SENATE BILL 795

J5 6lr2217
CF 6lr3675

By: **Senator Lam**
Introduced and read first time: February 6, 2026
Assigned to: Finance

A BILL ENTITLED

AN ACT concerning

Health Insurance – Vision Benefits – Regulation of Insurers and Vision Benefit Managers

FOR the purpose of establishing requirements for certain vision benefits, vision benefit plans, and vision discount plans; requiring an insurer or a vision benefit manager to disclose certain information on its website and in certain communications and maintain certain methods of communication for use by participating eye care providers; establishing certain requirements and prohibitions for contracts between insurers or vision benefit managers and participating eye care providers; establishing procedures for inclusion and credentialing of participating eye care providers in health benefit plans, vision benefit plans, or vision benefit discount plans; requiring an insurer or a vision benefit manager to comply with certain procedures before amending a provider agreement; establishing requirements for reimbursement of participating eye care providers by an insurer or a vision benefit manager; and generally relating to eye care providers and health benefit plans, vision benefit plans, and vision benefit discount plans.

BY repealing
Article – Insurance
Section 15–112.2(h)
Annotated Code of Maryland
(2017 Replacement Volume and 2025 Supplement)

BY adding to
Article – Insurance
Section 15–2201 through 15–2213 to be under the new subtitle "Subtitle 22. Vision Benefits, Vision Benefit Plans, and Vision Benefit Discount Plans"
Annotated Code of Maryland
(2017 Replacement Volume and 2025 Supplement)

EXPLANATION: **CAPITALS INDICATE MATTER ADDED TO EXISTING LAW.**
[Brackets**]** indicate matter deleted from existing law.

SECTION 1. BE IT ENACTED BY THE GENERAL ASSEMBLY OF MARYLAND, That the Laws of Maryland read as follows:

Article – Insurance

15–112.2.

[(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.**]**

SUBTITLE 22. VISION BENEFITS, VISION BENEFIT PLANS, AND VISION BENEFIT DISCOUNT PLANS.

15–2201.

(A) IN THIS SUBTITLE THE FOLLOWING WORDS HAVE THE MEANINGS INDICATED.

(B) "EYE CARE PROVIDER" MEANS AN INDIVIDUAL LICENSED TO PRACTICE OPTOMETRY UNDER TITLE 11 OF THE HEALTH OCCUPATIONS ARTICLE OR AN INDIVIDUAL LICENSED TO PRACTICE MEDICINE UNDER TITLE 14 OF THE HEALTH OCCUPATIONS ARTICLE.

(C) "VISION BENEFIT DISCOUNT PLAN" MEANS A POLICY, A CONTRACT, OR AN AGREEMENT OFFERED BY AN INSURER OR A VISION BENEFIT MANAGER THAT SOLELY PROVIDES FOR A DISCOUNT FOR VISION CARE SERVICES OR MATERIALS.

(D) (1) "VISION BENEFIT MANAGER" MEANS A PERSON THAT, TO THE EXTENT THAT THE PERSON IS ACTING FOR AN INSURER OR A VISION BENEFIT DISCOUNT PLAN, HAS:

(I) CONTROL OVER OR CUSTODY OF PREMIUMS, CONTRIBUTIONS, OR ANY OTHER MONEY ON BEHALF OF AN INSURER OR A VISION BENEFIT DISCOUNT PLAN OR WITH RESPECT TO A PLAN, FOR ANY PERIOD OF TIME; OR

(II) DISCRETIONARY AUTHORITY OVER THE ADJUSTMENT, PAYMENT, OR SETTLEMENT OF BENEFIT CLAIMS ON BEHALF OF AN INSURER OR A VISION BENEFIT PLAN, OR OVER THE INVESTMENT OF THE ASSETS OF AN INSURER OR A VISION BENEFIT PLAN.

(2) "VISION BENEFIT MANAGER" DOES NOT INCLUDE A PERSON THAT, WITH RESPECT TO A PARTICULAR HEALTH BENEFIT PLAN, VISION BENEFIT PLAN, OR VISION BENEFIT DISCOUNT PLAN:

(I) IS, OR IS AN EMPLOYEE, AN INSURANCE PRODUCER, OR A MANAGING GENERAL AGENT OF, AN INSURER OR A VISION BENEFIT PLAN THAT INSURES OR ADMINISTERS THE PLAN; OR

(II) IS AN INSURANCE PRODUCER THAT SOLICITS, PROCURES, OR NEGOTIATES A PLAN FOR A PLAN SPONSOR AND HAS NO AUTHORITY OVER THE ADJUSTMENT, PAYMENT, OR SETTLEMENT OF BENEFIT CLAIMS UNDER THE PLAN OR OVER THE INVESTMENT OR HANDLING OF THE PLAN'S ASSETS.

(E) "VISION BENEFIT PLAN" MEANS A POLICY, A CONTRACT, OR AN AGREEMENT OFFERED BY AN INSURER OR A VISION BENEFIT MANAGER TO AN ENROLLEE TO PAY FOR, REIMBURSE, OR OFFSET HEALTH AND VISION CARE COSTS.

15–2202.

THIS SUBTITLE APPLIES ONLY TO AN INSURER OR VISION BENEFIT MANAGER THAT ISSUES, SELLS, OR DELIVERS IN THE STATE A VISION BENEFIT PLAN OR VISION BENEFIT DISCOUNT PLAN OR PROVIDES COVERAGE FOR VISION–RELATED SERVICES UNDER A HEALTH BENEFIT PLAN.

15–2203.

(A) EACH INSURER AND VISION BENEFIT MANAGER SHALL PROVIDE A DISCLOSURE ON ITS WEBSITE AND GENERATE A DOCUMENT CONTAINING THE

FOLLOWING INFORMATION:

(1) THE LEGAL NAME AND ENTITY TYPE OF THE INSURER OR VISION BENEFIT MANAGER;

(2) THE LEGAL ADDRESS OF THE INSURER OR VISION BENEFIT MANAGER;

(3) THE STATE IN WHICH THE INSURER OR VISION BENEFIT MANAGER WAS FORMED OR ORGANIZED;

(4) THE PHYSICAL ADDRESS, MAILING ADDRESS, E–MAIL ADDRESS, AND TELEPHONE NUMBER OF THE HEADQUARTERS OF THE INSURER OR VISION BENEFIT MANAGER;

(5) (I) A LIST OF THE STATE AGENCIES WITH REGULATORY AUTHORITY OVER THE INSURER OR VISION BENEFIT MANAGER; OR

(II) IF THERE IS NO STATE AGENCY WITH REGULATORY AUTHORITY OVER THE INSURER OR VISION BENEFIT MANAGER, A STATEMENT THAT NO REGULATORY AUTHORITY EXISTS OVER THE INSURER OR VISION BENEFIT MANAGER;

(6) THE NAMES, PHYSICAL ADDRESSES, MAILING ADDRESSES, E–MAIL ADDRESSES, AND TELEPHONE NUMBERS OF ALL PARENT COMPANIES, RELATED HOLDING COMPANIES, AND WHOLLY OR PARTIALLY OWNED SUBSIDIARY COMPANIES;

(7) A LIST OF ALL FEDERAL AND STATE LITIGATION TO WHICH THE COMPANY HAS BEEN A PARTY IN THE IMMEDIATELY PRECEDING 5 YEARS; AND

(8) ALL FORMAL COMPLAINTS SUBMITTED TO THE ADMINISTRATION AGAINST THE INSURER OR VISION BENEFIT MANAGER IN THE IMMEDIATELY PRECEDING 5 YEARS BY A PURCHASER, AN ENROLLEE, OR AN EYE CARE PROVIDER.

