SECOND REGULAR SESSION

[PERFECTED]

HOUSE BILL NO. 1271

97TH GENERAL ASSEMBLY

INTRODUCED BY REPRESENTATIVES MOLENDORP (Sponsor), JONES (50), ROWDEN, FRAKER, REDMON, ROSS, MORRIS, DUGGER, HOSKINS, FLANIGAN, KEENEY, CORNEJO, KORMAN, CIERPIOT, RICHARDSON, HOUGH, ELMER, HAAHR, HINSON AND NETH (Co-sponsors).

4271H.01P D. ADAM CRUMBLISS, Chief Clerk

AN ACT

To amend chapter 376, RSMo, by adding thereto one new section relating to fees for optometric and ophthalmic services.

Be it enacted by the General Assembly of the state of Missouri, as follows:

Section A. Chapter 376, RSMo, is amended by adding thereto one new section, to be known as section 376.685, to read as follows:

376.685. 1. No agreement between a health carrier or other insurer that writes vision insurance and an optometrist for the provision of vision services on a preferred or in-network basis to plan members or insurance subscribers in connection with coverage under a stand-alone vision plan, medical plan, health benefit plan, or health insurance policy shall require that an optometrist provide optometric or ophthalmic services or materials at a fee limited or set by the plan or health carrier unless the services or materials are reimbursed as covered services under the contract.

2. No provider shall charge more for services or materials that are not covered under a health benefit or vision plan than his or her usual and customary rate for those services or materials.

3. No amount of a contractual discount shall result in a fee less than the health benefit or vision plan would pay for covered services or materials but for the application of an enrollee's contractual limitations of deductibles, co-payments, coinsurance, waiting

EXPLANATION — Matter enclosed in bold-faced brackets **[**thus**]** in the above bill is not enacted and is intended to be omitted from the law. Matter in **bold-face** type in the above bill is proposed language.

periods, annual or lifetime maximums, alternative benefit payments, or frequency limitations.

4. Reimbursement paid by the health benefit or vision plan for covered services or materials shall be reasonable and shall not provide nominal reimbursement in order to claim that services or materials are covered services. No health carrier shall provide de minimis reimbursement or coverage in an effort to avoid the requirements of this section.

5. For the purposes of this section, the following terms shall mean:

(1) "Covered services", optometric or ophthalmic services or materials for which reimbursement from the health benefit or vision plan is provided for by an enrollee's plan contract, or for which a reimbursement would be available but for the application of the enrollee's contractual limitations of deductibles, co-payments, coinsurance, waiting periods, annual or lifetime maximums, alternative benefit payments, or frequency limitations;

(2) "Health benefit plan", the same meaning as such term is defined in section 376.1350;

(3) "Health carrier", the same meaning as such term is defined in section 376.1350;

(4) "Materials", includes, but is not limited to, lenses, frames, devices containing lenses, prisms, lens treatment and coatings, contact lenses, orthoptics, vision training devices, and prosthetic devices to correct, relieve, or treat defects or abnormal conditions of the human eye or its adnexa;

(5) "Optometric services", any services within the scope of optometric practice under chapter 336;

(6) "Vision plan", any policy, contract of insurance, or discount plan issued by a health carrier, health benefit plan, or company which provides coverage or a discount for optometric or ophthalmic services or materials.

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