. September 28, 2011.

Acts 2019, 86th Leg., R.S., Ch. 116 (S.B. 1739), Sec. 3, eff. September 1, 2019.

Acts 2023, 88th Leg., R.S., Ch. 769 (H.B. 4611), Sec. 2.130, eff. April 1, 2025.

Sec. 1451.110. SELECTION OF DENTIST. An insured may select a dentist to provide the medical or surgical services or procedures scheduled in the health insurance policy that are within the scope of the dentist's license.

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

Sec. 1451.111. SELECTION OF DIETITIAN. An insured may

select a licensed dietitian or a provisionally licensed dietitian acting under the supervision of a licensed dietitian to provide the services scheduled in the health insurance policy that are within the scope of the dietitian's license.

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

Sec. 1451.112. SELECTION OF HEARING INSTRUMENT FITTER AND DISPENSER. An insured may select a hearing instrument fitter and dispenser to provide the services or procedures scheduled in the health insurance policy that are within the scope of the license of the fitter and dispenser.

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

Sec. 1451.113. SELECTION OF LICENSED CLINICAL SOCIAL WORKER. An insured may select a licensed clinical social worker to provide the services or procedures scheduled in the health insurance policy that:

(1) are within the scope of the social worker's license, including the provision of direct, diagnostic, preventive, or clinical services to individuals, families, and groups whose functioning is threatened or affected by social or psychological stress or health impairment; and

(2) are specified as services under the terms of the health insurance policy.

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

Amended by:

Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.042(a), eff. September 1, 2005.

Sec. 1451.114. SELECTION OF LICENSED PROFESSIONAL COUNSELOR. An insured may select a licensed professional counselor to provide the services scheduled in the health insurance policy that are within the scope of the counselor's license.

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

Amended by:

Acts 2009, 81st Leg., R.S., Ch. 221 (S.B. 1291), Sec. 1, eff. September 1, 2009.

Sec. 1451.115. SELECTION OF SURGICAL ASSISTANT. An insured may select a surgical assistant to provide the services or procedures scheduled in the health insurance policy that are within the scope of the assistant's license.

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

Sec. 1451.116. SELECTION OF MARRIAGE AND FAMILY THERAPIST. An insured may select a marriage and family therapist to provide the services scheduled in the health insurance policy that are within the scope of the therapist's license.

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

Amended by:

Acts 2009, 81st Leg., R.S., Ch. 221 (S.B. 1291), Sec. 2, eff. September 1, 2009.

Sec. 1451.117. SELECTION OF NURSE FIRST ASSISTANT. An insured may select a nurse first assistant to provide the services scheduled in the health insurance policy that:

(1) are within the scope of the nurse's license; and

(2) are requested by the physician whom the nurse is assisting.

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

Sec. 1451.118. SELECTION OF OCCUPATIONAL THERAPIST. An insured may select an occupational therapist to provide the services scheduled in the health insurance policy that are within the scope of the therapist's license.

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

Sec. 1451.119. SELECTION OF OPTOMETRIST. An insured may select an optometrist to provide the services or procedures scheduled in the health insurance policy that are within the scope of the optometrist's license.

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

Sec. 1451.120. SELECTION OF PHYSICAL THERAPIST. An insured

may select a physical therapist to provide the services scheduled in the health insurance policy that are within the scope of the therapist's license.

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

Sec. 1451.121. SELECTION OF PHYSICIAN ASSISTANT. An insured may select a physician assistant to provide the services scheduled in the health insurance policy that are within the scope of the assistant's license.

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

Sec. 1451.122. SELECTION OF PODIATRIST. An insured may select a podiatrist to provide the medical or surgical services or procedures scheduled in the health insurance policy that are within the scope of the podiatrist's license.

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

Sec. 1451.123. SELECTION OF PSYCHOLOGICAL ASSOCIATE. An insured may select a psychological associate to provide the services scheduled in the health insurance policy that are within the scope of the associate's license.

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

Sec. 1451.124. SELECTION OF PSYCHOLOGIST. An insured may select a psychologist to provide the services or procedures scheduled in the health insurance policy that are within the scope of the psychologist's license.

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

Sec. 1451.125. SELECTION OF SPEECH-LANGUAGE PATHOLOGIST. An insured may select a speech-language pathologist to evaluate speech or language, provide habilitative or rehabilitative services to restore speech or language loss, or correct a speech or language impairment if the services or procedures are scheduled in the health insurance policy.

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

Sec. 1451.126. REIMBURSEMENT FOR PHYSICAL MODALITIES AND PROCEDURES BY HEALTH INSURER, ADMINISTRATOR, HEALTH MAINTENANCE ORGANIZATION, OR PREFERRED PROVIDER BENEFIT PLAN ISSUER. (a) A health insurer or licensed third-party administrator may not deny reimbursement to a health care practitioner for the provision of covered services of physical modalities and procedures that are within the scope of the practitioner's practice if the services are performed in strict compliance with:

(1) laws and rules related to that practitioner's license; and

(2) the terms of the insurance policy or other coverage agreement.

(b) A health maintenance organization or preferred provider benefit plan issuer may not deny reimbursement to a participating health care practitioner for services provided under a coverage agreement solely because of the type of practitioner providing the services if the services are performed in strict compliance with:

(1) laws and rules related to that practitioner's license; and

(2) the terms of the insurance policy or other coverage agreement.

(c) This section may not be construed to circumvent any contractual provider network agreement between a health insurer or third-party administrator and a licensed health care practitioner. Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1451.1261. REIMBURSEMENT FOR CERTAIN SERVICES AND PROCEDURES PERFORMED BY PHARMACISTS. (a) Notwithstanding any other law, in addition to applying to a policy, agreement, or contract described by Section 1451.102, this section applies to any other individual or group health benefit plan that provides benefits described by Section 1451.102, including:

(1) a health benefit plan issued by:

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

(B) a health maintenance organization operating under Chapter 843; or

(C) a multiple employer welfare arrangement that holds a certificate of authority under Chapter 846;

(2) a small employer health benefit plan subject to Chapter 1501;

(3) a standard health benefit plan issued under Chapter 1507;

(4) health benefits provided by or through a church benefits board under Subchapter I, Chapter 22, Business Organizations Code;

(5) a regional or local health care program operated under Section 75.104, Health and Safety Code; and

(6) a self-funded health benefit plan sponsored by a professional employer organization under Chapter 91, Labor Code.

(b) This section does not apply to:

(1) a basic coverage plan under Chapter 1551;

(2) a basic plan under Chapter 1575;

(3) a primary care coverage plan under Chapter 1579;

(4) a plan providing basic coverage under Chapter 1601;

(5) the state Medicaid program, including the Medicaid managed care program operated under Chapters 540 and 540A, Government Code; or

(6) the child health plan program under Chapter 62, Health and Safety Code.

(c) Notwithstanding Section 1451.102, this section applies to coverage under a group health benefit plan provided to a resident of this state regardless of whether the group policy, agreement, or contract is delivered, issued for delivery, or renewed in this state.

