

As Reported by the House Insurance Committee

135th General Assembly

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H. B. No. 160

Representative Santucci

**Cosponsors: Representatives Hillyer, Stewart, Plummer, Ray, Hall, Click, Young,
T., Creech, Cross, Patton, Barhorst, Loychik, Lorenz**

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)(2)~~ (G)(2) of section 118
3963.02 of the Revised Code, except that, notwithstanding any 119
provision of a contract described in that division, this section 120
applies to the termination of a participating provider's 121
contract for any of the causes described in divisions (A), (D), 122
and (F)(1) and (2) of this section. 123

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

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

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

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

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

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

(H) Making, issuing, circulating, or causing or permitting	226
to be made, issued, or circulated, or preparing with intent to	227
so use, any statement to the effect that a policy of life	228
insurance is, is the equivalent of, or represents shares of	229
capital stock or any rights or options to subscribe for or	230
otherwise acquire any such shares in the life insurance company	231
issuing that policy or any other company.	232
(I) Making, issuing, circulating, or causing or permitting	233
to be made, issued or circulated, or preparing with intent to so	234
issue, any statement to the effect that payments to a	235
policyholder of the principal amounts of a pure endowment are	236
other than payments of a specific benefit for which specific	237
premiums have been paid.	238
(J) Making, issuing, circulating, or causing or permitting	239
to be made, issued, or circulated, or preparing with intent to	240
so use, any statement to the effect that any insurance company	241
was required to change a policy form or related material to	242
comply with Title XXXIX of the Revised Code or any regulation of	243
the superintendent of insurance, for the purpose of inducing or	244
intending to induce any policyholder or prospective policyholder	245
to purchase, amend, lapse, forfeit, change, or surrender	246
insurance.	247
(K) Aiding or abetting another to violate this section.	248
(L) Refusing to issue any policy of insurance, or	249
canceling or declining to renew such policy because of the sex	250
or marital status of the applicant, prospective insured,	251
insured, or policyholder.	252
(M) Making or permitting any unfair discrimination between	253
individuals of the same class and of essentially the same hazard	254

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

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

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

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

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

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

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

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

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

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

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

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

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

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

to any health status-related factor in relation to one or more	345
individuals, does either of the following:	346
(a) Terminates or fails to renew an existing individual	347
policy, contract, or plan of health benefits, or a health	348
benefit plan issued to an employer, for which an individual	349
would otherwise be eligible;	350
(b) With respect to a health benefit plan issued to an	351
employer, excludes or causes the exclusion of an individual from	352
coverage under an existing employer-provided policy, contract,	353
or plan of health benefits.	354
(2) The superintendent of insurance may adopt rules in	355
accordance with Chapter 119. of the Revised Code for purposes of	356
implementing division (T) (1) of this section.	357
(3) For purposes of division (T) (1) of this section,	358
"health status-related factor" means any of the following:	359
(a) Health status;	360
(b) Medical condition, including both physical and mental	361
illnesses;	362
(c) Claims experience;	363
(d) Receipt of health care;	364
(e) Medical history;	365
(f) Genetic information;	366
(g) Evidence of insurability, including conditions arising	367
out of acts of domestic violence;	368
(h) Disability.	369
(U) With respect to a health benefit plan issued to a	370

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(c) Knowingly causing, by threat of force, a family or 455
household member to believe that the person will cause imminent 456
physical harm to the family or household member. 457

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

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

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

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

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

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

The enumeration in sections 3901.19 to 3901.26 of the 482
Revised Code of specific unfair or deceptive acts or practices 483
in the business of insurance is not exclusive or restrictive or 484
intended to limit the powers of the superintendent of insurance 485
to adopt rules to implement this section, or to take action 486

under other sections of the Revised Code. 487

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

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

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

(B) A sickness and accident insurer or public employee 500
benefit plan shall provide the information required in this 501
division to all insured individuals receiving coverage under an 502
individual or group policy of sickness and accident insurance or 503
public employee benefit plan ~~providing coverage~~ for vision care 504
services ~~or,~~ vision care materials, or dental care services. The 505
information shall be in a conspicuous format, shall be easily 506
accessible to insured individuals, and shall do all of the 507
following: 508

(1) ~~Include~~ For vision care coverage, include the 509
following statement: 510

"IMPORTANT: If you opt to receive vision care services or 511
vision care materials that are not covered benefits under this 512
plan, a participating vision care provider may charge you his or 513
her normal fee for such services or materials. Prior to 514
providing you with vision care services or vision care materials 515

that are not covered benefits, the vision care provider will 516
provide you with an estimated cost for each service or material 517
upon your request." 518

(2) For dental care coverage, include the following 519
statement: 520

"IMPORTANT: If you opt to receive dental care services 521
that are not covered benefits under this plan, a participating 522
dental care provider may charge you his or her normal fee for 523
such services. Prior to providing you with dental care services 524
that are not covered benefits, the dental care provider will 525
provide you with an estimated cost for each service." 526

(3) Disclose any business interest the insurer or plan has 527
in a source or supplier of vision care materials; 528

~~(3)~~ (4) Include an explanation that the insured individual 529
may incur out-of-pocket expenses as a result of the purchase of 530
vision care services ~~or, vision care materials, or dental care~~ 531
services that are not covered ~~vision services~~. The explanation 532
shall be communicated in a manner and format similar to how the 533
insurer or plan provides an insured individual with information 534
on coverage levels and out-of-pocket expenses that may be 535
incurred by the insured individual under the policy or plan when 536
purchasing out-of-network vision care services ~~or, vision care~~ 537
materials, or dental care services. 538

(C) A pattern of continuous or repeated violations of this 539
section is an unfair and deceptive act or practice in the 540
business of insurance under sections 3901.19 to 3901.26 of the 541
Revised Code. 542

Sec. 3963.01. As used in this chapter: 543

(A) "Affiliate" means any person or entity that has 544

ownership or control of a contracting entity, is owned or 545
controlled by a contracting entity, or is under common ownership 546
or control with a contracting entity. 547

