

As Introduced

**134th General Assembly
Regular Session
2021-2022**

H. B. No. 344

Representative Stephens

Cosponsors: Representatives Cross, Fowler Arthur, Stewart



A BILL

To amend sections 1751.85, 1753.09, 3901.21, 1
3923.86, 3963.01, 3963.02, 3963.03, and 4715.30 2
of the Revised Code regarding limitations 3
imposed by health insurers on dental care 4
services. 5

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

Section 1. That sections 1751.85, 1753.09, 3901.21, 6
3923.86, 3963.01, 3963.02, 3963.03, and 4715.30 of the Revised 7
Code be amended to read as follows: 8

Sec. 1751.85. (A) As used in this section, "covered dental 9
services," "covered vision services," "dental care provider," 10
"vision care materials," and "vision care provider" have the 11
same meanings as in section 3963.01 of the Revised Code. 12

(B) A health insuring corporation shall provide the 13
information required in this division to all enrollees receiving 14
coverage under an individual or group health insuring 15
corporation policy, contract, or agreement ~~providing coverage~~ 16
for vision care services ~~or,~~ vision care materials, or dental 17
care services. The information shall be in a conspicuous format, 18

shall be easily accessible to enrollees, and shall do all of the 19
following: 20

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

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

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

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

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

~~(3)~~ (4) Include an explanation that the enrollee may incur 42
out-of-pocket expenses as a result of the purchase of vision 43
care services ~~or,~~ vision care materials, or dental care services 44
that are not covered ~~vision services~~. The explanation shall be 45
communicated in a manner and format similar to how the health 46
insuring corporation provides an enrollee with information on 47

coverage levels and out-of-pocket expenses that may be incurred 48
by the enrollee under the policy, contract, or agreement when 49
purchasing out-of-network vision care services ~~or,~~ vision care 50
materials, or dental care services. 51

(C) A pattern of continuous or repeated violations of this 52
section is an unfair and deceptive act or practice in the 53
business of insurance under sections 3901.19 to 3901.26 of the 54
Revised Code. 55

Sec. 1753.09. (A) Except as provided in division (D) of 56
this section, prior to terminating the participation of a 57
provider on the basis of the participating provider's failure to 58
meet the health insuring corporation's standards for quality or 59
utilization in the delivery of health care services, a health 60
insuring corporation shall give the participating provider 61
notice of the reason or reasons for its decision to terminate 62
the provider's participation and an opportunity to take 63
corrective action. The health insuring corporation shall develop 64
a performance improvement plan in conjunction with the 65
participating provider. If after being afforded the opportunity 66
to comply with the performance improvement plan, the 67
participating provider fails to do so, the health insuring 68
corporation may terminate the participation of the provider. 69

(B) (1) A participating provider whose participation has 70
been terminated under division (A) of this section may appeal 71
the termination to the appropriate medical director of the 72
health insuring corporation. The medical director shall give the 73
participating provider an opportunity to discuss with the 74
medical director the reason or reasons for the termination. 75

(2) If a satisfactory resolution of a participating 76
provider's appeal cannot be reached under division (B) (1) of 77

this section, the participating provider may appeal the 78
termination to a panel composed of participating providers who 79
have comparable or higher levels of education and training than 80
the participating provider making the appeal. A representative 81
of the participating provider's specialty shall be a member of 82
the panel, if possible. This panel shall hold a hearing, and 83
shall render its recommendation in the appeal within thirty days 84
after holding the hearing. The recommendation shall be presented 85
to the medical director and to the participating provider. 86

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

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

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

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

(F) (1) Nothing in this section prohibits a health insuring 105
corporation from rejecting a provider's application for 106

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

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

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

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

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

(A) Making, issuing, circulating, or causing or permitting 130
to be made, issued, or circulated, or preparing with intent to 131
so use, any estimate, illustration, circular, or statement 132
misrepresenting the terms of any policy issued or to be issued 133
or the benefits or advantages promised thereby or the dividends 134
or share of the surplus to be received thereon, or making any 135

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

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

(B) Making, publishing, disseminating, circulating, or 156
placing before the public or causing, directly or indirectly, to 157
be made, published, disseminated, circulated, or placed before 158
the public, in a newspaper, magazine, or other publication, or 159
in the form of a notice, circular, pamphlet, letter, or poster, 160
or over any radio station, or in any other way, or preparing 161
with intent to so use, an advertisement, announcement, or 162
statement containing any assertion, representation, or 163
statement, with respect to the business of insurance or with 164
respect to any person in the conduct of the person's insurance 165
business, which is untrue, deceptive, or misleading. 166

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

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

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

(E) Issuing or delivering or permitting agents, officers, 191
or employees to issue or deliver agency company stock or other 192
capital stock or benefit certificates or shares in any common- 193
law corporation or securities or any special or advisory board 194
contracts or other contracts of any kind promising returns and 195
profits as an inducement to insurance. 196

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

(G) (1) Except as otherwise expressly provided by law, 202
knowingly permitting or offering to make or making any contract 203
of life insurance, life annuity or accident and health 204
insurance, or agreement as to such contract other than as 205
plainly expressed in the contract issued thereon, or paying or 206
allowing, or giving or offering to pay, allow, or give, directly 207
or indirectly, as inducement to such insurance, or annuity, any 208
rebate of premiums payable on the contract, or any special favor 209
or advantage in the dividends or other benefits thereon, or any 210
valuable consideration or inducement whatever not specified in 211
the contract; or giving, or selling, or purchasing, or offering 212
to give, sell, or purchase, as inducement to such insurance or 213
annuity or in connection therewith, any stocks, bonds, or other 214
securities, or other obligations of any insurance company or 215
other corporation, association, or partnership, or any dividends 216
or profits accrued thereon, or anything of value whatsoever not 217
specified in the contract. 218

(2) Nothing in division (F) or division (G) (1) of this 219
section shall be construed as prohibiting any of the following 220
practices: (a) in the case of any contract of life insurance or 221
life annuity, paying bonuses to policyholders or otherwise 222
abatating their premiums in whole or in part out of surplus 223
accumulated from nonparticipating insurance, provided that any 224
such bonuses or abatement of premiums shall be fair and 225
equitable to policyholders and for the best interests of the 226
company and its policyholders; (b) in the case of life insurance 227

policies issued on the industrial debit plan, making allowance 228
to policyholders who have continuously for a specified period 229
made premium payments directly to an office of the insurer in an 230
amount which fairly represents the saving in collection 231
expenses; (c) readjustment of the rate of premium for a group 232
insurance policy based on the loss or expense experience 233
thereunder, at the end of the first or any subsequent policy 234
year of insurance thereunder, which may be made retroactive only 235
for such policy year. 236

(H) Making, issuing, circulating, or causing or permitting 237
to be made, issued, or circulated, or preparing with intent to 238
so use, any statement to the effect that a policy of life 239
insurance is, is the equivalent of, or represents shares of 240
capital stock or any rights or options to subscribe for or 241
otherwise acquire any such shares in the life insurance company 242
issuing that policy or any other company. 243

(I) Making, issuing, circulating, or causing or permitting 244
to be made, issued or circulated, or preparing with intent to so 245
issue, any statement to the effect that payments to a 246
policyholder of the principal amounts of a pure endowment are 247
other than payments of a specific benefit for which specific 248
premiums have been paid. 249

(J) Making, issuing, circulating, or causing or permitting 250
to be made, issued, or circulated, or preparing with intent to 251
so use, any statement to the effect that any insurance company 252
was required to change a policy form or related material to 253
comply with Title XXXIX of the Revised Code or any regulation of 254
the superintendent of insurance, for the purpose of inducing or 255
intending to induce any policyholder or prospective policyholder 256
to purchase, amend, lapse, forfeit, change, or surrender 257