(d) An insurer or other health benefit plan issuer or a third-party administrator or pharmacy benefit manager of a health benefit plan may not deny reimbursement to a pharmacist for the provision of a service or procedure within the scope of the pharmacist's license to practice pharmacy under Subtitle J, Title 3, Occupations Code, that:

(1) would be covered by the insurance policy or other coverage agreement if the service or procedure were provided by:

(A) a physician;

(B) an advanced practice nurse; or

(C) a physician assistant; and

(2) is performed by the pharmacist in strict compliance with laws and rules related to:

(A) the provision of the service or procedure; and

(B) the pharmacist's license.

(e) This section may not be construed to require an insurer or other health benefit plan issuer or a third-party administrator or pharmacy benefit manager to reimburse a pharmacist or pharmacy as an in-network or preferred provider.

Added by Acts 2019, 86th Leg., R.S., Ch. 324 (H.B. 3441), Sec. 1, eff. September 1, 2019.

Amended by:

Acts 2023, 88th Leg., R.S., Ch. 769 (H.B. 4611), Sec. 2.131, eff. April 1, 2025.

Sec. 1451.127. DUTY OF PERSON ARRANGING PROVIDER CONTRACTS FOR HEALTH INSURER OR HEALTH MAINTENANCE ORGANIZATION. (a) A person who arranges contracts with providers on behalf of a health maintenance organization or health insurer shall comply with laws related to the duties of the organization or insurer to notify and consider providers for those contracts.

(b) A violation of this section:

(1) is an unlawful practice under Section 15.05, Business & Commerce Code; and

(2) constitutes restraint of trade.

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

Sec. 1451.128. SELECTION OF PHARMACIST. An insured may select a pharmacist to provide the services scheduled in the health insurance policy that are within the scope of the pharmacist's license to practice pharmacy under Subtitle J, Title 3, Occupations Code.

Added by Acts 2019, 86th Leg., R.S., Ch. 281 (H.B. 1757), Sec. 2, eff. September 1, 2019.

SUBCHAPTER D. ACCESS TO OPTOMETRISTS USED UNDER MANAGED CARE PLAN

Sec. 1451.151. DEFINITION. In this subchapter, "managed care plan" means a plan under which a health maintenance organization, preferred provider benefit plan issuer, vision benefit plan issuer, vision benefit plan administrator, or other organization provides or arranges for health care benefits or vision benefits to plan participants and requires or encourages plan participants to use health care practitioners the plan designates.

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

Amended by:

Acts 2023, 88th Leg., R.S., Ch. 898 (H.B. 1696), Sec. 2, eff. September 1, 2023.

Sec. 1451.152. APPLICABILITY AND CONSTRUCTION OF SUBCHAPTER. (a) This subchapter applies only to a managed care plan that provides or arranges for benefits for vision or medical eye care services or procedures that are within the scope of an optometrist's or therapeutic optometrist's license.

(b) This subchapter does not require a managed care plan to provide vision or medical eye care services or procedures.

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

Sec. 1451.153. USE OF OPTOMETRIST OR THERAPEUTIC OPTOMETRIST. (a) A managed care plan may not:

(1) discriminate against a health care practitioner because the practitioner is an optometrist or a therapeutic optometrist;

(2) restrict or discourage a plan participant from obtaining covered vision or medical eye care services or procedures from a participating optometrist or therapeutic optometrist solely because the practitioner is an optometrist or therapeutic optometrist;

(3) exclude an optometrist or a therapeutic optometrist as a participating practitioner in the plan because the

optometrist or therapeutic optometrist does not have medical staff privileges at a hospital or at a particular hospital;

(4) identify a participating optometrist or therapeutic optometrist differently from another optometrist or therapeutic optometrist based on:

(A) a discount or incentive offered on a medical or vision care product or service, as defined by Section 1451.155, that is not a covered product or service, as defined by Section 1451.155, by the optometrist or therapeutic optometrist;

(B) the dollar amount, volume amount, or percent usage amount of any product or good purchased by the optometrist or therapeutic optometrist; or

(C) the brand, source, manufacturer, or supplier of a medical or vision care product or service, as defined by Section 1451.155, utilized by the optometrist or therapeutic optometrist to practice optometry;

(5) incentivize, recommend, encourage, persuade, or attempt to persuade an enrollee to obtain covered or uncovered products or services:

(A) at any particular participating optometrist or therapeutic optometrist instead of another participating optometrist or therapeutic optometrist;

(B) at a retail establishment owned by, partially owned by, contracted with, or otherwise affiliated with the managed care plan instead of a different participating optometrist or therapeutic optometrist; or

(C) at any Internet or virtual provider or retailer owned by, partially owned by, contracted with, or otherwise affiliated with the managed care plan instead of a different participating optometrist or therapeutic optometrist;

(6) exclude an optometrist or a therapeutic optometrist as a participating practitioner in the plan because the services or procedures provided by the optometrist or therapeutic optometrist may be provided by another type of health care practitioner; or

(7) as a condition for a therapeutic optometrist to be included in one or more of the plan's medical panels, require the

therapeutic optometrist to be included in, or to accept the terms of payment under or for, a particular vision panel in which the therapeutic optometrist does not otherwise wish to be included.

(b) A managed care plan shall:

(1) include optometrists and therapeutic optometrists as participating health care practitioners in the plan;

(2) include the name of a participating optometrist or therapeutic optometrist in any list of participating health care practitioners and give equal prominence to each name;

(3) provide directly to an optometrist, therapeutic optometrist, or plan enrollee immediate access by electronic means to an enrollee's complete plan coverage information, including in-network and out-of-network coverage details;

(4) publish complete plan information, including in-network and out-of-network coverage details, with any marketing materials that describe the plan benefits, including any summary plan description;

(5) allow an optometrist or a therapeutic optometrist to utilize any third-party claim-filing service, billing service, or electronic data interchange clearinghouse company that uses the standardized claim submission protocol of the National Uniform Claim Committee and that allows the optometrist or therapeutic optometrist to submit details for both services and vision care products to facilitate the authorization, submission, and reimbursement of claims; and

(6) allow an optometrist or a therapeutic optometrist to receive reimbursement through an electronic funds transfer.

(c) For the purposes of Subsection (a)(7), "medical panel" and "vision panel" have the meanings assigned by Section 1451.154(a).

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

Amended by:

Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.043, eff. September 1, 2005.

Acts 2011, 82nd Leg., R.S., Ch. 1147 (H.B. 1951), Sec. 12.001, eff. September 1, 2011.

Acts 2023, 88th Leg., R.S., Ch. 898 (H.B. 1696), Sec. 3, eff.

September 1, 2023.

Sec. 1451.154. PARTICIPATION OF THERAPEUTIC OPTOMETRIST. (a) In this section:

(1) "Medical panel" means the health care practitioners who are listed as participating providers in a managed care plan or who a patient seeking diagnosis or treatment of a medical disease, disorder, or condition is encouraged or required to use under a managed care plan.

(2) "Vision panel" means the optometrists and therapeutic optometrists who are listed as participating providers for routine eye examinations under a managed care plan or who a patient seeking a routine eye examination is encouraged or required to use under a managed care plan.

(b) A managed care plan must allow a therapeutic optometrist who is on one or more of the plan's vision panels to be a fully participating provider on the plan's medical panels to the full extent of the therapeutic optometrist's license to practice therapeutic optometry.