(B) "Basic health care services" has the same meaning as 548
in division (A) of section 1751.01 of the Revised Code, except 549
that it does not include any services listed in that division 550
that are provided by a pharmacist or nursing home. 551

(C) "Covered vision services" means vision care services 552
or vision care materials for which a reimbursement is available 553
under an enrollee's health care contract, or for which a 554
reimbursement would be available but for the application of 555
contractual limitations, such as a deductible, copayment, 556
coinsurance, waiting period, annual or lifetime maximum, 557
frequency limitation, alternative benefit payment, or any other 558
limitation. 559

(D) "Contracting entity" means any person that has a 560
primary business purpose of contracting with participating 561
providers for the delivery of health care services. 562

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

(F) "Credentialing" means the process of assessing and 570
validating the qualifications of a provider applying to be 571
approved by a contracting entity to provide basic health care 572
services, specialty health care services, or supplemental health 573

care services to enrollees. 574

~~(F)~~ (G) "Dental care provider" means a dentist licensed 575
under Chapter 4715. of the Revised Code. "Dental care provider" 576
does not include a dental hygienist licensed under Chapter 4715. 577
of the Revised Code. 578

(H) "Edit" means adjusting one or more procedure codes 579
billed by a participating provider on a claim for payment or a 580
practice that results in any of the following: 581

(1) Payment for some, but not all of the procedure codes 582
originally billed by a participating provider; 583

(2) Payment for a different procedure code than the 584
procedure code originally billed by a participating provider; 585

(3) A reduced payment as a result of services provided to 586
an enrollee that are claimed under more than one procedure code 587
on the same service date. 588

~~(G)~~ (I) "Electronic claims transport" means to accept and 589
digitize claims or to accept claims already digitized, to place 590
those claims into a format that complies with the electronic 591
transaction standards issued by the United States department of 592
health and human services pursuant to the "Health Insurance 593
Portability and Accountability Act of 1996," 110 Stat. 1955, 42 594
U.S.C. 1320d, et seq., as those electronic standards are 595
applicable to the parties and as those electronic standards are 596
updated from time to time, and to electronically transmit those 597
claims to the appropriate contracting entity, payer, or third- 598
party administrator. 599

~~(H)~~ (J) "Enrollee" means any person eligible for health 600
care benefits under a health benefit plan, including an eligible 601
recipient of medicaid, and includes all of the following terms: 602

(1) "Enrollee" and "subscriber" as defined by section 1751.01 of the Revised Code;	603 604
(2) "Member" as defined by section 1739.01 of the Revised Code;	605 606
(3) "Insured" and "plan member" pursuant to Chapter 3923. of the Revised Code;	607 608
(4) "Beneficiary" as defined by section 3901.38 of the Revised Code.	609 610
(I) <u>(K)</u> "Health care contract" means a contract entered into, materially amended, or renewed between a contracting entity and a participating provider for the delivery of basic health care services, specialty health care services, or supplemental health care services to enrollees.	611 612 613 614 615
(J) <u>(L)</u> "Health care services" means basic health care services, specialty health care services, and supplemental health care services.	616 617 618
(K) <u>(M)</u> "Material amendment" means an amendment to a health care contract that decreases the participating provider's payment or compensation, changes the administrative procedures in a way that may reasonably be expected to significantly increase the provider's administrative expenses, or adds a new product. A material amendment does not include any of the following:	619 620 621 622 623 624 625
(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;	626 627 628 629
(2) A decrease in payment or compensation that was	630

anticipated under the terms of the contract, if the amount and 631
date of applicability of the decrease is clearly identified in 632
the contract; 633

(3) An administrative change that may significantly 634
increase the provider's administrative expense, the specific 635
applicability of which is clearly identified in the contract; 636

(4) Changes to an existing prior authorization, 637
precertification, notification, or referral program that do not 638
substantially increase the provider's administrative expense; 639

(5) Changes to an edit program or to specific edits if the 640
participating provider is provided notice of the changes 641
pursuant to division (A) (1) of section 3963.04 of the Revised 642
Code and the notice includes information sufficient for the 643
provider to determine the effect of the change; 644

(6) Changes to a health care contract described in 645
division (B) of section 3963.04 of the Revised Code. 646

~~(L)~~ (N) "Participating provider" means a provider that has 647
a health care contract with a contracting entity and is entitled 648
to reimbursement for health care services rendered to an 649
enrollee under the health care contract. 650

~~(M)~~ (O) "Payer" means any person that assumes the 651
financial risk for the payment of claims under a health care 652
contract or the reimbursement for health care services provided 653
to enrollees by participating providers pursuant to a health 654
care contract. 655

~~(N)~~ (P) "Primary enrollee" means a person who is 656
responsible for making payments for participation in a health 657
care plan or an enrollee whose employment or other status is the 658
basis of eligibility for enrollment in a health care plan. 659

~~(O)~~ (Q) "Procedure codes" includes the American medical 660
association's current procedural terminology code, the American 661
dental association's current dental terminology, and the centers 662
for medicare and medicaid services health care common procedure 663
coding system. 664

~~(P)~~ (R) "Product" means one of the following types of 665
categories of coverage for which a participating provider may be 666
obligated to provide health care services pursuant to a health 667
care contract: 668

(1) A health maintenance organization or other product 669
provided by a health insuring corporation; 670

(2) A preferred provider organization; 671

(3) Medicare; 672

(4) Medicaid; 673

(5) Workers' compensation. 674

~~(Q)~~ (S) "Provider" means a physician, podiatrist, dentist, 675
chiropractor, optometrist, psychologist, physician assistant, 676
advanced practice registered nurse, occupational therapist, 677
massage therapist, physical therapist, licensed professional 678
counselor, licensed professional clinical counselor, hearing aid 679
dealer, orthotist, prosthetist, home health agency, hospice care 680
program, pediatric respite care program, or hospital, or a 681
provider organization or physician-hospital organization that is 682
acting exclusively as an administrator on behalf of a provider 683
to facilitate the provider's participation in health care 684
contracts. 685

