INSURANCE CODE

TITLE 8. HEALTH INSURANCE AND OTHER HEALTH COVERAGES

SUBTITLE H. HEALTH BENEFITS AND OTHER COVERAGES FOR GOVERNMENTAL EMPLOYEES

CHAPTER 1579. TEXAS SCHOOL EMPLOYEES UNIFORM GROUP HEALTH COVERAGE

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 1579.001. SHORT TITLE. This chapter may be cited as the Texas School Employees Uniform Group Health Coverage Act.

Added by Acts 2003, 78th Leg., ch. 1276, Sec. 10A.471(a), eff. Sept. 1, 2003.

Sec. 1579.002. GENERAL DEFINITIONS. In this chapter:

(1) "Administering firm" means any entity designated by the trustee to administer any coverages, services, benefits, or requirements under this chapter and the trustee's rules adopted under this chapter.

(2) "Trustee" means the Teacher Retirement System of Texas.

(3) "Charter school" means an open-enrollment charter school established under Subchapter D, Chapter 12, Education Code.

(4) "Health coverage plan" means any group policy or contract, hospital service agreement, health maintenance organization agreement, preferred provider arrangement, or any similar group arrangement or any combination of those policies, contracts, agreements, or arrangements that provides for, pays for, or reimburses expenses for health care services.

(5) "Participating entity" means an entity participating in the uniform group coverage program established under this chapter. The term includes:

(A) a school district;

(B) another educational district whose employees are members of the Teacher Retirement System of Texas;

(C) a regional education service center; and

(D) a charter school that meets the requirements of Section 1579.154.

(6) "Program" means the uniform group coverage program established under this chapter.

(7) "Regional education service center" means a regional education service center established under Chapter 8, Education Code.

(8) "Usual and customary rate" means the relevant allowable amount as described by the applicable master benefit plan document or policy.

Added by Acts 2003, 78th Leg., ch. 1276, Sec. 10A.471(a), eff. Sept. 1, 2003.

Amended by:

Acts 2019, 86th Leg., R.S., Ch. 1342 (S.B. 1264), Sec. 1.16, eff. September 1, 2019.

Sec. 1579.003. DEFINITION OF EMPLOYEE. In this chapter, "employee" means a participating member of the Teacher Retirement System of Texas who is employed by a participating entity and who is not receiving coverage from a program under Chapter 1551, 1575, or 1601. The term does not include an individual performing personal services as an independent contractor.

Added by Acts 2003, 78th Leg., ch. 1276, Sec. 10A.471(a), eff. Sept. 1, 2003.

Sec. 1579.004. DEFINITION OF DEPENDENT. In this chapter, "dependent" means:

(1) a spouse of a full-time employee or part-time employee;

(2) a child of a full-time or part-time employee if the child is younger than 26 years of age, including:

(A) an adopted child or child who is lawfully placed for adoption;

(B) a foster child, stepchild, or other child who is in a regular parent-child relationship; and

(C) a natural child;

(3) a full-time or part-time employee's natural child, adopted child, foster child, stepchild, or other child who is in a regular parent-child relationship and who lives with or has his or

her care provided by the employee or the surviving spouse on a regular basis, regardless of the child's age, if the child has a mental disability or is physically incapacitated to an extent that the child is dependent on the employee or surviving spouse for care or support, as determined by the board of trustees; and

(4) notwithstanding any other provision of this code, any other dependent of a full-time or part-time employee specified by rules adopted by the board of trustees.

Added by Acts 2003, 78th Leg., ch. 1276, Sec. 10A.471(a), eff. Sept. 1, 2003.

Amended by:

Acts 2011, 82nd Leg., R.S., Ch. 455 (S.B. 1667), Sec. 24, eff. September 1, 2011.

Acts 2013, 83rd Leg., R.S., Ch. 1078 (H.B. 3357), Sec. 20, eff. June 14, 2013.

Sec. 1579.005. CONFIDENTIALITY. (a) Section 825.507, Government Code, applies to records relating to an employee or dependent under the program and in the custody of the Teacher Retirement System of Texas or in the custody of an administrator, carrier, agent, attorney, consultant, or governmental body acting in cooperation with or on behalf of the system.

(b) The Teacher Retirement System of Texas may disclose to a health care provider, benefit provider, or claims administrator information in the records of an individual that the system determines is necessary to administer the program.

Added by Acts 2005, 79th Leg., Ch. 1359 (S.B. 1691), Sec. 48, eff. September 1, 2005.

Sec. 1579.006. EXEMPTION FROM PROCESS. (a) The following are exempt from execution, attachment, garnishment, or any other process:

(1) benefit payments, including optional benefit payments;

(2) contributions of active employees, the state, and a participating entity, and any other contributions;

(3) any rights, benefits, or payments accruing to any

person under this chapter; and

(4) any money in the Texas school employees uniform group coverage trust fund.

