

**As Introduced**

**132nd General Assembly  
Regular Session  
2017-2018**

**H. B. No. 156**

**Representative Schuring**

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**A BILL**

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

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

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

**Sec. 1739.05.** (A) A multiple employer welfare arrangement 9  
that is created pursuant to sections 1739.01 to 1739.22 of the 10  
Revised Code and that operates a group self-insurance program 11  
may be established only if any of the following applies: 12

(1) The arrangement has and maintains a minimum enrollment 13  
of three hundred employees of two or more employers. 14

(2) The arrangement has and maintains a minimum enrollment 15  
of three hundred self-employed individuals. 16

(3) The arrangement has and maintains a minimum enrollment 17  
of three hundred employees or self-employed individuals in any 18

combination of divisions (A) (1) and (2) of this section. 19

(B) A multiple employer welfare arrangement that is 20  
created pursuant to sections 1739.01 to 1739.22 of the Revised 21  
Code and that operates a group self-insurance program shall 22  
comply with all laws applicable to self-funded programs in this 23  
state, including sections 3901.04, 3901.041, 3901.19 to 3901.26, 24  
3901.38, 3901.381 to 3901.3814, 3901.40, 3901.45, 3901.46, 25  
3901.491, 3902.01 to 3902.14, 3923.041, 3923.24, 3923.282, 26  
3923.30, 3923.301, 3923.38, 3923.581, 3923.602, 3923.63, 27  
3923.80, 3923.84, 3923.85, 3923.851, 3923.86, 3924.031, 28  
3924.032, and 3924.27 of the Revised Code. 29

(C) A multiple employer welfare arrangement created 30  
pursuant to sections 1739.01 to 1739.22 of the Revised Code 31  
shall solicit enrollments only through agents or solicitors 32  
licensed pursuant to Chapter 3905. of the Revised Code to sell 33  
or solicit sickness and accident insurance. 34

(D) A multiple employer welfare arrangement created 35  
pursuant to sections 1739.01 to 1739.22 of the Revised Code 36  
shall provide benefits only to individuals who are members, 37  
employees of members, or the dependents of members or employees, 38  
or are eligible for continuation of coverage under section 39  
1751.53 or 3923.38 of the Revised Code or under Title X of the 40  
"Consolidated Omnibus Budget Reconciliation Act of 1985," 100 41  
Stat. 227, 29 U.S.C.A. 1161, as amended. 42

(E) A multiple employer welfare arrangement created 43  
pursuant to sections 1739.01 to 1739.22 of the Revised Code is 44  
subject to, and shall comply with, sections 3903.81 to 3903.93 45  
of the Revised Code in the same manner as other life or health 46  
insurers, as defined in section 3903.81 of the Revised Code. 47

Sec. 1751.85. (A) As used in this section, "vision care materials" has the same meaning as in section 3963.01 of the Revised Code. 48  
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(B) Each identification card or other document provided by a health insuring corporation to an enrollee pursuant to section 1751.11 of the Revised Code on or after the effective date of this section as evidence of coverage under an individual or group health insuring corporation policy, contract, or agreement providing coverage for vision care services or vision care materials shall do both of the following: 51  
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(1) Include the following statement: 58

"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." 59  
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(2) Disclose any business interest the health insuring corporation has in a source or supplier of vision care materials. 67  
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(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. 70  
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**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 74  
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meet the health insuring corporation's standards for quality or 77  
utilization in the delivery of health care services, a health 78  
insuring corporation shall give the participating provider 79  
notice of the reason or reasons for its decision to terminate 80  
the provider's participation and an opportunity to take 81  
corrective action. The health insuring corporation shall develop 82  
a performance improvement plan in conjunction with the 83  
participating provider. If after being afforded the opportunity 84  
to comply with the performance improvement plan, the 85  
participating provider fails to do so, the health insuring 86  
corporation may terminate the participation of the provider. 87

(B) (1) A participating provider whose participation has 88  
been terminated under division (A) of this section may appeal 89  
the termination to the appropriate medical director of the 90  
health insuring corporation. The medical director shall give the 91  
participating provider an opportunity to discuss with the 92  
medical director the reason or reasons for the termination. 93

(2) If a satisfactory resolution of a participating 94  
provider's appeal cannot be reached under division (B) (1) of 95  
this section, the participating provider may appeal the 96  
termination to a panel composed of participating providers who 97  
have comparable or higher levels of education and training than 98  
the participating provider making the appeal. A representative 99  
of the participating provider's specialty shall be a member of 100  
the panel, if possible. This panel shall hold a hearing, and 101  
shall render its recommendation in the appeal within thirty days 102  
after holding the hearing. The recommendation shall be presented 103  
to the medical director and to the participating provider. 104

(3) The medical director shall review and consider the 105  
panel's recommendation before making a decision. The decision 106

rendered by the medical director shall be final. 107

(C) A provider's status as a participating provider shall 108  
remain in effect during the appeal process set forth in division 109  
(B) of this section unless the termination was based on any of 110  
the reasons listed in division (D) of this section. 111

(D) Notwithstanding division (A) of this section, a 112  
provider's participation may be immediately terminated if the 113  
participating provider's conduct presents an imminent risk of 114  
harm to an enrollee or enrollees; or if there has occurred 115  
unacceptable quality of care, fraud, patient abuse, loss of 116  
clinical privileges, loss of professional liability coverage, 117  
incompetence, or loss of authority to practice in the 118  
participating provider's field; or if a governmental action has 119  
impaired the participating provider's ability to practice. 120

(E) Divisions (A) to (D) of this section apply only to 121  
providers who are natural persons. 122

(F) (1) Nothing in this section prohibits a health insuring 123  
corporation from rejecting a provider's application for 124  
participation, or from terminating a participating provider's 125  
contract, if the health insuring corporation determines that the 126  
health care needs of its enrollees are being met and no need 127  
exists for the provider's or participating provider's services. 128

(2) Nothing in this section shall be construed as 129  
prohibiting a health insuring corporation from terminating a 130  
participating provider who does not meet the terms and 131  
conditions of the participating provider's contract. 132

(3) Nothing in this section shall be construed as 133  
prohibiting a health insuring corporation from terminating a 134  
participating provider's contract pursuant to any provision of 135

the contract described in division ~~(E)~~(F) (2) of section 3963.02 136  
of the Revised Code, except that, notwithstanding any provision 137  
of a contract described in that division, this section applies 138  
to the termination of a participating provider's contract for 139  
any of the causes described in divisions (A), (D), and (F) (1) 140  
and (2) of this section. 141