"Provider" does not mean either of the following: 686

(1) A nursing home; 687

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

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

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

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

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

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

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

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: 717

(a) The third party accessing the participating provider's 718
services under the health care contract is an employer or other 719
entity providing coverage for health care services to its 720
employees or members, and that employer or entity has a contract 721
with the contracting entity or its affiliate for the 722
administration or processing of claims for payment for services 723
provided pursuant to the health care contract with the 724
participating provider. 725

(b) The third party accessing the participating provider's 726
services under the health care contract either is an affiliate 727
or subsidiary of the contracting entity or is providing 728
administrative services to, or receiving administrative services 729
from, the contracting entity or an affiliate or subsidiary of 730
the contracting entity. 731

(c) The health care contract specifically provides that it 732
applies to network rental arrangements and states that one 733
purpose of the contract is selling, renting, or giving the 734
contracting entity's rights to the services of the participating 735
provider, including other preferred provider organizations, and 736
the third party accessing the participating provider's services 737
is any of the following: 738

(i) A payer or a third-party administrator or other entity 739
responsible for administering claims on behalf of the payer; 740

(ii) A preferred provider organization or preferred 741
provider network that receives access to the participating 742
provider's services pursuant to an arrangement with the 743
preferred provider organization or preferred provider network in 744
a contract with the participating provider that is in compliance 745

with division (A) (1) (c) of this section, and is required to 746
comply with all of the terms, conditions, and affirmative 747
obligations to which the originally contracted primary 748
participating provider network is bound under its contract with 749
the participating provider, including, but not limited to, 750
obligations concerning patient steerage and the timeliness and 751
manner of reimbursement. 752

(iii) An entity that is engaged in the business of 753
providing electronic claims transport between the contracting 754
entity and the payer or third-party administrator and complies 755
with all of the applicable terms, conditions, and affirmative 756
obligations of the contracting entity's contract with the 757
participating provider including, but not limited to, 758
obligations concerning patient steerage and the timeliness and 759
manner of reimbursement. 760

(2) The contracting entity that sells, rents, or gives the 761
contracting entity's rights to the participating provider's 762
services pursuant to the contracting entity's health care 763
contract with the participating provider as provided in division 764
(A) (1) of this section shall do both of the following: 765

(a) Maintain a web page that contains a listing of third 766
parties described in divisions (A) (1) (b) and (c) of this section 767
with whom a contracting entity contracts for the purpose of 768
selling, renting, or giving the contracting entity's rights to 769
the services of participating providers that is updated at least 770
every six months and is accessible to all participating 771
providers, or maintain a toll-free telephone number accessible 772
to all participating providers by means of which participating 773
providers may access the same listing of third parties; 774

(b) Require that the third party accessing the 775

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

(3) Any information disclosed to a participating provider 784
under this section shall be considered proprietary and shall not 785
be distributed by the participating provider. 786

(4) Except as provided in division (A) (1) of this section, 787
no entity shall sell, rent, or give a contracting entity's 788
rights to the participating provider's services pursuant to a 789
health care contract. 790

(B) (1) No contracting entity shall require, as a condition 791
of contracting with the contracting entity, that a participating 792
provider provide services for all of the products offered by the 793
contracting entity. 794

(2) Division (B) (1) of this section shall not be construed 795
to do any of the following: 796

(a) Prohibit any participating provider from voluntarily 797
accepting an offer by a contracting entity to provide health 798
care services under all of the contracting entity's products; 799

(b) Prohibit any contracting entity from offering any 800
financial incentive or other form of consideration specified in 801
the health care contract for a participating provider to provide 802
health care services under all of the contracting entity's 803
products; 804

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

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

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

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

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

(D) No health care contract shall do any of the following:	834
(1) Prohibit any participating provider from entering into a health care contract with any other contracting entity;	835
(2) Prohibit any contracting entity from entering into a health care contract with any other provider;	836
(3) Preclude its use or disclosure for the purpose of enforcing this chapter or other state or federal law, except that a health care contract may require that appropriate measures be taken to preserve the confidentiality of any proprietary or trade-secret information.	837
(E) (1) No contract or agreement between a contracting entity and a vision care provider shall do any of the following:	838
(a) Require that a vision care provider accept as payment an amount set by the contracting entity for vision care services or vision care materials provided to an enrollee unless the services or materials are covered vision services.	839
(i) Notwithstanding division (E) (1) (a) of this section, a vision care provider may, in a contract with a contracting entity, choose to accept as payment an amount set by the contracting entity for vision care services or vision care materials provided to an enrollee that are not covered vision services.	840
(ii) No contract between a vision care provider and a contracting entity to provide covered vision services or vision care materials shall be contingent on whether the vision care provider has entered into an agreement addressing noncovered vision services pursuant to division (E) (1) (a) (i) of this section.	841
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(iii) A contracting entity may communicate to its 862
enrollees which vision care providers choose to accept as 863
payment an amount set by the contracting entity for vision care 864
services or vision care materials provided to an enrollee that 865
are not covered vision services pursuant to division (E) (1) (a) 866
(i) of this section. Any communication to this effect shall 867
treat all vision care providers equally in provider directories, 868
provider locators, and other marketing materials as 869
participating, in-network providers, annotated only as to their 870
decision to accept payment pursuant to division (E) (1) (a) (i) of 871
this section. 872

(b) Require that a vision care provider contract with a 873
plan offering supplemental or specialty health care services as 874
a condition of contracting with a plan offering basic health 875
care services; 876

(c) Directly limit a vision care provider's choice of 877
sources and suppliers of vision care materials; 878

(d) Include a provision that prohibits a vision care 879
provider from describing out-of-network options to an enrollee 880
in accordance with division (E) (2) of this section. 881

