

As Reported by the House Insurance Committee

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Sub. H. B. No. 156

Representative Schuring

Cosponsor: Representative Retherford

A BILL

To amend sections 1739.05, 1753.09, 3901.21, 1
3963.01, 3963.02, 3963.03, 4725.19, and 4731.22 2
and to enact sections 1751.85 and 3923.86 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, 1753.09, 3901.21, 6
3963.01, 3963.02, 3963.03, 4725.19, and 4731.22 be amended and 7
sections 1751.85 and 3923.86 of the Revised Code be enacted to 8
read as 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
3901.491, 3902.01 to 3902.14, 3923.041, 3923.24, 3923.282, 27
3923.30, 3923.301, 3923.38, 3923.581, 3923.602, 3923.63, 28
3923.80, 3923.84, 3923.85, 3923.851, 3923.86, 3924.031, 29
3924.032, and 3924.27 of the Revised Code. 30

(C) A multiple employer welfare arrangement created 31
pursuant to sections 1739.01 to 1739.22 of the Revised Code 32
shall solicit enrollments only through agents or solicitors 33
licensed pursuant to Chapter 3905. of the Revised Code to sell 34
or solicit sickness and accident insurance. 35

(D) A multiple employer welfare arrangement created 36
pursuant to sections 1739.01 to 1739.22 of the Revised Code 37
shall provide benefits only to individuals who are members, 38
employees of members, or the dependents of members or employees, 39
or are eligible for continuation of coverage under section 40
1751.53 or 3923.38 of the Revised Code or under Title X of the 41
"Consolidated Omnibus Budget Reconciliation Act of 1985," 100 42
Stat. 227, 29 U.S.C.A. 1161, as amended. 43

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

insurers, as defined in section 3903.81 of the Revised Code. 48

Sec. 1751.85. (A) As used in this section, "covered vision 49
services," "vision care materials," and "vision care provider" 50
have the same meanings as in section 3963.01 of the Revised 51
Code. 52

(B) A health insuring corporation shall provide the 53
information required in this division to all enrollees receiving 54
coverage under an individual or group health insuring 55
corporation policy, contract, or agreement providing coverage 56
for vision care services or vision care materials. The 57
information shall be in a conspicuous format, shall be easily 58
accessible to enrollees, and shall do all of the following: 59

(1) Include the following statement: 60

"IMPORTANT: If you opt to receive vision care services or 61
vision care materials that are not covered benefits under this 62
plan, a participating vision care provider may charge you his or 63
her normal fee for such services or materials. Prior to 64
providing you with vision care services or vision care materials 65
that are not covered benefits, the vision care provider will 66
provide you with an estimated cost for each service or material 67
upon your request." 68

(2) Disclose any business interest the health insuring 69
corporation has in a source or supplier of vision care 70
materials; 71

(3) Include an explanation that the enrollee may incur 72
out-of-pocket expenses as a result of the purchase of vision 73
care services or vision care materials that are not covered 74
vision services. The explanation shall be communicated in a 75
manner and format similar to how the health insuring corporation 76

provides an enrollee with information on coverage levels and 77
out-of-pocket expenses that may be incurred by the enrollee 78
under the policy, contract, or agreement when purchasing out-of- 79
network vision care services or vision care materials. 80

(C) A pattern of continuous or repeated violations of this 81
section is an unfair and deceptive act or practice in the 82
business of insurance under sections 3901.19 to 3901.26 of the 83
Revised Code. 84

Sec. 1753.09. (A) Except as provided in division (D) of 85
this section, prior to terminating the participation of a 86
provider on the basis of the participating provider's failure to 87
meet the health insuring corporation's standards for quality or 88
utilization in the delivery of health care services, a health 89
insuring corporation shall give the participating provider 90
notice of the reason or reasons for its decision to terminate 91
the provider's participation and an opportunity to take 92
corrective action. The health insuring corporation shall develop 93
a performance improvement plan in conjunction with the 94
participating provider. If after being afforded the opportunity 95
to comply with the performance improvement plan, the 96
participating provider fails to do so, the health insuring 97
corporation may terminate the participation of the provider. 98

(B) (1) A participating provider whose participation has 99
been terminated under division (A) of this section may appeal 100
the termination to the appropriate medical director of the 101
health insuring corporation. The medical director shall give the 102
participating provider an opportunity to discuss with the 103
medical director the reason or reasons for the termination. 104

(2) If a satisfactory resolution of a participating 105
provider's appeal cannot be reached under division (B) (1) of 106

this section, the participating provider may appeal the 107
termination to a panel composed of participating providers who 108
have comparable or higher levels of education and training than 109
the participating provider making the appeal. A representative 110
of the participating provider's specialty shall be a member of 111
the panel, if possible. This panel shall hold a hearing, and 112
shall render its recommendation in the appeal within thirty days 113
after holding the hearing. The recommendation shall be presented 114
to the medical director and to the participating provider. 115

(3) The medical director shall review and consider the 116
panel's recommendation before making a decision. The decision 117
rendered by the medical director shall be final. 118

(C) A provider's status as a participating provider shall 119
remain in effect during the appeal process set forth in division 120
(B) of this section unless the termination was based on any of 121
the reasons listed in division (D) of this section. 122

(D) Notwithstanding division (A) of this section, a 123
provider's participation may be immediately terminated if the 124
participating provider's conduct presents an imminent risk of 125
harm to an enrollee or enrollees; or if there has occurred 126
unacceptable quality of care, fraud, patient abuse, loss of 127
clinical privileges, loss of professional liability coverage, 128
incompetence, or loss of authority to practice in the 129
participating provider's field; or if a governmental action has 130
impaired the participating provider's ability to practice. 131

(E) Divisions (A) to (D) of this section apply only to 132
providers who are natural persons. 133

(F) (1) Nothing in this section prohibits a health insuring 134
corporation from rejecting a provider's application for 135

participation, or from terminating a participating provider's 136
contract, if the health insuring corporation determines that the 137
health care needs of its enrollees are being met and no need 138
exists for the provider's or participating provider's services. 139

(2) Nothing in this section shall be construed as 140
prohibiting a health insuring corporation from terminating a 141
participating provider who does not meet the terms and 142
conditions of the participating provider's contract. 143

(3) Nothing in this section shall be construed as 144
prohibiting a health insuring corporation from terminating a 145
participating provider's contract pursuant to any provision of 146
the contract described in division ~~(E)~~(F) (2) of section 3963.02 147
of the Revised Code, except that, notwithstanding any provision 148
of a contract described in that division, this section applies 149
to the termination of a participating provider's contract for 150
any of the causes described in divisions (A), (D), and (F) (1) 151
and (2) of this section. 152

(G) The superintendent of insurance may adopt rules as 153
necessary to implement and enforce sections 1753.06, 1753.07, 154
and 1753.09 of the Revised Code. Such rules shall be adopted in 155
accordance with Chapter 119. of the Revised Code. 156

Sec. 3901.21. The following are hereby defined as unfair 157
and deceptive acts or practices in the business of insurance: 158

(A) Making, issuing, circulating, or causing or permitting 159
to be made, issued, or circulated, or preparing with intent to 160
so use, any estimate, illustration, circular, or statement 161
misrepresenting the terms of any policy issued or to be issued 162
or the benefits or advantages promised thereby or the dividends 163
or share of the surplus to be received thereon, or making any 164

false or misleading statements as to the dividends or share of 165
surplus previously paid on similar policies, or making any 166
misleading representation or any misrepresentation as to the 167
financial condition of any insurer as shown by the last 168
preceding verified statement made by it to the insurance 169
department of this state, or as to the legal reserve system upon 170
which any life insurer operates, or using any name or title of 171
any policy or class of policies misrepresenting the true nature 172
thereof, or making any misrepresentation or incomplete 173
comparison to any person for the purpose of inducing or tending 174
to induce such person to purchase, amend, lapse, forfeit, 175
change, or surrender insurance. 176

Any written statement concerning the premiums for a policy 177
which refers to the net cost after credit for an assumed 178
dividend, without an accurate written statement of the gross 179
premiums, cash values, and dividends based on the insurer's 180
current dividend scale, which are used to compute the net cost 181
for such policy, and a prominent warning that the rate of 182
dividend is not guaranteed, is a misrepresentation for the 183
purposes of this division. 184

(B) Making, publishing, disseminating, circulating, or 185
placing before the public or causing, directly or indirectly, to 186
be made, published, disseminated, circulated, or placed before 187
the public, in a newspaper, magazine, or other publication, or 188
in the form of a notice, circular, pamphlet, letter, or poster, 189
or over any radio station, or in any other way, or preparing 190
with intent to so use, an advertisement, announcement, or 191
statement containing any assertion, representation, or 192
statement, with respect to the business of insurance or with 193
respect to any person in the conduct of the person's insurance 194
business, which is untrue, deceptive, or misleading. 195

