

As Introduced

133rd General Assembly

Regular Session

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S. B. No. 148

Senator Schuring

Cosponsors: Senators Eklund, Huffman, M., Terhar, Uecker

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 upon your 38
request." 39

(3) Disclose any business interest the health insuring 40
corporation has in a source or supplier of vision care materials 41
; 42

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

health insuring corporation provides an enrollee with 48
information on coverage levels and out-of-pocket expenses that 49
may be incurred by the enrollee under the policy, contract, or 50
agreement when purchasing out-of-network vision care services ~~or~~ 51
, vision care materials, or dental care services. 52

(C) A pattern of continuous or repeated violations of this 53
section is an unfair and deceptive act or practice in the 54
business of insurance under sections 3901.19 to 3901.26 of the 55
Revised Code. 56

Sec. 1753.09. (A) Except as provided in division (D) of 57
this section, prior to terminating the participation of a 58
provider on the basis of the participating provider's failure to 59
meet the health insuring corporation's standards for quality or 60
utilization in the delivery of health care services, a health 61
insuring corporation shall give the participating provider 62
notice of the reason or reasons for its decision to terminate 63
the provider's participation and an opportunity to take 64
corrective action. The health insuring corporation shall develop 65
a performance improvement plan in conjunction with the 66
participating provider. If after being afforded the opportunity 67
to comply with the performance improvement plan, the 68
participating provider fails to do so, the health insuring 69
corporation may terminate the participation of the provider. 70

(B) (1) A participating provider whose participation has 71
been terminated under division (A) of this section may appeal 72
the termination to the appropriate medical director of the 73
health insuring corporation. The medical director shall give the 74
participating provider an opportunity to discuss with the 75
medical director the reason or reasons for the termination. 76

(2) If a satisfactory resolution of a participating 77

provider's appeal cannot be reached under division (B)(1) of 78
this section, the participating provider may appeal the 79
termination to a panel composed of participating providers who 80
have comparable or higher levels of education and training than 81
the participating provider making the appeal. A representative 82
of the participating provider's specialty shall be a member of 83
the panel, if possible. This panel shall hold a hearing, and 84
shall render its recommendation in the appeal within thirty days 85
after holding the hearing. The recommendation shall be presented 86
to the medical director and to the participating provider. 87

(3) The medical director shall review and consider the 88
panel's recommendation before making a decision. The decision 89
rendered by the medical director shall be final. 90

(C) A provider's status as a participating provider shall 91
remain in effect during the appeal process set forth in division 92
(B) of this section unless the termination was based on any of 93
the reasons listed in division (D) of this section. 94

(D) Notwithstanding division (A) of this section, a 95
provider's participation may be immediately terminated if the 96
participating provider's conduct presents an imminent risk of 97
harm to an enrollee or enrollees; or if there has occurred 98
unacceptable quality of care, fraud, patient abuse, loss of 99
clinical privileges, loss of professional liability coverage, 100
incompetence, or loss of authority to practice in the 101
participating provider's field; or if a governmental action has 102
impaired the participating provider's ability to practice. 103

(E) Divisions (A) to (D) of this section apply only to 104
providers who are natural persons. 105

(F)(1) Nothing in this section prohibits a health insuring 106

corporation from rejecting a provider's application for 107
participation, or from terminating a participating provider's 108
contract, if the health insuring corporation determines that the 109
health care needs of its enrollees are being met and no need 110
exists for the provider's or participating provider's services. 111

(2) Nothing in this section shall be construed as 112
prohibiting a health insuring corporation from terminating a 113
participating provider who does not meet the terms and 114
conditions of the participating provider's contract. 115

(3) Nothing in this section shall be construed as 116
prohibiting a health insuring corporation from terminating a 117
participating provider's contract pursuant to any provision of 118
the contract described in division ~~(F)~~(G) (2) of section 3963.02 119
of the Revised Code, except that, notwithstanding any provision 120
of a contract described in that division, this section applies 121
to the termination of a participating provider's contract for 122
any of the causes described in divisions (A), (D), and (F) (1) 123
and (2) of this section. 124

(G) The superintendent of insurance may adopt rules as 125
necessary to implement and enforce sections 1753.06, 1753.07, 126
and 1753.09 of the Revised Code. Such rules shall be adopted in 127
accordance with Chapter 119. of the Revised Code. 128

Sec. 3901.21. The following are hereby defined as unfair 129
and deceptive acts or practices in the business of insurance: 130

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

or share of the surplus to be received thereon, or making any 136
false or misleading statements as to the dividends or share of 137
surplus previously paid on similar policies, or making any 138
misleading representation or any misrepresentation as to the 139
financial condition of any insurer as shown by the last 140
preceding verified statement made by it to the insurance 141
department of this state, or as to the legal reserve system upon 142
which any life insurer operates, or using any name or title of 143
any policy or class of policies misrepresenting the true nature 144
thereof, or making any misrepresentation or incomplete 145
comparison to any person for the purpose of inducing or tending 146
to induce such person to purchase, amend, lapse, forfeit, 147
change, or surrender insurance. 148

Any written statement concerning the premiums for a policy 149
which refers to the net cost after credit for an assumed 150
dividend, without an accurate written statement of the gross 151
premiums, cash values, and dividends based on the insurer's 152
current dividend scale, which are used to compute the net cost 153
for such policy, and a prominent warning that the rate of 154
dividend is not guaranteed, is a misrepresentation for the 155
purposes of this division. 156

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

business, which is untrue, deceptive, or misleading. 167

(C) Making, publishing, disseminating, or circulating, 168
directly or indirectly, or aiding, abetting, or encouraging the 169
making, publishing, disseminating, or circulating, or preparing 170
with intent to so use, any statement, pamphlet, circular, 171
article, or literature, which is false as to the financial 172
condition of an insurer and which is calculated to injure any 173
person engaged in the business of insurance. 174

(D) Filing with any supervisory or other public official, 175
or making, publishing, disseminating, circulating, or delivering 176
to any person, or placing before the public, or causing directly 177
or indirectly to be made, published, disseminated, circulated, 178
delivered to any person, or placed before the public, any false 179
statement of financial condition of an insurer. 180

Making any false entry in any book, report, or statement 181
of any insurer with intent to deceive any agent or examiner 182
lawfully appointed to examine into its condition or into any of 183
its affairs, or any public official to whom such insurer is 184
required by law to report, or who has authority by law to 185
examine into its condition or into any of its affairs, or, with 186
like intent, willfully omitting to make a true entry of any 187
material fact pertaining to the business of such insurer in any 188
book, report, or statement of such insurer, or mutilating, 189
destroying, suppressing, withholding, or concealing any of its 190
records. 191

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

profits as an inducement to insurance. 197

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

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

equitable to policyholders and for the best interests of the 227
company and its policyholders; (b) in the case of life insurance 228
policies issued on the industrial debit plan, making allowance 229
to policyholders who have continuously for a specified period 230
made premium payments directly to an office of the insurer in an 231
amount which fairly represents the saving in collection 232
expenses; (c) readjustment of the rate of premium for a group 233
insurance policy based on the loss or expense experience 234
thereunder, at the end of the first or any subsequent policy 235
year of insurance thereunder, which may be made retroactive only 236
for such policy year. 237

