

**As Introduced**

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**H. B. No. 275**

**Representative Schuring**

**Cosponsors: Representatives Ruhl, Smith, K., Blessing, Hood, Vitale**

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**A BILL**

To amend sections 1739.05, 1753.07, 1753.09, 1  
3901.21, 3963.01, 3963.02, and 3963.03 and to 2  
enact sections 1751.72 and 3923.84 of the 3  
Revised Code regarding limitations imposed by 4  
health insurers on vision care services. 5

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

**Section 1.** That sections 1739.05, 1753.07, 1753.09, 6  
3901.21, 3963.01, 3963.02, and 3963.03 be amended and sections 7  
1751.72 and 3923.84 of the Revised Code be enacted to read as 8  
follows: 9

**Sec. 1739.05.** (A) A multiple employer welfare arrangement 10  
that is created pursuant to sections 1739.01 to 1739.22 of the 11  
Revised Code and that operates a group self-insurance program 12  
may be established only if any of the following applies: 13

(1) The arrangement has and maintains a minimum enrollment 14  
of three hundred employees of two or more employers. 15

(2) The arrangement has and maintains a minimum enrollment 16  
of three hundred self-employed individuals. 17

(3) The arrangement has and maintains a minimum enrollment 18  
of three hundred employees or self-employed individuals in any 19  
combination of divisions (A) (1) and (2) of this section. 20

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

Sec. 1751.72. (A) As used in this section, "vision care 43  
materials" and "vision care provider" have the same meanings as 44  
in section 3963.01 of the Revised Code. 45

(B) No group health insuring corporation policy, contract, 46

or agreement providing coverage for vision care materials that 47  
is delivered, issued for delivery, or renewed in this state 48  
shall directly or indirectly limit or influence an enrollee's 49  
choice of sources and suppliers of vision care materials through 50  
its coverage practices or otherwise. 51

(C) No contract or agreement between a vision care 52  
provider and a health insuring corporation shall directly or 53  
indirectly influence an enrollee's or vision care provider's 54  
choice of sources and suppliers of vision care materials through 55  
its reimbursement policies or otherwise. 56

(D) A violation of this section is an unfair and deceptive 57  
act or practice in the business of insurance under sections 58  
3901.19 to 3901.26 of the Revised Code. 59

**Sec. 1753.07.** (A) (1) Prior to entering into a 60  
participation contract with a provider under section 1751.13 of 61  
the Revised Code, a health insuring corporation shall disclose 62  
basic information regarding its programs and procedures to the 63  
provider. The information shall include all of the following: 64

(a) How a participating provider is reimbursed for the 65  
participating provider's services, including the range and 66  
structure of any financial risk sharing arrangements, a 67  
description of any incentive plans, and, if reimbursed according 68  
to a type of fee-for-service arrangement, the level of 69  
reimbursement for the participating provider's services; 70

(b) Insofar as division (A) (1) of section 3963.03 of the 71  
Revised Code is applicable, all of the information that is 72  
described in that division and is not included in division (A) 73  
(1) (a) of this section. 74

(2) Prior to entering into a participation contract with a 75

provider under section 1751.13 of the Revised Code, a health 76  
insuring corporation shall disclose the following information 77  
upon the provider's request: 78

(a) How referrals to other participating providers or to 79  
nonparticipating providers are made; 80

(b) The availability of dispute resolution procedures and 81  
the potential for cost to be incurred; 82

(c) How a participating provider's name and address will 83  
be used in marketing materials. 84

(B) A health insuring corporation shall provide all of the 85  
following to a participating provider: 86

(1) Any material incorporated by reference into the 87  
participation contract, that is not otherwise available as a 88  
public record, if such material affects the participating 89  
provider; 90

(2) Administrative manuals related to provider 91  
participation, if any; 92

(3) Insofar as division (B) of section 3963.03 of the 93  
Revised Code is applicable, the summary disclosure form with the 94  
disclosures required under that division; 95

(4) A signed and dated copy of the final participation 96  
contract. 97

(C) ~~Nothing~~ Except as otherwise provided in division (E) 98  
of section 3963.02 of the Revised Code, nothing in this section 99  
requires a health insuring corporation providing specialty 100  
health care services or supplemental health care services to 101  
disclose the health insuring corporation's aggregate maximum 102  
allowable fee table used to determine providers' fees or fee 103

schedules. 104

**Sec. 1753.09.** (A) Except as provided in division (D) of 105  
this section, prior to terminating the participation of a 106  
provider on the basis of the participating provider's failure to 107  
meet the health insuring corporation's standards for quality or 108  
utilization in the delivery of health care services, a health 109  
insuring corporation shall give the participating provider 110  
notice of the reason or reasons for its decision to terminate 111  
the provider's participation and an opportunity to take 112  
corrective action. The health insuring corporation shall develop 113  
a performance improvement plan in conjunction with the 114  
participating provider. If after being afforded the opportunity 115  
to comply with the performance improvement plan, the 116  
participating provider fails to do so, the health insuring 117  
corporation may terminate the participation of the provider. 118

(B) (1) A participating provider whose participation has 119  
been terminated under division (A) of this section may appeal 120  
the termination to the appropriate medical director of the 121  
health insuring corporation. The medical director shall give the 122  
participating provider an opportunity to discuss with the 123  
medical director the reason or reasons for the termination. 124

(2) If a satisfactory resolution of a participating 125  
provider's appeal cannot be reached under division (B) (1) of 126  
this section, the participating provider may appeal the 127  
termination to a panel composed of participating providers who 128  
have comparable or higher levels of education and training than 129  
the participating provider making the appeal. A representative 130  
of the participating provider's specialty shall be a member of 131  
the panel, if possible. This panel shall hold a hearing, and 132  
shall render its recommendation in the appeal within thirty days 133

after holding the hearing. The recommendation shall be presented 134  
to the medical director and to the participating provider. 135

