As Reported by the Senate Insurance and Financial Institutions Committee

133rd General Assembly

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Senator Schuring

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

A BILL

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

insurance.

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

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

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

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

(O) Refusing, when offering maternity benefits under any individual or group sickness and accident insurance policy, to make maternity benefits available to the policyholder for the individual or individuals to be covered under any comparable policy to be issued for delivery in this state, including family members if the policy otherwise provides coverage for family members. Nothing in this division shall be construed to prohibit an insurer from imposing a reasonable waiting period for such benefits under an individual sickness and accident insurance policy issued to an individual who is not a federally eligible individual or a nonemployer-related group sickness and accident insurance policy, but in no event shall such waiting period

exceed two hundred seventy days.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(a) Health status;

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

(c) Claims experience;

(d) Receipt of health care;

(e) Medical history;

(f) Genetic information;

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

(h) Disability.

(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.

(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.

(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.

(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.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

violence" means any of the following acts:

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

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

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

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

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

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

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

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

(CC) With respect to private passenger automobile

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Sec. 3963.01. As used in this chapter:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

~~(I)~~ (K) "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.

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

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

in a way that may reasonably be expected to significantly increase the provider's administrative expenses, or adds a new product. A material amendment does not include any of the following:

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

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

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

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

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

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

~~(I)~~ (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 health care 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, chiropractor, optometrist, psychologist, physician assistant, advanced practice registered nurse, occupational therapist, massage therapist, physical therapist, licensed professional

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

"Provider" does not mean either of the following:

(1) A nursing home;

(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, orthopics, 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:

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

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

(c) The health care contract specifically provides that it applies to network rental arrangements and states that one purpose of the contract is selling, renting, or giving the contracting entity's rights to the services of the participating provider, including other preferred provider organizations, and

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

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

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

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

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

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

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

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

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

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

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

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

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

(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:

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

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

(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.

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

(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.

(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 provider from describing out-of-network options to an enrollee

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

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

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

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

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

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

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

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

(iv) The estimated pricing and reimbursement information

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

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

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

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

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

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

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

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

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

suppliers of vision care materials to enrollees;

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

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

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

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

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

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

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

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

(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.

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

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

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

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

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

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

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

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

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

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

(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;

(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;

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

(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.

(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.

(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. Subject to division ~~(F)~~ (G)(3) of this section, the health care contract shall state the time by which the parties must provide notice of termination for cause and to whom the parties shall give the notice.

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

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

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

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

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

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

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

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

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

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

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

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

submitted.

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

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

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

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

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

(3) The term of the health care contract;

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

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

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

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

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

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

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

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

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

Revised Code and the participating provider is encouraged to 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 summary disclosure form. Division (B)(3) of this section does not impair or affect any power of the department of insurance to enforce any applicable law.

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

"SUMMARY DISCLOSURE FORM

(1) Compensation terms

(a) Manner of payment

[ ] Fee for service

[ ] Capitation

[ ] Risk

[ ] Other _____ See _____

(b) Fee schedule available at _____

(c) Fee calculation schedule available at _____

(d) Identity of internal processing edits available at

_____

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

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

[ ] _____

[ ] _____

[ ] _____

[ ] _____

[ ] _____

(3) Term of this contract _____

(4) Contracting entity or payer responsible for processing payment available at _____

(5) Internal mechanism for resolving disputes regarding contract terms available at _____

(6) Addenda to contract

Title	Subject
(a)	
(b)	
(c)	
(d)	

(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.

IMPORTANT INFORMATION - PLEASE READ CAREFULLY

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

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

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

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

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

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

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

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

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

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

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

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

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

(5) Commission of an act in the course of practice that constitutes a misdemeanor in this state, regardless of the

jurisdiction in which the act was committed;

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

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

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

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

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

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

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

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

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

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

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

(15) Any of the following actions taken by an agency responsible for authorizing, certifying, or regulating an individual to practice a health care occupation or provide health care services in this state or another jurisdiction, for any reason other than the nonpayment of fees: the limitation, revocation, or suspension of an individual's license to

practice; acceptance of an individual's license surrender; denial of a license; refusal to renew or reinstate a license; imposition of probation; or issuance of an order of censure or other reprimand;

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

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

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

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

(C) Subject to Chapter 119. of the Revised Code, the board

may take one or more of the following disciplinary actions if one or more of the grounds for discipline listed in divisions (A) and (B) of this section exist:

(1) Censure the license or certificate holder;

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

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

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

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

(3) Suspend the certificate or license;

(4) Revoke the certificate or license.

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

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

met.

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

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

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

(F) Any holder of a certificate or license issued under this chapter who has pleaded guilty to, has been convicted of,

or has had a judicial finding of eligibility for intervention in lieu of conviction entered against the holder in this state for aggravated murder, murder, voluntary manslaughter, felonious assault, kidnapping, rape, sexual battery, gross sexual imposition, aggravated arson, aggravated robbery, or aggravated burglary, or who has pleaded guilty to, has been convicted of, or has had a judicial finding of eligibility for treatment or intervention in lieu of conviction entered against the holder in another jurisdiction for any substantially equivalent criminal offense, is automatically suspended from practice under this chapter in this state and any certificate or license issued to the holder under this chapter is automatically suspended, as of the date of the guilty plea, conviction, or judicial finding, whether the proceedings are brought in this state or another jurisdiction. Continued practice by an individual after the suspension of the individual's certificate or license under this division shall be considered practicing without a certificate or license. The board shall notify the suspended individual of the suspension of the individual's certificate or license under this division by certified mail or in person in accordance with section 119.07 of the Revised Code. If an individual whose certificate or license is suspended under this division fails to make a timely request for an adjudicatory hearing, the board shall enter a final order revoking the individual's certificate or license.

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

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

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

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

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

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

(H) Sanctions shall not be imposed under division (A)(13)

of this section against any certificate or license holder who waives deductibles and copayments as follows:

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

(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 other identifying information about patients or complainants whose confidentiality was protected by the state dental board when the information was in the board's possession. Measures to ensure confidentiality that may be taken by the court include sealing its records or deleting specific information from its records.

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

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

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

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