(H) Making, issuing, circulating, or causing or permitting 238
to be made, issued, or circulated, or preparing with intent to 239
so use, any statement to the effect that a policy of life 240
insurance is, is the equivalent of, or represents shares of 241
capital stock or any rights or options to subscribe for or 242
otherwise acquire any such shares in the life insurance company 243
issuing that policy or any other company. 244

(I) Making, issuing, circulating, or causing or permitting 245
to be made, issued or circulated, or preparing with intent to so 246
issue, any statement to the effect that payments to a 247
policyholder of the principal amounts of a pure endowment are 248
other than payments of a specific benefit for which specific 249
premiums have been paid. 250

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

intending to induce any policyholder or prospective policyholder 257
to purchase, amend, lapse, forfeit, change, or surrender 258
insurance. 259

(K) Aiding or abetting another to violate this section. 260

(L) Refusing to issue any policy of insurance, or 261
canceling or declining to renew such policy because of the sex 262
or marital status of the applicant, prospective insured, 263
insured, or policyholder. 264

(M) Making or permitting any unfair discrimination between 265
individuals of the same class and of essentially the same hazard 266
in the amount of premium, policy fees, or rates charged for any 267
policy or contract of insurance, other than life insurance, or 268
in the benefits payable thereunder, or in underwriting standards 269
and practices or eligibility requirements, or in any of the 270
terms or conditions of such contract, or in any other manner 271
whatever. 272

(N) Refusing to make available disability income insurance 273
solely because the applicant's principal occupation is that of 274
managing a household. 275

(O) Refusing, when offering maternity benefits under any 276
individual or group sickness and accident insurance policy, to 277
make maternity benefits available to the policyholder for the 278
individual or individuals to be covered under any comparable 279
policy to be issued for delivery in this state, including family 280
members if the policy otherwise provides coverage for family 281
members. Nothing in this division shall be construed to prohibit 282
an insurer from imposing a reasonable waiting period for such 283
benefits under an individual sickness and accident insurance 284
policy issued to an individual who is not a federally eligible 285

individual or a nonemployer-related group sickness and accident 286
insurance policy, but in no event shall such waiting period 287
exceed two hundred seventy days. 288

For purposes of division (O) of this section, "federally 289
eligible individual" means an eligible individual as defined in 290
45 C.F.R. 148.103. 291

(P) Using, or permitting to be used, a pattern settlement 292
as the basis of any offer of settlement. As used in this 293
division, "pattern settlement" means a method by which liability 294
is routinely imputed to a claimant without an investigation of 295
the particular occurrence upon which the claim is based and by 296
using a predetermined formula for the assignment of liability 297
arising out of occurrences of a similar nature. Nothing in this 298
division shall be construed to prohibit an insurer from 299
determining a claimant's liability by applying formulas or 300
guidelines to the facts and circumstances disclosed by the 301
insurer's investigation of the particular occurrence upon which 302
a claim is based. 303

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

defines "disability" as being presumed in the event that the 316
eyesight of the insured is lost. However, an insurer may exclude 317
from coverage disabilities consisting solely of blindness or 318
partial blindness when such conditions existed at the time the 319
policy was issued. To the extent that the provisions of this 320
division may appear to conflict with any provision of section 321
3999.16 of the Revised Code, this division applies. 322

(R) (1) Directly or indirectly offering to sell, selling, 323
or delivering, issuing for delivery, renewing, or using or 324
otherwise marketing any policy of insurance or insurance product 325
in connection with or in any way related to the grant of a 326
student loan guaranteed in whole or in part by an agency or 327
commission of this state or the United States, except insurance 328
that is required under federal or state law as a condition for 329
obtaining such a loan and the premium for which is included in 330
the fees and charges applicable to the loan; or, in the case of 331
an insurer or insurance agent, knowingly permitting any lender 332
making such loans to engage in such acts or practices in 333
connection with the insurer's or agent's insurance business. 334

(2) Except in the case of a violation of division (G) of 335
this section, division (R) (1) of this section does not apply to 336
either of the following: 337

(a) Acts or practices of an insurer, its agents, 338
representatives, or employees in connection with the grant of a 339
guaranteed student loan to its insured or the insured's spouse 340
or dependent children where such acts or practices take place 341
more than ninety days after the effective date of the insurance; 342

(b) Acts or practices of an insurer, its agents, 343
representatives, or employees in connection with the 344
solicitation, processing, or issuance of an insurance policy or 345

product covering the student loan borrower or the borrower's 346
spouse or dependent children, where such acts or practices take 347
place more than one hundred eighty days after the date on which 348
the borrower is notified that the student loan was approved. 349

(S) Denying coverage, under any health insurance or health 350
care policy, contract, or plan providing family coverage, to any 351
natural or adopted child of the named insured or subscriber 352
solely on the basis that the child does not reside in the 353
household of the named insured or subscriber. 354

(T)(1) Using any underwriting standard or engaging in any 355
other act or practice that, directly or indirectly, due solely 356
to any health status-related factor in relation to one or more 357
individuals, does either of the following: 358

(a) Terminates or fails to renew an existing individual 359
policy, contract, or plan of health benefits, or a health 360
benefit plan issued to an employer, for which an individual 361
would otherwise be eligible; 362

(b) With respect to a health benefit plan issued to an 363
employer, excludes or causes the exclusion of an individual from 364
coverage under an existing employer-provided policy, contract, 365
or plan of health benefits. 366

(2) The superintendent of insurance may adopt rules in 367
accordance with Chapter 119. of the Revised Code for purposes of 368
implementing division (T)(1) of this section. 369

(3) For purposes of division (T)(1) of this section, 370
"health status-related factor" means any of the following: 371

(a) Health status; 372

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

illnesses;	374
(c) Claims experience;	375
(d) Receipt of health care;	376
(e) Medical history;	377
(f) Genetic information;	378
(g) Evidence of insurability, including conditions arising out of acts of domestic violence;	379 380
(h) Disability.	381
(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.	382 383 384 385 386
(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.	387 388 389 390
(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.	391 392 393
(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.	394 395 396 397
(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	398 399 400

refusing to issue any individual policy or contract of health 401
insurance, for the reason that the insured or applicant for 402
insurance is or has been a victim of domestic violence; 403

(b) Adding a surcharge or rating factor to a premium of 404
any individual policy or contract of life or health insurance 405
for the reason that the insured or applicant for insurance is or 406
has been a victim of domestic violence; 407

(c) Denying coverage under, or limiting coverage under, 408
any policy or contract of life or health insurance, for the 409
reason that a claim under the policy or contract arises from an 410
incident of domestic violence; 411

(d) Inquiring, directly or indirectly, of an insured 412
under, or of an applicant for, a policy or contract of life or 413
health insurance, as to whether the insured or applicant is or 414
has been a victim of domestic violence, or inquiring as to 415
whether the insured or applicant has sought shelter or 416
protection from domestic violence or has sought medical or 417
psychological treatment as a victim of domestic violence. 418

