

**As Reported by the House Insurance Committee**

**132nd General Assembly**

**Regular Session**

**2017-2018**

**Sub. H. B. No. 156**

**Representative Schuring**

**Cosponsor: Representative Retherford**

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**A BILL**

To amend sections 1739.05, 1753.09, 3901.21, 1  
3963.01, 3963.02, 3963.03, 4725.19, and 4731.22 2  
and to enact sections 1751.85 and 3923.86 of the 3  
Revised Code regarding limitations imposed by 4  
health insurers on vision care services. 5

**BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF OHIO:**

**Section 1.** That sections 1739.05, 1753.09, 3901.21, 6  
3963.01, 3963.02, 3963.03, 4725.19, and 4731.22 be amended and 7  
sections 1751.85 and 3923.86 of the Revised Code be enacted to 8  
read as follows: 9

**Sec. 1739.05.** (A) A multiple employer welfare arrangement 10  
that is created pursuant to sections 1739.01 to 1739.22 of the 11  
Revised Code and that operates a group self-insurance program 12  
may be established only if any of the following applies: 13

(1) The arrangement has and maintains a minimum enrollment 14  
of three hundred employees of two or more employers. 15

(2) The arrangement has and maintains a minimum enrollment 16  
of three hundred self-employed individuals. 17

(3) The arrangement has and maintains a minimum enrollment 18  
of three hundred employees or self-employed individuals in any 19  
combination of divisions (A) (1) and (2) of this section. 20

(B) A multiple employer welfare arrangement that is 21  
created pursuant to sections 1739.01 to 1739.22 of the Revised 22  
Code and that operates a group self-insurance program shall 23  
comply with all laws applicable to self-funded programs in this 24  
state, including sections 3901.04, 3901.041, 3901.19 to 3901.26, 25  
3901.38, 3901.381 to 3901.3814, 3901.40, 3901.45, 3901.46, 26  
3901.491, 3902.01 to 3902.14, 3923.041, 3923.24, 3923.282, 27  
3923.30, 3923.301, 3923.38, 3923.581, 3923.602, 3923.63, 28  
3923.80, 3923.84, 3923.85, 3923.851, 3923.86, 3924.031, 29  
3924.032, and 3924.27 of the Revised Code. 30

(C) A multiple employer welfare arrangement created 31  
pursuant to sections 1739.01 to 1739.22 of the Revised Code 32  
shall solicit enrollments only through agents or solicitors 33  
licensed pursuant to Chapter 3905. of the Revised Code to sell 34  
or solicit sickness and accident insurance. 35

(D) A multiple employer welfare arrangement created 36  
pursuant to sections 1739.01 to 1739.22 of the Revised Code 37  
shall provide benefits only to individuals who are members, 38  
employees of members, or the dependents of members or employees, 39  
or are eligible for continuation of coverage under section 40  
1751.53 or 3923.38 of the Revised Code or under Title X of the 41  
"Consolidated Omnibus Budget Reconciliation Act of 1985," 100 42  
Stat. 227, 29 U.S.C.A. 1161, as amended. 43

(E) A multiple employer welfare arrangement created 44  
pursuant to sections 1739.01 to 1739.22 of the Revised Code is 45  
subject to, and shall comply with, sections 3903.81 to 3903.93 46  
of the Revised Code in the same manner as other life or health 47

insurers, as defined in section 3903.81 of the Revised Code. 48

Sec. 1751.85. (A) As used in this section, "covered vision services," "vision care materials," and "vision care provider" have the same meanings as in section 3963.01 of the Revised Code. 49  
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(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. The information shall be in a conspicuous format, shall be easily accessible to enrollees, and shall do all of the following: 53  
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(1) Include the following statement: 60

"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." 61  
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(2) Disclose any business interest the health insuring corporation has in a source or supplier of vision care materials; 69  
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(3) 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 that are not covered vision services. The explanation shall be communicated in a manner and format similar to how the health insuring corporation 72  
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provides an enrollee with information on coverage levels and 77  
out-of-pocket expenses that may be incurred by the enrollee 78  
under the policy, contract, or agreement when purchasing out-of- 79  
network vision care services or vision care materials. 80

(C) A pattern of continuous or repeated violations of this 81  
section is an unfair and deceptive act or practice in the 82  
business of insurance under sections 3901.19 to 3901.26 of the 83  
Revised Code. 84

**Sec. 1753.09.** (A) Except as provided in division (D) of 85  
this section, prior to terminating the participation of a 86  
provider on the basis of the participating provider's failure to 87  
meet the health insuring corporation's standards for quality or 88  
utilization in the delivery of health care services, a health 89  
insuring corporation shall give the participating provider 90  
notice of the reason or reasons for its decision to terminate 91  
the provider's participation and an opportunity to take 92  
corrective action. The health insuring corporation shall develop 93  
a performance improvement plan in conjunction with the 94  
participating provider. If after being afforded the opportunity 95  
to comply with the performance improvement plan, the 96  
participating provider fails to do so, the health insuring 97  
corporation may terminate the participation of the provider. 98

(B) (1) A participating provider whose participation has 99  
been terminated under division (A) of this section may appeal 100  
the termination to the appropriate medical director of the 101  
health insuring corporation. The medical director shall give the 102  
participating provider an opportunity to discuss with the 103  
medical director the reason or reasons for the termination. 104

(2) If a satisfactory resolution of a participating 105  
provider's appeal cannot be reached under division (B) (1) of 106

this section, the participating provider may appeal the 107  
termination to a panel composed of participating providers who 108  
have comparable or higher levels of education and training than 109  
the participating provider making the appeal. A representative 110  
of the participating provider's specialty shall be a member of 111  
the panel, if possible. This panel shall hold a hearing, and 112  
shall render its recommendation in the appeal within thirty days 113  
after holding the hearing. The recommendation shall be presented 114  
to the medical director and to the participating provider. 115

(3) The medical director shall review and consider the 116  
panel's recommendation before making a decision. The decision 117  
rendered by the medical director shall be final. 118

(C) A provider's status as a participating provider shall 119  
remain in effect during the appeal process set forth in division 120  
(B) of this section unless the termination was based on any of 121  
the reasons listed in division (D) of this section. 122

(D) Notwithstanding division (A) of this section, a 123  
provider's participation may be immediately terminated if the 124  
participating provider's conduct presents an imminent risk of 125  
harm to an enrollee or enrollees; or if there has occurred 126  
unacceptable quality of care, fraud, patient abuse, loss of 127  
clinical privileges, loss of professional liability coverage, 128  
incompetence, or loss of authority to practice in the 129  
participating provider's field; or if a governmental action has 130  
impaired the participating provider's ability to practice. 131

(E) Divisions (A) to (D) of this section apply only to 132  
providers who are natural persons. 133

(F) (1) Nothing in this section prohibits a health insuring 134  
corporation from rejecting a provider's application for 135

participation, or from terminating a participating provider's 136  
contract, if the health insuring corporation determines that the 137  
health care needs of its enrollees are being met and no need 138  
exists for the provider's or participating provider's services. 139

(2) Nothing in this section shall be construed as 140  
prohibiting a health insuring corporation from terminating a 141  
participating provider who does not meet the terms and 142  
conditions of the participating provider's contract. 143

(3) Nothing in this section shall be construed as 144  
prohibiting a health insuring corporation from terminating a 145  
participating provider's contract pursuant to any provision of 146  
the contract described in division ~~(E)~~(F) (2) of section 3963.02 147  
of the Revised Code, except that, notwithstanding any provision 148  
of a contract described in that division, this section applies 149  
to the termination of a participating provider's contract for 150  
any of the causes described in divisions (A), (D), and (F) (1) 151  
and (2) of this section. 152

(G) The superintendent of insurance may adopt rules as 153  
necessary to implement and enforce sections 1753.06, 1753.07, 154  
and 1753.09 of the Revised Code. Such rules shall be adopted in 155  
accordance with Chapter 119. of the Revised Code. 156

**Sec. 3901.21.** The following are hereby defined as unfair 157  
and deceptive acts or practices in the business of insurance: 158

(A) Making, issuing, circulating, or causing or permitting 159  
to be made, issued, or circulated, or preparing with intent to 160  
so use, any estimate, illustration, circular, or statement 161  
misrepresenting the terms of any policy issued or to be issued 162  
or the benefits or advantages promised thereby or the dividends 163  
or share of the surplus to be received thereon, or making any 164

false or misleading statements as to the dividends or share of 165  
surplus previously paid on similar policies, or making any 166  
misleading representation or any misrepresentation as to the 167  
financial condition of any insurer as shown by the last 168  
preceding verified statement made by it to the insurance 169  
department of this state, or as to the legal reserve system upon 170  
which any life insurer operates, or using any name or title of 171  
any policy or class of policies misrepresenting the true nature 172  
thereof, or making any misrepresentation or incomplete 173  
comparison to any person for the purpose of inducing or tending 174  
to induce such person to purchase, amend, lapse, forfeit, 175  
change, or surrender insurance. 176

Any written statement concerning the premiums for a policy 177  
which refers to the net cost after credit for an assumed 178  
dividend, without an accurate written statement of the gross 179  
premiums, cash values, and dividends based on the insurer's 180  
current dividend scale, which are used to compute the net cost 181  
for such policy, and a prominent warning that the rate of 182  
dividend is not guaranteed, is a misrepresentation for the 183  
purposes of this division. 184

(B) Making, publishing, disseminating, circulating, or 185  
placing before the public or causing, directly or indirectly, to 186  
be made, published, disseminated, circulated, or placed before 187  
the public, in a newspaper, magazine, or other publication, or 188  
in the form of a notice, circular, pamphlet, letter, or poster, 189  
or over any radio station, or in any other way, or preparing 190  
with intent to so use, an advertisement, announcement, or 191  
statement containing any assertion, representation, or 192  
statement, with respect to the business of insurance or with 193  
respect to any person in the conduct of the person's insurance 194  
business, which is untrue, deceptive, or misleading. 195

(C) Making, publishing, disseminating, or circulating, 196  
directly or indirectly, or aiding, abetting, or encouraging the 197  
making, publishing, disseminating, or circulating, or preparing 198  
with intent to so use, any statement, pamphlet, circular, 199  
article, or literature, which is false as to the financial 200  
condition of an insurer and which is calculated to injure any 201  
person engaged in the business of insurance. 202

(D) Filing with any supervisory or other public official, 203  
or making, publishing, disseminating, circulating, or delivering 204  
to any person, or placing before the public, or causing directly 205  
or indirectly to be made, published, disseminated, circulated, 206  
delivered to any person, or placed before the public, any false 207  
statement of financial condition of an insurer. 208

Making any false entry in any book, report, or statement 209  
of any insurer with intent to deceive any agent or examiner 210  
lawfully appointed to examine into its condition or into any of 211  
its affairs, or any public official to whom such insurer is 212  
required by law to report, or who has authority by law to 213  
examine into its condition or into any of its affairs, or, with 214  
like intent, willfully omitting to make a true entry of any 215  
material fact pertaining to the business of such insurer in any 216  
book, report, or statement of such insurer, or mutilating, 217  
destroying, suppressing, withholding, or concealing any of its 218  
records. 219

(E) Issuing or delivering or permitting agents, officers, 220  
or employees to issue or deliver agency company stock or other 221  
capital stock or benefit certificates or shares in any common- 222  
law corporation or securities or any special or advisory board 223  
contracts or other contracts of any kind promising returns and 224  
profits as an inducement to insurance. 225



(F) Making or permitting any unfair discrimination among 226  
individuals of the same class and equal expectation of life in 227  
the rates charged for any contract of life insurance or of life 228  
annuity or in the dividends or other benefits payable thereon, 229  
or in any other of the terms and conditions of such contract. 230

(G) (1) Except as otherwise expressly provided by law, 231  
knowingly permitting or offering to make or making any contract 232  
of life insurance, life annuity or accident and health 233  
insurance, or agreement as to such contract other than as 234  
plainly expressed in the contract issued thereon, or paying or 235  
allowing, or giving or offering to pay, allow, or give, directly 236  
or indirectly, as inducement to such insurance, or annuity, any 237  
rebate of premiums payable on the contract, or any special favor 238  
or advantage in the dividends or other benefits thereon, or any 239  
valuable consideration or inducement whatever not specified in 240  
the contract; or giving, or selling, or purchasing, or offering 241  
to give, sell, or purchase, as inducement to such insurance or 242  
annuity or in connection therewith, any stocks, bonds, or other 243  
securities, or other obligations of any insurance company or 244  
other corporation, association, or partnership, or any dividends 245  
or profits accrued thereon, or anything of value whatsoever not 246  
specified in the contract. 247