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| insurance. | 258 |
| (K) Aiding or abetting another to violate this section. | 259 |
| (L) Refusing to issue any policy of insurance, or | 260 |
| canceling or declining to renew such policy because of the sex | 261 |
| or marital status of the applicant, prospective insured, | 262 |
| insured, or policyholder. | 263 |
| (M) Making or permitting any unfair discrimination between | 264 |
| individuals of the same class and of essentially the same hazard | 265 |
| in the amount of premium, policy fees, or rates charged for any | 266 |
| policy or contract of insurance, other than life insurance, or | 267 |
| in the benefits payable thereunder, or in underwriting standards | 268 |
| and practices or eligibility requirements, or in any of the | 269 |
| terms or conditions of such contract, or in any other manner | 270 |
| whatever. | 271 |
| (N) Refusing to make available disability income insurance | 272 |
| solely because the applicant's principal occupation is that of | 273 |
| managing a household. | 274 |
| (O) Refusing, when offering maternity benefits under any | 275 |
| individual or group sickness and accident insurance policy, to | 276 |
| make maternity benefits available to the policyholder for the | 277 |
| individual or individuals to be covered under any comparable | 278 |
| policy to be issued for delivery in this state, including family | 279 |
| members if the policy otherwise provides coverage for family | 280 |
| members. Nothing in this division shall be construed to prohibit | 281 |
| an insurer from imposing a reasonable waiting period for such | 282 |
| benefits under an individual sickness and accident insurance | 283 |
| policy issued to an individual who is not a federally eligible | 284 |
| individual or a nonemployer-related group sickness and accident | 285 |
| insurance policy, but in no event shall such waiting period | 286 |

exceed two hundred seventy days. 287

For purposes of division (O) of this section, "federally 288
eligible individual" means an eligible individual as defined in 289
45 C.F.R. 148.103. 290

(P) Using, or permitting to be used, a pattern settlement 291
as the basis of any offer of settlement. As used in this 292
division, "pattern settlement" means a method by which liability 293
is routinely imputed to a claimant without an investigation of 294
the particular occurrence upon which the claim is based and by 295
using a predetermined formula for the assignment of liability 296
arising out of occurrences of a similar nature. Nothing in this 297
division shall be construed to prohibit an insurer from 298
determining a claimant's liability by applying formulas or 299
guidelines to the facts and circumstances disclosed by the 300
insurer's investigation of the particular occurrence upon which 301
a claim is based. 302

(Q) Refusing to insure, or refusing to continue to insure, 303
or limiting the amount, extent, or kind of life or sickness and 304
accident insurance or annuity coverage available to an 305
individual, or charging an individual a different rate for the 306
same coverage solely because of blindness or partial blindness. 307
With respect to all other conditions, including the underlying 308
cause of blindness or partial blindness, persons who are blind 309
or partially blind shall be subject to the same standards of 310
sound actuarial principles or actual or reasonably anticipated 311
actuarial experience as are sighted persons. Refusal to insure 312
includes, but is not limited to, denial by an insurer of 313
disability insurance coverage on the grounds that the policy 314
defines "disability" as being presumed in the event that the 315
eyesight of the insured is lost. However, an insurer may exclude 316

from coverage disabilities consisting solely of blindness or 317
partial blindness when such conditions existed at the time the 318
policy was issued. To the extent that the provisions of this 319
division may appear to conflict with any provision of section 320
3999.16 of the Revised Code, this division applies. 321

(R) (1) Directly or indirectly offering to sell, selling, 322
or delivering, issuing for delivery, renewing, or using or 323
otherwise marketing any policy of insurance or insurance product 324
in connection with or in any way related to the grant of a 325
student loan guaranteed in whole or in part by an agency or 326
commission of this state or the United States, except insurance 327
that is required under federal or state law as a condition for 328
obtaining such a loan and the premium for which is included in 329
the fees and charges applicable to the loan; or, in the case of 330
an insurer or insurance agent, knowingly permitting any lender 331
making such loans to engage in such acts or practices in 332
connection with the insurer's or agent's insurance business. 333

(2) Except in the case of a violation of division (G) of 334
this section, division (R) (1) of this section does not apply to 335
either of the following: 336

(a) Acts or practices of an insurer, its agents, 337
representatives, or employees in connection with the grant of a 338
guaranteed student loan to its insured or the insured's spouse 339
or dependent children where such acts or practices take place 340
more than ninety days after the effective date of the insurance; 341

(b) Acts or practices of an insurer, its agents, 342
representatives, or employees in connection with the 343
solicitation, processing, or issuance of an insurance policy or 344
product covering the student loan borrower or the borrower's 345
spouse or dependent children, where such acts or practices take 346

place more than one hundred eighty days after the date on which 347
the borrower is notified that the student loan was approved. 348

(S) Denying coverage, under any health insurance or health 349
care policy, contract, or plan providing family coverage, to any 350
natural or adopted child of the named insured or subscriber 351
solely on the basis that the child does not reside in the 352
household of the named insured or subscriber. 353

(T) (1) Using any underwriting standard or engaging in any 354
other act or practice that, directly or indirectly, due solely 355
to any health status-related factor in relation to one or more 356
individuals, does either of the following: 357

(a) Terminates or fails to renew an existing individual 358
policy, contract, or plan of health benefits, or a health 359
benefit plan issued to an employer, for which an individual 360
would otherwise be eligible; 361

(b) With respect to a health benefit plan issued to an 362
employer, excludes or causes the exclusion of an individual from 363
coverage under an existing employer-provided policy, contract, 364
or plan of health benefits. 365

(2) The superintendent of insurance may adopt rules in 366
accordance with Chapter 119. of the Revised Code for purposes of 367
implementing division (T) (1) of this section. 368

(3) For purposes of division (T) (1) of this section, 369
"health status-related factor" means any of the following: 370

(a) Health status; 371

(b) Medical condition, including both physical and mental 372
illnesses; 373

(c) Claims experience; 374

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| (d) Receipt of health care; | 375 |
| (e) Medical history; | 376 |
| (f) Genetic information; | 377 |
| (g) Evidence of insurability, including conditions arising out of acts of domestic violence; | 378 379 |
| (h) Disability. | 380 |
| (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. | 381 382 383 384 385 |
| (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. | 386 387 388 389 |
| (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. | 390 391 392 |
| (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. | 393 394 395 396 |
| (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; | 397 398 399 400 401 402 |

(b) Adding a surcharge or rating factor to a premium of 403
any individual policy or contract of life or health insurance 404
for the reason that the insured or applicant for insurance is or 405
has been a victim of domestic violence; 406

(c) Denying coverage under, or limiting coverage under, 407
any policy or contract of life or health insurance, for the 408
reason that a claim under the policy or contract arises from an 409
incident of domestic violence; 410

(d) Inquiring, directly or indirectly, of an insured 411
under, or of an applicant for, a policy or contract of life or 412
health insurance, as to whether the insured or applicant is or 413
has been a victim of domestic violence, or inquiring as to 414
whether the insured or applicant has sought shelter or 415
protection from domestic violence or has sought medical or 416
psychological treatment as a victim of domestic violence. 417

(2) Nothing in division (Y)(1) of this section shall be 418
construed to prohibit an insurer from inquiring as to, or from 419
underwriting or rating a risk on the basis of, a person's 420
physical or mental condition, even if the condition has been 421
caused by domestic violence, provided that all of the following 422
apply: 423

(a) The insurer routinely considers the condition in 424
underwriting or in rating risks, and does so in the same manner 425
for a victim of domestic violence as for an insured or applicant 426
who is not a victim of domestic violence; 427

(b) The insurer does not refuse to issue any policy or 428
contract of life or health insurance or cancel or refuse to 429
renew any policy or contract of life insurance, solely on the 430
basis of the condition, except where such refusal to issue, 431

cancellation, or refusal to renew is based on sound actuarial 432
principles or is related to actual or reasonably anticipated 433
experience; 434

(c) The insurer does not consider a person's status as 435
being or as having been a victim of domestic violence, in 436
itself, to be a physical or mental condition; 437

(d) The underwriting or rating of a risk on the basis of 438
the condition is not used to evade the intent of division (Y) (1) 439
of this section, or of any other provision of the Revised Code. 440

(3) (a) Nothing in division (Y) (1) of this section shall be 441
construed to prohibit an insurer from refusing to issue a policy 442
or contract of life insurance insuring the life of a person who 443
is or has been a victim of domestic violence if the person who 444
committed the act of domestic violence is the applicant for the 445
insurance or would be the owner of the insurance policy or 446
contract. 447