(B) THE DISCLOSURE REQUIRED UNDER SUBSECTION (A) OF THIS SECTION SHALL BE:

(1) WRITTEN IN PLAIN LANGUAGE;

(2) DISPLAYED IN AT LEAST 10 POINT FONT;

(3) PROMINENTLY DISPLAYED ON A PUBLICLY ACCESSIBLE SECTION

OF THE INSURER'S OR VISION BENEFIT MANAGER'S WEBSITE TITLED "REQUIRED TRANSPARENCY INFORMATION FOR PATIENTS, DOCTORS, AND PURCHASERS"; AND

(4) CONTAINED IN A SEPARATE DOCUMENT ENTITLED "REQUIRED TRANSPARENCY INFORMATION FOR PATIENTS, DOCTORS, AND PURCHASERS" THAT IS INCLUDED WITH ALL DOCUMENTS AND DOCUMENT PACKAGES PROVIDED TO CURRENT OR PROSPECTIVE ENROLLEES, PURCHASERS, OR PARTICIPATING EYE CARE PROVIDERS, AND STATE AGENCIES WITH REGULATORY AUTHORITY OVER THE INSURER OR VISION BENEFIT MANAGER.

15–2204.

(A) (1) EACH INSURER OR VISION BENEFIT MANAGER SHALL MAINTAIN A TELEPHONE NUMBER TO RECEIVE QUESTIONS AND COMMUNICATIONS FROM PARTICIPATING EYE CARE PROVIDERS.

(2) THE TELEPHONE NUMBER REQUIRED UNDER PARAGRAPH (1) OF THIS SUBSECTION SHALL ALLOW PARTICIPATING EYE CARE PROVIDERS TO COMMUNICATE WITH COMPANY REPRESENTATIVES DURING NORMAL BUSINESS HOURS AND TO LEAVE VOICE MESSAGES AT ALL TIMES.

(B) (1) EACH INSURER OR VISION BENEFIT MANAGER SHALL MAINTAIN A PHYSICAL MAILING ADDRESS AND AN E–MAIL ADDRESS TO RECEIVE COMMUNICATIONS FROM PARTICIPATING EYE CARE PROVIDERS.

(2) AN INSURER OR A VISION BENEFIT MANAGER SHALL, ON THE WEBSITE OF THE INSURER OR VISION BENEFIT MANAGER AND IN ANY PROVIDER AGREEMENT, HANDBOOK, MANUAL, OR RELATED POLICY DOCUMENT:

(I) PROMINENTLY DISPLAY THE PHYSICAL MAILING ADDRESS AND E–MAIL ADDRESS REQUIRED UNDER PARAGRAPH (1) OF THIS SUBSECTION; AND

(II) PROVIDE INSTRUCTIONS FOR THE SUBMISSION OF QUESTIONS, DISPUTES, AND COMMUNICATIONS USING THE PHYSICAL MAILING ADDRESS AND E–MAIL ADDRESS REQUIRED UNDER PARAGRAPH (1) OF THIS SUBSECTION.

(C) AN INSURER OR A VISION BENEFIT MANAGER SHALL:

(1) HAVE THE ABILITY TO HAVE A LIVE TELEPHONE DISCUSSION WITHIN 24 HOURS AFTER AN INITIAL TELEPHONE CALL IS MADE TO OR A VOICE MESSAGE IS LEFT WITH THE INSURER OR VISION BENEFIT MANAGER;

(2) ACKNOWLEDGE RECEIPT OF AN E–MAIL MESSAGE WITHIN 1 HOUR; AND

(3) RESPOND TO SUBSTANTIVE QUESTIONS SUBMITTED VIA E–MAIL WITHIN 72 HOURS.

(D) AN INSURER OR A VISION BENEFIT MANAGER SHALL, AT ALL TIMES, MAKE AVAILABLE TO A PARTICIPATING EYE CARE PROVIDER THE MOST UP–TO–DATE PROVIDER AGREEMENTS, FEE SCHEDULES, PROVIDER HANDBOOKS, PROVIDER MANUALS, AND RELATED POLICY DOCUMENTS THROUGH THE WEBSITE OF THE INSURER OR VISION BENEFIT MANAGER.

(E) ON REQUEST OF A STATE AGENCY WITH REGULATORY AUTHORITY OVER THE INSURER OR VISION BENEFIT MANAGER, THE INSURER OR VISION BENEFIT MANAGER SHALL SUBMIT ALL REQUESTED INFORMATION RELATING TO THE HEALTH BENEFIT PLAN, VISION BENEFIT PLAN, OR VISION BENEFIT DISCOUNT PLAN.

15–2205.

(A) AN AGREEMENT OR CONTRACT BETWEEN AN INSURER OR A VISION BENEFIT MANAGER AND A PARTICIPATING EYE CARE PROVIDER:

(1) SHALL:

(I) 1. INCLUDE A FEE SCHEDULE THAT SPECIFIES, FOR EACH COVERED SERVICE AND COVERED MATERIAL, THE CORRESPONDING ALLOWED AMOUNT, AMOUNT OF REIMBURSEMENT TO BE PAID TO THE PARTICIPATING EYE CARE PROVIDER, AND ANY FORM OF COST–SHARING AMOUNT TO BE PAID BY THE ENROLLEE TO THE PARTICIPATING EYE CARE PROVIDER; AND

2. PROVIDE THAT THE AMOUNT OF TIME FOR AN INSURER OR A VISION BENEFIT MANAGER TO RECOVER A REIMBURSEMENT AMOUNT FROM A PARTICIPATING EYE CARE PROVIDER SHALL BE THE SAME TIME PERIOD ALLOWED FOR AN INSURER OR A VISION BENEFIT MANAGER TO REMIT REIMBURSEMENT TO A PARTICIPATING EYE CARE PROVIDER FOLLOWING THE SUBMISSION OF A CLEAN CLAIM, UNLESS THE INSURER OR VISION BENEFIT MANAGER IS CONDUCTING AN AUDIT OF ALL OF THE PARTICIPATING EYE CARE PROVIDER'S CLAIMS BASED ON A REASONABLE BELIEF THAT THE PARTICIPATING EYE CARE PROVIDER HAS ENGAGED IN FRAUD, WASTE, OR ABUSE; AND

(II) INCLUDE A COPY OF THE MOST RECENT PLAN PROVIDER MANUAL AND ANY POLICIES REFERRED TO IN THE PROVIDER AGREEMENT

WHENEVER THE INSURER OR VISION BENEFIT MANAGER SENDS A PROVIDER AGREEMENT TO A PROSPECTIVE OR PARTICIPATING EYE CARE PROVIDER; AND

(2) MAY NOT:

(I) REQUIRE A PARTICIPATING EYE CARE PROVIDER TO PROVIDE SERVICES OR MATERIALS AT A FEE LIMITED OR SET BY THE INSURER OR VISION BENEFIT MANAGER UNLESS THE SERVICES OR MATERIALS ARE DEFINED AND REIMBURSED AS COVERED SERVICES OR COVERED MATERIALS UNDER THE AGREEMENT OR CONTRACT;

(II) CONTAIN A FEE SCHEDULE, A REIMBURSEMENT AMOUNT, OR ANY OTHER PROVISION THAT REQUIRES THE PARTICIPATING EYE CARE PROVIDER TO PROVIDE COVERED SERVICES OR COVERED MATERIALS TO AN ENROLLEE AT A FINANCIAL LOSS AFTER CONSIDERATION OF ALL APPLICABLE DEDUCTIBLES, COPAYS, COINSURANCES, DISCOUNTS, REBATES, OR CHARGEBACKS; OR

(III) RESTRICT OR LIMIT, DIRECTLY OR INDIRECTLY, THE PARTICIPATING EYE CARE PROVIDER'S CHOICE OR USE OF SOURCES AND SUPPLIERS OF COVERED OR UNCOVERED SERVICES OR MATERIALS PROVIDED BY THE PARTICIPATING EYE CARE PROVIDER TO AN ENROLLEE.

(B) (1) AN INSURER OR A VISION BENEFIT MANAGER SHALL USE STANDARDIZED CODES, NAMES, DESCRIPTIONS, AND DEFINITIONS PUBLISHED IN THE HEALTHCARE COMMON PROCEDURE CODING SYSTEM TO:

(I) IDENTIFY AND DESCRIBE COVERED SERVICES AND COVERED MATERIALS TO PURCHASERS, ENROLLEES, AND PARTICIPATING EYE CARE PROVIDERS; AND

(II) CREATE AND OFFER A FEE SCHEDULE FOR COVERED SERVICES AND COVERED MATERIALS IN AN AGREEMENT BETWEEN THE INSURER OR VISION BENEFIT MANAGER AND THE PARTICIPATING EYE CARE PROVIDER.

(2) AN INSURER OR A VISION BENEFIT MANAGER MAY NOT ALTER OR ATTEMPT TO ALTER THE MEANING OF ANY STANDARDIZED CODES, NAMES, DESCRIPTIONS, AND DEFINITIONS PUBLISHED IN THE HEALTHCARE COMMON PROCEDURE CODING SYSTEM.

(C) A FEE SCHEDULE DEVELOPED BY AN INSURER OR A VISION BENEFIT MANAGER OR REIMBURSEMENT ISSUED TO A PARTICIPATING EYE CARE PROVIDER BY AN INSURER OR A VISION BENEFIT MANAGER:

(1) SHALL PROVIDE FOR REIMBURSEMENT FOR ALL COVERED SERVICES AND COVERED MATERIALS; AND

(2) MAY NOT BE NOMINAL OR DE MINIMIS.

(D) ALL AMOUNTS ALLOWED UNDER A FEE SCHEDULE AND REIMBURSEMENTS PAID BY AN INSURER OR A VISION BENEFIT MANAGER SHALL BE CLEARLY AND INDIVIDUALLY LISTED ON A FEE SCHEDULE MADE AVAILABLE TO THE PARTICIPATING EYE CARE PROVIDER:

(1) AT THE TIME AN AGREEMENT IS OFFERED TO THE PARTICIPATING EYE CARE PROVIDER BY THE INSURER OR VISION BENEFIT MANAGER;

(2) WITHIN 10 BUSINESS DAYS AFTER THE DATE AN APPLICATION IS MADE TO BECOME A PARTICIPATING EYE CARE PROVIDER WITH THE INSURER OR VISION BENEFIT MANAGER; AND

(3) AT ALL TIMES BY ELECTRONIC MEANS.

(E) AN INSURER OR A VISION BENEFIT MANAGER MAY NOT:

(1) ADVERTISE, CLAIM, OR REPRESENT TO PURCHASERS OR ENROLLEES THAT SERVICES AND MATERIALS PROVIDED BY A PARTICIPATING EYE CARE PROVIDER ARE COVERED, INCLUDED, OR COVERED WITH AN ADDITIONAL DEDUCTIBLE, COPAY, OR COINSURANCE IF THE INSURER OR VISION BENEFIT MANAGER DOES NOT REMIT AN ACTUAL PAYMENT AS FULL OR PARTIAL REIMBURSEMENT TO THE PARTICIPATING EYE CARE PROVIDER;

(2) RESTRICT A PARTICIPATING EYE CARE PROVIDER FROM:

(I) ENGAGING IN DIRECT NEGOTIATION WITH THE INSURER OR VISION BENEFIT MANAGER REGARDING REIMBURSEMENT FEE SCHEDULES, EVEN IF THE PARTICIPATING EYE CARE PROVIDER IS AN INDIVIDUAL OR A MEMBER OF A GROUP OF EYE CARE PROVIDERS PRACTICING UNDER A SINGLE EMPLOYER IDENTIFICATION NUMBER OR TAX IDENTIFICATION NUMBER; OR

(II) AGREEING TO A DIFFERENT FEE SCHEDULE FROM THE FEE SCHEDULE PROVIDED BY THE INSURER OR VISION BENEFIT MANAGER TO OTHER PARTICIPATING EYE CARE PROVIDERS;

(3) DESIGNATE A SERVICE OR MATERIAL AS A COVERED SERVICE OR COVERED MATERIAL IF THE REIMBURSEMENT AMOUNT TO THE PARTICIPATING EYE

CARE PROVIDER IS COMPOSED OF ONLY AN ENROLLEE'S PAYMENT TO THE PARTICIPATING EYE CARE PROVIDER;

(4) CONDITION APPLICATION TO OR NETWORK PARTICIPATION IN A HEALTH BENEFIT PLAN, VISION BENEFIT PLAN, OR VISION BENEFIT DISCOUNT PLAN BY AN EYE CARE PROVIDER BASED ON THE EYE CARE PROVIDER'S USUAL AND CUSTOMARY PRICING OR DISCOUNTS ON USUAL AND CUSTOMARY PRICING FOR SERVICES OR MATERIALS THAT ARE NOT COVERED SERVICES OR MATERIALS;

(5) CONDITION A PROPOSED OR EFFECTIVE FEE SCHEDULE BASED ON THE EYE CARE PROVIDER'S USUAL AND CUSTOMARY PRICING OR DISCOUNTS ON USUAL AND CUSTOMARY PRICING FOR SERVICES OR MATERIALS THAT ARE NOT COVERED SERVICES OR MATERIALS;

(6) REIMBURSE A PARTICIPATING EYE CARE PROVIDER A DIFFERENT AMOUNT FOR COVERED SERVICES OR COVERED MATERIALS BECAUSE OF THE PARTICIPATING EYE CARE PROVIDER'S CHOICE OF:

(I) OPTICAL LABORATORY;

(II) SOURCE OF SUPPLIER FOR CONTACT LENSES, OPHTHALMIC LENSES, OPHTHALMIC GLASSES FRAMES, OR OTHER SERVICES OR MATERIALS;

(III) EQUIPMENT USED FOR PATIENT CARE;

(IV) RETAIL OPTICAL AFFILIATION;

(V) VISION SUPPORT ORGANIZATION;