(2) Nothing in division (F) or division (G) (1) of this 248  
section shall be construed as prohibiting any of the following 249  
practices: (a) in the case of any contract of life insurance or 250  
life annuity, paying bonuses to policyholders or otherwise 251  
abating their premiums in whole or in part out of surplus 252  
accumulated from nonparticipating insurance, provided that any 253  
such bonuses or abatement of premiums shall be fair and 254  
equitable to policyholders and for the best interests of the 255  
company and its policyholders; (b) in the case of life insurance 256

policies issued on the industrial debit plan, making allowance 257  
to policyholders who have continuously for a specified period 258  
made premium payments directly to an office of the insurer in an 259  
amount which fairly represents the saving in collection 260  
expenses; (c) readjustment of the rate of premium for a group 261  
insurance policy based on the loss or expense experience 262  
thereunder, at the end of the first or any subsequent policy 263  
year of insurance thereunder, which may be made retroactive only 264  
for such policy year. 265

(H) Making, issuing, circulating, or causing or permitting 266  
to be made, issued, or circulated, or preparing with intent to 267  
so use, any statement to the effect that a policy of life 268  
insurance is, is the equivalent of, or represents shares of 269  
capital stock or any rights or options to subscribe for or 270  
otherwise acquire any such shares in the life insurance company 271  
issuing that policy or any other company. 272

(I) Making, issuing, circulating, or causing or permitting 273  
to be made, issued or circulated, or preparing with intent to so 274  
issue, any statement to the effect that payments to a 275  
policyholder of the principal amounts of a pure endowment are 276  
other than payments of a specific benefit for which specific 277  
premiums have been paid. 278

(J) Making, issuing, circulating, or causing or permitting 279  
to be made, issued, or circulated, or preparing with intent to 280  
so use, any statement to the effect that any insurance company 281  
was required to change a policy form or related material to 282  
comply with Title XXXIX of the Revised Code or any regulation of 283  
the superintendent of insurance, for the purpose of inducing or 284  
intending to induce any policyholder or prospective policyholder 285  
to purchase, amend, lapse, forfeit, change, or surrender 286

insurance.	287
(K) Aiding or abetting another to violate this section.	288
(L) Refusing to issue any policy of insurance, or	289
canceling or declining to renew such policy because of the sex	290
or marital status of the applicant, prospective insured,	291
insured, or policyholder.	292
(M) Making or permitting any unfair discrimination between	293
individuals of the same class and of essentially the same hazard	294
in the amount of premium, policy fees, or rates charged for any	295
policy or contract of insurance, other than life insurance, or	296
in the benefits payable thereunder, or in underwriting standards	297
and practices or eligibility requirements, or in any of the	298
terms or conditions of such contract, or in any other manner	299
whatever.	300
(N) Refusing to make available disability income insurance	301
solely because the applicant's principal occupation is that of	302
managing a household.	303
(O) Refusing, when offering maternity benefits under any	304
individual or group sickness and accident insurance policy, to	305
make maternity benefits available to the policyholder for the	306
individual or individuals to be covered under any comparable	307
policy to be issued for delivery in this state, including family	308
members if the policy otherwise provides coverage for family	309
members. Nothing in this division shall be construed to prohibit	310
an insurer from imposing a reasonable waiting period for such	311
benefits under an individual sickness and accident insurance	312
policy issued to an individual who is not a federally eligible	313
individual or a nonemployer-related group sickness and accident	314
insurance policy, but in no event shall such waiting period	315

exceed two hundred seventy days. 316

For purposes of division (O) of this section, "federally 317  
eligible individual" means an eligible individual as defined in 318  
45 C.F.R. 148.103. 319

(P) Using, or permitting to be used, a pattern settlement 320  
as the basis of any offer of settlement. As used in this 321  
division, "pattern settlement" means a method by which liability 322  
is routinely imputed to a claimant without an investigation of 323  
the particular occurrence upon which the claim is based and by 324  
using a predetermined formula for the assignment of liability 325  
arising out of occurrences of a similar nature. Nothing in this 326  
division shall be construed to prohibit an insurer from 327  
determining a claimant's liability by applying formulas or 328  
guidelines to the facts and circumstances disclosed by the 329  
insurer's investigation of the particular occurrence upon which 330  
a claim is based. 331

(Q) Refusing to insure, or refusing to continue to insure, 332  
or limiting the amount, extent, or kind of life or sickness and 333  
accident insurance or annuity coverage available to an 334  
individual, or charging an individual a different rate for the 335  
same coverage solely because of blindness or partial blindness. 336  
With respect to all other conditions, including the underlying 337  
cause of blindness or partial blindness, persons who are blind 338  
or partially blind shall be subject to the same standards of 339  
sound actuarial principles or actual or reasonably anticipated 340  
actuarial experience as are sighted persons. Refusal to insure 341  
includes, but is not limited to, denial by an insurer of 342  
disability insurance coverage on the grounds that the policy 343  
defines "disability" as being presumed in the event that the 344  
eyesight of the insured is lost. However, an insurer may exclude 345

from coverage disabilities consisting solely of blindness or 346  
partial blindness when such conditions existed at the time the 347  
policy was issued. To the extent that the provisions of this 348  
division may appear to conflict with any provision of section 349  
3999.16 of the Revised Code, this division applies. 350

(R) (1) Directly or indirectly offering to sell, selling, 351  
or delivering, issuing for delivery, renewing, or using or 352  
otherwise marketing any policy of insurance or insurance product 353  
in connection with or in any way related to the grant of a 354  
student loan guaranteed in whole or in part by an agency or 355  
commission of this state or the United States, except insurance 356  
that is required under federal or state law as a condition for 357  
obtaining such a loan and the premium for which is included in 358  
the fees and charges applicable to the loan; or, in the case of 359  
an insurer or insurance agent, knowingly permitting any lender 360  
making such loans to engage in such acts or practices in 361  
connection with the insurer's or agent's insurance business. 362

(2) Except in the case of a violation of division (G) of 363  
this section, division (R) (1) of this section does not apply to 364  
either of the following: 365

(a) Acts or practices of an insurer, its agents, 366  
representatives, or employees in connection with the grant of a 367  
guaranteed student loan to its insured or the insured's spouse 368  
or dependent children where such acts or practices take place 369  
more than ninety days after the effective date of the insurance; 370

(b) Acts or practices of an insurer, its agents, 371  
representatives, or employees in connection with the 372  
solicitation, processing, or issuance of an insurance policy or 373  
product covering the student loan borrower or the borrower's 374  
spouse or dependent children, where such acts or practices take 375

place more than one hundred eighty days after the date on which 376  
the borrower is notified that the student loan was approved. 377

(S) Denying coverage, under any health insurance or health 378  
care policy, contract, or plan providing family coverage, to any 379  
natural or adopted child of the named insured or subscriber 380  
solely on the basis that the child does not reside in the 381  
household of the named insured or subscriber. 382

(T)(1) Using any underwriting standard or engaging in any 383  
other act or practice that, directly or indirectly, due solely 384  
to any health status-related factor in relation to one or more 385  
individuals, does either of the following: 386

(a) Terminates or fails to renew an existing individual 387  
policy, contract, or plan of health benefits, or a health 388  
benefit plan issued to an employer, for which an individual 389  
would otherwise be eligible; 390

(b) With respect to a health benefit plan issued to an 391  
employer, excludes or causes the exclusion of an individual from 392  
coverage under an existing employer-provided policy, contract, 393  
or plan of health benefits. 394

(2) The superintendent of insurance may adopt rules in 395  
accordance with Chapter 119. of the Revised Code for purposes of 396  
implementing division (T)(1) of this section. 397

(3) For purposes of division (T)(1) of this section, 398  
"health status-related factor" means any of the following: 399

(a) Health status; 400

(b) Medical condition, including both physical and mental 401  
illnesses; 402

(c) Claims experience; 403

(d) Receipt of health care;	404
(e) Medical history;	405
(f) Genetic information;	406
(g) Evidence of insurability, including conditions arising out of acts of domestic violence;	407 408
(h) Disability.	409
(U) With respect to a health benefit plan issued to a 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.	410 411 412 413 414
(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.	415 416 417 418
(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.	419 420 421
(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.	422 423 424 425
(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;	426 427 428 429 430 431

(b) Adding a surcharge or rating factor to a premium of 432  
any individual policy or contract of life or health insurance 433  
for the reason that the insured or applicant for insurance is or 434  
has been a victim of domestic violence; 435

(c) Denying coverage under, or limiting coverage under, 436  
any policy or contract of life or health insurance, for the 437  
reason that a claim under the policy or contract arises from an 438  
incident of domestic violence; 439

(d) Inquiring, directly or indirectly, of an insured 440  
under, or of an applicant for, a policy or contract of life or 441  
health insurance, as to whether the insured or applicant is or 442  
has been a victim of domestic violence, or inquiring as to 443  
whether the insured or applicant has sought shelter or 444  
protection from domestic violence or has sought medical or 445  
psychological treatment as a victim of domestic violence. 446

(2) Nothing in division (Y) (1) of this section shall be 447  
construed to prohibit an insurer from inquiring as to, or from 448  
underwriting or rating a risk on the basis of, a person's 449  
physical or mental condition, even if the condition has been 450  
caused by domestic violence, provided that all of the following 451  
apply: 452

(a) The insurer routinely considers the condition in 453  
underwriting or in rating risks, and does so in the same manner 454  
for a victim of domestic violence as for an insured or applicant 455  
who is not a victim of domestic violence; 456

(b) The insurer does not refuse to issue any policy or 457  
contract of life or health insurance or cancel or refuse to 458  
renew any policy or contract of life insurance, solely on the 459  
basis of the condition, except where such refusal to issue, 460



cancellation, or refusal to renew is based on sound actuarial 461  
principles or is related to actual or reasonably anticipated 462  
experience; 463

(c) The insurer does not consider a person's status as 464  
being or as having been a victim of domestic violence, in 465  
itself, to be a physical or mental condition; 466

(d) The underwriting or rating of a risk on the basis of 467  
the condition is not used to evade the intent of division (Y) (1) 468  
of this section, or of any other provision of the Revised Code. 469

(3) (a) Nothing in division (Y) (1) of this section shall be 470  
construed to prohibit an insurer from refusing to issue a policy 471  
or contract of life insurance insuring the life of a person who 472  
is or has been a victim of domestic violence if the person who 473  
committed the act of domestic violence is the applicant for the 474  
insurance or would be the owner of the insurance policy or 475  
contract. 476

(b) Nothing in division (Y) (2) of this section shall be 477  
construed to permit an insurer to cancel or refuse to renew any 478  
policy or contract of health insurance in violation of the 479  
"Health Insurance Portability and Accountability Act of 1996," 480  
110 Stat. 1955, 42 U.S.C.A. 300gg-41(b), as amended, or in a 481  
manner that violates or is inconsistent with any provision of 482  
the Revised Code that implements the "Health Insurance 483  
Portability and Accountability Act of 1996." 484

(4) An insurer is immune from any civil or criminal 485  
liability that otherwise might be incurred or imposed as a 486  
result of any action taken by the insurer to comply with 487  
division (Y) of this section. 488

(5) As used in division (Y) of this section, "domestic 489

violence" means any of the following acts:	490
(a) Knowingly causing or attempting to cause physical harm to a family or household member;	491 492
(b) Recklessly causing serious physical harm to a family or household member;	493 494
(c) Knowingly causing, by threat of force, a family or household member to believe that the person will cause imminent physical harm to the family or household member.	495 496 497
For the purpose of division (Y) (5) of this section, "family or household member" has the same meaning as in section 2919.25 of the Revised Code.	498 499 500
Nothing in division (Y) (5) of this section shall be construed to require, as a condition to the application of division (Y) of this section, that the act described in division (Y) (5) of this section be the basis of a criminal prosecution.	501 502 503 504
(Z) Disclosing a coroner's records by an insurer in violation of section 313.10 of the Revised Code.	505 506
(AA) Making, issuing, circulating, or causing or permitting to be made, issued, or circulated any statement or representation that a life insurance policy or annuity is a contract for the purchase of funeral goods or services.	507 508 509 510
(BB) <u>With respect to a health care contract as defined in section 3963.01 of the Revised Code that covers vision services, as defined in that section, including any of the contract terms prohibited under or failing to make the disclosures required under division (E) of section 3963.02 of the Revised Code.</u>	511 512 513 514 515
(CC) <u>With respect to private passenger automobile insurance, charging premium rates that are excessive,</u>	516 517

inadequate, or unfairly discriminatory, pursuant to division (D) 518  
of section 3937.02 of the Revised Code, based solely on the 519  
location of the residence of the insured. 520