(c) A therapeutic optometrist who is included in a managed care plan's medical panels under Subsection (b) must:

(1) abide by the terms and conditions of the managed care plan;

(2) satisfy the managed care plan's credentialing standards for therapeutic optometrists; and

(3) provide proof that the Texas Optometry Board considers the therapeutic optometrist's license to practice therapeutic optometry to be in good standing.

(d) Repealed by Acts 2023, 88th Leg., R.S., Ch. 898 (H.B. 1696), Sec. 10, eff. September 1, 2023.

Added by Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.044(a), eff. September 1, 2005.

Amended by:

Acts 2023, 88th Leg., R.S., Ch. 898 (H.B. 1696), Sec. 4, eff. September 1, 2023.

Acts 2023, 88th Leg., R.S., Ch. 898 (H.B. 1696), Sec. 5, eff. September 1, 2023.

Acts 2023, 88th Leg., R.S., Ch. 898 (H.B. 1696), Sec. 10, eff. September 1, 2023.

The following section was amended by the 89th Legislature. Pending publication of the current statutes, see H.B. 3211, 89th Legislature, Regular Session, for amendments affecting the following section.

Sec. 1451.155. CONTRACTS WITH OPTOMETRISTS OR THERAPEUTIC OPTOMETRISTS. (a) In this section:

(1) "Chargeback" means a dollar amount, fee, surcharge, or item of value that reduces, modifies, or offsets all or part of the patient responsibility, provider reimbursement, or fee schedule for a covered product or service.

(2) "Covered product or service" means a medical or vision care product or service for which reimbursement is available under an enrollee's managed care plan contract or for which reimbursement is available subject to a contractual limitation, including:

(A) a deductible;

(B) a copayment;

(C) coinsurance;

(D) a waiting period;

(E) an annual or lifetime maximum limit;

(F) a frequency limitation; or

(G) an alternative benefit payment.

(3) "Medical or vision care product or service" means a product or service provided within the scope of the practice of optometry or therapeutic optometry under Chapter 351, Occupations Code.

(a-1) For the purposes of this section, a product or service reimbursed to an optometrist or therapeutic optometrist at a nominal or de minimis rate is not a covered product or service.

(a-2) For the purposes of this section, a product or service reimbursed to an optometrist or therapeutic optometrist solely by the enrollee is not a covered product or service.

(b) A contract between a managed care plan and an optometrist or therapeutic optometrist may not limit the fee the

optometrist or therapeutic optometrist may charge for a product or service that is not a covered product or service.

(c) A contract between a managed care plan and an optometrist or therapeutic optometrist may not require a discount on a product or service that is not a covered product or service.

(d) A contract between a managed care plan and an optometrist or therapeutic optometrist may not contain a provision authorizing a chargeback to the patient, optometrist, or therapeutic optometrist if the chargeback is for a covered product or service that the managed care plan does not incur the cost to produce, deliver, or provide to the patient, optometrist, or therapeutic optometrist.

(e) A contract between a managed care plan and an optometrist or therapeutic optometrist may not contain a provision authorizing a reimbursement fee schedule for a covered product or service that is different from the fee schedule applicable to another optometrist or therapeutic optometrist because of the optometrist's or therapeutic optometrist's choice of:

(1) optical laboratory;

(2) source or supplier of:

(A) contact lenses;

(B) ophthalmic lenses;

(C) ophthalmic glasses frames; or

(D) covered or uncovered products or services;

(3) equipment used for patient care;

(4) retail optical affiliation;

(5) vision support organization;

(6) group purchasing organization;

(7) doctor alliance;

(8) professional trade association membership;

(9) affiliation with an arrangement defined as a franchise by 16 C.F.R. Part 436;

(10) electronic health record software, electronic medical record software, or practice management software; or

(11) third-party claim-filing service, billing service, or electronic data interchange clearinghouse company.

(f) A managed care plan may not change a contract between a

managed care plan and an optometrist or therapeutic optometrist, including terms, reimbursements, or fee schedules, unless the managed care plan provides written notice of the change to the optometrist or therapeutic optometrist at least 90 days before the date the proposed change takes effect.

(g) A contract between a managed care plan and an optometrist or therapeutic optometrist may not contain a provision requiring the optometrist or therapeutic optometrist to provide a covered product at a loss.

(h) A contract between a managed care plan and an optometrist or therapeutic optometrist may not contain a provision requiring the optometrist or therapeutic optometrist to accept a reimbursement payment in the form of a virtual credit card or any other payment method where a processing fee, administrative fee, percentage amount, or dollar amount is assessed to receive the reimbursement payment, except in the case of a nominal fee assessed by the optometrist's or therapeutic optometrist's bank to receive an electronic funds transfer.

Added by Acts 2013, 83rd Leg., R.S., Ch. 755 (S.B. 632), Sec. 1, eff. September 1, 2013.

Amended by:

Acts 2023, 88th Leg., R.S., Ch. 898 (H.B. 1696), Sec. 6, eff. September 1, 2023.

Sec. 1451.156. CERTAIN CONDUCT PROHIBITED. (a) A managed care plan, as described by Section 1451.152(a), may not directly or indirectly:

(1) control or attempt to control the professional judgment, manner of practice, or practice of an optometrist or therapeutic optometrist;

(2) employ an optometrist or therapeutic optometrist to provide a vision care product or service as defined by Section 1451.155;

(3) pay an optometrist or therapeutic optometrist for a service not provided;

(4) reimburse an optometrist or therapeutic optometrist a different amount for a covered product or service as

defined by Section 1451.155 because of the optometrist's or therapeutic optometrist's choice of:

(A) optical laboratory;

(B) source or supplier of:

(i) contact lenses;

(ii) ophthalmic lenses;

(iii) ophthalmic glasses frames; or

(iv) covered or uncovered products or services;

(C) equipment used for patient care;

(D) retail optical affiliation;

(E) vision support organization;

(F) group purchasing organization;

(G) doctor alliance;

(H) professional trade association membership;

(I) affiliation with an arrangement defined as a franchise by 16 C.F.R. Part 436;

(J) electronic health record software, electronic medical record software, or practice management software; or

(K) third-party claim-filing service, billing service, or electronic data interchange clearinghouse company;

(5) restrict, limit, or influence an optometrist's or therapeutic optometrist's choice of sources or suppliers of services or materials, including optical laboratories used by the optometrist or therapeutic optometrist to provide services or materials to a patient;

(6) restrict, limit, or influence an optometrist's or therapeutic optometrist's choice of electronic health record software, electronic medical record software, or practice management software;

(7) restrict, limit, or influence an optometrist's or therapeutic optometrist's choice of third-party claim-filing service, billing service, or electronic data interchange clearinghouse company;

(8) restrict or limit an optometrist's or therapeutic optometrist's access to a patient's complete plan coverage

information, including in-network and out-of-network coverage details;

(9) apply a chargeback, as defined by Section 1451.155, to a patient, optometrist, or therapeutic optometrist if the chargeback is for a covered product or service that the managed care plan does not incur the cost to produce, deliver, or provide to the patient, optometrist, or therapeutic optometrist;

(10) require an optometrist or therapeutic optometrist to provide a covered product at a loss;

(11) require an optometrist or therapeutic optometrist to disclose a patient's confidential or protected health information unless the disclosure is authorized by the patient or permitted without authorization under the Health Insurance Portability and Accountability Act of 1996 (42 U.S.C. Section 1320d et seq.) or under Section 602.053;