(VI) GROUP PURCHASING ORGANIZATION;

(VII) DOCTOR ALLIANCE;

(VIII) PROFESSIONAL TRADE ASSOCIATION MEMBERSHIP;

(IX) ELECTRONIC HEALTH RECORD SOFTWARE, ELECTRONIC MEDICAL RECORD SOFTWARE, OR PRACTICE MANAGEMENT SOFTWARE; OR

(X) THIRD–PARTY CLAIM FILING SERVICE, BILLING SERVICE, OR ELECTRONIC DATA INTERCHANGE CLEARINGHOUSE COMPANY;

(7) REQUIRE A PARTICIPATING EYE CARE PROVIDER, A PURCHASER, OR AN ENROLLEE OF A HEALTH PLAN, VISION BENEFIT PLAN, OR VISION BENEFIT

DISCOUNT PLAN TO OBTAIN PRIOR AUTHORIZATION, PREAUTHORIZATION, PRECERTIFICATION, OR ANY SIMILAR MECHANISM THAT RESTRICTS THE ENROLLEE FROM RECEIVING A COVERED SERVICE OR COVERED MATERIAL RECOMMENDED BY THE PARTICIPATING EYE CARE PROVIDER AND REQUESTED BY THE ENROLLEE; OR

(8) IN THE COURSE OF ADJUDICATING A CLAIM FOR REIMBURSEMENT, ALTER, DELETE, SUBSTITUTE, OR OTHERWISE CHANGE ANY CODE OR MODIFIER SUBMITTED BY THE PARTICIPATING EYE CARE PROVIDER, INCLUDING BY DOWNCODING, BUNDLING, OR REASSIGNING TO A DIFFERENT CODE, IF THE CHANGE WOULD REDUCE PAYMENT OR OTHERWISE ADVERSELY AFFECT THE PARTICIPATING EYE CARE PROVIDER OR ENROLLEE.

(F) (1) AN INSURER OR A VISION BENEFIT MANAGER SHALL REMIT TO THE PARTICIPATING EYE CARE PROVIDER THE CONTRACTED REIMBURSEMENT AMOUNT FROM THE FEE SCHEDULE FOR A COVERED SERVICE OR COVERED MATERIAL PROVIDED TO AN ENROLLEE IF THE ENROLLEE IS VERIFIED TO BE ELIGIBLE BY THE PARTICIPATING EYE CARE PROVIDER THROUGH CUSTOMARY VERIFICATION METHODS OF THE INSURER OR VISION BENEFIT MANAGER TO RECEIVE THE COVERED SERVICE OR COVERED MATERIAL ON THE DATE OF SERVICE.

(2) AN INSURER OR A VISION BENEFIT MANAGER MAY NOT RETROACTIVELY REVERSE A REIMBURSEMENT OR WITHHOLD A FUTURE REIMBURSEMENT TO A PARTICIPATING EYE CARE PROVIDER WHO RELIED IN GOOD FAITH ON AN INDIVIDUAL'S PRESENTED COVERAGE CREDENTIALS AND THE CUSTOMARY VERIFICATION METHODS OF THE INSURER OR VISION BENEFIT MANAGER IF THE INSURER OR VISION BENEFIT MANAGER LATER DETERMINES THAT THE ENROLLEE WAS INELIGIBLE TO RECEIVE THE COVERED SERVICES OR COVERED MATERIALS ON THE DATE OF SERVICE.

(G) (1) A PARTICIPATING EYE CARE PROVIDER MAY OFFER AN ENROLLEE THE OPPORTUNITY TO PAY THE PARTICIPATING EYE CARE PROVIDER DIRECTLY FOR COVERED SERVICES OR COVERED MATERIALS IF THE DIRECT PAYMENT WOULD BE LESS COSTLY TO THE ENROLLEE THAN THE TOTAL OUT–OF–POCKET COST REQUIRED UNDER THE TERMS OF THE HEALTH BENEFIT PLAN OR VISION BENEFIT PLAN.

(2) AN INSURER OR A VISION BENEFIT MANAGER MAY NOT SUBJECT A PARTICIPATING EYE CARE PROVIDER TO AN AUDIT, REMOVE THE PARTICIPATING EYE CARE PROVIDER FROM PARTICIPATION IN THE NETWORK, OR OTHERWISE PENALIZE OR DISCRIMINATE AGAINST A PARTICIPATING EYE CARE PROVIDER FOR OFFERING AN ENROLLEE THE OPPORTUNITY TO PAY THE PARTICIPATING EYE CARE PROVIDER DIRECTLY UNDER PARAGRAPH (1) OF THIS SUBSECTION.

(H) AN AGREEMENT BETWEEN AN INSURER OR A VISION BENEFIT MANAGER AND A PARTICIPATING EYE CARE PROVIDER MAY NOT REQUIRE THE PARTICIPATING EYE CARE PROVIDER TO ACCEPT A REIMBURSEMENT PAYMENT IN THE FORM OF A VIRTUAL CREDIT CARD OR A FORM OF PAYMENT IN WHICH A PROCESSING FEE, ADMINISTRATIVE FEE, PERCENTAGE AMOUNT, OR DOLLAR AMOUNT IS ASSESSED TO THE PROVIDER TO RECEIVE THE REIMBURSEMENT PAYMENT.

15–2206.

(A) THIS SECTION APPLIES TO AN AGREEMENT AN INSURER OR A VISION BENEFIT MANAGER ENTERS INTO WITH ANOTHER ENTITY TO PROVIDE AN ENROLLEE WITH COVERED SERVICES OR COVERED MATERIALS.

(B) AN AGREEMENT BETWEEN AN INSURER OR A VISION BENEFIT PLAN AND A PARTICIPATING EYE CARE PROVIDER MAY NOT REQUIRE THE PARTICIPATING EYE CARE PROVIDER TO PARTICIPATE IN, BE CREDENTIALED BY, OR ENTER INTO AN AGREEMENT WITH:

(1) A SPECIFIC VISION BENEFIT PLAN OR VISION BENEFIT DISCOUNT PLAN AS A CONDITION OF PARTICIPATION IN THE HEALTH BENEFIT PLAN PROVIDER NETWORK OF THE INSURER OR VISION BENEFIT MANAGER; OR

(2) A SPECIFIC HEALTH BENEFIT PLAN AS A CONDITION OF PARTICIPATION IN THE VISION BENEFIT PLAN OR VISION BENEFIT DISCOUNT PLAN PROVIDER NETWORK OF THE INSURER OR VISION BENEFIT MANAGER.

(C) AN INSURER OR A VISION BENEFIT MANAGER ISSUING OR RENEWING A HEALTH BENEFIT PLAN, VISION BENEFIT PLAN, OR VISION BENEFIT DISCOUNT PLAN THAT PROVIDES BENEFITS FOR COVERED SERVICES OR COVERED MATERIALS PROVIDED BY A PHYSICIAN OR THAT ARE WITHIN THE SCOPE OF PRACTICE OF AN OPTOMETRIST LICENSED UNDER TITLE 11 OF THE HEALTH OCCUPATIONS ARTICLE SHALL PROVIDE THE SAME REIMBURSEMENT FOR COVERED SERVICES AND COVERED MATERIALS TO OPTOMETRISTS AT THE SAME RATE AS THE COVERED SERVICES AND COVERED MATERIALS WHEN PROVIDED BY A PHYSICIAN.