The enumeration in sections 3901.19 to 3901.26 of the 521  
Revised Code of specific unfair or deceptive acts or practices 522  
in the business of insurance is not exclusive or restrictive or 523  
intended to limit the powers of the superintendent of insurance 524  
to adopt rules to implement this section, or to take action 525  
under other sections of the Revised Code. 526

This section does not prohibit the sale of shares of any 527  
investment company registered under the "Investment Company Act 528  
of 1940," 54 Stat. 789, 15 U.S.C.A. 80a-1, as amended, or any 529  
policies, annuities, or other contracts described in section 530  
3907.15 of the Revised Code. 531

As used in this section, "estimate," "statement," 532  
"representation," "misrepresentation," "advertisement," or 533  
"announcement" includes oral or written occurrences. 534

Sec. 3923.86. (A) As used in this section, "covered vision 535  
services," "vision care materials," and "vision care provider" 536  
have the same meanings as in section 3963.01 of the Revised 537  
Code. 538

(B) A sickness and accident insurer or public employee 539  
benefit plan shall provide the information required in this 540  
division to all insured individuals receiving coverage under an 541  
individual or group policy of sickness and accident insurance or 542  
public employee benefit plan providing coverage for vision care 543  
services or vision care materials. The information shall be in a 544  
conspicuous format, shall be easily accessible to insured 545  
individuals, and shall do all of the following: 546

<u>(1) Include the following statement:</u>	547
<u>"IMPORTANT: If you opt to receive vision care services or</u>	548
<u>vision care materials that are not covered benefits under this</u>	549
<u>plan, a participating vision care provider may charge you his or</u>	550
<u>her normal fee for such services or materials. Prior to</u>	551
<u>providing you with vision care services or vision care materials</u>	552
<u>that are not covered benefits, the vision care provider will</u>	553
<u>provide you with an estimated cost for each service or material</u>	554
<u>upon your request."</u>	555
<u>(2) Disclose any business interest the insurer or plan has</u>	556
<u>in a source or supplier of vision care materials;</u>	557
<u>(3) Include an explanation that the insured individual may</u>	558
<u>incur out-of-pocket expenses as a result of the purchase of</u>	559
<u>vision care services or vision care materials that are not</u>	560
<u>covered vision services. The explanation shall be communicated</u>	561
<u>in a manner and format similar to how the insurer or plan</u>	562
<u>provides an insured individual with information on coverage</u>	563
<u>levels and out-of-pocket expenses that may be incurred by the</u>	564
<u>insured individual under the policy or plan when purchasing out-</u>	565
<u>of-network vision care services or vision care materials.</u>	566
<u>(C) A pattern of continuous or repeated violations of this</u>	567
<u>section is an unfair and deceptive act or practice in the</u>	568
<u>business of insurance under sections 3901.19 to 3901.26 of the</u>	569
<u>Revised Code.</u>	570
<b>Sec. 3963.01.</b> As used in this chapter:	571
(A) "Affiliate" means any person or entity that has	572
ownership or control of a contracting entity, is owned or	573
controlled by a contracting entity, or is under common ownership	574
or control with a contracting entity.	575

(B) "Basic health care services" has the same meaning as 576  
in division (A) of section 1751.01 of the Revised Code, except 577  
that it does not include any services listed in that division 578  
that are provided by a pharmacist or nursing home. 579

(C) "Covered vision services" means vision care services 580  
or vision care materials for which a reimbursement is available 581  
under an enrollee's health care contract, or for which a 582  
reimbursement would be available but for the application of 583  
contractual limitations such as a deductible, copayment, 584  
coinsurance, waiting period, annual or lifetime maximum, 585  
frequency limitation, alternative benefit payment, or any other 586  
limitation. 587

(D) "Contracting entity" means any person that has a 588  
primary business purpose of contracting with participating 589  
providers for the delivery of health care services. 590

~~(D)~~ (E) "Credentialing" means the process of assessing and 591  
validating the qualifications of a provider applying to be 592  
approved by a contracting entity to provide basic health care 593  
services, specialty health care services, or supplemental health 594  
care services to enrollees. 595

~~(E)~~ (F) "Edit" means adjusting one or more procedure codes 596  
billed by a participating provider on a claim for payment or a 597  
practice that results in any of the following: 598

(1) Payment for some, but not all of the procedure codes 599  
originally billed by a participating provider; 600

(2) Payment for a different procedure code than the 601  
procedure code originally billed by a participating provider; 602

(3) A reduced payment as a result of services provided to 603  
an enrollee that are claimed under more than one procedure code 604

on the same service date. 605

~~(F)~~(G) "Electronic claims transport" means to accept and 606  
digitize claims or to accept claims already digitized, to place 607  
those claims into a format that complies with the electronic 608  
transaction standards issued by the United States department of 609  
health and human services pursuant to the "Health Insurance 610  
Portability and Accountability Act of 1996," 110 Stat. 1955, 42 611  
U.S.C. 1320d, et seq., as those electronic standards are 612  
applicable to the parties and as those electronic standards are 613  
updated from time to time, and to electronically transmit those 614  
claims to the appropriate contracting entity, payer, or third- 615  
party administrator. 616

~~(G)~~(H) "Enrollee" means any person eligible for health 617  
care benefits under a health benefit plan, including an eligible 618  
recipient of medicaid, and includes all of the following terms: 619

(1) "Enrollee" and "subscriber" as defined by section 620  
1751.01 of the Revised Code; 621

(2) "Member" as defined by section 1739.01 of the Revised 622  
Code; 623

(3) "Insured" and "plan member" pursuant to Chapter 3923. 624  
of the Revised Code; 625

(4) "Beneficiary" as defined by section 3901.38 of the 626  
Revised Code. 627

~~(H)~~(I) "Health care contract" means a contract entered 628  
into, materially amended, or renewed between a contracting 629  
entity and a participating provider for the delivery of basic 630  
health care services, specialty health care services, or 631  
supplemental health care services to enrollees. 632

~~(I)~~ (J) "Health care services" means basic health care services, specialty health care services, and supplemental health care services.

~~(J)~~ (K) "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:

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

(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;

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

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

(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;

(6) Changes to a health care contract described in 662  
division (B) of section 3963.04 of the Revised Code. 663

~~(K)~~(L) "Participating provider" means a provider that has 664  
a health care contract with a contracting entity and is entitled 665  
to reimbursement for health care services rendered to an 666  
enrollee under the health care contract. 667

~~(L)~~(M) "Payer" means any person that assumes the 668  
financial risk for the payment of claims under a health care 669  
contract or the reimbursement for health care services provided 670  
to enrollees by participating providers pursuant to a health 671  
care contract. 672

~~(M)~~(N) "Primary enrollee" means a person who is 673  
responsible for making payments for participation in a health 674  
care plan or an enrollee whose employment or other status is the 675  
basis of eligibility for enrollment in a health care plan. 676

~~(N)~~(O) "Procedure codes" includes the American medical 677  
association's current procedural terminology code, the American 678  
dental association's current dental terminology, and the centers 679  
for medicare and medicaid services health care common procedure 680  
coding system. 681

~~(O)~~(P) "Product" means one of the following types of 682  
categories of coverage for which a participating provider may be 683  
obligated to provide health care services pursuant to a health 684  
care contract: 685

(1) A health maintenance organization or other product 686  
provided by a health insuring corporation; 687

(2) A preferred provider organization; 688

(3) Medicare; 689



(4) Medicaid;	690
(5) Workers' compensation.	691
<del>(P)</del> <u>(Q)</u> "Provider" means a physician, podiatrist, dentist,	692
chiropractor, optometrist, psychologist, physician assistant,	693
advanced practice registered nurse, occupational therapist,	694
massage therapist, physical therapist, licensed professional	695
counselor, licensed professional clinical counselor, hearing aid	696
dealer, orthotist, prosthetist, home health agency, hospice care	697
program, pediatric respite care program, or hospital, or a	698
provider organization or physician-hospital organization that is	699
acting exclusively as an administrator on behalf of a provider	700
to facilitate the provider's participation in health care	701
contracts. "Provider" does not mean a pharmacist, pharmacy,	702
nursing home, or a provider organization or physician-hospital	703
organization that leases the provider organization's or	704
physician-hospital organization's network to a third party or	705
contracts directly with employers or health and welfare funds.	706
<del>(Q)</del> <u>(R)</u> "Specialty health care services" has the same	707
meaning as in section 1751.01 of the Revised Code, except that	708
it does not include any services listed in division (B) of	709
section 1751.01 of the Revised Code that are provided by a	710
pharmacist or a nursing home.	711
<del>(R)</del> <u>(S)</u> "Supplemental health care services" has the same	712
meaning as in division (B) of section 1751.01 of the Revised	713
Code, except that it does not include any services listed in	714
that division that are provided by a pharmacist or nursing home.	715
<u>(T) "Vision care materials" includes lenses, devices</u>	716
<u>containing lenses, prisms, lens treatments and coatings, contact</u>	717
<u>lenses, orthotics, vision training, and any prosthetic device</u>	718

necessary to correct, relieve, or treat any defect or abnormal 719  
condition of the human eye or its adnexa. 720

(U) "Vision care provider" means either of the following: 721

(1) An optometrist licensed under Chapter 4725. of the 722  
Revised Code; 723

(2) A physician authorized under Chapter 4731. of the 724  
Revised Code to practice medicine and surgery or osteopathic 725  
medicine and surgery. 726

**Sec. 3963.02.** (A) (1) No contracting entity shall sell, 727  
rent, or give a third party the contracting entity's rights to a 728  
participating provider's services pursuant to the contracting 729  
entity's health care contract with the participating provider 730  
unless one of the following applies: 731

(a) The third party accessing the participating provider's 732  
services under the health care contract is an employer or other 733  
entity providing coverage for health care services to its 734  
employees or members, and that employer or entity has a contract 735  
with the contracting entity or its affiliate for the 736  
administration or processing of claims for payment for services 737  
provided pursuant to the health care contract with the 738  
participating provider. 739

(b) The third party accessing the participating provider's 740  
services under the health care contract either is an affiliate 741  
or subsidiary of the contracting entity or is providing 742  
administrative services to, or receiving administrative services 743  
from, the contracting entity or an affiliate or subsidiary of 744  
the contracting entity. 745

(c) The health care contract specifically provides that it 746  
applies to network rental arrangements and states that one 747

purpose of the contract is selling, renting, or giving the 748  
contracting entity's rights to the services of the participating 749  
provider, including other preferred provider organizations, and 750  
the third party accessing the participating provider's services 751  
is any of the following: 752

(i) A payer or a third-party administrator or other entity 753  
responsible for administering claims on behalf of the payer; 754

(ii) A preferred provider organization or preferred 755  
provider network that receives access to the participating 756  
provider's services pursuant to an arrangement with the 757  
preferred provider organization or preferred provider network in 758  
a contract with the participating provider that is in compliance 759  
with division (A) (1) (c) of this section, and is required to 760  
comply with all of the terms, conditions, and affirmative 761  
obligations to which the originally contracted primary 762  
participating provider network is bound under its contract with 763  
the participating provider, including, but not limited to, 764  
obligations concerning patient steerage and the timeliness and 765  
manner of reimbursement. 766

(iii) An entity that is engaged in the business of 767  
providing electronic claims transport between the contracting 768  
entity and the payer or third-party administrator and complies 769  
with all of the applicable terms, conditions, and affirmative 770  
obligations of the contracting entity's contract with the 771  
participating provider including, but not limited to, 772  
obligations concerning patient steerage and the timeliness and 773  
manner of reimbursement. 774

(2) The contracting entity that sells, rents, or gives the 775  
contracting entity's rights to the participating provider's 776  
services pursuant to the contracting entity's health care 777

contract with the participating provider as provided in division 778  
(A) (1) of this section shall do both of the following: 779

(a) Maintain a web page that contains a listing of third 780  
parties described in divisions (A) (1) (b) and (c) of this section 781  
with whom a contracting entity contracts for the purpose of 782  
selling, renting, or giving the contracting entity's rights to 783  
the services of participating providers that is updated at least 784  
every six months and is accessible to all participating 785  
providers, or maintain a toll-free telephone number accessible 786  
to all participating providers by means of which participating 787  
providers may access the same listing of third parties; 788

(b) Require that the third party accessing the 789  
participating provider's services through the participating 790  
provider's health care contract is obligated to comply with all 791  
of the applicable terms and conditions of the contract, 792  
including, but not limited to, the products for which the 793  
participating provider has agreed to provide services, except 794  
that a payer receiving administrative services from the 795  
contracting entity or its affiliate shall be solely responsible 796  
for payment to the participating provider. 797

(3) Any information disclosed to a participating provider 798  
under this section shall be considered proprietary and shall not 799  
be distributed by the participating provider. 800