The provisions of divisions (E) (1) (a) to (d) of this 882
section shall be effective for contracts entered into, amended, 883
or renewed on or after January 1, 2019. 884

(2) A vision care provider recommending an out-of-network 885
source or supplier of vision care materials to an enrollee shall 886
notify the enrollee in writing that the source or supplier is 887
out-of-network and shall inform the enrollee of the cost of 888
those materials. The vision care provider shall also disclose in 889
writing to an enrollee any business interest the provider has in 890

a recommended out-of-network source or supplier utilized by the 891
enrollee. 892

(3) A vision care provider who chooses not to accept as 893
payment an amount set by a contracting entity for vision care 894
services or vision care materials that are not covered vision 895
services shall do both of the following: 896

(a) Upon the request of an enrollee seeking vision care 897
services or vision care materials that are not covered vision 898
services, provide to the enrollee pricing and reimbursement 899
information, including all of the following: 900

(i) The estimated fee or discounted price suggested by the 901
contracting entity for the noncovered service or material; 902

(ii) The estimated fee charged by the vision care provider 903
for the noncovered service or material; 904

(iii) The amount the vision care provider expects to be 905
reimbursed by the contracting entity for the noncovered service 906
or material; 907

(iv) The estimated pricing and reimbursement information 908
for any covered services or materials that are also expected to 909
be provided during the enrollee's visit. 910

(b) Post, in a conspicuous place, a notice stating the 911
following: 912

"IMPORTANT: This vision care provider does not accept the 913
fee schedule set by your insurer for vision care services and 914
vision care materials that are not covered benefits under your 915
plan and instead charges his or her normal fee for those 916
services and materials. This vision care provider will provide 917
you with an estimated cost for each non-covered service or 918

material upon your request."	919
(4) Nothing in division (E) of this section shall do any	920
of the following:	921
(a) Restrict or limit a contracting entity's determination	922
of specific amounts of coverage or reimbursement for the use of	923
network or out-of-network sources or suppliers of vision care	924
materials as set forth in an enrollee's benefit plan;	925
(b) Restrict or limit a contracting entity's ability to	926
enter into an agreement with another contracting entity or an	927
affiliate of another contracting entity;	928
(c) Restrict or limit a health care plan's ability to	929
enter into an agreement with a vision care plan to deliver	930
routine vision care services that are covered under an	931
enrollee's plan;	932
(d) Restrict or limit a vision care plan network from	933
acting as a network for a health care plan;	934
(e) Prohibit a contracting entity from requiring	935
participating vision care providers to offer network sources or	936
suppliers of vision care materials to enrollees;	937
(f) Prohibit an enrollee from utilizing a network source	938
or supplier of vision care materials as set forth in an	939
enrollee's plan;	940
(g) Prohibit a participating vision care provider from	941
accepting as payment an amount that is the same as the amount	942
set by the contracting entity for vision care services or vision	943
care materials that are not covered vision services.	944
<u>(F)(F) (1) No contract or agreement between a contracting</u>	945
<u>entity and a dental care provider shall do any of the following:</u>	946

(a) Require that a dental care provider accept as payment an amount set by the contracting entity for dental care services provided to an enrollee unless the services are covered dental services. 947
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(i) Notwithstanding division (F)(1)(a) of this section, a dental care provider may, in a contract with a contracting entity, choose to accept as payment an amount set by the contracting entity for dental care services provided to an enrollee that are not covered dental services. 951
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(ii) No contract between a dental care provider and a contracting entity to provide covered dental services shall be contingent on whether the dental care provider has entered into an agreement addressing noncovered dental services pursuant to division (F)(1)(a)(i) of this section. 956
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(iii) A contracting entity may communicate to its enrollees which dental care providers choose to accept as payment an amount set by the contracting entity for dental care services provided to an enrollee that are not covered dental services pursuant to division (F)(1)(a)(i) of this section. Any communication to this effect shall treat all dental care providers equally in provider directories, provider locators, and other marketing materials as participating, in-network providers, annotated only as to their decision to accept payment pursuant to division (F)(1)(a)(i) of this section. 961
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(b) Require that a dental care provider contract with a plan offering supplemental or specialty health care services as a condition of contracting with a plan offering basic health care services. 971
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The provisions of divisions (F)(1)(a) and (b) of this 975

section apply to contracts entered into, amended, or renewed on 976
or after January 1, 2024. 977

(2) A dental care provider who chooses not to accept as 978
payment an amount set by a contracting entity for dental care 979
services that are not covered dental services shall do both of 980
the following: 981

(a) Provide to an enrollee seeking dental care services 982
that are not covered dental services pricing and reimbursement 983
information, including all of the following: 984

(i) The estimated fee or discounted price suggested by the 985
contracting entity for the noncovered service; 986

(ii) The estimated fee charged by the dental care provider 987
for the noncovered service; 988

(iii) The amount the dental care provider expects to be 989
reimbursed by the contracting entity for the noncovered service; 990

(iv) The estimated pricing and reimbursement information 991
for any covered services that are also expected to be provided 992
during the enrollee's visit. 993

(b) Post, in a conspicuous place, a notice stating the 994
following: 995

"IMPORTANT: This dental care provider does not accept the 996
fee schedule set by your insurer for dental care services that 997
are not covered benefits under your plan and instead charges his 998
or her normal fee for those services. This dental care provider 999
will provide you with an estimated cost for each noncovered 1000
service." 1001

(3) Nothing in division (F) of this section shall do any 1002
of the following: 1003