(3) The medical director shall review and consider the 136  
panel's recommendation before making a decision. The decision 137  
rendered by the medical director shall be final. 138

(C) A provider's status as a participating provider shall 139  
remain in effect during the appeal process set forth in division 140  
(B) of this section unless the termination was based on any of 141  
the reasons listed in division (D) of this section. 142

(D) Notwithstanding division (A) of this section, a 143  
provider's participation may be immediately terminated if the 144  
participating provider's conduct presents an imminent risk of 145  
harm to an enrollee or enrollees; or if there has occurred 146  
unacceptable quality of care, fraud, patient abuse, loss of 147  
clinical privileges, loss of professional liability coverage, 148  
incompetence, or loss of authority to practice in the 149  
participating provider's field; or if a governmental action has 150  
impaired the participating provider's ability to practice. 151

(E) Divisions (A) to (D) of this section apply only to 152  
providers who are natural persons. 153

(F) (1) Nothing in this section prohibits a health insuring 154  
corporation from rejecting a provider's application for 155  
participation, or from terminating a participating provider's 156  
contract, if the health insuring corporation determines that the 157  
health care needs of its enrollees are being met and no need 158  
exists for the provider's or participating provider's services. 159

(2) Nothing in this section shall be construed as 160  
prohibiting a health insuring corporation from terminating a 161  
participating provider who does not meet the terms and 162

conditions of the participating provider's contract. 163

(3) Nothing in this section shall be construed as 164  
prohibiting a health insuring corporation from terminating a 165  
participating provider's contract pursuant to any provision of 166  
the contract described in division ~~(E)~~(F) (2) of section 3963.02 167  
of the Revised Code, except that, notwithstanding any provision 168  
of a contract described in that division, this section applies 169  
to the termination of a participating provider's contract for 170  
any of the causes described in divisions (A), (D), and (F) (1) 171  
and (2) of this section. 172

(G) The superintendent of insurance may adopt rules as 173  
necessary to implement and enforce sections 1753.06, 1753.07, 174  
and 1753.09 of the Revised Code. Such rules shall be adopted in 175  
accordance with Chapter 119. of the Revised Code. 176

**Sec. 3901.21.** The following are hereby defined as unfair 177  
and deceptive acts or practices in the business of insurance: 178

(A) Making, issuing, circulating, or causing or permitting 179  
to be made, issued, or circulated, or preparing with intent to 180  
so use, any estimate, illustration, circular, or statement 181  
misrepresenting the terms of any policy issued or to be issued 182  
or the benefits or advantages promised thereby or the dividends 183  
or share of the surplus to be received thereon, or making any 184  
false or misleading statements as to the dividends or share of 185  
surplus previously paid on similar policies, or making any 186  
misleading representation or any misrepresentation as to the 187  
financial condition of any insurer as shown by the last 188  
preceding verified statement made by it to the insurance 189  
department of this state, or as to the legal reserve system upon 190  
which any life insurer operates, or using any name or title of 191  
any policy or class of policies misrepresenting the true nature 192

thereof, or making any misrepresentation or incomplete 193  
comparison to any person for the purpose of inducing or tending 194  
to induce such person to purchase, amend, lapse, forfeit, 195  
change, or surrender insurance. 196

Any written statement concerning the premiums for a policy 197  
which refers to the net cost after credit for an assumed 198  
dividend, without an accurate written statement of the gross 199  
premiums, cash values, and dividends based on the insurer's 200  
current dividend scale, which are used to compute the net cost 201  
for such policy, and a prominent warning that the rate of 202  
dividend is not guaranteed, is a misrepresentation for the 203  
purposes of this division. 204

(B) Making, publishing, disseminating, circulating, or 205  
placing before the public or causing, directly or indirectly, to 206  
be made, published, disseminated, circulated, or placed before 207  
the public, in a newspaper, magazine, or other publication, or 208  
in the form of a notice, circular, pamphlet, letter, or poster, 209  
or over any radio station, or in any other way, or preparing 210  
with intent to so use, an advertisement, announcement, or 211  
statement containing any assertion, representation, or 212  
statement, with respect to the business of insurance or with 213  
respect to any person in the conduct of the person's insurance 214  
business, which is untrue, deceptive, or misleading. 215

(C) Making, publishing, disseminating, or circulating, 216  
directly or indirectly, or aiding, abetting, or encouraging the 217  
making, publishing, disseminating, or circulating, or preparing 218  
with intent to so use, any statement, pamphlet, circular, 219  
article, or literature, which is false as to the financial 220  
condition of an insurer and which is calculated to injure any 221  
person engaged in the business of insurance. 222



(D) Filing with any supervisory or other public official, 223  
or making, publishing, disseminating, circulating, or delivering 224  
to any person, or placing before the public, or causing directly 225  
or indirectly to be made, published, disseminated, circulated, 226  
delivered to any person, or placed before the public, any false 227  
statement of financial condition of an insurer. 228

Making any false entry in any book, report, or statement 229  
of any insurer with intent to deceive any agent or examiner 230  
lawfully appointed to examine into its condition or into any of 231  
its affairs, or any public official to whom such insurer is 232  
required by law to report, or who has authority by law to 233  
examine into its condition or into any of its affairs, or, with 234  
like intent, willfully omitting to make a true entry of any 235  
material fact pertaining to the business of such insurer in any 236  
book, report, or statement of such insurer, or mutilating, 237  
destroying, suppressing, withholding, or concealing any of its 238  
records. 239

(E) Issuing or delivering or permitting agents, officers, 240  
or employees to issue or deliver agency company stock or other 241  
capital stock or benefit certificates or shares in any common- 242  
law corporation or securities or any special or advisory board 243  
contracts or other contracts of any kind promising returns and 244  
profits as an inducement to insurance. 245