(D) AN INSURER OR A VISION BENEFIT MANAGER SHALL APPLY THE SAME TERMS AND CONDITIONS OF PARTICIPATION FOR ALL PARTICIPATING EYE CARE PROVIDERS IRRESPECTIVE OF THE PARTICIPATING EYE CARE PROVIDER'S EDUCATIONAL CREDENTIALS.

(E) AN INSURER OR A VISION BENEFIT MANAGER MAY NOT REQUIRE A PARTICIPATING EYE CARE PROVIDER TO POSSESS, OFFER, OR SELL MATERIALS OR COVERED MATERIALS IN ITS OFFICE AS A CONDITION OF PARTICIPATION IN THE

PROVIDER NETWORK OF THE HEALTH BENEFIT PLAN, VISION BENEFIT PLAN, OR VISION BENEFIT DISCOUNT PLAN.

(F) (1) THIS SUBSECTION APPLIES TO ALL PLANS SOLD, ADMINISTERED, OR OFFERED BY A HEALTH BENEFIT PLAN, VISION BENEFIT PLAN, OR VISION BENEFIT DISCOUNT PLAN.

(2) AN INSURER OR A VISION BENEFIT MANAGER MAY NOT REQUIRE A PARTICIPATING EYE CARE PROVIDER TO PARTICIPATE IN THE NETWORK OF ANY OF THE INSURER'S OR VISION BENEFIT MANAGER'S OTHER HEALTH BENEFIT PLANS, VISION BENEFIT PLANS, OR VISION BENEFIT DISCOUNT PLANS, AS A CONDITION OF PARTICIPATION IN A NETWORK OF THE INSURER, VISION BENEFIT PLAN, OR VISION BENEFIT DISCOUNT PLAN.

(3) AN INSURER OR A VISION BENEFIT MANAGER MAY NOT WITHHOLD PARTICIPATION IN THE NETWORK OF ONE OR MORE OF THE INSURER'S OR VISION BENEFIT MANAGER'S OTHER HEALTH BENEFIT PLANS, VISION BENEFIT PLANS, OR VISION BENEFIT DISCOUNT PLANS FROM A PARTICIPATING EYE CARE PROVIDER WHO:

(I) HAS COMPLETED THE CREDENTIALING REQUIREMENTS OF THE INSURER OR VISION BENEFIT MANAGER; AND

(II) IS ALREADY PARTICIPATING IN ONE OR MORE OF THE INSURER'S OR VISION BENEFIT MANAGER'S HEALTH BENEFIT PLANS, VISION BENEFIT PLANS, OR VISION BENEFIT DISCOUNT PLANS.

15–2207.

(A) AN INSURER'S OR A VISION BENEFIT MANAGER'S APPLICATION FOR INCLUSION AND CREDENTIALING AS A PARTICIPATING EYE CARE PROVIDER IN A HEALTH BENEFIT PLAN, VISION BENEFIT PLAN, OR VISION BENEFIT DISCOUNT PLAN MAY REQUIRE ONLY:

(1) THE STANDARDIZED INFORMATION SPECIFIED IN § 15–112.1 OF THIS TITLE; OR

(2) INFORMATION SPECIFIED IN THE COUNCIL FOR AFFORDABLE QUALITY HEALTHCARE CREDENTIALING APPLICATION.

(B) AN INSURER OR A VISION BENEFIT MANAGER SHALL IMPOSE THE SAME APPLICATION AND CREDENTIALING REQUIREMENTS ON ALL PARTICIPATING EYE CARE PROVIDERS IN THE HEALTH BENEFIT PLAN, VISION BENEFIT PLAN, OR VISION

BENEFIT DISCOUNT PLAN.

(C) AN INSURER OR A VISION BENEFIT PLAN SHALL PROVIDE A PROPOSED PARTICIPATING PROVIDER AGREEMENT, INCLUDING APPLICABLE FEE SCHEDULES, PROVIDER HANDBOOKS, AND PROVIDER MANUALS, TO AN EYE CARE PROVIDER WITHIN 10 BUSINESS DAYS AFTER RECEIVING THE EYE CARE PROVIDER'S APPLICATION FOR INCLUSION AND CREDENTIALING AS A PARTICIPATING PROVIDER IN THE HEALTH BENEFIT PLAN, VISION BENEFIT PLAN, OR VISION BENEFIT DISCOUNT PLAN.

(D) (1) AN INSURER OR A VISION BENEFIT MANAGER SHALL COMPLETE THE CREDENTIALING DETERMINATION OF THE APPLICANT EYE CARE PROVIDER AND NOTIFY THE APPLICANT EYE CARE PROVIDER OF THE APPROVAL OR DENIAL OF AN EYE CARE PROVIDER'S APPLICATION FOR INCLUSION AND CREDENTIALING AS A PARTICIPATING PROVIDER IN THE HEALTH BENEFIT PLAN, VISION BENEFIT PLAN, OR VISION BENEFIT DISCOUNT PLAN WITHIN 30 BUSINESS DAYS AFTER RECEIVING THE APPLICATION.

(2) A NOTIFICATION OF AN APPROVAL PROVIDED UNDER PARAGRAPH (1) OF THIS SUBSECTION SHALL INCLUDE:

(I) A PROPOSED PROVIDER AGREEMENT FOR ACCEPTANCE AND SIGNATURE OF THE EYE CARE PROVIDER; AND

(II) THE NAME, TELEPHONE NUMBER, AND E–MAIL ADDRESS OF A REPRESENTATIVE OF THE INSURER OR VISION BENEFIT MANAGER TO PROVIDE THE EYE CARE PROVIDER WITH THE OPPORTUNITY TO:

1. CONTACT THE REPRESENTATIVE TO DISCUSS THE PROPOSED AGREEMENT BEFORE SIGNING; AND

2. ELECTRONICALLY SEND PROPOSED MODIFICATIONS TO THE PROPOSED AGREEMENT TO THE REPRESENTATIVE.

(3) AN INSURER OR A VISION BENEFIT MANAGER SHALL RESPOND TO A PROPOSED MODIFICATION SUBMITTED UNDER PARAGRAPH (2)(II)2 OF THIS SUBSECTION WITHIN 5 BUSINESS DAYS AFTER RECEIPT.

(4) (I) AN INSURER OR A VISION BENEFIT MANAGER SHALL PROVIDE AN APPROVED EYE CARE PROVIDER 90 BUSINESS DAYS TO EXECUTE THE PARTICIPATING PROVIDER AGREEMENT DELIVERED UNDER PARAGRAPH (2)(I) OF THIS SUBSECTION.

(II) IF AN APPROVED EYE CARE PROVIDER HAS NOT EXECUTED THE PARTICIPATING PROVIDER AGREEMENT DELIVERED UNDER PARAGRAPH (2)(I) OF THIS SUBSECTION WITHIN 90 BUSINESS DAYS AFTER RECEIPT, THE INSURER OR VISION BENEFIT MANAGER MAY RETRACT THE PARTICIPATING PROVIDER AGREEMENT.