(b) Nothing in division (Y) (2) of this section shall be 448
construed to permit an insurer to cancel or refuse to renew any 449
policy or contract of health insurance in violation of the 450
"Health Insurance Portability and Accountability Act of 1996," 451
110 Stat. 1955, 42 U.S.C.A. 300gg-41(b), as amended, or in a 452
manner that violates or is inconsistent with any provision of 453
the Revised Code that implements the "Health Insurance 454
Portability and Accountability Act of 1996." 455

(4) An insurer is immune from any civil or criminal 456
liability that otherwise might be incurred or imposed as a 457
result of any action taken by the insurer to comply with 458
division (Y) of this section. 459

(5) As used in division (Y) of this section, "domestic 460

violence" means any of the following acts: 461

(a) Knowingly causing or attempting to cause physical harm 462
to a family or household member; 463

(b) Recklessly causing serious physical harm to a family 464
or household member; 465

(c) Knowingly causing, by threat of force, a family or 466
household member to believe that the person will cause imminent 467
physical harm to the family or household member. 468

For the purpose of division (Y) (5) of this section, 469
"family or household member" has the same meaning as in section 470
2919.25 of the Revised Code. 471

Nothing in division (Y) (5) of this section shall be 472
construed to require, as a condition to the application of 473
division (Y) of this section, that the act described in division 474
(Y) (5) of this section be the basis of a criminal prosecution. 475

(Z) Disclosing a coroner's records by an insurer in 476
violation of section 313.10 of the Revised Code. 477

(AA) Making, issuing, circulating, or causing or 478
permitting to be made, issued, or circulated any statement or 479
representation that a life insurance policy or annuity is a 480
contract for the purchase of funeral goods or services. 481

(BB) With respect to a health care contract as defined in 482
section 3963.01 of the Revised Code that covers vision or dental 483
services, as defined in that section, including any of the 484
contract terms prohibited under or failing to make the 485
disclosures required under division (E) or (F) of section 486
3963.02 of the Revised Code. 487

(CC) With respect to private passenger automobile 488

insurance, charging premium rates that are excessive, 489
inadequate, or unfairly discriminatory, pursuant to division (D) 490
of section 3937.02 of the Revised Code, based solely on the 491
location of the residence of the insured. 492

The enumeration in sections 3901.19 to 3901.26 of the 493
Revised Code of specific unfair or deceptive acts or practices 494
in the business of insurance is not exclusive or restrictive or 495
intended to limit the powers of the superintendent of insurance 496
to adopt rules to implement this section, or to take action 497
under other sections of the Revised Code. 498

This section does not prohibit the sale of shares of any 499
investment company registered under the "Investment Company Act 500
of 1940," 54 Stat. 789, 15 U.S.C.A. 80a-1, as amended, or any 501
policies, annuities, or other contracts described in section 502
3907.15 of the Revised Code. 503

As used in this section, "estimate," "statement," 504
"representation," "misrepresentation," "advertisement," or 505
"announcement" includes oral or written occurrences. 506

Sec. 3923.86. (A) As used in this section, "covered dental 507
services," "covered vision services," "dental care provider," 508
"vision care materials," and "vision care provider" have the 509
same meanings as in section 3963.01 of the Revised Code. 510

(B) A sickness and accident insurer or public employee 511
benefit plan shall provide the information required in this 512
division to all insured individuals receiving coverage under an 513
individual or group policy of sickness and accident insurance or 514
public employee benefit plan ~~providing coverage~~ for vision care 515
services ~~or,~~ vision care materials, or dental care services. The 516
information shall be in a conspicuous format, shall be easily 517

accessible to insured individuals, and shall do all of the 518
following: 519

(1) ~~Include~~ For vision care coverage, include the 520
following statement: 521

"IMPORTANT: If you opt to receive vision care services or 522
vision care materials that are not covered benefits under this 523
plan, a participating vision care provider may charge you his or 524
her normal fee for such services or materials. Prior to 525
providing you with vision care services or vision care materials 526
that are not covered benefits, the vision care provider will 527
provide you with an estimated cost for each service or material 528
upon your request." 529

(2) For dental care coverage, include the following 530
statement: 531

"IMPORTANT: If you opt to receive dental care services 532
that are not covered benefits under this plan, a participating 533
dental care provider may charge you his or her normal fee for 534
such services. Prior to providing you with dental care services 535
that are not covered benefits, the dental care provider will 536
provide you with an estimated cost for each service." 537

(3) Disclose any business interest the insurer or plan has 538
in a source or supplier of vision care materials; 539

~~(3)~~ (4) Include an explanation that the insured individual 540
may incur out-of-pocket expenses as a result of the purchase of 541
vision care services ~~or,~~ vision care materials, or dental care 542
services that are not covered ~~vision services~~. The explanation 543
shall be communicated in a manner and format similar to how the 544
insurer or plan provides an insured individual with information 545
on coverage levels and out-of-pocket expenses that may be 546

incurred by the insured individual under the policy or plan when 547
purchasing out-of-network vision care services ~~or,~~ vision care 548
materials, or dental care services. 549

(C) A pattern of continuous or repeated violations of this 550
section is an unfair and deceptive act or practice in the 551
business of insurance under sections 3901.19 to 3901.26 of the 552
Revised Code. 553

Sec. 3963.01. As used in this chapter: 554

(A) "Affiliate" means any person or entity that has 555
ownership or control of a contracting entity, is owned or 556
controlled by a contracting entity, or is under common ownership 557
or control with a contracting entity. 558

(B) "Basic health care services" has the same meaning as 559
in division (A) of section 1751.01 of the Revised Code, except 560
that it does not include any services listed in that division 561
that are provided by a pharmacist or nursing home. 562

(C) "Covered vision services" means vision care services 563
or vision care materials for which a reimbursement is available 564
under an enrollee's health care contract, or for which a 565
reimbursement would be available but for the application of 566
contractual limitations, such as a deductible, copayment, 567
coinsurance, waiting period, annual or lifetime maximum, 568
frequency limitation, alternative benefit payment, or any other 569
limitation. 570

(D) "Contracting entity" means any person that has a 571
primary business purpose of contracting with participating 572
providers for the delivery of health care services. 573

(E) "Covered dental services" means dental care services 574
for which reimbursement is available under an enrollee's health 575

care contract, or for which a reimbursement would be available 576
but for the application of contractual limitations, such as a 577
deductible, copayment, coinsurance, waiting period, annual or 578
lifetime maximum, frequency limitation, alternative benefit 579
payment, or any other limitation. 580

(F) "Credentialing" means the process of assessing and 581
validating the qualifications of a provider applying to be 582
approved by a contracting entity to provide basic health care 583
services, specialty health care services, or supplemental health 584
care services to enrollees. 585

~~(F)~~ (G) "Dental care provider" means a dentist licensed 586
under Chapter 4715. of the Revised Code. "Dental care provider" 587
does not include a dental hygienist licensed under Chapter 4715. 588
of the Revised Code. 589

(H) "Edit" means adjusting one or more procedure codes 590
billed by a participating provider on a claim for payment or a 591
practice that results in any of the following: 592

(1) Payment for some, but not all of the procedure codes 593
originally billed by a participating provider; 594

(2) Payment for a different procedure code than the 595
procedure code originally billed by a participating provider; 596

(3) A reduced payment as a result of services provided to 597
an enrollee that are claimed under more than one procedure code 598
on the same service date. 599

~~(G)~~ (I) "Electronic claims transport" means to accept and 600
digitize claims or to accept claims already digitized, to place 601
those claims into a format that complies with the electronic 602
transaction standards issued by the United States department of 603
health and human services pursuant to the "Health Insurance 604

Portability and Accountability Act of 1996," 110 Stat. 1955, 42 605
U.S.C. 1320d, et seq., as those electronic standards are 606
applicable to the parties and as those electronic standards are 607
updated from time to time, and to electronically transmit those 608
claims to the appropriate contracting entity, payer, or third- 609
party administrator. 610

~~(H)~~ (J) "Enrollee" means any person eligible for health 611
care benefits under a health benefit plan, including an eligible 612
recipient of medicaid, and includes all of the following terms: 613

(1) "Enrollee" and "subscriber" as defined by section 614
1751.01 of the Revised Code; 615

(2) "Member" as defined by section 1739.01 of the Revised 616
Code; 617

(3) "Insured" and "plan member" pursuant to Chapter 3923. 618
of the Revised Code; 619

(4) "Beneficiary" as defined by section 3901.38 of the 620
Revised Code. 621

~~(I)~~ (K) "Health care contract" means a contract entered 622
into, materially amended, or renewed between a contracting 623
entity and a participating provider for the delivery of basic 624
health care services, specialty health care services, or 625
supplemental health care services to enrollees. 626

~~(J)~~ (L) "Health care services" means basic health care 627
services, specialty health care services, and supplemental 628
health care services. 629

~~(K)~~ (M) "Material amendment" means an amendment to a 630
health care contract that decreases the participating provider's 631
payment or compensation, changes the administrative procedures 632

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 division (B) of section 3963.04 of the Revised Code.

