Amendment No. **AM_135_1833**

Sub. S. B. No. 40

As Passed by the Senate

_________________________ moved to amend as follows:

In line 1 of the title, after "To" insert "amend sections 1751.85, 1753.09, 3901.21, 3923.86, 3963.01, 3963.02, 3963.03, and 4715.30 and to"

In line 3 of the title, after "Compact" insert "and to address limitations imposed by health insurers on dental care services"

In line 4, after "That" insert "sections 1751.85, 1753.09, 3901.21, 3923.86, 3963.01, 3963.02, 3963.03, and 4715.30 be amended and"

After line 5, insert:

"**Sec. 1751.85.** (A) As used in this section, "covered dental services," "covered vision services," "dental care provider," "vision care materials," and "vision care provider" have the same meanings as in section 3963.01 of the Revised Code.

(B) A health insuring corporation shall provide the information required in this division to all enrollees receiving coverage under an individual or group health insuring corporation policy, contract, or agreement ~~providing coverage~~ for vision care services ~~or~~, vision care materials, or dental

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care services. The information shall be in a conspicuous format, shall be easily accessible to enrollees, and shall do all of the following: 18 19 20

(1) ~~Include~~ For vision care coverage, include the following statement: 21 22

"IMPORTANT: If you opt to receive vision care services or vision care materials that are not covered benefits under this plan, a participating vision care provider may charge you his or her normal fee for such services or materials. Prior to providing you with vision care services or vision care materials that are not covered benefits, the vision care provider will provide you with an estimated cost for each service or material upon your request." 23 24 25 26 27 28 29 30

(2) For dental care coverage, include the following statement: 31 32

"IMPORTANT: If you opt to receive dental care services that are not covered benefits under this plan, a participating dental care provider may charge you his or her normal fee for such services. Prior to providing you with dental care services that are not covered benefits, the dental care provider will provide you with an estimated cost for each service." 33 34 35 36 37 38

(3) Disclose any business interest the health insuring corporation has in a source or supplier of vision care materials; 39 40 41

~~(3)~~ (4) Include an explanation that the enrollee may incur out-of-pocket expenses as a result of the purchase of vision care services ~~or~~, vision care materials, or dental care services that are not covered ~~vision services~~. The explanation shall be communicated in a manner and format similar to how the health 42 43 44 45 46

insuring corporation provides an enrollee with information on coverage levels and out-of-pocket expenses that may be incurred by the enrollee under the policy, contract, or agreement when purchasing out-of-network vision care services ~~or~~, vision care materials, or dental care services.

(C) A pattern of continuous or repeated violations of this section is an unfair and deceptive act or practice in the business of insurance under sections 3901.19 to 3901.26 of the Revised Code.

Sec. 1753.09. (A) Except as provided in division (D) of this section, prior to terminating the participation of a provider on the basis of the participating provider's failure to meet the health insuring corporation's standards for quality or utilization in the delivery of health care services, a health insuring corporation shall give the participating provider notice of the reason or reasons for its decision to terminate the provider's participation and an opportunity to take corrective action. The health insuring corporation shall develop a performance improvement plan in conjunction with the participating provider. If after being afforded the opportunity to comply with the performance improvement plan, the participating provider fails to do so, the health insuring corporation may terminate the participation of the provider.

(B)(1) A participating provider whose participation has been terminated under division (A) of this section may appeal the termination to the appropriate medical director of the health insuring corporation. The medical director shall give the participating provider an opportunity to discuss with the medical director the reason or reasons for the termination.

(2) If a satisfactory resolution of a participating

provider's appeal cannot be reached under division (B)(1) of this section, the participating provider may appeal the termination to a panel composed of participating providers who have comparable or higher levels of education and training than the participating provider making the appeal. A representative of the participating provider's specialty shall be a member of the panel, if possible. This panel shall hold a hearing, and shall render its recommendation in the appeal within thirty days after holding the hearing. The recommendation shall be presented to the medical director and to the participating provider. 77 78 79 80 81 82 83 84 85 86

(3) The medical director shall review and consider the panel's recommendation before making a decision. The decision rendered by the medical director shall be final. 87 88 89

(C) A provider's status as a participating provider shall remain in effect during the appeal process set forth in division (B) of this section unless the termination was based on any of the reasons listed in division (D) of this section. 90 91 92 93

(D) Notwithstanding division (A) of this section, a provider's participation may be immediately terminated if the participating provider's conduct presents an imminent risk of harm to an enrollee or enrollees; or if there has occurred unacceptable quality of care, fraud, patient abuse, loss of clinical privileges, loss of professional liability coverage, incompetence, or loss of authority to practice in the participating provider's field; or if a governmental action has impaired the participating provider's ability to practice. 94 95 96 97 98 99 100 101 102

(E) Divisions (A) to (D) of this section apply only to providers who are natural persons. 103 104

(F)(1) Nothing in this section prohibits a health insuring 105

corporation from rejecting a provider's application for 106
participation, or from terminating a participating provider's 107
contract, if the health insuring corporation determines that the 108
health care needs of its enrollees are being met and no need 109
exists for the provider's or participating provider's services. 110

(2) Nothing in this section shall be construed as 111
prohibiting a health insuring corporation from terminating a 112
participating provider who does not meet the terms and 113
conditions of the participating provider's contract. 114

(3) Nothing in this section shall be construed as 115
prohibiting a health insuring corporation from terminating a 116
participating provider's contract pursuant to any provision of 117
the contract described in division ~~(F)(2)~~ (G)(2) of section 118
3963.02 of the Revised Code, except that, notwithstanding any 119
provision of a contract described in that division, this section 120
applies to the termination of a participating provider's 121
contract for any of the causes described in divisions (A), (D), 122
and (F)(1) and (2) of this section. 123

(G) The superintendent of insurance may adopt rules as 124
necessary to implement and enforce sections 1753.06, 1753.07, 125
and 1753.09 of the Revised Code. Such rules shall be adopted in 126
accordance with Chapter 119. of the Revised Code. 127

Sec. 3901.21. The following are hereby defined as unfair 128
and deceptive acts or practices in the business of insurance: 129

(A) Making, issuing, circulating, or causing or permitting 130
to be made, issued, or circulated, or preparing with intent to 131
so use, any estimate, illustration, circular, or statement 132
misrepresenting the terms of any policy issued or to be issued 133
or the benefits or advantages promised thereby or the dividends 134

or share of the surplus to be received thereon, or making any false or misleading statements as to the dividends or share of surplus previously paid on similar policies, or making any misleading representation or any misrepresentation as to the financial condition of any insurer as shown by the last preceding verified statement made by it to the insurance department of this state, or as to the legal reserve system upon which any life insurer operates, or using any name or title of any policy or class of policies misrepresenting the true nature thereof, or making any misrepresentation or incomplete comparison to any person for the purpose of inducing or tending to induce such person to purchase, amend, lapse, forfeit, change, or surrender insurance. 135 136 137 138 139 140 141 142 143 144 145 146 147

Any written statement concerning the premiums for a policy which refers to the net cost after credit for an assumed dividend, without an accurate written statement of the gross premiums, cash values, and dividends based on the insurer's current dividend scale, which are used to compute the net cost for such policy, and a prominent warning that the rate of dividend is not guaranteed, is a misrepresentation for the purposes of this division. 148 149 150 151 152 153 154 155

(B) Making, publishing, disseminating, circulating, or placing before the public or causing, directly or indirectly, to be made, published, disseminated, circulated, or placed before the public, in a newspaper, magazine, or other publication, or in the form of a notice, circular, pamphlet, letter, or poster, or over any radio station, or in any other way, or preparing with intent to so use, an advertisement, announcement, or statement containing any assertion, representation, or statement, with respect to the business of insurance or with respect to any person in the conduct of the person's insurance 156 157 158 159 160 161 162 163 164 165

business, which is untrue, deceptive, or misleading. 166

(C) Making, publishing, disseminating, or circulating, directly or indirectly, or aiding, abetting, or encouraging the making, publishing, disseminating, or circulating, or preparing with intent to so use, any statement, pamphlet, circular, article, or literature, which is false as to the financial condition of an insurer and which is calculated to injure any person engaged in the business of insurance. 167 168 169 170 171 172 173

(D) Filing with any supervisory or other public official, or making, publishing, disseminating, circulating, or delivering to any person, or placing before the public, or causing directly or indirectly to be made, published, disseminated, circulated, delivered to any person, or placed before the public, any false statement of financial condition of an insurer. 174 175 176 177 178 179

Making any false entry in any book, report, or statement of any insurer with intent to deceive any agent or examiner lawfully appointed to examine into its condition or into any of its affairs, or any public official to whom such insurer is required by law to report, or who has authority by law to examine into its condition or into any of its affairs, or, with like intent, willfully omitting to make a true entry of any material fact pertaining to the business of such insurer in any book, report, or statement of such insurer, or mutilating, destroying, suppressing, withholding, or concealing any of its records. 180 181 182 183 184 185 186 187 188 189 190