(2) Nothing in division (Y) (1) of this section shall be 419
construed to prohibit an insurer from inquiring as to, or from 420
underwriting or rating a risk on the basis of, a person's 421
physical or mental condition, even if the condition has been 422
caused by domestic violence, provided that all of the following 423
apply: 424

(a) The insurer routinely considers the condition in 425
underwriting or in rating risks, and does so in the same manner 426
for a victim of domestic violence as for an insured or applicant 427
who is not a victim of domestic violence; 428

(b) The insurer does not refuse to issue any policy or 429

contract of life or health insurance or cancel or refuse to 430
renew any policy or contract of life insurance, solely on the 431
basis of the condition, except where such refusal to issue, 432
cancellation, or refusal to renew is based on sound actuarial 433
principles or is related to actual or reasonably anticipated 434
experience; 435

(c) The insurer does not consider a person's status as 436
being or as having been a victim of domestic violence, in 437
itself, to be a physical or mental condition; 438

(d) The underwriting or rating of a risk on the basis of 439
the condition is not used to evade the intent of division (Y) (1) 440
of this section, or of any other provision of the Revised Code. 441

(3) (a) Nothing in division (Y) (1) of this section shall be 442
construed to prohibit an insurer from refusing to issue a policy 443
or contract of life insurance insuring the life of a person who 444
is or has been a victim of domestic violence if the person who 445
committed the act of domestic violence is the applicant for the 446
insurance or would be the owner of the insurance policy or 447
contract. 448

(b) Nothing in division (Y) (2) of this section shall be 449
construed to permit an insurer to cancel or refuse to renew any 450
policy or contract of health insurance in violation of the 451
"Health Insurance Portability and Accountability Act of 1996," 452
110 Stat. 1955, 42 U.S.C.A. 300gg-41(b), as amended, or in a 453
manner that violates or is inconsistent with any provision of 454
the Revised Code that implements the "Health Insurance 455
Portability and Accountability Act of 1996." 456

(4) An insurer is immune from any civil or criminal 457
liability that otherwise might be incurred or imposed as a 458

result of any action taken by the insurer to comply with 459
division (Y) of this section. 460

(5) As used in division (Y) of this section, "domestic 461
violence" means any of the following acts: 462

(a) Knowingly causing or attempting to cause physical harm 463
to a family or household member; 464

(b) Recklessly causing serious physical harm to a family 465
or household member; 466

(c) Knowingly causing, by threat of force, a family or 467
household member to believe that the person will cause imminent 468
physical harm to the family or household member. 469

For the purpose of division (Y)(5) of this section, 470
"family or household member" has the same meaning as in section 471
2919.25 of the Revised Code. 472

Nothing in division (Y)(5) of this section shall be 473
construed to require, as a condition to the application of 474
division (Y) of this section, that the act described in division 475
(Y)(5) of this section be the basis of a criminal prosecution. 476

(Z) Disclosing a coroner's records by an insurer in 477
violation of section 313.10 of the Revised Code. 478

(AA) Making, issuing, circulating, or causing or 479
permitting to be made, issued, or circulated any statement or 480
representation that a life insurance policy or annuity is a 481
contract for the purchase of funeral goods or services. 482

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

disclosures required under division (E) or (F) of section 487
3963.02 of the Revised Code. 488

(CC) With respect to private passenger automobile 489
insurance, charging premium rates that are excessive, 490
inadequate, or unfairly discriminatory, pursuant to division (D) 491
of section 3937.02 of the Revised Code, based solely on the 492
location of the residence of the insured. 493

The enumeration in sections 3901.19 to 3901.26 of the 494
Revised Code of specific unfair or deceptive acts or practices 495
in the business of insurance is not exclusive or restrictive or 496
intended to limit the powers of the superintendent of insurance 497
to adopt rules to implement this section, or to take action 498
under other sections of the Revised Code. 499

This section does not prohibit the sale of shares of any 500
investment company registered under the "Investment Company Act 501
of 1940," 54 Stat. 789, 15 U.S.C.A. 80a-1, as amended, or any 502
policies, annuities, or other contracts described in section 503
3907.15 of the Revised Code. 504

As used in this section, "estimate," "statement," 505
"representation," "misrepresentation," "advertisement," or 506
"announcement" includes oral or written occurrences. 507

Sec. 3923.86. (A) As used in this section, "covered dental 508
services," "covered vision services," "dental care provider," 509
"vision care materials," and "vision care provider" have the 510
same meanings as in section 3963.01 of the Revised Code. 511

(B) A sickness and accident insurer or public employee 512
benefit plan shall provide the information required in this 513
division to all insured individuals receiving coverage under an 514
individual or group policy of sickness and accident insurance or 515

public employee benefit plan ~~providing coverage~~ for vision care 516
services ~~or~~, vision care materials, or dental care services. 517
The information shall be in a conspicuous format, shall be 518
easily accessible to insured individuals, and shall do all of 519
the following: 520

(1) ~~Include~~ For vision care coverage, include the 521
following statement: 522

"IMPORTANT: If you opt to receive vision care services or 523
vision care materials that are not covered benefits under this 524
plan, a participating vision care provider may charge you his or 525
her normal fee for such services or materials. Prior to 526
providing you with vision care services or vision care materials 527
that are not covered benefits, the vision care provider will 528
provide you with an estimated cost for each service or material 529
upon your request." 530

(2) For dental care coverage, include the following 531
statement: 532

"IMPORTANT: If you opt to receive dental care services 533
that are not covered benefits under this plan, a participating 534
dental care provider may charge you his or her normal fee for 535
such services. Prior to providing you with dental care services 536
that are not covered benefits, the dental care provider will 537
provide you with an estimated cost for each service upon your 538
request." 539

(3) Disclose any business interest the insurer or plan has 540
in a source or supplier of vision care materials; 541

~~(3)~~ (4) Include an explanation that the insured individual 542
may incur out-of-pocket expenses as a result of the purchase of 543
vision care services ~~or~~, vision care materials, or dental care 544

services that are not covered ~~vision services~~. The explanation 545
shall be communicated in a manner and format similar to how the 546
insurer or plan provides an insured individual with information 547
on coverage levels and out-of-pocket expenses that may be 548
incurred by the insured individual under the policy or plan when 549
purchasing out-of-network vision care services ~~or~~, vision care 550
materials, or dental care services. 551

(C) A pattern of continuous or repeated violations of this 552
section is an unfair and deceptive act or practice in the 553
business of insurance under sections 3901.19 to 3901.26 of the 554
Revised Code. 555

Sec. 3963.01. As used in this chapter: 556

(A) "Affiliate" means any person or entity that has 557
ownership or control of a contracting entity, is owned or 558
controlled by a contracting entity, or is under common ownership 559
or control with a contracting entity. 560

(B) "Basic health care services" has the same meaning as 561
in division (A) of section 1751.01 of the Revised Code, except 562
that it does not include any services listed in that division 563
that are provided by a pharmacist or nursing home. 564