(F) Making or permitting any unfair discrimination among 246  
individuals of the same class and equal expectation of life in 247  
the rates charged for any contract of life insurance or of life 248  
annuity or in the dividends or other benefits payable thereon, 249  
or in any other of the terms and conditions of such contract. 250

(G) (1) Except as otherwise expressly provided by law, 251  
knowingly permitting or offering to make or making any contract 252

of life insurance, life annuity or accident and health 253  
insurance, or agreement as to such contract other than as 254  
plainly expressed in the contract issued thereon, or paying or 255  
allowing, or giving or offering to pay, allow, or give, directly 256  
or indirectly, as inducement to such insurance, or annuity, any 257  
rebate of premiums payable on the contract, or any special favor 258  
or advantage in the dividends or other benefits thereon, or any 259  
valuable consideration or inducement whatever not specified in 260  
the contract; or giving, or selling, or purchasing, or offering 261  
to give, sell, or purchase, as inducement to such insurance or 262  
annuity or in connection therewith, any stocks, bonds, or other 263  
securities, or other obligations of any insurance company or 264  
other corporation, association, or partnership, or any dividends 265  
or profits accrued thereon, or anything of value whatsoever not 266  
specified in the contract. 267

(2) Nothing in division (F) or division (G)(1) of this 268  
section shall be construed as prohibiting any of the following 269  
practices: (a) in the case of any contract of life insurance or 270  
life annuity, paying bonuses to policyholders or otherwise 271  
abating their premiums in whole or in part out of surplus 272  
accumulated from nonparticipating insurance, provided that any 273  
such bonuses or abatement of premiums shall be fair and 274  
equitable to policyholders and for the best interests of the 275  
company and its policyholders; (b) in the case of life insurance 276  
policies issued on the industrial debit plan, making allowance 277  
to policyholders who have continuously for a specified period 278  
made premium payments directly to an office of the insurer in an 279  
amount which fairly represents the saving in collection 280  
expenses; (c) readjustment of the rate of premium for a group 281  
insurance policy based on the loss or expense experience 282  
thereunder, at the end of the first or any subsequent policy 283

year of insurance thereunder, which may be made retroactive only 284  
for such policy year. 285

(H) Making, issuing, circulating, or causing or permitting 286  
to be made, issued, or circulated, or preparing with intent to 287  
so use, any statement to the effect that a policy of life 288  
insurance is, is the equivalent of, or represents shares of 289  
capital stock or any rights or options to subscribe for or 290  
otherwise acquire any such shares in the life insurance company 291  
issuing that policy or any other company. 292

(I) Making, issuing, circulating, or causing or permitting 293  
to be made, issued or circulated, or preparing with intent to so 294  
issue, any statement to the effect that payments to a 295  
policyholder of the principal amounts of a pure endowment are 296  
other than payments of a specific benefit for which specific 297  
premiums have been paid. 298

(J) Making, issuing, circulating, or causing or permitting 299  
to be made, issued, or circulated, or preparing with intent to 300  
so use, any statement to the effect that any insurance company 301  
was required to change a policy form or related material to 302  
comply with Title XXXIX of the Revised Code or any regulation of 303  
the superintendent of insurance, for the purpose of inducing or 304  
intending to induce any policyholder or prospective policyholder 305  
to purchase, amend, lapse, forfeit, change, or surrender 306  
insurance. 307

(K) Aiding or abetting another to violate this section. 308

(L) Refusing to issue any policy of insurance, or 309  
canceling or declining to renew such policy because of the sex 310  
or marital status of the applicant, prospective insured, 311  
insured, or policyholder. 312

(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 343  
the particular occurrence upon which the claim is based and by 344  
using a predetermined formula for the assignment of liability 345  
arising out of occurrences of a similar nature. Nothing in this 346  
division shall be construed to prohibit an insurer from 347  
determining a claimant's liability by applying formulas or 348  
guidelines to the facts and circumstances disclosed by the 349  
insurer's investigation of the particular occurrence upon which 350  
a claim is based. 351

(Q) Refusing to insure, or refusing to continue to insure, 352  
or limiting the amount, extent, or kind of life or sickness and 353  
accident insurance or annuity coverage available to an 354  
individual, or charging an individual a different rate for the 355  
same coverage solely because of blindness or partial blindness. 356  
With respect to all other conditions, including the underlying 357  
cause of blindness or partial blindness, persons who are blind 358  
or partially blind shall be subject to the same standards of 359  
sound actuarial principles or actual or reasonably anticipated 360  
actuarial experience as are sighted persons. Refusal to insure 361  
includes, but is not limited to, denial by an insurer of 362  
disability insurance coverage on the grounds that the policy 363  
defines "disability" as being presumed in the event that the 364  
eyesight of the insured is lost. However, an insurer may exclude 365  
from coverage disabilities consisting solely of blindness or 366  
partial blindness when such conditions existed at the time the 367  
policy was issued. To the extent that the provisions of this 368  
division may appear to conflict with any provision of section 369  
3999.16 of the Revised Code, this division applies. 370

(R) (1) Directly or indirectly offering to sell, selling, 371  
or delivering, issuing for delivery, renewing, or using or 372  
otherwise marketing any policy of insurance or insurance product 373

in connection with or in any way related to the grant of a 374  
student loan guaranteed in whole or in part by an agency or 375  
commission of this state or the United States, except insurance 376  
that is required under federal or state law as a condition for 377  
obtaining such a loan and the premium for which is included in 378  
the fees and charges applicable to the loan; or, in the case of 379  
an insurer or insurance agent, knowingly permitting any lender 380  
making such loans to engage in such acts or practices in 381  
connection with the insurer's or agent's insurance business. 382

(2) Except in the case of a violation of division (G) of 383  
this section, division (R)(1) of this section does not apply to 384  
either of the following: 385