(12) require an optometrist or therapeutic optometrist to disclose or report a medical history or diagnosis as a condition to file a claim, adjudicate a claim, or receive reimbursement for a routine or wellness vision eye exam;

(13) require an optometrist or therapeutic optometrist to disclose or report a patient's glasses prescription, contact lens prescription, ophthalmic device measurements, facial photograph, or unique anatomical measurements as a condition to file a claim, adjudicate a claim, or receive reimbursement for a claim unless the information is needed for the managed care plan to manufacture or cause to be manufactured a covered product that is submitted on the claim;

(14) require an optometrist or therapeutic optometrist to disclose any patient information, other than information identified on the version of the Health Insurance Claim Form approved by the National Uniform Claim Committee as of March 1, 2023, as a condition to file a claim, adjudicate a claim, or receive reimbursement for a claim unless the information is needed for the managed care plan to manufacture or cause to be manufactured a covered product that is submitted on the claim; or

(15) require an optometrist or therapeutic optometrist to accept a reimbursement payment in the form of a

virtual credit card or any other payment method where a processing fee, administrative fee, percentage amount, or dollar amount is assessed to receive the reimbursement payment, except in the case of a nominal fee assessed by the optometrist's or therapeutic optometrist's bank to receive an electronic funds transfer.

(b) Subsection (a)(2) does not prohibit a managed care plan from employing an optometrist or therapeutic optometrist for utilization review or for operations of the managed care plan.

(c) Subsection (a)(3) does not prohibit the use of capitation as a method of payment.

(d) Repealed by Acts 2023, 88th Leg., R.S., Ch. 898 (H.B. 1696), Sec. 10, eff. September 1, 2023.

(e) An optometrist or therapeutic optometrist must disclose to a patient any business interest the optometrist or therapeutic optometrist has in an out-of-network supplier or manufacturer to which the optometrist or therapeutic optometrist refers the patient.

(f) This section shall be liberally construed to prevent managed care plans from controlling or attempting to control the professional judgment, manner of practice, or practice of an optometrist or therapeutic optometrist.

Added by Acts 2015, 84th Leg., R.S., Ch. 1271 (S.B. 684), Sec. 3, eff. September 1, 2015.

Amended by:

Acts 2023, 88th Leg., R.S., Ch. 898 (H.B. 1696), Sec. 7, eff. September 1, 2023.

Acts 2023, 88th Leg., R.S., Ch. 898 (H.B. 1696), Sec. 8, eff. September 1, 2023.

Acts 2023, 88th Leg., R.S., Ch. 898 (H.B. 1696), Sec. 10, eff. September 1, 2023.

The following section was amended by the 89th Legislature. Pending publication of the current statutes, see H.B. 3211, 89th Legislature, Regular Session, for amendments affecting the following section.

Sec. 1451.157. EXTRAPOLATION PROHIBITED. (a) In this section:

(1) "Extrapolation" means a mathematical process or technique used by a vision care plan in the audit of an optometrist or therapeutic optometrist to estimate audit results or findings for a larger batch or group of claims not reviewed by the plan.

(2) "Vision care plan" means a limited-scope policy, agreement, contract, or evidence of coverage that provides coverage for eye care expenses but does not provide comprehensive medical coverage.

(b) A vision care plan may not use extrapolation to complete an audit of a participating optometrist or therapeutic optometrist. Any additional payment due to a participating optometrist or therapeutic optometrist or any refund due to the vision care plan must be based on the actual overpayment or underpayment and may not be based on an extrapolation.

Added by Acts 2023, 88th Leg., R.S., Ch. 898 (H.B. 1696), Sec. 9, eff. September 1, 2023.

Sec. 1451.158. ENFORCEMENT OF SUBCHAPTER. (a) A violation of this subchapter by a managed care plan is subject to an administrative penalty under Chapter 84.

(b) The commissioner shall take all reasonable actions to ensure compliance with this subchapter, including issuing orders to enforce this subchapter.

Added by Acts 2023, 88th Leg., R.S., Ch. 898 (H.B. 1696), Sec. 9, eff. September 1, 2023.

SUBCHAPTER E. DENTAL CARE BENEFITS IN HEALTH INSURANCE POLICIES OR EMPLOYEE BENEFIT PLANS

Sec. 1451.201. DEFINITIONS. In this subchapter:

(1) "Dental care service" means a service provided to a person to prevent, alleviate, cure, or heal a human dental illness or injury.

(2) "Employee benefit plan" means a plan, fund, or program established or maintained by an employer or employee organization.

(3) "Health insurance policy" means any individual,

group, blanket, or franchise insurance policy, insurance agreement, or group hospital service contract.

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

Sec. 1451.202. APPLICABILITY AND CONSTRUCTION OF SUBCHAPTER. (a) This subchapter applies only to an employee benefit plan or health insurance policy delivered, issued for delivery, renewed, or contracted for in this state to the extent that:

(1) the employee benefit plan is established or maintained to provide dental care services, through insurance or otherwise, for the plan's participants or the beneficiaries of the plan's participants; or

(2) the health insurance policy provides benefits for dental care services.

(b) This subchapter does not apply to a health maintenance organization governed by Chapter 843.

(c) The exemptions and exceptions of Sections 881.002 and 881.004 and Article 21.41 do not apply to this subchapter.

(d) This subchapter does not require an employee benefit plan or health insurance policy to provide any type of benefits for dental care expenses.

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

Sec. 1451.203. CONFLICTING PROVISIONS. A provision of an employee benefit plan or health insurance policy that conflicts with this subchapter is void to the extent of the conflict.

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

Sec. 1451.204. CERTAIN CONDUCT PERMITTED. (a) Notwithstanding any other provision of this subchapter, a dentist may contract directly with a patient to provide dental care services to the patient as authorized by law.

(b) Notwithstanding any other provision of this subchapter, a person providing a health insurance policy or employee benefit plan or an employer or an employee organization may:

(1) make information available to its insureds,

beneficiaries, participants, employees, or members regarding dental care services through the distribution of factually accurate information about dental care services and the rates, fees, locations, and hours for the services if the information is distributed on the request of a dentist;

(2) establish an administrative mechanism to facilitate payments for dental care services from an insured, beneficiary, participant, employee, or member to a dentist chosen by the insured, beneficiary, participant, employee, or member; or

(3) nondiscriminatorily pay or reimburse its insured, beneficiary, participant, employee, or member for the cost of dental care services provided by a dentist chosen by the insured, beneficiary, participant, employee, or member.

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

Sec. 1451.205. DISCLOSURE OF BENEFIT TERMS. (a) An employee benefit plan or health insurance policy shall:

(1) if applicable, disclose that the benefit for dental care services offered is limited to the least costly treatment; and

(2) specify in dollars and cents the amount of the payment or reimbursement to be provided for dental care services or define and explain the standard on which payment of benefits or reimbursement for the cost of dental care services is based, such as:

(A) "usual and customary" fees;

(B) "reasonable and customary" fees;

(C) "usual, customary, and reasonable" fees; or

(D) words of similar meaning.

(b) A person or entity who provides or issues an employee benefit plan or health insurance policy or the employer or employee organization, if applicable, shall establish an Internet website to provide resources and information to dentists, insureds, participants, employees, and members.