(a) Restrict or limit a contracting entity's ability to enter into an agreement with another contracting entity or an affiliate of another contracting entity; 1004
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(b) Restrict or limit a health care plan's ability to enter into an agreement with a dental care plan to deliver routine dental care services that are covered under an enrollee's plan; 1007
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(c) Restrict or limit a dental care plan network from acting as a network for a health care plan; 1011
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(d) Prohibit a participating dental care provider from accepting as payment an amount that is the same as the amount set by the contracting entity for dental care services that are not covered dental services. 1013
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~~(1)~~ (G) (1) In addition to any other lawful reasons for terminating a health care contract, a health care contract may only be terminated under the circumstances described in division (A) (3) of section 3963.04 of the Revised Code. 1017
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(2) If the health care contract provides for termination for cause by either party, the health care contract shall state the reasons that may be used for termination for cause, which terms shall be reasonable. Once the contracting entity and the participating provider have signed the health care contract, it is presumed that the reasons stated in the health care contract for termination for cause by either party are reasonable. 1021
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Subject to division ~~(F) (3)~~ (G) (3) of this section, the health care contract shall state the time by which the parties must provide notice of termination for cause and to whom the parties shall give the notice. 1028
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(3) Nothing in divisions ~~(F) (1)~~ (G) (1) and (2) of this 1032

section shall be construed as prohibiting any health insuring 1033
corporation from terminating a participating provider's contract 1034
for any of the causes described in divisions (A), (D), and (F) 1035
(1) and (2) of section 1753.09 of the Revised Code. 1036

Notwithstanding any provision in a health care contract pursuant 1037
to division ~~(F)(2)~~(G)(2) of this section, section 1753.09 of 1038
the Revised Code applies to the termination of a participating 1039
provider's contract for any of the causes described in divisions 1040
(A), (D), and (F)(1) and (2) of section 1753.09 of the Revised 1041
Code. 1042

(4) Subject to sections 3963.01 to 3963.11 of the Revised 1043
Code, nothing in this section prohibits the termination of a 1044
health care contract without cause if the health care contract 1045
otherwise provides for termination without cause. 1046

(5) Nothing in division ~~(F)~~(G) of this section shall be 1047
construed to expand the regulatory authority of the 1048
superintendent to vision care providers or dental care 1049
providers. 1050

~~(G)(1)~~(H)(1) Disputes among parties to a health care 1051
contract that only concern the enforcement of the contract 1052
rights conferred by section 3963.02, divisions (A) and (D) of 1053
section 3963.03, and section 3963.04 of the Revised Code are 1054
subject to a mutually agreed upon arbitration mechanism that is 1055
binding on all parties. The arbitrator may award reasonable 1056
attorney's fees and costs for arbitration relating to the 1057
enforcement of this section to the prevailing party. 1058

(2) The arbitrator shall make the arbitrator's decision in 1059
an arbitration proceeding having due regard for any applicable 1060
rules, bulletins, rulings, or decisions issued by the department 1061
of insurance or any court concerning the enforcement of the 1062

contract rights conferred by section 3963.02, divisions (A) and 1063
(D) of section 3963.03, and section 3963.04 of the Revised Code. 1064

(3) A party shall not simultaneously maintain an 1065
arbitration proceeding as described in division ~~(G) (1)~~ (H) (1) of 1066
this section and pursue a complaint with the superintendent of 1067
insurance to investigate the subject matter of the arbitration 1068
proceeding. However, if a complaint is filed with the department 1069
of insurance, the superintendent may choose to investigate the 1070
complaint or, after reviewing the complaint, advise the 1071
complainant to proceed with arbitration to resolve the 1072
complaint. The superintendent may request to receive a copy of 1073
the results of the arbitration. If the superintendent of 1074
insurance notifies an insurer or a health insuring corporation 1075
in writing that the superintendent has initiated a market 1076
conduct examination into the specific subject matter of the 1077
arbitration proceeding pending against that insurer or health 1078
insuring corporation, the arbitration proceeding shall be stayed 1079
at the request of the insurer or health insuring corporation 1080
pending the outcome of the market conduct investigation by the 1081
superintendent. 1082

Sec. 3963.03. (A) Each health care contract shall include 1083
all of the following information: 1084

(1) (a) Information sufficient for the participating 1085
provider to determine the compensation or payment terms for 1086
health care services, including all of the following, subject to 1087
division (A) (1) (b) of this section: 1088

(i) The manner of payment, such as fee-for-service, 1089
capitation, or risk; 1090

(ii) The fee schedule of procedure codes reasonably 1091

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

(iii) The effect, if any, on payment or compensation if 1106
more than one procedure code applies to the service also shall 1107
be stated. This requirement may be satisfied by providing a 1108
clearly understandable, readily available mechanism, such as a 1109
specific web site address, that allows a participating provider 1110
to determine the effect of procedure codes on payment or 1111
compensation before a service is provided or a claim is 1112
submitted. 1113

(b) If the contracting entity is unable to include the 1114
information described in divisions (A) (1) (a) (ii) and (iii) of 1115
this section, the contracting entity shall include both of the 1116
following types of information instead: 1117

(i) The methodology used to calculate any fee schedule, 1118
such as relative value unit system and conversion factor or 1119
percentage of billed charges. If applicable, the methodology 1120
disclosure shall include the name of any relative value unit 1121

system, its version, edition, or publication date, any 1122
applicable conversion or geographic factor, and any date by 1123
which compensation or fee schedules may be changed by the 1124
methodology as anticipated at the time of contract. 1125

(ii) The identity of any internal processing edits, 1126
including the publisher, product name, version, and version 1127
update of any editing software. 1128

(c) If the contracting entity is not the payer and is 1129
unable to include the information described in division (A) (1) 1130
(a) or (b) of this section, then the contracting entity shall 1131
provide by telephone a readily available mechanism, such as a 1132
specific web site address, that allows the participating 1133
provider to obtain that information from the payer. 1134

(2) Any product or network for which the participating 1135
provider is to provide services; 1136

(3) The term of the health care contract; 1137

(4) A specific web site address that contains the identity 1138
of the contracting entity or payer responsible for the 1139
processing of the participating provider's compensation or 1140
payment; 1141