(C) Making, publishing, disseminating, or circulating, 196
directly or indirectly, or aiding, abetting, or encouraging the 197
making, publishing, disseminating, or circulating, or preparing 198
with intent to so use, any statement, pamphlet, circular, 199
article, or literature, which is false as to the financial 200
condition of an insurer and which is calculated to injure any 201
person engaged in the business of insurance. 202

(D) Filing with any supervisory or other public official, 203
or making, publishing, disseminating, circulating, or delivering 204
to any person, or placing before the public, or causing directly 205
or indirectly to be made, published, disseminated, circulated, 206
delivered to any person, or placed before the public, any false 207
statement of financial condition of an insurer. 208

Making any false entry in any book, report, or statement 209
of any insurer with intent to deceive any agent or examiner 210
lawfully appointed to examine into its condition or into any of 211
its affairs, or any public official to whom such insurer is 212
required by law to report, or who has authority by law to 213
examine into its condition or into any of its affairs, or, with 214
like intent, willfully omitting to make a true entry of any 215
material fact pertaining to the business of such insurer in any 216
book, report, or statement of such insurer, or mutilating, 217
destroying, suppressing, withholding, or concealing any of its 218
records. 219

(E) Issuing or delivering or permitting agents, officers, 220
or employees to issue or deliver agency company stock or other 221
capital stock or benefit certificates or shares in any common- 222
law corporation or securities or any special or advisory board 223
contracts or other contracts of any kind promising returns and 224
profits as an inducement to insurance. 225

(F) Making or permitting any unfair discrimination among 226
individuals of the same class and equal expectation of life in 227
the rates charged for any contract of life insurance or of life 228
annuity or in the dividends or other benefits payable thereon, 229
or in any other of the terms and conditions of such contract. 230

(G) (1) Except as otherwise expressly provided by law, 231
knowingly permitting or offering to make or making any contract 232
of life insurance, life annuity or accident and health 233
insurance, or agreement as to such contract other than as 234
plainly expressed in the contract issued thereon, or paying or 235
allowing, or giving or offering to pay, allow, or give, directly 236
or indirectly, as inducement to such insurance, or annuity, any 237
rebate of premiums payable on the contract, or any special favor 238
or advantage in the dividends or other benefits thereon, or any 239
valuable consideration or inducement whatever not specified in 240
the contract; or giving, or selling, or purchasing, or offering 241
to give, sell, or purchase, as inducement to such insurance or 242
annuity or in connection therewith, any stocks, bonds, or other 243
securities, or other obligations of any insurance company or 244
other corporation, association, or partnership, or any dividends 245
or profits accrued thereon, or anything of value whatsoever not 246
specified in the contract. 247

(2) Nothing in division (F) or division (G) (1) of this 248
section shall be construed as prohibiting any of the following 249
practices: (a) in the case of any contract of life insurance or 250
life annuity, paying bonuses to policyholders or otherwise 251
abating their premiums in whole or in part out of surplus 252
accumulated from nonparticipating insurance, provided that any 253
such bonuses or abatement of premiums shall be fair and 254
equitable to policyholders and for the best interests of the 255
company and its policyholders; (b) in the case of life insurance 256

policies issued on the industrial debit plan, making allowance 257
to policyholders who have continuously for a specified period 258
made premium payments directly to an office of the insurer in an 259
amount which fairly represents the saving in collection 260
expenses; (c) readjustment of the rate of premium for a group 261
insurance policy based on the loss or expense experience 262
thereunder, at the end of the first or any subsequent policy 263
year of insurance thereunder, which may be made retroactive only 264
for such policy year. 265

(H) Making, issuing, circulating, or causing or permitting 266
to be made, issued, or circulated, or preparing with intent to 267
so use, any statement to the effect that a policy of life 268
insurance is, is the equivalent of, or represents shares of 269
capital stock or any rights or options to subscribe for or 270
otherwise acquire any such shares in the life insurance company 271
issuing that policy or any other company. 272

(I) Making, issuing, circulating, or causing or permitting 273
to be made, issued or circulated, or preparing with intent to so 274
issue, any statement to the effect that payments to a 275
policyholder of the principal amounts of a pure endowment are 276
other than payments of a specific benefit for which specific 277
premiums have been paid. 278

(J) Making, issuing, circulating, or causing or permitting 279
to be made, issued, or circulated, or preparing with intent to 280
so use, any statement to the effect that any insurance company 281
was required to change a policy form or related material to 282
comply with Title XXXIX of the Revised Code or any regulation of 283
the superintendent of insurance, for the purpose of inducing or 284
intending to induce any policyholder or prospective policyholder 285
to purchase, amend, lapse, forfeit, change, or surrender 286

insurance.	287
(K) Aiding or abetting another to violate this section.	288
(L) Refusing to issue any policy of insurance, or	289
canceling or declining to renew such policy because of the sex	290
or marital status of the applicant, prospective insured,	291
insured, or policyholder.	292
(M) Making or permitting any unfair discrimination between	293
individuals of the same class and of essentially the same hazard	294
in the amount of premium, policy fees, or rates charged for any	295
policy or contract of insurance, other than life insurance, or	296
in the benefits payable thereunder, or in underwriting standards	297
and practices or eligibility requirements, or in any of the	298
terms or conditions of such contract, or in any other manner	299
whatever.	300
(N) Refusing to make available disability income insurance	301
solely because the applicant's principal occupation is that of	302
managing a household.	303
(O) Refusing, when offering maternity benefits under any	304
individual or group sickness and accident insurance policy, to	305
make maternity benefits available to the policyholder for the	306
individual or individuals to be covered under any comparable	307
policy to be issued for delivery in this state, including family	308
members if the policy otherwise provides coverage for family	309
members. Nothing in this division shall be construed to prohibit	310
an insurer from imposing a reasonable waiting period for such	311
benefits under an individual sickness and accident insurance	312
policy issued to an individual who is not a federally eligible	313
individual or a nonemployer-related group sickness and accident	314
insurance policy, but in no event shall such waiting period	315

exceed two hundred seventy days. 316

For purposes of division (O) of this section, "federally 317
eligible individual" means an eligible individual as defined in 318
45 C.F.R. 148.103. 319

(P) Using, or permitting to be used, a pattern settlement 320
as the basis of any offer of settlement. As used in this 321
division, "pattern settlement" means a method by which liability 322
is routinely imputed to a claimant without an investigation of 323
the particular occurrence upon which the claim is based and by 324
using a predetermined formula for the assignment of liability 325
arising out of occurrences of a similar nature. Nothing in this 326
division shall be construed to prohibit an insurer from 327
determining a claimant's liability by applying formulas or 328
guidelines to the facts and circumstances disclosed by the 329
insurer's investigation of the particular occurrence upon which 330
a claim is based. 331

(Q) Refusing to insure, or refusing to continue to insure, 332
or limiting the amount, extent, or kind of life or sickness and 333
accident insurance or annuity coverage available to an 334
individual, or charging an individual a different rate for the 335
same coverage solely because of blindness or partial blindness. 336
With respect to all other conditions, including the underlying 337
cause of blindness or partial blindness, persons who are blind 338
or partially blind shall be subject to the same standards of 339
sound actuarial principles or actual or reasonably anticipated 340
actuarial experience as are sighted persons. Refusal to insure 341
includes, but is not limited to, denial by an insurer of 342
disability insurance coverage on the grounds that the policy 343
defines "disability" as being presumed in the event that the 344
eyesight of the insured is lost. However, an insurer may exclude 345

from coverage disabilities consisting solely of blindness or 346
partial blindness when such conditions existed at the time the 347
policy was issued. To the extent that the provisions of this 348
division may appear to conflict with any provision of section 349
3999.16 of the Revised Code, this division applies. 350

(R) (1) Directly or indirectly offering to sell, selling, 351
or delivering, issuing for delivery, renewing, or using or 352
otherwise marketing any policy of insurance or insurance product 353
in connection with or in any way related to the grant of a 354
student loan guaranteed in whole or in part by an agency or 355
commission of this state or the United States, except insurance 356
that is required under federal or state law as a condition for 357
obtaining such a loan and the premium for which is included in 358
the fees and charges applicable to the loan; or, in the case of 359
an insurer or insurance agent, knowingly permitting any lender 360
making such loans to engage in such acts or practices in 361
connection with the insurer's or agent's insurance business. 362

(2) Except in the case of a violation of division (G) of 363
this section, division (R) (1) of this section does not apply to 364
either of the following: 365

