Amend **SB 418** on third reading as follows:

(1) In SECTION 4 of the bill, strike Subsection (h), Section 3E, Article 3.70-3C, Insurance Code, as added by second reading amendment No. 8 by Smithee, and substitute the following:

(h)(1) Except as provided by this subsection and notwithstanding any other provision of this article, if an insurer declines to verify a medical care or health care service under this section, the physician or provider is not required to comply with any contractual requirement that the physician or provider hold a patient harmless for the medical care or health care service under Section 3(k) of this article. A contract between an insurer and a physician or provider must provide that the exercise of the physician's or provider's rights under this subsection may not be the basis for termination of or discrimination against the physician or provider under the contract or the basis for a penalty or discrimination against the physician or provider in participation in other health care products or plans.

(2) If an insurer in error declines to verify a medical service or health care service under this section, and the patient pays any amount in excess of the contractual amount, less any appropriate co-payments or deductibles, the patient may recover the amount in excess of the contractual amount from the physician or provider if:

(A) not later than the 180th day after the date the patient receives notice of the declination, the patient provides written notice to the physician or provider of the insurer's correction of the declination; and

(B) requests a refund of the overpayments.

(3) An insurer that makes an error in declination of verification shall inform the insured and physician or provider of the error without delay and pay to the insured any payment made by the insured to the physician or provider by the insured up to the contractual amount less any appropriate copayments or deductibles. Any remaining contractual amount not paid by the insurer shall be paid to the physician or provider in accordance with this article.

(2) In SECTION 19 of the bill, strike Subsection (h), Section 843.347, Insurance Code, as added by second reading

amendment No. 8 by Smithee, and substitute the following:

(h) Except as provided by this subsection and Subsections (i) and (j) and notwithstanding any other provision of this chapter, if a health maintenance organization declines to verify a health care service under this section, the physician or provider is not required to comply with any contractual requirement that the physician or provider hold a patient harmless for the health care service under Section 843.361. A contract between a health maintenance organization and a physician or provider must provide that the exercise of the physician's or provider's rights under this subsection may not be the basis for termination of or discrimination against the physician or provider under the contract or the basis for a penalty or discrimination against the physician or provider in participation in other health care products or plans.

(i) If a health maintenance organization in error declines to verify a health care service under this section, and the patient pays any amount in excess of the contractual amount, less any appropriate copayments or deductibles, the patient may recover the amount in excess of the contractual amount from the physician or provider if:

(1) not later than the 180th day after the date the patient receives notice of the declination, the patient provides written notice to the physician or provider of the health maintenance organization's correction of the declination; and

(2) requests a refund of the overpayments.

(j) A health maintenance organization that makes an error in declination of verification shall inform the patient and physician or provider of the error without delay and pay to the patient any payment made by the patient to the physician or provider by the patient up to the contractual amount less any appropriate co-payments or deductibles. Any remaining contractual amount not paid by the health maintenance organization to the patient shall be paid to the physician or provider in accordance with this chapter.