HOUSE OF REPRESENTATIVES

KENTUCKY GENERAL ASSEMBLY AMENDMENT FORM

2025 REGULAR SESSION

Amend printed copy of **HB 210/HCS 1**

Starting on page 1, line 3, to page 3, line 11, delete Section 1 in its entirety and insert in lieu thereof the following:

"➔SECTION 1. A NEW SECTION OF SUBTITLE 17C OF KRS CHAPTER 304 IS CREATED TO READ AS FOLLOWS:

(1) As used in this section:

(a) "Covered person" means an individual who is covered by a dental, vision, or hearing benefit plan;

(b) "Dental, vision, or hearing benefit plan" means a limited health service benefit plan that provides coverage for dental, vision, or hearing services;

(c) "Dental, vision, or hearing services":

1. Means services for the diagnosis, prevention, treatment, or cure of a dental, vision, or hearing condition, illness, injury, or disease; and

2. Does not include services delivered by a provider that are billed as medical expenses under a health insurance plan; and

(d) "Provider":

1. Means an individual or entity, acting within the scope of the individual or entity's licensure or certification, that provides dental, vision, or hearing services or supplies defined by the dental, vision, or hearing benefit plan; and

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Amendment No. HFA Rep. Rep. Deanna Gordon

Committee Amendment Signed:

Floor Amendment LRC Drafter:

Adopted: Date:

Rejected: Doc. ID: XXXX

2. Does not include a physician organization or physician hospital organization that leases or rents its network to a third party.

(2) (a) An insurer providing coverage under a dental, vision, or hearing benefit plan shall honor a written assignment of benefits due under the plan that is:

1. Made:

a. By a covered person to a provider for dental, vision, or hearing services provided to the covered person; and

b. On a form established by the commissioner in an administrative regulation promulgated in accordance with KRS Chapter 13A and subsection (3) of this section; and

2. Signed by the covered person and the provider.

(b) A provider with a valid assignment under paragraph (a) of this subsection shall provide the following to the insurer when submitting a request for payment pursuant to the assignment:

1. A copy of the dually signed assignment; and

2. Any information or documentation necessary for verifying coverage, or required for claims processing, under the dental, vision, or hearing benefit plan.

(c) 1. Upon a provider's compliance with paragraph (b) of this subsection, the insurer shall make payments for covered services directly to the provider.

2. A payment made to a provider under subparagraph 1. of this paragraph shall be made according to the same criteria and payment schedule under which the insurer would have been required to make the payment to the covered person if the benefits due under the plan had not been assigned.

(3) The form established by the commissioner under subsection (2)(a)1.b. of this section

shall include a notice informing the covered person that:

(a) The provider, as applicable:

1. Is an out-of-network provider;

2. May charge the covered person for noncovered services; and

3. May charge the covered person for any portion of the cost of a covered service that is not reimbursed under the dental, vision, or hearing benefit plan;

(b) Any assignment of benefits is optional; and

(c) If the covered person has accrued a credit balance on his or her account, the provider shall:

1. Notify the covered person of the credit balance with the provider within thirty (30) days; and

2. a. Except as provided in subdivision b. of this subparagraph, refund any credit balance that has accrued on the covered person's account with the provider within thirty (30) days of receiving a request for refund from the covered person; and

b. If, under the assignment, the provider collects payment from the covered person and subsequently receives payment from the insurer, refund the covered person within thirty (30) days of receiving the payment from the insurer unless the provider and covered person agree otherwise in writing.

(4) (a) An assignment of benefits may be revoked by the covered person, with or without the consent of the provider, by submitting the revocation, in writing, to the insurer.

(b) An insurer that receives a revocation referenced in paragraph (a) of this subsection shall promptly send a dated and time-stamped copy of the revocation to the provider.

(c) A revocation made in accordance with this subsection shall:

1. Become effective when the insurer receives a copy of the revocation; and

2. Only be effective for any charges incurred on or after the effective date established under subparagraph 1. of this paragraph.

(5) This section shall not be construed to limit an insurer's ability to:

(a) Determine the scope of a dental, vision, or hearing benefit plan's benefits, services, or other terms that are not in conflict with this section; or

(b) Negotiate any contract with a provider regarding reimbursement rates or any other lawful provisions that are not in conflict with this section.".