(4) Except as provided in division (A) (1) of this section, 801  
no entity shall sell, rent, or give a contracting entity's 802  
rights to the participating provider's services pursuant to a 803  
health care contract. 804

(B) (1) No contracting entity shall require, as a condition 805  
of contracting with the contracting entity, that a participating 806

provider provide services for all of the products offered by the 807  
contracting entity. 808

(2) Division (B)(1) of this section shall not be construed 809  
to do any of the following: 810

(a) Prohibit any participating provider from voluntarily 811  
accepting an offer by a contracting entity to provide health 812  
care services under all of the contracting entity's products; 813

(b) Prohibit any contracting entity from offering any 814  
financial incentive or other form of consideration specified in 815  
the health care contract for a participating provider to provide 816  
health care services under all of the contracting entity's 817  
products; 818

(c) Require any contracting entity to contract with a 819  
participating provider to provide health care services for less 820  
than all of the contracting entity's products if the contracting 821  
entity does not wish to do so. 822

(3) (a) Notwithstanding division (B)(2) of this section, no 823  
contracting entity shall require, as a condition of contracting 824  
with the contracting entity, that the participating provider 825  
accept any future product offering that the contracting entity 826  
makes. 827

(b) If a participating provider refuses to accept any 828  
future product offering that the contracting entity makes, the 829  
contracting entity may terminate the health care contract based 830  
on the participating provider's refusal upon written notice to 831  
the participating provider no sooner than one hundred eighty 832  
days after the refusal. 833

(4) Once the contracting entity and the participating 834  
provider have signed the health care contract, it is presumed 835

that the financial incentive or other form of consideration that 836  
is specified in the health care contract pursuant to division 837  
(B) (2) (b) of this section is the financial incentive or other 838  
form of consideration that was offered by the contracting entity 839  
to induce the participating provider to enter into the contract. 840

(C) No contracting entity shall require, as a condition of 841  
contracting with the contracting entity, that a participating 842  
provider waive or forego any right or benefit expressly 843  
conferred upon a participating provider by state or federal law. 844  
However, this division does not prohibit a contracting entity 845  
from restricting a participating provider's scope of practice 846  
for the services to be provided under the contract. 847

(D) No health care contract shall do any of the following: 848

(1) Prohibit any participating provider from entering into 849  
a health care contract with any other contracting entity; 850

(2) Prohibit any contracting entity from entering into a 851  
health care contract with any other provider; 852

(3) Preclude its use or disclosure for the purpose of 853  
enforcing this chapter or other state or federal law, except 854  
that a health care contract may require that appropriate 855  
measures be taken to preserve the confidentiality of any 856  
proprietary or trade-secret information. 857

(E) (1) No contract or agreement between a contracting 858  
entity and a vision care provider shall do any of the following: 859

(a) Require that a vision care provider accept as payment 860  
an amount set by the contracting entity for vision care services 861  
or vision care materials provided to an enrollee unless the 862  
services or materials are covered vision services. 863

(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. 864  
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(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. 870  
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(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. 876  
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(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; 887  
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(c) Directly limit a vision care provider's choice of sources and suppliers of vision care materials; 891  
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(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. 893  
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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. 896  
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(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. 899  
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(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: 907  
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(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: 911  
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(i) The estimated fee or discounted price suggested by the contracting entity for the noncovered service or material; 915  
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(ii) The estimated fee charged by the vision care provider for the noncovered service or material; 917  
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(iii) The amount the vision care provider expects to be reimbursed by the contracting entity for the noncovered service or material; 919  
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(iv) The estimated pricing and reimbursement information 922  
for any covered services or materials that are also expected to 923  
be provided during the enrollee's visit. 924

(b) Post, in a conspicuous place, a notice stating the 925  
following: 926

"IMPORTANT: This vision care provider does not accept the 927  
fee schedule set by your insurer for vision care services and 928  
vision care materials that are not covered benefits under your 929  
plan and instead charges his or her normal fee for those 930  
services and materials. This vision care provider will provide 931  
you with an estimated cost for each non-covered service or 932  
material upon your request." 933

(4) Nothing in division (E) of this section shall do any 934  
of the following: 935

(a) Restrict or limit a contracting entity's determination 936  
of specific amounts of coverage or reimbursement for the use of 937  
network or out-of-network sources or suppliers of vision care 938  
materials as set forth in an enrollee's benefit plan; 939

(b) Restrict or limit a contracting entity's ability to 940  
enter into an agreement with another contracting entity or an 941  
affiliate of another contracting entity; 942

(c) Restrict or limit a health care plan's ability to 943  
enter into an agreement with a vision care plan to deliver 944  
routine vision care services that are covered under an 945  
enrollee's plan; 946

(d) Restrict or limit a vision care plan network from 947  
acting as a network for a health care plan; 948

(e) Prohibit a contracting entity from requiring 949

participating vision care providers to offer network sources or 950  
suppliers of vision care materials to enrollees; 951

(f) Prohibit an enrollee from utilizing a network source 952  
or supplier of vision care materials as set forth in an 953  
enrollee's plan; 954

(g) Prohibit a participating vision care provider from 955  
accepting as payment an amount that is the same as the amount 956  
set by the contracting entity for vision care services or vision 957  
care materials that are not covered vision services. 958

(F) (1) In addition to any other lawful reasons for 959  
terminating a health care contract, a health care contract may 960  
only be terminated under the circumstances described in division 961  
(A) (3) of section 3963.04 of the Revised Code. 962

(2) If the health care contract provides for termination 963  
for cause by either party, the health care contract shall state 964  
the reasons that may be used for termination for cause, which 965  
terms shall be reasonable. Once the contracting entity and the 966  
participating provider have signed the health care contract, it 967  
is presumed that the reasons stated in the health care contract 968  
for termination for cause by either party are reasonable. 969  
Subject to division ~~(E)~~ (F) (3) of this section, the health care 970  
contract shall state the time by which the parties must provide 971  
notice of termination for cause and to whom the parties shall 972  
give the notice. 973

(3) Nothing in divisions ~~(E)~~ (F) (1) and (2) of this section 974  
shall be construed as prohibiting any health insuring 975  
corporation from terminating a participating provider's contract 976  
for any of the causes described in divisions (A), (D), and (F) 977  
(1) and (2) of section 1753.09 of the Revised Code. 978

Notwithstanding any provision in a health care contract pursuant 979  
to division ~~(E)~~(F) (2) of this section, section 1753.09 of the 980  
Revised Code applies to the termination of a participating 981  
provider's contract for any of the causes described in divisions 982  
(A), (D), and (F) (1) and (2) of section 1753.09 of the Revised 983  
Code. 984

(4) Subject to sections 3963.01 to 3963.11 of the Revised 985  
Code, nothing in this section prohibits the termination of a 986  
health care contract without cause if the health care contract 987  
otherwise provides for termination without cause. 988

~~(F)~~(G) (1) Disputes among parties to a health care contract 989  
that only concern the enforcement of the contract rights 990  
conferred by section 3963.02, divisions (A) and (D) of section 991  
3963.03, and section 3963.04 of the Revised Code are subject to 992  
a mutually agreed upon arbitration mechanism that is binding on 993  
all parties. The arbitrator may award reasonable attorney's fees 994  
and costs for arbitration relating to the enforcement of this 995  
section to the prevailing party. 996

(2) The arbitrator shall make the arbitrator's decision in 997  
an arbitration proceeding having due regard for any applicable 998  
rules, bulletins, rulings, or decisions issued by the department 999  
of insurance or any court concerning the enforcement of the 1000  
contract rights conferred by section 3963.02, divisions (A) and 1001  
(D) of section 3963.03, and section 3963.04 of the Revised Code. 1002

(3) A party shall not simultaneously maintain an 1003  
arbitration proceeding as described in division ~~(F)~~(G) (1) of 1004  
this section and pursue a complaint with the superintendent of 1005  
insurance to investigate the subject matter of the arbitration 1006  
proceeding. However, if a complaint is filed with the department 1007  
of insurance, the superintendent may choose to investigate the 1008

complaint or, after reviewing the complaint, advise the 1009  
complainant to proceed with arbitration to resolve the 1010  
complaint. The superintendent may request to receive a copy of 1011  
the results of the arbitration. If the superintendent of 1012  
insurance notifies an insurer or a health insuring corporation 1013  
in writing that the superintendent has initiated a market 1014  
conduct examination into the specific subject matter of the 1015  
arbitration proceeding pending against that insurer or health 1016  
insuring corporation, the arbitration proceeding shall be stayed 1017  
at the request of the insurer or health insuring corporation 1018  
pending the outcome of the market conduct investigation by the 1019  
superintendent. 1020

**Sec. 3963.03.** (A) Each health care contract shall include 1021  
all of the following information: 1022

(1) (a) Information sufficient for the participating 1023  
provider to determine the compensation or payment terms for 1024  
health care services, including all of the following, subject to 1025  
division (A) (1) (b) of this section: 1026

(i) The manner of payment, such as fee-for-service, 1027  
capitation, or risk; 1028

(ii) The fee schedule of procedure codes reasonably 1029  
expected to be billed by a participating provider's specialty 1030  
for services provided pursuant to the health care contract and 1031  
the associated payment or compensation for each procedure code. 1032  
A fee schedule may be provided electronically. Upon request, a 1033  
contracting entity shall provide a participating provider with 1034  
the fee schedule for any other procedure codes requested and a 1035  
written fee schedule, that shall not be required more frequently 1036  
than twice per year excluding when it is provided in connection 1037  
with any change to the schedule. This requirement may be 1038

satisfied by providing a clearly understandable, readily 1039  
available mechanism, such as a specific web site address, that 1040  
allows a participating provider to determine the effect of 1041  
procedure codes on payment or compensation before a service is 1042  
provided or a claim is submitted. 1043

(iii) The effect, if any, on payment or compensation if 1044  
more than one procedure code applies to the service also shall 1045  
be stated. This requirement may be satisfied by providing a 1046  
clearly understandable, readily available mechanism, such as a 1047  
specific web site address, that allows a participating provider 1048  
to determine the effect of procedure codes on payment or 1049  
compensation before a service is provided or a claim is 1050  
submitted. 1051

(b) If the contracting entity is unable to include the 1052  
information described in ~~division~~ divisions (A) (1) (a) (ii) and 1053  
(iii) of this section, the contracting entity shall include both 1054  
of the following types of information instead: 1055

(i) The methodology used to calculate any fee schedule, 1056  
such as relative value unit system and conversion factor or 1057  
percentage of billed charges. If applicable, the methodology 1058  
disclosure shall include the name of any relative value unit 1059  
system, its version, edition, or publication date, any 1060  
applicable conversion or geographic factor, and any date by 1061  
which compensation or fee schedules may be changed by the 1062  
methodology as anticipated at the time of contract. 1063

(ii) The identity of any internal processing edits, 1064  
including the publisher, product name, version, and version 1065  
update of any editing software. 1066

(c) If the contracting entity is not the payer and is 1067

unable to include the information described in division (A) (1) 1068  
(a) or (b) of this section, then the contracting entity shall 1069  
provide by telephone a readily available mechanism, such as a 1070  
specific web site address, that allows the participating 1071  
provider to obtain that information from the payer. 1072

(2) Any product or network for which the participating 1073  
provider is to provide services; 1074

(3) The term of the health care contract; 1075

(4) A specific web site address that contains the identity 1076  
of the contracting entity or payer responsible for the 1077  
processing of the participating provider's compensation or 1078  
payment; 1079

(5) Any internal mechanism provided by the contracting 1080  
entity to resolve disputes concerning the interpretation or 1081  
application of the terms and conditions of the contract. A 1082  
contracting entity may satisfy this requirement by providing a 1083  
clearly understandable, readily available mechanism, such as a 1084  
specific web site address or an appendix, that allows a 1085  
participating provider to determine the procedures for the 1086  
internal mechanism to resolve those disputes. 1087

(6) A list of addenda, if any, to the contract. 1088

(B) (1) Each contracting entity shall include a summary 1089  
disclosure form with a health care contract that includes all of 1090  
the information specified in division (A) of this section. The 1091  
information in the summary disclosure form shall refer to the 1092  
location in the health care contract, whether a page number, 1093  
section of the contract, appendix, or other identifiable 1094  
location, that specifies the provisions in the contract to which 1095  
the information in the form refers. 1096

(2) The summary disclosure form shall include all of the 1097  
following statements: 1098

(a) That the form is a guide to the health care contract 1099  
and that the terms and conditions of the health care contract 1100  
constitute the contract rights of the parties; 1101

(b) That reading the form is not a substitute for reading 1102  
the entire health care contract; 1103