(a) Acts or practices of an insurer, its agents, 366
representatives, or employees in connection with the grant of a 367
guaranteed student loan to its insured or the insured's spouse 368
or dependent children where such acts or practices take place 369
more than ninety days after the effective date of the insurance; 370

(b) Acts or practices of an insurer, its agents, 371
representatives, or employees in connection with the 372
solicitation, processing, or issuance of an insurance policy or 373
product covering the student loan borrower or the borrower's 374
spouse or dependent children, where such acts or practices take 375

place more than one hundred eighty days after the date on which 376
the borrower is notified that the student loan was approved. 377

(S) Denying coverage, under any health insurance or health 378
care policy, contract, or plan providing family coverage, to any 379
natural or adopted child of the named insured or subscriber 380
solely on the basis that the child does not reside in the 381
household of the named insured or subscriber. 382

(T)(1) Using any underwriting standard or engaging in any 383
other act or practice that, directly or indirectly, due solely 384
to any health status-related factor in relation to one or more 385
individuals, does either of the following: 386

(a) Terminates or fails to renew an existing individual 387
policy, contract, or plan of health benefits, or a health 388
benefit plan issued to an employer, for which an individual 389
would otherwise be eligible; 390

(b) With respect to a health benefit plan issued to an 391
employer, excludes or causes the exclusion of an individual from 392
coverage under an existing employer-provided policy, contract, 393
or plan of health benefits. 394

(2) The superintendent of insurance may adopt rules in 395
accordance with Chapter 119. of the Revised Code for purposes of 396
implementing division (T)(1) of this section. 397

(3) For purposes of division (T)(1) of this section, 398
"health status-related factor" means any of the following: 399

(a) Health status; 400

(b) Medical condition, including both physical and mental 401
illnesses; 402

(c) Claims experience; 403

(d) Receipt of health care;	404
(e) Medical history;	405
(f) Genetic information;	406
(g) Evidence of insurability, including conditions arising out of acts of domestic violence;	407 408
(h) Disability.	409
(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.	410 411 412 413 414
(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.	415 416 417 418
(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.	419 420 421
(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.	422 423 424 425
(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;	426 427 428 429 430 431

(b) Adding a surcharge or rating factor to a premium of 432
any individual policy or contract of life or health insurance 433
for the reason that the insured or applicant for insurance is or 434
has been a victim of domestic violence; 435

(c) Denying coverage under, or limiting coverage under, 436
any policy or contract of life or health insurance, for the 437
reason that a claim under the policy or contract arises from an 438
incident of domestic violence; 439

(d) Inquiring, directly or indirectly, of an insured 440
under, or of an applicant for, a policy or contract of life or 441
health insurance, as to whether the insured or applicant is or 442
has been a victim of domestic violence, or inquiring as to 443
whether the insured or applicant has sought shelter or 444
protection from domestic violence or has sought medical or 445
psychological treatment as a victim of domestic violence. 446

(2) Nothing in division (Y) (1) of this section shall be 447
construed to prohibit an insurer from inquiring as to, or from 448
underwriting or rating a risk on the basis of, a person's 449
physical or mental condition, even if the condition has been 450
caused by domestic violence, provided that all of the following 451
apply: 452

(a) The insurer routinely considers the condition in 453
underwriting or in rating risks, and does so in the same manner 454
for a victim of domestic violence as for an insured or applicant 455
who is not a victim of domestic violence; 456

(b) The insurer does not refuse to issue any policy or 457
contract of life or health insurance or cancel or refuse to 458
renew any policy or contract of life insurance, solely on the 459
basis of the condition, except where such refusal to issue, 460

cancellation, or refusal to renew is based on sound actuarial 461
principles or is related to actual or reasonably anticipated 462
experience; 463

(c) The insurer does not consider a person's status as 464
being or as having been a victim of domestic violence, in 465
itself, to be a physical or mental condition; 466

(d) The underwriting or rating of a risk on the basis of 467
the condition is not used to evade the intent of division (Y) (1) 468
of this section, or of any other provision of the Revised Code. 469

(3) (a) Nothing in division (Y) (1) of this section shall be 470
construed to prohibit an insurer from refusing to issue a policy 471
or contract of life insurance insuring the life of a person who 472
is or has been a victim of domestic violence if the person who 473
committed the act of domestic violence is the applicant for the 474
insurance or would be the owner of the insurance policy or 475
contract. 476

(b) Nothing in division (Y) (2) of this section shall be 477
construed to permit an insurer to cancel or refuse to renew any 478
policy or contract of health insurance in violation of the 479
"Health Insurance Portability and Accountability Act of 1996," 480
110 Stat. 1955, 42 U.S.C.A. 300gg-41(b), as amended, or in a 481
manner that violates or is inconsistent with any provision of 482
the Revised Code that implements the "Health Insurance 483
Portability and Accountability Act of 1996." 484

(4) An insurer is immune from any civil or criminal 485
liability that otherwise might be incurred or imposed as a 486
result of any action taken by the insurer to comply with 487
division (Y) of this section. 488

(5) As used in division (Y) of this section, "domestic 489

violence" means any of the following acts: 490

(a) Knowingly causing or attempting to cause physical harm 491
to a family or household member; 492

(b) Recklessly causing serious physical harm to a family 493
or household member; 494

(c) Knowingly causing, by threat of force, a family or 495
household member to believe that the person will cause imminent 496
physical harm to the family or household member. 497

For the purpose of division (Y) (5) of this section, 498
"family or household member" has the same meaning as in section 499
2919.25 of the Revised Code. 500

Nothing in division (Y) (5) of this section shall be 501
construed to require, as a condition to the application of 502
division (Y) of this section, that the act described in division 503
(Y) (5) of this section be the basis of a criminal prosecution. 504

(Z) Disclosing a coroner's records by an insurer in 505
violation of section 313.10 of the Revised Code. 506

(AA) Making, issuing, circulating, or causing or 507
permitting to be made, issued, or circulated any statement or 508
representation that a life insurance policy or annuity is a 509
contract for the purchase of funeral goods or services. 510

(BB) With respect to a health care contract as defined in 511
section 3963.01 of the Revised Code that covers vision services, 512
as defined in that section, including any of the contract terms 513
prohibited under or failing to make the disclosures required 514
under division (E) of section 3963.02 of the Revised Code. 515

(CC) With respect to private passenger automobile 516
insurance, charging premium rates that are excessive, 517

inadequate, or unfairly discriminatory, pursuant to division (D) 518
of section 3937.02 of the Revised Code, based solely on the 519
location of the residence of the insured. 520

The enumeration in sections 3901.19 to 3901.26 of the 521
Revised Code of specific unfair or deceptive acts or practices 522
in the business of insurance is not exclusive or restrictive or 523
intended to limit the powers of the superintendent of insurance 524
to adopt rules to implement this section, or to take action 525
under other sections of the Revised Code. 526

This section does not prohibit the sale of shares of any 527
investment company registered under the "Investment Company Act 528
of 1940," 54 Stat. 789, 15 U.S.C.A. 80a-1, as amended, or any 529
policies, annuities, or other contracts described in section 530
3907.15 of the Revised Code. 531

As used in this section, "estimate," "statement," 532
"representation," "misrepresentation," "advertisement," or 533
"announcement" includes oral or written occurrences. 534

Sec. 3923.86. (A) As used in this section, "covered vision 535
services," "vision care materials," and "vision care provider" 536
have the same meanings as in section 3963.01 of the Revised 537
Code. 538

(B) A sickness and accident insurer or public employee 539
benefit plan shall provide the information required in this 540
division to all insured individuals receiving coverage under an 541
individual or group policy of sickness and accident insurance or 542
public employee benefit plan providing coverage for vision care 543
services or vision care materials. The information shall be in a 544
conspicuous format, shall be easily accessible to insured 545
individuals, and shall do all of the following: 546

(1) Include the following statement: 547

"IMPORTANT: If you opt to receive vision care services or 548
vision care materials that are not covered benefits under this 549
plan, a participating vision care provider may charge you his or 550
her normal fee for such services or materials. Prior to 551
providing you with vision care services or vision care materials 552
that are not covered benefits, the vision care provider will 553
provide you with an estimated cost for each service or material 554
upon your request." 555

(2) Disclose any business interest the insurer or plan has 556
in a source or supplier of vision care materials; 557

(3) Include an explanation that the insured individual may 558
incur out-of-pocket expenses as a result of the purchase of 559
vision care services or vision care materials that are not 560
covered vision services. The explanation shall be communicated 561
in a manner and format similar to how the insurer or plan 562
provides an insured individual with information on coverage 563
levels and out-of-pocket expenses that may be incurred by the 564
insured individual under the policy or plan when purchasing out- 565
of-network vision care services or vision care materials. 566