(b) The items listed in Subsection (a) may not be assigned except for direct payment to benefit providers as authorized by the trustee by contract, rule, or otherwise.

Added by Acts 2005, 79th Leg., Ch. 1359 (S.B. 1691), Sec. 48, eff. September 1, 2005.

Sec. 1579.007. EXEMPTION FROM STATE TAXES AND FEES. A premium or contribution on a policy, insurance contract, or agreement authorized by this chapter is not subject to any state tax, regulatory fee, or surcharge, including a premium or maintenance tax or fee.

Added by Acts 2005, 79th Leg., Ch. 1359 (S.B. 1691), Sec. 48, eff. September 1, 2005.

Sec. 1579.008. COVERAGE EXEMPT FROM INSURANCE LAW. A coverage plan provided under this chapter is exempt from any other insurance law, including common law, that does not expressly apply to the plan or this chapter.

Added by Acts 2005, 79th Leg., Ch. 1359 (S.B. 1691), Sec. 48, eff. September 1, 2005.

Text of section effective until September 01, 2025

Sec. 1579.009. BALANCE BILLING PROHIBITION NOTICE. (a) The administrator of a managed care plan provided under this chapter shall provide written notice in accordance with this section in an explanation of benefits provided to the enrollee and the physician or health care provider in connection with a health care or medical service or supply or transport provided by an out-of-network provider. The notice must include:

(1) a statement of the billing prohibition under Section 1579.109, 1579.110, 1579.111, or 1579.112, as applicable;

(2) the total amount the physician or provider may bill the enrollee under the enrollee's managed care plan and an itemization of copayments, coinsurance, deductibles, and other

amounts included in that total; and

(3) for an explanation of benefits provided to the physician or provider, information required by commissioner rule advising the physician or provider of the availability of mediation or arbitration, as applicable, under Chapter 1467.

(b) The administrator shall provide the explanation of benefits with the notice required by this section to a physician or health care provider not later than the date the administrator makes a payment under Section 1579.109, 1579.110, 1579.111, or 1579.112, as applicable.

Added by Acts 2019, 86th Leg., R.S., Ch. 1342 (S.B. 1264), Sec. 1.17, eff. September 1, 2019.

Amended by:

Acts 2023, 88th Leg., R.S., Ch. 981 (S.B. 2476), Sec. 13(a), eff. September 1, 2023.

Acts 2023, 88th Leg., R.S., Ch. 981 (S.B. 2476), Sec. 13(b), eff. September 1, 2025.

Text of section effective on September 01, 2025

Sec. 1579.009. BALANCE BILLING PROHIBITION NOTICE. (a) The administrator of a managed care plan provided under this chapter shall provide written notice in accordance with this section in an explanation of benefits provided to the enrollee and the physician or health care provider in connection with a health care or medical service or supply provided by an out-of-network provider. The notice must include:

(1) a statement of the billing prohibition under Section 1579.109, 1579.110, or 1579.111, as applicable;

(2) the total amount the physician or provider may bill the enrollee under the enrollee's managed care plan and an itemization of copayments, coinsurance, deductibles, and other amounts included in that total; and

(3) for an explanation of benefits provided to the physician or provider, information required by commissioner rule advising the physician or provider of the availability of mediation or arbitration, as applicable, under Chapter 1467.

(b) The administrator shall provide the explanation of

benefits with the notice required by this section to a physician or health care provider not later than the date the administrator makes a payment under Section 1579.109, 1579.110, or 1579.111, as applicable.

Added by Acts 2019, 86th Leg., R.S., Ch. 1342 (S.B. 1264), Sec. 1.17, eff. September 1, 2019.

Amended by:

Acts 2023, 88th Leg., R.S., Ch. 981 (S.B. 2476), Sec. 13(a), eff. September 1, 2023.

Acts 2023, 88th Leg., R.S., Ch. 981 (S.B. 2476), Sec. 13(b), eff. September 1, 2025.

Sec. 1579.010. INFORMATION REGARDING APPEALS. The trustee shall develop and distribute informational materials to individuals enrolled in a health coverage plan provided under this chapter regarding:

(1) an enrollee's right to appeal denial of an adverse determination, as defined by Section 4201.002, to an independent review organization;

(2) the procedures for appealing to an independent review organization; and

(3) the assistance available from the trustee in navigating the procedures for appeal.

Added by Acts 2021, 87th Leg., R.S., Ch. 141 (H.B. 1585), Sec. 18, eff. May 26, 2021.

SUBCHAPTER B. ADMINISTRATION

Sec. 1579.051. ADMINISTRATION OF GROUP PROGRAM. The Teacher Retirement System of Texas, as trustee, shall implement and administer the uniform group coverage program described by this chapter.

Added by Acts 2003, 78th Leg., ch. 1276, Sec. 10A.471(a), eff. Sept. 1, 2003.