(C) "Covered vision services" means vision care services 565
or vision care materials for which a reimbursement is available 566
under an enrollee's health care contract, or for which a 567
reimbursement would be available but for the application of 568
contractual limitations, such as a deductible, copayment, 569
coinsurance, waiting period, annual or lifetime maximum, 570
frequency limitation, alternative benefit payment, or any other 571
limitation. 572

(D) "Contracting entity" means any person that has a 573

primary business purpose of contracting with participating 574
providers for the delivery of health care services. 575

(E) "Covered dental services" means dental care services 576
for which reimbursement is available under an enrollee's health 577
care contract, or for which a reimbursement would be available 578
but for the application of contractual limitations, such as a 579
deductible, copayment, coinsurance, waiting period, annual or 580
lifetime maximum, frequency limitation, alternative benefit 581
payment, or any other limitation. 582

(F) "Credentialing" means the process of assessing and 583
validating the qualifications of a provider applying to be 584
approved by a contracting entity to provide basic health care 585
services, specialty health care services, or supplemental health 586
care services to enrollees. 587

~~(F)~~ (G) "Dental care provider" means a dentist licensed 588
under Chapter 4715. of the Revised Code. "Dental care provider" 589
does not include a dental hygienist licensed under Chapter 4715. 590
of the Revised Code. 591

(H) "Edit" means adjusting one or more procedure codes 592
billed by a participating provider on a claim for payment or a 593
practice that results in any of the following: 594

(1) Payment for some, but not all of the procedure codes 595
originally billed by a participating provider; 596

(2) Payment for a different procedure code than the 597
procedure code originally billed by a participating provider; 598

(3) A reduced payment as a result of services provided to 599
an enrollee that are claimed under more than one procedure code 600
on the same service date. 601

~~(G)~~ (I) "Electronic claims transport" means to accept and 602
digitize claims or to accept claims already digitized, to place 603
those claims into a format that complies with the electronic 604
transaction standards issued by the United States department of 605
health and human services pursuant to the "Health Insurance 606
Portability and Accountability Act of 1996," 110 Stat. 1955, 42 607
U.S.C. 1320d, et seq., as those electronic standards are 608
applicable to the parties and as those electronic standards are 609
updated from time to time, and to electronically transmit those 610
claims to the appropriate contracting entity, payer, or third- 611
party administrator. 612

~~(H)~~ (J) "Enrollee" means any person eligible for health 613
care benefits under a health benefit plan, including an eligible 614
recipient of medicaid, and includes all of the following terms: 615

(1) "Enrollee" and "subscriber" as defined by section 616
1751.01 of the Revised Code; 617

(2) "Member" as defined by section 1739.01 of the Revised 618
Code; 619

(3) "Insured" and "plan member" pursuant to Chapter 3923. 620
of the Revised Code; 621

(4) "Beneficiary" as defined by section 3901.38 of the 622
Revised Code. 623

~~(I)~~ (K) "Health care contract" means a contract entered 624
into, materially amended, or renewed between a contracting 625
entity and a participating provider for the delivery of basic 626
health care services, specialty health care services, or 627
supplemental health care services to enrollees. 628

~~(J)~~ (L) "Health care services" means basic health care 629
services, specialty health care services, and supplemental 630

health care services. 631

~~(K)~~ (M) "Material amendment" means an amendment to a 632
health care contract that decreases the participating provider's 633
payment or compensation, changes the administrative procedures 634
in a way that may reasonably be expected to significantly 635
increase the provider's administrative expenses, or adds a new 636
product. A material amendment does not include any of the 637
following: 638

(1) A decrease in payment or compensation resulting solely 639
from a change in a published fee schedule upon which the payment 640
or compensation is based and the date of applicability is 641
clearly identified in the contract; 642

(2) A decrease in payment or compensation that was 643
anticipated under the terms of the contract, if the amount and 644
date of applicability of the decrease is clearly identified in 645
the contract; 646

(3) An administrative change that may significantly 647
increase the provider's administrative expense, the specific 648
applicability of which is clearly identified in the contract; 649

(4) Changes to an existing prior authorization, 650
precertification, notification, or referral program that do not 651
substantially increase the provider's administrative expense; 652

(5) Changes to an edit program or to specific edits if the 653
participating provider is provided notice of the changes 654
pursuant to division (A)(1) of section 3963.04 of the Revised 655
Code and the notice includes information sufficient for the 656
provider to determine the effect of the change; 657

(6) Changes to a health care contract described in 658
division (B) of section 3963.04 of the Revised Code. 659

~~(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
financial risk for the payment of claims under a health care
contract or the reimbursement for health care services provided
to enrollees by participating providers pursuant to a health
care contract.

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

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

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

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

(2) A preferred provider organization;

(3) Medicare;

(4) Medicaid;

(5) Workers' compensation.

~~(Q)~~ (S) "Provider" means a physician, podiatrist, dentist, 688
chiropractor, optometrist, psychologist, physician assistant, 689
advanced practice registered nurse, occupational therapist, 690
massage therapist, physical therapist, licensed professional 691
counselor, licensed professional clinical counselor, hearing aid 692
dealer, orthotist, prosthetist, home health agency, hospice care 693
program, pediatric respite care program, or hospital, or a 694
provider organization or physician-hospital organization that is 695
acting exclusively as an administrator on behalf of a provider 696
to facilitate the provider's participation in health care 697
contracts. 698

"Provider" does not mean either of the following: 699

(1) A nursing home; 700

(2) A provider organization or physician-hospital 701
organization that leases the provider organization's or 702
physician-hospital organization's network to a third party or 703
contracts directly with employers or health and welfare funds. 704

~~(R)~~ (T) "Specialty health care services" has the same 705
meaning as in section 1751.01 of the Revised Code, except that 706
it does not include any services listed in division (B) of 707
section 1751.01 of the Revised Code that are provided by a 708
pharmacist or a nursing home. 709

~~(S)~~ (U) "Supplemental health care services" has the same 710
meaning as in division (B) of section 1751.01 of the Revised 711
Code, except that it does not include any services listed in 712
that division that are provided by a pharmacist or nursing home. 713

~~(T)~~ (V) "Vision care materials" includes lenses, devices 714
containing lenses, prisms, lens treatments and coatings, contact 715
lenses, orthoptics, vision training, and any prosthetic device 716

necessary to correct, relieve, or treat any defect or abnormal 717
condition of the human eye or its adnexa. 718

~~(U)~~ (W) "Vision care provider" means either of the 719
following: 720

(1) An optometrist licensed under Chapter 4725. of the 721
Revised Code; 722

(2) A physician authorized under Chapter 4731. of the 723
Revised Code to practice medicine and surgery or osteopathic 724
medicine and surgery. 725

Sec. 3963.02. (A) (1) No contracting entity shall sell, 726
rent, or give a third party the contracting entity's rights to a 727
participating provider's services pursuant to the contracting 728
entity's health care contract with the participating provider 729
unless one of the following applies: 730

(a) The third party accessing the participating provider's 731
services under the health care contract is an employer or other 732
entity providing coverage for health care services to its 733
employees or members, and that employer or entity has a contract 734
with the contracting entity or its affiliate for the 735
administration or processing of claims for payment for services 736
provided pursuant to the health care contract with the 737
participating provider. 738