(c) That by signing the health care contract, the 1104  
participating provider will be bound by the contract's terms and 1105  
conditions; 1106

(d) That the terms and conditions of the health care 1107  
contract may be amended pursuant to section 3963.04 of the 1108  
Revised Code and the participating provider is encouraged to 1109  
carefully read any proposed amendments sent after execution of 1110  
the contract; 1111

(e) That nothing in the summary disclosure form creates 1112  
any additional rights or causes of action in favor of either 1113  
party. 1114

(3) No contracting entity that includes any information in 1115  
the summary disclosure form with the reasonable belief that the 1116  
information is truthful or accurate shall be subject to a civil 1117  
action for damages or to binding arbitration based on the 1118  
summary disclosure form. Division (B) (3) of this section does 1119  
not impair or affect any power of the department of insurance to 1120  
enforce any applicable law. 1121

(4) The summary disclosure form described in divisions (B) 1122  
(1) and (2) of this section shall be in substantially the 1123  
following form: 1124

"SUMMARY DISCLOSURE FORM	1125
(1) Compensation terms	1126
(a) Manner of payment	1127
[ ] Fee for service	1128
[ ] Capitation	1129
[ ] Risk	1130
[ ] Other ..... See .....	1131
(b) Fee schedule available at .....	1132
(c) Fee calculation schedule available at .....	1133
(d) Identity of internal processing edits available at .....	1134 1135
(e) Information in (c) and (d) is not required if information in (b) is provided.	1136 1137
(2) List of products or networks covered by this contract	1138
[ ] .....	1139
[ ] .....	1140
[ ] .....	1141
[ ] .....	1142
[ ] .....	1143
(3) Term of this contract .....	1144
(4) Contracting entity or payer responsible for processing payment available at .....	1145 1146
(5) Internal mechanism for resolving disputes regarding contract terms available at .....	1147 1148



(6) Addenda to contract	1149
Title	1150
Subject	1150
(a)	1151
(b)	1152
(c)	1153
(d)	1154
(7) Telephone number to access a readily available	1155
mechanism, such as a specific web site address, to allow a	1156
participating provider to receive the information in (1) through	1157
(6) from the payer.	1158
IMPORTANT INFORMATION - PLEASE READ CAREFULLY	1159
The information provided in this Summary Disclosure Form	1160
is a guide to the attached Health Care Contract as defined in	1161
section <del>3963.01(G)</del> <u>3963.01(I)</u> of the Ohio Revised Code. The	1162
terms and conditions of the attached Health Care Contract	1163
constitute the contract rights of the parties.	1164
Reading this Summary Disclosure Form is not a substitute	1165
for reading the entire Health Care Contract. When you sign the	1166
Health Care Contract, you will be bound by its terms and	1167
conditions. These terms and conditions may be amended over time	1168
pursuant to section 3963.04 of the Ohio Revised Code. You are	1169
encouraged to read any proposed amendments that are sent to you	1170
after execution of the Health Care Contract.	1171
Nothing in this Summary Disclosure Form creates any	1172
additional rights or causes of action in favor of either party."	1173
(C) When a contracting entity presents a proposed health	1174
care contract for consideration by a provider, the contracting	1175

entity shall provide in writing or make reasonably available the 1176  
information required in division (A) (1) of this section. 1177

(D) The contracting entity shall identify any utilization 1178  
management, quality improvement, or a similar program that the 1179  
contracting entity uses to review, monitor, evaluate, or assess 1180  
the services provided pursuant to a health care contract. The 1181  
contracting entity shall disclose the policies, procedures, or 1182  
guidelines of such a program applicable to a participating 1183  
provider upon request by the participating provider within 1184  
fourteen days after the date of the request. 1185

(E) Nothing in this section shall be construed as 1186  
preventing or affecting the application of section 1753.07 of 1187  
the Revised Code that would otherwise apply to a contract with a 1188  
participating provider. 1189

(F) The requirements of division (C) of this section do 1190  
not prohibit a contracting entity from requiring a reasonable 1191  
confidentiality agreement between the provider and the 1192  
contracting entity regarding the terms of the proposed health 1193  
care contract. If either party violates the confidentiality 1194  
agreement, a party to the confidentiality agreement may bring a 1195  
civil action to enjoin the other party from continuing any act 1196  
that is in violation of the confidentiality agreement, to 1197  
recover damages, to terminate the contract, or to obtain any 1198  
combination of relief. 1199

**Sec. 4725.19.** (A) In accordance with Chapter 119. of the 1200  
Revised Code and by an affirmative vote of a majority of its 1201  
members, the state vision professionals board, for any of the 1202  
reasons specified in division (B) of this section, shall refuse 1203  
to grant a certificate of licensure to practice optometry to an 1204  
applicant and may, with respect to a licensed optometrist, do 1205

one or more of the following:	1206
(1) Suspend the operation of any certificate of licensure,	1207
topical ocular pharmaceutical agents certificate, or therapeutic	1208
pharmaceutical agents certificate, or all certificates granted	1209
by it to the optometrist;	1210
(2) Permanently revoke any or all of the certificates;	1211
(3) Limit or otherwise place restrictions on any or all of	1212
the certificates;	1213
(4) Reprimand the optometrist;	1214
(5) Impose a monetary penalty. If the reason for which the	1215
board is imposing the penalty involves a criminal offense that	1216
carries a fine under the Revised Code, the penalty shall not	1217
exceed the maximum fine that may be imposed for the criminal	1218
offense. In any other case, the penalty imposed by the board	1219
shall not exceed five hundred dollars.	1220
(6) Require the optometrist to take corrective action	1221
courses.	1222
The amount and content of corrective action courses shall	1223
be established by the board in rules adopted under section	1224
4725.09 of the Revised Code.	1225
(B) The sanctions specified in division (A) of this	1226
section may be taken by the board for any of the following	1227
reasons:	1228
(1) Committing fraud in passing the licensing examination	1229
or making false or purposely misleading statements in an	1230
application for a certificate of licensure;	1231
(2) Being at any time guilty of immorality, regardless of	1232

the jurisdiction in which the act was committed;	1233
(3) Being guilty of dishonesty or unprofessional conduct	1234
in the practice of optometry;	1235
(4) Being at any time guilty of a felony, regardless of	1236
the jurisdiction in which the act was committed;	1237
(5) Being at any time guilty of a misdemeanor committed in	1238
the course of practice, regardless of the jurisdiction in which	1239
the act was committed;	1240
(6) Violating the conditions of any limitation or other	1241
restriction placed by the board on any certificate issued by the	1242
board;	1243
(7) Engaging in the practice of optometry as provided in	1244
division (A) (1), (2), or (3) of section 4725.01 of the Revised	1245
Code when the certificate authorizing that practice is under	1246
suspension, in which case the board shall permanently revoke the	1247
certificate;	1248
(8) Being denied a license to practice optometry in	1249
another state or country or being subject to any other sanction	1250
by the optometric licensing authority of another state or	1251
country, other than sanctions imposed for the nonpayment of	1252
fees;	1253
(9) Departing from or failing to conform to acceptable and	1254
prevailing standards of care in the practice of optometry as	1255
followed by similar practitioners under the same or similar	1256
circumstances, regardless of whether actual injury to a patient	1257
is established;	1258
(10) Failing to maintain comprehensive patient records;	1259
(11) Advertising a price of optical accessories, eye	1260

examinations, or other products or services by any means that	1261
would deceive or mislead the public;	1262
(12) Being addicted to the use of alcohol, stimulants,	1263
narcotics, or any other substance which impairs the intellect	1264
and judgment to such an extent as to hinder or diminish the	1265
performance of the duties included in the person's practice of	1266
optometry;	1267
(13) Engaging in the practice of optometry as provided in	1268
division (A) (2) or (3) of section 4725.01 of the Revised Code	1269
without authority to do so or, if authorized, in a manner	1270
inconsistent with the authority granted;	1271
(14) Failing to make a report to the board as required by	1272
division (A) of section 4725.21 or section 4725.31 of the	1273
Revised Code;	1274
(15) Soliciting patients from door to door or establishing	1275
temporary offices, in which case the board shall suspend all	1276
certificates held by the optometrist;	1277
(16) Except as provided in division (D) of this section:	1278
(a) Waiving the payment of all or any part of a deductible	1279
or copayment that a patient, pursuant to a health insurance or	1280
health care policy, contract, or plan that covers optometric	1281
services, would otherwise be required to pay if the waiver is	1282
used as an enticement to a patient or group of patients to	1283
receive health care services from that optometrist.	1284
(b) Advertising that the optometrist will waive the	1285
payment of all or any part of a deductible or copayment that a	1286
patient, pursuant to a health insurance or health care policy,	1287
contract, or plan that covers optometric services, would	1288
otherwise be required to pay.	1289

(17) Failing to comply with the requirements in section 1290  
3719.061 of the Revised Code before issuing for a minor a 1291  
prescription for an analgesic controlled substance authorized 1292  
pursuant to section 4725.091 of the Revised Code that is an 1293  
opioid analgesic, as defined in section 3719.01 of the Revised 1294  
Code; 1295

(18) Violating the rules adopted under section 4725.66 of 1296  
the Revised Code; 1297

(19) A pattern of continuous or repeated violations of 1298  
division (E) (2) or (3) of section 3963.02 of the Revised Code. 1299

(C) Any person who is the holder of a certificate of 1300  
licensure, or who is an applicant for a certificate of licensure 1301  
against whom is preferred any charges, shall be furnished by the 1302  
board with a copy of the complaint and shall have a hearing 1303  
before the board in accordance with Chapter 119. of the Revised 1304  
Code. 1305

(D) Sanctions shall not be imposed under division (B) (17) 1306  
of this section against any optometrist who waives deductibles 1307  
and copayments: 1308

(1) In compliance with the health benefit plan that 1309  
expressly allows such a practice. Waiver of the deductibles or 1310  
copayments shall be made only with the full knowledge and 1311  
consent of the plan purchaser, payer, and third-party 1312  
administrator. Documentation of the consent shall be made 1313  
available to the board upon request. 1314

(2) For professional services rendered to any other 1315  
optometrist licensed by the board, to the extent allowed by 1316  
sections 4725.01 to 4725.34 of the Revised Code and the rules of 1317  
the board. 1318

**Sec. 4731.22.** (A) The state medical board, by an 1319  
affirmative vote of not fewer than six of its members, may 1320  
limit, revoke, or suspend a license or certificate to practice 1321  
or certificate to recommend, refuse to grant a license or 1322  
certificate, refuse to renew a license or certificate, refuse to 1323  
reinstate a license or certificate, or reprimand or place on 1324  
probation the holder of a license or certificate if the 1325  
individual applying for or holding the license or certificate is 1326  
found by the board to have committed fraud during the 1327  
administration of the examination for a license or certificate 1328  
to practice or to have committed fraud, misrepresentation, or 1329  
deception in applying for, renewing, or securing any license or 1330  
certificate to practice or certificate to recommend issued by 1331  
the board. 1332

(B) The board, by an affirmative vote of not fewer than 1333  
six members, shall, to the extent permitted by law, limit, 1334  
revoke, or suspend a license or certificate to practice or 1335  
certificate to recommend, refuse to issue a license or 1336  
certificate, refuse to renew a license or certificate, refuse to 1337  
reinstate a license or certificate, or reprimand or place on 1338  
probation the holder of a license or certificate for one or more 1339  
of the following reasons: 1340

(1) Permitting one's name or one's license or certificate 1341  
to practice to be used by a person, group, or corporation when 1342  
the individual concerned is not actually directing the treatment 1343  
given; 1344

(2) Failure to maintain minimal standards applicable to 1345  
the selection or administration of drugs, or failure to employ 1346  
acceptable scientific methods in the selection of drugs or other 1347  
modalities for treatment of disease; 1348

(3) Except as provided in section 4731.97 of the Revised Code, selling, giving away, personally furnishing, prescribing, or administering drugs for other than legal and legitimate therapeutic purposes or a plea of guilty to, a judicial finding of guilt of, or a judicial finding of eligibility for intervention in lieu of conviction of, a violation of any federal or state law regulating the possession, distribution, or use of any drug;

(4) Willfully betraying a professional confidence.

For purposes of this division, "willfully betraying a professional confidence" does not include providing any information, documents, or reports under sections 307.621 to 307.629 of the Revised Code to a child fatality review board; does not include providing any information, documents, or reports to the director of health pursuant to guidelines established under section 3701.70 of the Revised Code; does not include written notice to a mental health professional under section 4731.62 of the Revised Code; and does not include the making of a report of an employee's use of a drug of abuse, or a report of a condition of an employee other than one involving the use of a drug of abuse, to the employer of the employee as described in division (B) of section 2305.33 of the Revised Code. Nothing in this division affects the immunity from civil liability conferred by section 2305.33 or 4731.62 of the Revised Code upon a physician who makes a report in accordance with section 2305.33 or notifies a mental health professional in accordance with section 4731.62 of the Revised Code. As used in this division, "employee," "employer," and "physician" have the same meanings as in section 2305.33 of the Revised Code.

