SENATE COMMITTEE SUBSTITUTE

FOR

SENATE BILL NO. 1180

AN ACT

To repeal section 376.427, RSMo, and to enact in lieu thereof one new section relating to prepaid dental plans.

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

Section A. Section 376.427, RSMo, is repealed and one new section enacted in lieu thereof, to be known as section 376.427, to read as follows:

376.427. 1. As used in this section, the following terms mean:

(1) "Health benefit plan", as such term is defined in section 376.1350. The term "health benefit plan" shall also include a prepaid dental plan, as defined in section 354.700;

(2) "Health care services", medical, surgical, dental, podiatric, pharmaceutical, chiropractic, licensed ambulance service, and optometric services;

(3) "Health carrier" or "carrier", as such term is defined in section 376.1350. The term "health carrier" or "carrier" shall also include a prepaid dental plan corporation, as defined in section 354.700;

(4) "Insured", any person entitled to benefits under a contract of accident and sickness insurance, or medical-payment insurance issued as a supplement to liability insurance but not including any other coverages contained in a liability or a workers' compensation policy, issued by an insurer;

(5) "Insurer", any person, reciprocal exchange, interinsurer, fraternal benefit society, health services corporation, self-insured group arrangement to the extent

not prohibited by federal law, prepaid dental plan corporation as defined in section 354.700, or any other legal entity engaged in the business of insurance;

(6) "Provider", a physician, hospital, dentist, podiatrist, chiropractor, pharmacy, licensed ambulance service, or optometrist, licensed by this state.

2. Upon receipt of an assignment of benefits made by the insured to a provider, the insurer shall issue the instrument of payment for a claim for payment for health care services in the name of the provider. All claims shall be paid within thirty days of the receipt by the insurer of all documents reasonably needed to determine the claim.

3. Nothing in this section shall preclude an insurer from voluntarily issuing an instrument of payment in the single name of the provider.

4. Except as provided in subsection 5 of this section, this section shall not require any insurer, health services corporation, health maintenance corporation, prepaid dental plan corporation as defined in section 354.700, or preferred provider organization which directly contracts with certain members of a class of providers for the delivery of health care services to issue payment as provided pursuant to this section to those members of the class which do not have a contract with the insurer.

5. When a patient's health benefit plan does not include or require payment to out-of-network providers for all or most covered services, which would otherwise be covered if the patient received such services from a provider in the **[**carrier's**]** health benefit plan's network, including but not limited to health maintenance organization plans, as such term is defined in section 354.400, or a health benefit plan offered by a carrier consistent with subdivision (19) of section 376.426, payment for all

services shall be made directly to the providers when the health carrier has authorized such services to be received from a provider outside the **[**carrier's**]** health benefit plan's network.