Sec. 1579.052. AUTHORITY TO ADOPT RULES; OTHER AUTHORITY. (a) The trustee may adopt rules relating to the program as

considered necessary by the trustee.

(b) The trustee may adopt rules to administer the program, including rules relating to adjudication of claims and expelling participants from the program for cause.

(c) The trustee may contract with independent and experienced group insurance consultants and actuaries for advice and counsel in implementing and administering the program.

(d) The trustee may enter into interagency contracts with any agency of the state, including the Employees Retirement System of Texas and the department, for the purpose of assistance in implementing the program.

(e) The trustee shall take the actions it considers necessary to devise, implement, and administer the program.

Added by Acts 2003, 78th Leg., ch. 1276, Sec. 10A.471(a), eff. Sept. 1, 2003.

Amended by:

Acts 2005, 79th Leg., Ch. 1359 (S.B. 1691), Sec. 49, eff. September 1, 2005.

Sec. 1579.053. PERSONNEL. The trustee may hire and compensate employees as necessary to implement the program.

Added by Acts 2003, 78th Leg., ch. 1276, Sec. 10A.471(a), eff. Sept. 1, 2003.

Sec. 1579.054. COMPETITIVE BIDDING REQUIREMENTS; RULES. A contract to provide group health coverage under this chapter may be awarded only through competitive bidding under rules adopted by the trustee.

Added by Acts 2003, 78th Leg., ch. 1276, Sec. 10A.471(a), eff. Sept. 1, 2003.

Sec. 1579.055. CONTRACT AWARD; CONSIDERATIONS. (a) In awarding a contract to provide group benefits under this chapter, the trustee is not required to select the lowest bid and may consider also any relevant criteria, including the bidder's:

(1) ability to service contracts;

(2) past experiences; and

(3) financial stability.

(b) If the trustee awards a contract to a bidder whose bid deviates from that advertised, the trustee shall record the deviation and fully justify the reason for the deviation in the minutes of the next board meeting.

Added by Acts 2003, 78th Leg., ch. 1276, Sec. 10A.471(a), eff. Sept. 1, 2003.

Sec. 1579.057. PHARMACY BENEFIT MANAGER CONTRACTS. (a) In awarding a contract to provide pharmacy benefit manager services under this chapter, the trustee is not required to select the lowest bid but must select a contract that meets the criteria established by this section.

(b) The contract must state that:

(1) the trustee is entitled to audit the pharmacy benefit manager to verify costs and discounts associated with drug claims, pharmacy benefit manager compliance with contract requirements, and services provided by subcontractors;

(2) the audit must be conducted by an independent auditor in accordance with established auditing standards; and

(3) to conduct the audit, the trustee and the independent auditor are entitled access to information related to the services and the costs associated with the services performed under the contract, including access to the pharmacy benefit manager's facilities, records, contracts, medical records, and agreements with subcontractors.

(c) The contract must define the information that the pharmacy benefit manager is required to provide to the trustee concerning the audit of the retail, independent, and mail order pharmacies performing services under the contract and describe how the results of these audits must be reported to the trustee, including how often the results must be reported. The contract must state whether the pharmacy benefit manager is required to return recovered overpayments to the trustee.

(d) The contract must state that any audit of a mail order pharmacy owned by the pharmacy benefit manager must be conducted by an independent auditor selected by the trustee in accordance with

established auditing standards.

Added by Acts 2009, 81st Leg., R.S., Ch. 1207 (S.B. 704), Sec. 7, eff. September 1, 2009.

SUBCHAPTER C. COVERAGES

Sec. 1579.101. PLANS OF GROUP COVERAGES. (a) The trustee by rule shall establish plans of group coverages for employees participating in the program and their dependents.

(b) The plans must include at least two tiers of group coverage, with coverage at different levels in each tier, ranging from the catastrophic care coverage plan to the primary care coverage plan. Each tier must contain a health coverage plan.

(c) The trustee by rule shall define the requirements of each coverage plan and tier of coverage.

(d) Comparable coverage plans of each tier of coverage established must be offered to employees of all participating entities.

Added by Acts 2003, 78th Leg., ch. 1276, Sec. 10A.471(a), eff. Sept. 1, 2003.

Sec. 1579.102. CATASTROPHIC CARE COVERAGE PLAN. The coverage provided under the catastrophic care coverage plan shall be prescribed by the trustee by rule and must provide coverage at least as extensive as the coverage provided under the TRS-Care 1 plan operated under Chapter 1575.

Added by Acts 2003, 78th Leg., ch. 1276, Sec. 10A.471(a), eff. Sept. 1, 2003.

Amended by:

Acts 2005, 79th Leg., Ch. 1359 (S.B. 1691), Sec. 50, eff. September 1, 2005.