(G) The superintendent of insurance may adopt rules as 142  
necessary to implement and enforce sections 1753.06, 1753.07, 143  
and 1753.09 of the Revised Code. Such rules shall be adopted in 144  
accordance with Chapter 119. of the Revised Code. 145

**Sec. 3901.21.** The following are hereby defined as unfair 146  
and deceptive acts or practices in the business of insurance: 147

(A) Making, issuing, circulating, or causing or permitting 148  
to be made, issued, or circulated, or preparing with intent to 149  
so use, any estimate, illustration, circular, or statement 150  
misrepresenting the terms of any policy issued or to be issued 151  
or the benefits or advantages promised thereby or the dividends 152  
or share of the surplus to be received thereon, or making any 153  
false or misleading statements as to the dividends or share of 154  
surplus previously paid on similar policies, or making any 155  
misleading representation or any misrepresentation as to the 156  
financial condition of any insurer as shown by the last 157  
preceding verified statement made by it to the insurance 158  
department of this state, or as to the legal reserve system upon 159  
which any life insurer operates, or using any name or title of 160  
any policy or class of policies misrepresenting the true nature 161  
thereof, or making any misrepresentation or incomplete 162  
comparison to any person for the purpose of inducing or tending 163  
to induce such person to purchase, amend, lapse, forfeit, 164  
change, or surrender insurance. 165

Any written statement concerning the premiums for a policy 166  
which refers to the net cost after credit for an assumed 167  
dividend, without an accurate written statement of the gross 168  
premiums, cash values, and dividends based on the insurer's 169  
current dividend scale, which are used to compute the net cost 170  
for such policy, and a prominent warning that the rate of 171  
dividend is not guaranteed, is a misrepresentation for the 172  
purposes of this division. 173

(B) Making, publishing, disseminating, circulating, or 174  
placing before the public or causing, directly or indirectly, to 175  
be made, published, disseminated, circulated, or placed before 176  
the public, in a newspaper, magazine, or other publication, or 177  
in the form of a notice, circular, pamphlet, letter, or poster, 178  
or over any radio station, or in any other way, or preparing 179  
with intent to so use, an advertisement, announcement, or 180  
statement containing any assertion, representation, or 181  
statement, with respect to the business of insurance or with 182  
respect to any person in the conduct of the person's insurance 183  
business, which is untrue, deceptive, or misleading. 184

(C) Making, publishing, disseminating, or circulating, 185  
directly or indirectly, or aiding, abetting, or encouraging the 186  
making, publishing, disseminating, or circulating, or preparing 187  
with intent to so use, any statement, pamphlet, circular, 188  
article, or literature, which is false as to the financial 189  
condition of an insurer and which is calculated to injure any 190  
person engaged in the business of insurance. 191

(D) Filing with any supervisory or other public official, 192  
or making, publishing, disseminating, circulating, or delivering 193  
to any person, or placing before the public, or causing directly 194  
or indirectly to be made, published, disseminated, circulated, 195

delivered to any person, or placed before the public, any false statement of financial condition of an insurer. 196  
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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. 198  
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(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. 209  
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(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. 215  
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(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 220  
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or indirectly, as inducement to such insurance, or annuity, any 226  
rebate of premiums payable on the contract, or any special favor 227  
or advantage in the dividends or other benefits thereon, or any 228  
valuable consideration or inducement whatever not specified in 229  
the contract; or giving, or selling, or purchasing, or offering 230  
to give, sell, or purchase, as inducement to such insurance or 231  
annuity or in connection therewith, any stocks, bonds, or other 232  
securities, or other obligations of any insurance company or 233  
other corporation, association, or partnership, or any dividends 234  
or profits accrued thereon, or anything of value whatsoever not 235  
specified in the contract. 236

(2) Nothing in division (F) or division (G)(1) of this 237  
section shall be construed as prohibiting any of the following 238  
practices: (a) in the case of any contract of life insurance or 239  
life annuity, paying bonuses to policyholders or otherwise 240  
abating their premiums in whole or in part out of surplus 241  
accumulated from nonparticipating insurance, provided that any 242  
such bonuses or abatement of premiums shall be fair and 243  
equitable to policyholders and for the best interests of the 244  
company and its policyholders; (b) in the case of life insurance 245  
policies issued on the industrial debit plan, making allowance 246  
to policyholders who have continuously for a specified period 247  
made premium payments directly to an office of the insurer in an 248  
amount which fairly represents the saving in collection 249  
expenses; (c) readjustment of the rate of premium for a group 250  
insurance policy based on the loss or expense experience 251  
thereunder, at the end of the first or any subsequent policy 252  
year of insurance thereunder, which may be made retroactive only 253  
for such policy year. 254

(H) Making, issuing, circulating, or causing or permitting 255  
to be made, issued, or circulated, or preparing with intent to 256

so use, any statement to the effect that a policy of life 257  
insurance is, is the equivalent of, or represents shares of 258  
capital stock or any rights or options to subscribe for or 259  
otherwise acquire any such shares in the life insurance company 260  
issuing that policy or any other company. 261

(I) Making, issuing, circulating, or causing or permitting 262  
to be made, issued or circulated, or preparing with intent to so 263  
issue, any statement to the effect that payments to a 264  
policyholder of the principal amounts of a pure endowment are 265  
other than payments of a specific benefit for which specific 266  
premiums have been paid. 267

(J) Making, issuing, circulating, or causing or permitting 268  
to be made, issued, or circulated, or preparing with intent to 269  
so use, any statement to the effect that any insurance company 270  
was required to change a policy form or related material to 271  
comply with Title XXXIX of the Revised Code or any regulation of 272  
the superintendent of insurance, for the purpose of inducing or 273  
intending to induce any policyholder or prospective policyholder 274  
to purchase, amend, lapse, forfeit, change, or surrender 275  
insurance. 276

(K) Aiding or abetting another to violate this section. 277

(L) Refusing to issue any policy of insurance, or 278  
canceling or declining to renew such policy because of the sex 279  
or marital status of the applicant, prospective insured, 280  
insured, or policyholder. 281

(M) Making or permitting any unfair discrimination between 282  
individuals of the same class and of essentially the same hazard 283  
in the amount of premium, policy fees, or rates charged for any 284  
policy or contract of insurance, other than life insurance, or 285

in the benefits payable thereunder, or in underwriting standards 286  
and practices or eligibility requirements, or in any of the 287  
terms or conditions of such contract, or in any other manner 288  
whatever. 289

