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§15–112.2.

(a) (1) In this section the following words have the meanings indicated.

(2) "Capitated dental provider panel" means a provider panel for one or more dental plan organizations offering contracts only for dental services reimbursed on a capitated basis for certain services.

(3) "Carrier" means:

(i) an insurer;

(ii) a nonprofit health service plan;

(iii) a health maintenance organization; or

(iv) a dental plan organization.

(4) "Enrollee" means a person entitled to health care benefits from a carrier.

(5) "Fee–for–service dental provider panel" means a provider panel for one or more dental plan organizations, insurers, or nonprofit health service plans offering contracts only for dental services reimbursed on a full or discounted fee–for–service basis.

(6) "HMO provider panel" means a provider panel for one or more health maintenance organizations.

(7) "Managed care organization" has the meaning stated in § 15–101 of the Health – General Article.

(8) "Non–HMO provider panel" means a provider panel for one or more nonprofit health service plans or insurers.

(9) "Provider" has the meaning stated in § 19–701 of the Health – General Article.

(10) "Provider contract" means a contract:

(i) between a provider and a carrier, an affiliate of a carrier, or an entity that contracts with a provider to serve a carrier; and

(ii) under which the provider agrees to provide health care services to enrollees.

(11) "Provider panel" means the providers that contract either directly or through a subcontracting entity with a carrier to provide health care services to enrollees.

(b) (1) A provider contract may not contain a provision that requires a provider:

(i) as a condition of participating in a non–HMO provider panel, to participate in an HMO provider panel; or

(ii) as a condition of participating in a fee–for–service dental provider panel, to participate in a capitated dental provider panel.

(2) Notwithstanding paragraph (1) of this subsection, a provider contract may contain a provision that requires a provider, as a condition of participating in a non–HMO provider panel, an HMO provider panel, or a dental provider panel, to participate in a managed care organization.

(c) (1) This subsection does not apply to a provider contract for a dental provider panel.

(2) Each provider contract shall disclose the carriers comprising each provider panel.

(d) (1) This subsection does not apply to a provider contract for a dental provider panel.

(2) If a provider contract includes more than one schedule of applicable fees, the provider contract may not contain a provision that requires a provider as a condition of participation to accept each schedule of applicable fees included in the provider contract.

(3) If a provider rejects a schedule of applicable fees, the provider contract may not require the provider to treat the enrollees of the carriers that reimburse the provider in accordance with any of the rejected schedules of applicable fees.

(4) Notwithstanding the provisions of paragraph (1) of this subsection, a provider contract may include a provision that requires a provider, as a condition of participation, to accept each schedule of applicable fees for a carrier that is not affiliated through common ownership with the entity arranging the provider panel.

(e) If a provider elects to terminate participation on a provider panel, the provider shall:

(1) notify the carrier at least 90 days before the date of termination; and

(2) for at least 90 days after the date of the notice of termination, continue to furnish health care services to an enrollee of the carrier for whom the provider was

responsible for the delivery of health care services before the notice of termination.

(f) A provider contract may not contain a provision that requires a participating dental provider, as a condition of continued participation in a capitated dental provider panel or a fee–for–service dental provider panel, to accept an added, revised, or amended fee schedule that contains a lower fee.

(g) (1) In this subsection, "covered services" means health care services that are reimbursable under a policy or contract for dental services between an enrollee and a carrier, subject to any contractual limitations on benefits, including deductibles, copayments, or frequency limitations.

(2) A carrier may not include in a dental provider contract a provision that requires a dental provider to provide health care services that are not covered services at a fee set by the carrier.

(h) (1) In this subsection, "covered services" means health care services that are reimbursable under a policy or contract for vision services between an enrollee and a carrier, subject to any contractual limitations on benefits, including deductibles, copayments, or frequency limitations.

(2) A carrier may not include in a vision provider contract a provision that requires a vision provider:

(i) to provide health care services that are not covered services at a fee set by the carrier; or

(ii) to provide discounts on materials that are not covered benefits.

(3) (i) A carrier may not include in a vision provider contract a provision that requires a vision provider, as a condition of participation in a fee–for–service vision provider panel, to participate in a capitated vision provider panel.

(ii) Notwithstanding subparagraph (i) of this paragraph, a vision provider contract may contain a provision that requires a vision provider, as a condition of participating in a non–HMO vision provider panel or an HMO vision provider panel to participate in a managed care organization.

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