Amend **CSHB 1772** (house committee printing) as follows:

(1) On page 3, strike lines 15-20 and substitute:

Sec. 1301.0042. APPLICABILITY OF INSURANCE LAW. (a) Except as provided by Subsection (b), a provision of this code or another insurance law of this state that applies to a preferred provider benefit plan applies to an exclusive provider benefit plan except to the extent that the commissioner determines the provision to be inconsistent with the function and purpose of an exclusive provider benefit plan.

(b) An exclusive provider benefit plan may not provide dental care benefits.

(2) On page 4, line 3, strike "Section" and substitute "Sections 1301.0052 and".

(3) On page 5, line 3, strike "Section 1301.0051" and substitute "Sections 1301.0051, 1301.0052, 1301.0053, and 1301.0056".

(4) On page 6, between lines 18 and 19, insert:

Sec. 1301.0052. EXCLUSIVE PROVIDER BENEFIT PLANS: REFERRALS FOR MEDICALLY NECESSARY SERVICES. (a) If a covered service is medically necessary and is not available through a preferred provider, the issuer of an exclusive provider benefit plan, on the request of a preferred provider, shall:

(1) approve the referral of an insured to a nonpreferred provider within a reasonable period; and

(2) fully reimburse the nonpreferred provider at the usual and customary rate or at a rate agreed to by the issuer and the nonpreferred provider.

(b) An exclusive provider benefit plan must provide for a review by a health care provider with expertise in the same specialty as or a specialty similar to the type of health care provider to whom a referral is requested under Subsection (a) before the issuer of the plan may deny the referral.

Sec. 1301.0053. EXCLUSIVE PROVIDER BENEFIT PLANS: EMERGENCY CARE. If a nonpreferred provider provides emergency care as defined by Section 1301.155 to an enrollee in an exclusive provider benefit plan, the issuer of the plan shall reimburse the nonpreferred provider at the usual and customary rate or at a rate

agreed to by the issuer and the nonpreferred provider for the provision of the services.

Sec. 1301.0056. EXAMINATIONS AND FEES. (a) The commissioner may examine an insurer to determine the quality and adequacy of a network used by an exclusive provider benefit plan offered by the insurer under this chapter. An insurer is subject to a qualifying examination of the insurer's exclusive provider benefit plans and subsequent quality of care examinations by the commissioner at least once every five years. Documentation provided to the commissioner during an examination conducted under this section is confidential and is not subject to disclosure as public information under Chapter 552, Government Code.

(b) An insurer examined under this section shall pay the cost of the examination in an amount determined by the commissioner.

(c) The department shall collect an assessment in an amount determined by the commissioner from the insurer at the time of the examination to cover all expenses attributable directly to the examination, including the salaries and expenses of department employees and all reasonable expenses of the department necessary for the administration of this chapter.

(d) The department shall deposit an assessment collected under this section to the credit of the Texas Department of Insurance operating account. Money deposited under this subsection shall be used to pay the salaries and expenses of examiners and all other expenses relating to the examination of insurers under this section.

(5) On page 7, between lines 3 and 4, insert:

(c) An identification card or similar document issued by an insurer to an insured in an exclusive provider benefit plan must display:

(1) the first date on which the insured became insured under the plan;

(2) a toll-free number that a physician or health care provider may use to obtain the date on which the insured became insured under the plan; and

(3) the acronym "EPO" or the phrase "Exclusive

Provider Organization" on the card in a location of the insurer's choice.