(N) Refusing to make available disability income insurance 290  
solely because the applicant's principal occupation is that of 291  
managing a household. 292

(O) Refusing, when offering maternity benefits under any 293  
individual or group sickness and accident insurance policy, to 294  
make maternity benefits available to the policyholder for the 295  
individual or individuals to be covered under any comparable 296  
policy to be issued for delivery in this state, including family 297  
members if the policy otherwise provides coverage for family 298  
members. Nothing in this division shall be construed to prohibit 299  
an insurer from imposing a reasonable waiting period for such 300  
benefits under an individual sickness and accident insurance 301  
policy issued to an individual who is not a federally eligible 302  
individual or a nonemployer-related group sickness and accident 303  
insurance policy, but in no event shall such waiting period 304  
exceed two hundred seventy days. 305

For purposes of division (O) of this section, "federally 306  
eligible individual" means an eligible individual as defined in 307  
45 C.F.R. 148.103. 308

(P) Using, or permitting to be used, a pattern settlement 309  
as the basis of any offer of settlement. As used in this 310  
division, "pattern settlement" means a method by which liability 311  
is routinely imputed to a claimant without an investigation of 312  
the particular occurrence upon which the claim is based and by 313  
using a predetermined formula for the assignment of liability 314  
arising out of occurrences of a similar nature. Nothing in this 315

division shall be construed to prohibit an insurer from 316  
determining a claimant's liability by applying formulas or 317  
guidelines to the facts and circumstances disclosed by the 318  
insurer's investigation of the particular occurrence upon which 319  
a claim is based. 320

(Q) Refusing to insure, or refusing to continue to insure, 321  
or limiting the amount, extent, or kind of life or sickness and 322  
accident insurance or annuity coverage available to an 323  
individual, or charging an individual a different rate for the 324  
same coverage solely because of blindness or partial blindness. 325  
With respect to all other conditions, including the underlying 326  
cause of blindness or partial blindness, persons who are blind 327  
or partially blind shall be subject to the same standards of 328  
sound actuarial principles or actual or reasonably anticipated 329  
actuarial experience as are sighted persons. Refusal to insure 330  
includes, but is not limited to, denial by an insurer of 331  
disability insurance coverage on the grounds that the policy 332  
defines "disability" as being presumed in the event that the 333  
eyesight of the insured is lost. However, an insurer may exclude 334  
from coverage disabilities consisting solely of blindness or 335  
partial blindness when such conditions existed at the time the 336  
policy was issued. To the extent that the provisions of this 337  
division may appear to conflict with any provision of section 338  
3999.16 of the Revised Code, this division applies. 339

(R) (1) Directly or indirectly offering to sell, selling, 340  
or delivering, issuing for delivery, renewing, or using or 341  
otherwise marketing any policy of insurance or insurance product 342  
in connection with or in any way related to the grant of a 343  
student loan guaranteed in whole or in part by an agency or 344  
commission of this state or the United States, except insurance 345  
that is required under federal or state law as a condition for 346

obtaining such a loan and the premium for which is included in 347  
the fees and charges applicable to the loan; or, in the case of 348  
an insurer or insurance agent, knowingly permitting any lender 349  
making such loans to engage in such acts or practices in 350  
connection with the insurer's or agent's insurance business. 351

(2) Except in the case of a violation of division (G) of 352  
this section, division (R)(1) of this section does not apply to 353  
either of the following: 354

(a) Acts or practices of an insurer, its agents, 355  
representatives, or employees in connection with the grant of a 356  
guaranteed student loan to its insured or the insured's spouse 357  
or dependent children where such acts or practices take place 358  
more than ninety days after the effective date of the insurance; 359

(b) Acts or practices of an insurer, its agents, 360  
representatives, or employees in connection with the 361  
solicitation, processing, or issuance of an insurance policy or 362  
product covering the student loan borrower or the borrower's 363  
spouse or dependent children, where such acts or practices take 364  
place more than one hundred eighty days after the date on which 365  
the borrower is notified that the student loan was approved. 366

(S) Denying coverage, under any health insurance or health 367  
care policy, contract, or plan providing family coverage, to any 368  
natural or adopted child of the named insured or subscriber 369  
solely on the basis that the child does not reside in the 370  
household of the named insured or subscriber. 371

(T)(1) Using any underwriting standard or engaging in any 372  
other act or practice that, directly or indirectly, due solely 373  
to any health status-related factor in relation to one or more 374  
individuals, does either of the following: 375

(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;	376 377 378 379
(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.	380 381 382 383
(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.	384 385 386
(3) For purposes of division (T) (1) of this section, "health status-related factor" means any of the following:	387 388
(a) Health status;	389
(b) Medical condition, including both physical and mental illnesses;	390 391
(c) Claims experience;	392
(d) Receipt of health care;	393
(e) Medical history;	394
(f) Genetic information;	395
(g) Evidence of insurability, including conditions arising out of acts of domestic violence;	396 397
(h) Disability.	398
(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	399 400 401 402

3924.01 of the Revised Code.	403
(V) Using any program, scheme, device, or other unfair act	404
or practice that, directly or indirectly, causes or results in	405
the placing of coverage for adverse risks with another carrier,	406
as defined in section 3924.01 of the Revised Code.	407
(W) Failing to comply with section 3923.23, 3923.231,	408
3923.232, 3923.233, or 3923.234 of the Revised Code by engaging	409
in any unfair, discriminatory reimbursement practice.	410
(X) Intentionally establishing an unfair premium for, or	411
misrepresenting the cost of, any insurance policy financed under	412
a premium finance agreement of an insurance premium finance	413
company.	414
(Y) (1) (a) Limiting coverage under, refusing to issue,	415
canceling, or refusing to renew, any individual policy or	416
contract of life insurance, or limiting coverage under or	417
refusing to issue any individual policy or contract of health	418
insurance, for the reason that the insured or applicant for	419
insurance is or has been a victim of domestic violence;	420
(b) Adding a surcharge or rating factor to a premium of	421
any individual policy or contract of life or health insurance	422
for the reason that the insured or applicant for insurance is or	423
has been a victim of domestic violence;	424
(c) Denying coverage under, or limiting coverage under,	425
any policy or contract of life or health insurance, for the	426
reason that a claim under the policy or contract arises from an	427
incident of domestic violence;	428
(d) Inquiring, directly or indirectly, of an insured	429
under, or of an applicant for, a policy or contract of life or	430
health insurance, as to whether the insured or applicant is or	431

has been a victim of domestic violence, or inquiring as to 432  
whether the insured or applicant has sought shelter or 433  
protection from domestic violence or has sought medical or 434  
psychological treatment as a victim of domestic violence. 435