(E) Issuing or delivering or permitting agents, officers, or employees to issue or deliver agency company stock or other capital stock or benefit certificates or shares in any common-law corporation or securities or any special or advisory board contracts or other contracts of any kind promising returns and 191 192 193 194 195

profits as an inducement to insurance. 196

(F) Except as provided in section 3901.213 of the Revised Code, making or permitting any unfair discrimination among individuals of the same class and equal expectation of life in the rates charged for any contract of life insurance or of life annuity or in the dividends or other benefits payable thereon, or in any other of the terms and conditions of such contract. 197 198 199 200 201 202

(G)(1) Except as otherwise expressly provided by law, including as provided in section 3901.213 of the Revised Code, knowingly permitting or offering to make or making any contract of life insurance, life annuity or accident and health insurance, or agreement as to such contract other than as plainly expressed in the contract issued thereon, or paying or allowing, or giving or offering to pay, allow, or give, directly or indirectly, as inducement to such insurance, or annuity, any rebate of premiums payable on the contract, or any special favor or advantage in the dividends or other benefits thereon, or any valuable consideration or inducement whatever not specified in the contract; or giving, or selling, or purchasing, or offering to give, sell, or purchase, as inducement to such insurance or annuity or in connection therewith, any stocks, bonds, or other securities, or other obligations of any insurance company or other corporation, association, or partnership, or any dividends or profits accrued thereon, or anything of value whatsoever not specified in the contract. 203 204 205 206 207 208 209 210 211 212 213 214 215 216 217 218 219 220

(2) An insurer, producer, or representative of either shall not offer or provide insurance as an inducement to the purchase of another policy of insurance and shall not use the words "free" or "no cost," or words of similar import, to such effect in an advertisement. 221 222 223 224 225

(H) Making, issuing, circulating, or causing or permitting to be made, issued, or circulated, or preparing with intent to so use, any statement to the effect that a policy of life insurance is, is the equivalent of, or represents shares of capital stock or any rights or options to subscribe for or otherwise acquire any such shares in the life insurance company issuing that policy or any other company. 226 227 228 229 230 231 232

(I) Making, issuing, circulating, or causing or permitting to be made, issued or circulated, or preparing with intent to so issue, any statement to the effect that payments to a policyholder of the principal amounts of a pure endowment are other than payments of a specific benefit for which specific premiums have been paid. 233 234 235 236 237 238

(J) Making, issuing, circulating, or causing or permitting to be made, issued, or circulated, or preparing with intent to so use, any statement to the effect that any insurance company was required to change a policy form or related material to comply with Title XXXIX of the Revised Code or any regulation of the superintendent of insurance, for the purpose of inducing or intending to induce any policyholder or prospective policyholder to purchase, amend, lapse, forfeit, change, or surrender insurance. 239 240 241 242 243 244 245 246 247

(K) Aiding or abetting another to violate this section. 248

(L) Refusing to issue any policy of insurance, or canceling or declining to renew such policy because of the sex or marital status of the applicant, prospective insured, insured, or policyholder. 249 250 251 252

(M) Making or permitting any unfair discrimination between individuals of the same class and of essentially the same hazard 253 254

in the amount of premium, policy fees, or rates charged for any policy or contract of insurance, other than life insurance, or in the benefits payable thereunder, or in underwriting standards and practices or eligibility requirements, or in any of the terms or conditions of such contract, or in any other manner whatever. 255 256 257 258 259 260

(N) Refusing to make available disability income insurance solely because the applicant's principal occupation is that of managing a household. 261 262 263

(O) Refusing, when offering maternity benefits under any individual or group sickness and accident insurance policy, to make maternity benefits available to the policyholder for the individual or individuals to be covered under any comparable policy to be issued for delivery in this state, including family members if the policy otherwise provides coverage for family members. Nothing in this division shall be construed to prohibit an insurer from imposing a reasonable waiting period for such benefits under an individual sickness and accident insurance policy issued to an individual who is not a federally eligible individual or a nonemployer-related group sickness and accident insurance policy, but in no event shall such waiting period exceed two hundred seventy days. 264 265 266 267 268 269 270 271 272 273 274 275 276

For purposes of division (O) of this section, "federally eligible individual" means an eligible individual as defined in 45 C.F.R. 148.103. 277 278 279

(P) Using, or permitting to be used, a pattern settlement as the basis of any offer of settlement. As used in this division, "pattern settlement" means a method by which liability is routinely imputed to a claimant without an investigation of the particular occurrence upon which the claim is based and by 280 281 282 283 284

using a predetermined formula for the assignment of liability arising out of occurrences of a similar nature. Nothing in this division shall be construed to prohibit an insurer from determining a claimant's liability by applying formulas or guidelines to the facts and circumstances disclosed by the insurer's investigation of the particular occurrence upon which a claim is based. 285 286 287 288 289 290 291

(Q) Refusing to insure, or refusing to continue to insure, or limiting the amount, extent, or kind of life or sickness and accident insurance or annuity coverage available to an individual, or charging an individual a different rate for the same coverage solely because of blindness or partial blindness. With respect to all other conditions, including the underlying cause of blindness or partial blindness, persons who are blind or partially blind shall be subject to the same standards of sound actuarial principles or actual or reasonably anticipated actuarial experience as are sighted persons. Refusal to insure includes, but is not limited to, denial by an insurer of disability insurance coverage on the grounds that the policy defines "disability" as being presumed in the event that the eyesight of the insured is lost. However, an insurer may exclude from coverage disabilities consisting solely of blindness or partial blindness when such conditions existed at the time the policy was issued. To the extent that the provisions of this division may appear to conflict with any provision of section 3999.16 of the Revised Code, this division applies. 292 293 294 295 296 297 298 299 300 301 302 303 304 305 306 307 308 309 310

(R)(1) Directly or indirectly offering to sell, selling, or delivering, issuing for delivery, renewing, or using or otherwise marketing any policy of insurance or insurance product in connection with or in any way related to the grant of a student loan guaranteed in whole or in part by an agency or 311 312 313 314 315

commission of this state or the United States, except insurance that is required under federal or state law as a condition for obtaining such a loan and the premium for which is included in the fees and charges applicable to the loan; or, in the case of an insurer or insurance agent, knowingly permitting any lender making such loans to engage in such acts or practices in connection with the insurer's or agent's insurance business. 316 317 318 319 320 321 322

(2) Except in the case of a violation of division (G) of this section, division (R)(1) of this section does not apply to either of the following: 323 324 325

(a) Acts or practices of an insurer, its agents, representatives, or employees in connection with the grant of a guaranteed student loan to its insured or the insured's spouse or dependent children where such acts or practices take place more than ninety days after the effective date of the insurance; 326 327 328 329 330

(b) Acts or practices of an insurer, its agents, representatives, or employees in connection with the solicitation, processing, or issuance of an insurance policy or product covering the student loan borrower or the borrower's spouse or dependent children, where such acts or practices take place more than one hundred eighty days after the date on which the borrower is notified that the student loan was approved. 331 332 333 334 335 336 337

(S) Denying coverage, under any health insurance or health care policy, contract, or plan providing family coverage, to any natural or adopted child of the named insured or subscriber solely on the basis that the child does not reside in the household of the named insured or subscriber. 338 339 340 341 342

(T)(1) Using any underwriting standard or engaging in any other act or practice that, directly or indirectly, due solely 343 344

to any health status-related factor in relation to one or more individuals, does either of the following: 345 346

(a) Terminates or fails to renew an existing individual policy, contract, or plan of health benefits, or a health benefit plan issued to an employer, for which an individual would otherwise be eligible; 347 348 349 350

(b) With respect to a health benefit plan issued to an employer, excludes or causes the exclusion of an individual from coverage under an existing employer-provided policy, contract, or plan of health benefits. 351 352 353 354

(2) The superintendent of insurance may adopt rules in accordance with Chapter 119. of the Revised Code for purposes of implementing division (T)(1) of this section. 355 356 357

(3) For purposes of division (T)(1) of this section, "health status-related factor" means any of the following: 358 359

(a) Health status; 360

(b) Medical condition, including both physical and mental illnesses; 361 362

(c) Claims experience; 363

(d) Receipt of health care; 364

(e) Medical history; 365

(f) Genetic information; 366

(g) Evidence of insurability, including conditions arising out of acts of domestic violence; 367 368

(h) Disability. 369

(U) With respect to a health benefit plan issued to a 370

small employer, as those terms are defined in section 3924.01 of the Revised Code, negligently or willfully placing coverage for adverse risks with a certain carrier, as defined in section 3924.01 of the Revised Code. 371 372 373 374

(V) Using any program, scheme, device, or other unfair act or practice that, directly or indirectly, causes or results in the placing of coverage for adverse risks with another carrier, as defined in section 3924.01 of the Revised Code. 375 376 377 378

(W) Failing to comply with section 3923.23, 3923.231, 3923.232, 3923.233, or 3923.234 of the Revised Code by engaging in any unfair, discriminatory reimbursement practice. 379 380 381

(X) Intentionally establishing an unfair premium for, or misrepresenting the cost of, any insurance policy financed under a premium finance agreement of an insurance premium finance company. 382 383 384 385