Sec. 1579.104. OPTIONAL COVERAGES. The trustee may not offer optional coverages, other than optional permanent life insurance, optional long-term care insurance, and optional disability insurance, to employees participating in the program. This section does not affect the right of a participating

entity to offer optional coverages to its employees under terms and conditions established by the participating entity.

Added by Acts 2003, 78th Leg., ch. 1276, Sec. 10A.471(a), eff. Sept. 1, 2003.

Reenacted by Acts 2005, 79th Leg., Ch. 1359 (S.B. 1691), Sec. 51(a), eff. September 1, 2005.

Sec. 1579.1045. ALTERNATIVE GROUP HEALTH COVERAGE PROHIBITED. Notwithstanding any other law, a participating entity may not offer or make available to the entity's employees or their dependents group health coverage not provided under the program.

Added by Acts 2021, 87th Leg., R.S., Ch. 399 (S.B. 1444), Sec. 1, eff. September 1, 2021.

Sec. 1579.105. PREEXISTING CONDITION LIMITATION. During the initial period of eligibility, coverage provided under the program may not be made subject to a preexisting condition limitation.

Added by Acts 2003, 78th Leg., ch. 1276, Sec. 10A.471(a), eff. Sept. 1, 2003.

Sec. 1579.106. PRIOR AUTHORIZATION FOR CERTAIN DRUGS. (a) In this section, "drug formulary" means a list of drugs preferred for use and eligible for coverage by a health coverage plan.

(b) A health coverage plan provided under this chapter that uses a drug formulary in providing a prescription drug benefit must require prior authorization for coverage of the following categories of prescribed drugs if the specific drug prescribed is not included in the formulary:

(1) a gastrointestinal drug;

(2) a cholesterol-lowering drug;

(3) an anti-inflammatory drug;

(4) an antihistamine drug; and

(5) an antidepressant drug.

(c) Every 12 months the trustee shall submit to the comptroller and the Legislative Budget Board a report regarding any cost savings achieved in the program through implementation of the

prior authorization requirement of this section. The report must cover the previous 12-month period.

(d) In the report under Subsection (c), the trustee:

(1) may include any cost savings achieved in the program for coverage of prescribed drugs that are not included in the categories listed in Subsection (b) for which prior authorization is required by a health coverage plan provided under this chapter; and

(2) considering cost and medical necessity, shall identify any categories of prescribed drugs in addition to the categories listed in Subsection (b) for which requiring prior authorization could achieve cost savings.

Added by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 1G.003, eff. April 1, 2009.

Amended by:

Acts 2021, 87th Leg., R.S., Ch. 141 (H.B. 1585), Sec. 19, eff. May 26, 2021.

Sec. 1579.1061. EXEMPTION FROM PREAUTHORIZATION REQUIREMENTS FOR PHYSICIANS AND HEALTH CARE PROVIDERS PROVIDING CERTAIN HEALTH CARE SERVICES. A preauthorization process used by a health coverage plan provided under this chapter is subject to the same limitations and requirements provided by Subchapter N, Chapter 4201, for a preauthorization process used by an insurer.

Added by Acts 2021, 87th Leg., R.S., Ch. 1018 (H.B. 3459), Sec. 3, eff. September 1, 2021.

Sec. 1579.107. DISEASE MANAGEMENT SERVICES. (a) In this section, "disease management services" means services to assist an individual manage a disease or other chronic health condition, such as heart disease, diabetes, respiratory illness, end-stage renal disease, HIV infection, or AIDS, and with respect to which the trustee identifies populations requiring disease management.

(b) A health coverage plan provided under this chapter must provide disease management services or coverage for disease management services in the manner required by the trustee, including:

(1) patient self-management education;

(2) provider education;

(3) evidence-based models and minimum standards of care;

(4) standardized protocols and participation criteria; and

(5) physician-directed or physician-supervised care.

Added by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 1G.003, eff. April 1, 2009.

Sec. 1579.108. LIMITATIONS. The trustee may not contract for or provide a health coverage plan that excludes from participation in the network a general hospital that:

(1) is located in the geographical service area or areas of the health coverage plan that includes a county that:

(A) has a population of at least 100,000 and not more than 233,500; and

(B) is located in the Texas-Louisiana border region, as that term is defined in Section 2056.002(e), Government Code; and

(2) agrees to provide medical and health care services under the plan subject to the same terms as other hospital providers under the plan.

Added by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 1G.003, eff. April 1, 2009.

Amended by:

Acts 2011, 82nd Leg., R.S., Ch. 1163 (H.B. 2702), Sec. 58, eff. September 1, 2011.

Acts 2023, 88th Leg., R.S., Ch. 644 (H.B. 4559), Sec. 118, eff. September 1, 2023.

Sec. 1579.109. EMERGENCY CARE PAYMENTS. (a) In this section, "emergency care" has the meaning assigned by Section 1301.155.