(2) Nothing in division (Y) (1) of this section shall be 436  
construed to prohibit an insurer from inquiring as to, or from 437  
underwriting or rating a risk on the basis of, a person's 438  
physical or mental condition, even if the condition has been 439  
caused by domestic violence, provided that all of the following 440  
apply: 441

(a) The insurer routinely considers the condition in 442  
underwriting or in rating risks, and does so in the same manner 443  
for a victim of domestic violence as for an insured or applicant 444  
who is not a victim of domestic violence; 445

(b) The insurer does not refuse to issue any policy or 446  
contract of life or health insurance or cancel or refuse to 447  
renew any policy or contract of life insurance, solely on the 448  
basis of the condition, except where such refusal to issue, 449  
cancellation, or refusal to renew is based on sound actuarial 450  
principles or is related to actual or reasonably anticipated 451  
experience; 452

(c) The insurer does not consider a person's status as 453  
being or as having been a victim of domestic violence, in 454  
itself, to be a physical or mental condition; 455

(d) The underwriting or rating of a risk on the basis of 456  
the condition is not used to evade the intent of division (Y) (1) 457  
of this section, or of any other provision of the Revised Code. 458

(3) (a) Nothing in division (Y) (1) of this section shall be 459  
construed to prohibit an insurer from refusing to issue a policy 460

or contract of life insurance insuring the life of a person who 461  
is or has been a victim of domestic violence if the person who 462  
committed the act of domestic violence is the applicant for the 463  
insurance or would be the owner of the insurance policy or 464  
contract. 465

(b) Nothing in division (Y) (2) of this section shall be 466  
construed to permit an insurer to cancel or refuse to renew any 467  
policy or contract of health insurance in violation of the 468  
"Health Insurance Portability and Accountability Act of 1996," 469  
110 Stat. 1955, 42 U.S.C.A. 300gg-41(b), as amended, or in a 470  
manner that violates or is inconsistent with any provision of 471  
the Revised Code that implements the "Health Insurance 472  
Portability and Accountability Act of 1996." 473

(4) An insurer is immune from any civil or criminal 474  
liability that otherwise might be incurred or imposed as a 475  
result of any action taken by the insurer to comply with 476  
division (Y) of this section. 477

(5) As used in division (Y) of this section, "domestic 478  
violence" means any of the following acts: 479

(a) Knowingly causing or attempting to cause physical harm 480  
to a family or household member; 481

(b) Recklessly causing serious physical harm to a family 482  
or household member; 483

(c) Knowingly causing, by threat of force, a family or 484  
household member to believe that the person will cause imminent 485  
physical harm to the family or household member. 486

For the purpose of division (Y) (5) of this section, 487  
"family or household member" has the same meaning as in section 488  
2919.25 of the Revised Code. 489

Nothing in division (Y) (5) of this section shall be 490  
construed to require, as a condition to the application of 491  
division (Y) of this section, that the act described in division 492  
(Y) (5) of this section be the basis of a criminal prosecution. 493

(Z) Disclosing a coroner's records by an insurer in 494  
violation of section 313.10 of the Revised Code. 495

(AA) Making, issuing, circulating, or causing or 496  
permitting to be made, issued, or circulated any statement or 497  
representation that a life insurance policy or annuity is a 498  
contract for the purchase of funeral goods or services. 499

(BB) With respect to a health care contract as defined in 500  
section 3963.01 of the Revised Code that covers vision services, 501  
as defined in that section, including any of the contract terms 502  
prohibited under or failing to make the disclosures required 503  
under division (E) of section 3963.02 of the Revised Code. 504

(CC) With respect to private passenger automobile 505  
insurance, charging premium rates that are excessive, 506  
inadequate, or unfairly discriminatory, pursuant to division (D) 507  
of section 3937.02 of the Revised Code, based solely on the 508  
location of the residence of the insured. 509

The enumeration in sections 3901.19 to 3901.26 of the 510  
Revised Code of specific unfair or deceptive acts or practices 511  
in the business of insurance is not exclusive or restrictive or 512  
intended to limit the powers of the superintendent of insurance 513  
to adopt rules to implement this section, or to take action 514  
under other sections of the Revised Code. 515

This section does not prohibit the sale of shares of any 516  
investment company registered under the "Investment Company Act 517  
of 1940," 54 Stat. 789, 15 U.S.C.A. 80a-1, as amended, or any 518

policies, annuities, or other contracts described in section 519  
3907.15 of the Revised Code. 520

As used in this section, "estimate," "statement," 521  
"representation," "misrepresentation," "advertisement," or 522  
"announcement" includes oral or written occurrences. 523

Sec. 3923.86. (A) As used in this section, "vision care 524  
materials" has the same meaning as in section 3963.01 of the 525  
Revised Code. 526

(B) Each identification card or other document provided by 527  
a sickness and accident insurer or public employee benefit plan 528  
to an insured on or after the effective date of this section as 529  
evidence of coverage under a policy of individual or group 530  
sickness and accident insurance or a public employee benefit 531  
plan providing coverage for vision care services or vision care 532  
materials shall do both of the following: 533

(1) Include the following statement: 534

"IMPORTANT: If you opt to receive vision care services or 535  
vision care materials that are not covered benefits under this 536  
plan, a participating vision care provider may charge you his or 537  
her normal fee for such services or materials. Prior to 538  
providing you with vision care services or vision care materials 539  
that are not covered benefits, the vision care provider will 540  
provide you with an estimated cost for each service or material 541  
upon your request." 542

(2) Disclose any business interest the insurer or plan has 543  
in a source or supplier of vision care materials. 544

(C) A pattern of continuous or repeated violations of this 545  
section is an unfair and deceptive act or practice in the 546  
business of insurance under sections 3901.19 to 3901.26 of the 547

<u>Revised Code.</u>	548
<b>Sec. 3963.01.</b> As used in this chapter:	549
(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.	550 551 552 553
(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.	554 555 556 557
(C) <u>"Covered vision services" means vision 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.</u>	558 559 560 561 562 563 564 565
<u>(D)</u> "Contracting entity" means any person that has a primary business purpose of contracting with participating providers for the delivery of health care services.	566 567 568
<del>(D)</del> <u>(E)</u> "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.	569 570 571 572 573
<del>(E)</del> <u>(F)</u> "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:	574 575 576