(c) An employee benefit plan or health insurance policy provider or issuer shall make accessible on the Internet website established under Subsection (b) information about the plan or

policy sufficient for patients and dentists to determine the type of dental care services covered by the plan or policy, the percentage of the allowed charges for a covered service that will be paid or reimbursed under the plan or policy, and, for a contracting provider dentist, an estimate of the amount of the payment or reimbursement available for the provider's services under the plan or policy. Access to the Internet website must be at no charge to patients under the plan or policy and dentists providing dental care services to the patients.

(d) An employee benefit plan or health insurance policy provider or issuer is not required to comply with Subsection (b) or (c) for a plan or policy that:

(1) provides for payment of the benefit for dental care services under the plan or policy:

(A) as an indemnity benefit based on a fixed schedule, regardless of the cost of the dental care service;

(B) on a cash-payment-only basis;

(C) directly to the beneficiary of the plan or policy or to the beneficiary's assigns; and

(D) regardless of other coverage; and

(2) does not provide for a copayment, a deductible, a network, or contracting provider dentists.

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

Amended by:

Acts 2019, 86th Leg., R.S., Ch. 1290 (H.B. 2486), Sec. 1, eff. September 1, 2019.

Sec. 1451.206. PAYMENT OR REIMBURSEMENT OF DENTIST. (a) The employee benefit plan or health insurance policy shall:

(1) provide:

(A) that payment or reimbursement for a noncontracting provider dentist shall be the same as payment or reimbursement for a contracting provider dentist;

(B) that the party to or beneficiary of the plan or policy may assign the right to payment or reimbursement to the dentist who provides the dental care services; and

(C) one or more methods of payment or

reimbursement that provide the dentist 100 percent of the contracted amount of the payment or reimbursement and that do not require the dentist to incur a fee to access the payment or reimbursement; and

(2) disclose on the Internet website required under Section 1451.205 and on request of a dentist or a party to or beneficiary of the plan or policy the fees, if any, associated with the methods of payment or reimbursement available under the plan or policy.

(b) Notwithstanding Subsection (a)(1), the employee benefit plan or health insurance policy is not required to make payment or reimbursement in an amount greater than:

(1) the amount specified in the plan or policy; or

(2) the fee the providing dentist charges for the dental care services provided.

(c) If the right to payment or reimbursement is assigned as provided by Subsection (a)(2):

(1) payment or reimbursement shall be made directly to the designated dentist; and

(2) direct payment to the designated dentist discharges the payor's obligation.

(d) An employee benefit plan or health insurance policy provider or issuer may not recover an overpayment made to a dentist unless:

(1) not later than the 180th day after the date the dentist receives the payment, the provider or issuer provides written notice of the overpayment to the dentist that includes the basis and specific reasons for the request for recovery of funds; and

(2) the dentist:

(A) fails to provide a written objection to the request for recovery of funds and does not make arrangements for repayment of the requested funds on or before the 45th day after the date the dentist receives the notice; or

(B) objects to the request in accordance with the procedure described by Subsection (e) and exhausts all rights of appeal.

(e) An employee benefit plan or health insurance policy provider or issuer shall provide a dentist with the opportunity to challenge an overpayment recovery request and establish written policies and procedures for a dentist to object to an overpayment recovery request. The procedures must allow the dentist to access the claims information in dispute.

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

Amended by:

Acts 2019, 86th Leg., R.S., Ch. 1290 (H.B. 2486), Sec. 2, eff. September 1, 2019.

Acts 2023, 88th Leg., R.S., Ch. 1002 (H.B. 1527), Sec. 1, eff. September 1, 2023.

Sec. 1451.2065. CONTRACTS WITH DENTISTS. (a) In this section:

(1) "Covered service" means a dental care service for which reimbursement is available under a patient's employee benefit plan or health insurance policy, or for which reimbursement is available subject to a contractual limitation, including:

(A) a deductible;

(B) a copayment;

(C) coinsurance;

(D) a waiting period;

(E) an annual or lifetime maximum limit;

(F) a frequency limitation;

(G) an alternative benefit payment; or

(H) any other limitation.

(2) "Insurer" means a provider or issuer of an employee benefit plan or health insurance policy.

(b) A contract between an insurer and a dentist may not:

(1) limit the fee the dentist may charge for a service that is not a covered service; or

(2) include a provision that both:

(A) allows the insurer to disallow a service, resulting in denial of payment to the dentist for a service that ordinarily would have been covered; and

(B) prohibits the dentist from billing for and

collecting the amount owed from the patient for that service if there is a dental necessity, as defined by Section 32.054, Human Resources Code, for that service.

Added by Acts 2011, 82nd Leg., R.S., Ch. 1061 (S.B. 554), Sec. 2, eff. September 1, 2011.

Amended by:

Acts 2023, 88th Leg., R.S., Ch. 1002 (H.B. 1527), Sec. 2, eff. September 1, 2023.

Sec. 1451.207. PROHIBITED CONDUCT. (a) An employee benefit plan or health insurance policy may not:

(1) interfere with or prevent an individual who is a party to or beneficiary of the plan or policy from selecting a dentist of the individual's choice to provide a dental care service the plan or policy offers if the dentist selected is licensed in this state to provide the service;

(2) deny a dentist the right to participate as a contracting provider under the plan or policy if the dentist is licensed to provide the dental care services the plan or policy offers;

(3) authorize a person to regulate, interfere with, or intervene in the provision of dental care services a dentist provides a patient, including diagnosis, if the dentist practices within the scope of the dentist's license;

(4) require a dentist to make or obtain a dental x-ray or other diagnostic aid in providing dental care services; or

(5) deduct the amount of an overpayment of a claim from a payment or reimbursement for a dental care service provided by a dentist who did not receive the overpayment.

(b) Subsection (a)(4) does not prohibit a request for an existing dental x-ray or other existing diagnostic aid for a determination of benefits payable under an employee benefit plan or health insurance policy.

(c) This section does not prohibit the predetermination of benefits for dental care expenses before the attending dentist provides treatment. In this subsection, "predetermination" means an estimate by the patient's employee benefit plan or health

insurance policy provider or issuer of:

(1) the patient's eligibility under the plan or policy for benefits or covered services;

(2) the amount of the patient's deductible, copayment, or coinsurance related to benefits or covered services; and

(3) the maximum benefit limits for benefits or covered services.

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

Amended by:

Acts 2019, 86th Leg., R.S., Ch. 1290 (H.B. 2486), Sec. 3, eff. September 1, 2019.

Sec. 1451.208. PRIOR AUTHORIZATION OF DENTAL CARE SERVICES. (a) For purposes of this section, "prior authorization" means a written and verifiable determination that one or more specific dental care services are covered under the patient's employee benefit plan or health insurance policy and are payable and reimbursable in a specific stated amount, subject to applicable coinsurance and deductible amounts. The term:

(1) includes preauthorization or similar authorization; and

(2) does not include a predetermination as defined by Section 1451.207(c).

(b) For services for which a prior authorization is required, on request of a patient or treating dentist, an employee benefit plan or health insurance policy provider or issuer shall provide to the dentist a written prior authorization of benefits for a dental care service for the patient. The prior authorization must include a specific benefit payment or reimbursement amount. Except as provided by Subsection (c), the plan or policy provider or issuer may not pay or reimburse the dentist in an amount that is less than the amount stated in the prior authorization.