(b) The third party accessing the participating provider's 739
services under the health care contract either is an affiliate 740
or subsidiary of the contracting entity or is providing 741
administrative services to, or receiving administrative services 742
from, the contracting entity or an affiliate or subsidiary of 743
the contracting entity. 744

(c) The health care contract specifically provides that it 745

applies to network rental arrangements and states that one 746
purpose of the contract is selling, renting, or giving the 747
contracting entity's rights to the services of the participating 748
provider, including other preferred provider organizations, and 749
the third party accessing the participating provider's services 750
is any of the following: 751

(i) A payer or a third-party administrator or other entity 752
responsible for administering claims on behalf of the payer; 753

(ii) A preferred provider organization or preferred 754
provider network that receives access to the participating 755
provider's services pursuant to an arrangement with the 756
preferred provider organization or preferred provider network in 757
a contract with the participating provider that is in compliance 758
with division (A) (1) (c) of this section, and is required to 759
comply with all of the terms, conditions, and affirmative 760
obligations to which the originally contracted primary 761
participating provider network is bound under its contract with 762
the participating provider, including, but not limited to, 763
obligations concerning patient steerage and the timeliness and 764
manner of reimbursement. 765

(iii) An entity that is engaged in the business of 766
providing electronic claims transport between the contracting 767
entity and the payer or third-party administrator and complies 768
with all of the applicable terms, conditions, and affirmative 769
obligations of the contracting entity's contract with the 770
participating provider including, but not limited to, 771
obligations concerning patient steerage and the timeliness and 772
manner of reimbursement. 773

(2) The contracting entity that sells, rents, or gives the 774
contracting entity's rights to the participating provider's 775

services pursuant to the contracting entity's health care 776
contract with the participating provider as provided in division 777
(A) (1) of this section shall do both of the following: 778

(a) Maintain a web page that contains a listing of third 779
parties described in divisions (A) (1) (b) and (c) of this section 780
with whom a contracting entity contracts for the purpose of 781
selling, renting, or giving the contracting entity's rights to 782
the services of participating providers that is updated at least 783
every six months and is accessible to all participating 784
providers, or maintain a toll-free telephone number accessible 785
to all participating providers by means of which participating 786
providers may access the same listing of third parties; 787

(b) Require that the third party accessing the 788
participating provider's services through the participating 789
provider's health care contract is obligated to comply with all 790
of the applicable terms and conditions of the contract, 791
including, but not limited to, the products for which the 792
participating provider has agreed to provide services, except 793
that a payer receiving administrative services from the 794
contracting entity or its affiliate shall be solely responsible 795
for payment to the participating provider. 796

(3) Any information disclosed to a participating provider 797
under this section shall be considered proprietary and shall not 798
be distributed by the participating provider. 799

(4) Except as provided in division (A) (1) of this section, 800
no entity shall sell, rent, or give a contracting entity's 801
rights to the participating provider's services pursuant to a 802
health care contract. 803

(B) (1) No contracting entity shall require, as a condition 804

of contracting with the contracting entity, that a participating 805
provider provide services for all of the products offered by the 806
contracting entity. 807

(2) Division (B)(1) of this section shall not be construed 808
to do any of the following: 809

(a) Prohibit any participating provider from voluntarily 810
accepting an offer by a contracting entity to provide health 811
care services under all of the contracting entity's products; 812

(b) Prohibit any contracting entity from offering any 813
financial incentive or other form of consideration specified in 814
the health care contract for a participating provider to provide 815
health care services under all of the contracting entity's 816
products; 817

(c) Require any contracting entity to contract with a 818
participating provider to provide health care services for less 819
than all of the contracting entity's products if the contracting 820
entity does not wish to do so. 821

(3) (a) Notwithstanding division (B)(2) of this section, no 822
contracting entity shall require, as a condition of contracting 823
with the contracting entity, that the participating provider 824
accept any future product offering that the contracting entity 825
makes. 826

(b) If a participating provider refuses to accept any 827
future product offering that the contracting entity makes, the 828
contracting entity may terminate the health care contract based 829
on the participating provider's refusal upon written notice to 830
the participating provider no sooner than one hundred eighty 831
days after the refusal. 832

(4) Once the contracting entity and the participating 833

provider have signed the health care contract, it is presumed 834
that the financial incentive or other form of consideration that 835
is specified in the health care contract pursuant to division 836
(B) (2) (b) of this section is the financial incentive or other 837
form of consideration that was offered by the contracting entity 838
to induce the participating provider to enter into the contract. 839

(C) No contracting entity shall require, as a condition of 840
contracting with the contracting entity, that a participating 841
provider waive or forgo any right or benefit expressly conferred 842
upon a participating provider by state or federal law. However, 843
this division does not prohibit a contracting entity from 844
restricting a participating provider's scope of practice for the 845
services to be provided under the contract. 846

(D) No health care contract shall do any of the following: 847

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

(2) Prohibit any contracting entity from entering into a 850
health care contract with any other provider; 851

(3) Preclude its use or disclosure for the purpose of 852
enforcing this chapter or other state or federal law, except 853
that a health care contract may require that appropriate 854
measures be taken to preserve the confidentiality of any 855
proprietary or trade-secret information. 856

(E) (1) No contract or agreement between a contracting 857
entity and a vision care provider shall do any of the following: 858

(a) Require that a vision care provider accept as payment 859
an amount set by the contracting entity for vision care services 860
or vision care materials provided to an enrollee unless the 861
services or materials are covered vision services. 862

(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.

(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.

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

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

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

(d) Include a provision that prohibits a vision care 892
provider from describing out-of-network options to an enrollee 893
in accordance with division (E)(2) of this section. 894

The provisions of divisions (E)(1)(a) to (d) of this 895
section shall be effective for contracts entered into, amended, 896
or renewed on or after January 1, 2019. 897

(2) A vision care provider recommending an out-of-network 898
source or supplier of vision care materials to an enrollee shall 899
notify the enrollee in writing that the source or supplier is 900
out-of-network and shall inform the enrollee of the cost of 901
those materials. The vision care provider shall also disclose in 902
writing to an enrollee any business interest the provider has in 903
a recommended out-of-network source or supplier utilized by the 904
enrollee. 905

(3) A vision care provider who chooses not to accept as 906
payment an amount set by a contracting entity for vision care 907
services or vision care materials that are not covered vision 908
services shall do both of the following: 909

(a) Upon the request of an enrollee seeking vision care 910
services or vision care materials that are not covered vision 911
services, provide to the enrollee pricing and reimbursement 912
information, including all of the following: 913

(i) The estimated fee or discounted price suggested by the 914
contracting entity for the noncovered service or material; 915

(ii) The estimated fee charged by the vision care provider 916
for the noncovered service or material; 917

(iii) The amount the vision care provider expects to be 918
reimbursed by the contracting entity for the noncovered service 919
or material; 920

(iv) The estimated pricing and reimbursement information 921
for any covered services or materials that are also expected to 922
be provided during the enrollee's visit. 923