(1) Payment for some, but not all of the procedure codes originally billed by a participating provider;	577 578
(2) Payment for a different procedure code than the procedure code originally billed by a participating provider;	579 580
(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.	581 582 583
<del>(F)</del> <u>(G)</u> "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.	584 585 586 587 588 589 590 591 592 593 594
<del>(G)</del> <u>(H)</u> "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:	595 596 597
(1) "Enrollee" and "subscriber" as defined by section 1751.01 of the Revised Code;	598 599
(2) "Member" as defined by section 1739.01 of the Revised Code;	600 601
(3) "Insured" and "plan member" pursuant to Chapter 3923. of the Revised Code;	602 603
(4) "Beneficiary" as defined by section 3901.38 of the	604

Revised Code. 605

~~(H)~~ (I) "Health care contract" means a contract entered 606  
into, materially amended, or renewed between a contracting 607  
entity and a participating provider for the delivery of basic 608  
health care services, specialty health care services, or 609  
supplemental health care services to enrollees. 610

~~(I)~~ (J) "Health care services" means basic health care 611  
services, specialty health care services, and supplemental 612  
health care services. 613

~~(J)~~ (K) "Material amendment" means an amendment to a 614  
health care contract that decreases the participating provider's 615  
payment or compensation, changes the administrative procedures 616  
in a way that may reasonably be expected to significantly 617  
increase the provider's administrative expenses, or adds a new 618  
product. A material amendment does not include any of the 619  
following: 620

(1) A decrease in payment or compensation resulting solely 621  
from a change in a published fee schedule upon which the payment 622  
or compensation is based and the date of applicability is 623  
clearly identified in the contract; 624

(2) A decrease in payment or compensation that was 625  
anticipated under the terms of the contract, if the amount and 626  
date of applicability of the decrease is clearly identified in 627  
the contract; 628

(3) An administrative change that may significantly 629  
increase the provider's administrative expense, the specific 630  
applicability of which is clearly identified in the contract; 631

(4) Changes to an existing prior authorization, 632  
precertification, notification, or referral program that do not 633

substantially increase the provider's administrative expense; 634

(5) Changes to an edit program or to specific edits if the 635  
participating provider is provided notice of the changes 636  
pursuant to division (A)(1) of section 3963.04 of the Revised 637  
Code and the notice includes information sufficient for the 638  
provider to determine the effect of the change; 639

(6) Changes to a health care contract described in 640  
division (B) of section 3963.04 of the Revised Code. 641

~~(K)~~(L) "Participating provider" means a provider that has 642  
a health care contract with a contracting entity and is entitled 643  
to reimbursement for health care services rendered to an 644  
enrollee under the health care contract. 645

~~(L)~~(M) "Payer" means any person that assumes the 646  
financial risk for the payment of claims under a health care 647  
contract or the reimbursement for health care services provided 648  
to enrollees by participating providers pursuant to a health 649  
care contract. 650

~~(M)~~(N) "Primary enrollee" means a person who is 651  
responsible for making payments for participation in a health 652  
care plan or an enrollee whose employment or other status is the 653  
basis of eligibility for enrollment in a health care plan. 654

~~(N)~~(O) "Procedure codes" includes the American medical 655  
association's current procedural terminology code, the American 656  
dental association's current dental terminology, and the centers 657  
for medicare and medicaid services health care common procedure 658  
coding system. 659

~~(O)~~(P) "Product" means one of the following types of 660  
categories of coverage for which a participating provider may be 661  
obligated to provide health care services pursuant to a health 662

care contract: 663

(1) A health maintenance organization or other product 664  
provided by a health insuring corporation; 665

(2) A preferred provider organization; 666

(3) Medicare; 667

(4) Medicaid; 668

(5) Workers' compensation. 669

~~(P)~~(Q) "Provider" means a physician, podiatrist, dentist, 670  
chiropractor, optometrist, psychologist, physician assistant, 671  
advanced practice registered nurse, occupational therapist, 672  
massage therapist, physical therapist, licensed professional 673  
counselor, licensed professional clinical counselor, hearing aid 674  
dealer, orthotist, prosthetist, home health agency, hospice care 675  
program, pediatric respite care program, or hospital, or a 676  
provider organization or physician-hospital organization that is 677  
acting exclusively as an administrator on behalf of a provider 678  
to facilitate the provider's participation in health care 679  
contracts. "Provider" does not mean a pharmacist, pharmacy, 680  
nursing home, or a provider organization or physician-hospital 681  
organization that leases the provider organization's or 682  
physician-hospital organization's network to a third party or 683  
contracts directly with employers or health and welfare funds. 684

~~(Q)~~(R) "Specialty health care services" has the same 685  
meaning as in section 1751.01 of the Revised Code, except that 686  
it does not include any services listed in division (B) of 687  
section 1751.01 of the Revised Code that are provided by a 688  
pharmacist or a nursing home. 689

~~(R)~~(S) "Supplemental health care services" has the same 690

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

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

(1) A person licensed as an optometrist pursuant to Chapter 4725. of the Revised Code;

(2) A person who holds a certificate under Chapter 4731. of the Revised Code to practice 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 720  
from, the contracting entity or an affiliate or subsidiary of 721  
the contracting entity. 722

(c) The health care contract specifically provides that it 723  
applies to network rental arrangements and states that one 724  
purpose of the contract is selling, renting, or giving the 725  
contracting entity's rights to the services of the participating 726  
provider, including other preferred provider organizations, and 727  
the third party accessing the participating provider's services 728  
is any of the following: 729

(i) A payer or a third-party administrator or other entity 730  
responsible for administering claims on behalf of the payer; 731

(ii) A preferred provider organization or preferred 732  
provider network that receives access to the participating 733  
provider's services pursuant to an arrangement with the 734  
preferred provider organization or preferred provider network in 735  
a contract with the participating provider that is in compliance 736  
with division (A)(1)(c) of this section, and is required to 737  
comply with all of the terms, conditions, and affirmative 738  
obligations to which the originally contracted primary 739  
participating provider network is bound under its contract with 740  
the participating provider, including, but not limited to, 741  
obligations concerning patient steerage and the timeliness and 742  
manner of reimbursement. 743