(Y)(1)(a) Limiting coverage under, refusing to issue, canceling, or refusing to renew, any individual policy or contract of life insurance, or limiting coverage under or refusing to issue any individual policy or contract of health insurance, for the reason that the insured or applicant for insurance is or has been a victim of domestic violence; 386 387 388 389 390 391

(b) Adding a surcharge or rating factor to a premium of any individual policy or contract of life or health insurance for the reason that the insured or applicant for insurance is or has been a victim of domestic violence; 392 393 394 395

(c) Denying coverage under, or limiting coverage under, any policy or contract of life or health insurance, for the reason that a claim under the policy or contract arises from an incident of domestic violence; 396 397 398 399

(d) Inquiring, directly or indirectly, of an insured under, or of an applicant for, a policy or contract of life or health insurance, as to whether the insured or applicant is or has been a victim of domestic violence, or inquiring as to whether the insured or applicant has sought shelter or protection from domestic violence or has sought medical or psychological treatment as a victim of domestic violence. 400 401 402 403 404 405 406

(2) Nothing in division (Y)(1) of this section shall be construed to prohibit an insurer from inquiring as to, or from underwriting or rating a risk on the basis of, a person's physical or mental condition, even if the condition has been caused by domestic violence, provided that all of the following apply: 407 408 409 410 411 412

(a) The insurer routinely considers the condition in underwriting or in rating risks, and does so in the same manner for a victim of domestic violence as for an insured or applicant who is not a victim of domestic violence; 413 414 415 416

(b) The insurer does not refuse to issue any policy or contract of life or health insurance or cancel or refuse to renew any policy or contract of life insurance, solely on the basis of the condition, except where such refusal to issue, cancellation, or refusal to renew is based on sound actuarial principles or is related to actual or reasonably anticipated experience; 417 418 419 420 421 422 423

(c) The insurer does not consider a person's status as being or as having been a victim of domestic violence, in itself, to be a physical or mental condition; 424 425 426

(d) The underwriting or rating of a risk on the basis of the condition is not used to evade the intent of division (Y)(1) 427 428

of this section, or of any other provision of the Revised Code. 429

(3)(a) Nothing in division (Y)(1) of this section shall be construed to prohibit an insurer from refusing to issue a policy or contract of life insurance insuring the life of a person who is or has been a victim of domestic violence if the person who committed the act of domestic violence is the applicant for the insurance or would be the owner of the insurance policy or contract. 430 431 432 433 434 435 436

(b) Nothing in division (Y)(2) of this section shall be construed to permit an insurer to cancel or refuse to renew any policy or contract of health insurance in violation of the "Health Insurance Portability and Accountability Act of 1996," 110 Stat. 1955, 42 U.S.C.A. 300gg-41(b), as amended, or in a manner that violates or is inconsistent with any provision of the Revised Code that implements the "Health Insurance Portability and Accountability Act of 1996." 437 438 439 440 441 442 443 444

(4) An insurer is immune from any civil or criminal liability that otherwise might be incurred or imposed as a result of any action taken by the insurer to comply with division (Y) of this section. 445 446 447 448

(5) As used in division (Y) of this section, "domestic violence" means any of the following acts: 449 450

(a) Knowingly causing or attempting to cause physical harm to a family or household member; 451 452

(b) Recklessly causing serious physical harm to a family or household member; 453 454

(c) Knowingly causing, by threat of force, a family or household member to believe that the person will cause imminent 455 456

physical harm to the family or household member. 457

For the purpose of division (Y)(5) of this section, 458
"family or household member" has the same meaning as in section 459
2919.25 of the Revised Code. 460

Nothing in division (Y)(5) of this section shall be 461
construed to require, as a condition to the application of 462
division (Y) of this section, that the act described in division 463
(Y)(5) of this section be the basis of a criminal prosecution. 464

(Z) Disclosing a coroner's records by an insurer in 465
violation of section 313.10 of the Revised Code. 466

(AA) Making, issuing, circulating, or causing or 467
permitting to be made, issued, or circulated any statement or 468
representation that a life insurance policy or annuity is a 469
contract for the purchase of funeral goods or services. 470

(BB) With respect to a health care contract as defined in 471
section 3963.01 of the Revised Code that covers vision or dental 472
services, as defined in that section, including any of the 473
contract terms prohibited under or failing to make the 474
disclosures required under division (E) or (F) of section 475
3963.02 of the Revised Code. 476

(CC) With respect to private passenger automobile 477
insurance, charging premium rates that are excessive, 478
inadequate, or unfairly discriminatory, pursuant to division (D) 479
of section 3937.02 of the Revised Code, based solely on the 480
location of the residence of the insured. 481

The enumeration in sections 3901.19 to 3901.26 of the 482
Revised Code of specific unfair or deceptive acts or practices 483
in the business of insurance is not exclusive or restrictive or 484

intended to limit the powers of the superintendent of insurance 485
to adopt rules to implement this section, or to take action 486
under other sections of the Revised Code. 487

This section does not prohibit the sale of shares of any 488
investment company registered under the "Investment Company Act 489
of 1940," 54 Stat. 789, 15 U.S.C.A. 80a-1, as amended, or any 490
policies, annuities, or other contracts described in section 491
3907.15 of the Revised Code. 492

As used in this section, "estimate," "statement," 493
"representation," "misrepresentation," "advertisement," or 494
"announcement" includes oral or written occurrences. 495

Sec. 3923.86. (A) As used in this section, "covered 496
dental services," "covered vision services," "dental care 497
provider," "vision care materials," and "vision care provider" 498
have the same meanings as in section 3963.01 of the Revised 499
Code. 500

(B) A sickness and accident insurer or public employee 501
benefit plan shall provide the information required in this 502
division to all insured individuals receiving coverage under an 503
individual or group policy of sickness and accident insurance or 504
public employee benefit plan ~~providing coverage~~ for vision care 505
services ~~or~~, vision care materials, or dental care services. The 506
information shall be in a conspicuous format, shall be easily 507
accessible to insured individuals, and shall do all of the 508
following: 509

(1) ~~Include~~ For vision care coverage, include the 510
following statement: 511

"IMPORTANT: If you opt to receive vision care services or 512
vision care materials that are not covered benefits under this 513

plan, a participating vision care provider may charge you his or 514
her normal fee for such services or materials. Prior to 515
providing you with vision care services or vision care materials 516
that are not covered benefits, the vision care provider will 517
provide you with an estimated cost for each service or material 518
upon your request." 519

(2) For dental care coverage, include the following 520
statement: 521

"IMPORTANT: If you opt to receive dental care services 522
that are not covered benefits under this plan, a participating 523
dental care provider may charge you his or her normal fee for 524
such services. Prior to providing you with dental care services 525
that are not covered benefits, the dental care provider will 526
provide you with an estimated cost for each service." 527

(3) Disclose any business interest the insurer or plan has 528
in a source or supplier of vision care materials; 529

~~(3)~~ (4) Include an explanation that the insured individual 530
may incur out-of-pocket expenses as a result of the purchase of 531
vision care services ~~or~~, vision care materials, or dental care 532
services that are not covered ~~vision services~~. The explanation 533
shall be communicated in a manner and format similar to how the 534
insurer or plan provides an insured individual with information 535
on coverage levels and out-of-pocket expenses that may be 536
incurred by the insured individual under the policy or plan when 537
purchasing out-of-network vision care services ~~or~~, vision care 538
materials, or dental care services. 539

(C) A pattern of continuous or repeated violations of this 540
section is an unfair and deceptive act or practice in the 541
business of insurance under sections 3901.19 to 3901.26 of the 542

Revised Code. 543

Sec. 3963.01. As used in this chapter: 544

(A) "Affiliate" means any person or entity that has ownership or control of a contracting entity, is owned or controlled by a contracting entity, or is under common ownership or control with a contracting entity. 545 546 547 548

(B) "Basic health care services" has the same meaning as in division (A) of section 1751.01 of the Revised Code, except that it does not include any services listed in that division that are provided by a pharmacist or nursing home. 549 550 551 552

(C) "Covered vision services" means vision care services or vision care materials for which a reimbursement is available under an enrollee's health care contract, or for which a reimbursement would be available but for the application of contractual limitations, such as a deductible, copayment, coinsurance, waiting period, annual or lifetime maximum, frequency limitation, alternative benefit payment, or any other limitation. 553 554 555 556 557 558 559 560

(D) "Contracting entity" means any person that has a primary business purpose of contracting with participating providers for the delivery of health care services. 561 562 563

(E) "Covered dental services" means dental care services for which reimbursement is available under an enrollee's health care contract, or for which a reimbursement would be available but for the application of contractual limitations, such as a deductible, copayment, coinsurance, waiting period, annual or lifetime maximum, frequency limitation, alternative benefit payment, or any other limitation. 564 565 566 567 568 569 570

(F) "Credentialing" means the process of assessing and validating the qualifications of a provider applying to be approved by a contracting entity to provide basic health care services, specialty health care services, or supplemental health care services to enrollees. 571 572 573 574 575

~~(F)~~ (G) "Dental care provider" means a dentist licensed under Chapter 4715. of the Revised Code. "Dental care provider" does not include a dental hygienist licensed under Chapter 4715. of the Revised Code. 576 577 578 579