(5) Any internal mechanism provided by the contracting 1142
entity to resolve disputes concerning the interpretation or 1143
application of the terms and conditions of the contract. A 1144
contracting entity may satisfy this requirement by providing a 1145
clearly understandable, readily available mechanism, such as a 1146
specific web site address or an appendix, that allows a 1147
participating provider to determine the procedures for the 1148
internal mechanism to resolve those disputes. 1149

(6) A list of addenda, if any, to the contract. 1150

(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 carefully read any proposed amendments sent after execution of the contract;

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

(3) No contracting entity that includes any information in the summary disclosure form with the reasonable belief that the information is truthful or accurate shall be subject to a civil

action for damages or to binding arbitration based on the 1180
summary disclosure form. Division (B)(3) of this section does 1181
not impair or affect any power of the department of insurance to 1182
enforce any applicable law. 1183

(4) The summary disclosure form described in divisions (B) 1184
(1) and (2) of this section shall be in substantially the 1185
following form: 1186

"SUMMARY DISCLOSURE FORM 1187

(1) Compensation terms 1188

(a) Manner of payment 1189

[] Fee for service 1190

[] Capitation 1191

[] Risk 1192

[] Other _____ See _____ 1193

(b) Fee schedule available at _____ 1194

(c) Fee calculation schedule available at _____ 1195

(d) Identity of internal processing edits available at 1196

_____ 1197

(e) Information in (c) and (d) is not required if 1198

information in (b) is provided. 1199

(2) List of products or networks covered by this contract 1200

[] _____ 1201

[] _____ 1202

[] _____ 1203

[] _____	1204
[] _____	1205
(3) Term of this contract _____	1206
(4) Contracting entity or payer responsible for processing payment available at _____	1207 1208
(5) Internal mechanism for resolving disputes regarding contract terms available at _____	1209 1210
(6) Addenda to contract	1211
Title Subject	1212
(a)	1213
(b)	1214
(c)	1215
(d)	1216
(7) Telephone number to access a readily available mechanism, such as a specific web site address, to allow a participating provider to receive the information in (1) through (6) from the payer.	1217 1218 1219 1220
IMPORTANT INFORMATION - PLEASE READ CAREFULLY	1221
The information provided in this Summary Disclosure Form is a guide to the attached Health Care Contract as defined in section 3963.01- (I) -(K) of the Ohio Revised Code. The terms and conditions of the attached Health Care Contract constitute the contract rights of the parties.	1222 1223 1224 1225 1226
Reading this Summary Disclosure Form is not a substitute for reading the entire Health Care Contract. When you sign the Health Care Contract, you will be bound by its terms and	1227 1228 1229

conditions. These terms and conditions may be amended over time 1230
pursuant to section 3963.04 of the Ohio Revised Code. You are 1231
encouraged to read any proposed amendments that are sent to you 1232
after execution of the Health Care Contract. 1233

Nothing in this Summary Disclosure Form creates any 1234
additional rights or causes of action in favor of either party." 1235

(C) When a contracting entity presents a proposed health 1236
care contract for consideration by a provider, the contracting 1237
entity shall provide in writing or make reasonably available the 1238
information required in division (A)(1) of this section. 1239

(D) The contracting entity shall identify any utilization 1240
management, quality improvement, or a similar program that the 1241
contracting entity uses to review, monitor, evaluate, or assess 1242
the services provided pursuant to a health care contract. The 1243
contracting entity shall disclose the policies, procedures, or 1244
guidelines of such a program applicable to a participating 1245
provider upon request by the participating provider within 1246
fourteen days after the date of the request. 1247

(E) Nothing in this section shall be construed as 1248
preventing or affecting the application of section 1753.07 of 1249
the Revised Code that would otherwise apply to a contract with a 1250
participating provider. 1251

(F) The requirements of division (C) of this section do 1252
not prohibit a contracting entity from requiring a reasonable 1253
confidentiality agreement between the provider and the 1254
contracting entity regarding the terms of the proposed health 1255
care contract. If either party violates the confidentiality 1256
agreement, a party to the confidentiality agreement may bring a 1257
civil action to enjoin the other party from continuing any act 1258

that is in violation of the confidentiality agreement, to 1259
recover damages, to terminate the contract, or to obtain any 1260
combination of relief. 1261

Sec. 4715.30. (A) Except as provided in division (K) of 1262
this section, an applicant for or holder of a certificate or 1263
license issued under this chapter is subject to disciplinary 1264
action by the state dental board for any of the following 1265
reasons: 1266

(1) Employing or cooperating in fraud or material 1267
deception in applying for or obtaining a license or certificate; 1268

(2) Obtaining or attempting to obtain money or anything of 1269
value by intentional misrepresentation or material deception in 1270
the course of practice; 1271

(3) Advertising services in a false or misleading manner 1272
or violating the board's rules governing time, place, and manner 1273
of advertising; 1274

(4) Commission of an act that constitutes a felony in this 1275
state, regardless of the jurisdiction in which the act was 1276
committed; 1277

(5) Commission of an act in the course of practice that 1278
constitutes a misdemeanor in this state, regardless of the 1279
jurisdiction in which the act was committed; 1280

(6) Conviction of, a plea of guilty to, a judicial finding 1281
of guilt of, a judicial finding of guilt resulting from a plea 1282
of no contest to, or a judicial finding of eligibility for 1283
intervention in lieu of conviction for, any felony or of a 1284
misdemeanor committed in the course of practice; 1285