(iii) An entity that is engaged in the business of 744  
providing electronic claims transport between the contracting 745  
entity and the payer or third-party administrator and complies 746  
with all of the applicable terms, conditions, and affirmative 747  
obligations of the contracting entity's contract with the 748  
participating provider including, but not limited to, 749

obligations concerning patient steerage and the timeliness and 750  
manner of reimbursement. 751

(2) The contracting entity that sells, rents, or gives the 752  
contracting entity's rights to the participating provider's 753  
services pursuant to the contracting entity's health care 754  
contract with the participating provider as provided in division 755  
(A) (1) of this section shall do both of the following: 756

(a) Maintain a web page that contains a listing of third 757  
parties described in divisions (A) (1) (b) and (c) of this section 758  
with whom a contracting entity contracts for the purpose of 759  
selling, renting, or giving the contracting entity's rights to 760  
the services of participating providers that is updated at least 761  
every six months and is accessible to all participating 762  
providers, or maintain a toll-free telephone number accessible 763  
to all participating providers by means of which participating 764  
providers may access the same listing of third parties; 765

(b) Require that the third party accessing the 766  
participating provider's services through the participating 767  
provider's health care contract is obligated to comply with all 768  
of the applicable terms and conditions of the contract, 769  
including, but not limited to, the products for which the 770  
participating provider has agreed to provide services, except 771  
that a payer receiving administrative services from the 772  
contracting entity or its affiliate shall be solely responsible 773  
for payment to the participating provider. 774

(3) Any information disclosed to a participating provider 775  
under this section shall be considered proprietary and shall not 776  
be distributed by the participating provider. 777

(4) Except as provided in division (A) (1) of this section, 778

no entity shall sell, rent, or give a contracting entity's 779  
rights to the participating provider's services pursuant to a 780  
health care contract. 781

(B) (1) No contracting entity shall require, as a condition 782  
of contracting with the contracting entity, that a participating 783  
provider provide services for all of the products offered by the 784  
contracting entity. 785

(2) Division (B) (1) of this section shall not be construed 786  
to do any of the following: 787

(a) Prohibit any participating provider from voluntarily 788  
accepting an offer by a contracting entity to provide health 789  
care services under all of the contracting entity's products; 790

(b) Prohibit any contracting entity from offering any 791  
financial incentive or other form of consideration specified in 792  
the health care contract for a participating provider to provide 793  
health care services under all of the contracting entity's 794  
products; 795

(c) Require any contracting entity to contract with a 796  
participating provider to provide health care services for less 797  
than all of the contracting entity's products if the contracting 798  
entity does not wish to do so. 799

(3) (a) Notwithstanding division (B) (2) of this section, no 800  
contracting entity shall require, as a condition of contracting 801  
with the contracting entity, that the participating provider 802  
accept any future product offering that the contracting entity 803  
makes. 804

(b) If a participating provider refuses to accept any 805  
future product offering that the contracting entity makes, the 806  
contracting entity may terminate the health care contract based 807

on the participating provider's refusal upon written notice to 808  
the participating provider no sooner than one hundred eighty 809  
days after the refusal. 810

(4) Once the contracting entity and the participating 811  
provider have signed the health care contract, it is presumed 812  
that the financial incentive or other form of consideration that 813  
is specified in the health care contract pursuant to division 814  
(B) (2) (b) of this section is the financial incentive or other 815  
form of consideration that was offered by the contracting entity 816  
to induce the participating provider to enter into the contract. 817

(C) No contracting entity shall require, as a condition of 818  
contracting with the contracting entity, that a participating 819  
provider waive or forego any right or benefit expressly 820  
conferred upon a participating provider by state or federal law. 821  
However, this division does not prohibit a contracting entity 822  
from restricting a participating provider's scope of practice 823  
for the services to be provided under the contract. 824

(D) No health care contract shall do any of the following: 825

(1) Prohibit any participating provider from entering into 826  
a health care contract with any other contracting entity; 827

(2) Prohibit any contracting entity from entering into a 828  
health care contract with any other provider; 829

(3) Preclude its use or disclosure for the purpose of 830  
enforcing this chapter or other state or federal law, except 831  
that a health care contract may require that appropriate 832  
measures be taken to preserve the confidentiality of any 833  
proprietary or trade-secret information. 834

(E) (1) No contract or agreement between a contracting 835  
entity and a vision care provider shall do any of the following: 836

(a) Require that a participating vision care provider 837  
accept as payment an amount set by the contracting entity for 838  
vision care services or vision care materials provided to an 839  
enrollee unless the services or materials are covered vision 840  
services; 841

(b) Require that a participating vision care provider 842  
participate in a health care contract as a condition to 843  
participating in any other health care contract; 844

(c) Directly limit a participating vision care provider's 845  
choice of sources and suppliers of vision care materials; 846

(d) Include a provision that prohibits a vision care 847  
provider from describing out-of-network options to an enrollee. 848

(2) A vision care provider recommending an out-of-network 849  
source or supplier of vision care materials to an enrollee shall 850  
notify the enrollee in writing that the source or supplier is 851  
out-of-network and shall inform the enrollee of the cost of 852  
those materials. The vision care provider shall also disclose in 853  
writing to an enrollee any business interest the provider has in 854  
a recommended out-of-network source or supplier utilized by the 855  
enrollee. 856

(3) A vision care provider who chooses not to accept as 857  
payment an amount set by a contracting entity for vision care 858  
services or vision care materials that are not covered vision 859  
services shall do both of the following: 860

(a) Provide an enrollee seeking vision care services or 861  
vision care materials that are not covered vision services with 862  
an estimated cost of those services or materials, upon the 863  
request of the enrollee; 864

(b) Post, in a conspicuous place, a notice stating the 865

following: 866

"IMPORTANT: This vision care provider does not accept the 867  
fee schedule set by your insurer for vision care services and 868  
vision care materials that are not covered benefits under your 869  
plan and instead charges his or her normal fee for those 870  
services and materials. This vision care provider will provide 871  
you with an estimated cost for each non-covered service or 872  
material upon your request." 873

(4) Nothing in division (E) of this section shall do 874  
either of the following: 875

(a) Restrict or limit a contracting entity's determination 876  
of specific amounts of coverage or reimbursement for the use of 877  
network or out-of-network sources or suppliers of vision care 878  
materials as set forth in an enrollee's benefit plan. 879

(b) Restrict or limit a contracting entity's ability to 880  
enter into an agreement with another contracting entity or an 881  
affiliate of another contracting entity. 882