(H) "Edit" means adjusting one or more procedure codes billed by a participating provider on a claim for payment or a practice that results in any of the following: 580 581 582

(1) Payment for some, but not all of the procedure codes originally billed by a participating provider; 583 584

(2) Payment for a different procedure code than the procedure code originally billed by a participating provider; 585 586

(3) A reduced payment as a result of services provided to an enrollee that are claimed under more than one procedure code on the same service date. 587 588 589

~~(G)~~ (I) "Electronic claims transport" means to accept and digitize claims or to accept claims already digitized, to place those claims into a format that complies with the electronic transaction standards issued by the United States department of health and human services pursuant to the "Health Insurance Portability and Accountability Act of 1996," 110 Stat. 1955, 42 U.S.C. 1320d, et seq., as those electronic standards are applicable to the parties and as those electronic standards are updated from time to time, and to electronically transmit those claims to the appropriate contracting entity, payer, or third- 590 591 592 593 594 595 596 597 598 599

party administrator. 600

~~(H)~~ <u>(J)</u> "Enrollee" means any person eligible for health care benefits under a health benefit plan, including an eligible recipient of medicaid, and includes all of the following terms: 601 602 603

(1) "Enrollee" and "subscriber" as defined by section 1751.01 of the Revised Code; 604 605

(2) "Member" as defined by section 1739.01 of the Revised Code; 606 607

(3) "Insured" and "plan member" pursuant to Chapter 3923. of the Revised Code; 608 609

(4) "Beneficiary" as defined by section 3901.38 of the Revised Code. 610 611

~~(I)~~ <u>(K)</u> "Health care contract" means a contract entered into, materially amended, or renewed between a contracting entity and a participating provider for the delivery of basic health care services, specialty health care services, or supplemental health care services to enrollees. 612 613 614 615 616

~~(J)~~ <u>(L)</u> "Health care services" means basic health care services, specialty health care services, and supplemental health care services. 617 618 619

~~(K)~~ <u>(M)</u> "Material amendment" means an amendment to a health care contract that decreases the participating provider's payment or compensation, changes the administrative procedures in a way that may reasonably be expected to significantly increase the provider's administrative expenses, or adds a new product. A material amendment does not include any of the following: 620 621 622 623 624 625 626

(1) A decrease in payment or compensation resulting solely 627

from a change in a published fee schedule upon which the payment or compensation is based and the date of applicability is clearly identified in the contract; 628 629 630

(2) A decrease in payment or compensation that was anticipated under the terms of the contract, if the amount and date of applicability of the decrease is clearly identified in the contract; 631 632 633 634

(3) An administrative change that may significantly increase the provider's administrative expense, the specific applicability of which is clearly identified in the contract; 635 636 637

(4) Changes to an existing prior authorization, precertification, notification, or referral program that do not substantially increase the provider's administrative expense; 638 639 640

(5) Changes to an edit program or to specific edits if the participating provider is provided notice of the changes pursuant to division (A)(1) of section 3963.04 of the Revised Code and the notice includes information sufficient for the provider to determine the effect of the change; 641 642 643 644 645

(6) Changes to a health care contract described in division (B) of section 3963.04 of the Revised Code. 646 647

~~(L)~~ (N) "Participating provider" means a provider that has a health care contract with a contracting entity and is entitled to reimbursement for health care services rendered to an enrollee under the health care contract. 648 649 650 651

~~(M)~~ (O) "Payer" means any person that assumes the financial risk for the payment of claims under a health care contract or the reimbursement for health care services provided to enrollees by participating providers pursuant to a health 652 653 654 655

care contract. 656

~~(N)~~ (P) "Primary enrollee" means a person who is 657
responsible for making payments for participation in a health 658
care plan or an enrollee whose employment or other status is the 659
basis of eligibility for enrollment in a health care plan. 660

~~(O)~~ (Q) "Procedure codes" includes the American medical 661
association's current procedural terminology code, the American 662
dental association's current dental terminology, and the centers 663
for medicare and medicaid services health care common procedure 664
coding system. 665

~~(P)~~ (R) "Product" means one of the following types of 666
categories of coverage for which a participating provider may be 667
obligated to provide health care services pursuant to a health 668
care contract: 669

(1) A health maintenance organization or other product 670
provided by a health insuring corporation; 671

(2) A preferred provider organization; 672

(3) Medicare; 673

(4) Medicaid; 674

(5) Workers' compensation. 675

~~(Q)~~ (S) "Provider" means a physician, podiatrist, dentist, 676
chiropractor, optometrist, psychologist, physician assistant, 677
advanced practice registered nurse, occupational therapist, 678
massage therapist, physical therapist, licensed professional 679
counselor, licensed professional clinical counselor, hearing aid 680
dealer, orthotist, prosthetist, home health agency, hospice care 681
program, pediatric respite care program, or hospital, or a 682
provider organization or physician-hospital organization that is 683

acting exclusively as an administrator on behalf of a provider 684
to facilitate the provider's participation in health care 685
contracts. 686

"Provider" does not mean either of the following: 687

(1) A nursing home; 688

(2) A provider organization or physician-hospital 689
organization that leases the provider organization's or 690
physician-hospital organization's network to a third party or 691
contracts directly with employers or health and welfare funds. 692

~~(R)~~ (T) "Specialty health care services" has the same 693
meaning as in section 1751.01 of the Revised Code, except that 694
it does not include any services listed in division (B) of 695
section 1751.01 of the Revised Code that are provided by a 696
pharmacist or a nursing home. 697

~~(S)~~ (U) "Supplemental health care services" has the same 698
meaning as in division (B) of section 1751.01 of the Revised 699
Code, except that it does not include any services listed in 700
that division that are provided by a pharmacist or nursing home. 701

~~(T)~~ (V) "Vision care materials" includes lenses, devices 702
containing lenses, prisms, lens treatments and coatings, contact 703
lenses, orthopics, vision training, and any prosthetic device 704
necessary to correct, relieve, or treat any defect or abnormal 705
condition of the human eye or its adnexa. 706

~~(U)~~ (W) "Vision care provider" means either of the 707
following: 708

(1) An optometrist licensed under Chapter 4725. of the 709
Revised Code; 710

(2) A physician authorized under Chapter 4731. of the 711

Revised Code to practice medicine and surgery or osteopathic medicine and surgery. 712 713

Sec. 3963.02. (A)(1) No contracting entity shall sell, rent, or give a third party the contracting entity's rights to a participating provider's services pursuant to the contracting entity's health care contract with the participating provider unless one of the following applies: 714 715 716 717 718

(a) The third party accessing the participating provider's services under the health care contract is an employer or other entity providing coverage for health care services to its employees or members, and that employer or entity has a contract with the contracting entity or its affiliate for the administration or processing of claims for payment for services provided pursuant to the health care contract with the participating provider. 719 720 721 722 723 724 725 726

(b) The third party accessing the participating provider's services under the health care contract either is an affiliate or subsidiary of the contracting entity or is providing administrative services to, or receiving administrative services from, the contracting entity or an affiliate or subsidiary of the contracting entity. 727 728 729 730 731 732

(c) The health care contract specifically provides that it applies to network rental arrangements and states that one purpose of the contract is selling, renting, or giving the contracting entity's rights to the services of the participating provider, including other preferred provider organizations, and the third party accessing the participating provider's services is any of the following: 733 734 735 736 737 738 739

(i) A payer or a third-party administrator or other entity 740

responsible for administering claims on behalf of the payer; 741

(ii) A preferred provider organization or preferred provider network that receives access to the participating provider's services pursuant to an arrangement with the preferred provider organization or preferred provider network in a contract with the participating provider that is in compliance with division (A)(1)(c) of this section, and is required to comply with all of the terms, conditions, and affirmative obligations to which the originally contracted primary participating provider network is bound under its contract with the participating provider, including, but not limited to, obligations concerning patient steerage and the timeliness and manner of reimbursement. 742 743 744 745 746 747 748 749 750 751 752 753

(iii) An entity that is engaged in the business of providing electronic claims transport between the contracting entity and the payer or third-party administrator and complies with all of the applicable terms, conditions, and affirmative obligations of the contracting entity's contract with the participating provider including, but not limited to, obligations concerning patient steerage and the timeliness and manner of reimbursement. 754 755 756 757 758 759 760 761

(2) The contracting entity that sells, rents, or gives the contracting entity's rights to the participating provider's services pursuant to the contracting entity's health care contract with the participating provider as provided in division (A)(1) of this section shall do both of the following: 762 763 764 765 766

(a) Maintain a web page that contains a listing of third parties described in divisions (A)(1)(b) and (c) of this section with whom a contracting entity contracts for the purpose of selling, renting, or giving the contracting entity's rights to 767 768 769 770

the services of participating providers that is updated at least every six months and is accessible to all participating providers, or maintain a toll-free telephone number accessible to all participating providers by means of which participating providers may access the same listing of third parties; 771 772 773 774 775

(b) Require that the third party accessing the participating provider's services through the participating provider's health care contract is obligated to comply with all of the applicable terms and conditions of the contract, including, but not limited to, the products for which the participating provider has agreed to provide services, except that a payer receiving administrative services from the contracting entity or its affiliate shall be solely responsible for payment to the participating provider. 776 777 778 779 780 781 782 783 784