(c) An employee benefit plan or health insurance policy provider or issuer that preauthorizes a dental care service under Subsection (b) may deny a claim for the dental care service or reduce payment or reimbursement to the dentist for the service only if:

(1) the denial or reduction is in accordance with the patient's employee benefit plan or health insurance policy benefit limitations, including an annual maximum or frequency of treatment limitation, and the patient met the benefit limitation after the date the prior authorization was issued;

(2) the documentation for the claim fails to reasonably support the claim as preauthorized;

(3) the preauthorized dental care service was not medically necessary based on the prevailing standard of care on the date of the service, or is subject to denial under the conditions for coverage under the patient's plan or policy in effect at the time the service was preauthorized, because of a change in the patient's condition or because the patient received additional dental care services after the date the prior authorization was issued;

(4) a payor other than the employee benefit plan or health insurance policy provider or issuer is responsible for payment of the claim;

(5) the dentist received full payment for the preauthorized dental care service on which the claim is based;

(6) the claim is fraudulent;

(7) the prior authorization was based wholly or partly on a material error in information provided to the employee benefit plan or health insurance policy provider or issuer by any person not related to the provider or issuer; or

(8) the patient was otherwise ineligible for the dental care service under the patient's plan or policy, and the plan or policy provider or issuer did not know and could not reasonably have known that the patient was ineligible for the dental care service on the date the plan or policy provider or issuer preauthorized the dental care service.

Added by Acts 2019, 86th Leg., R.S., Ch. 1290 (H.B. 2486), Sec. 4, eff. September 1, 2019.

The following section was amended by the 89th Legislature. Pending publication of the current statutes, see H.B. 1620, 89th Legislature, Regular Session, for amendments affecting the

following section.

Sec. 1451.209. REQUIREMENTS FOR THIRD PARTY ACCESS TO PROVIDER NETWORKS. (a) At the time a provider network contract is entered into or when material modifications are made to the contract relevant to granting a third party access to the contract, an employee benefit plan or health insurance policy provider or issuer shall allow any dentist that is part of the provider network to elect not to participate in the third party access to the contract and to elect not to enter into a contract directly with the third party that will obtain access to the provider network. This subsection does not permit the plan or policy provider or issuer to cancel or otherwise end a contractual relationship with a dentist if the dentist elects to not participate in or agree to third party access to the provider network contract.

(b) An employee benefit plan or health insurance policy provider or issuer that enters into a provider network contract with a dentist, or a contracting entity that has leased or acquired the provider network contract, may grant a third party access to the provider network contract or to a dentist's dental care services or contractual discounts provided under the contract only if:

(1) the provider network contract conspicuously states that the provider or issuer or contracting entity may enter into an agreement with a third party that allows the third party to obtain the provider's, issuer's, or contracting entity's rights and responsibilities as if the third party were the provider, issuer, or contracting entity;

(2) if the contracting entity is an employee benefit plan or health insurance policy provider or issuer, the provider network contract conspicuously states, in addition to the language required by Subdivision (1), that the dentist may elect not to participate in third party access to the provider network contract:

(A) at the time the provider network contract is entered into; or

(B) when there are material modifications to the provider network contract relevant to granting a third party access to the provider network contract;

(3) the third party accessing the provider network

contract agrees to comply with all of the original contract's terms, including the contracted fee schedule and obligations concerning patient steerage;

(4) the provider, issuer, or other contracting entity provides in writing to the dentist the names of all third parties with access to the provider network in existence as of the date the contract is entered into;

(5) the provider, issuer, or other contracting entity identifies all current third parties with access to the provider network on its Internet website with a list updated at least once every 90 days;

(6) the provider, issuer, or other contracting entity requires a third party with access to the provider network to identify the source of any discount on all remittance advices or explanations of payment under which a discount is taken, provided that this subsection does not apply to electronic transactions mandated by the Health Insurance Portability and Accountability Act of 1996 (Pub. L. No. 104-191);

(7) the provider, issuer, or other contracting entity provides written or electronic notice to network dentists that a third party will lease, acquire, or obtain access to the provider network at least 30 days before the lease or access takes effect;

(8) the provider, issuer, or other contracting entity provides written or electronic notice to network dentists of the termination of the provider network contract at least 30 days before the termination date;

(9) a third party's right to a dentist's discounted rate ceases as of the termination date of the provider network contract; and

(10) the provider, issuer, or other contracting entity makes available a copy of the provider network contract relied on in the adjudication of a claim to a network dentist not later than the 30th day after the date the dentist requests a copy of that contract.

(c) Subsections (b)(7) and (8) do not apply to a contracting entity that only organizes and leases networks but does not engage in the business of insurance.

(d) A person may not bind or require a dentist to perform dental care services under a provider network contract that has been sold, leased, or assigned to a third party or for which a third party has otherwise obtained provider network access in violation of this section.

(e) This section does not apply:

(1) if access to a provider network contract is granted to:

(A) a third party operating in accordance with the same brand licensee program as the employee benefit plan provider, health insurance policy issuer, or other contracting entity selling or leasing the provider network contract, provided that the third party accessing the provider network contract agrees to comply with all of the original contract's terms, including the contracted fee schedule and obligations concerning patient steerage; or

(B) an entity that is an affiliate of the employee benefit plan provider, health insurance policy issuer, or other contracting entity selling or leasing the provider network contract, provided that:

(i) the provider, issuer, or entity publicly discloses the names of the affiliates on its Internet website; and

(ii) the affiliate accessing the provider network contract agrees to comply with all of the original contract's terms, including the contracted fee schedule and obligations concerning patient steerage;

(2) to the child health plan program under Chapter 62, Health and Safety Code, or the health benefits plan for children under Chapter 63, Health and Safety Code; or

(3) to a Medicaid managed care program operated under Chapter 533, Government Code, or a Medicaid program operated under Chapter 32, Human Resources Code.

Added by Acts 2023, 88th Leg., R.S., Ch. 1002 (H.B. 1527), Sec. 3, eff. September 1, 2023.

SUBCHAPTER F. ACCESS TO OBSTETRICAL OR GYNECOLOGICAL CARE

Sec. 1451.251. DEFINITION. In this subchapter, "enrollee" means an individual enrolled in a health benefit plan.

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

Sec. 1451.252. APPLICABILITY OF SUBCHAPTER. This subchapter applies only to a health benefit plan that requires an enrollee to obtain certain specialty health care services through a referral made by a primary care physician or other gatekeeper and 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 that is 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. 1451.253. EXCEPTION. This subchapter does not apply to:

(1) a plan that provides coverage:

(A) only for a specified disease;

(B) only for accidental death or dismemberment;

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

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

(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;

(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 1451.252; or

(7) any health benefit plan that does not provide:

(A) benefits related to pregnancy; or

(B) well-woman care benefits.

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

Sec. 1451.254. RULES. The commissioner shall adopt rules

necessary to implement this subchapter.

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

Sec. 1451.255. RIGHT OF FEMALE ENROLLEE TO SELECT OBSTETRICIAN OR GYNECOLOGIST. (a) Except as provided by Subsection (b), a health benefit plan shall permit a female enrollee to select, in addition to a primary care physician, an obstetrician or gynecologist to provide the enrollee with health care services that are within the scope of the professional specialty practice of a properly credentialed obstetrician or gynecologist.