(b) Post, in a conspicuous place, a notice stating the 924
following: 925

"IMPORTANT: This vision care provider does not accept the 926
fee schedule set by your insurer for vision care services and 927
vision care materials that are not covered benefits under your 928
plan and instead charges his or her normal fee for those 929
services and materials. This vision care provider will provide 930
you with an estimated cost for each non-covered service or 931
material upon your request." 932

(4) Nothing in division (E) of this section shall do any 933
of the following: 934

(a) Restrict or limit a contracting entity's determination 935
of specific amounts of coverage or reimbursement for the use of 936
network or out-of-network sources or suppliers of vision care 937
materials as set forth in an enrollee's benefit plan; 938

(b) Restrict or limit a contracting entity's ability to 939
enter into an agreement with another contracting entity or an 940
affiliate of another contracting entity; 941

(c) Restrict or limit a health care plan's ability to 942
enter into an agreement with a vision care plan to deliver 943
routine vision care services that are covered under an 944
enrollee's plan; 945

(d) Restrict or limit a vision care plan network from 946
acting as a network for a health care plan; 947

(e) Prohibit a contracting entity from requiring 948

participating vision care providers to offer network sources or 949
suppliers of vision care materials to enrollees; 950

(f) Prohibit an enrollee from utilizing a network source 951
or supplier of vision care materials as set forth in an 952
enrollee's plan; 953

(g) Prohibit a participating vision care provider from 954
accepting as payment an amount that is the same as the amount 955
set by the contracting entity for vision care services or vision 956
care materials that are not covered vision services. 957

(F) (1) No contract or agreement between a contracting 958
entity and a dental care provider shall do any of the following: 959

(a) Require that a dental care provider accept as payment 960
an amount set by the contracting entity for dental care services 961
provided to an enrollee unless the services are covered dental 962
services. 963

(i) Notwithstanding division (F) (1) (a) of this section, a 964
dental care provider may, in a contract with a contracting 965
entity, choose to accept as payment an amount set by the 966
contracting entity for dental care services provided to an 967
enrollee that are not covered dental services. 968

(ii) No contract between a dental care provider and a 969
contracting entity to provide covered dental services shall be 970
contingent on whether the dental care provider has entered into 971
an agreement addressing noncovered dental services pursuant to 972
division (F) (1) (a) (i) of this section. 973

(iii) A contracting entity may communicate to its 974
enrollees which dental care providers choose to accept as 975
payment an amount set by the contracting entity for dental care 976
services provided to an enrollee that are not covered dental 977

services pursuant to division (F)(1)(a)(i) of this section. Any 978
communication to this effect shall treat all dental care 979
providers equally in provider directories, provider locators, 980
and other marketing materials as participating, in-network 981
providers, annotated only as to their decision to accept payment 982
pursuant to division (F)(1)(a)(i) of this section. 983

(b) Require that a dental care provider contract with a 984
plan offering supplemental or specialty health care services as 985
a condition of contracting with a plan offering basic health 986
care services. 987

The provisions of divisions (F)(1)(a) and (b) of this 988
section shall be effective for contracts entered into, amended, 989
or renewed on or after January 1, 2020. 990

(2) A dental care provider who chooses not to accept as 991
payment an amount set by a contracting entity for dental care 992
services that are not covered dental services shall do both of 993
the following: 994

(a) Upon the request of an enrollee seeking dental care 995
services that are not covered dental services, provide to the 996
enrollee pricing and reimbursement information, including all of 997
the following: 998

(i) The estimated fee or discounted price suggested by the 999
contracting entity for the noncovered service; 1000

(ii) The estimated fee charged by the dental care provider 1001
for the noncovered service; 1002

(iii) The amount the dental care provider expects to be 1003
reimbursed by the contracting entity for the noncovered service 1004

i 1005

(iv) The estimated pricing and reimbursement information 1006
for any covered services that are also expected to be provided 1007
during the enrollee's visit. 1008

(b) Post, in a conspicuous place, a notice stating the 1009
following: 1010

"IMPORTANT: This dental care provider does not accept the 1011
fee schedule set by your insurer for dental care services that 1012
are not covered benefits under your plan and instead charges his 1013
or her normal fee for those services. This dental care provider 1014
will provide you with an estimated cost for each noncovered 1015
service upon your request." 1016

(3) Nothing in division (F) of this section shall do any 1017
of the following: 1018

(a) Restrict or limit a contracting entity's ability to 1019
enter into an agreement with another contracting entity or an 1020
affiliate of another contracting entity; 1021

(b) Restrict or limit a health care plan's ability to 1022
enter into an agreement with a dental care plan to deliver 1023
routine dental care services that are covered under an 1024
enrollee's plan; 1025

(c) Restrict or limit a dental care plan network from 1026
acting as a network for a health care plan; 1027

(d) Prohibit a participating dental care provider from 1028
accepting as payment an amount that is the same as the amount 1029
set by the contracting entity for dental care services that are 1030
not covered dental services. 1031

(G)(1) In addition to any other lawful reasons for 1032
terminating a health care contract, a health care contract may 1033

only be terminated under the circumstances described in division 1034
(A) (3) of section 3963.04 of the Revised Code. 1035

(2) If the health care contract provides for termination 1036
for cause by either party, the health care contract shall state 1037
the reasons that may be used for termination for cause, which 1038
terms shall be reasonable. Once the contracting entity and the 1039
participating provider have signed the health care contract, it 1040
is presumed that the reasons stated in the health care contract 1041
for termination for cause by either party are reasonable. 1042
Subject to division ~~(F)~~(G) (3) of this section, the health care 1043
contract shall state the time by which the parties must provide 1044
notice of termination for cause and to whom the parties shall 1045
give the notice. 1046

(3) Nothing in divisions ~~(F)~~(G) (1) and (2) of this section 1047
shall be construed as prohibiting any health insuring 1048
corporation from terminating a participating provider's contract 1049
for any of the causes described in divisions (A), (D), and (F) 1050
(1) and (2) of section 1753.09 of the Revised Code. 1051
Notwithstanding any provision in a health care contract pursuant 1052
to division ~~(F)~~(G) (2) of this section, section 1753.09 of the 1053
Revised Code applies to the termination of a participating 1054
provider's contract for any of the causes described in divisions 1055
(A), (D), and (F) (1) and (2) of section 1753.09 of the Revised 1056
Code. 1057

(4) Subject to sections 3963.01 to 3963.11 of the Revised 1058
Code, nothing in this section prohibits the termination of a 1059
health care contract without cause if the health care contract 1060
otherwise provides for termination without cause. 1061

(5) Nothing in division ~~(F)~~(G) of this section shall be 1062
construed to expand the regulatory authority of the 1063

superintendent to vision care providers or dental care 1064
providers. 1065

~~(G)~~ (H) (1) Disputes among parties to a health care contract 1066
that only concern the enforcement of the contract rights 1067
conferred by section 3963.02, divisions (A) and (D) of section 1068
3963.03, and section 3963.04 of the Revised Code are subject to 1069
a mutually agreed upon arbitration mechanism that is binding on 1070
all parties. The arbitrator may award reasonable attorney's fees 1071
and costs for arbitration relating to the enforcement of this 1072
section to the prevailing party. 1073