(3) Any information disclosed to a participating provider under this section shall be considered proprietary and shall not be distributed by the participating provider. 785 786 787

(4) Except as provided in division (A)(1) of this section, no entity shall sell, rent, or give a contracting entity's rights to the participating provider's services pursuant to a health care contract. 788 789 790 791

(B)(1) No contracting entity shall require, as a condition of contracting with the contracting entity, that a participating provider provide services for all of the products offered by the contracting entity. 792 793 794 795

(2) Division (B)(1) of this section shall not be construed to do any of the following: 796 797

(a) Prohibit any participating provider from voluntarily accepting an offer by a contracting entity to provide health 798 799

care services under all of the contracting entity's products; 800

(b) Prohibit any contracting entity from offering any financial incentive or other form of consideration specified in the health care contract for a participating provider to provide health care services under all of the contracting entity's products; 801 802 803 804 805

(c) Require any contracting entity to contract with a participating provider to provide health care services for less than all of the contracting entity's products if the contracting entity does not wish to do so. 806 807 808 809

(3)(a) Notwithstanding division (B)(2) of this section, no contracting entity shall require, as a condition of contracting with the contracting entity, that the participating provider accept any future product offering that the contracting entity makes. 810 811 812 813 814

(b) If a participating provider refuses to accept any future product offering that the contracting entity makes, the contracting entity may terminate the health care contract based on the participating provider's refusal upon written notice to the participating provider no sooner than one hundred eighty days after the refusal. 815 816 817 818 819 820

(4) Once the contracting entity and the participating provider have signed the health care contract, it is presumed that the financial incentive or other form of consideration that is specified in the health care contract pursuant to division (B)(2)(b) of this section is the financial incentive or other form of consideration that was offered by the contracting entity to induce the participating provider to enter into the contract. 821 822 823 824 825 826 827

(C) No contracting entity shall require, as a condition of 828

contracting with the contracting entity, that a participating provider waive or forgo any right or benefit expressly conferred upon a participating provider by state or federal law. However, this division does not prohibit a contracting entity from restricting a participating provider's scope of practice for the services to be provided under the contract. 829 830 831 832 833 834

(D) No health care contract shall do any of the following: 835

(1) Prohibit any participating provider from entering into a health care contract with any other contracting entity; 836 837

(2) Prohibit any contracting entity from entering into a health care contract with any other provider; 838 839

(3) Preclude its use or disclosure for the purpose of enforcing this chapter or other state or federal law, except that a health care contract may require that appropriate measures be taken to preserve the confidentiality of any proprietary or trade-secret information. 840 841 842 843 844

(E)(1) No contract or agreement between a contracting entity and a vision care provider shall do any of the following: 845 846

(a) Require that a vision care provider accept as payment an amount set by the contracting entity for vision care services or vision care materials provided to an enrollee unless the services or materials are covered vision services. 847 848 849 850

(i) Notwithstanding division (E)(1)(a) of this section, a vision care provider may, in a contract with a contracting entity, choose to accept as payment an amount set by the contracting entity for vision care services or vision care materials provided to an enrollee that are not covered vision services. 851 852 853 854 855 856

(ii) No contract between a vision care provider and a contracting entity to provide covered vision services or vision care materials shall be contingent on whether the vision care provider has entered into an agreement addressing noncovered vision services pursuant to division (E)(1)(a)(i) of this section. 857 858 859 860 861 862

(iii) A contracting entity may communicate to its enrollees which vision care providers choose to accept as payment an amount set by the contracting entity for vision care services or vision care materials provided to an enrollee that are not covered vision services pursuant to division (E)(1)(a)(i) of this section. Any communication to this effect shall treat all vision care providers equally in provider directories, provider locators, and other marketing materials as participating, in-network providers, annotated only as to their decision to accept payment pursuant to division (E)(1)(a)(i) of this section. 863 864 865 866 867 868 869 870 871 872 873

(b) Require that a vision care provider contract with a plan offering supplemental or specialty health care services as a condition of contracting with a plan offering basic health care services; 874 875 876 877

(c) Directly limit a vision care provider's choice of sources and suppliers of vision care materials; 878 879

(d) Include a provision that prohibits a vision care provider from describing out-of-network options to an enrollee in accordance with division (E)(2) of this section. 880 881 882

The provisions of divisions (E)(1)(a) to (d) of this section shall be effective for contracts entered into, amended, or renewed on or after January 1, 2019. 883 884 885

(2) A vision care provider recommending an out-of-network source or supplier of vision care materials to an enrollee shall notify the enrollee in writing that the source or supplier is out-of-network and shall inform the enrollee of the cost of those materials. The vision care provider shall also disclose in writing to an enrollee any business interest the provider has in a recommended out-of-network source or supplier utilized by the enrollee. 886 887 888 889 890 891 892 893

(3) A vision care provider who chooses not to accept as payment an amount set by a contracting entity for vision care services or vision care materials that are not covered vision services shall do both of the following: 894 895 896 897

(a) Upon the request of an enrollee seeking vision care services or vision care materials that are not covered vision services, provide to the enrollee pricing and reimbursement information, including all of the following: 898 899 900 901

(i) The estimated fee or discounted price suggested by the contracting entity for the noncovered service or material; 902 903

(ii) The estimated fee charged by the vision care provider for the noncovered service or material; 904 905

(iii) The amount the vision care provider expects to be reimbursed by the contracting entity for the noncovered service or material; 906 907 908

(iv) The estimated pricing and reimbursement information for any covered services or materials that are also expected to be provided during the enrollee's visit. 909 910 911

(b) Post, in a conspicuous place, a notice stating the following: 912 913

"IMPORTANT: This vision care provider does not accept the fee schedule set by your insurer for vision care services and vision care materials that are not covered benefits under your plan and instead charges his or her normal fee for those services and materials. This vision care provider will provide you with an estimated cost for each non-covered service or material upon your request." 914 915 916 917 918 919 920

(4) Nothing in division (E) of this section shall do any of the following: 921 922

(a) Restrict or limit a contracting entity's determination of specific amounts of coverage or reimbursement for the use of network or out-of-network sources or suppliers of vision care materials as set forth in an enrollee's benefit plan; 923 924 925 926

(b) Restrict or limit a contracting entity's ability to enter into an agreement with another contracting entity or an affiliate of another contracting entity; 927 928 929

(c) Restrict or limit a health care plan's ability to enter into an agreement with a vision care plan to deliver routine vision care services that are covered under an enrollee's plan; 930 931 932 933

(d) Restrict or limit a vision care plan network from acting as a network for a health care plan; 934 935

(e) Prohibit a contracting entity from requiring participating vision care providers to offer network sources or suppliers of vision care materials to enrollees; 936 937 938

(f) Prohibit an enrollee from utilizing a network source or supplier of vision care materials as set forth in an enrollee's plan; 939 940 941

(g) Prohibit a participating vision care provider from accepting as payment an amount that is the same as the amount set by the contracting entity for vision care services or vision care materials that are not covered vision services.

~~(F)~~ (F)(1) No contract or agreement between a contracting entity and a dental care provider shall do any of the following:

(a) Require that a dental care provider accept as payment an amount set by the contracting entity for dental care services provided to an enrollee unless the services are covered dental services.

(i) Notwithstanding division (F)(1)(a) of this section, a dental care provider may, in a contract with a contracting entity, choose to accept as payment an amount set by the contracting entity for dental care services provided to an enrollee that are not covered dental services.

(ii) No contract between a dental care provider and a contracting entity to provide covered dental services shall be contingent on whether the dental care provider has entered into an agreement addressing noncovered dental services pursuant to division (F)(1)(a)(i) of this section.

(iii) A contracting entity may communicate to its enrollees which dental care providers choose to accept as payment an amount set by the contracting entity for dental care services provided to an enrollee that are not covered dental services pursuant to division (F)(1)(a)(i) of this section. Any communication to this effect shall treat all dental care providers equally in provider directories, provider locators, and other marketing materials as participating, in-network providers, annotated only as to their decision to accept payment

pursuant to division (F)(1)(a)(i) of this section. 971

(b) Require that a dental care provider contract with a plan offering supplemental or specialty health care services as a condition of contracting with a plan offering basic health care services. 972 973 974 975

The provisions of divisions (F)(1)(a) and (b) of this section apply to contracts entered into, amended, or renewed on or after January 1, 2025. 976 977 978

(2) A dental care provider who chooses not to accept as payment an amount set by a contracting entity for dental care services that are not covered dental services shall do both of the following: 979 980 981 982

(a) Provide to an enrollee seeking dental care services that are not covered dental services pricing and reimbursement information, including all of the following: 983 984 985

(i) The estimated fee or discounted price suggested by the contracting entity for the noncovered service; 986 987

(ii) The estimated fee charged by the dental care provider for the noncovered service; 988 989

(iii) The amount the dental care provider expects to be reimbursed by the contracting entity for the noncovered service; 990 991

(iv) The estimated pricing and reimbursement information for any covered services that are also expected to be provided during the enrollee's visit. 992 993 994