(b) The administrator of a managed care plan provided under this chapter shall pay for covered emergency care performed by or a covered supply related to that care provided by an out-of-network

provider at the usual and customary rate or at an agreed rate. The administrator shall make a payment required by this subsection directly to the provider not later than, as applicable:

(1) the 30th day after the date the administrator receives an electronic claim for those services that includes all information necessary for the administrator to pay the claim; or

(2) the 45th day after the date the administrator receives a nonelectronic claim for those services that includes all information necessary for the administrator to pay the claim.

(c) For emergency care subject to this section or a supply related to that care, an out-of-network provider or a person asserting a claim as an agent or assignee of the provider may not bill an enrollee in, and the enrollee does not have financial responsibility for, an amount greater than an applicable copayment, coinsurance, and deductible under the enrollee's managed care plan that:

(1) is based on:

(A) the amount initially determined payable by the administrator; or

(B) if applicable, a modified amount as determined under the administrator's internal appeal process; and

(2) is not based on any additional amount determined to be owed to the provider under Chapter 1467.

Added by Acts 2019, 86th Leg., R.S., Ch. 1342 (S.B. 1264), Sec. 1.18, eff. September 1, 2019.

Sec. 1579.110. OUT-OF-NETWORK FACILITY-BASED PROVIDER PAYMENTS. (a) In this section, "facility-based provider" means a physician or health care provider who provides health care or medical services to patients of a health care facility.

(b) Except as provided by Subsection (d), the administrator of a managed care plan provided under this chapter shall pay for a covered health care or medical service performed for or a covered supply related to that service provided to an enrollee by an out-of-network provider who is a facility-based provider at the usual and customary rate or at an agreed rate if the provider performed the service at a health care facility that is a

participating provider. The administrator shall make a payment required by this subsection directly to the provider not later than, as applicable:

(1) the 30th day after the date the administrator receives an electronic claim for those services that includes all information necessary for the administrator to pay the claim; or

(2) the 45th day after the date the administrator receives a nonelectronic claim for those services that includes all information necessary for the administrator to pay the claim.

(c) Except as provided by Subsection (d), an out-of-network provider who is a facility-based provider or a person asserting a claim as an agent or assignee of the provider may not bill an enrollee receiving a health care or medical service or supply described by Subsection (b) in, and the enrollee does not have financial responsibility for, an amount greater than an applicable copayment, coinsurance, and deductible under the enrollee's managed care plan that:

(1) is based on:

(A) the amount initially determined payable by the administrator; or

(B) if applicable, a modified amount as determined under the administrator's internal appeal process; and

(2) is not based on any additional amount determined to be owed to the provider under Chapter 1467.

(d) This section does not apply to a nonemergency health care or medical service:

(1) that an enrollee elects to receive in writing in advance of the service with respect to each out-of-network provider providing the service; and

(2) for which an out-of-network provider, before providing the service, provides a complete written disclosure to the enrollee that:

(A) explains that the provider does not have a contract with the enrollee's managed care plan;

(B) discloses projected amounts for which the enrollee may be responsible; and

(C) discloses the circumstances under which the

enrollee would be responsible for those amounts.

Added by Acts 2019, 86th Leg., R.S., Ch. 1342 (S.B. 1264), Sec. 1.18, eff. September 1, 2019.

Sec. 1579.111. OUT-OF-NETWORK DIAGNOSTIC IMAGING PROVIDER OR LABORATORY SERVICE PROVIDER PAYMENTS. (a) In this section, "diagnostic imaging provider" and "laboratory service provider" have the meanings assigned by Section 1467.001.

(b) Except as provided by Subsection (d), the administrator of a managed care plan provided under this chapter shall pay for a covered health care or medical service performed for or a covered supply related to that service provided to an enrollee by an out-of-network provider who is a diagnostic imaging provider or laboratory service provider at the usual and customary rate or at an agreed rate if the provider performed the service in connection with a health care or medical service performed by a participating provider. The administrator shall make a payment required by this subsection directly to the provider not later than, as applicable:

(1) the 30th day after the date the administrator receives an electronic claim for those services that includes all information necessary for the administrator to pay the claim; or

(2) the 45th day after the date the administrator receives a nonelectronic claim for those services that includes all information necessary for the administrator to pay the claim.

(c) Except as provided by Subsection (d), an out-of-network provider who is a diagnostic imaging provider or laboratory service provider or a person asserting a claim as an agent or assignee of the provider may not bill an enrollee receiving a health care or medical service or supply described by Subsection (b) in, and the enrollee does not have financial responsibility for, an amount greater than an applicable copayment, coinsurance, and deductible under the enrollee's managed care plan that:

(1) is based on:

(A) the amount initially determined payable by the administrator; or

(B) if applicable, a modified amount as determined under the administrator's internal appeal process; and

(2) is not based on any additional amount determined to be owed to the provider under Chapter 1467.