(2) The arbitrator shall make the arbitrator's decision in 1074
an arbitration proceeding having due regard for any applicable 1075
rules, bulletins, rulings, or decisions issued by the department 1076
of insurance or any court concerning the enforcement of the 1077
contract rights conferred by section 3963.02, divisions (A) and 1078
(D) of section 3963.03, and section 3963.04 of the Revised Code. 1079

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

insuring corporation, the arbitration proceeding shall be stayed 1094
at the request of the insurer or health insuring corporation 1095
pending the outcome of the market conduct investigation by the 1096
superintendent. 1097

Sec. 3963.03. (A) Each health care contract shall include 1098
all of the following information: 1099

(1) (a) Information sufficient for the participating 1100
provider to determine the compensation or payment terms for 1101
health care services, including all of the following, subject to 1102
division (A) (1) (b) of this section: 1103

(i) The manner of payment, such as fee-for-service, 1104
capitation, or risk; 1105

(ii) The fee schedule of procedure codes reasonably 1106
expected to be billed by a participating provider's specialty 1107
for services provided pursuant to the health care contract and 1108
the associated payment or compensation for each procedure code. 1109
A fee schedule may be provided electronically. Upon request, a 1110
contracting entity shall provide a participating provider with 1111
the fee schedule for any other procedure codes requested and a 1112
written fee schedule, that shall not be required more frequently 1113
than twice per year excluding when it is provided in connection 1114
with any change to the schedule. This requirement may be 1115
satisfied by providing a clearly understandable, readily 1116
available mechanism, such as a specific web site address, that 1117
allows a participating provider to determine the effect of 1118
procedure codes on payment or compensation before a service is 1119
provided or a claim is submitted. 1120

(iii) The effect, if any, on payment or compensation if 1121
more than one procedure code applies to the service also shall 1122

be stated. This requirement may be satisfied by providing a 1123
clearly understandable, readily available mechanism, such as a 1124
specific web site address, that allows a participating provider 1125
to determine the effect of procedure codes on payment or 1126
compensation before a service is provided or a claim is 1127
submitted. 1128

(b) If the contracting entity is unable to include the 1129
information described in divisions (A)(1)(a)(ii) and (iii) of 1130
this section, the contracting entity shall include both of the 1131
following types of information instead: 1132

(i) The methodology used to calculate any fee schedule, 1133
such as relative value unit system and conversion factor or 1134
percentage of billed charges. If applicable, the methodology 1135
disclosure shall include the name of any relative value unit 1136
system, its version, edition, or publication date, any 1137
applicable conversion or geographic factor, and any date by 1138
which compensation or fee schedules may be changed by the 1139
methodology as anticipated at the time of contract. 1140

(ii) The identity of any internal processing edits, 1141
including the publisher, product name, version, and version 1142
update of any editing software. 1143

(c) If the contracting entity is not the payer and is 1144
unable to include the information described in division (A)(1) 1145
(a) or (b) of this section, then the contracting entity shall 1146
provide by telephone a readily available mechanism, such as a 1147
specific web site address, that allows the participating 1148
provider to obtain that information from the payer. 1149

(2) Any product or network for which the participating 1150
provider is to provide services; 1151

(3) The term of the health care contract; 1152

(4) A specific web site address that contains the identity 1153
of the contracting entity or payer responsible for the 1154
processing of the participating provider's compensation or 1155
payment; 1156

(5) Any internal mechanism provided by the contracting 1157
entity to resolve disputes concerning the interpretation or 1158
application of the terms and conditions of the contract. A 1159
contracting entity may satisfy this requirement by providing a 1160
clearly understandable, readily available mechanism, such as a 1161
specific web site address or an appendix, that allows a 1162
participating provider to determine the procedures for the 1163
internal mechanism to resolve those disputes. 1164

(6) A list of addenda, if any, to the contract. 1165

(B) (1) Each contracting entity shall include a summary 1166
disclosure form with a health care contract that includes all of 1167
the information specified in division (A) of this section. The 1168
information in the summary disclosure form shall refer to the 1169
location in the health care contract, whether a page number, 1170
section of the contract, appendix, or other identifiable 1171
location, that specifies the provisions in the contract to which 1172
the information in the form refers. 1173

(2) The summary disclosure form shall include all of the 1174
following statements: 1175

(a) That the form is a guide to the health care contract 1176
and that the terms and conditions of the health care contract 1177
constitute the contract rights of the parties; 1178

(b) That reading the form is not a substitute for reading 1179
the entire health care contract; 1180

(c) That by signing the health care contract, the 1181
participating provider will be bound by the contract's terms and 1182
conditions; 1183

(d) That the terms and conditions of the health care 1184
contract may be amended pursuant to section 3963.04 of the 1185
Revised Code and the participating provider is encouraged to 1186
carefully read any proposed amendments sent after execution of 1187
the contract; 1188

(e) That nothing in the summary disclosure form creates 1189
any additional rights or causes of action in favor of either 1190
party. 1191

(3) No contracting entity that includes any information in 1192
the summary disclosure form with the reasonable belief that the 1193
information is truthful or accurate shall be subject to a civil 1194
action for damages or to binding arbitration based on the 1195
summary disclosure form. Division (B)(3) of this section does 1196
not impair or affect any power of the department of insurance to 1197
enforce any applicable law. 1198

(4) The summary disclosure form described in divisions (B) 1199
(1) and (2) of this section shall be in substantially the 1200
following form: 1201

"SUMMARY DISCLOSURE FORM 1202

(1) Compensation terms 1203

(a) Manner of payment 1204

[] Fee for service 1205

[] Capitation 1206

[] Risk 1207

[] Other	See	1208
(b) Fee schedule available at		1209
(c) Fee calculation schedule available at		1210
(d) Identity of internal processing edits available		1211
at		1212
(e) Information in (c) and (d) is not required if		1213
information in (b) is provided.		1214
(2) List of products or networks covered by this contract		1215
[]		1216
[]		1217
[]		1218
[]		1219
[]		1220
(3) Term of this contract		1221
(4) Contracting entity or payer responsible for processing		1222
payment available at		1223
(5) Internal mechanism for resolving disputes regarding		1224
contract terms available at		1225
(6) Addenda to contract		1226
Title	Subject	1227
(a)		1228
(b)		1229
(c)		1230
(d)		1231

(7) Telephone number to access a readily available 1232
mechanism, such as a specific web site address, to allow a 1233
participating provider to receive the information in (1) through 1234
(6) from the payer. 1235

IMPORTANT INFORMATION - PLEASE READ CAREFULLY 1236

The information provided in this Summary Disclosure Form 1237
is a guide to the attached Health Care Contract as defined in 1238
section 3963.01~~-(I)-(K)~~ of the Ohio Revised Code. The terms and 1239
conditions of the attached Health Care Contract constitute the 1240
contract rights of the parties. 1241

