

As Introduced

132nd General Assembly

Regular Session

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H. B. No. 156

Representative Schuring

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 196
statement of financial condition of an insurer. 197

Making any false entry in any book, report, or statement 198
of any insurer with intent to deceive any agent or examiner 199
lawfully appointed to examine into its condition or into any of 200
its affairs, or any public official to whom such insurer is 201
required by law to report, or who has authority by law to 202
examine into its condition or into any of its affairs, or, with 203
like intent, willfully omitting to make a true entry of any 204
material fact pertaining to the business of such insurer in any 205
book, report, or statement of such insurer, or mutilating, 206
destroying, suppressing, withholding, or concealing any of its 207
records. 208

(E) Issuing or delivering or permitting agents, officers, 209
or employees to issue or deliver agency company stock or other 210
capital stock or benefit certificates or shares in any common- 211
law corporation or securities or any special or advisory board 212
contracts or other contracts of any kind promising returns and 213
profits as an inducement to insurance. 214

(F) Making or permitting any unfair discrimination among 215
individuals of the same class and equal expectation of life in 216
the rates charged for any contract of life insurance or of life 217
annuity or in the dividends or other benefits payable thereon, 218
or in any other of the terms and conditions of such contract. 219

(G) (1) Except as otherwise expressly provided by law, 220
knowingly permitting or offering to make or making any contract 221
of life insurance, life annuity or accident and health 222
insurance, or agreement as to such contract other than as 223
plainly expressed in the contract issued thereon, or paying or 224
allowing, or giving or offering to pay, allow, or give, directly 225

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 376
policy, contract, or plan of health benefits, or a health 377
benefit plan issued to an employer, for which an individual 378
would otherwise be eligible; 379

(b) With respect to a health benefit plan issued to an 380
employer, excludes or causes the exclusion of an individual from 381
coverage under an existing employer-provided policy, contract, 382
or plan of health benefits. 383

(2) The superintendent of insurance may adopt rules in 384
accordance with Chapter 119. of the Revised Code for purposes of 385
implementing division (T)(1) of this section. 386

(3) For purposes of division (T)(1) of this section, 387
"health status-related factor" means any of the following: 388

(a) Health status; 389

(b) Medical condition, including both physical and mental 390
illnesses; 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 396
out of acts of domestic violence; 397

(h) Disability. 398

(U) With respect to a health benefit plan issued to a 399
small employer, as those terms are defined in section 3924.01 of 400
the Revised Code, negligently or willfully placing coverage for 401
adverse risks with a certain carrier, as defined in section 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

Revised Code. 548

Sec. 3963.01. As used in this chapter: 549

(A) "Affiliate" means any person or entity that has 550
ownership or control of a contracting entity, is owned or 551
controlled by a contracting entity, or is under common ownership 552
or control with a contracting entity. 553

(B) "Basic health care services" has the same meaning as 554
in division (A) of section 1751.01 of the Revised Code, except 555
that it does not include any services listed in that division 556
that are provided by a pharmacist or nursing home. 557

(C) "Covered vision services" means vision services or 558
vision care materials for which a reimbursement is available 559
under an enrollee's health care contract, or for which a 560
reimbursement would be available but for the application of 561
contractual limitations such as a deductible, copayment, 562
coinsurance, waiting period, annual or lifetime maximum, 563
frequency limitation, alternative benefit payment, or any other 564
limitation. 565

(D) "Contracting entity" means any person that has a 566
primary business purpose of contracting with participating 567
providers for the delivery of health care services. 568

~~(D)~~ (E) "Credentialing" means the process of assessing and 569
validating the qualifications of a provider applying to be 570
approved by a contracting entity to provide basic health care 571
services, specialty health care services, or supplemental health 572
care services to enrollees. 573

~~(E)~~ (F) "Edit" means adjusting one or more procedure codes 574
billed by a participating provider on a claim for payment or a 575
practice that results in any of the following: 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

~~(F)~~ (G) "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
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~~(G)~~ (H) "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 691
Code, except that it does not include any services listed in 692
that division that are provided by a pharmacist or nursing home. 693

(T) "Vision care materials" includes lenses, devices 694
containing lenses, prisms, lens treatments and coatings, contact 695
lenses, orthoptics, vision training, and any prosthetic device 696
necessary to correct, relieve, or treat any defect or abnormal 697
condition of the human eye or its adnexa. 698

(U) "Vision care provider" means either of the following: 699

(1) A person licensed as an optometrist pursuant to 700
Chapter 4725. of the Revised Code; 701

(2) A person who holds a certificate under Chapter 4731. 702
of the Revised Code to practice medicine and surgery. 703

Sec. 3963.02. (A) (1) No contracting entity shall sell, 704
rent, or give a third party the contracting entity's rights to a 705
participating provider's services pursuant to the contracting 706
entity's health care contract with the participating provider 707
unless one of the following applies: 708

(a) The third party accessing the participating provider's 709
services under the health care contract is an employer or other 710
entity providing coverage for health care services to its 711
employees or members, and that employer or entity has a contract 712
with the contracting entity or its affiliate for the 713
administration or processing of claims for payment for services 714
provided pursuant to the health care contract with the 715
participating provider. 716

(b) The third party accessing the participating provider's 717
services under the health care contract either is an affiliate 718
or subsidiary of the contracting entity or is providing 719

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:

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

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

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

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

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

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

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 3963.01(G) <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