(E) AN INSURER OR A VISION BENEFIT MANAGER SHALL ALLOW AN EYE CARE PROVIDER TO BECOME A PARTICIPATING EYE CARE PROVIDER IN THE HEALTH BENEFIT PLAN, VISION BENEFIT PLAN, OR VISION BENEFIT DISCOUNT PLAN IF:

(1) THE EYE CARE PROVIDER MEETS THE CREDENTIALING REQUIREMENTS OF THE INSURER OR VISION BENEFIT MANAGER; AND

(2) THE EYE CARE PROVIDER SIGNS THE APPLICABLE PROVIDER AGREEMENT.

(F) AN INSURER OR A VISION BENEFIT MANAGER MAY NOT EXCLUDE AN EYE CARE PROVIDER FROM APPLYING TO BECOME OR FROM BECOMING A PARTICIPATING PROVIDER IN THE NETWORK OF A HEALTH BENEFIT PLAN, VISION BENEFIT PLAN, OR VISION BENEFIT DISCOUNT PLAN BASED ON:

(1) THE AGGREGATE NUMBER OF EYE CARE PROVIDERS IN THE STATE, OR A COUNTY, CITY, ZIP CODE, OR OTHER GEOGRAPHICALLY DEFINED SERVICE AREA;

(2) THE TIME, DISTANCE, OR APPOINTMENT AVAILABILITY FOR AN ENROLLEE TO ACCESS A PARTICIPATING EYE CARE PROVIDER; OR

(3) THE EYE CARE PROVIDER'S PROFESSIONAL DESIGNATION, INDEPENDENT PRACTICE AFFILIATION, OR PARTICIPATION IN OTHER HEALTH BENEFIT PLANS, VISION BENEFIT PLANS, OR VISION BENEFIT DISCOUNT PLANS.

(G) WITHIN 20 DAYS AFTER THE EXECUTION OF A PARTICIPATING PROVIDER AGREEMENT, AN INSURER OR A VISION BENEFIT MANAGER SHALL:

(1) INCLUDE THE PARTICIPATING EYE CARE PROVIDER AS A PARTICIPATING PROVIDER IN THE HEALTH BENEFIT PLAN, VISION BENEFIT PLAN, OR VISION BENEFIT DISCOUNT PLAN; AND

(2) LIST THE PARTICIPATING EYE CARE PROVIDER IN ALL PLAN DIRECTORIES AVAILABLE TO ENROLLEES AND THE PUBLIC.

(H) (1) IF AN INSURER OR A VISION BENEFIT MANAGER DENIES AN EYE

CARE PROVIDER'S APPLICATION FOR INCLUSION AND CREDENTIALING AS A PARTICIPATING PROVIDER IN A HEALTH BENEFIT PLAN, VISION BENEFIT PLAN, OR VISION BENEFIT DISCOUNT PLAN, THE INSURER OR VISION BENEFIT MANAGER SHALL DELIVER A DETAILED EXPLANATION FOR THE DENIAL TO THE APPLICANT EYE CARE PROVIDER ELECTRONICALLY AND IN WRITING BY CERTIFIED MAIL.

(2) (I) AN INSURER OR A VISION BENEFIT MANAGER SHALL ALLOW AN EYE CARE PROVIDER TO APPEAL A DENIAL OF AN APPLICATION FOR INCLUSION AND CREDENTIALING AS A PARTICIPATING PROVIDER WITHIN A REASONABLE PERIOD OF TIME.

(II) AN INSURER OR A VISION BENEFIT MANAGER SHALL RENDER A DECISION ON AN APPEAL FILED UNDER SUBPARAGRAPH (I) OF THIS PARAGRAPH WITHIN 30 DAYS AFTER THE INSURER'S OR VISION BENEFIT MANAGER'S RECEIPT OF THE REQUEST FOR THE APPEAL.

(3) IF AN APPEAL FILED UNDER PARAGRAPH (2) OF THIS SUBSECTION IS DENIED BY THE INSURER OR VISION BENEFIT MANAGER:

(I) THE INSURER OR VISION BENEFIT MANAGER SHALL DELIVER A DETAILED EXPLANATION FOR THE DENIAL TO THE APPLICANT EYE CARE PROVIDER ELECTRONICALLY AND IN WRITING BY CERTIFIED MAIL; AND

(II) THE EYE CARE PROVIDER MAY APPEAL THE DECISION TO THE ADMINISTRATION.

(I) AN EYE CARE PROVIDER MAY NOT SUBMIT ANOTHER APPLICATION FOR INCLUSION AND CREDENTIALING AS A PARTICIPATING PROVIDER WITHIN 180 DAYS AFTER THE EYE CARE PROVIDER'S MOST RECENT APPLICATION FOR INCLUSION AND CREDENTIALING AS A PARTICIPATING PROVIDER IN THE SAME HEALTH BENEFIT PLAN, VISION BENEFIT PLAN, OR VISION BENEFIT DISCOUNT PLAN WAS:

(1) DENIED; OR

(2) APPROVED BUT A PARTICIPATING PROVIDER AGREEMENT WAS NOT EXECUTED.

(J) AN INSURER OR A VISION BENEFIT MANAGER:

(1) SHALL MAINTAIN A PROVIDER AGREEMENT AS A DISTINCT AND SEPARATE DOCUMENT FROM ANY CREDENTIALING MATERIALS; AND

(2) MAY NOT CONSTRUE RECREDENTIALING AS RECONTRACTING

WITH A PARTICIPATING EYE CARE PROVIDER.

15–2208.

(A) (1) AT LEAST 90 DAYS BEFORE THE EFFECTIVE DATE OF AN ALTERATION TO A PROVIDER AGREEMENT OR A PROVIDER MANUAL INCORPORATED BY REFERENCE INTO A PROVIDER AGREEMENT, AN INSURER OR A VISION BENEFIT MANAGER SHALL:

(I) PROVIDE NOTICE TO THE PARTICIPATING EYE CARE PROVIDER OF THE PROPOSED CHANGE; AND

(II) IF REQUESTED BY THE PARTICIPATING EYE CARE PROVIDER, DISCUSS THE PROPOSED CHANGES IN A FACE–TO–FACE OR VIRTUAL MEETING WITH THE PARTICIPATING EYE CARE PROVIDER.

(2) THE NOTICE REQUIRED UNDER PARAGRAPH (1) OF THIS SUBSECTION SHALL:

(I) CONTAIN A COVER LETTER ENUMERATING THE PROPOSED CHANGES;

(II) CONTAIN A COPY OF THE AMENDED DOCUMENT WITH THE CHANGES CLEARLY MARKED; AND

(III) BE STRUCTURED TO INCLUDE IMPLICATIONS OF THE AGREEMENT OR NONAGREEMENT TO THE PROPOSED CHANGES BY THE PARTICIPATING EYE CARE PROVIDER.

(3) IF A PARTICIPATING EYE CARE PROVIDER DOES NOT PROVIDE WRITTEN APPROVAL OF PROPOSED CHANGES PROVIDED UNDER PARAGRAPH (1) OF THIS SUBSECTION WITHIN 90 DAYS AFTER THE PROPOSED EFFECTIVE DATE:

(I) THE EXISTING PROVIDER AGREEMENT SHALL REMAIN IN FORCE BETWEEN THE PARTIES; AND

(II) THE INSURER OR VISION BENEFIT MANAGER MAY NOT REMOVE THE PARTICIPATING EYE CARE PROVIDER FROM PARTICIPATION IN THE HEALTH BENEFIT PLAN, VISION BENEFIT PLAN, OR VISION BENEFIT DISCOUNT PLAN BASED ON THE PARTICIPATING EYE CARE PROVIDER'S FAILURE TO APPROVE THE PROPOSED CHANGES.