(C) A pattern of continuous or repeated violations of this 567
section is an unfair and deceptive act or practice in the 568
business of insurance under sections 3901.19 to 3901.26 of the 569
Revised Code. 570

Sec. 3963.01. As used in this chapter: 571

(A) "Affiliate" means any person or entity that has 572
ownership or control of a contracting entity, is owned or 573
controlled by a contracting entity, or is under common ownership 574
or control with a contracting entity. 575

(B) "Basic health care services" has the same meaning as 576
in division (A) of section 1751.01 of the Revised Code, except 577
that it does not include any services listed in that division 578
that are provided by a pharmacist or nursing home. 579

(C) "Covered vision services" means vision care services 580
or vision care materials for which a reimbursement is available 581
under an enrollee's health care contract, or for which a 582
reimbursement would be available but for the application of 583
contractual limitations such as a deductible, copayment, 584
coinsurance, waiting period, annual or lifetime maximum, 585
frequency limitation, alternative benefit payment, or any other 586
limitation. 587

(D) "Contracting entity" means any person that has a 588
primary business purpose of contracting with participating 589
providers for the delivery of health care services. 590

~~(D)~~ (E) "Credentialing" means the process of assessing and 591
validating the qualifications of a provider applying to be 592
approved by a contracting entity to provide basic health care 593
services, specialty health care services, or supplemental health 594
care services to enrollees. 595

~~(E)~~ (F) "Edit" means adjusting one or more procedure codes 596
billed by a participating provider on a claim for payment or a 597
practice that results in any of the following: 598

(1) Payment for some, but not all of the procedure codes 599
originally billed by a participating provider; 600

(2) Payment for a different procedure code than the 601
procedure code originally billed by a participating provider; 602

(3) A reduced payment as a result of services provided to 603
an enrollee that are claimed under more than one procedure code 604

on the same service date. 605

~~(F)~~ (G) "Electronic claims transport" means to accept and 606
digitize claims or to accept claims already digitized, to place 607
those claims into a format that complies with the electronic 608
transaction standards issued by the United States department of 609
health and human services pursuant to the "Health Insurance 610
Portability and Accountability Act of 1996," 110 Stat. 1955, 42 611
U.S.C. 1320d, et seq., as those electronic standards are 612
applicable to the parties and as those electronic standards are 613
updated from time to time, and to electronically transmit those 614
claims to the appropriate contracting entity, payer, or third- 615
party administrator. 616

~~(G)~~ (H) "Enrollee" means any person eligible for health 617
care benefits under a health benefit plan, including an eligible 618
recipient of medicaid, and includes all of the following terms: 619

(1) "Enrollee" and "subscriber" as defined by section 620
1751.01 of the Revised Code; 621

(2) "Member" as defined by section 1739.01 of the Revised 622
Code; 623

(3) "Insured" and "plan member" pursuant to Chapter 3923. 624
of the Revised Code; 625

(4) "Beneficiary" as defined by section 3901.38 of the 626
Revised Code. 627

~~(H)~~ (I) "Health care contract" means a contract entered 628
into, materially amended, or renewed between a contracting 629
entity and a participating provider for the delivery of basic 630
health care services, specialty health care services, or 631
supplemental health care services to enrollees. 632

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

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

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

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

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

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

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

(6) Changes to a health care contract described in 662
division (B) of section 3963.04 of the Revised Code. 663

~~(K)~~ (L) "Participating provider" means a provider that has 664
a health care contract with a contracting entity and is entitled 665
to reimbursement for health care services rendered to an 666
enrollee under the health care contract. 667

~~(L)~~ (M) "Payer" means any person that assumes the 668
financial risk for the payment of claims under a health care 669
contract or the reimbursement for health care services provided 670
to enrollees by participating providers pursuant to a health 671
care contract. 672

~~(M)~~ (N) "Primary enrollee" means a person who is 673
responsible for making payments for participation in a health 674
care plan or an enrollee whose employment or other status is the 675
basis of eligibility for enrollment in a health care plan. 676

~~(N)~~ (O) "Procedure codes" includes the American medical 677
association's current procedural terminology code, the American 678
dental association's current dental terminology, and the centers 679
for medicare and medicaid services health care common procedure 680
coding system. 681

~~(O)~~ (P) "Product" means one of the following types of 682
categories of coverage for which a participating provider may be 683
obligated to provide health care services pursuant to a health 684
care contract: 685

(1) A health maintenance organization or other product 686
provided by a health insuring corporation; 687

(2) A preferred provider organization; 688

(3) Medicare; 689

(4) Medicaid; 690

(5) Workers' compensation. 691

~~(P)~~(Q) "Provider" means a physician, podiatrist, dentist, 692
chiropractor, optometrist, psychologist, physician assistant, 693
advanced practice registered nurse, occupational therapist, 694
massage therapist, physical therapist, licensed professional 695
counselor, licensed professional clinical counselor, hearing aid 696
dealer, orthotist, prosthetist, home health agency, hospice care 697
program, pediatric respite care program, or hospital, or a 698
provider organization or physician-hospital organization that is 699
acting exclusively as an administrator on behalf of a provider 700
to facilitate the provider's participation in health care 701
contracts. "Provider" does not mean a pharmacist, pharmacy, 702
nursing home, or a provider organization or physician-hospital 703
organization that leases the provider organization's or 704
physician-hospital organization's network to a third party or 705
contracts directly with employers or health and welfare funds. 706

~~(Q)~~(R) "Specialty health care services" has the same 707
meaning as in section 1751.01 of the Revised Code, except that 708
it does not include any services listed in division (B) of 709
section 1751.01 of the Revised Code that are provided by a 710
pharmacist or a nursing home. 711

~~(R)~~(S) "Supplemental health care services" has the same 712
meaning as in division (B) of section 1751.01 of the Revised 713
Code, except that it does not include any services listed in 714
that division that are provided by a pharmacist or nursing home. 715

(T) "Vision care materials" includes lenses, devices 716
containing lenses, prisms, lens treatments and coatings, contact 717
lenses, orthotics, vision training, and any prosthetic device 718

necessary to correct, relieve, or treat any defect or abnormal 719
condition of the human eye or its adnexa. 720

(U) "Vision care provider" means either of the following: 721

(1) An optometrist licensed under Chapter 4725. of the 722
Revised Code; 723

(2) A physician authorized under Chapter 4731. of the 724
Revised Code to practice medicine and surgery or osteopathic 725
medicine and surgery. 726

Sec. 3963.02. (A) (1) No contracting entity shall sell, 727
rent, or give a third party the contracting entity's rights to a 728
participating provider's services pursuant to the contracting 729
entity's health care contract with the participating provider 730
unless one of the following applies: 731

(a) The third party accessing the participating provider's 732
services under the health care contract is an employer or other 733
entity providing coverage for health care services to its 734
employees or members, and that employer or entity has a contract 735
with the contracting entity or its affiliate for the 736
administration or processing of claims for payment for services 737
provided pursuant to the health care contract with the 738
participating provider. 739

(b) The third party accessing the participating provider's 740
services under the health care contract either is an affiliate 741
or subsidiary of the contracting entity or is providing 742
administrative services to, or receiving administrative services 743
from, the contracting entity or an affiliate or subsidiary of 744
the contracting entity. 745

(c) The health care contract specifically provides that it 746
applies to network rental arrangements and states that one 747

purpose of the contract is selling, renting, or giving the 748
contracting entity's rights to the services of the participating 749
provider, including other preferred provider organizations, and 750
the third party accessing the participating provider's services 751
is any of the following: 752

(i) A payer or a third-party administrator or other entity 753
responsible for administering claims on behalf of the payer; 754

(ii) A preferred provider organization or preferred 755
provider network that receives access to the participating 756
provider's services pursuant to an arrangement with the 757
preferred provider organization or preferred provider network in 758
a contract with the participating provider that is in compliance 759
with division (A)(1)(c) of this section, and is required to 760
comply with all of the terms, conditions, and affirmative 761
obligations to which the originally contracted primary 762
participating provider network is bound under its contract with 763
the participating provider, including, but not limited to, 764
obligations concerning patient steerage and the timeliness and 765
manner of reimbursement. 766

(iii) An entity that is engaged in the business of 767
providing electronic claims transport between the contracting 768
entity and the payer or third-party administrator and complies 769
with all of the applicable terms, conditions, and affirmative 770
obligations of the contracting entity's contract with the 771
participating provider including, but not limited to, 772
obligations concerning patient steerage and the timeliness and 773
manner of reimbursement. 774

(2) The contracting entity that sells, rents, or gives the 775
contracting entity's rights to the participating provider's 776
services pursuant to the contracting entity's health care 777

contract with the participating provider as provided in division 778
(A) (1) of this section shall do both of the following: 779