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

~~(M)~~ (O) "Payer" means any person that assumes the 662
financial risk for the payment of claims under a health care 663
contract or the reimbursement for health care services provided 664
to enrollees by participating providers pursuant to a health 665
care contract. 666

~~(N)~~ (P) "Primary enrollee" means a person who is 667
responsible for making payments for participation in a health 668
care plan or an enrollee whose employment or other status is the 669
basis of eligibility for enrollment in a health care plan. 670

~~(O)~~ (Q) "Procedure codes" includes the American medical 671
association's current procedural terminology code, the American 672
dental association's current dental terminology, and the centers 673
for medicare and medicaid services health care common procedure 674
coding system. 675

~~(P)~~ (R) "Product" means one of the following types of 676
categories of coverage for which a participating provider may be 677
obligated to provide health care services pursuant to a health 678
care contract: 679

(1) A health maintenance organization or other product 680
provided by a health insuring corporation; 681

(2) A preferred provider organization; 682

(3) Medicare; 683

(4) Medicaid; 684

(5) Workers' compensation. 685

~~(Q)~~ (S) "Provider" means a physician, podiatrist, dentist, 686
chiropractor, optometrist, psychologist, physician assistant, 687
advanced practice registered nurse, occupational therapist, 688
massage therapist, physical therapist, licensed professional 689

counselor, licensed professional clinical counselor, hearing aid 690
dealer, orthotist, prosthetist, home health agency, hospice care 691
program, pediatric respite care program, or hospital, or a 692
provider organization or physician-hospital organization that is 693
acting exclusively as an administrator on behalf of a provider 694
to facilitate the provider's participation in health care 695
contracts. 696

"Provider" does not mean either of the following: 697

(1) A nursing home; 698

(2) A provider organization or physician-hospital 699
organization that leases the provider organization's or 700
physician-hospital organization's network to a third party or 701
contracts directly with employers or health and welfare funds. 702

~~(R)~~(T) "Specialty health care services" has the same 703
meaning as in section 1751.01 of the Revised Code, except that 704
it does not include any services listed in division (B) of 705
section 1751.01 of the Revised Code that are provided by a 706
pharmacist or a nursing home. 707

~~(S)~~(U) "Supplemental health care services" has the same 708
meaning as in division (B) of section 1751.01 of the Revised 709
Code, except that it does not include any services listed in 710
that division that are provided by a pharmacist or nursing home. 711

~~(T)~~(V) "Vision care materials" includes lenses, devices 712
containing lenses, prisms, lens treatments and coatings, contact 713
lenses, orthotics, vision training, and any prosthetic device 714
necessary to correct, relieve, or treat any defect or abnormal 715
condition of the human eye or its adnexa. 716

~~(U)~~(W) "Vision care provider" means either of the 717
following: 718

| | |
|---|--|
| (1) An optometrist licensed under Chapter 4725. of the Revised Code; | 719 720 |
| (2) A physician authorized under Chapter 4731. of the Revised Code to practice medicine and surgery or osteopathic medicine and surgery. | 721 722 723 |
| Sec. 3963.02. (A) (1) No contracting entity shall sell, rent, or give a third party the contracting entity's rights to a participating provider's services pursuant to the contracting entity's health care contract with the participating provider unless one of the following applies: | 724 725 726 727 728 |
| (a) The third party accessing the participating provider's services under the health care contract is an employer or other entity providing coverage for health care services to its employees or members, and that employer or entity has a contract with the contracting entity or its affiliate for the administration or processing of claims for payment for services provided pursuant to the health care contract with the participating provider. | 729 730 731 732 733 734 735 736 |
| (b) The third party accessing the participating provider's services under the health care contract either is an affiliate or subsidiary of the contracting entity or is providing administrative services to, or receiving administrative services from, the contracting entity or an affiliate or subsidiary of the contracting entity. | 737 738 739 740 741 742 |
| (c) The health care contract specifically provides that it applies to network rental arrangements and states that one purpose of the contract is selling, renting, or giving the contracting entity's rights to the services of the participating provider, including other preferred provider organizations, and | 743 744 745 746 747 |

the third party accessing the participating provider's services 748
is any of the following: 749

(i) A payer or a third-party administrator or other entity 750
responsible for administering claims on behalf of the payer; 751

(ii) A preferred provider organization or preferred 752
provider network that receives access to the participating 753
provider's services pursuant to an arrangement with the 754
preferred provider organization or preferred provider network in 755
a contract with the participating provider that is in compliance 756
with division (A) (1) (c) of this section, and is required to 757
comply with all of the terms, conditions, and affirmative 758
obligations to which the originally contracted primary 759
participating provider network is bound under its contract with 760
the participating provider, including, but not limited to, 761
obligations concerning patient steerage and the timeliness and 762
manner of reimbursement. 763

(iii) An entity that is engaged in the business of 764
providing electronic claims transport between the contracting 765
entity and the payer or third-party administrator and complies 766
with all of the applicable terms, conditions, and affirmative 767
obligations of the contracting entity's contract with the 768
participating provider including, but not limited to, 769
obligations concerning patient steerage and the timeliness and 770
manner of reimbursement. 771

(2) The contracting entity that sells, rents, or gives the 772
contracting entity's rights to the participating provider's 773
services pursuant to the contracting entity's health care 774
contract with the participating provider as provided in division 775
(A) (1) of this section shall do both of the following: 776

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

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

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

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

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

(2) Division (B)(1) of this section shall not be construed 806
to do any of the following: 807

(a) Prohibit any participating provider from voluntarily 808
accepting an offer by a contracting entity to provide health 809
care services under all of the contracting entity's products; 810

(b) Prohibit any contracting entity from offering any 811
financial incentive or other form of consideration specified in 812
the health care contract for a participating provider to provide 813
health care services under all of the contracting entity's 814
products; 815

(c) Require any contracting entity to contract with a 816
participating provider to provide health care services for less 817
than all of the contracting entity's products if the contracting 818
entity does not wish to do so. 819

(3) (a) Notwithstanding division (B)(2) of this section, no 820
contracting entity shall require, as a condition of contracting 821
with the contracting entity, that the participating provider 822
accept any future product offering that the contracting entity 823
makes. 824

(b) If a participating provider refuses to accept any 825
future product offering that the contracting entity makes, the 826
contracting entity may terminate the health care contract based 827
on the participating provider's refusal upon written notice to 828
the participating provider no sooner than one hundred eighty 829
days after the refusal. 830

(4) Once the contracting entity and the participating 831
provider have signed the health care contract, it is presumed 832
that the financial incentive or other form of consideration that 833
is specified in the health care contract pursuant to division 834

(B) (2) (b) of this section is the financial incentive or other 835
form of consideration that was offered by the contracting entity 836
to induce the participating provider to enter into the contract. 837

(C) No contracting entity shall require, as a condition of 838
contracting with the contracting entity, that a participating 839
provider waive or forgo any right or benefit expressly conferred 840
upon a participating provider by state or federal law. However, 841
this division does not prohibit a contracting entity from 842
restricting a participating provider's scope of practice for the 843
services to be provided under the contract. 844

(D) No health care contract shall do any of the following: 845

(1) Prohibit any participating provider from entering into 846
a health care contract with any other contracting entity; 847

(2) Prohibit any contracting entity from entering into a 848
health care contract with any other provider; 849

(3) Preclude its use or disclosure for the purpose of 850
enforcing this chapter or other state or federal law, except 851
that a health care contract may require that appropriate 852
measures be taken to preserve the confidentiality of any 853
proprietary or trade-secret information. 854