(a) Acts or practices of an insurer, its agents, 386  
representatives, or employees in connection with the grant of a 387  
guaranteed student loan to its insured or the insured's spouse 388  
or dependent children where such acts or practices take place 389  
more than ninety days after the effective date of the insurance; 390

(b) Acts or practices of an insurer, its agents, 391  
representatives, or employees in connection with the 392  
solicitation, processing, or issuance of an insurance policy or 393  
product covering the student loan borrower or the borrower's 394  
spouse or dependent children, where such acts or practices take 395  
place more than one hundred eighty days after the date on which 396  
the borrower is notified that the student loan was approved. 397

(S) Denying coverage, under any health insurance or health 398  
care policy, contract, or plan providing family coverage, to any 399  
natural or adopted child of the named insured or subscriber 400  
solely on the basis that the child does not reside in the 401  
household of the named insured or subscriber. 402

(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; 459

(d) Inquiring, directly or indirectly, of an insured 460  
under, or of an applicant for, a policy or contract of life or 461  
health insurance, as to whether the insured or applicant is or 462  
has been a victim of domestic violence, or inquiring as to 463  
whether the insured or applicant has sought shelter or 464  
protection from domestic violence or has sought medical or 465  
psychological treatment as a victim of domestic violence. 466

(2) Nothing in division (Y) (1) of this section shall be 467  
construed to prohibit an insurer from inquiring as to, or from 468  
underwriting or rating a risk on the basis of, a person's 469  
physical or mental condition, even if the condition has been 470  
caused by domestic violence, provided that all of the following 471  
apply: 472

(a) The insurer routinely considers the condition in 473  
underwriting or in rating risks, and does so in the same manner 474  
for a victim of domestic violence as for an insured or applicant 475  
who is not a victim of domestic violence; 476

(b) The insurer does not refuse to issue any policy or 477  
contract of life or health insurance or cancel or refuse to 478  
renew any policy or contract of life insurance, solely on the 479  
basis of the condition, except where such refusal to issue, 480  
cancellation, or refusal to renew is based on sound actuarial 481  
principles or is related to actual or reasonably anticipated 482  
experience; 483

(c) The insurer does not consider a person's status as 484  
being or as having been a victim of domestic violence, in 485  
itself, to be a physical or mental condition; 486

(d) The underwriting or rating of a risk on the basis of 487

the condition is not used to evade the intent of division (Y) (1) 488  
of this section, or of any other provision of the Revised Code. 489

(3) (a) Nothing in division (Y) (1) of this section shall be 490  
construed to prohibit an insurer from refusing to issue a policy 491  
or contract of life insurance insuring the life of a person who 492  
is or has been a victim of domestic violence if the person who 493  
committed the act of domestic violence is the applicant for the 494  
insurance or would be the owner of the insurance policy or 495  
contract. 496

(b) Nothing in division (Y) (2) of this section shall be 497  
construed to permit an insurer to cancel or refuse to renew any 498  
policy or contract of health insurance in violation of the 499  
"Health Insurance Portability and Accountability Act of 1996," 500  
110 Stat. 1955, 42 U.S.C.A. 300gg-41(b), as amended, or in a 501  
manner that violates or is inconsistent with any provision of 502  
the Revised Code that implements the "Health Insurance 503  
Portability and Accountability Act of 1996." 504

(4) An insurer is immune from any civil or criminal 505  
liability that otherwise might be incurred or imposed as a 506  
result of any action taken by the insurer to comply with 507  
division (Y) of this section. 508

(5) As used in division (Y) of this section, "domestic 509  
violence" means any of the following acts: 510

(a) Knowingly causing or attempting to cause physical harm 511  
to a family or household member; 512

(b) Recklessly causing serious physical harm to a family 513  
or household member; 514

(c) Knowingly causing, by threat of force, a family or 515  
household member to believe that the person will cause imminent 516

physical harm to the family or household member. 517

For the purpose of division (Y) (5) of this section, 518  
"family or household member" has the same meaning as in section 519  
2919.25 of the Revised Code. 520

Nothing in division (Y) (5) of this section shall be 521  
construed to require, as a condition to the application of 522  
division (Y) of this section, that the act described in division 523  
(Y) (5) of this section be the basis of a criminal prosecution. 524

(Z) Disclosing a coroner's records by an insurer in 525  
violation of section 313.10 of the Revised Code. 526

(AA) Making, issuing, circulating, or causing or 527  
permitting to be made, issued, or circulated any statement or 528  
representation that a life insurance policy or annuity is a 529  
contract for the purchase of funeral goods or services. 530

(BB) With respect to a health care contract as defined in 531  
section 3963.01 of the Revised Code that covers vision services, 532  
as defined in that section, including any of the contract terms 533  
prohibited under division (E) of section 3963.02 of the Revised 534  
Code. 535

(CC) With respect to private passenger automobile 536  
insurance, charging premium rates that are excessive, 537  
inadequate, or unfairly discriminatory, pursuant to division (D) 538  
of section 3937.02 of the Revised Code, based solely on the 539  
location of the residence of the insured. 540

The enumeration in sections 3901.19 to 3901.26 of the 541  
Revised Code of specific unfair or deceptive acts or practices 542  
in the business of insurance is not exclusive or restrictive or 543  
intended to limit the powers of the superintendent of insurance 544  
to adopt rules to implement this section, or to take action 545

under other sections of the Revised Code. 546

This section does not prohibit the sale of shares of any 547  
investment company registered under the "Investment Company Act 548  
of 1940," 54 Stat. 789, 15 U.S.C.A. 80a-1, as amended, or any 549  
policies, annuities, or other contracts described in section 550  
3907.15 of the Revised Code. 551

As used in this section, "estimate," "statement," 552  
"representation," "misrepresentation," "advertisement," or 553  
"announcement" includes oral or written occurrences. 554