(a) Maintain a web page that contains a listing of third 780
parties described in divisions (A) (1) (b) and (c) of this section 781
with whom a contracting entity contracts for the purpose of 782
selling, renting, or giving the contracting entity's rights to 783
the services of participating providers that is updated at least 784
every six months and is accessible to all participating 785
providers, or maintain a toll-free telephone number accessible 786
to all participating providers by means of which participating 787
providers may access the same listing of third parties; 788

(b) Require that the third party accessing the 789
participating provider's services through the participating 790
provider's health care contract is obligated to comply with all 791
of the applicable terms and conditions of the contract, 792
including, but not limited to, the products for which the 793
participating provider has agreed to provide services, except 794
that a payer receiving administrative services from the 795
contracting entity or its affiliate shall be solely responsible 796
for payment to the participating provider. 797

(3) Any information disclosed to a participating provider 798
under this section shall be considered proprietary and shall not 799
be distributed by the participating provider. 800

(4) Except as provided in division (A) (1) of this section, 801
no entity shall sell, rent, or give a contracting entity's 802
rights to the participating provider's services pursuant to a 803
health care contract. 804

(B) (1) No contracting entity shall require, as a condition 805
of contracting with the contracting entity, that a participating 806

provider provide services for all of the products offered by the 807
contracting entity. 808

(2) Division (B) (1) of this section shall not be construed 809
to do any of the following: 810

(a) Prohibit any participating provider from voluntarily 811
accepting an offer by a contracting entity to provide health 812
care services under all of the contracting entity's products; 813

(b) Prohibit any contracting entity from offering any 814
financial incentive or other form of consideration specified in 815
the health care contract for a participating provider to provide 816
health care services under all of the contracting entity's 817
products; 818

(c) Require any contracting entity to contract with a 819
participating provider to provide health care services for less 820
than all of the contracting entity's products if the contracting 821
entity does not wish to do so. 822

(3) (a) Notwithstanding division (B) (2) of this section, no 823
contracting entity shall require, as a condition of contracting 824
with the contracting entity, that the participating provider 825
accept any future product offering that the contracting entity 826
makes. 827

(b) If a participating provider refuses to accept any 828
future product offering that the contracting entity makes, the 829
contracting entity may terminate the health care contract based 830
on the participating provider's refusal upon written notice to 831
the participating provider no sooner than one hundred eighty 832
days after the refusal. 833

(4) Once the contracting entity and the participating 834
provider have signed the health care contract, it is presumed 835

that the financial incentive or other form of consideration that 836
is specified in the health care contract pursuant to division 837
(B) (2) (b) of this section is the financial incentive or other 838
form of consideration that was offered by the contracting entity 839
to induce the participating provider to enter into the contract. 840

(C) No contracting entity shall require, as a condition of 841
contracting with the contracting entity, that a participating 842
provider waive or forego any right or benefit expressly 843
conferred upon a participating provider by state or federal law. 844
However, this division does not prohibit a contracting entity 845
from restricting a participating provider's scope of practice 846
for the services to be provided under the contract. 847

(D) No health care contract shall do any of the following: 848

(1) Prohibit any participating provider from entering into 849
a health care contract with any other contracting entity; 850

(2) Prohibit any contracting entity from entering into a 851
health care contract with any other provider; 852

(3) Preclude its use or disclosure for the purpose of 853
enforcing this chapter or other state or federal law, except 854
that a health care contract may require that appropriate 855
measures be taken to preserve the confidentiality of any 856
proprietary or trade-secret information. 857

(E) (1) No contract or agreement between a contracting 858
entity and a vision care provider shall do any of the following: 859

(a) Require that a vision care provider accept as payment 860
an amount set by the contracting entity for vision care services 861
or vision care materials provided to an enrollee unless the 862
services or materials are covered vision services. 863

(i) Notwithstanding division (E) (1) (a) of this section, a 864
vision care provider may, in a contract with a contracting 865
entity, choose to accept as payment an amount set by the 866
contracting entity for vision care services or vision care 867
materials provided to an enrollee that are not covered vision 868
services. 869

(ii) No contract between a vision care provider and a 870
contracting entity to provide covered vision services or vision 871
care materials shall be contingent on whether the vision care 872
provider has entered into an agreement addressing noncovered 873
vision services pursuant to division (E) (1) (a) (i) of this 874
section. 875

(iii) A contracting entity may communicate to its 876
enrollees which vision care providers choose to accept as 877
payment an amount set by the contracting entity for vision care 878
services or vision care materials provided to an enrollee that 879
are not covered vision services pursuant to division (E) (1) (a) 880
(i) of this section. Any communication to this effect shall 881
treat all vision care providers equally in provider directories, 882
provider locators, and other marketing materials as 883
participating, in-network providers, annotated only as to their 884
decision to accept payment pursuant to division (E) (1) (a) (i) of 885
this section. 886

(b) Require that a vision care provider contract with a 887
plan offering supplemental or specialty health care services as 888
a condition of contracting with a plan offering basic health 889
care services; 890

(c) Directly limit a vision care provider's choice of 891
sources and suppliers of vision care materials; 892

(d) Include a provision that prohibits a vision care 893
provider from describing out-of-network options to an enrollee 894
in accordance with division (E)(2) of this section. 895

The provisions of divisions (E)(1)(a) to (d) of this 896
section shall be effective for contracts entered into, amended, 897
or renewed on or after January 1, 2019. 898

(2) A vision care provider recommending an out-of-network 899
source or supplier of vision care materials to an enrollee shall 900
notify the enrollee in writing that the source or supplier is 901
out-of-network and shall inform the enrollee of the cost of 902
those materials. The vision care provider shall also disclose in 903
writing to an enrollee any business interest the provider has in 904
a recommended out-of-network source or supplier utilized by the 905
enrollee. 906

(3) A vision care provider who chooses not to accept as 907
payment an amount set by a contracting entity for vision care 908
services or vision care materials that are not covered vision 909
services shall do both of the following: 910

(a) Upon the request of an enrollee seeking vision care 911
services or vision care materials that are not covered vision 912
services, provide to the enrollee pricing and reimbursement 913
information, including all of the following: 914

(i) The estimated fee or discounted price suggested by the 915
contracting entity for the noncovered service or material; 916

(ii) The estimated fee charged by the vision care provider 917
for the noncovered service or material; 918

(iii) The amount the vision care provider expects to be 919
reimbursed by the contracting entity for the noncovered service 920
or material; 921

(iv) The estimated pricing and reimbursement information 922
for any covered services or materials that are also expected to 923
be provided during the enrollee's visit. 924

(b) Post, in a conspicuous place, a notice stating the 925
following: 926

"IMPORTANT: This vision care provider does not accept the 927
fee schedule set by your insurer for vision care services and 928
vision care materials that are not covered benefits under your 929
plan and instead charges his or her normal fee for those 930
services and materials. This vision care provider will provide 931
you with an estimated cost for each non-covered service or 932
material upon your request." 933

(4) Nothing in division (E) of this section shall do any 934
of the following: 935

(a) Restrict or limit a contracting entity's determination 936
of specific amounts of coverage or reimbursement for the use of 937
network or out-of-network sources or suppliers of vision care 938
materials as set forth in an enrollee's benefit plan; 939

(b) Restrict or limit a contracting entity's ability to 940
enter into an agreement with another contracting entity or an 941
affiliate of another contracting entity; 942

(c) Restrict or limit a health care plan's ability to 943
enter into an agreement with a vision care plan to deliver 944
routine vision care services that are covered under an 945
enrollee's plan; 946

(d) Restrict or limit a vision care plan network from 947
acting as a network for a health care plan; 948

(e) Prohibit a contracting entity from requiring 949

participating vision care providers to offer network sources or 950
suppliers of vision care materials to enrollees; 951

(f) Prohibit an enrollee from utilizing a network source 952
or supplier of vision care materials as set forth in an 953
enrollee's plan; 954

(g) Prohibit a participating vision care provider from 955
accepting as payment an amount that is the same as the amount 956
set by the contracting entity for vision care services or vision 957
care materials that are not covered vision services. 958

(F) (1) In addition to any other lawful reasons for 959
terminating a health care contract, a health care contract may 960
only be terminated under the circumstances described in division 961
(A) (3) of section 3963.04 of the Revised Code. 962

(2) If the health care contract provides for termination 963
for cause by either party, the health care contract shall state 964
the reasons that may be used for termination for cause, which 965
terms shall be reasonable. Once the contracting entity and the 966
participating provider have signed the health care contract, it 967
is presumed that the reasons stated in the health care contract 968
for termination for cause by either party are reasonable. 969
Subject to division ~~(E)~~ (F) (3) of this section, the health care 970
contract shall state the time by which the parties must provide 971
notice of termination for cause and to whom the parties shall 972
give the notice. 973