(5) Making a false, fraudulent, deceptive, or misleading



statement in the solicitation of or advertising for patients; in 1379  
relation to the practice of medicine and surgery, osteopathic 1380  
medicine and surgery, podiatric medicine and surgery, or a 1381  
limited branch of medicine; or in securing or attempting to 1382  
secure any license or certificate to practice issued by the 1383  
board. 1384

As used in this division, "false, fraudulent, deceptive, 1385  
or misleading statement" means a statement that includes a 1386  
misrepresentation of fact, is likely to mislead or deceive 1387  
because of a failure to disclose material facts, is intended or 1388  
is likely to create false or unjustified expectations of 1389  
favorable results, or includes representations or implications 1390  
that in reasonable probability will cause an ordinarily prudent 1391  
person to misunderstand or be deceived. 1392

(6) A departure from, or the failure to conform to, 1393  
minimal standards of care of similar practitioners under the 1394  
same or similar circumstances, whether or not actual injury to a 1395  
patient is established; 1396

(7) Representing, with the purpose of obtaining 1397  
compensation or other advantage as personal gain or for any 1398  
other person, that an incurable disease or injury, or other 1399  
incurable condition, can be permanently cured; 1400

(8) The obtaining of, or attempting to obtain, money or 1401  
anything of value by fraudulent misrepresentations in the course 1402  
of practice; 1403

(9) A plea of guilty to, a judicial finding of guilt of, 1404  
or a judicial finding of eligibility for intervention in lieu of 1405  
conviction for, a felony; 1406

(10) Commission of an act that constitutes a felony in 1407

this state, regardless of the jurisdiction in which the act was 1408  
committed; 1409

(11) A plea of guilty to, a judicial finding of guilt of, 1410  
or a judicial finding of eligibility for intervention in lieu of 1411  
conviction for, a misdemeanor committed in the course of 1412  
practice; 1413

(12) Commission of an act in the course of practice that 1414  
constitutes a misdemeanor in this state, regardless of the 1415  
jurisdiction in which the act was committed; 1416

(13) A plea of guilty to, a judicial finding of guilt of, 1417  
or a judicial finding of eligibility for intervention in lieu of 1418  
conviction for, a misdemeanor involving moral turpitude; 1419

(14) Commission of an act involving moral turpitude that 1420  
constitutes a misdemeanor in this state, regardless of the 1421  
jurisdiction in which the act was committed; 1422

(15) Violation of the conditions of limitation placed by 1423  
the board upon a license or certificate to practice; 1424

(16) Failure to pay license renewal fees specified in this 1425  
chapter; 1426

(17) Except as authorized in section 4731.31 of the 1427  
Revised Code, engaging in the division of fees for referral of 1428  
patients, or the receiving of a thing of value in return for a 1429  
specific referral of a patient to utilize a particular service 1430  
or business; 1431

(18) Subject to section 4731.226 of the Revised Code, 1432  
violation of any provision of a code of ethics of the American 1433  
medical association, the American osteopathic association, the 1434  
American podiatric medical association, or any other national 1435

professional organizations that the board specifies by rule. The 1436  
state medical board shall obtain and keep on file current copies 1437  
of the codes of ethics of the various national professional 1438  
organizations. The individual whose license or certificate is 1439  
being suspended or revoked shall not be found to have violated 1440  
any provision of a code of ethics of an organization not 1441  
appropriate to the individual's profession. 1442

For purposes of this division, a "provision of a code of 1443  
ethics of a national professional organization" does not include 1444  
any provision that would preclude the making of a report by a 1445  
physician of an employee's use of a drug of abuse, or of a 1446  
condition of an employee other than one involving the use of a 1447  
drug of abuse, to the employer of the employee as described in 1448  
division (B) of section 2305.33 of the Revised Code. Nothing in 1449  
this division affects the immunity from civil liability 1450  
conferred by that section upon a physician who makes either type 1451  
of report in accordance with division (B) of that section. As 1452  
used in this division, "employee," "employer," and "physician" 1453  
have the same meanings as in section 2305.33 of the Revised 1454  
Code. 1455

(19) Inability to practice according to acceptable and 1456  
prevailing standards of care by reason of mental illness or 1457  
physical illness, including, but not limited to, physical 1458  
deterioration that adversely affects cognitive, motor, or 1459  
perceptive skills. 1460

In enforcing this division, the board, upon a showing of a 1461  
possible violation, may compel any individual authorized to 1462  
practice by this chapter or who has submitted an application 1463  
pursuant to this chapter to submit to a mental examination, 1464  
physical examination, including an HIV test, or both a mental 1465

and a physical examination. The expense of the examination is 1466  
the responsibility of the individual compelled to be examined. 1467  
Failure to submit to a mental or physical examination or consent 1468  
to an HIV test ordered by the board constitutes an admission of 1469  
the allegations against the individual unless the failure is due 1470  
to circumstances beyond the individual's control, and a default 1471  
and final order may be entered without the taking of testimony 1472  
or presentation of evidence. If the board finds an individual 1473  
unable to practice because of the reasons set forth in this 1474  
division, the board shall require the individual to submit to 1475  
care, counseling, or treatment by physicians approved or 1476  
designated by the board, as a condition for initial, continued, 1477  
reinstated, or renewed authority to practice. An individual 1478  
affected under this division shall be afforded an opportunity to 1479  
demonstrate to the board the ability to resume practice in 1480  
compliance with acceptable and prevailing standards under the 1481  
provisions of the individual's license or certificate. For the 1482  
purpose of this division, any individual who applies for or 1483  
receives a license or certificate to practice under this chapter 1484  
accepts the privilege of practicing in this state and, by so 1485  
doing, shall be deemed to have given consent to submit to a 1486  
mental or physical examination when directed to do so in writing 1487  
by the board, and to have waived all objections to the 1488  
admissibility of testimony or examination reports that 1489  
constitute a privileged communication. 1490

(20) Except as provided in division (F)(1)(b) of section 1491  
4731.282 of the Revised Code or when civil penalties are imposed 1492  
under section 4731.225 of the Revised Code, and subject to 1493  
section 4731.226 of the Revised Code, violating or attempting to 1494  
violate, directly or indirectly, or assisting in or abetting the 1495  
violation of, or conspiring to violate, any provisions of this 1496

chapter or any rule promulgated by the board. 1497

This division does not apply to a violation or attempted 1498  
violation of, assisting in or abetting the violation of, or a 1499  
conspiracy to violate, any provision of this chapter or any rule 1500  
adopted by the board that would preclude the making of a report 1501  
by a physician of an employee's use of a drug of abuse, or of a 1502  
condition of an employee other than one involving the use of a 1503  
drug of abuse, to the employer of the employee as described in 1504  
division (B) of section 2305.33 of the Revised Code. Nothing in 1505  
this division affects the immunity from civil liability 1506  
conferred by that section upon a physician who makes either type 1507  
of report in accordance with division (B) of that section. As 1508  
used in this division, "employee," "employer," and "physician" 1509  
have the same meanings as in section 2305.33 of the Revised 1510  
Code. 1511

(21) The violation of section 3701.79 of the Revised Code 1512  
or of any abortion rule adopted by the director of health 1513  
pursuant to section 3701.341 of the Revised Code; 1514

(22) Any of the following actions taken by an agency 1515  
responsible for authorizing, certifying, or regulating an 1516  
individual to practice a health care occupation or provide 1517  
health care services in this state or another jurisdiction, for 1518  
any reason other than the nonpayment of fees: the limitation, 1519  
revocation, or suspension of an individual's license to 1520  
practice; acceptance of an individual's license surrender; 1521  
denial of a license; refusal to renew or reinstate a license; 1522  
imposition of probation; or issuance of an order of censure or 1523  
other reprimand; 1524

(23) The violation of section 2919.12 of the Revised Code 1525  
or the performance or inducement of an abortion upon a pregnant 1526

woman with actual knowledge that the conditions specified in 1527  
division (B) of section 2317.56 of the Revised Code have not 1528  
been satisfied or with a heedless indifference as to whether 1529  
those conditions have been satisfied, unless an affirmative 1530  
defense as specified in division (H) (2) of that section would 1531  
apply in a civil action authorized by division (H) (1) of that 1532  
section; 1533

(24) The revocation, suspension, restriction, reduction, 1534  
or termination of clinical privileges by the United States 1535  
department of defense or department of veterans affairs or the 1536  
termination or suspension of a certificate of registration to 1537  
prescribe drugs by the drug enforcement administration of the 1538  
United States department of justice; 1539

(25) Termination or suspension from participation in the 1540  
medicare or medicaid programs by the department of health and 1541  
human services or other responsible agency for any act or acts 1542  
that also would constitute a violation of division (B) (2), (3), 1543  
(6), (8), or (19) of this section; 1544

(26) Impairment of ability to practice according to 1545  
acceptable and prevailing standards of care because of habitual 1546  
or excessive use or abuse of drugs, alcohol, or other substances 1547  
that impair ability to practice. 1548

For the purposes of this division, any individual 1549  
authorized to practice by this chapter accepts the privilege of 1550  
practicing in this state subject to supervision by the board. By 1551  
filing an application for or holding a license or certificate to 1552  
practice under this chapter, an individual shall be deemed to 1553  
have given consent to submit to a mental or physical examination 1554  
when ordered to do so by the board in writing, and to have 1555  
waived all objections to the admissibility of testimony or 1556

examination reports that constitute privileged communications. 1557

If it has reason to believe that any individual authorized 1558  
to practice by this chapter or any applicant for licensure or 1559  
certification to practice suffers such impairment, the board may 1560  
compel the individual to submit to a mental or physical 1561  
examination, or both. The expense of the examination is the 1562  
responsibility of the individual compelled to be examined. Any 1563  
mental or physical examination required under this division 1564  
shall be undertaken by a treatment provider or physician who is 1565  
qualified to conduct the examination and who is chosen by the 1566  
board. 1567

Failure to submit to a mental or physical examination 1568  
ordered by the board constitutes an admission of the allegations 1569  
against the individual unless the failure is due to 1570  
circumstances beyond the individual's control, and a default and 1571  
final order may be entered without the taking of testimony or 1572  
presentation of evidence. If the board determines that the 1573  
individual's ability to practice is impaired, the board shall 1574  
suspend the individual's license or certificate or deny the 1575  
individual's application and shall require the individual, as a 1576  
condition for initial, continued, reinstated, or renewed 1577  
licensure or certification to practice, to submit to treatment. 1578

Before being eligible to apply for reinstatement of a 1579  
license or certificate suspended under this division, the 1580  
impaired practitioner shall demonstrate to the board the ability 1581  
to resume practice in compliance with acceptable and prevailing 1582  
standards of care under the provisions of the practitioner's 1583  
license or certificate. The demonstration shall include, but 1584  
shall not be limited to, the following: 1585

(a) Certification from a treatment provider approved under 1586

section 4731.25 of the Revised Code that the individual has 1587  
successfully completed any required inpatient treatment; 1588

(b) Evidence of continuing full compliance with an 1589  
aftercare contract or consent agreement; 1590

(c) Two written reports indicating that the individual's 1591  
ability to practice has been assessed and that the individual 1592  
has been found capable of practicing according to acceptable and 1593  
prevailing standards of care. The reports shall be made by 1594  
individuals or providers approved by the board for making the 1595  
assessments and shall describe the basis for their 1596  
determination. 1597

The board may reinstate a license or certificate suspended 1598  
under this division after that demonstration and after the 1599  
individual has entered into a written consent agreement. 1600

When the impaired practitioner resumes practice, the board 1601  
shall require continued monitoring of the individual. The 1602  
monitoring shall include, but not be limited to, compliance with 1603  
the written consent agreement entered into before reinstatement 1604  
or with conditions imposed by board order after a hearing, and, 1605  
upon termination of the consent agreement, submission to the 1606  
board for at least two years of annual written progress reports 1607  
made under penalty of perjury stating whether the individual has 1608  
maintained sobriety. 1609

(27) A second or subsequent violation of section 4731.66 1610  
or 4731.69 of the Revised Code; 1611

(28) Except as provided in division (N) of this section: 1612

(a) Waiving the payment of all or any part of a deductible 1613  
or copayment that a patient, pursuant to a health insurance or 1614  
health care policy, contract, or plan that covers the 1615



individual's services, otherwise would be required to pay if the 1616  
waiver is used as an enticement to a patient or group of 1617  
patients to receive health care services from that individual; 1618