(d) This section does not apply to a nonemergency health care or medical service:

(1) that an enrollee elects to receive in writing in advance of the service with respect to each out-of-network provider providing the service; and

(2) for which an out-of-network provider, before providing the service, provides a complete written disclosure to the enrollee that:

(A) explains that the provider does not have a contract with the enrollee's managed care plan;

(B) discloses projected amounts for which the enrollee may be responsible; and

(C) discloses the circumstances under which the enrollee would be responsible for those amounts.

Added by Acts 2019, 86th Leg., R.S., Ch. 1342 (S.B. 1264), Sec. 1.18, eff. September 1, 2019.

For expiration of this section, see Subsection (f).

Sec. 1579.112. OUT-OF-NETWORK EMERGENCY MEDICAL SERVICES PROVIDER PAYMENTS. (a) In this section, "emergency medical services provider" has the meaning assigned by Section 773.003, Health and Safety Code, except that the term does not include an air ambulance.

(b) Except as provided by Subsection (c), the administrator of a managed care plan provided under this chapter shall pay for a covered health care or medical service performed for, or a covered supply or covered transport related to that service provided to, an enrollee by an out-of-network provider who is an emergency medical services provider at:

(1) if the political subdivision has submitted the rate to the department under Section 38.006, the rate set, controlled, or regulated by the political subdivision in which:

(A) the service originated; or

(B) the transport originated if transport is provided; or

(2) if the political subdivision has not submitted the rate to the department, the lesser of:

(A) the provider's billed charge; or

(B) 325 percent of the current Medicare rate, including any applicable extenders and modifiers.

(c) The administrator shall adjust a payment required by Subsection (b)(1) each plan year by increasing the payment by the lesser of the Medicare Inflation Index or 10 percent of the provider's previous calendar year rates.

(d) The administrator shall make a payment required by this section directly to the provider not later than, as applicable:

(1) the 30th day after the date the administrator receives an electronic claim for those services that includes all information necessary for the administrator to pay the claim; or

(2) the 45th day after the date the administrator receives a nonelectronic claim for those services that includes all information necessary for the administrator to pay the claim.

(e) An out-of-network provider who is an emergency medical services provider or a person asserting a claim as an agent or assignee of the provider may not bill an enrollee receiving a health care or medical service or supply or transport described by Subsection (b) in, and the enrollee does not have financial responsibility for, an amount greater than an applicable copayment, coinsurance, and deductible under the enrollee's managed care plan that is based on:

(1) the amount initially determined payable by the administrator; or

(2) if applicable, a modified amount as determined under the administrator's internal appeal process.

(f) This section expires September 1, 2025.

Added by Acts 2023, 88th Leg., R.S., Ch. 981 (S.B. 2476), Sec. 14, eff. September 1, 2023.

SUBCHAPTER D. PARTICIPATING ENTITIES

Sec. 1579.151. REQUIRED PARTICIPATION OF SCHOOL DISTRICTS WITH 500 OR FEWER EMPLOYEES. (a) Each school district with 500 or

fewer employees and each regional education service center is required to participate in the program.

(b) Notwithstanding Subsection (a), a school district otherwise subject to Subsection (a) that, on January 1, 2001, was individually self-funded for the provision of health coverage to its employees may elect not to participate in the program.

(c) An educational district described by Section 1579.002(5)(B) that, on January 1, 2001, had 500 or fewer employees may elect not to participate in the program.

(d) Expired.

Added by Acts 2003, 78th Leg., ch. 1276, Sec. 10A.471(a), eff. Sept. 1, 2003.

Sec. 1579.152. PARTICIPATION OF OTHER SCHOOL DISTRICTS. Effective September 1, 2005, a school district with more than 500 employees may elect to participate in the program. A school district that elects to participate under this section shall apply for participation in the manner prescribed by the trustee by rule.

Added by Acts 2003, 78th Leg., ch. 1276, Sec. 10A.471(a), eff. Sept. 1, 2003.

Sec. 1579.153. PARTICIPATION BY CERTAIN RISK POOLS. (a) In determining the number of employees of a school district for purposes of Sections 1579.151 and 1579.152, school districts that, on January 1, 2001, were members of a risk pool established under the authority of Chapter 172, Local Government Code, as provided by Section 22.004, Education Code, may elect to be treated as a single unit. A school district shall elect whether to be considered as a member of a risk pool under this section by notifying the trustee not later than September 1, 2001.

(b) A risk pool in existence on January 1, 2001, that, as of that date, provided group health coverage to 500 or fewer school district employees may elect to participate in the program.

(c) A school district with 500 or fewer employees that is a member of a risk pool described by Subsection (a) that provides group health coverage to more than 500 school district employees must elect, not later than September 1, 2001, whether to be treated

as a school district with 500 or fewer employees or as part of a unit with more than 500 employees. The school district must notify the trustee of the election, in the manner prescribed by the trustee, not later than September 1, 2001.