(3) Nothing in divisions ~~(E)~~ (F) (1) and (2) of this section 974
shall be construed as prohibiting any health insuring 975
corporation from terminating a participating provider's contract 976
for any of the causes described in divisions (A), (D), and (F) 977
(1) and (2) of section 1753.09 of the Revised Code. 978

Notwithstanding any provision in a health care contract pursuant 979
to division ~~(E)~~(F) (2) of this section, section 1753.09 of the 980
Revised Code applies to the termination of a participating 981
provider's contract for any of the causes described in divisions 982
(A), (D), and (F) (1) and (2) of section 1753.09 of the Revised 983
Code. 984

(4) Subject to sections 3963.01 to 3963.11 of the Revised 985
Code, nothing in this section prohibits the termination of a 986
health care contract without cause if the health care contract 987
otherwise provides for termination without cause. 988

~~(F)~~(G) (1) Disputes among parties to a health care contract 989
that only concern the enforcement of the contract rights 990
conferred by section 3963.02, divisions (A) and (D) of section 991
3963.03, and section 3963.04 of the Revised Code are subject to 992
a mutually agreed upon arbitration mechanism that is binding on 993
all parties. The arbitrator may award reasonable attorney's fees 994
and costs for arbitration relating to the enforcement of this 995
section to the prevailing party. 996

(2) The arbitrator shall make the arbitrator's decision in 997
an arbitration proceeding having due regard for any applicable 998
rules, bulletins, rulings, or decisions issued by the department 999
of insurance or any court concerning the enforcement of the 1000
contract rights conferred by section 3963.02, divisions (A) and 1001
(D) of section 3963.03, and section 3963.04 of the Revised Code. 1002

(3) A party shall not simultaneously maintain an 1003
arbitration proceeding as described in division ~~(F)~~(G) (1) of 1004
this section and pursue a complaint with the superintendent of 1005
insurance to investigate the subject matter of the arbitration 1006
proceeding. However, if a complaint is filed with the department 1007
of insurance, the superintendent may choose to investigate the 1008

complaint or, after reviewing the complaint, advise the 1009
complainant to proceed with arbitration to resolve the 1010
complaint. The superintendent may request to receive a copy of 1011
the results of the arbitration. If the superintendent of 1012
insurance notifies an insurer or a health insuring corporation 1013
in writing that the superintendent has initiated a market 1014
conduct examination into the specific subject matter of the 1015
arbitration proceeding pending against that insurer or health 1016
insuring corporation, the arbitration proceeding shall be stayed 1017
at the request of the insurer or health insuring corporation 1018
pending the outcome of the market conduct investigation by the 1019
superintendent. 1020

Sec. 3963.03. (A) Each health care contract shall include 1021
all of the following information: 1022

(1) (a) Information sufficient for the participating 1023
provider to determine the compensation or payment terms for 1024
health care services, including all of the following, subject to 1025
division (A) (1) (b) of this section: 1026

(i) The manner of payment, such as fee-for-service, 1027
capitation, or risk; 1028

(ii) The fee schedule of procedure codes reasonably 1029
expected to be billed by a participating provider's specialty 1030
for services provided pursuant to the health care contract and 1031
the associated payment or compensation for each procedure code. 1032
A fee schedule may be provided electronically. Upon request, a 1033
contracting entity shall provide a participating provider with 1034
the fee schedule for any other procedure codes requested and a 1035
written fee schedule, that shall not be required more frequently 1036
than twice per year excluding when it is provided in connection 1037
with any change to the schedule. This requirement may be 1038

satisfied by providing a clearly understandable, readily 1039
available mechanism, such as a specific web site address, that 1040
allows a participating provider to determine the effect of 1041
procedure codes on payment or compensation before a service is 1042
provided or a claim is submitted. 1043

(iii) The effect, if any, on payment or compensation if 1044
more than one procedure code applies to the service also shall 1045
be stated. This requirement may be satisfied by providing a 1046
clearly understandable, readily available mechanism, such as a 1047
specific web site address, that allows a participating provider 1048
to determine the effect of procedure codes on payment or 1049
compensation before a service is provided or a claim is 1050
submitted. 1051

(b) If the contracting entity is unable to include the 1052
information described in ~~division~~ divisions (A) (1) (a) (ii) and 1053
(iii) of this section, the contracting entity shall include both 1054
of the following types of information instead: 1055

(i) The methodology used to calculate any fee schedule, 1056
such as relative value unit system and conversion factor or 1057
percentage of billed charges. If applicable, the methodology 1058
disclosure shall include the name of any relative value unit 1059
system, its version, edition, or publication date, any 1060
applicable conversion or geographic factor, and any date by 1061
which compensation or fee schedules may be changed by the 1062
methodology as anticipated at the time of contract. 1063

(ii) The identity of any internal processing edits, 1064
including the publisher, product name, version, and version 1065
update of any editing software. 1066

(c) If the contracting entity is not the payer and is 1067

unable to include the information described in division (A) (1) 1068
(a) or (b) of this section, then the contracting entity shall 1069
provide by telephone a readily available mechanism, such as a 1070
specific web site address, that allows the participating 1071
provider to obtain that information from the payer. 1072

(2) Any product or network for which the participating 1073
provider is to provide services; 1074

(3) The term of the health care contract; 1075

(4) A specific web site address that contains the identity 1076
of the contracting entity or payer responsible for the 1077
processing of the participating provider's compensation or 1078
payment; 1079

(5) Any internal mechanism provided by the contracting 1080
entity to resolve disputes concerning the interpretation or 1081
application of the terms and conditions of the contract. A 1082
contracting entity may satisfy this requirement by providing a 1083
clearly understandable, readily available mechanism, such as a 1084
specific web site address or an appendix, that allows a 1085
participating provider to determine the procedures for the 1086
internal mechanism to resolve those disputes. 1087

(6) A list of addenda, if any, to the contract. 1088

(B) (1) Each contracting entity shall include a summary 1089
disclosure form with a health care contract that includes all of 1090
the information specified in division (A) of this section. The 1091
information in the summary disclosure form shall refer to the 1092
location in the health care contract, whether a page number, 1093
section of the contract, appendix, or other identifiable 1094
location, that specifies the provisions in the contract to which 1095
the information in the form refers. 1096

(2) The summary disclosure form shall include all of the 1097
following statements: 1098

(a) That the form is a guide to the health care contract 1099
and that the terms and conditions of the health care contract 1100
constitute the contract rights of the parties; 1101

(b) That reading the form is not a substitute for reading 1102
the entire health care contract; 1103

(c) That by signing the health care contract, the 1104
participating provider will be bound by the contract's terms and 1105
conditions; 1106

(d) That the terms and conditions of the health care 1107
contract may be amended pursuant to section 3963.04 of the 1108
Revised Code and the participating provider is encouraged to 1109
carefully read any proposed amendments sent after execution of 1110
the contract; 1111

(e) That nothing in the summary disclosure form creates 1112
any additional rights or causes of action in favor of either 1113
party. 1114

(3) No contracting entity that includes any information in 1115
the summary disclosure form with the reasonable belief that the 1116
information is truthful or accurate shall be subject to a civil 1117
action for damages or to binding arbitration based on the 1118
summary disclosure form. Division (B)(3) of this section does 1119
not impair or affect any power of the department of insurance to 1120
enforce any applicable law. 1121

(4) The summary disclosure form described in divisions (B) 1122
(1) and (2) of this section shall be in substantially the 1123
following form: 1124

"SUMMARY DISCLOSURE FORM	1125
(1) Compensation terms	1126
(a) Manner of payment	1127
[] Fee for service	1128
[] Capitation	1129
[] Risk	1130
[] Other See	1131
(b) Fee schedule available at	1132
(c) Fee calculation schedule available at	1133
(d) Identity of internal processing edits available	1134
at	1135
(e) Information in (c) and (d) is not required if	1136
information in (b) is provided.	1137
(2) List of products or networks covered by this contract	1138
[]	1139
[]	1140
[]	1141
[]	1142
[]	1143
(3) Term of this contract	1144
(4) Contracting entity or payer responsible for processing	1145
payment available at	1146
(5) Internal mechanism for resolving disputes regarding	1147
contract terms available at	1148

