[Tex. Ins. Code § 1301.164.]

§ 1301.164. Out-of-Network Facility-Based Providers: Preferred Provider Benefit Plans

(a) In this section, "facility-based provider" means a physician or health care provider who provides medical care or health care services to patients of a health care facility.

(b) Except as provided by Subsection (d), an insurer shall pay for a covered medical care or health care service performed for or a covered supply related to that service provided to an insured 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 preferred provider. The insurer 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 insurer receives an electronic clean claim as defined by Section 1301.101 for those services that includes all information necessary for the insurer to pay the claim; or

(2) the 45th day after the date the insurer receives a nonelectronic clean claim as defined by Section 1301.101 for those services that includes all information necessary for the insurer 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 insured receiving a medical care or health care service or supply described by Subsection (b) in, and the insured does not have financial responsibility for, an amount greater than an applicable copayment, coinsurance, and deductible under the insured's preferred provider benefit plan that:

(1) is based on:

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

(B) if applicable, a modified amount as determined under the insurer'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 insured 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 insured that:

(A) explains that the provider does not have a contract with the insured's preferred provider benefit plan;

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

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

(e) This section may not be construed to require the imposition of a penalty under Section 1301.137.