(d) For purposes of this section, participation in the program by school districts covered by a risk pool is limited to school districts covered by the risk pool as of January 1, 2001.

Added by Acts 2003, 78th Leg., ch. 1276, Sec. 10A.471(a), eff. Sept. 1, 2003.

Sec. 1579.154. PARTICIPATION BY CHARTER SCHOOLS; ELIGIBILITY. (a) A charter school is eligible to participate in the program if the school agrees:

(1) that all records of the school relating to participation in the program are open to inspection by the trustee, the administering firm, the commissioner of education, or a designee of any of those entities; and

(2) to have the school's accounts relating to participation in the program annually audited by a certified public accountant at the school's expense.

(b) A charter school must notify the trustee of the school's intent to participate in the program in the manner and within the time required by rules adopted by the trustee.

Added by Acts 2003, 78th Leg., ch. 1276, Sec. 10A.471(a), eff. Sept. 1, 2003.

Sec. 1579.155. PROGRAM PARTICIPATION: ELECTION. (a) Effective September 1, 2022, a participating entity may elect to discontinue the entity's participation in the program by providing written notice to the trustee not later than December 31 of the year preceding the first day of the plan year in which the election will be effective.

(b) A participating entity that elects to discontinue participation in the program under Subsection (a) may not elect to:

(1) participate in the program until the fifth anniversary of the effective date of the entity's election to discontinue participation; or

(2) discontinue the entity's participation after an election described by Subdivision (1) until the fifth anniversary of the effective date of that election.

(c) Effective September 1, 2022, an entity that elects to participate in the program shall provide written notice to the trustee not later than December 31 of the year preceding the first day of the plan year in which the election will be effective. The entity may not elect to discontinue the entity's participation until the fifth anniversary of the effective date of the entity's election to participate.

(d) The trustee by rule shall prescribe the time and manner for making an election under this section and may adopt rules necessary to administer this section.

Added by Acts 2021, 87th Leg., R.S., Ch. 399 (S.B. 1444), Sec. 2, eff. September 1, 2021.

SUBCHAPTER E. PARTICIPATION BY EMPLOYEE

Sec. 1579.201. DEFINITION. In this subchapter, "full-time employee" and "part-time employee" have the meanings assigned by rules adopted by the trustee.

Added by Acts 2003, 78th Leg., ch. 1276, Sec. 10A.471(a), eff. Sept. 1, 2003.

Sec. 1579.202. ELIGIBLE EMPLOYEES. (a) Except as provided by Section 1579.204, participation in the program is limited to employees of participating entities who are full-time employees and to part-time employees who are participating members in the Teacher Retirement System of Texas.

(b) An employee described by Subsection (a) who applies for coverage during an open enrollment period prescribed by the trustee is automatically covered by the catastrophic care coverage plan unless the employee:

(1) specifically waives coverage under this chapter;

(2) selects a higher tier coverage plan; or

(3) is expelled from the program.

Added by Acts 2003, 78th Leg., ch. 1276, Sec. 10A.471(a), eff. Sept.

1, 2003.

Sec. 1579.203. SELECTION OF COVERAGE. (a) A participating employee may select coverage in any coverage plan offered by the trustee.

(b) The employee is not required to continue participation in the coverage plan initially selected and may select a higher or lower tier coverage plan than the plan initially selected by the employee in the manner provided by rules adopted by the trustee.

(c) If the combined contributions received from the state and the employing participating entity under Subchapter F exceed the cost of a coverage plan selected by the employee, the employee may use the excess amount of contributions to obtain coverage under a higher tier coverage plan or to pay all or part of the cost of coverage for the employee's dependents.

(d) A married couple, both of whom are eligible for coverage under the program, may pool the amount of contributions to which the couple are entitled under the program to obtain coverage for themselves and dependent coverage.

Added by Acts 2003, 78th Leg., ch. 1276, Sec. 10A.471(a), eff. Sept. 1, 2003.

Sec. 1579.204. CERTAIN PART-TIME EMPLOYEES. A part-time employee of a participating entity who is not a participating member in the Teacher Retirement System of Texas is eligible to participate in the program only if the employee pays all of the premiums and other costs associated with the health coverage plan selected by the employee.

Added by Acts 2003, 78th Leg., ch. 1276, Sec. 10A.471(a), eff. Sept. 1, 2003.

Sec. 1579.205. PAYMENT BY PARTICIPATING ENTITY. Notwithstanding Section 1579.204, a participating entity may pay any portion of what otherwise would be the employee share of premiums and other costs associated with the coverage selected by the employee.

Added by Acts 2003, 78th Leg., ch. 1276, Sec. 10A.471(a), eff. Sept.

1, 2003.