(6) Addenda to contract	1149
Title Subject	1150
(a)	1151
(b)	1152
(c)	1153
(d)	1154
(7) Telephone number to access a readily available	1155
mechanism, such as a specific web site address, to allow a	1156
participating provider to receive the information in (1) through	1157
(6) from the payer.	1158
IMPORTANT INFORMATION - PLEASE READ CAREFULLY	1159
The information provided in this Summary Disclosure Form	1160
is a guide to the attached Health Care Contract as defined in	1161
section 3963.01(G) <u>3963.01(I)</u> of the Ohio Revised Code. The	1162
terms and conditions of the attached Health Care Contract	1163
constitute the contract rights of the parties.	1164
Reading this Summary Disclosure Form is not a substitute	1165
for reading the entire Health Care Contract. When you sign the	1166
Health Care Contract, you will be bound by its terms and	1167
conditions. These terms and conditions may be amended over time	1168
pursuant to section 3963.04 of the Ohio Revised Code. You are	1169
encouraged to read any proposed amendments that are sent to you	1170
after execution of the Health Care Contract.	1171
Nothing in this Summary Disclosure Form creates any	1172
additional rights or causes of action in favor of either party."	1173
(C) When a contracting entity presents a proposed health	1174
care contract for consideration by a provider, the contracting	1175

entity shall provide in writing or make reasonably available the 1176
information required in division (A) (1) of this section. 1177

(D) The contracting entity shall identify any utilization 1178
management, quality improvement, or a similar program that the 1179
contracting entity uses to review, monitor, evaluate, or assess 1180
the services provided pursuant to a health care contract. The 1181
contracting entity shall disclose the policies, procedures, or 1182
guidelines of such a program applicable to a participating 1183
provider upon request by the participating provider within 1184
fourteen days after the date of the request. 1185

(E) Nothing in this section shall be construed as 1186
preventing or affecting the application of section 1753.07 of 1187
the Revised Code that would otherwise apply to a contract with a 1188
participating provider. 1189

(F) The requirements of division (C) of this section do 1190
not prohibit a contracting entity from requiring a reasonable 1191
confidentiality agreement between the provider and the 1192
contracting entity regarding the terms of the proposed health 1193
care contract. If either party violates the confidentiality 1194
agreement, a party to the confidentiality agreement may bring a 1195
civil action to enjoin the other party from continuing any act 1196
that is in violation of the confidentiality agreement, to 1197
recover damages, to terminate the contract, or to obtain any 1198
combination of relief. 1199

Sec. 4725.19. (A) In accordance with Chapter 119. of the 1200
Revised Code and by an affirmative vote of a majority of its 1201
members, the state vision professionals board, for any of the 1202
reasons specified in division (B) of this section, shall refuse 1203
to grant a certificate of licensure to practice optometry to an 1204
applicant and may, with respect to a licensed optometrist, do 1205

one or more of the following: 1206

(1) Suspend the operation of any certificate of licensure, 1207
topical ocular pharmaceutical agents certificate, or therapeutic 1208
pharmaceutical agents certificate, or all certificates granted 1209
by it to the optometrist; 1210

(2) Permanently revoke any or all of the certificates; 1211

(3) Limit or otherwise place restrictions on any or all of 1212
the certificates; 1213

(4) Reprimand the optometrist; 1214

(5) Impose a monetary penalty. If the reason for which the 1215
board is imposing the penalty involves a criminal offense that 1216
carries a fine under the Revised Code, the penalty shall not 1217
exceed the maximum fine that may be imposed for the criminal 1218
offense. In any other case, the penalty imposed by the board 1219
shall not exceed five hundred dollars. 1220

(6) Require the optometrist to take corrective action 1221
courses. 1222

The amount and content of corrective action courses shall 1223
be established by the board in rules adopted under section 1224
4725.09 of the Revised Code. 1225

(B) The sanctions specified in division (A) of this 1226
section may be taken by the board for any of the following 1227
reasons: 1228

(1) Committing fraud in passing the licensing examination 1229
or making false or purposely misleading statements in an 1230
application for a certificate of licensure; 1231

(2) Being at any time guilty of immorality, regardless of 1232

the jurisdiction in which the act was committed;	1233
(3) Being guilty of dishonesty or unprofessional conduct	1234
in the practice of optometry;	1235
(4) Being at any time guilty of a felony, regardless of	1236
the jurisdiction in which the act was committed;	1237
(5) Being at any time guilty of a misdemeanor committed in	1238
the course of practice, regardless of the jurisdiction in which	1239
the act was committed;	1240
(6) Violating the conditions of any limitation or other	1241
restriction placed by the board on any certificate issued by the	1242
board;	1243
(7) Engaging in the practice of optometry as provided in	1244
division (A) (1), (2), or (3) of section 4725.01 of the Revised	1245
Code when the certificate authorizing that practice is under	1246
suspension, in which case the board shall permanently revoke the	1247
certificate;	1248
(8) Being denied a license to practice optometry in	1249
another state or country or being subject to any other sanction	1250
by the optometric licensing authority of another state or	1251
country, other than sanctions imposed for the nonpayment of	1252
fees;	1253
(9) Departing from or failing to conform to acceptable and	1254
prevailing standards of care in the practice of optometry as	1255
followed by similar practitioners under the same or similar	1256
circumstances, regardless of whether actual injury to a patient	1257
is established;	1258
(10) Failing to maintain comprehensive patient records;	1259
(11) Advertising a price of optical accessories, eye	1260

examinations, or other products or services by any means that 1261
would deceive or mislead the public; 1262

(12) Being addicted to the use of alcohol, stimulants, 1263
narcotics, or any other substance which impairs the intellect 1264
and judgment to such an extent as to hinder or diminish the 1265
performance of the duties included in the person's practice of 1266
optometry; 1267

(13) Engaging in the practice of optometry as provided in 1268
division (A) (2) or (3) of section 4725.01 of the Revised Code 1269
without authority to do so or, if authorized, in a manner 1270
inconsistent with the authority granted; 1271

(14) Failing to make a report to the board as required by 1272
division (A) of section 4725.21 or section 4725.31 of the 1273
Revised Code; 1274

(15) Soliciting patients from door to door or establishing 1275
temporary offices, in which case the board shall suspend all 1276
certificates held by the optometrist; 1277

(16) Except as provided in division (D) of this section: 1278

(a) Waiving the payment of all or any part of a deductible 1279
or copayment that a patient, pursuant to a health insurance or 1280
health care policy, contract, or plan that covers optometric 1281
services, would otherwise be required to pay if the waiver is 1282
used as an enticement to a patient or group of patients to 1283
receive health care services from that optometrist. 1284

(b) Advertising that the optometrist will waive the 1285
payment of all or any part of a deductible or copayment that a 1286
patient, pursuant to a health insurance or health care policy, 1287
contract, or plan that covers optometric services, would 1288
otherwise be required to pay. 1289

(17) Failing to comply with the requirements in section 1290
3719.061 of the Revised Code before issuing for a minor a 1291
prescription for an analgesic controlled substance authorized 1292
pursuant to section 4725.091 of the Revised Code that is an 1293
opioid analgesic, as defined in section 3719.01 of the Revised 1294
Code; 1295

(18) Violating the rules adopted under section 4725.66 of 1296
the Revised Code; 1297

(19) A pattern of continuous or repeated violations of 1298
division (E) (2) or (3) of section 3963.02 of the Revised Code. 1299

(C) Any person who is the holder of a certificate of 1300
licensure, or who is an applicant for a certificate of licensure 1301
against whom is preferred any charges, shall be furnished by the 1302
board with a copy of the complaint and shall have a hearing 1303
before the board in accordance with Chapter 119. of the Revised 1304
Code. 1305

(D) Sanctions shall not be imposed under division (B) (17) 1306
of this section against any optometrist who waives deductibles 1307
and copayments: 1308

(1) In compliance with the health benefit plan that 1309
expressly allows such a practice. Waiver of the deductibles or 1310
copayments shall be made only with the full knowledge and 1311
consent of the plan purchaser, payer, and third-party 1312
administrator. Documentation of the consent shall be made 1313
available to the board upon request. 1314

(2) For professional services rendered to any other 1315
optometrist licensed by the board, to the extent allowed by 1316
sections 4725.01 to 4725.34 of the Revised Code and the rules of 1317
the board. 1318

Sec. 4731.22. (A) The state medical board, by an 1319
affirmative vote of not fewer than six of its members, may 1320
limit, revoke, or suspend a license or certificate to practice 1321
or certificate to recommend, refuse to grant a license or 1322
certificate, refuse to renew a license or certificate, refuse to 1323
reinstate a license or certificate, or reprimand or place on 1324
probation the holder of a license or certificate if the 1325
individual applying for or holding the license or certificate is 1326
found by the board to have committed fraud during the 1327
administration of the examination for a license or certificate 1328
to practice or to have committed fraud, misrepresentation, or 1329
deception in applying for, renewing, or securing any license or 1330
certificate to practice or certificate to recommend issued by 1331
the board. 1332

(B) The board, by an affirmative vote of not fewer than 1333
six members, shall, to the extent permitted by law, limit, 1334
revoke, or suspend a license or certificate to practice or 1335
certificate to recommend, refuse to issue a license or 1336
certificate, refuse to renew a license or certificate, refuse to 1337
reinstate a license or certificate, or reprimand or place on 1338
probation the holder of a license or certificate for one or more 1339
of the following reasons: 1340

(1) Permitting one's name or one's license or certificate 1341
to practice to be used by a person, group, or corporation when 1342
the individual concerned is not actually directing the treatment 1343
given; 1344

(2) Failure to maintain minimal standards applicable to 1345
the selection or administration of drugs, or failure to employ 1346
acceptable scientific methods in the selection of drugs or other 1347
modalities for treatment of disease; 1348

(3) Except as provided in section 4731.97 of the Revised Code, selling, giving away, personally furnishing, prescribing, or administering drugs for other than legal and legitimate therapeutic purposes or a plea of guilty to, a judicial finding of guilt of, or a judicial finding of eligibility for intervention in lieu of conviction of, a violation of any federal or state law regulating the possession, distribution, or use of any drug;

(4) Willfully betraying a professional confidence.

