

**Sec. 38a-472h. Fees charged by dentists and optometrists for noncovered benefits.**

**Notice and posting required.** (a) No insurer, health care center, fraternal benefit society, hospital service corporation, medical service corporation or other entity delivering, issuing for delivery, renewing, amending or continuing:

(1) An individual or a group dental plan in this state shall include in any contract with a dentist licensed pursuant to chapter 379 that is entered into, renewed or amended on or after January 1, 2012, any provision that requires such dentist to accept as payment an amount set by such insurer, center, society, corporation or entity for services or procedures provided to an insured or enrollee that are not covered benefits under such insured's or enrollee's plan; or

(2) An individual or a group vision plan in this state shall include in any contract with an optometrist licensed pursuant to chapter 380 that is entered into, renewed or amended on or after January 1, 2016, any provision that requires such optometrist to accept as payment an amount set by such insurer, center, society, corporation or entity for services or procedures provided to an insured or enrollee that are not covered benefits under such insured's or enrollee's plan.

(b) No dentist or optometrist shall charge more for services or procedures that are not covered benefits than such dentist's or optometrist's usual and customary rate for such services or procedures.

(c) (1) Each evidence of coverage for an individual or a group dental plan shall include the following statement:

“IMPORTANT: If you opt to receive dental services or procedures that are not covered benefits under this plan, a participating dental provider may charge you his or her usual and customary rate for such services or procedures. Prior to providing you with dental services or procedures that are not covered benefits, the dental provider should provide you with a treatment plan that includes each anticipated service or procedure to be provided and the estimated cost of each such service or procedure. To fully understand your coverage, you may wish to review your evidence of coverage document.”

(2) Each evidence of coverage for an individual or a group vision plan shall include the following statement:

“IMPORTANT: If you opt to receive optometric services or procedures that are not covered benefits under this plan, a participating optometrist may charge you his or her usual and customary rate for such services or procedures. Prior to providing you with optometric services or procedures that are not covered benefits, the optometrist should

provide you with a treatment plan that includes each anticipated service or procedure to be provided and the estimated cost of each such service or procedure. To fully understand your coverage, you may wish to review your evidence of coverage document.”

(d) Each dentist and optometrist shall post, in a conspicuous place, a notice stating that services or procedures that are not covered benefits under an insurance policy or plan might not be offered at a discounted rate.

(e) The provisions of this section shall not apply to (1) a self-insured plan that covers dental services or optometric services, or (2) a contract that is incorporated in or derived from a collective bargaining agreement or in which some or all of the material terms are subject to a collective bargaining process.