(E) (1) No contract or agreement between a contracting 855
entity and a vision care provider shall do any of the following: 856

(a) Require that a vision care provider accept as payment 857
an amount set by the contracting entity for vision care services 858
or vision care materials provided to an enrollee unless the 859
services or materials are covered vision services. 860

(i) Notwithstanding division (E) (1) (a) of this section, a 861
vision care provider may, in a contract with a contracting 862

entity, choose to accept as payment an amount set by the 863
contracting entity for vision care services or vision care 864
materials provided to an enrollee that are not covered vision 865
services. 866

(ii) No contract between a vision care provider and a 867
contracting entity to provide covered vision services or vision 868
care materials shall be contingent on whether the vision care 869
provider has entered into an agreement addressing noncovered 870
vision services pursuant to division (E) (1) (a) (i) of this 871
section. 872

(iii) A contracting entity may communicate to its 873
enrollees which vision care providers choose to accept as 874
payment an amount set by the contracting entity for vision care 875
services or vision care materials provided to an enrollee that 876
are not covered vision services pursuant to division (E) (1) (a) 877
(i) of this section. Any communication to this effect shall 878
treat all vision care providers equally in provider directories, 879
provider locators, and other marketing materials as 880
participating, in-network providers, annotated only as to their 881
decision to accept payment pursuant to division (E) (1) (a) (i) of 882
this section. 883

(b) Require that a vision care provider contract with a 884
plan offering supplemental or specialty health care services as 885
a condition of contracting with a plan offering basic health 886
care services; 887

(c) Directly limit a vision care provider's choice of 888
sources and suppliers of vision care materials; 889

(d) Include a provision that prohibits a vision care 890
provider from describing out-of-network options to an enrollee 891

in accordance with division (E)(2) of this section. 892

The provisions of divisions (E)(1)(a) to (d) of this 893
section shall be effective for contracts entered into, amended, 894
or renewed on or after January 1, 2019. 895

(2) A vision care provider recommending an out-of-network 896
source or supplier of vision care materials to an enrollee shall 897
notify the enrollee in writing that the source or supplier is 898
out-of-network and shall inform the enrollee of the cost of 899
those materials. The vision care provider shall also disclose in 900
writing to an enrollee any business interest the provider has in 901
a recommended out-of-network source or supplier utilized by the 902
enrollee. 903

(3) A vision care provider who chooses not to accept as 904
payment an amount set by a contracting entity for vision care 905
services or vision care materials that are not covered vision 906
services shall do both of the following: 907

(a) Upon the request of an enrollee seeking vision care 908
services or vision care materials that are not covered vision 909
services, provide to the enrollee pricing and reimbursement 910
information, including all of the following: 911

(i) The estimated fee or discounted price suggested by the 912
contracting entity for the noncovered service or material; 913

(ii) The estimated fee charged by the vision care provider 914
for the noncovered service or material; 915

(iii) The amount the vision care provider expects to be 916
reimbursed by the contracting entity for the noncovered service 917
or material; 918

(iv) The estimated pricing and reimbursement information 919

for any covered services or materials that are also expected to 920
be provided during the enrollee's visit. 921

(b) Post, in a conspicuous place, a notice stating the 922
following: 923

"IMPORTANT: This vision care provider does not accept the 924
fee schedule set by your insurer for vision care services and 925
vision care materials that are not covered benefits under your 926
plan and instead charges his or her normal fee for those 927
services and materials. This vision care provider will provide 928
you with an estimated cost for each non-covered service or 929
material upon your request." 930

(4) Nothing in division (E) of this section shall do any 931
of the following: 932

(a) Restrict or limit a contracting entity's determination 933
of specific amounts of coverage or reimbursement for the use of 934
network or out-of-network sources or suppliers of vision care 935
materials as set forth in an enrollee's benefit plan; 936

(b) Restrict or limit a contracting entity's ability to 937
enter into an agreement with another contracting entity or an 938
affiliate of another contracting entity; 939

(c) Restrict or limit a health care plan's ability to 940
enter into an agreement with a vision care plan to deliver 941
routine vision care services that are covered under an 942
enrollee's plan; 943

(d) Restrict or limit a vision care plan network from 944
acting as a network for a health care plan; 945

(e) Prohibit a contracting entity from requiring 946
participating vision care providers to offer network sources or 947

suppliers of vision care materials to enrollees; 948

(f) Prohibit an enrollee from utilizing a network source 949
or supplier of vision care materials as set forth in an 950
enrollee's plan; 951

(g) Prohibit a participating vision care provider from 952
accepting as payment an amount that is the same as the amount 953
set by the contracting entity for vision care services or vision 954
care materials that are not covered vision services. 955

(F) (1) No contract or agreement between a contracting 956
entity and a dental care provider shall do any of the following: 957

(a) Require that a dental care provider accept as payment 958
an amount set by the contracting entity for dental care services 959
provided to an enrollee unless the services are covered dental 960
services. 961

(i) Notwithstanding division (F) (1) (a) of this section, a 962
dental care provider may, in a contract with a contracting 963
entity, choose to accept as payment an amount set by the 964
contracting entity for dental care services provided to an 965
enrollee that are not covered dental services. 966

(ii) No contract between a dental care provider and a 967
contracting entity to provide covered dental services shall be 968
contingent on whether the dental care provider has entered into 969
an agreement addressing noncovered dental services pursuant to 970
division (F) (1) (a) (i) of this section. 971

(iii) A contracting entity may communicate to its 972
enrollees which dental care providers choose to accept as 973
payment an amount set by the contracting entity for dental care 974
services provided to an enrollee that are not covered dental 975
services pursuant to division (F) (1) (a) (i) of this section. Any 976

communication to this effect shall treat all dental care 977
providers equally in provider directories, provider locators, 978
and other marketing materials as participating, in-network 979
providers, annotated only as to their decision to accept payment 980
pursuant to division (F)(1)(a)(i) of this section. 981

(b) Require that a dental care provider contract with a 982
plan offering supplemental or specialty health care services as 983
a condition of contracting with a plan offering basic health 984
care services. 985

The provisions of divisions (F)(1)(a) and (b) of this 986
section apply to contracts entered into, amended, or renewed on 987
or after January 1, 2022. 988

(2) A dental care provider who chooses not to accept as 989
payment an amount set by a contracting entity for dental care 990
services that are not covered dental services shall do both of 991
the following: 992

(a) Provide to an enrollee seeking dental care services 993
that are not covered dental services pricing and reimbursement 994
information, including all of the following: 995

(i) The estimated fee or discounted price suggested by the 996
contracting entity for the noncovered service; 997

(ii) The estimated fee charged by the dental care provider 998
for the noncovered service; 999

(iii) The amount the dental care provider expects to be 1000
reimbursed by the contracting entity for the noncovered service; 1001

(iv) The estimated pricing and reimbursement information 1002
for any covered services that are also expected to be provided 1003
during the enrollee's visit. 1004

(b) Post, in a conspicuous place, a notice stating the 1005
following: 1006

"IMPORTANT: This dental care provider does not accept the 1007
fee schedule set by your insurer for dental care services that 1008
are not covered benefits under your plan and instead charges his 1009
or her normal fee for those services. This dental care provider 1010
will provide you with an estimated cost for each noncovered 1011
service." 1012

(3) Nothing in division (F) of this section shall do any 1013
of the following: 1014

(a) Restrict or limit a contracting entity's ability to 1015
enter into an agreement with another contracting entity or an 1016
affiliate of another contracting entity; 1017

(b) Restrict or limit a health care plan's ability to 1018
enter into an agreement with a dental care plan to deliver 1019
routine dental care services that are covered under an 1020
enrollee's plan; 1021

(c) Restrict or limit a dental care plan network from 1022
acting as a network for a health care plan; 1023

(d) Prohibit a participating dental care provider from 1024
accepting as payment an amount that is the same as the amount 1025
set by the contracting entity for dental care services that are 1026
not covered dental services. 1027

(G) (1) In addition to any other lawful reasons for 1028
terminating a health care contract, a health care contract may 1029
only be terminated under the circumstances described in division 1030
(A) (3) of section 3963.04 of the Revised Code. 1031