Reading this Summary Disclosure Form is not a substitute 1242
for reading the entire Health Care Contract. When you sign the 1243
Health Care Contract, you will be bound by its terms and 1244
conditions. These terms and conditions may be amended over time 1245
pursuant to section 3963.04 of the Ohio Revised Code. You are 1246
encouraged to read any proposed amendments that are sent to you 1247
after execution of the Health Care Contract. 1248

Nothing in this Summary Disclosure Form creates any 1249
additional rights or causes of action in favor of either party." 1250

(C) When a contracting entity presents a proposed health 1251
care contract for consideration by a provider, the contracting 1252
entity shall provide in writing or make reasonably available the 1253
information required in division (A)(1) of this section. 1254

(D) The contracting entity shall identify any utilization 1255
management, quality improvement, or a similar program that the 1256
contracting entity uses to review, monitor, evaluate, or assess 1257
the services provided pursuant to a health care contract. The 1258
contracting entity shall disclose the policies, procedures, or 1259
guidelines of such a program applicable to a participating 1260

provider upon request by the participating provider within 1261
fourteen days after the date of the request. 1262

(E) Nothing in this section shall be construed as 1263
preventing or affecting the application of section 1753.07 of 1264
the Revised Code that would otherwise apply to a contract with a 1265
participating provider. 1266

(F) The requirements of division (C) of this section do 1267
not prohibit a contracting entity from requiring a reasonable 1268
confidentiality agreement between the provider and the 1269
contracting entity regarding the terms of the proposed health 1270
care contract. If either party violates the confidentiality 1271
agreement, a party to the confidentiality agreement may bring a 1272
civil action to enjoin the other party from continuing any act 1273
that is in violation of the confidentiality agreement, to 1274
recover damages, to terminate the contract, or to obtain any 1275
combination of relief. 1276

Sec. 4715.30. (A) An applicant for or holder of a 1277
certificate or license issued under this chapter is subject to 1278
disciplinary action by the state dental board for any of the 1279
following reasons: 1280

(1) Employing or cooperating in fraud or material 1281
deception in applying for or obtaining a license or certificate; 1282

(2) Obtaining or attempting to obtain money or anything of 1283
value by intentional misrepresentation or material deception in 1284
the course of practice; 1285

(3) Advertising services in a false or misleading manner 1286
or violating the board's rules governing time, place, and manner 1287
of advertising; 1288

(4) Commission of an act that constitutes a felony in this 1289

state, regardless of the jurisdiction in which the act was 1290
committed; 1291

(5) Commission of an act in the course of practice that 1292
constitutes a misdemeanor in this state, regardless of the 1293
jurisdiction in which the act was committed; 1294

(6) Conviction of, a plea of guilty to, a judicial finding 1295
of guilt of, a judicial finding of guilt resulting from a plea 1296
of no contest to, or a judicial finding of eligibility for 1297
intervention in lieu of conviction for, any felony or of a 1298
misdemeanor committed in the course of practice; 1299

(7) Engaging in lewd or immoral conduct in connection with 1300
the provision of dental services; 1301

(8) Selling, prescribing, giving away, or administering 1302
drugs for other than legal and legitimate therapeutic purposes, 1303
or conviction of, a plea of guilty to, a judicial finding of 1304
guilt of, a judicial finding of guilt resulting from a plea of 1305
no contest to, or a judicial finding of eligibility for 1306
intervention in lieu of conviction for, a violation of any 1307
federal or state law regulating the possession, distribution, or 1308
use of any drug; 1309

(9) Providing or allowing dental hygienists, expanded 1310
function dental auxiliaries, or other practitioners of auxiliary 1311
dental occupations working under the certificate or license 1312
holder's supervision, or a dentist holding a temporary limited 1313
continuing education license under division (C) of section 1314
4715.16 of the Revised Code working under the certificate or 1315
license holder's direct supervision, to provide dental care that 1316
departs from or fails to conform to accepted standards for the 1317
profession, whether or not injury to a patient results; 1318

(10) Inability to practice under accepted standards of the 1319
profession because of physical or mental disability, dependence 1320
on alcohol or other drugs, or excessive use of alcohol or other 1321
drugs; 1322

(11) Violation of any provision of this chapter or any 1323
rule adopted thereunder; 1324

(12) Failure to use universal blood and body fluid 1325
precautions established by rules adopted under section 4715.03 1326
of the Revised Code; 1327

(13) Except as provided in division (H) of this section, 1328
either of the following: 1329

(a) Waiving the payment of all or any part of a deductible 1330
or copayment that a patient, pursuant to a health insurance or 1331
health care policy, contract, or plan that covers dental 1332
services, would otherwise be required to pay if the waiver is 1333
used as an enticement to a patient or group of patients to 1334
receive health care services from that certificate or license 1335
holder; 1336

(b) Advertising that the certificate or license holder 1337
will waive the payment of all or any part of a deductible or 1338
copayment that a patient, pursuant to a health insurance or 1339
health care policy, contract, or plan that covers dental 1340
services, would otherwise be required to pay. 1341

(14) Failure to comply with section 4715.302 or 4729.79 of 1342
the Revised Code, unless the state board of pharmacy no longer 1343
maintains a drug database pursuant to section 4729.75 of the 1344
Revised Code; 1345

(15) Any of the following actions taken by an agency 1346
responsible for authorizing, certifying, or regulating an 1347

individual to practice a health care occupation or provide 1348
health care services in this state or another jurisdiction, for 1349
any reason other than the nonpayment of fees: the limitation, 1350
revocation, or suspension of an individual's license to 1351
practice; acceptance of an individual's license surrender; 1352
denial of a license; refusal to renew or reinstate a license; 1353
imposition of probation; or issuance of an order of censure or 1354
other reprimand; 1355

(16) Failure to cooperate in an investigation conducted by 1356
the board under division (D) of section 4715.03 of the Revised 1357
Code, including failure to comply with a subpoena or order 1358
issued by the board or failure to answer truthfully a question 1359
presented by the board at a deposition or in written 1360
interrogatories, except that failure to cooperate with an 1361
investigation shall not constitute grounds for discipline under 1362
this section if a court of competent jurisdiction has issued an 1363
order that either quashes a subpoena or permits the individual 1364
to withhold the testimony or evidence in issue; 1365

(17) Failure to comply with the requirements in section 1366
3719.061 of the Revised Code before issuing for a minor a 1367
prescription for an opioid analgesic, as defined in section 1368
3719.01 of the Revised Code; 1369

(18) 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

Section 2. That existing sections 1751.85, 1753.09, 1541
3901.21, 3923.86, 3963.01, 3963.02, 3963.03, and 4715.30 of the 1542
Revised Code are hereby repealed. 1543

Section 3 The General Assembly, applying the principle 1544
stated in division (B) of section 1.52 of the Revised Code that 1545
amendments are to be harmonized if reasonably capable of 1546
simultaneous operation, finds that the following sections, 1547
presented in this act as composites of the sections as amended 1548
by the acts indicated, are the resulting version of the sections 1549
in effect prior to the effective date of the sections as 1550
presented in this act: 1551

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

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