(7) Engaging in lewd or immoral conduct in connection with 1286

the provision of dental services;	1287
(8) Selling, prescribing, giving away, or administering	1288
drugs for other than legal and legitimate therapeutic purposes,	1289
or conviction of, a plea of guilty to, a judicial finding of	1290
guilt of, a judicial finding of guilt resulting from a plea of	1291
no contest to, or a judicial finding of eligibility for	1292
intervention in lieu of conviction for, a violation of any	1293
federal or state law regulating the possession, distribution, or	1294
use of any drug;	1295
(9) Providing or allowing dental hygienists, expanded	1296
function dental auxiliaries, or other practitioners of auxiliary	1297
dental occupations working under the certificate or license	1298
holder's supervision, or a dentist holding a temporary limited	1299
continuing education license under division (C) of section	1300
4715.16 of the Revised Code working under the certificate or	1301
license holder's direct supervision, to provide dental care that	1302
departs from or fails to conform to accepted standards for the	1303
profession, whether or not injury to a patient results;	1304
(10) Inability to practice under accepted standards of the	1305
profession because of physical or mental disability, dependence	1306
on alcohol or other drugs, or excessive use of alcohol or other	1307
drugs;	1308
(11) Violation of any provision of this chapter or any	1309
rule adopted thereunder;	1310
(12) Failure to use universal blood and body fluid	1311
precautions established by rules adopted under section 4715.03	1312
of the Revised Code;	1313
(13) Except as provided in division (H) of this section,	1314
either of the following:	1315

(a) Waiving the payment of all or any part of a deductible 1316
or copayment that a patient, pursuant to a health insurance or 1317
health care policy, contract, or plan that covers dental 1318
services, would otherwise be required to pay if the waiver is 1319
used as an enticement to a patient or group of patients to 1320
receive health care services from that certificate or license 1321
holder; 1322

(b) Advertising that the certificate or license holder 1323
will waive the payment of all or any part of a deductible or 1324
copayment that a patient, pursuant to a health insurance or 1325
health care policy, contract, or plan that covers dental 1326
services, would otherwise be required to pay. 1327

(14) Failure to comply with section 4715.302 or 4729.79 of 1328
the Revised Code, unless the state board of pharmacy no longer 1329
maintains a drug database pursuant to section 4729.75 of the 1330
Revised Code; 1331

(15) Any of the following actions taken by an agency 1332
responsible for authorizing, certifying, or regulating an 1333
individual to practice a health care occupation or provide 1334
health care services in this state or another jurisdiction, for 1335
any reason other than the nonpayment of fees: the limitation, 1336
revocation, or suspension of an individual's license to 1337
practice; acceptance of an individual's license surrender; 1338
denial of a license; refusal to renew or reinstate a license; 1339
imposition of probation; or issuance of an order of censure or 1340
other reprimand; 1341

(16) Failure to cooperate in an investigation conducted by 1342
the board under division (D) of section 4715.03 of the Revised 1343
Code, including failure to comply with a subpoena or order 1344
issued by the board or failure to answer truthfully a question 1345

presented by the board at a deposition or in written 1346
interrogatories, except that failure to cooperate with an 1347
investigation shall not constitute grounds for discipline under 1348
this section if a court of competent jurisdiction has issued an 1349
order that either quashes a subpoena or permits the individual 1350
to withhold the testimony or evidence in issue; 1351

(17) Failure to comply with the requirements in section 1352
3719.061 of the Revised Code before issuing for a minor a 1353
prescription for an opioid analgesic, as defined in section 1354
3719.01 of the Revised Code; 1355

(18) Failure to comply with the requirements of sections 1356
4715.71 and 4715.72 of the Revised Code regarding the operation 1357
of a mobile dental facility; 1358

(19) A pattern of continuous or repeated violations of 1359
division (F) (2) of section 3963.02 of the Revised Code. 1360

(B) A manager, proprietor, operator, or conductor of a 1361
dental facility shall be subject to disciplinary action if any 1362
dentist, dental hygienist, expanded function dental auxiliary, 1363
or qualified personnel providing services in the facility is 1364
found to have committed a violation listed in division (A) of 1365
this section and the manager, proprietor, operator, or conductor 1366
knew of the violation and permitted it to occur on a recurring 1367
basis. 1368

(C) Subject to Chapter 119. of the Revised Code, the board 1369
may take one or more of the following disciplinary actions if 1370
one or more of the grounds for discipline listed in divisions 1371
(A) and (B) of this section exist: 1372

(1) Censure the license or certificate holder; 1373

(2) Place the license or certificate on probationary 1374

status for such period of time the board determines necessary	1375
and require the holder to:	1376
(a) Report regularly to the board upon the matters which	1377
are the basis of probation;	1378
(b) Limit practice to those areas specified by the board;	1379
(c) Continue or renew professional education until a	1380
satisfactory degree of knowledge or clinical competency has been	1381
attained in specified areas.	1382
(3) Suspend the certificate or license;	1383
(4) Revoke the certificate or license.	1384
Where the board places a holder of a license or	1385
certificate on probationary status pursuant to division (C) (2)	1386
of this section, the board may subsequently suspend or revoke	1387
the license or certificate if it determines that the holder has	1388
not met the requirements of the probation or continues to engage	1389
in activities that constitute grounds for discipline pursuant to	1390
division (A) or (B) of this section.	1391
Any order suspending a license or certificate shall state	1392
the conditions under which the license or certificate will be	1393
restored, which may include a conditional restoration during	1394
which time the holder is in a probationary status pursuant to	1395
division (C) (2) of this section. The board shall restore the	1396
license or certificate unconditionally when such conditions are	1397
met.	1398
(D) If the physical or mental condition of an applicant or	1399
a license or certificate holder is at issue in a disciplinary	1400
proceeding, the board may order the license or certificate	1401
holder to submit to reasonable examinations by an individual	1402

designated or approved by the board and at the board's expense. 1403
The physical examination may be conducted by any individual 1404
authorized by the Revised Code to do so, including a physician 1405
assistant, a clinical nurse specialist, a certified nurse 1406
practitioner, or a certified nurse-midwife. Any written 1407
documentation of the physical examination shall be completed by 1408
the individual who conducted the examination. 1409

Failure to comply with an order for an examination shall 1410
be grounds for refusal of a license or certificate or summary 1411
suspension of a license or certificate under division (E) of 1412
this section. 1413