(b) Post, in a conspicuous place, a notice stating the following: 995 996

"IMPORTANT: This dental care provider does not accept the 997

fee schedule set by your insurer for dental care services that are not covered benefits under your plan and instead charges his or her normal fee for those services. This dental care provider will provide you with an estimated cost for each noncovered service." 998 999 1000 1001 1002

(3) Nothing in division (F) of this section shall do any of the following: 1003 1004

(a) Restrict or limit a contracting entity's ability to enter into an agreement with another contracting entity or an affiliate of another contracting entity; 1005 1006 1007

(b) Restrict or limit a health care plan's ability to enter into an agreement with a dental care plan to deliver routine dental care services that are covered under an enrollee's plan; 1008 1009 1010 1011

(c) Restrict or limit a dental care plan network from acting as a network for a health care plan; 1012 1013

(d) Prohibit a participating dental care provider from accepting as payment an amount that is the same as the amount set by the contracting entity for dental care services that are not covered dental services. 1014 1015 1016 1017

~~(1)~~ (G)(1) In addition to any other lawful reasons for terminating a health care contract, a health care contract may only be terminated under the circumstances described in division (A)(3) of section 3963.04 of the Revised Code. 1018 1019 1020 1021

(2) If the health care contract provides for termination for cause by either party, the health care contract shall state the reasons that may be used for termination for cause, which terms shall be reasonable. Once the contracting entity and the 1022 1023 1024 1025

participating provider have signed the health care contract, it is presumed that the reasons stated in the health care contract for termination for cause by either party are reasonable. Subject to division ~~(F)(3)~~ (G)(3) of this section, the health care contract shall state the time by which the parties must provide notice of termination for cause and to whom the parties shall give the notice.

(3) Nothing in divisions ~~(F)(1)~~ (G)(1) and (2) of this section shall be construed as prohibiting any health insuring corporation from terminating a participating provider's contract for any of the causes described in divisions (A), (D), and (F)(1) and (2) of section 1753.09 of the Revised Code. Notwithstanding any provision in a health care contract pursuant to division ~~(F)(2)~~ (G)(2) of this section, section 1753.09 of the Revised Code applies to the termination of a participating provider's contract for any of the causes described in divisions (A), (D), and (F)(1) and (2) of section 1753.09 of the Revised Code.

(4) Subject to sections 3963.01 to 3963.11 of the Revised Code, nothing in this section prohibits the termination of a health care contract without cause if the health care contract otherwise provides for termination without cause.

(5) Nothing in division ~~(F)~~ (G) of this section shall be construed to expand the regulatory authority of the superintendent to vision care providers or dental care providers.

~~(G)(1)~~ (H)(1) Disputes among parties to a health care contract that only concern the enforcement of the contract rights conferred by section 3963.02, divisions (A) and (D) of section 3963.03, and section 3963.04 of the Revised Code are

subject to a mutually agreed upon arbitration mechanism that is 1056
binding on all parties. The arbitrator may award reasonable 1057
attorney's fees and costs for arbitration relating to the 1058
enforcement of this section to the prevailing party. 1059

(2) The arbitrator shall make the arbitrator's decision in 1060
an arbitration proceeding having due regard for any applicable 1061
rules, bulletins, rulings, or decisions issued by the department 1062
of insurance or any court concerning the enforcement of the 1063
contract rights conferred by section 3963.02, divisions (A) and 1064
(D) of section 3963.03, and section 3963.04 of the Revised Code. 1065

(3) A party shall not simultaneously maintain an 1066
arbitration proceeding as described in division ~~(G)(1)~~ (H)(1) of 1067
this section and pursue a complaint with the superintendent of 1068
insurance to investigate the subject matter of the arbitration 1069
proceeding. However, if a complaint is filed with the department 1070
of insurance, the superintendent may choose to investigate the 1071
complaint or, after reviewing the complaint, advise the 1072
complainant to proceed with arbitration to resolve the 1073
complaint. The superintendent may request to receive a copy of 1074
the results of the arbitration. If the superintendent of 1075
insurance notifies an insurer or a health insuring corporation 1076
in writing that the superintendent has initiated a market 1077
conduct examination into the specific subject matter of the 1078
arbitration proceeding pending against that insurer or health 1079
insuring corporation, the arbitration proceeding shall be stayed 1080
at the request of the insurer or health insuring corporation 1081
pending the outcome of the market conduct investigation by the 1082
superintendent. 1083

Sec. 3963.03. (A) Each health care contract shall include 1084
all of the following information: 1085

(1)(a) Information sufficient for the participating provider to determine the compensation or payment terms for health care services, including all of the following, subject to division (A)(1)(b) of this section: 1086 1087 1088 1089

(i) The manner of payment, such as fee-for-service, capitation, or risk; 1090 1091

(ii) The fee schedule of procedure codes reasonably expected to be billed by a participating provider's specialty for services provided pursuant to the health care contract and the associated payment or compensation for each procedure code. A fee schedule may be provided electronically. Upon request, a contracting entity shall provide a participating provider with the fee schedule for any other procedure codes requested and a written fee schedule, that shall not be required more frequently than twice per year excluding when it is provided in connection with any change to the schedule. This requirement may be satisfied by providing a clearly understandable, readily available mechanism, such as a specific web site address, that allows a participating provider to determine the effect of procedure codes on payment or compensation before a service is provided or a claim is submitted. 1092 1093 1094 1095 1096 1097 1098 1099 1100 1101 1102 1103 1104 1105 1106

(iii) The effect, if any, on payment or compensation if more than one procedure code applies to the service also shall be stated. This requirement may be satisfied by providing a clearly understandable, readily available mechanism, such as a specific web site address, that allows a participating provider to determine the effect of procedure codes on payment or compensation before a service is provided or a claim is submitted. 1107 1108 1109 1110 1111 1112 1113 1114

(b) If the contracting entity is unable to include the 1115

information described in divisions (A)(1)(a)(ii) and (iii) of this section, the contracting entity shall include both of the following types of information instead: 1116 1117 1118

(i) The methodology used to calculate any fee schedule, such as relative value unit system and conversion factor or percentage of billed charges. If applicable, the methodology disclosure shall include the name of any relative value unit system, its version, edition, or publication date, any applicable conversion or geographic factor, and any date by which compensation or fee schedules may be changed by the methodology as anticipated at the time of contract. 1119 1120 1121 1122 1123 1124 1125 1126

(ii) The identity of any internal processing edits, including the publisher, product name, version, and version update of any editing software. 1127 1128 1129

(c) If the contracting entity is not the payer and is unable to include the information described in division (A)(1)(a) or (b) of this section, then the contracting entity shall provide by telephone a readily available mechanism, such as a specific web site address, that allows the participating provider to obtain that information from the payer. 1130 1131 1132 1133 1134 1135

(2) Any product or network for which the participating provider is to provide services; 1136 1137

(3) The term of the health care contract; 1138

(4) A specific web site address that contains the identity of the contracting entity or payer responsible for the processing of the participating provider's compensation or payment; 1139 1140 1141 1142

(5) Any internal mechanism provided by the contracting 1143

entity to resolve disputes concerning the interpretation or application of the terms and conditions of the contract. A contracting entity may satisfy this requirement by providing a clearly understandable, readily available mechanism, such as a specific web site address or an appendix, that allows a participating provider to determine the procedures for the internal mechanism to resolve those disputes. 1144 1145 1146 1147 1148 1149 1150

(6) A list of addenda, if any, to the contract. 1151

(B)(1) Each contracting entity shall include a summary disclosure form with a health care contract that includes all of the information specified in division (A) of this section. The information in the summary disclosure form shall refer to the location in the health care contract, whether a page number, section of the contract, appendix, or other identifiable location, that specifies the provisions in the contract to which the information in the form refers. 1152 1153 1154 1155 1156 1157 1158 1159

(2) The summary disclosure form shall include all of the following statements: 1160 1161

(a) That the form is a guide to the health care contract and that the terms and conditions of the health care contract constitute the contract rights of the parties; 1162 1163 1164

(b) That reading the form is not a substitute for reading the entire health care contract; 1165 1166

(c) That by signing the health care contract, the participating provider will be bound by the contract's terms and conditions; 1167 1168 1169

(d) That the terms and conditions of the health care contract may be amended pursuant to section 3963.04 of the 1170 1171

Revised Code and the participating provider is encouraged to carefully read any proposed amendments sent after execution of the contract; 1172 1173 1174

(e) That nothing in the summary disclosure form creates any additional rights or causes of action in favor of either party. 1175 1176 1177

(3) No contracting entity that includes any information in the summary disclosure form with the reasonable belief that the information is truthful or accurate shall be subject to a civil action for damages or to binding arbitration based on the summary disclosure form. Division (B)(3) of this section does not impair or affect any power of the department of insurance to enforce any applicable law. 1178 1179 1180 1181 1182 1183 1184

(4) The summary disclosure form described in divisions (B)(1) and (2) of this section shall be in substantially the following form: 1185 1186 1187