(B) A PROVIDER AGREEMENT MAY NOT BE TERMINATED BY THE INSURER

OR VISION BENEFIT MANAGER UNLESS:

(1) THE PARTICIPATING EYE CARE PROVIDER HAS COMMITTED A MATERIAL BREACH;

(2) THE INSURER OR VISION BENEFIT MANAGER PROVIDES THE PARTICIPATING EYE CARE PROVIDER WITH WRITTEN NOTICE SPECIFYING THE ALLEGED BREACH; AND

(3) THE PARTICIPATING EYE CARE PROVIDER FAILS TO REMEDY THE ALLEGED BREACH TO THE REASONABLE SATISFACTION OF THE INSURER OR VISION BENEFIT MANAGER WITHIN 30 DAYS AFTER NOTIFICATION OF THE ALLEGED BREACH.

(C) AN INSURER OR A VISION BENEFIT MANAGER MAY NOT REQUIRE A PARTICIPATING EYE CARE PROVIDER TO ESTABLISH A SECURITY INTEREST IN ALL OR PART OF ITS PROPERTY AND ASSETS IN A SUM EQUIVALENT TO FUNDS OWED TO THE INSURER OR VISION BENEFIT MANAGER AT TERMINATION.

(D) A PROVIDER AGREEMENT BETWEEN AN INSURER OR A VISION BENEFIT MANAGER AND A PARTICIPATING EYE CARE PROVIDER SHALL SPECIFY THAT EACH PARTY SHALL BE RESPONSIBLE FOR ITS OWN ARBITRATION COSTS, CONTINGENT ON A FEE–SHIFTING PROVISION THAT GRANTS PREVAILING PARTY STATUS.

(E) (1) AN INSURER OR A VISION BENEFIT MANAGER MAY NOT RETALIATE AGAINST AN EYE CARE PROVIDER FOR:

(I) DISCUSSING, OR ATTEMPTING IN GOOD FAITH TO NEGOTIATE, THE TERMS OF A PROVIDER AGREEMENT WITH THE INSURER OR VISION BENEFIT MANAGER; OR

(II) FILING A COMPLAINT AGAINST THE INSURER OR VISION BENEFIT MANAGER WITH ANY STATE AGENCY WITH REGULATORY AUTHORITY OVER THE INSURER OR VISION BENEFIT MANAGER.

(2) THE COMMISSIONER MAY IMPOSE PENALTIES AGAINST AN INSURER OR A VISION BENEFIT MANAGER FOR A VIOLATION OF THIS SUBSECTION.

15–2209.

(A) AN INSURER OR A VISION BENEFIT MANAGER MAY NOT:

(1) CONTROL OR ATTEMPT TO CONTROL THE PROFESSIONAL

JUDGMENT, MANNER OF PRACTICE, OR PRACTICE OF A PARTICIPATING EYE CARE PROVIDER;

(2) EMPLOY A PARTICIPATING EYE CARE PROVIDER TO PROVIDE A COVERED SERVICE OR COVERED MATERIAL;

(3) RESTRICT, LIMIT, OR INFLUENCE A PARTICIPATING EYE CARE PROVIDER'S CHOICE OF ELECTRONIC HEALTH RECORD SOFTWARE, ELECTRONIC MEDICAL RECORD SOFTWARE, PRACTICE MANAGEMENT SOFTWARE, OR THIRD–PARTY CLAIM FILING SERVICE, BILLING SERVICE, OR ELECTRONIC DATA INTERCHANGE CLEARINGHOUSE COMPANY;

(4) RESTRICT, LIMIT, OR INFLUENCE A PARTICIPATING EYE CARE PROVIDER'S CHOICE OF SOURCES OR SUPPLIERS OF SERVICES OR MATERIALS, INCLUDING OPTICAL LABORATORIES, USED BY THE PARTICIPATING EYE CARE PROVIDER TO PROVIDE SERVICES OR MATERIALS TO THE ENROLLEE;

(5) RESTRICT OR LIMIT A PARTICIPATING EYE CARE PROVIDER'S ACCESS TO AN ENROLLEE'S COMPLETE PLAN COVERAGE INFORMATION, INCLUDING IN–NETWORK AND OUT–OF–NETWORK COVERAGE DETAILS;

(6) APPLY A CHARGEBACK TO AN ENROLLEE OR EYE CARE PROVIDER FOR A COVERED PRODUCT OR SERVICE FOR WHICH THE INSURER OR VISION BENEFIT MANAGER DOES NOT INCUR THE COST TO PRODUCE, DELIVER, OR PROVIDE TO THE ENROLLEE OR PARTICIPATING EYE CARE PROVIDER;

(7) SOLICIT PATIENTS OR REFERRALS FOR SUPPLIES ON BEHALF OF THE INSURER OR VISION BENEFIT PLAN OR ITS AFFILIATES BY IDENTIFYING PARTICIPATING EYE CARE PROVIDERS IN AN INACCURATE OR MISLEADING MANNER IN ANY LIST OF PARTICIPATING PROVIDERS OR ANY COMMUNICATIONS TO PURCHASERS OR ENROLLEES;

(8) FALSELY REPRESENT THE NUMBER OF PARTICIPATING EYE CARE PROVIDERS IN A REGION;

(9) FALSELY REPRESENT THE BENEFITS THAT CONSTITUTE A HEALTH BENEFIT PLAN, VISION BENEFIT PLAN, OR VISION BENEFIT DISCOUNT PLAN TO CLIENTS, GROUPS, PURCHASERS, COMPANIES, ENROLLEES, OR PROSPECTIVE ENROLLEES;

(10) STATE IN ANY MARKETING OR ADVERTISING FOR A HEALTH BENEFIT PLAN, VISION BENEFIT PLAN, OR VISION BENEFIT DISCOUNT PLAN THAT A COVERED SERVICE OR COVERED MATERIAL IS "FREE", "NO CHARGE",

"COMPLIMENTARY", OR ANY SIMILAR LANGUAGE TO INDUCE A CLIENT, A GROUP, AN EMPLOYER, A PURCHASER, A COMPANY, AN ENROLLEE, OR A PROSPECTIVE ENROLLEE TO PURCHASE SERVICES FROM THE INSURER, VISION BENEFIT MANAGER, OR AFFILIATE OF THE INSURER OR VISION BENEFIT MANAGER;

(11) OFFER ENROLLEES OF A HEALTH BENEFIT PLAN, VISION BENEFIT PLAN, OR VISION BENEFIT DISCOUNT PLAN VARYING DEDUCTIBLES, COPAYS, COINSURANCE, COVERAGE AMOUNTS, REBATES, GIFT CARDS, OR OTHER INCENTIVES TO OBTAIN SERVICES OR MATERIALS FROM:

(I) A PARTICULAR EYE CARE PROVIDER; OR

(II) A RETAIL ESTABLISHMENT OR INTERNET OR VIRTUAL PROVIDER OR RETAILER OWNED BY, PARTIALLY OWNED BY, CONTRACTED WITH, OR OTHERWISE AFFILIATED WITH THE INSURER OR VISION BENEFIT MANAGER; OR

(12) REQUIRE AN EYE CARE PROVIDER TO DISCLOSE OR REPORT:

(I) AN ENROLLEE'S CONFIDENTIAL OR PROTECTED HEALTH INFORMATION UNLESS THE DISCLOSURE IS EXPRESSLY AUTHORIZED BY THE ENROLLEE OR PERMITTED WITHOUT AUTHORIZATION UNDER THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996;

(II) AN ENROLLEE'S MEDICAL HISTORY OR DIAGNOSIS AS A CONDITION TO FILE A CLAIM, ADJUDICATE A CLAIM, OR RECEIVE REIMBURSEMENT FOR A ROUTINE OR WELLNESS EYE EXAM; OR

(III) UNLESS THE INFORMATION IS NEEDED BY THE INSURER OR VISION BENEFIT MANAGER TO AID IN THE MANUFACTURE OF A COVERED PRODUCT OR COVERED MATERIAL SUBMITTED ON THE APPLICABLE CLAIM:

1. AN ENROLLEE'S GLASSES OR CONTACT LENS PRESCRIPTION, OPHTHALMIC DEVICE MEASUREMENT, OR FACIAL PHOTOGRAPH; OR

2. ANY ENROLLEE INFORMATION OTHER THAN INFORMATION IDENTIFIED IN THE CURRENT APPLICABLE VERSION OF THE HEALTH INSURANCE CLAIM FORM APPROVED BY THE NATIONAL UNIFORM CLAIM COMMITTEE AS A CONDITION TO ADJUDICATE A CLAIM, FILE A CLAIM, OR RECEIVE REIMBURSEMENT.

(B) A COMMUNICATION FROM AN INSURER OR A VISION BENEFIT MANAGER THAT DISTINGUISHES BETWEEN EYE CARE PROVIDERS OR THAT OTHERWISE CLAIMS PROFESSIONAL SUPERIORITY OR THE PERFORMANCE OF A SERVICE IN A SUPERIOR

MANNER SHALL BE SUBJECT TO VERIFICATION BY THE ADMINISTRATION IF THE COMMUNICATION REFERENCES:

(1) A DISCOUNT OR AN INCENTIVE OFFERED BY A PARTICIPATING EYE CARE PROVIDER ON NONCOVERED SERVICES OR NONCOVERED MATERIALS;

(2) THE DOLLAR AMOUNT, VOLUME AMOUNT, OR PERCENTAGE USAGE AMOUNT OF ANY MATERIAL, PRODUCT, OR GOOD PURCHASED BY A PARTICIPATING EYE CARE PROVIDER; OR

(3) THE BRAND, SOURCE, MANUFACTURER, OR SUPPLIER OF A COVERED SERVICE OR COVERED MATERIAL UTILIZED BY A PARTICIPATING EYE CARE PROVIDER.

(C) THIS SECTION MAY NOT BE CONSTRUED TO LIMIT OR PROHIBIT ADVERTISEMENTS THAT DO NOT OTHERWISE VIOLATE THIS SUBTITLE OR TITLE 13 OF THE COMMERCIAL LAW ARTICLE.

15–2210.

(A) AN INSURER OR A VISION BENEFIT MANAGER MAY NOT USE EXTRAPOLATION TO COMPLETE AN AUDIT OF A PARTICIPATING EYE CARE PROVIDER.

(B) ANY ADDITIONAL PAYMENT DUE TO A PARTICIPATING EYE CARE PROVIDER OR ANY REFUND DUE TO AN INSURER OR A VISION BENEFIT MANAGER SHALL BE BASED ON THE ACTUAL OVERPAYMENT OR UNDERPAYMENT AS DETERMINED AFTER AN INVESTIGATION BY THE INSURER OR VISION BENEFIT MANAGER.

(C) AN INVESTIGATION CONDUCTED UNDER SUBSECTION (B) OF THIS SECTION MAY NOT CONCLUDE UNTIL THE PARTICIPATING EYE CARE PROVIDER WHO IS SUBJECT TO THE INVESTIGATION HAS EXHAUSTED ALL OPPORTUNITIES TO APPEAL THE INSURER'S OR VISION BENEFIT MANAGER'S FINDINGS UNDER THE PROVIDER MANUAL OR POLICY DOCUMENT AND ANY APPLICABLE LAWS.

15–2211.

(A) SUBJECT TO SUBSECTION (B) OF THIS SECTION, AN EYE CARE PROVIDER ADVERSELY AFFECTED BY A VIOLATION OF THIS SUBTITLE MAY BRING AN ACTION FOR INJUNCTIVE RELIEF AND TO RECOVER MONETARY DAMAGES INCLUDING DIRECT, INDIRECT, COMPENSATORY, AND PUNITIVE DAMAGES PLUS ATTORNEY'S FEES AND COSTS.

(B) DAMAGES AWARDED IN AN ACTION BROUGHT UNDER SUBSECTION (A) OF THIS SECTION MAY NOT EXCEED $10,000 PER VIOLATION.

15–2212.

(A) AN INSURER OR A VISION BENEFIT MANAGER MAY NOT REQUIRE A PARTICIPATING EYE CARE PROVIDER TO OPT INTO OR OPT OUT OF THE PROVISIONS OF THIS SUBTITLE.

(B) ANY SUBCONTRACT AGREEMENT BETWEEN A PARTICIPATING EYE CARE PROVIDER AND ANOTHER PROVIDER TO PROVIDE LICENSED HEALTH CARE SERVICES TO AN ENROLLEE OR COVERED DEPENDENT OF AN ENROLLEE OF A HEALTH BENEFIT PLAN, VISION BENEFIT PLAN, OR VISION BENEFIT DISCOUNT PLAN IN WHICH THE SUBCONTRACTED PROVIDER WILL SEEK REIMBURSEMENT FROM THE PLAN OR THE ENROLLEE FOR THE SUBCONTRACTED SERVICES SHALL MEET THE REQUIREMENTS OF THIS SUBTITLE.

(C) ANY CONTRACTUAL LANGUAGE THAT VIOLATES THIS SUBTITLE SHALL BE VOID AND UNENFORCEABLE AS A MATTER OF LAW.

15–2213.

THE COMMISSIONER SHALL ADOPT REGULATIONS TO:

(1) PROVIDE A MECHANISM FOR AGGRIEVED INDIVIDUALS TO SUBMIT COMPLAINTS TO THE COMMISSIONER FOR REVIEW, INVESTIGATION, AND DISCIPLINE, AS APPROPRIATE; AND

(2) ENSURE THAT INSURERS AND VISION BENEFIT MANAGERS COMPLY WITH THE REQUIREMENTS OF THIS SUBTITLE.

SECTION 2. AND BE IT FURTHER ENACTED, That this Act shall apply to all policies, contracts, and health benefit plans issued, delivered, or renewed in the State on or after January 1, 2027.

SECTION 3. AND BE IT FURTHER ENACTED, That this Act shall take effect January 1, 2027.