(F) (1) In addition to any other lawful reasons for 883  
terminating a health care contract, a health care contract may 884  
only be terminated under the circumstances described in division 885  
(A) (3) of section 3963.04 of the Revised Code. 886

(2) If the health care contract provides for termination 887  
for cause by either party, the health care contract shall state 888  
the reasons that may be used for termination for cause, which 889  
terms shall be reasonable. Once the contracting entity and the 890  
participating provider have signed the health care contract, it 891  
is presumed that the reasons stated in the health care contract 892  
for termination for cause by either party are reasonable. 893  
Subject to division (E) (3) of this section, the health care 894

contract shall state the time by which the parties must provide 895  
notice of termination for cause and to whom the parties shall 896  
give the notice. 897

(3) Nothing in divisions ~~(E)~~(F)(1) and (2) of this section 898  
shall be construed as prohibiting any health insuring 899  
corporation from terminating a participating provider's contract 900  
for any of the causes described in divisions (A), (D), and (F) 901  
(1) and (2) of section 1753.09 of the Revised Code. 902  
Notwithstanding any provision in a health care contract pursuant 903  
to division ~~(E)~~(F)(2) of this section, section 1753.09 of the 904  
Revised Code applies to the termination of a participating 905  
provider's contract for any of the causes described in divisions 906  
(A), (D), and (F)(1) and (2) of section 1753.09 of the Revised 907  
Code. 908

(4) Subject to sections 3963.01 to 3963.11 of the Revised 909  
Code, nothing in this section prohibits the termination of a 910  
health care contract without cause if the health care contract 911  
otherwise provides for termination without cause. 912

~~(F)~~(G)(1) Disputes among parties to a health care contract 913  
that only concern the enforcement of the contract rights 914  
conferred by section 3963.02, divisions (A) and (D) of section 915  
3963.03, and section 3963.04 of the Revised Code are subject to 916  
a mutually agreed upon arbitration mechanism that is binding on 917  
all parties. The arbitrator may award reasonable attorney's fees 918  
and costs for arbitration relating to the enforcement of this 919  
section to the prevailing party. 920

(2) The arbitrator shall make the arbitrator's decision in 921  
an arbitration proceeding having due regard for any applicable 922  
rules, bulletins, rulings, or decisions issued by the department 923  
of insurance or any court concerning the enforcement of the 924

contract rights conferred by section 3963.02, divisions (A) and 925  
(D) of section 3963.03, and section 3963.04 of the Revised Code. 926

(3) A party shall not simultaneously maintain an 927  
arbitration proceeding as described in division ~~(F)~~(G)(1) of 928  
this section and pursue a complaint with the superintendent of 929  
insurance to investigate the subject matter of the arbitration 930  
proceeding. However, if a complaint is filed with the department 931  
of insurance, the superintendent may choose to investigate the 932  
complaint or, after reviewing the complaint, advise the 933  
complainant to proceed with arbitration to resolve the 934  
complaint. The superintendent may request to receive a copy of 935  
the results of the arbitration. If the superintendent of 936  
insurance notifies an insurer or a health insuring corporation 937  
in writing that the superintendent has initiated a market 938  
conduct examination into the specific subject matter of the 939  
arbitration proceeding pending against that insurer or health 940  
insuring corporation, the arbitration proceeding shall be stayed 941  
at the request of the insurer or health insuring corporation 942  
pending the outcome of the market conduct investigation by the 943  
superintendent. 944

**Sec. 3963.03.** (A) Each health care contract shall include 945  
all of the following information: 946

(1) (a) Information sufficient for the participating 947  
provider to determine the compensation or payment terms for 948  
health care services, including all of the following, subject to 949  
division (A) (1) (b) of this section: 950

(i) The manner of payment, such as fee-for-service, 951  
capitation, or risk; 952

(ii) The fee schedule of procedure codes reasonably 953

expected to be billed by a participating provider's specialty 954  
for services provided pursuant to the health care contract and 955  
the associated payment or compensation for each procedure code. 956  
A fee schedule may be provided electronically. Upon request, a 957  
contracting entity shall provide a participating provider with 958  
the fee schedule for any other procedure codes requested and a 959  
written fee schedule, that shall not be required more frequently 960  
than twice per year excluding when it is provided in connection 961  
with any change to the schedule. This requirement may be 962  
satisfied by providing a clearly understandable, readily 963  
available mechanism, such as a specific web site address, that 964  
allows a participating provider to determine the effect of 965  
procedure codes on payment or compensation before a service is 966  
provided or a claim is submitted. 967

(iii) The effect, if any, on payment or compensation if 968  
more than one procedure code applies to the service also shall 969  
be stated. This requirement may be satisfied by providing a 970  
clearly understandable, readily available mechanism, such as a 971  
specific web site address, that allows a participating provider 972  
to determine the effect of procedure codes on payment or 973  
compensation before a service is provided or a claim is 974  
submitted. 975

(b) If the contracting entity is unable to include the 976  
information described in ~~division~~ divisions (A) (1) (a) (ii) and 977  
(iii) of this section, the contracting entity shall include both 978  
of the following types of information instead: 979

(i) The methodology used to calculate any fee schedule, 980  
such as relative value unit system and conversion factor or 981  
percentage of billed charges. If applicable, the methodology 982  
disclosure shall include the name of any relative value unit 983

system, its version, edition, or publication date, any	984
applicable conversion or geographic factor, and any date by	985
which compensation or fee schedules may be changed by the	986
methodology as anticipated at the time of contract.	987
(ii) The identity of any internal processing edits,	988
including the publisher, product name, version, and version	989
update of any editing software.	990
(c) If the contracting entity is not the payer and is	991
unable to include the information described in division (A) (1)	992
(a) or (b) of this section, then the contracting entity shall	993
provide by telephone a readily available mechanism, such as a	994
specific web site address, that allows the participating	995
provider to obtain that information from the payer.	996
(2) Any product or network for which the participating	997
provider is to provide services;	998
(3) The term of the health care contract;	999
(4) A specific web site address that contains the identity	1000
of the contracting entity or payer responsible for the	1001
processing of the participating provider's compensation or	1002
payment;	1003
(5) Any internal mechanism provided by the contracting	1004
entity to resolve disputes concerning the interpretation or	1005
application of the terms and conditions of the contract. A	1006
contracting entity may satisfy this requirement by providing a	1007
clearly understandable, readily available mechanism, such as a	1008
specific web site address or an appendix, that allows a	1009
participating provider to determine the procedures for the	1010
internal mechanism to resolve those disputes.	1011
(6) A list of addenda, if any, to the contract.	1012