"SUMMARY DISCLOSURE FORM 1188

(1) Compensation terms 1189

(a) Manner of payment 1190

[ ] Fee for service 1191

[ ] Capitation 1192

[ ] Risk 1193

[ ] Other _______________ See _______________ 1194

(b) Fee schedule available at _______________ 1195

(c) Fee calculation schedule available at _______________ 1196

(d) Identity of internal processing edits available at 1197

_______________ 1198

(e) Information in (c) and (d) is not required if information in (b) is provided. 1199 1200

(2) List of products or networks covered by this contract 1201

[ ] _______________ 1202

[ ] _______________ 1203

[ ] _______________ 1204

[ ] _______________ 1205

[ ] _______________ 1206

(3) Term of this contract _______________ 1207

(4) Contracting entity or payer responsible for processing payment available at _______________ 1208 1209

(5) Internal mechanism for resolving disputes regarding contract terms available at _______________ 1210 1211

(6) Addenda to contract 1212

Title Subject 1213

(a) 1214

(b) 1215

(c) 1216

(d) 1217

(7) Telephone number to access a readily available mechanism, such as a specific web site address, to allow a participating provider to receive the information in (1) through (6) from the payer. 1218 1219 1220 1221

IMPORTANT INFORMATION - PLEASE READ CAREFULLY

The information provided in this Summary Disclosure Form is a guide to the attached Health Care Contract as defined in section 3963.01 ~~(I)~~ (K) of the Ohio Revised Code. The terms and conditions of the attached Health Care Contract constitute the contract rights of the parties.

Reading this Summary Disclosure Form is not a substitute for reading the entire Health Care Contract. When you sign the Health Care Contract, you will be bound by its terms and conditions. These terms and conditions may be amended over time pursuant to section 3963.04 of the Ohio Revised Code. You are encouraged to read any proposed amendments that are sent to you after execution of the Health Care Contract.

Nothing in this Summary Disclosure Form creates any additional rights or causes of action in favor of either party."

(C) When a contracting entity presents a proposed health care contract for consideration by a provider, the contracting entity shall provide in writing or make reasonably available the information required in division (A)(1) of this section.

(D) The contracting entity shall identify any utilization management, quality improvement, or a similar program that the contracting entity uses to review, monitor, evaluate, or assess the services provided pursuant to a health care contract. The contracting entity shall disclose the policies, procedures, or guidelines of such a program applicable to a participating provider upon request by the participating provider within fourteen days after the date of the request.

(E) Nothing in this section shall be construed as preventing or affecting the application of section 1753.07 of

the Revised Code that would otherwise apply to a contract with a participating provider. 1251 1252

(F) The requirements of division (C) of this section do not prohibit a contracting entity from requiring a reasonable confidentiality agreement between the provider and the contracting entity regarding the terms of the proposed health care contract. If either party violates the confidentiality agreement, a party to the confidentiality agreement may bring a civil action to enjoin the other party from continuing any act that is in violation of the confidentiality agreement, to recover damages, to terminate the contract, or to obtain any combination of relief." 1253 1254 1255 1256 1257 1258 1259 1260 1261 1262

After line 1086, insert: 1263

"**Sec. 4715.30.** (A) Except as provided in division (K) of this section, an applicant for or holder of a certificate or license issued under this chapter is subject to disciplinary action by the state dental board for any of the following reasons: 1264 1265 1266 1267 1268

(1) Employing or cooperating in fraud or material deception in applying for or obtaining a license or certificate; 1269 1270

(2) Obtaining or attempting to obtain money or anything of value by intentional misrepresentation or material deception in the course of practice; 1271 1272 1273

(3) Advertising services in a false or misleading manner or violating the board's rules governing time, place, and manner of advertising; 1274 1275 1276

(4) Commission of an act that constitutes a felony in this state, regardless of the jurisdiction in which the act was 1277 1278

committed; 1279

(5) Commission of an act in the course of practice that constitutes a misdemeanor in this state, regardless of the jurisdiction in which the act was committed; 1280 1281 1282

(6) Conviction of, a plea of guilty to, a judicial finding of guilt of, a judicial finding of guilt resulting from a plea of no contest to, or a judicial finding of eligibility for intervention in lieu of conviction for, any felony or of a misdemeanor committed in the course of practice; 1283 1284 1285 1286 1287

(7) Engaging in lewd or immoral conduct in connection with the provision of dental services; 1288 1289

(8) Selling, prescribing, giving away, or administering drugs for other than legal and legitimate therapeutic purposes, or conviction of, a plea of guilty to, a judicial finding of guilt of, a judicial finding of guilt resulting from a plea of no contest to, or a judicial finding of eligibility for intervention in lieu of conviction for, a violation of any federal or state law regulating the possession, distribution, or use of any drug; 1290 1291 1292 1293 1294 1295 1296 1297

(9) Providing or allowing dental hygienists, expanded function dental auxiliaries, or other practitioners of auxiliary dental occupations working under the certificate or license holder's supervision, or a dentist holding a temporary limited continuing education license under division (C) of section 4715.16 of the Revised Code working under the certificate or license holder's direct supervision, to provide dental care that departs from or fails to conform to accepted standards for the profession, whether or not injury to a patient results; 1298 1299 1300 1301 1302 1303 1304 1305 1306

(10) Inability to practice under accepted standards of the 1307

profession because of physical or mental disability, dependence on alcohol or other drugs, or excessive use of alcohol or other drugs; 1308 1309 1310

(11) Violation of any provision of this chapter or any rule adopted thereunder; 1311 1312

(12) Failure to use universal blood and body fluid precautions established by rules adopted under section 4715.03 of the Revised Code; 1313 1314 1315

(13) Except as provided in division (H) of this section, either of the following: 1316 1317

(a) Waiving the payment of all or any part of a deductible or copayment that a patient, pursuant to a health insurance or health care policy, contract, or plan that covers dental services, would otherwise be required to pay if the waiver is used as an enticement to a patient or group of patients to receive health care services from that certificate or license holder; 1318 1319 1320 1321 1322 1323 1324

(b) Advertising that the certificate or license holder will waive the payment of all or any part of a deductible or copayment that a patient, pursuant to a health insurance or health care policy, contract, or plan that covers dental services, would otherwise be required to pay. 1325 1326 1327 1328 1329

(14) Failure to comply with section 4715.302 or 4729.79 of the Revised Code, unless the state board of pharmacy no longer maintains a drug database pursuant to section 4729.75 of the Revised Code; 1330 1331 1332 1333

(15) Any of the following actions taken by an agency responsible for authorizing, certifying, or regulating an 1334 1335

individual to practice a health care occupation or provide health care services in this state or another jurisdiction, for any reason other than the nonpayment of fees: the limitation, revocation, or suspension of an individual's license to practice; acceptance of an individual's license surrender; denial of a license; refusal to renew or reinstate a license; imposition of probation; or issuance of an order of censure or other reprimand; 1336 1337 1338 1339 1340 1341 1342 1343

(16) Failure to cooperate in an investigation conducted by the board under division (D) of section 4715.03 of the Revised Code, including failure to comply with a subpoena or order issued by the board or failure to answer truthfully a question presented by the board at a deposition or in written interrogatories, except that failure to cooperate with an investigation shall not constitute grounds for discipline under this section if a court of competent jurisdiction has issued an order that either quashes a subpoena or permits the individual to withhold the testimony or evidence in issue; 1344 1345 1346 1347 1348 1349 1350 1351 1352 1353

(17) Failure to comply with the requirements in section 3719.061 of the Revised Code before issuing for a minor a prescription for an opioid analgesic, as defined in section 3719.01 of the Revised Code; 1354 1355 1356 1357

(18) Failure to comply with the requirements of sections 4715.71 and 4715.72 of the Revised Code regarding the operation of a mobile dental facility; 1358 1359 1360

(19) A pattern of continuous or repeated violations of division (F)(2) of section 3963.02 of the Revised Code. 1361 1362

(B) A manager, proprietor, operator, or conductor of a dental facility shall be subject to disciplinary action if any 1363 1364

dentist, dental hygienist, expanded function dental auxiliary, or qualified personnel providing services in the facility is found to have committed a violation listed in division (A) of this section and the manager, proprietor, operator, or conductor knew of the violation and permitted it to occur on a recurring basis. 1365 1366 1367 1368 1369 1370

(C) Subject to Chapter 119. of the Revised Code, the board may take one or more of the following disciplinary actions if one or more of the grounds for discipline listed in divisions (A) and (B) of this section exist: 1371 1372 1373 1374

(1) Censure the license or certificate holder; 1375

(2) Place the license or certificate on probationary status for such period of time the board determines necessary and require the holder to: 1376 1377 1378

(a) Report regularly to the board upon the matters which are the basis of probation; 1379 1380

(b) Limit practice to those areas specified by the board; 1381

(c) Continue or renew professional education until a satisfactory degree of knowledge or clinical competency has been attained in specified areas. 1382 1383 1384