(E) If a license or certificate holder has failed to 1414
comply with an order under division (D) of this section, the 1415
board may apply to the court of common pleas of the county in 1416
which the holder resides for an order temporarily suspending the 1417
holder's license or certificate, without a prior hearing being 1418
afforded by the board, until the board conducts an adjudication 1419
hearing pursuant to Chapter 119. of the Revised Code. If the 1420
court temporarily suspends a holder's license or certificate, 1421
the board shall give written notice of the suspension personally 1422
or by certified mail to the license or certificate holder. Such 1423
notice shall inform the license or certificate holder of the 1424
right to a hearing pursuant to Chapter 119. of the Revised Code. 1425

(F) Any holder of a certificate or license issued under 1426
this chapter who has pleaded guilty to, has been convicted of, 1427
or has had a judicial finding of eligibility for intervention in 1428
lieu of conviction entered against the holder in this state for 1429
aggravated murder, murder, voluntary manslaughter, felonious 1430
assault, kidnapping, rape, sexual battery, gross sexual 1431
imposition, aggravated arson, aggravated robbery, or aggravated 1432

burglary, or who has pleaded guilty to, has been convicted of, 1433
or has had a judicial finding of eligibility for treatment or 1434
intervention in lieu of conviction entered against the holder in 1435
another jurisdiction for any substantially equivalent criminal 1436
offense, is automatically suspended from practice under this 1437
chapter in this state and any certificate or license issued to 1438
the holder under this chapter is automatically suspended, as of 1439
the date of the guilty plea, conviction, or judicial finding, 1440
whether the proceedings are brought in this state or another 1441
jurisdiction. Continued practice by an individual after the 1442
suspension of the individual's certificate or license under this 1443
division shall be considered practicing without a certificate or 1444
license. The board shall notify the suspended individual of the 1445
suspension of the individual's certificate or license under this 1446
division by certified mail or in person in accordance with 1447
section 119.07 of the Revised Code. If an individual whose 1448
certificate or license is suspended under this division fails to 1449
make a timely request for an adjudicatory hearing, the board 1450
shall enter a final order revoking the individual's certificate 1451
or license. 1452

(G) If the supervisory investigative panel determines both 1453
of the following, the panel may recommend that the board suspend 1454
an individual's certificate or license without a prior hearing: 1455

(1) That there is clear and convincing evidence that an 1456
individual has violated division (A) of this section; 1457

(2) That the individual's continued practice presents a 1458
danger of immediate and serious harm to the public. 1459

Written allegations shall be prepared for consideration by 1460
the board. The board, upon review of those allegations and by an 1461
affirmative vote of not fewer than four dentist members of the 1462

board and seven of its members in total, excluding any member on 1463
the supervisory investigative panel, may suspend a certificate 1464
or license without a prior hearing. A telephone conference call 1465
may be utilized for reviewing the allegations and taking the 1466
vote on the summary suspension. 1467

The board shall issue a written order of suspension by 1468
certified mail or in person in accordance with section 119.07 of 1469
the Revised Code. The order shall not be subject to suspension 1470
by the court during pendency or any appeal filed under section 1471
119.12 of the Revised Code. If the individual subject to the 1472
summary suspension requests an adjudicatory hearing by the 1473
board, the date set for the hearing shall be within fifteen 1474
days, but not earlier than seven days, after the individual 1475
requests the hearing, unless otherwise agreed to by both the 1476
board and the individual. 1477

Any summary suspension imposed under this division shall 1478
remain in effect, unless reversed on appeal, until a final 1479
adjudicative order issued by the board pursuant to this section 1480
and Chapter 119. of the Revised Code becomes effective. The 1481
board shall issue its final adjudicative order within seventy- 1482
five days after completion of its hearing. A failure to issue 1483
the order within seventy-five days shall result in dissolution 1484
of the summary suspension order but shall not invalidate any 1485
subsequent, final adjudicative order. 1486

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

(1) In compliance with the health benefit plan that 1490
expressly allows such a practice. Waiver of the deductibles or 1491
copayments shall be made only with the full knowledge and 1492

consent of the plan purchaser, payer, and third-party administrator. Documentation of the consent shall be made available to the board upon request.

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

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

(J) The board may share any information it receives pursuant to an investigation under division (D) of section 4715.03 of the Revised Code, including patient records and patient record information, with law enforcement agencies, other licensing boards, and other governmental agencies that are prosecuting, adjudicating, or investigating alleged violations of statutes or administrative rules. An agency or board that receives the information shall comply with the same requirements regarding confidentiality as those with which the state dental board must comply, notwithstanding any conflicting provision of the Revised Code or procedure of the agency or board that applies when it is dealing with other information in its possession. In a judicial proceeding, the information may be admitted into evidence only in accordance with the Rules of Evidence, but the court shall require that appropriate measures are taken to ensure that confidentiality is maintained with

respect to any part of the information that contains names or 1523
other identifying information about patients or complainants 1524
whose confidentiality was protected by the state dental board 1525
when the information was in the board's possession. Measures to 1526
ensure confidentiality that may be taken by the court include 1527
sealing its records or deleting specific information from its 1528
records. 1529

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

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

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

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

Section 3. The General Assembly, applying the principle 1540
stated in division (B) of section 1.52 of the Revised Code that 1541
amendments are to be harmonized if reasonably capable of 1542
simultaneous operation, finds that the following sections, 1543
presented in this act as composites of the sections as amended 1544
by the acts indicated, are the resulting version of the sections 1545
in effect prior to the effective date of the sections as 1546
presented in this act: 1547

Section 3963.01 of the Revised Code as amended by both 1548
H.B. 156 and S.B. 265 of the 132nd General Assembly. 1549

Section 3963.02 of the Revised Code as amended by both 1550
H.B. 156 and S.B. 273 of the 132nd General Assembly. 1551

Section 4715.30 of the Revised Code as amended by both	1552
H.B. 203 and H.B. 263 of the 133rd General Assembly.	1553