(B) (1) Each contracting entity shall include a summary 1013  
disclosure form with a health care contract that includes all of 1014  
the information specified in division (A) of this section. The 1015  
information in the summary disclosure form shall refer to the 1016  
location in the health care contract, whether a page number, 1017  
section of the contract, appendix, or other identifiable 1018  
location, that specifies the provisions in the contract to which 1019  
the information in the form refers. 1020

(2) The summary disclosure form shall include all of the 1021  
following statements: 1022

(a) That the form is a guide to the health care contract 1023  
and that the terms and conditions of the health care contract 1024  
constitute the contract rights of the parties; 1025

(b) That reading the form is not a substitute for reading 1026  
the entire health care contract; 1027

(c) That by signing the health care contract, the 1028  
participating provider will be bound by the contract's terms and 1029  
conditions; 1030

(d) That the terms and conditions of the health care 1031  
contract may be amended pursuant to section 3963.04 of the 1032  
Revised Code and the participating provider is encouraged to 1033  
carefully read any proposed amendments sent after execution of 1034  
the contract; 1035

(e) That nothing in the summary disclosure form creates 1036  
any additional rights or causes of action in favor of either 1037  
party. 1038

(3) No contracting entity that includes any information in 1039  
the summary disclosure form with the reasonable belief that the 1040  
information is truthful or accurate shall be subject to a civil 1041

action for damages or to binding arbitration based on the 1042  
summary disclosure form. Division (B)(3) of this section does 1043  
not impair or affect any power of the department of insurance to 1044  
enforce any applicable law. 1045

(4) The summary disclosure form described in divisions (B) 1046  
(1) and (2) of this section shall be in substantially the 1047  
following form: 1048

"SUMMARY DISCLOSURE FORM 1049

(1) Compensation terms 1050

(a) Manner of payment 1051

[ ] Fee for service 1052

[ ] Capitation 1053

[ ] Risk 1054

[ ] Other ..... See ..... 1055

(b) Fee schedule available at ..... 1056

(c) Fee calculation schedule available at ..... 1057

(d) Identity of internal processing edits available 1058  
at ..... 1059

(e) Information in (c) and (d) is not required if 1060  
information in (b) is provided. 1061

(2) List of products or networks covered by this contract 1062

[ ] ..... 1063

[ ] ..... 1064

[ ] ..... 1065

[ ] .....	1066
[ ] .....	1067
(3) Term of this contract .....	1068
(4) Contracting entity or payer responsible for processing payment available at .....	1069 1070
(5) Internal mechanism for resolving disputes regarding contract terms available at .....	1071 1072
(6) Addenda to contract	1073
Title                  Subject	1074
(a)	1075
(b)	1076
(c)	1077
(d)	1078
(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.	1079 1080 1081 1082
IMPORTANT INFORMATION - PLEASE READ CAREFULLY	1083
The information provided in this Summary Disclosure Form is a guide to the attached Health Care Contract as defined in section <del>3963.01(G)</del> <u>3963.01(I)</u> of the Ohio Revised Code. The terms and conditions of the attached Health Care Contract constitute the contract rights of the parties.	1084 1085 1086 1087 1088
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	1089 1090 1091

conditions. These terms and conditions may be amended over time 1092  
pursuant to section 3963.04 of the Ohio Revised Code. You are 1093  
encouraged to read any proposed amendments that are sent to you 1094  
after execution of the Health Care Contract. 1095

Nothing in this Summary Disclosure Form creates any 1096  
additional rights or causes of action in favor of either party." 1097

(C) When a contracting entity presents a proposed health 1098  
care contract for consideration by a provider, the contracting 1099  
entity shall provide in writing or make reasonably available the 1100  
information required in division (A)(1) of this section. 1101

(D) The contracting entity shall identify any utilization 1102  
management, quality improvement, or a similar program that the 1103  
contracting entity uses to review, monitor, evaluate, or assess 1104  
the services provided pursuant to a health care contract. The 1105  
contracting entity shall disclose the policies, procedures, or 1106  
guidelines of such a program applicable to a participating 1107  
provider upon request by the participating provider within 1108  
fourteen days after the date of the request. 1109

(E) Nothing in this section shall be construed as 1110  
preventing or affecting the application of section 1753.07 of 1111  
the Revised Code that would otherwise apply to a contract with a 1112  
participating provider. 1113

(F) The requirements of division (C) of this section do 1114  
not prohibit a contracting entity from requiring a reasonable 1115  
confidentiality agreement between the provider and the 1116  
contracting entity regarding the terms of the proposed health 1117  
care contract. If either party violates the confidentiality 1118  
agreement, a party to the confidentiality agreement may bring a 1119  
civil action to enjoin the other party from continuing any act 1120

that is in violation of the confidentiality agreement, to 1121  
recover damages, to terminate the contract, or to obtain any 1122  
combination of relief. 1123

**Section 2.** That existing sections 1739.05, 1753.09, 1124  
3901.21, 3963.01, 3963.02, and 3963.03 of the Revised Code are 1125  
hereby repealed. 1126

**Section 3.** The following represent the General Assembly's 1127  
intent and findings: 1128

(A) The provisions of this act seek to prevent health 1129  
insuring corporations, vision insurers, vision benefit plans, 1130  
and other contracting entities from establishing fee limitations 1131  
on services and vision care materials that are not covered 1132  
vision services for enrollees under an insurance plan. 1133

(B) Strategies by health insuring corporations, vision 1134  
insurers, vision benefit plans, and other contracting entities 1135  
to adopt or impose a deductible, copayment, coinsurance, or any 1136  
other requirement in such a way as to provide de minimis 1137  
reimbursement for services or vision care materials as a method 1138  
to avoid the impact of this law is contrary to the spirit and 1139  
intent of the General Assembly. 1140

**Section 4.** Section 1739.05 of the Revised Code is 1141  
presented in this act as a composite of the section as amended 1142  
by both Sub. H.B. 463 and Sub. S.B. 319 of the 131st General 1143  
Assembly. The General Assembly, applying the principle stated in 1144  
division (B) of section 1.52 of the Revised Code that amendments 1145  
are to be harmonized if reasonably capable of simultaneous 1146  
operation, finds that the composite is the resulting version of 1147  
the section in effect prior to the effective date of the section 1148  
as presented in this act. 1149