Sec. 3923.84. (A) As used in this section, "vision care 555  
materials" and "vision care provider" have the same meanings as 556  
in section 3963.01 of the Revised Code. 557

(B) No policy of individual or group sickness and accident 558  
insurance providing coverage for vision care materials that is 559  
delivered, issued for delivery, or renewed in this state and no 560  
public employee benefit plan providing coverage for vision care 561  
materials that is established or modified in this state shall 562  
directly or indirectly limit or influence an insured's choice of 563  
sources and suppliers of vision care materials through its 564  
coverage practices or otherwise. 565

(C) No contract or agreement between a vision care 566  
provider and a sickness and accident insurer or a public 567  
employee benefit plan shall directly or indirectly limit or 568  
influence an insured's or vision care provider's choice of 569  
sources and suppliers of vision care materials through its 570  
reimbursement policies or otherwise. 571

(D) A violation of this section is an unfair and deceptive 572  
act or practice in the business of insurance under sections 573  
3901.19 to 3901.26 of the Revised Code. 574

<b>Sec. 3963.01.</b> As used in this chapter:	575
(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.	576 577 578 579
(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.	580 581 582 583
(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>	584 585 586 587 588 589 590 591
<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.	592 593 594
<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.	595 596 597 598 599
<del>(E)</del> <u>(F)</u> "Discount medical plan" has the same meaning as in <u>section 3961.01 of the Revised Code.</u>	600 601
<u>(G)</u> "Edit" means adjusting one or more procedure codes billed by a participating provider on a claim for payment or a	602 603

practice that results in any of the following: 604

(1) Payment for some, but not all of the procedure codes 605  
originally billed by a participating provider; 606

(2) Payment for a different procedure code than the 607  
procedure code originally billed by a participating provider; 608

(3) A reduced payment as a result of services provided to 609  
an enrollee that are claimed under more than one procedure code 610  
on the same service date. 611

~~(F)~~ (H) "Electronic claims transport" means to accept and 612  
digitize claims or to accept claims already digitized, to place 613  
those claims into a format that complies with the electronic 614  
transaction standards issued by the United States department of 615  
health and human services pursuant to the "Health Insurance 616  
Portability and Accountability Act of 1996," 110 Stat. 1955, 42 617  
U.S.C. 1320d, et seq., as those electronic standards are 618  
applicable to the parties and as those electronic standards are 619  
updated from time to time, and to electronically transmit those 620  
claims to the appropriate contracting entity, payer, or third- 621  
party administrator. 622

~~(G)~~ (I) "Enrollee" means any person eligible for health 623  
care benefits under a health benefit plan, including an eligible 624  
recipient of medicaid, and includes all of the following terms: 625

(1) "Enrollee" and "subscriber" as defined by section 626  
1751.01 of the Revised Code; 627

(2) "Member" as defined by section 1739.01 of the Revised 628  
Code; 629

(3) "Insured" and "plan member" pursuant to Chapter 3923. 630  
of the Revised Code; 631

(4) "Beneficiary" as defined by section 3901.38 of the Revised Code. 632  
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~~(H)~~(J) "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. 634  
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~~(I)~~(K) "Health care services" means basic health care services, specialty health care services, and supplemental health care services. 639  
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~~(J)~~(L) "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: 642  
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(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; 649  
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(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; 653  
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(3) An administrative change that may significantly increase the provider's administrative expense, the specific applicability of which is clearly identified in the contract; 657  
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(4) Changes to an existing prior authorization, 660

precertification, notification, or referral program that do not 661  
substantially increase the provider's administrative expense; 662

(5) Changes to an edit program or to specific edits if the 663  
participating provider is provided notice of the changes 664  
pursuant to division (A)(1) of section 3963.04 of the Revised 665  
Code and the notice includes information sufficient for the 666  
provider to determine the effect of the change; 667

(6) Changes to a health care contract described in 668  
division (B) of section 3963.04 of the Revised Code. 669

~~(K)~~(M) "Participating provider" means a provider that has 670  
a health care contract with a contracting entity and is entitled 671  
to reimbursement for health care services rendered to an 672  
enrollee under the health care contract. 673

~~(L)~~(N) "Payer" means any person that assumes the 674  
financial risk for the payment of claims under a health care 675  
contract or the reimbursement for health care services provided 676  
to enrollees by participating providers pursuant to a health 677  
care contract. 678

~~(M)~~(O) "Primary enrollee" means a person who is 679  
responsible for making payments for participation in a health 680  
care plan or an enrollee whose employment or other status is the 681  
basis of eligibility for enrollment in a health care plan. 682

~~(N)~~(P) "Procedure codes" includes the American medical 683  
association's current procedural terminology code, the American 684  
dental association's current dental terminology, and the centers 685  
for medicare and medicaid services health care common procedure 686  
coding system. 687

~~(O)~~(Q) "Product" means one of the following types of 688  
categories of coverage for which a participating provider may be 689



obligated to provide health care services pursuant to a health care contract: 690  
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(1) A health maintenance organization or other product provided by a health insuring corporation; 692  
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(2) A preferred provider organization; 694

(3) Medicare; 695

(4) Medicaid; 696

(5) Workers' compensation. 697

~~(P)~~(R) "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 a pharmacist, pharmacy, nursing home, or 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. 698  
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~~(Q)~~(S) "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. 713  
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~~(R)~~(T) "Supplemental health care services" has the same 718  
meaning as in division (B) of section 1751.01 of the Revised 719  
Code, except that it does not include any services listed in 720  
that division that are provided by a pharmacist or nursing home. 721

(U) "Vision care materials" includes lenses, devices 722  
containing lenses, prisms, lens treatments and coatings, contact 723  
lenses, orthoptics, vision training, and any prosthetic device 724  
necessary to correct, relieve, or treat any defect or abnormal 725  
condition of the human eye or its adnexa. 726