(2) If the health care contract provides for termination 1032

for cause by either party, the health care contract shall state 1033
the reasons that may be used for termination for cause, which 1034
terms shall be reasonable. Once the contracting entity and the 1035
participating provider have signed the health care contract, it 1036
is presumed that the reasons stated in the health care contract 1037
for termination for cause by either party are reasonable. 1038
Subject to division ~~(F)~~(G) (3) of this section, the health care 1039
contract shall state the time by which the parties must provide 1040
notice of termination for cause and to whom the parties shall 1041
give the notice. 1042

(3) Nothing in divisions ~~(F)~~(G) (1) and (2) of this section 1043
shall be construed as prohibiting any health insuring 1044
corporation from terminating a participating provider's contract 1045
for any of the causes described in divisions (A), (D), and (F) 1046
(1) and (2) of section 1753.09 of the Revised Code. 1047
Notwithstanding any provision in a health care contract pursuant 1048
to division ~~(F)~~(G) (2) of this section, section 1753.09 of the 1049
Revised Code applies to the termination of a participating 1050
provider's contract for any of the causes described in divisions 1051
(A), (D), and (F) (1) and (2) of section 1753.09 of the Revised 1052
Code. 1053

(4) Subject to sections 3963.01 to 3963.11 of the Revised 1054
Code, nothing in this section prohibits the termination of a 1055
health care contract without cause if the health care contract 1056
otherwise provides for termination without cause. 1057

(5) Nothing in division ~~(F)~~(G) of this section shall be 1058
construed to expand the regulatory authority of the 1059
superintendent to vision care providers or dental care 1060
providers. 1061

~~(G)~~(H) (1) Disputes among parties to a health care contract 1062

that only concern the enforcement of the contract rights 1063
conferred by section 3963.02, divisions (A) and (D) of section 1064
3963.03, and section 3963.04 of the Revised Code are subject to 1065
a mutually agreed upon arbitration mechanism that is binding on 1066
all parties. The arbitrator may award reasonable attorney's fees 1067
and costs for arbitration relating to the enforcement of this 1068
section to the prevailing party. 1069

(2) The arbitrator shall make the arbitrator's decision in 1070
an arbitration proceeding having due regard for any applicable 1071
rules, bulletins, rulings, or decisions issued by the department 1072
of insurance or any court concerning the enforcement of the 1073
contract rights conferred by section 3963.02, divisions (A) and 1074
(D) of section 3963.03, and section 3963.04 of the Revised Code. 1075

(3) A party shall not simultaneously maintain an 1076
arbitration proceeding as described in division ~~(G)~~(H)(1) of 1077
this section and pursue a complaint with the superintendent of 1078
insurance to investigate the subject matter of the arbitration 1079
proceeding. However, if a complaint is filed with the department 1080
of insurance, the superintendent may choose to investigate the 1081
complaint or, after reviewing the complaint, advise the 1082
complainant to proceed with arbitration to resolve the 1083
complaint. The superintendent may request to receive a copy of 1084
the results of the arbitration. If the superintendent of 1085
insurance notifies an insurer or a health insuring corporation 1086
in writing that the superintendent has initiated a market 1087
conduct examination into the specific subject matter of the 1088
arbitration proceeding pending against that insurer or health 1089
insuring corporation, the arbitration proceeding shall be stayed 1090
at the request of the insurer or health insuring corporation 1091
pending the outcome of the market conduct investigation by the 1092
superintendent. 1093

Sec. 3963.03. (A) Each health care contract shall include 1094
all of the following information: 1095

(1) (a) Information sufficient for the participating 1096
provider to determine the compensation or payment terms for 1097
health care services, including all of the following, subject to 1098
division (A) (1) (b) of this section: 1099

(i) The manner of payment, such as fee-for-service, 1100
capitation, or risk; 1101

(ii) The fee schedule of procedure codes reasonably 1102
expected to be billed by a participating provider's specialty 1103
for services provided pursuant to the health care contract and 1104
the associated payment or compensation for each procedure code. 1105
A fee schedule may be provided electronically. Upon request, a 1106
contracting entity shall provide a participating provider with 1107
the fee schedule for any other procedure codes requested and a 1108
written fee schedule, that shall not be required more frequently 1109
than twice per year excluding when it is provided in connection 1110
with any change to the schedule. This requirement may be 1111
satisfied by providing a clearly understandable, readily 1112
available mechanism, such as a specific web site address, that 1113
allows a participating provider to determine the effect of 1114
procedure codes on payment or compensation before a service is 1115
provided or a claim is submitted. 1116

(iii) The effect, if any, on payment or compensation if 1117
more than one procedure code applies to the service also shall 1118
be stated. This requirement may be satisfied by providing a 1119
clearly understandable, readily available mechanism, such as a 1120
specific web site address, that allows a participating provider 1121
to determine the effect of procedure codes on payment or 1122
compensation before a service is provided or a claim is 1123

submitted. 1124

(b) If the contracting entity is unable to include the 1125
information described in divisions (A) (1) (a) (ii) and (iii) of 1126
this section, the contracting entity shall include both of the 1127
following types of information instead: 1128

(i) The methodology used to calculate any fee schedule, 1129
such as relative value unit system and conversion factor or 1130
percentage of billed charges. If applicable, the methodology 1131
disclosure shall include the name of any relative value unit 1132
system, its version, edition, or publication date, any 1133
applicable conversion or geographic factor, and any date by 1134
which compensation or fee schedules may be changed by the 1135
methodology as anticipated at the time of contract. 1136

(ii) The identity of any internal processing edits, 1137
including the publisher, product name, version, and version 1138
update of any editing software. 1139

(c) If the contracting entity is not the payer and is 1140
unable to include the information described in division (A) (1) 1141
(a) or (b) of this section, then the contracting entity shall 1142
provide by telephone a readily available mechanism, such as a 1143
specific web site address, that allows the participating 1144
provider to obtain that information from the payer. 1145

(2) Any product or network for which the participating 1146
provider is to provide services; 1147

(3) The term of the health care contract; 1148

(4) A specific web site address that contains the identity 1149
of the contracting entity or payer responsible for the 1150
processing of the participating provider's compensation or 1151
payment; 1152

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

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

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

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

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

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

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

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

Revised Code and the participating provider is encouraged to 1182
carefully read any proposed amendments sent after execution of 1183
the contract; 1184

(e) That nothing in the summary disclosure form creates 1185
any additional rights or causes of action in favor of either 1186
party. 1187

(3) No contracting entity that includes any information in 1188
the summary disclosure form with the reasonable belief that the 1189
information is truthful or accurate shall be subject to a civil 1190
action for damages or to binding arbitration based on the 1191
summary disclosure form. Division (B) (3) of this section does 1192
not impair or affect any power of the department of insurance to 1193
enforce any applicable law. 1194

(4) The summary disclosure form described in divisions (B) 1195
(1) and (2) of this section shall be in substantially the 1196
following form: 1197

"SUMMARY DISCLOSURE FORM 1198

(1) Compensation terms 1199

(a) Manner of payment 1200

[] Fee for service 1201

[] Capitation 1202

[] Risk 1203

[] Other _____ See _____ 1204

(b) Fee schedule available at _____ 1205

(c) Fee calculation schedule available at _____ 1206

(d) Identity of internal processing edits available at 1207

| | |
|--|------|
| _____ | 1208 |
| (e) Information in (c) and (d) is not required if | 1209 |
| information in (b) is provided. | 1210 |
| (2) List of products or networks covered by this contract | 1211 |
| [] _____ | 1212 |
| [] _____ | 1213 |
| [] _____ | 1214 |
| [] _____ | 1215 |
| [] _____ | 1216 |
| (3) Term of this contract _____ | 1217 |
| (4) Contracting entity or payer responsible for processing | 1218 |
| payment available at _____ | 1219 |
| (5) Internal mechanism for resolving disputes regarding | 1220 |
| contract terms available at _____ | 1221 |
| (6) Addenda to contract | 1222 |
| Title Subject | 1223 |
| (a) | 1224 |
| (b) | 1225 |
| (c) | 1226 |
| (d) | 1227 |
| (7) Telephone number to access a readily available | 1228 |
| mechanism, such as a specific web site address, to allow a | 1229 |
| participating provider to receive the information in (1) through | 1230 |
| (6) from the payer. | 1231 |