(b) A health benefit plan may limit an enrollee's self-referral under Subsection (a) to only one participating obstetrician or gynecologist to provide both gynecological and obstetrical care to the enrollee. This subsection does not affect the right of an enrollee to select the physician who provides that care.

(c) This section does not preclude an enrollee from selecting a qualified physician, including a family physician or internal medicine physician, to provide the enrollee with health care services described by Subsection (a).

(d) This section does not affect the authority of a health benefit plan issuer to establish selection criteria regarding other physicians who provide services under the plan.

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

Sec. 1451.256. DIRECT ACCESS TO SERVICES OF OBSTETRICIAN OR GYNECOLOGIST. (a) In this section, "health care services" includes:

(1) one well-woman examination each year;

(2) care related to pregnancy;

(3) care for any active gynecological condition; and

(4) diagnosis, treatment, and referral for any disease or condition that is within the scope of the professional specialty practice of a properly credentialed obstetrician or gynecologist.

(b) In addition to other benefits authorized under the health benefit plan, a health benefit plan shall permit an enrollee

who selects an obstetrician or gynecologist under Section 1451.255 to have direct access to the health care services of that selected physician without:

(1) a referral from the enrollee's primary care physician; or

(2) prior authorization or precertification from the plan issuer.

(c) A health benefit plan may not impose a copayment or deductible for direct access to health care services as required by this section unless the same copayment or deductible is imposed for access to other health care services provided under the plan.

(d) This section does not affect the authority of a health benefit plan issuer to require an obstetrician or gynecologist selected by an enrollee under Section 1451.255 to forward information concerning the medical care of the enrollee to the enrollee's primary care physician.

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

Sec. 1451.257. AVAILABILITY OF PROVIDERS. To ensure access to services that are within the scope of the professional specialty practice of a properly credentialed obstetrician or gynecologist, a health benefit plan shall include in the classification of persons authorized to provide medical services under the plan a sufficient number of properly credentialed obstetricians and gynecologists.

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

Sec. 1451.258. NOTICE OF AVAILABLE PROVIDERS. (a) A health benefit plan issuer shall provide to each person covered under the plan a timely written notice of the choices of the types of physician providers available for the direct access required under this subchapter.

(b) The notice must be stated in clear and accurate language.

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

Sec. 1451.259. LIMITS ON PHYSICIAN SANCTIONS. (a) A health benefit plan may not sanction or terminate a primary care physician

because of female enrollees' access to participating obstetricians and gynecologists under this subchapter.

(b) A health benefit plan may not impose a financial or other penalty on an obstetrician or gynecologist selected under Section 1451.255, or on the enrollee who selected the physician, because the selected physician failed to provide to the enrollee's primary care physician information concerning the medical care of the enrollee if the selected physician made a reasonable good faith effort to forward the information.

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

Sec. 1451.260. ADMINISTRATIVE PENALTY. An entity that operates a health benefit plan in violation of this subchapter is subject to an administrative penalty as provided by Chapter 84.

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

SUBCHAPTER G. ACCESS TO DIETITIAN SERVICES

Sec. 1451.301. APPLICABILITY OF GENERAL PROVISIONS OF OTHER LAW. The provisions of Chapter 1201, including provisions relating to the applicability, purpose, and enforcement of that chapter, the construction of policies under that chapter, rulemaking under that chapter, and definitions of terms applicable in that chapter, apply to this subchapter.

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

Sec. 1451.302. DIETITIAN SERVICES. An individual or group accident and health insurance policy delivered or issued for delivery in this state may not:

(1) exclude or deny coverage for services performed by:

(A) a dietitian; or

(B) a provisionally licensed dietitian acting under the supervision of a dietitian; or

(2) refuse payment or reimbursement for charges for services described by Subdivision (1) if the services:

(A) are in the scope of the dietitian's license;

(B) are related to an injury or illness the policy covers if the services are scheduled in the policy; and

(C) are provided under a professional recommendation of a physician whose treatment or examination for the injury or illness would be covered by the policy and would be payable or reimbursable under the policy.

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

SUBCHAPTER H. DISABILITY CERTIFIED BY PODIATRIST

Sec. 1451.351. LOSS OF INCOME BENEFITS FOR DISABILITY TREATABLE BY PODIATRIST. (a) This section applies only to an insurance policy delivered, issued for delivery, or renewed in this state that provides benefits covering loss of income as a result of an acute temporary disability caused by sickness or injury.

(b) An insurance policy may not deny payment of benefits described by Subsection (a) solely because the disability is certified or attested to by a podiatrist if the disability is caused by a sickness or injury that may be treated within the scope of the podiatrist's license.

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

SUBCHAPTER I. USE OF OSTEOPATHIC HOSPITAL

Sec. 1451.401. CONTRACT WITH OSTEOPATHIC HOSPITAL. A health maintenance organization or preferred provider benefit plan issuer that contracts with a hospital to provide services to covered individuals may not refuse to contract with an osteopathic hospital solely because the hospital is an osteopathic hospital.

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

Sec. 1451.402. SERVICES AT OSTEOPATHIC HOSPITAL. A health maintenance organization or preferred provider benefit plan issuer that provides benefits for inpatient or outpatient services provided by an allopathic hospital shall seek to provide benefits for similar services provided by an osteopathic hospital if there is an osteopathic hospital within the service area of the health

maintenance organization or preferred provider benefit plan issuer that will provide the services at a substantially similar cost.
Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1451.403. REQUEST FOR ACTION OF COMMISSIONER. An aggrieved party may request that the commissioner conduct an investigation, review, hearing, or other proceeding to determine compliance with this subchapter.
Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1451.404. ENFORCEMENT. The commissioner shall take all reasonable actions to ensure compliance with this subchapter, including issuing orders and assessing penalties.
Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

SUBCHAPTER J. REIMBURSEMENT OF HEALTH CARE PROVIDERS

Sec. 1451.451. REIMBURSEMENT UNDER MEDICAID-BASED FEE SCHEDULE. (a) An insurance company, health maintenance organization, or preferred provider organization that contracts with a health care provider to provide services in connection with Chapter 540 or 540A, Government Code, as applicable, or Chapter 62, Health and Safety Code, may not require the health care provider to provide access to or transfer the provider's name and contracted discounted fee for use with health benefit plans issued to individuals and groups under Chapter 1271 or 1301.

(b) An insurance company, health maintenance organization, or preferred provider organization may provide access to or transfer a provider's name and discounted fee described by Subsection (a) only if:

(1) the insurance company, health maintenance organization, or preferred provider organization provides written notice to the provider that is printed in conspicuous boldface type near a separate signature line and includes a statement substantially similar to the following: "By signing on this line, you may be agreeing to apply this company's Medicaid or CHIP fee schedule to services you provide to commercial insurance or HMO

enrollees."; and

(2) the provider authorizes the access or transfer and agrees to accept the contracted discounted fee by signing the notice described in Subdivision (1).

Added by Acts 2013, 83rd Leg., R.S., Ch. 778 (S.B. 1221), Sec. 1, eff. June 14, 2013.

Amended by:

Acts 2023, 88th Leg., R.S., Ch. 769 (H.B. 4611), Sec. 2.132, eff. April 1, 2025.