(b) Advertising that the individual will waive the payment 1619  
of all or any part of a deductible or copayment that a patient, 1620  
pursuant to a health insurance or health care policy, contract, 1621  
or plan that covers the individual's services, otherwise would 1622  
be required to pay. 1623

(29) Failure to use universal blood and body fluid 1624  
precautions established by rules adopted under section 4731.051 1625  
of the Revised Code; 1626

(30) Failure to provide notice to, and receive 1627  
acknowledgment of the notice from, a patient when required by 1628  
section 4731.143 of the Revised Code prior to providing 1629  
nonemergency professional services, or failure to maintain that 1630  
notice in the patient's medical record; 1631

(31) Failure of a physician supervising a physician 1632  
assistant to maintain supervision in accordance with the 1633  
requirements of Chapter 4730. of the Revised Code and the rules 1634  
adopted under that chapter; 1635

(32) Failure of a physician or podiatrist to enter into a 1636  
standard care arrangement with a clinical nurse specialist, 1637  
certified nurse-midwife, or certified nurse practitioner with 1638  
whom the physician or podiatrist is in collaboration pursuant to 1639  
section 4731.27 of the Revised Code or failure to fulfill the 1640  
responsibilities of collaboration after entering into a standard 1641  
care arrangement; 1642

(33) Failure to comply with the terms of a consult 1643  
agreement entered into with a pharmacist pursuant to section 1644

4729.39 of the Revised Code;	1645
(34) Failure to cooperate in an investigation conducted by the board under division (F) of this section, including failure to comply with a subpoena or order issued by the board or failure to answer truthfully a question presented by the board in an investigative interview, an investigative office conference, 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;	1646 1647 1648 1649 1650 1651 1652 1653 1654 1655 1656
(35) Failure to supervise an oriental medicine practitioner or acupuncturist in accordance with Chapter 4762. of the Revised Code and the board's rules for providing that supervision;	1657 1658 1659 1660
(36) Failure to supervise an anesthesiologist assistant in accordance with Chapter 4760. of the Revised Code and the board's rules for supervision of an anesthesiologist assistant;	1661 1662 1663
(37) Assisting suicide, as defined in section 3795.01 of the Revised Code;	1664 1665
(38) Failure to comply with the requirements of section 2317.561 of the Revised Code;	1666 1667
(39) Failure to supervise a radiologist assistant in accordance with Chapter 4774. of the Revised Code and the board's rules for supervision of radiologist assistants;	1668 1669 1670
(40) Performing or inducing an abortion at an office or facility with knowledge that the office or facility fails to post the notice required under section 3701.791 of the Revised	1671 1672 1673

Code;	1674
(41) Failure to comply with the standards and procedures established in rules under section 4731.054 of the Revised Code for the operation of or the provision of care at a pain management clinic;	1675 1676 1677 1678
(42) Failure to comply with the standards and procedures established in rules under section 4731.054 of the Revised Code for providing supervision, direction, and control of individuals at a pain management clinic;	1679 1680 1681 1682
(43) Failure to comply with the requirements of section 4729.79 or 4731.055 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;	1683 1684 1685 1686
(44) Failure to comply with the requirements of section 2919.171, 2919.202, or 2919.203 of the Revised Code or failure to submit to the department of health in accordance with a court order a complete report as described in section 2919.171 or 2919.202 of the Revised Code;	1687 1688 1689 1690 1691
(45) Practicing at a facility that is subject to licensure as a category III terminal distributor of dangerous drugs with a pain management clinic classification unless the person operating the facility has obtained and maintains the license with the classification;	1692 1693 1694 1695 1696
(46) Owning a facility that is subject to licensure as a category III terminal distributor of dangerous drugs with a pain management clinic classification unless the facility is licensed with the classification;	1697 1698 1699 1700
(47) Failure to comply with the requirement regarding maintaining notes described in division (B) of section 2919.191	1701 1702

of the Revised Code or failure to satisfy the requirements of 1703  
section 2919.191 of the Revised Code prior to performing or 1704  
inducing an abortion upon a pregnant woman; 1705

(48) Failure to comply with the requirements in section 1706  
3719.061 of the Revised Code before issuing for a minor a 1707  
prescription for an opioid analgesic, as defined in section 1708  
3719.01 of the Revised Code; 1709

(49) Failure to comply with the requirements of section 1710  
4731.30 of the Revised Code or rules adopted under section 1711  
4731.301 of the Revised Code when recommending treatment with 1712  
medical marijuana; 1713

(50) Practicing at a facility, clinic, or other location 1714  
that is subject to licensure as a category III terminal 1715  
distributor of dangerous drugs with an office-based opioid 1716  
treatment classification unless the person operating that place 1717  
has obtained and maintains the license with the classification; 1718

(51) Owning a facility, clinic, or other location that is 1719  
subject to licensure as a category III terminal distributor of 1720  
dangerous drugs with an office-based opioid treatment 1721  
classification unless that place is licensed with the 1722  
classification; 1723

(52) A pattern of continuous or repeated violations of 1724  
division (E) (2) or (3) of section 3963.02 of the Revised Code. 1725

(C) Disciplinary actions taken by the board under 1726  
divisions (A) and (B) of this section shall be taken pursuant to 1727  
an adjudication under Chapter 119. of the Revised Code, except 1728  
that in lieu of an adjudication, the board may enter into a 1729  
consent agreement with an individual to resolve an allegation of 1730  
a violation of this chapter or any rule adopted under it. A 1731

consent agreement, when ratified by an affirmative vote of not 1732  
fewer than six members of the board, shall constitute the 1733  
findings and order of the board with respect to the matter 1734  
addressed in the agreement. If the board refuses to ratify a 1735  
consent agreement, the admissions and findings contained in the 1736  
consent agreement shall be of no force or effect. 1737

A telephone conference call may be utilized for 1738  
ratification of a consent agreement that revokes or suspends an 1739  
individual's license or certificate to practice or certificate 1740  
to recommend. The telephone conference call shall be considered 1741  
a special meeting under division (F) of section 121.22 of the 1742  
Revised Code. 1743

If the board takes disciplinary action against an 1744  
individual under division (B) of this section for a second or 1745  
subsequent plea of guilty to, or judicial finding of guilt of, a 1746  
violation of section 2919.123 of the Revised Code, the 1747  
disciplinary action shall consist of a suspension of the 1748  
individual's license or certificate to practice for a period of 1749  
at least one year or, if determined appropriate by the board, a 1750  
more serious sanction involving the individual's license or 1751  
certificate to practice. Any consent agreement entered into 1752  
under this division with an individual that pertains to a second 1753  
or subsequent plea of guilty to, or judicial finding of guilt 1754  
of, a violation of that section shall provide for a suspension 1755  
of the individual's license or certificate to practice for a 1756  
period of at least one year or, if determined appropriate by the 1757  
board, a more serious sanction involving the individual's 1758  
license or certificate to practice. 1759

(D) For purposes of divisions (B) (10), (12), and (14) of 1760  
this section, the commission of the act may be established by a 1761

finding by the board, pursuant to an adjudication under Chapter 1762  
119. of the Revised Code, that the individual committed the act. 1763  
The board does not have jurisdiction under those divisions if 1764  
the trial court renders a final judgment in the individual's 1765  
favor and that judgment is based upon an adjudication on the 1766  
merits. The board has jurisdiction under those divisions if the 1767  
trial court issues an order of dismissal upon technical or 1768  
procedural grounds. 1769

(E) The sealing of conviction records by any court shall 1770  
have no effect upon a prior board order entered under this 1771  
section or upon the board's jurisdiction to take action under 1772  
this section if, based upon a plea of guilty, a judicial finding 1773  
of guilt, or a judicial finding of eligibility for intervention 1774  
in lieu of conviction, the board issued a notice of opportunity 1775  
for a hearing prior to the court's order to seal the records. 1776  
The board shall not be required to seal, destroy, redact, or 1777  
otherwise modify its records to reflect the court's sealing of 1778  
conviction records. 1779

(F) (1) The board shall investigate evidence that appears 1780  
to show that a person has violated any provision of this chapter 1781  
or any rule adopted under it. Any person may report to the board 1782  
in a signed writing any information that the person may have 1783  
that appears to show a violation of any provision of this 1784  
chapter or any rule adopted under it. In the absence of bad 1785  
faith, any person who reports information of that nature or who 1786  
testifies before the board in any adjudication conducted under 1787  
Chapter 119. of the Revised Code shall not be liable in damages 1788  
in a civil action as a result of the report or testimony. Each 1789  
complaint or allegation of a violation received by the board 1790  
shall be assigned a case number and shall be recorded by the 1791  
board. 1792

(2) Investigations of alleged violations of this chapter 1793  
or any rule adopted under it shall be supervised by the 1794  
supervising member elected by the board in accordance with 1795  
section 4731.02 of the Revised Code and by the secretary as 1796  
provided in section 4731.39 of the Revised Code. The president 1797  
may designate another member of the board to supervise the 1798  
investigation in place of the supervising member. No member of 1799  
the board who supervises the investigation of a case shall 1800  
participate in further adjudication of the case. 1801

(3) In investigating a possible violation of this chapter 1802  
or any rule adopted under this chapter, or in conducting an 1803  
inspection under division (E) of section 4731.054 of the Revised 1804  
Code, the board may question witnesses, conduct interviews, 1805  
administer oaths, order the taking of depositions, inspect and 1806  
copy any books, accounts, papers, records, or documents, issue 1807  
subpoenas, and compel the attendance of witnesses and production 1808  
of books, accounts, papers, records, documents, and testimony, 1809  
except that a subpoena for patient record information shall not 1810  
be issued without consultation with the attorney general's 1811  
office and approval of the secretary and supervising member of 1812  
the board. 1813

(a) Before issuance of a subpoena for patient record 1814  
information, the secretary and supervising member shall 1815  
determine whether there is probable cause to believe that the 1816  
complaint filed alleges a violation of this chapter or any rule 1817  
adopted under it and that the records sought are relevant to the 1818  
alleged violation and material to the investigation. The 1819  
subpoena may apply only to records that cover a reasonable 1820  
period of time surrounding the alleged violation. 1821

(b) On failure to comply with any subpoena issued by the 1822

board and after reasonable notice to the person being 1823  
subpoenaed, the board may move for an order compelling the 1824  
production of persons or records pursuant to the Rules of Civil 1825  
Procedure. 1826

(c) A subpoena issued by the board may be served by a 1827  
sheriff, the sheriff's deputy, or a board employee designated by 1828  
the board. Service of a subpoena issued by the board may be made 1829  
by delivering a copy of the subpoena to the person named 1830  
therein, reading it to the person, or leaving it at the person's 1831  
usual place of residence, usual place of business, or address on 1832  
file with the board. When serving a subpoena to an applicant for 1833  
or the holder of a license or certificate issued under this 1834  
chapter, service of the subpoena may be made by certified mail, 1835  
return receipt requested, and the subpoena shall be deemed 1836  
served on the date delivery is made or the date the person 1837  
refuses to accept delivery. If the person being served refuses 1838  
to accept the subpoena or is not located, service may be made to 1839  
an attorney who notifies the board that the attorney is 1840  
representing the person. 1841

(d) A sheriff's deputy who serves a subpoena shall receive 1842  
the same fees as a sheriff. Each witness who appears before the 1843  
board in obedience to a subpoena shall receive the fees and 1844  
mileage provided for under section 119.094 of the Revised Code. 1845

(4) All hearings, investigations, and inspections of the 1846  
board shall be considered civil actions for the purposes of 1847  
section 2305.252 of the Revised Code. 1848

(5) A report required to be submitted to the board under 1849  
this chapter, a complaint, or information received by the board 1850  
pursuant to an investigation or pursuant to an inspection under 1851  
division (E) of section 4731.054 of the Revised Code is 1852



confidential and not subject to discovery in any civil action. 1853

The board shall conduct all investigations or inspections 1854  
and proceedings in a manner that protects the confidentiality of 1855  
patients and persons who file complaints with the board. The 1856  
board shall not make public the names or any other identifying 1857  
information about patients or complainants unless proper consent 1858  
is given or, in the case of a patient, a waiver of the patient 1859  
privilege exists under division (B) of section 2317.02 of the 1860  
Revised Code, except that consent or a waiver of that nature is 1861  
not required if the board possesses reliable and substantial 1862  
evidence that no bona fide physician-patient relationship 1863  
exists. 1864