IMPORTANT INFORMATION - PLEASE READ CAREFULLY 1232

The information provided in this Summary Disclosure Form 1233
is a guide to the attached Health Care Contract as defined in 1234
section 3963.01-~~(I)~~(K) of the Ohio Revised Code. The terms and 1235
conditions of the attached Health Care Contract constitute the 1236
contract rights of the parties. 1237

Reading this Summary Disclosure Form is not a substitute 1238
for reading the entire Health Care Contract. When you sign the 1239
Health Care Contract, you will be bound by its terms and 1240
conditions. These terms and conditions may be amended over time 1241
pursuant to section 3963.04 of the Ohio Revised Code. You are 1242
encouraged to read any proposed amendments that are sent to you 1243
after execution of the Health Care Contract. 1244

Nothing in this Summary Disclosure Form creates any 1245
additional rights or causes of action in favor of either party." 1246

(C) When a contracting entity presents a proposed health 1247
care contract for consideration by a provider, the contracting 1248
entity shall provide in writing or make reasonably available the 1249
information required in division (A) (1) of this section. 1250

(D) The contracting entity shall identify any utilization 1251
management, quality improvement, or a similar program that the 1252
contracting entity uses to review, monitor, evaluate, or assess 1253
the services provided pursuant to a health care contract. The 1254
contracting entity shall disclose the policies, procedures, or 1255
guidelines of such a program applicable to a participating 1256
provider upon request by the participating provider within 1257
fourteen days after the date of the request. 1258

(E) Nothing in this section shall be construed as 1259
preventing or affecting the application of section 1753.07 of 1260

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

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

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

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

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

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

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

(5) Commission of an act in the course of practice that

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| constitutes a misdemeanor in this state, regardless of the | 1290 |
| jurisdiction in which the act was committed; | 1291 |
| (6) Conviction of, a plea of guilty to, a judicial finding | 1292 |
| of guilt of, a judicial finding of guilt resulting from a plea | 1293 |
| of no contest to, or a judicial finding of eligibility for | 1294 |
| intervention in lieu of conviction for, any felony or of a | 1295 |
| misdemeanor committed in the course of practice; | 1296 |
| (7) Engaging in lewd or immoral conduct in connection with | 1297 |
| the provision of dental services; | 1298 |
| (8) Selling, prescribing, giving away, or administering | 1299 |
| drugs for other than legal and legitimate therapeutic purposes, | 1300 |
| or conviction of, a plea of guilty to, a judicial finding of | 1301 |
| guilt of, a judicial finding of guilt resulting from a plea of | 1302 |
| no contest to, or a judicial finding of eligibility for | 1303 |
| intervention in lieu of conviction for, a violation of any | 1304 |
| federal or state law regulating the possession, distribution, or | 1305 |
| use of any drug; | 1306 |
| (9) Providing or allowing dental hygienists, expanded | 1307 |
| function dental auxiliaries, or other practitioners of auxiliary | 1308 |
| dental occupations working under the certificate or license | 1309 |
| holder's supervision, or a dentist holding a temporary limited | 1310 |
| continuing education license under division (C) of section | 1311 |
| 4715.16 of the Revised Code working under the certificate or | 1312 |
| license holder's direct supervision, to provide dental care that | 1313 |
| departs from or fails to conform to accepted standards for the | 1314 |
| profession, whether or not injury to a patient results; | 1315 |
| (10) Inability to practice under accepted standards of the | 1316 |
| profession because of physical or mental disability, dependence | 1317 |
| on alcohol or other drugs, or excessive use of alcohol or other | 1318 |

| | |
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| drugs; | 1319 |
| (11) Violation of any provision of this chapter or any | 1320 |
| rule adopted thereunder; | 1321 |
| (12) Failure to use universal blood and body fluid | 1322 |
| precautions established by rules adopted under section 4715.03 | 1323 |
| of the Revised Code; | 1324 |
| (13) Except as provided in division (H) of this section, | 1325 |
| either of the following: | 1326 |
| (a) Waiving the payment of all or any part of a deductible | 1327 |
| or copayment that a patient, pursuant to a health insurance or | 1328 |
| health care policy, contract, or plan that covers dental | 1329 |
| services, would otherwise be required to pay if the waiver is | 1330 |
| used as an enticement to a patient or group of patients to | 1331 |
| receive health care services from that certificate or license | 1332 |
| holder; | 1333 |
| (b) Advertising that the certificate or license holder | 1334 |
| will waive the payment of all or any part of a deductible or | 1335 |
| copayment that a patient, pursuant to a health insurance or | 1336 |
| health care policy, contract, or plan that covers dental | 1337 |
| services, would otherwise be required to pay. | 1338 |
| (14) Failure to comply with section 4715.302 or 4729.79 of | 1339 |
| the Revised Code, unless the state board of pharmacy no longer | 1340 |
| maintains a drug database pursuant to section 4729.75 of the | 1341 |
| Revised Code; | 1342 |
| (15) Any of the following actions taken by an agency | 1343 |
| responsible for authorizing, certifying, or regulating an | 1344 |
| individual to practice a health care occupation or provide | 1345 |
| health care services in this state or another jurisdiction, for | 1346 |
| any reason other than the nonpayment of fees: the limitation, | 1347 |

revocation, or suspension of an individual's license to 1348
practice; acceptance of an individual's license surrender; 1349
denial of a license; refusal to renew or reinstate a license; 1350
imposition of probation; or issuance of an order of censure or 1351
other reprimand; 1352

(16) Failure to cooperate in an investigation conducted by 1353
the board under division (D) of section 4715.03 of the Revised 1354
Code, including failure to comply with a subpoena or order 1355
issued by the board or failure to answer truthfully a question 1356
presented by the board at a deposition or in written 1357
interrogatories, except that failure to cooperate with an 1358
investigation shall not constitute grounds for discipline under 1359
this section if a court of competent jurisdiction has issued an 1360
order that either quashes a subpoena or permits the individual 1361
to withhold the testimony or evidence in issue; 1362

(17) Failure to comply with the requirements in section 1363
3719.061 of the Revised Code before issuing for a minor a 1364
prescription for an opioid analgesic, as defined in section 1365
3719.01 of the Revised Code; 1366

(18) Failure to comply with the requirements of sections 1367
4715.71 and 4715.72 of the Revised Code regarding the operation 1368
of a mobile dental facility; 1369

(19) A pattern of continuous or repeated violations of 1370
division (F) (2) of section 3963.02 of the Revised Code. 1371

(B) A manager, proprietor, operator, or conductor of a 1372
dental facility shall be subject to disciplinary action if any 1373
dentist, dental hygienist, expanded function dental auxiliary, 1374
or qualified personnel providing services in the facility is 1375
found to have committed a violation listed in division (A) of 1376

this section and the manager, proprietor, operator, or conductor 1377
knew of the violation and permitted it to occur on a recurring 1378
basis. 1379

(C) Subject to Chapter 119. of the Revised Code, the board 1380
may take one or more of the following disciplinary actions if 1381
one or more of the grounds for discipline listed in divisions 1382
(A) and (B) of this section exist: 1383

(1) Censure the license or certificate holder; 1384

(2) Place the license or certificate on probationary 1385
status for such period of time the board determines necessary 1386
and require the holder to: 1387

(a) Report regularly to the board upon the matters which 1388
are the basis of probation; 1389

(b) Limit practice to those areas specified by the board; 1390

(c) Continue or renew professional education until a 1391
satisfactory degree of knowledge or clinical competency has been 1392
attained in specified areas. 1393

(3) Suspend the certificate or license; 1394

(4) Revoke the certificate or license. 1395

Where the board places a holder of a license or 1396
certificate on probationary status pursuant to division (C) (2) 1397
of this section, the board may subsequently suspend or revoke 1398
the license or certificate if it determines that the holder has 1399
not met the requirements of the probation or continues to engage 1400
in activities that constitute grounds for discipline pursuant to 1401
division (A) or (B) of this section. 1402