SUBCHAPTER F. CONTRIBUTIONS

Sec. 1579.251. STATE ASSISTANCE. (a) The state shall assist employees of participating school districts and charter schools in the purchase of group health coverage under this chapter by providing for each covered employee the amount of $900 each state fiscal year or a greater amount as provided by the General Appropriations Act. The state contribution shall be distributed through the school finance formulas under Chapters 48 and 49, Education Code, and used by school districts and charter schools as provided by Section 48.275, Education Code.

(b) The state shall assist employees of participating regional education service centers and educational districts described by Section 1579.002(5)(B) in the purchase of group health coverage under this chapter by providing to the employing service center or educational district, for each covered employee, the amount of $900 each state fiscal year or a greater amount as provided by the General Appropriations Act.

Added by Acts 2003, 78th Leg., ch. 1276, Sec. 10A.471(a), eff. Sept. 1, 2003.

Amended by:

Acts 2009, 81st Leg., R.S., Ch. 1328 (H.B. 3646), Sec. 83, eff. September 1, 2009.

Acts 2019, 86th Leg., R.S., Ch. 943 (H.B. 3), Sec. 3.085, eff. September 1, 2019.

Sec. 1579.252. CONTRIBUTION BY PARTICIPATING ENTITIES. A participating entity shall make contributions for the program as provided by Chapter 1581.

Added by Acts 2003, 78th Leg., ch. 1276, Sec. 10A.471(a), eff. Sept. 1, 2003.

Sec. 1579.253. CONTRIBUTION BY EMPLOYEE. (a) An employee covered by the program shall pay that portion of the cost of coverage selected by the employee that exceeds the amount of the

state contribution under Section 1579.251 and the participating entity contribution under Section 1579.252.

(b) The employee may pay the employee's contribution under this subsection from the amount distributed to the employee under Subchapter D, Chapter 22, Education Code.

(c) Notwithstanding Subsection (a), a participating entity may pay any portion of what otherwise would be the employee share of premiums and other costs associated with the coverage selected by the employee.

Added by Acts 2003, 78th Leg., ch. 1276, Sec. 10A.471(a), eff. Sept. 1, 2003.

Amended by:

Acts 2005, 79th Leg., Ch. 899 (S.B. 1863), Sec. 18.04, eff. September 1, 2005.

Acts 2005, 79th Leg., Ch. 1359 (S.B. 1691), Sec. 52, eff. September 1, 2005.

Sec. 1579.254. CONTRIBUTIONS HELD IN TRUST FOR FUND. A participating entity:

(1) shall hold contributions required by this subchapter in trust for the Texas school employees uniform group coverage trust fund and its participants; and

(2) may not divert the contributions for any other purpose.

Added by Acts 2005, 79th Leg., Ch. 1359 (S.B. 1691), Sec. 53, eff. September 1, 2005.

Sec. 1579.255. INTEREST ASSESSED ON LATE PAYMENT OF CONTRIBUTIONS BY PARTICIPATING ENTITIES. (a) A participating entity that does not remit to the trustee all contributions required by this subchapter before the seventh day after the last day of the month shall pay to the Texas school employees uniform group coverage trust fund:

(1) the contributions; and

(2) interest on the unpaid amounts at the annual rate of six percent compounded monthly.

(b) On request, the trustee may grant a waiver of the

deadline imposed by this section based on a participating entity's financial or technological resources.

Added by Acts 2005, 79th Leg., Ch. 1359 (S.B. 1691), Sec. 53, eff. September 1, 2005.

SUBCHAPTER G. TEXAS SCHOOL EMPLOYEES UNIFORM GROUP COVERAGE TRUST FUND

Sec. 1579.301. FUND; ADMINISTRATION. The Texas school employees uniform group coverage trust fund is a trust fund with the comptroller.

Added by Acts 2003, 78th Leg., ch. 1276, Sec. 10A.471(a), eff. Sept. 1, 2003.

Sec. 1579.302. COMPOSITION OF FUND. The fund is composed of:

(1) all contributions made to the fund under this chapter from employees, participating entities, and the state;

(2) contributions made by employees or participating entities for optional coverages;

(3) investment income;

(4) any additional amounts appropriated by the legislature for contingency reserves, administrative expenses, or other expenses; and

(5) any other money required or authorized to be paid into the fund.

Added by Acts 2003, 78th Leg., ch. 1276, Sec. 10A.471(a), eff. Sept. 1, 2003.

Sec. 1579.303. PAYMENTS FROM FUND. The trustee may use amounts in the fund only to provide group coverages under this chapter and to pay the expenses of administering the program.

Added by Acts 2003, 78th Leg., ch. 1276, Sec. 10A.471(a), eff. Sept. 1, 2003.

Sec. 1579.304. INVESTMENT OF FUND. The trustee may invest assets of the fund in the manner provided by Section 67(a)(3),

Article XVI, Texas Constitution.

Added by Acts 2003, 78th Leg., ch. 1276, Sec. 10A.471(a), eff. Sept. 1, 2003.