The board may share any information it receives pursuant 1865  
to an investigation or inspection, including patient records and 1866  
patient record information, with law enforcement agencies, other 1867  
licensing boards, and other governmental agencies that are 1868  
prosecuting, adjudicating, or investigating alleged violations 1869  
of statutes or administrative rules. An agency or board that 1870  
receives the information shall comply with the same requirements 1871  
regarding confidentiality as those with which the state medical 1872  
board must comply, notwithstanding any conflicting provision of 1873  
the Revised Code or procedure of the agency or board that 1874  
applies when it is dealing with other information in its 1875  
possession. In a judicial proceeding, the information may be 1876  
admitted into evidence only in accordance with the Rules of 1877  
Evidence, but the court shall require that appropriate measures 1878  
are taken to ensure that confidentiality is maintained with 1879  
respect to any part of the information that contains names or 1880  
other identifying information about patients or complainants 1881  
whose confidentiality was protected by the state medical board 1882  
when the information was in the board's possession. Measures to 1883

ensure confidentiality that may be taken by the court include 1884  
sealing its records or deleting specific information from its 1885  
records. 1886

(6) On a quarterly basis, the board shall prepare a report 1887  
that documents the disposition of all cases during the preceding 1888  
three months. The report shall contain the following information 1889  
for each case with which the board has completed its activities: 1890

(a) The case number assigned to the complaint or alleged 1891  
violation; 1892

(b) The type of license or certificate to practice, if 1893  
any, held by the individual against whom the complaint is 1894  
directed; 1895

(c) A description of the allegations contained in the 1896  
complaint; 1897

(d) The disposition of the case. 1898

The report shall state how many cases are still pending 1899  
and shall be prepared in a manner that protects the identity of 1900  
each person involved in each case. The report shall be a public 1901  
record under section 149.43 of the Revised Code. 1902

(G) If the secretary and supervising member determine both 1903  
of the following, they may recommend that the board suspend an 1904  
individual's license or certificate to practice or certificate 1905  
to recommend without a prior hearing: 1906

(1) That there is clear and convincing evidence that an 1907  
individual has violated division (B) of this section; 1908

(2) That the individual's continued practice presents a 1909  
danger of immediate and serious harm to the public. 1910

Written allegations shall be prepared for consideration by 1911  
the board. The board, upon review of those allegations and by an 1912  
affirmative vote of not fewer than six of its members, excluding 1913  
the secretary and supervising member, may suspend a license or 1914  
certificate without a prior hearing. A telephone conference call 1915  
may be utilized for reviewing the allegations and taking the 1916  
vote on the summary suspension. 1917

The board shall issue a written order of suspension by 1918  
certified mail or in person in accordance with section 119.07 of 1919  
the Revised Code. The order shall not be subject to suspension 1920  
by the court during pendency of any appeal filed under section 1921  
119.12 of the Revised Code. If the individual subject to the 1922  
summary suspension requests an adjudicatory hearing by the 1923  
board, the date set for the hearing shall be within fifteen 1924  
days, but not earlier than seven days, after the individual 1925  
requests the hearing, unless otherwise agreed to by both the 1926  
board and the individual. 1927

Any summary suspension imposed under this division shall 1928  
remain in effect, unless reversed on appeal, until a final 1929  
adjudicative order issued by the board pursuant to this section 1930  
and Chapter 119. of the Revised Code becomes effective. The 1931  
board shall issue its final adjudicative order within seventy- 1932  
five days after completion of its hearing. A failure to issue 1933  
the order within seventy-five days shall result in dissolution 1934  
of the summary suspension order but shall not invalidate any 1935  
subsequent, final adjudicative order. 1936

(H) If the board takes action under division (B) (9), (11), 1937  
or (13) of this section and the judicial finding of guilt, 1938  
guilty plea, or judicial finding of eligibility for intervention 1939  
in lieu of conviction is overturned on appeal, upon exhaustion 1940

of the criminal appeal, a petition for reconsideration of the 1941  
order may be filed with the board along with appropriate court 1942  
documents. Upon receipt of a petition of that nature and 1943  
supporting court documents, the board shall reinstate the 1944  
individual's license or certificate to practice. The board may 1945  
then hold an adjudication under Chapter 119. of the Revised Code 1946  
to determine whether the individual committed the act in 1947  
question. Notice of an opportunity for a hearing shall be given 1948  
in accordance with Chapter 119. of the Revised Code. If the 1949  
board finds, pursuant to an adjudication held under this 1950  
division, that the individual committed the act or if no hearing 1951  
is requested, the board may order any of the sanctions 1952  
identified under division (B) of this section. 1953

(I) The license or certificate to practice issued to an 1954  
individual under this chapter and the individual's practice in 1955  
this state are automatically suspended as of the date of the 1956  
individual's second or subsequent plea of guilty to, or judicial 1957  
finding of guilt of, a violation of section 2919.123 of the 1958  
Revised Code. In addition, the license or certificate to 1959  
practice or certificate to recommend issued to an individual 1960  
under this chapter and the individual's practice in this state 1961  
are automatically suspended as of the date the individual pleads 1962  
guilty to, is found by a judge or jury to be guilty of, or is 1963  
subject to a judicial finding of eligibility for intervention in 1964  
lieu of conviction in this state or treatment or intervention in 1965  
lieu of conviction in another jurisdiction for any of the 1966  
following criminal offenses in this state or a substantially 1967  
equivalent criminal offense in another jurisdiction: aggravated 1968  
murder, murder, voluntary manslaughter, felonious assault, 1969  
kidnapping, rape, sexual battery, gross sexual imposition, 1970  
aggravated arson, aggravated robbery, or aggravated burglary. 1971

Continued practice after suspension shall be considered 1972  
practicing without a license or certificate. 1973

The board shall notify the individual subject to the 1974  
suspension by certified mail or in person in accordance with 1975  
section 119.07 of the Revised Code. If an individual whose 1976  
license or certificate is automatically suspended under this 1977  
division fails to make a timely request for an adjudication 1978  
under Chapter 119. of the Revised Code, the board shall do 1979  
whichever of the following is applicable: 1980

(1) If the automatic suspension under this division is for 1981  
a second or subsequent plea of guilty to, or judicial finding of 1982  
guilt of, a violation of section 2919.123 of the Revised Code, 1983  
the board shall enter an order suspending the individual's 1984  
license or certificate to practice for a period of at least one 1985  
year or, if determined appropriate by the board, imposing a more 1986  
serious sanction involving the individual's license or 1987  
certificate to practice. 1988

(2) In all circumstances in which division (I)(1) of this 1989  
section does not apply, enter a final order permanently revoking 1990  
the individual's license or certificate to practice. 1991

(J) If the board is required by Chapter 119. of the 1992  
Revised Code to give notice of an opportunity for a hearing and 1993  
if the individual subject to the notice does not timely request 1994  
a hearing in accordance with section 119.07 of the Revised Code, 1995  
the board is not required to hold a hearing, but may adopt, by 1996  
an affirmative vote of not fewer than six of its members, a 1997  
final order that contains the board's findings. In that final 1998  
order, the board may order any of the sanctions identified under 1999  
division (A) or (B) of this section. 2000

(K) Any action taken by the board under division (B) of this section resulting in a suspension from practice shall be accompanied by a written statement of the conditions under which the individual's license or certificate to practice may be reinstated. The board shall adopt rules governing conditions to be imposed for reinstatement. Reinstatement of a license or certificate suspended pursuant to division (B) of this section requires an affirmative vote of not fewer than six members of the board.

(L) When the board refuses to grant or issue a license or certificate to practice to an applicant, revokes an individual's license or certificate to practice, refuses to renew an individual's license or certificate to practice, or refuses to reinstate an individual's license or certificate to practice, the board may specify that its action is permanent. An individual subject to a permanent action taken by the board is forever thereafter ineligible to hold a license or certificate to practice and the board shall not accept an application for reinstatement of the license or certificate or for issuance of a new license or certificate.

(M) Notwithstanding any other provision of the Revised Code, all of the following apply:

(1) The surrender of a license or certificate issued under this chapter shall not be effective unless or until accepted by the board. A telephone conference call may be utilized for acceptance of the surrender of an individual's license or certificate to practice. The telephone conference call shall be considered a special meeting under division (F) of section 121.22 of the Revised Code. Reinstatement of a license or certificate surrendered to the board requires an affirmative

vote of not fewer than six members of the board. 2031

(2) An application for a license or certificate made under 2032  
the provisions of this chapter may not be withdrawn without 2033  
approval of the board. 2034

(3) Failure by an individual to renew a license or 2035  
certificate to practice in accordance with this chapter or a 2036  
certificate to recommend in accordance with rules adopted under 2037  
section 4731.301 of the Revised Code shall not remove or limit 2038  
the board's jurisdiction to take any disciplinary action under 2039  
this section against the individual. 2040

(4) At the request of the board, a license or certificate 2041  
holder shall immediately surrender to the board a license or 2042  
certificate that the board has suspended, revoked, or 2043  
permanently revoked. 2044

(N) Sanctions shall not be imposed under division (B) (28) 2045  
of this section against any person who waives deductibles and 2046  
copayments as follows: 2047

(1) In compliance with the health benefit plan that 2048  
expressly allows such a practice. Waiver of the deductibles or 2049  
copayments shall be made only with the full knowledge and 2050  
consent of the plan purchaser, payer, and third-party 2051  
administrator. Documentation of the consent shall be made 2052  
available to the board upon request. 2053

(2) For professional services rendered to any other person 2054  
authorized to practice pursuant to this chapter, to the extent 2055  
allowed by this chapter and rules adopted by the board. 2056

(O) Under the board's investigative duties described in 2057  
this section and subject to division (F) of this section, the 2058  
board shall develop and implement a quality intervention program 2059

designed to improve through remedial education the clinical and 2060  
communication skills of individuals authorized under this 2061  
chapter to practice medicine and surgery, osteopathic medicine 2062  
and surgery, and podiatric medicine and surgery. In developing 2063  
and implementing the quality intervention program, the board may 2064  
do all of the following: 2065

(1) Offer in appropriate cases as determined by the board 2066  
an educational and assessment program pursuant to an 2067  
investigation the board conducts under this section; 2068

(2) Select providers of educational and assessment 2069  
services, including a quality intervention program panel of case 2070  
reviewers; 2071

(3) Make referrals to educational and assessment service 2072  
providers and approve individual educational programs 2073  
recommended by those providers. The board shall monitor the 2074  
progress of each individual undertaking a recommended individual 2075  
educational program. 2076

(4) Determine what constitutes successful completion of an 2077  
individual educational program and require further monitoring of 2078  
the individual who completed the program or other action that 2079  
the board determines to be appropriate; 2080

(5) Adopt rules in accordance with Chapter 119. of the 2081  
Revised Code to further implement the quality intervention 2082  
program. 2083

An individual who participates in an individual 2084  
educational program pursuant to this division shall pay the 2085  
financial obligations arising from that educational program. 2086

**Section 2.** That existing sections 1739.05, 1753.09, 2087  
3901.21, 3963.01, 3963.02, 3963.03, 4725.19, and 4731.22 of the 2088



Revised Code are hereby repealed. 2089

**Section 3.** The following represent the General Assembly's 2090  
intent and findings: 2091

(A) The provisions of this act seek to prevent health 2092  
insuring corporations, vision insurers, vision benefit plans, 2093  
and other contracting entities from establishing fee limitations 2094  
on vision care services and vision care materials that are not 2095  
covered vision services for enrollees under an insurance plan. 2096

(B) Strategies by health insuring corporations, vision 2097  
insurers, vision benefit plans, and other contracting entities 2098  
to adopt or impose a deductible, copayment, coinsurance, or any 2099  
other requirement in such a way as to provide de minimis 2100  
reimbursement for services or vision care materials as a method 2101  
to avoid the impact of this law is contrary to the spirit and 2102  
intent of the General Assembly. 2103

(C) The provisions of this act concerning the declaration 2104  
by vision care providers on whether to accept or not accept as 2105  
payment an amount set by the contracting entity for vision care 2106  
services and vision care materials that are not covered vision 2107  
services and the publication of such declaration to enrollees by 2108  
health insuring corporations, vision insurers, vision benefit 2109  
plans, and other contracting entities, should treat providers 2110  
equally regardless of the declaration made and should be 2111  
communicated in such a manner as not to imply that the vision 2112  
care provider is favored or disfavored based on the declaration. 2113

**Section 4.** Section 1739.05 of the Revised Code is 2114  
presented in this act as a composite of the section as amended 2115  
by both Sub. H.B. 463 and Sub. S.B. 319 of the 131st General 2116  
Assembly. The General Assembly, applying the principle stated in 2117

division (B) of section 1.52 of the Revised Code that amendments	2118
are to be harmonized if reasonably capable of simultaneous	2119
operation, finds that the composite is the resulting version of	2120
the section in effect prior to the effective date of the section	2121
as presented in this act.	2122