(V) "Vision care provider" means either of the following: 727

(1) A person licensed as an optometrist pursuant to 728  
Chapter 4725. of the Revised Code; 729

(2) A person who holds a certificate under Chapter 4731. 730  
of the Revised Code to practice medicine and surgery and is 731  
certified by the American board of ophthalmology. 732

**Sec. 3963.02.** (A) (1) No contracting entity shall sell, 733  
rent, or give a third party the contracting entity's rights to a 734  
participating provider's services pursuant to the contracting 735  
entity's health care contract with the participating provider 736  
unless one of the following applies: 737

(a) The third party accessing the participating provider's 738  
services under the health care contract is an employer or other 739  
entity providing coverage for health care services to its 740  
employees or members, and that employer or entity has a contract 741  
with the contracting entity or its affiliate for the 742  
administration or processing of claims for payment for services 743  
provided pursuant to the health care contract with the 744  
participating provider. 745

(b) The third party accessing the participating provider's 746

services under the health care contract either is an affiliate 747  
or subsidiary of the contracting entity or is providing 748  
administrative services to, or receiving administrative services 749  
from, the contracting entity or an affiliate or subsidiary of 750  
the contracting entity. 751

(c) The health care contract specifically provides that it 752  
applies to network rental arrangements and states that one 753  
purpose of the contract is selling, renting, or giving the 754  
contracting entity's rights to the services of the participating 755  
provider, including other preferred provider organizations, and 756  
the third party accessing the participating provider's services 757  
is any of the following: 758

(i) A payer or a third-party administrator or other entity 759  
responsible for administering claims on behalf of the payer; 760

(ii) A preferred provider organization or preferred 761  
provider network that receives access to the participating 762  
provider's services pursuant to an arrangement with the 763  
preferred provider organization or preferred provider network in 764  
a contract with the participating provider that is in compliance 765  
with division (A) (1) (c) of this section, and is required to 766  
comply with all of the terms, conditions, and affirmative 767  
obligations to which the originally contracted primary 768  
participating provider network is bound under its contract with 769  
the participating provider, including, but not limited to, 770  
obligations concerning patient steerage and the timeliness and 771  
manner of reimbursement. 772

(iii) An entity that is engaged in the business of 773  
providing electronic claims transport between the contracting 774  
entity and the payer or third-party administrator and complies 775  
with all of the applicable terms, conditions, and affirmative 776

obligations of the contracting entity's contract with the 777  
participating provider including, but not limited to, 778  
obligations concerning patient steerage and the timeliness and 779  
manner of reimbursement. 780

(2) The contracting entity that sells, rents, or gives the 781  
contracting entity's rights to the participating provider's 782  
services pursuant to the contracting entity's health care 783  
contract with the participating provider as provided in division 784  
(A) (1) of this section shall do both of the following: 785

(a) Maintain a web page that contains a listing of third 786  
parties described in divisions (A) (1) (b) and (c) of this section 787  
with whom a contracting entity contracts for the purpose of 788  
selling, renting, or giving the contracting entity's rights to 789  
the services of participating providers that is updated at least 790  
every six months and is accessible to all participating 791  
providers, or maintain a toll-free telephone number accessible 792  
to all participating providers by means of which participating 793  
providers may access the same listing of third parties; 794

(b) Require that the third party accessing the 795  
participating provider's services through the participating 796  
provider's health care contract is obligated to comply with all 797  
of the applicable terms and conditions of the contract, 798  
including, but not limited to, the products for which the 799  
participating provider has agreed to provide services, except 800  
that a payer receiving administrative services from the 801  
contracting entity or its affiliate shall be solely responsible 802  
for payment to the participating provider. 803

(3) Any information disclosed to a participating provider 804  
under this section shall be considered proprietary and shall not 805  
be distributed by the participating provider. 806

(4) Except as provided in division (A) (1) of this section, 807  
no entity shall sell, rent, or give a contracting entity's 808  
rights to the participating provider's services pursuant to a 809  
health care contract. 810

(B) (1) No contracting entity shall require, as a condition 811  
of contracting with the contracting entity, that a participating 812  
provider provide services for all of the products offered by the 813  
contracting entity. 814

(2) Division (B) (1) of this section shall not be construed 815  
to do any of the following: 816

(a) Prohibit any participating provider from voluntarily 817  
accepting an offer by a contracting entity to provide health 818  
care services under all of the contracting entity's products; 819

(b) Prohibit any contracting entity from offering any 820  
financial incentive or other form of consideration specified in 821  
the health care contract for a participating provider to provide 822  
health care services under all of the contracting entity's 823  
products; 824

(c) Require any contracting entity to contract with a 825  
participating provider to provide health care services for less 826  
than all of the contracting entity's products if the contracting 827  
entity does not wish to do so. 828

(3) (a) Notwithstanding division (B) (2) of this section, no 829  
contracting entity shall require, as a condition of contracting 830  
with the contracting entity, that the participating provider 831  
accept any future product offering that the contracting entity 832  
makes. 833

(b) If a participating provider refuses to accept any 834  
future product offering that the contracting entity makes, the 835

contracting entity may terminate the health care contract based 836  
on the participating provider's refusal upon written notice to 837  
the participating provider no sooner than one hundred eighty 838  
days after the refusal. 839

(4) Once the contracting entity and the participating 840  
provider have signed the health care contract, it is presumed 841  
that the financial incentive or other form of consideration that 842  
is specified in the health care contract pursuant to division 843  
(B) (2) (b) of this section is the financial incentive or other 844  
form of consideration that was offered by the contracting entity 845  
to induce the participating provider to enter into the contract. 846

(C) No contracting entity shall require, as a condition of 847  
contracting with the contracting entity, that a participating 848  
provider waive or forego any right or benefit expressly 849  
conferred upon a participating provider by state or federal law. 850  
However, this division does not prohibit a contracting entity 851  
from restricting a participating provider's scope of practice 852  
for the services to be provided under the contract. 853