Any order suspending a license or certificate shall state 1403

the conditions under which the license or certificate will be 1404
restored, which may include a conditional restoration during 1405
which time the holder is in a probationary status pursuant to 1406
division (C) (2) of this section. The board shall restore the 1407
license or certificate unconditionally when such conditions are 1408
met. 1409

(D) If the physical or mental condition of an applicant or 1410
a license or certificate holder is at issue in a disciplinary 1411
proceeding, the board may order the license or certificate 1412
holder to submit to reasonable examinations by an individual 1413
designated or approved by the board and at the board's expense. 1414
The physical examination may be conducted by any individual 1415
authorized by the Revised Code to do so, including a physician 1416
assistant, a clinical nurse specialist, a certified nurse 1417
practitioner, or a certified nurse-midwife. Any written 1418
documentation of the physical examination shall be completed by 1419
the individual who conducted the examination. 1420

Failure to comply with an order for an examination shall 1421
be grounds for refusal of a license or certificate or summary 1422
suspension of a license or certificate under division (E) of 1423
this section. 1424

(E) If a license or certificate holder has failed to 1425
comply with an order under division (D) of this section, the 1426
board may apply to the court of common pleas of the county in 1427
which the holder resides for an order temporarily suspending the 1428
holder's license or certificate, without a prior hearing being 1429
afforded by the board, until the board conducts an adjudication 1430
hearing pursuant to Chapter 119. of the Revised Code. If the 1431
court temporarily suspends a holder's license or certificate, 1432
the board shall give written notice of the suspension personally 1433

or by certified mail to the license or certificate holder. Such 1434
notice shall inform the license or certificate holder of the 1435
right to a hearing pursuant to Chapter 119. of the Revised Code. 1436

(F) Any holder of a certificate or license issued under 1437
this chapter who has pleaded guilty to, has been convicted of, 1438
or has had a judicial finding of eligibility for intervention in 1439
lieu of conviction entered against the holder in this state for 1440
aggravated murder, murder, voluntary manslaughter, felonious 1441
assault, kidnapping, rape, sexual battery, gross sexual 1442
imposition, aggravated arson, aggravated robbery, or aggravated 1443
burglary, or who has pleaded guilty to, has been convicted of, 1444
or has had a judicial finding of eligibility for treatment or 1445
intervention in lieu of conviction entered against the holder in 1446
another jurisdiction for any substantially equivalent criminal 1447
offense, is automatically suspended from practice under this 1448
chapter in this state and any certificate or license issued to 1449
the holder under this chapter is automatically suspended, as of 1450
the date of the guilty plea, conviction, or judicial finding, 1451
whether the proceedings are brought in this state or another 1452
jurisdiction. Continued practice by an individual after the 1453
suspension of the individual's certificate or license under this 1454
division shall be considered practicing without a certificate or 1455
license. The board shall notify the suspended individual of the 1456
suspension of the individual's certificate or license under this 1457
division by certified mail or in person in accordance with 1458
section 119.07 of the Revised Code. If an individual whose 1459
certificate or license is suspended under this division fails to 1460
make a timely request for an adjudicatory hearing, the board 1461
shall enter a final order revoking the individual's certificate 1462
or license. 1463

(G) If the supervisory investigative panel determines both 1464

of the following, the panel may recommend that the board suspend 1465
an individual's certificate or license without a prior hearing: 1466

(1) That there is clear and convincing evidence that an 1467
individual has violated division (A) of this section; 1468

(2) That the individual's continued practice presents a 1469
danger of immediate and serious harm to the public. 1470

Written allegations shall be prepared for consideration by 1471
the board. The board, upon review of those allegations and by an 1472
affirmative vote of not fewer than four dentist members of the 1473
board and seven of its members in total, excluding any member on 1474
the supervisory investigative panel, may suspend a certificate 1475
or license without a prior hearing. A telephone conference call 1476
may be utilized for reviewing the allegations and taking the 1477
vote on the summary suspension. 1478

The board shall issue a written order of suspension by 1479
certified mail or in person in accordance with section 119.07 of 1480
the Revised Code. The order shall not be subject to suspension 1481
by the court during pendency or any appeal filed under section 1482
119.12 of the Revised Code. If the individual subject to the 1483
summary suspension requests an adjudicatory hearing by the 1484
board, the date set for the hearing shall be within fifteen 1485
days, but not earlier than seven days, after the individual 1486
requests the hearing, unless otherwise agreed to by both the 1487
board and the individual. 1488

Any summary suspension imposed under this division shall 1489
remain in effect, unless reversed on appeal, until a final 1490
adjudicative order issued by the board pursuant to this section 1491
and Chapter 119. of the Revised Code becomes effective. The 1492
board shall issue its final adjudicative order within seventy- 1493

five days after completion of its hearing. A failure to issue 1494
the order within seventy-five days shall result in dissolution 1495
of the summary suspension order but shall not invalidate any 1496
subsequent, final adjudicative order. 1497

(H) Sanctions shall not be imposed under division (A) (13) 1498
of this section against any certificate or license holder who 1499
waives deductibles and copayments as follows: 1500

(1) In compliance with the health benefit plan that 1501
expressly allows such a practice. Waiver of the deductibles or 1502
copayments shall be made only with the full knowledge and 1503
consent of the plan purchaser, payer, and third-party 1504
administrator. Documentation of the consent shall be made 1505
available to the board upon request. 1506

(2) For professional services rendered to any other person 1507
who holds a certificate or license issued pursuant to this 1508
chapter to the extent allowed by this chapter and the rules of 1509
the board. 1510

(I) In no event shall the board consider or raise during a 1511
hearing required by Chapter 119. of the Revised Code the 1512
circumstances of, or the fact that the board has received, one 1513
or more complaints about a person unless the one or more 1514
complaints are the subject of the hearing or resulted in the 1515
board taking an action authorized by this section against the 1516
person on a prior occasion. 1517

(J) The board may share any information it receives 1518
pursuant to an investigation under division (D) of section 1519
4715.03 of the Revised Code, including patient records and 1520
patient record information, with law enforcement agencies, other 1521
licensing boards, and other governmental agencies that are 1522

prosecuting, adjudicating, or investigating alleged violations 1523
of statutes or administrative rules. An agency or board that 1524
receives the information shall comply with the same requirements 1525
regarding confidentiality as those with which the state dental 1526
board must comply, notwithstanding any conflicting provision of 1527
the Revised Code or procedure of the agency or board that 1528
applies when it is dealing with other information in its 1529
possession. In a judicial proceeding, the information may be 1530
admitted into evidence only in accordance with the Rules of 1531
Evidence, but the court shall require that appropriate measures 1532
are taken to ensure that confidentiality is maintained with 1533
respect to any part of the information that contains names or 1534
other identifying information about patients or complainants 1535
whose confidentiality was protected by the state dental board 1536
when the information was in the board's possession. Measures to 1537
ensure confidentiality that may be taken by the court include 1538
sealing its records or deleting specific information from its 1539
records. 1540

(K) The board shall not refuse to issue a license or 1541
certificate to an applicant for either of the following reasons 1542
unless the refusal is in accordance with section 9.79 of the 1543
Revised Code: 1544

(1) A conviction or plea of guilty to an offense; 1545

(2) A judicial finding of eligibility for treatment or 1546
intervention in lieu of a conviction. 1547

Section 2. That existing sections 1751.85, 1753.09, 1548
3901.21, 3923.86, 3963.01, 3963.02, 3963.03, and 4715.30 of the 1549
Revised Code are hereby repealed. 1550

Section 3. The General Assembly, applying the principle 1551

stated in division (B) of section 1.52 of the Revised Code that 1552
amendments are to be harmonized if reasonably capable of 1553
simultaneous operation, finds that the following sections, 1554
presented in this act as composites of the sections as amended 1555
by the acts indicated, are the resulting version of the sections 1556
in effect prior to the effective date of the sections as 1557
presented in this act: 1558

Section 3963.01 of the Revised Code as amended by both 1559
H.B. 156 and S.B. 265 of the 132nd General Assembly. 1560

Section 3963.02 of the Revised Code as amended by both 1561
H.B. 156 and S.B. 273 of the 132nd General Assembly. 1562

Section 4715.30 of the Revised Code as amended by both 1563
H.B. 203 and H.B. 263 of the 133rd General Assembly. 1564