(3) Suspend the certificate or license; 1385

(4) Revoke the certificate or license. 1386

Where the board places a holder of a license or certificate on probationary status pursuant to division (C)(2) of this section, the board may subsequently suspend or revoke the license or certificate if it determines that the holder has not met the requirements of the probation or continues to engage in activities that constitute grounds for discipline pursuant to 1387 1388 1389 1390 1391 1392

division (A) or (B) of this section. 1393

Any order suspending a license or certificate shall state the conditions under which the license or certificate will be restored, which may include a conditional restoration during which time the holder is in a probationary status pursuant to division (C)(2) of this section. The board shall restore the license or certificate unconditionally when such conditions are met. 1394 1395 1396 1397 1398 1399 1400

(D) If the physical or mental condition of an applicant or a license or certificate holder is at issue in a disciplinary proceeding, the board may order the license or certificate holder to submit to reasonable examinations by an individual designated or approved by the board and at the board's expense. The physical examination may be conducted by any individual authorized by the Revised Code to do so, including a physician assistant, a clinical nurse specialist, a certified nurse practitioner, or a certified nurse-midwife. Any written documentation of the physical examination shall be completed by the individual who conducted the examination. 1401 1402 1403 1404 1405 1406 1407 1408 1409 1410 1411

Failure to comply with an order for an examination shall be grounds for refusal of a license or certificate or summary suspension of a license or certificate under division (E) of this section. 1412 1413 1414 1415

(E) If a license or certificate holder has failed to comply with an order under division (D) of this section, the board may apply to the court of common pleas of the county in which the holder resides for an order temporarily suspending the holder's license or certificate, without a prior hearing being afforded by the board, until the board conducts an adjudication hearing pursuant to Chapter 119. of the Revised Code. If the 1416 1417 1418 1419 1420 1421 1422

court temporarily suspends a holder's license or certificate, 1423
the board shall give written notice of the suspension personally 1424
or by certified mail to the license or certificate holder. Such 1425
notice shall inform the license or certificate holder of the 1426
right to a hearing pursuant to Chapter 119. of the Revised Code. 1427

(F) Any holder of a certificate or license issued under 1428
this chapter who has pleaded guilty to, has been convicted of, 1429
or has had a judicial finding of eligibility for intervention in 1430
lieu of conviction entered against the holder in this state for 1431
aggravated murder, murder, voluntary manslaughter, felonious 1432
assault, kidnapping, rape, sexual battery, gross sexual 1433
imposition, aggravated arson, aggravated robbery, or aggravated 1434
burglary, or who has pleaded guilty to, has been convicted of, 1435
or has had a judicial finding of eligibility for treatment or 1436
intervention in lieu of conviction entered against the holder in 1437
another jurisdiction for any substantially equivalent criminal 1438
offense, is automatically suspended from practice under this 1439
chapter in this state and any certificate or license issued to 1440
the holder under this chapter is automatically suspended, as of 1441
the date of the guilty plea, conviction, or judicial finding, 1442
whether the proceedings are brought in this state or another 1443
jurisdiction. Continued practice by an individual after the 1444
suspension of the individual's certificate or license under this 1445
division shall be considered practicing without a certificate or 1446
license. The board shall notify the suspended individual of the 1447
suspension of the individual's certificate or license under this 1448
division in accordance with sections 119.05 and 119.07 of the 1449
Revised Code. If an individual whose certificate or license is 1450
suspended under this division fails to make a timely request for 1451
an adjudicatory hearing, the board shall enter a final order 1452
revoking the individual's certificate or license. 1453

(G) If the supervisory investigative panel determines both of the following, the panel may recommend that the board suspend an individual's certificate or license without a prior hearing: 1454 1455 1456

(1) That there is clear and convincing evidence that an individual has violated division (A) of this section; 1457 1458

(2) That the individual's continued practice presents a danger of immediate and serious harm to the public. 1459 1460

Written allegations shall be prepared for consideration by the board. The board, upon review of those allegations and by an affirmative vote of not fewer than four dentist members of the board and seven of its members in total, excluding any member on the supervisory investigative panel, may suspend a certificate or license without a prior hearing. A telephone conference call may be utilized for reviewing the allegations and taking the vote on the summary suspension. 1461 1462 1463 1464 1465 1466 1467 1468

The board shall serve a written order of suspension in accordance with sections 119.05 and 119.07 of the Revised Code. The order shall not be subject to suspension by the court during pendency or any appeal filed under section 119.12 of the Revised Code. If the individual subject to the summary suspension requests an adjudicatory hearing by the board, the date set for the hearing shall be within fifteen days, but not earlier than seven days, after the individual requests the hearing, unless otherwise agreed to by both the board and the individual. 1469 1470 1471 1472 1473 1474 1475 1476 1477

Any summary suspension imposed under this division shall remain in effect, unless reversed on appeal, until a final adjudicative order issued by the board pursuant to this section and Chapter 119. of the Revised Code becomes effective. The board shall issue its final adjudicative order within seventy- 1478 1479 1480 1481 1482

five days after completion of its hearing. A failure to issue the order within seventy-five days shall result in dissolution of the summary suspension order but shall not invalidate any subsequent, final adjudicative order. 1483 1484 1485 1486

(H) Sanctions shall not be imposed under division (A)(13) of this section against any certificate or license holder who waives deductibles and copayments as follows: 1487 1488 1489

(1) In compliance with the health benefit plan that expressly allows such a practice. Waiver of the deductibles or copayments shall be made only with the full knowledge and consent of the plan purchaser, payer, and third-party administrator. Documentation of the consent shall be made available to the board upon request. 1490 1491 1492 1493 1494 1495

(2) For professional services rendered to any other person who holds a certificate or license issued pursuant to this chapter to the extent allowed by this chapter and the rules of the board. 1496 1497 1498 1499

(I) In no event shall the board consider or raise during a hearing required by Chapter 119. of the Revised Code the circumstances of, or the fact that the board has received, one or more complaints about a person unless the one or more complaints are the subject of the hearing or resulted in the board taking an action authorized by this section against the person on a prior occasion. 1500 1501 1502 1503 1504 1505 1506

(J) The board may share any information it receives pursuant to an investigation under division (D) of section 4715.03 of the Revised Code, including patient records and patient record information, with law enforcement agencies, other licensing boards, and other governmental agencies that are 1507 1508 1509 1510 1511

prosecuting, adjudicating, or investigating alleged violations 1512
of statutes or administrative rules. An agency or board that 1513
receives the information shall comply with the same requirements 1514
regarding confidentiality as those with which the state dental 1515
board must comply, notwithstanding any conflicting provision of 1516
the Revised Code or procedure of the agency or board that 1517
applies when it is dealing with other information in its 1518
possession. In a judicial proceeding, the information may be 1519
admitted into evidence only in accordance with the Rules of 1520
Evidence, but the court shall require that appropriate measures 1521
are taken to ensure that confidentiality is maintained with 1522
respect to any part of the information that contains names or 1523
other identifying information about patients or complainants 1524
whose confidentiality was protected by the state dental board 1525
when the information was in the board's possession. Measures to 1526
ensure confidentiality that may be taken by the court include 1527
sealing its records or deleting specific information from its 1528
records. 1529

(K) The board shall not refuse to issue a license or 1530
certificate to an applicant for either of the following reasons 1531
unless the refusal is in accordance with section 9.79 of the 1532
Revised Code: 1533

(1) A conviction or plea of guilty to an offense; 1534

(2) A judicial finding of eligibility for treatment or 1535
intervention in lieu of a conviction. 1536

Section 2. That existing sections 1751.85, 1753.09, 1537
3901.21, 3923.86, 3963.01, 3963.02, 3963.03, and 4715.30 of the 1538
Revised Code are hereby repealed." 1539

In line 1087, delete "**2**" and insert "**3**"; delete "Section" and insert 1540
"Sections 4715.271 and 4715.272 of the Revised Code, as enacted by 1541

section"; delete "takes" and insert ", take" 1542

After line 1088, insert: 1543

"**Section 4.** The General Assembly, applying the principle stated in division (B) of section 1.52 of the Revised Code that amendments are to be harmonized if reasonably capable of simultaneous operation, finds that the following sections, presented in this act as composites of the sections as amended by the acts indicated, are the resulting version of the sections in effect prior to the effective date of the sections as presented in this act: 1544 1545 1546 1547 1548 1549 1550 1551

Section 3963.01 of the Revised Code as amended by both H.B. 156 and S.B. 265 of the 132nd General Assembly. 1552 1553

Section 3963.02 of the Revised Code as amended by both H.B. 156 and S.B. 273 of the 132nd General Assembly." 1554 1555

The motion was __________ agreed to.

SYNOPSIS 1556

Non-covered dental services 1557

R.C. 1751.85, 1753.09, 3901.21, 3923.86, 3963.01, 3963.02, 3963.03, and 4715.30 1558 1559

-Requires health plan issuers to notify covered persons that they may incur out-of-pocket expenses for dental care services that are not covered services. 1560 1561 1562

-Prohibits, beginning January 1, 2025, a contracting entity from requiring that a dental care provider accept a 1563 1564

payment amount set by the contracting entity for dental care services unless those services are covered services. 1565 1566

-Makes a violation of the above provisions an unfair and deceptive act in the business of insurance. 1567 1568

-Requires dental care providers to disclose pricing and certain other information for dental care services that are not covered services. 1569 1570 1571

-Subjects providers who violate the bill's disclosure requirements to professional discipline. 1572 1573