(D) No health care contract shall do any of the following: 854

(1) Prohibit any participating provider from entering into 855  
a health care contract with any other contracting entity; 856

(2) Prohibit any contracting entity from entering into a 857  
health care contract with any other provider; 858

(3) Preclude its use or disclosure for the purpose of 859  
enforcing this chapter or other state or federal law, except 860  
that a health care contract may require that appropriate 861  
measures be taken to preserve the confidentiality of any 862  
proprietary or trade-secret information. 863

(E) (1) No contracting entity shall require in any health 864

care contract that covers vision care either of the following: 865

(a) That a participating vision care provider provide 866  
services or vision care materials to an enrollee at a fee set or 867  
limited by the contracting entity unless the vision services or 868  
materials are covered vision services; 869

(b) That a participating vision care provider participate 870  
in a health care contract or discount medical plan as a 871  
condition to participating in any other health care contract or 872  
discount medical plan. 873

(2) No vision care provider shall charge more for services 874  
and vision care materials that are not covered vision services 875  
than the vision care provider's usual and customary rate for 876  
those services and materials. 877

(3) Nothing in division (E) of this section shall prohibit 878  
an enrollee from using a discount card from a discount medical 879  
plan that offers coverage for vision services or vision care 880  
materials from a vision care provider if all of the following 881  
conditions are met: 882

(a) The vision care provider participates in the discount 883  
medical plan voluntarily. 884

(b) The vision care provider is not required to 885  
participate in another discount medical plan with different 886  
provider terms and conditions or another health care contract as 887  
a condition to participate in the discount medical plan. 888

(c) The discount medical plan program does not make or 889  
include any payment to the vision care provider. 890

(F) (1) In addition to any other lawful reasons for 891  
terminating a health care contract, a health care contract may 892

only be terminated under the circumstances described in division 893  
(A) (3) of section 3963.04 of the Revised Code. 894

(2) If the health care contract provides for termination 895  
for cause by either party, the health care contract shall state 896  
the reasons that may be used for termination for cause, which 897  
terms shall be reasonable. Once the contracting entity and the 898  
participating provider have signed the health care contract, it 899  
is presumed that the reasons stated in the health care contract 900  
for termination for cause by either party are reasonable. 901  
Subject to division (E) (3) of this section, the health care 902  
contract shall state the time by which the parties must provide 903  
notice of termination for cause and to whom the parties shall 904  
give the notice. 905

(3) Nothing in divisions ~~(E)~~(F) (1) and (2) of this section 906  
shall be construed as prohibiting any health insuring 907  
corporation from terminating a participating provider's contract 908  
for any of the causes described in divisions (A), (D), and (F) 909  
(1) and (2) of section 1753.09 of the Revised Code. 910  
Notwithstanding any provision in a health care contract pursuant 911  
to division ~~(E)~~(F) (2) of this section, section 1753.09 of the 912  
Revised Code applies to the termination of a participating 913  
provider's contract for any of the causes described in divisions 914  
(A), (D), and (F) (1) and (2) of section 1753.09 of the Revised 915  
Code. 916

(4) Subject to sections 3963.01 to 3963.11 of the Revised 917  
Code, nothing in this section prohibits the termination of a 918  
health care contract without cause if the health care contract 919  
otherwise provides for termination without cause. 920

~~(F)~~(G) (1) Disputes among parties to a health care contract 921  
that only concern the enforcement of the contract rights 922



conferred by section 3963.02, divisions (A) and (D) of section 923  
3963.03, and section 3963.04 of the Revised Code are subject to 924  
a mutually agreed upon arbitration mechanism that is binding on 925  
all parties. The arbitrator may award reasonable attorney's fees 926  
and costs for arbitration relating to the enforcement of this 927  
section to the prevailing party. 928

(2) The arbitrator shall make the arbitrator's decision in 929  
an arbitration proceeding having due regard for any applicable 930  
rules, bulletins, rulings, or decisions issued by the department 931  
of insurance or any court concerning the enforcement of the 932  
contract rights conferred by section 3963.02, divisions (A) and 933  
(D) of section 3963.03, and section 3963.04 of the Revised Code. 934

(3) A party shall not simultaneously maintain an 935  
arbitration proceeding as described in division ~~(F)~~(G)(1) of 936  
this section and pursue a complaint with the superintendent of 937  
insurance to investigate the subject matter of the arbitration 938  
proceeding. However, if a complaint is filed with the department 939  
of insurance, the superintendent may choose to investigate the 940  
complaint or, after reviewing the complaint, advise the 941  
complainant to proceed with arbitration to resolve the 942  
complaint. The superintendent may request to receive a copy of 943  
the results of the arbitration. If the superintendent of 944  
insurance notifies an insurer or a health insuring corporation 945  
in writing that the superintendent has initiated a market 946  
conduct examination into the specific subject matter of the 947  
arbitration proceeding pending against that insurer or health 948  
insuring corporation, the arbitration proceeding shall be stayed 949  
at the request of the insurer or health insuring corporation 950  
pending the outcome of the market conduct investigation by the 951  
superintendent. 952

**Sec. 3963.03.** (A) Each health care contract shall include 953  
all of the following information: 954

(1) (a) Information sufficient for the participating 955  
provider to determine the compensation or payment terms for 956  
health care services, including all of the following, subject to 957  
division (A) (1) (b) of this section: 958

(i) The manner of payment, such as fee-for-service, 959  
capitation, or risk; 960