SUBCHAPTER K. HEALTH CARE PROVIDER DIRECTORIES

Sec. 1451.501. DEFINITIONS. In this subchapter:

(1) "Facility" has the meaning assigned by Section 324.001, Health and Safety Code.

(1-a) "Facility-based physician or provider" means a physician or health care provider:

(A) to whom a facility has granted clinical privileges; and

(B) who provides services to patients of the facility under those clinical privileges.

(1-b) "Health care provider" means a practitioner, institutional provider, or other person or organization that furnishes health care services and that is licensed or otherwise authorized to practice in this state. The term includes a pharmacist, pharmacy, hospital, nursing home, or other medical or health-related service facility that provides care for the sick or injured or other care. The term does not include a physician.

(2) "Physician" means an individual licensed to practice medicine in this state.

Added by Acts 2015, 84th Leg., R.S., Ch. 1038 (H.B. 1624), Sec. 2, eff. September 1, 2015.

Amended by:

Acts 2019, 86th Leg., R.S., Ch. 1218 (S.B. 1742), Sec. 1.01, eff. September 1, 2019.

Acts 2023, 88th Leg., R.S., Ch. 18 (S.B. 1003), Sec. 1, eff. September 1, 2023.

Sec. 1451.502. APPLICABILITY OF SUBCHAPTER. This subchapter applies only to a health benefit plan that provides benefits for medical or surgical expenses incurred as a result of a health condition, accident, or sickness, including an individual, group, blanket, or franchise insurance policy or insurance agreement, a group hospital service contract, or a small or large employer group contract or similar coverage document that is offered by:

(1) an insurance company;

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

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

(4) a stipulated premium company operating under Chapter 884;

(5) a reciprocal exchange operating under Chapter 942;

(6) a health maintenance organization operating under Chapter 843;

(7) a multiple employer welfare arrangement that holds a certificate of authority under Chapter 846; or

(8) an approved nonprofit health corporation that holds a certificate of authority under Chapter 844.

Added by Acts 2015, 84th Leg., R.S., Ch. 1038 (H.B. 1624), Sec. 2, eff. September 1, 2015.

Sec. 1451.503. EXCEPTION. This subchapter does not apply to:

(1) a health benefit plan that provides coverage:

(A) only for a specified disease or for another single 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;

(E) for credit insurance;

(F) only for dental or vision care;

(G) only for hospital expenses; or

(H) only for indemnity for hospital confinement;

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

(3) a workers' compensation insurance policy;

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

(5) 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 1451.502;

(6) the child health plan program under Chapter 62, Health and Safety Code, or the health benefits plan for children under Chapter 63, Health and Safety Code; or

(7) a Medicaid managed care program operated under Chapter 540 or 540A, Government Code, as applicable, or a Medicaid program operated under Chapter 32, Human Resources Code.

Added by Acts 2015, 84th Leg., R.S., Ch. 1038 (H.B. 1624), Sec. 2, eff. September 1, 2015.

Amended by:

Acts 2023, 88th Leg., R.S., Ch. 769 (H.B. 4611), Sec. 2.133, eff. April 1, 2025.

Sec. 1451.504. PHYSICIAN AND HEALTH CARE PROVIDER DIRECTORIES. (a) A health benefit plan issuer that offers coverage for health care services through preferred providers, exclusive providers, or a network of physicians or health care providers shall develop and maintain a physician and health care provider directory in accordance with this subchapter.

(b) The directory must include the name, street address, specialty, if any, and telephone number of each physician and health care provider described by Subsection (a) and indicate whether the physician or provider is accepting new patients.

(c) Except as provided by Subsection (e), for each health care provider that is a facility included in the directory under this section, the directory must:

(1) list under the facility name separate headings for specialties, including radiologists, anesthesiologists, nurse anesthetists, anesthesiologist assistants, pathologists, emergency department physicians, neonatologists, nurse midwives, surgical assistants, physical therapists, occupational therapists, speech-language pathologists, and any other specialty identified by commissioner rule;

(2) list under each heading described by Subdivision (1) each facility-based physician or provider described by Subsection (a) practicing in the specialty corresponding with that heading that is a preferred provider, exclusive provider, or network physician or provider;

(3) for the facility and each facility-based physician or provider described by Subdivision (2), clearly indicate each health benefit plan issued by the issuer that may provide coverage for the services provided by that facility or facility-based physician or provider; and

(4) include the facility in a listing of all facilities included in the directory indicating:

(A) the name of the facility;

(B) the municipality in which the facility is located or county in which the facility is located if the facility is in the unincorporated area of the county;

(C) for each specialty of facility-based physician or provider practicing at the facility, the name, street address, and telephone number of any facility-based physician or provider that is a preferred provider, exclusive provider, or network physician or provider or of the physician or provider group in which the facility-based physician or provider practices;

(D) each health benefit plan issued by the issuer that may provide coverage for the services provided by the facility; and

(E) each health benefit plan issued by the issuer that may provide coverage for the services provided by each

facility-based physician or provider group.

(d) The directory must list a facility-based physician or provider individually and, if the physician or provider belongs to a physician or provider group, as part of the physician or provider group.

(e) The directory is not required to list a physician or health care provider who is employed by the facility.

Added by Acts 2015, 84th Leg., R.S., Ch. 1038 (H.B. 1624), Sec. 2, eff. September 1, 2015.

Amended by:

Acts 2019, 86th Leg., R.S., Ch. 1218 (S.B. 1742), Sec. 1.02, eff. September 1, 2019.

Acts 2023, 88th Leg., R.S., Ch. 18 (S.B. 1003), Sec. 2, eff. September 1, 2023.

Sec. 1451.505. PHYSICIAN AND HEALTH CARE PROVIDER DIRECTORY ON INTERNET WEBSITE. (a) A health benefit plan issuer shall display on a public Internet website maintained by the issuer the directory required by Section 1451.504. A direct electronic link to the directory must be displayed in a conspicuous manner in the electronic summary of benefits and coverage of each health benefit plan issued by the health benefit plan issuer on the Internet website.

(b) The health benefit plan issuer shall clearly indicate in the directory each health benefit plan issued by the issuer that may provide coverage for services provided by each physician or health care provider included in the directory.

(c) The directory must be:

(1) electronically searchable by physician or health care provider name, specialty, if any, facility, and location; and

(2) publicly accessible without necessity of providing a password, a user name, or personally identifiable information.

(d) The health benefit plan issuer shall conduct an ongoing review of the directory and correct or update the information as necessary. Except as provided by Subsection (e), corrections and updates, if any, must be made not less than once each month.

(e) The health benefit plan issuer shall conspicuously display in the directory required by Section 1451.504 an e-mail address and a toll-free telephone number to which any individual may report any inaccuracy in the directory. If the issuer receives a report from any person that specifically identified directory information may be inaccurate, the issuer shall investigate the report and correct the information, as necessary, not later than the seventh day after the date the report is received.

Added by Acts 2015, 84th Leg., R.S., Ch. 1038 (H.B. 1624), Sec. 2, eff. September 1, 2015.

Amended by:

Acts 2019, 86th Leg., R.S., Ch. 1218 (S.B. 1742), Sec. 1.03, eff. September 1, 2019.