(ii) The fee schedule of procedure codes reasonably 961  
expected to be billed by a participating provider's specialty 962  
for services provided pursuant to the health care contract and 963  
the associated payment or compensation for each procedure code. 964  
A fee schedule may be provided electronically. Upon request, a 965  
contracting entity shall provide a participating provider with 966  
the fee schedule for any other procedure codes requested and a 967  
written fee schedule, that shall not be required more frequently 968  
than twice per year excluding when it is provided in connection 969  
with any change to the schedule. This requirement may be 970  
satisfied by providing a clearly understandable, readily 971  
available mechanism, such as a specific web site address, that 972  
allows a participating provider to determine the effect of 973  
procedure codes on payment or compensation before a service is 974  
provided or a claim is submitted. 975

(iii) The effect, if any, on payment or compensation if 976  
more than one procedure code applies to the service also shall 977  
be stated. This requirement may be satisfied by providing a 978  
clearly understandable, readily available mechanism, such as a 979  
specific web site address, that allows a participating provider 980  
to determine the effect of procedure codes on payment or 981  
compensation before a service is provided or a claim is 982

submitted. 983

(b) If the contracting entity is unable to include the 984  
information described in ~~division~~ divisions (A) (1) (a) (ii) and 985  
(iii) of this section, the contracting entity shall include both 986  
of the following types of information instead: 987

(i) The methodology used to calculate any fee schedule, 988  
such as relative value unit system and conversion factor or 989  
percentage of billed charges. If applicable, the methodology 990  
disclosure shall include the name of any relative value unit 991  
system, its version, edition, or publication date, any 992  
applicable conversion or geographic factor, and any date by 993  
which compensation or fee schedules may be changed by the 994  
methodology as anticipated at the time of contract. 995

(ii) The identity of any internal processing edits, 996  
including the publisher, product name, version, and version 997  
update of any editing software. 998

(c) If the contracting entity is not the payer and is 999  
unable to include the information described in division (A) (1) 1000  
(a) or (b) of this section, then the contracting entity shall 1001  
provide by telephone a readily available mechanism, such as a 1002  
specific web site address, that allows the participating 1003  
provider to obtain that information from the payer. 1004

(2) Any product or network for which the participating 1005  
provider is to provide services; 1006

(3) The term of the health care contract; 1007

(4) A specific web site address that contains the identity 1008  
of the contracting entity or payer responsible for the 1009  
processing of the participating provider's compensation or 1010  
payment; 1011

(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 1041  
carefully read any proposed amendments sent after execution of 1042  
the contract; 1043

(e) That nothing in the summary disclosure form creates 1044  
any additional rights or causes of action in favor of either 1045  
party. 1046

(3) No contracting entity that includes any information in 1047  
the summary disclosure form with the reasonable belief that the 1048  
information is truthful or accurate shall be subject to a civil 1049  
action for damages or to binding arbitration based on the 1050  
summary disclosure form. Division (B) (3) of this section does 1051  
not impair or affect any power of the department of insurance to 1052  
enforce any applicable law. 1053

(4) The summary disclosure form described in divisions (B) 1054  
(1) and (2) of this section shall be in substantially the 1055  
following form: 1056

"SUMMARY DISCLOSURE FORM 1057

(1) Compensation terms 1058

(a) Manner of payment 1059

[ ] Fee for service 1060

[ ] Capitation 1061

[ ] Risk 1062

[ ] Other ..... See ..... 1063

(b) Fee schedule available at ..... 1064

(c) Fee calculation schedule available at ..... 1065

(d) Identity of internal processing edits available 1066

at .....	1067
(e) Information in (c) and (d) is not required if information in (b) is provided.	1068 1069
(2) List of products or networks covered by this contract	1070
[ ] .....	1071
[ ] .....	1072
[ ] .....	1073
[ ] .....	1074
[ ] .....	1075
(3) Term of this contract .....	1076
(4) Contracting entity or payer responsible for processing payment available at .....	1077 1078
(5) Internal mechanism for resolving disputes regarding contract terms available at .....	1079 1080
(6) Addenda to contract	1081
Title                    Subject	1082
(a)	1083
(b)	1084
(c)	1085
(d)	1086
(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.	1087 1088 1089 1090

IMPORTANT INFORMATION - PLEASE READ CAREFULLY 1091

The information provided in this Summary Disclosure Form 1092  
is a guide to the attached Health Care Contract as defined in 1093  
section ~~3963.01(G)~~3963.01(J) of the Ohio Revised Code. The 1094  
terms and conditions of the attached Health Care Contract 1095  
constitute the contract rights of the parties. 1096

Reading this Summary Disclosure Form is not a substitute 1097  
for reading the entire Health Care Contract. When you sign the 1098  
Health Care Contract, you will be bound by its terms and 1099  
conditions. These terms and conditions may be amended over time 1100  
pursuant to section 3963.04 of the Ohio Revised Code. You are 1101  
encouraged to read any proposed amendments that are sent to you 1102  
after execution of the Health Care Contract. 1103

Nothing in this Summary Disclosure Form creates any 1104  
additional rights or causes of action in favor of either party." 1105

(C) When a contracting entity presents a proposed health 1106  
care contract for consideration by a provider, the contracting 1107  
entity shall provide in writing or make reasonably available the 1108  
information required in division (A)(1) of this section. 1109

(D) The contracting entity shall identify any utilization 1110  
management, quality improvement, or a similar program that the 1111  
contracting entity uses to review, monitor, evaluate, or assess 1112  
the services provided pursuant to a health care contract. The 1113  
contracting entity shall disclose the policies, procedures, or 1114  
guidelines of such a program applicable to a participating 1115  
provider upon request by the participating provider within 1116  
fourteen days after the date of the request. 1117

(E) Nothing in this section shall be construed as 1118  
preventing or affecting the application of section 1753.07 of 1119

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.

**Section 2.** That existing sections 1739.05, 1753.07, 1753.09, 3901.21, 3963.01, 3963.02, and 3963.03 of the Revised Code are hereby repealed.

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

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

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