For purposes of this division, "willfully betraying a professional confidence" does not include providing any information, documents, or reports under sections 307.621 to 307.629 of the Revised Code to a child fatality review board; does not include providing any information, documents, or reports to the director of health pursuant to guidelines established under section 3701.70 of the Revised Code; does not include written notice to a mental health professional under section 4731.62 of the Revised Code; and does not include the making of a report of an employee's use of a drug of abuse, or a report of a condition of an employee other than one involving the use of a drug of abuse, to the employer of the employee as described in division (B) of section 2305.33 of the Revised Code. Nothing in this division affects the immunity from civil liability conferred by section 2305.33 or 4731.62 of the Revised Code upon a physician who makes a report in accordance with section 2305.33 or notifies a mental health professional in accordance with section 4731.62 of the Revised Code. As used in this division, "employee," "employer," and "physician" have the same meanings as in section 2305.33 of the Revised Code.

(5) Making a false, fraudulent, deceptive, or misleading

statement in the solicitation of or advertising for patients; in 1379
relation to the practice of medicine and surgery, osteopathic 1380
medicine and surgery, podiatric medicine and surgery, or a 1381
limited branch of medicine; or in securing or attempting to 1382
secure any license or certificate to practice issued by the 1383
board. 1384

As used in this division, "false, fraudulent, deceptive, 1385
or misleading statement" means a statement that includes a 1386
misrepresentation of fact, is likely to mislead or deceive 1387
because of a failure to disclose material facts, is intended or 1388
is likely to create false or unjustified expectations of 1389
favorable results, or includes representations or implications 1390
that in reasonable probability will cause an ordinarily prudent 1391
person to misunderstand or be deceived. 1392

(6) A departure from, or the failure to conform to, 1393
minimal standards of care of similar practitioners under the 1394
same or similar circumstances, whether or not actual injury to a 1395
patient is established; 1396

(7) Representing, with the purpose of obtaining 1397
compensation or other advantage as personal gain or for any 1398
other person, that an incurable disease or injury, or other 1399
incurable condition, can be permanently cured; 1400

(8) The obtaining of, or attempting to obtain, money or 1401
anything of value by fraudulent misrepresentations in the course 1402
of practice; 1403

(9) A plea of guilty to, a judicial finding of guilt of, 1404
or a judicial finding of eligibility for intervention in lieu of 1405
conviction for, a felony; 1406

(10) Commission of an act that constitutes a felony in 1407

this state, regardless of the jurisdiction in which the act was 1408
committed; 1409

(11) A plea of guilty to, a judicial finding of guilt of, 1410
or a judicial finding of eligibility for intervention in lieu of 1411
conviction for, a misdemeanor committed in the course of 1412
practice; 1413

(12) Commission of an act in the course of practice that 1414
constitutes a misdemeanor in this state, regardless of the 1415
jurisdiction in which the act was committed; 1416

(13) A plea of guilty to, a judicial finding of guilt of, 1417
or a judicial finding of eligibility for intervention in lieu of 1418
conviction for, a misdemeanor involving moral turpitude; 1419

(14) Commission of an act involving moral turpitude that 1420
constitutes a misdemeanor in this state, regardless of the 1421
jurisdiction in which the act was committed; 1422

(15) Violation of the conditions of limitation placed by 1423
the board upon a license or certificate to practice; 1424

(16) Failure to pay license renewal fees specified in this 1425
chapter; 1426

(17) Except as authorized in section 4731.31 of the 1427
Revised Code, engaging in the division of fees for referral of 1428
patients, or the receiving of a thing of value in return for a 1429
specific referral of a patient to utilize a particular service 1430
or business; 1431

(18) Subject to section 4731.226 of the Revised Code, 1432
violation of any provision of a code of ethics of the American 1433
medical association, the American osteopathic association, the 1434
American podiatric medical association, or any other national 1435

professional organizations that the board specifies by rule. The 1436
state medical board shall obtain and keep on file current copies 1437
of the codes of ethics of the various national professional 1438
organizations. The individual whose license or certificate is 1439
being suspended or revoked shall not be found to have violated 1440
any provision of a code of ethics of an organization not 1441
appropriate to the individual's profession. 1442

For purposes of this division, a "provision of a code of 1443
ethics of a national professional organization" does not include 1444
any provision that would preclude the making of a report by a 1445
physician of an employee's use of a drug of abuse, or of a 1446
condition of an employee other than one involving the use of a 1447
drug of abuse, to the employer of the employee as described in 1448
division (B) of section 2305.33 of the Revised Code. Nothing in 1449
this division affects the immunity from civil liability 1450
conferred by that section upon a physician who makes either type 1451
of report in accordance with division (B) of that section. As 1452
used in this division, "employee," "employer," and "physician" 1453
have the same meanings as in section 2305.33 of the Revised 1454
Code. 1455

(19) Inability to practice according to acceptable and 1456
prevailing standards of care by reason of mental illness or 1457
physical illness, including, but not limited to, physical 1458
deterioration that adversely affects cognitive, motor, or 1459
perceptive skills. 1460

In enforcing this division, the board, upon a showing of a 1461
possible violation, may compel any individual authorized to 1462
practice by this chapter or who has submitted an application 1463
pursuant to this chapter to submit to a mental examination, 1464
physical examination, including an HIV test, or both a mental 1465

and a physical examination. The expense of the examination is 1466
the responsibility of the individual compelled to be examined. 1467
Failure to submit to a mental or physical examination or consent 1468
to an HIV test ordered by the board constitutes an admission of 1469
the allegations against the individual unless the failure is due 1470
to circumstances beyond the individual's control, and a default 1471
and final order may be entered without the taking of testimony 1472
or presentation of evidence. If the board finds an individual 1473
unable to practice because of the reasons set forth in this 1474
division, the board shall require the individual to submit to 1475
care, counseling, or treatment by physicians approved or 1476
designated by the board, as a condition for initial, continued, 1477
reinstated, or renewed authority to practice. An individual 1478
affected under this division shall be afforded an opportunity to 1479
demonstrate to the board the ability to resume practice in 1480
compliance with acceptable and prevailing standards under the 1481
provisions of the individual's license or certificate. For the 1482
purpose of this division, any individual who applies for or 1483
receives a license or certificate to practice under this chapter 1484
accepts the privilege of practicing in this state and, by so 1485
doing, shall be deemed to have given consent to submit to a 1486
mental or physical examination when directed to do so in writing 1487
by the board, and to have waived all objections to the 1488
admissibility of testimony or examination reports that 1489
constitute a privileged communication. 1490

(20) Except as provided in division (F)(1)(b) of section 1491
4731.282 of the Revised Code or when civil penalties are imposed 1492
under section 4731.225 of the Revised Code, and subject to 1493
section 4731.226 of the Revised Code, violating or attempting to 1494
violate, directly or indirectly, or assisting in or abetting the 1495
violation of, or conspiring to violate, any provisions of this 1496

chapter or any rule promulgated by the board. 1497

This division does not apply to a violation or attempted 1498
violation of, assisting in or abetting the violation of, or a 1499
conspiracy to violate, any provision of this chapter or any rule 1500
adopted by the board that would preclude the making of a report 1501
by a physician of an employee's use of a drug of abuse, or of a 1502
condition of an employee other than one involving the use of a 1503
drug of abuse, to the employer of the employee as described in 1504
division (B) of section 2305.33 of the Revised Code. Nothing in 1505
this division affects the immunity from civil liability 1506
conferred by that section upon a physician who makes either type 1507
of report in accordance with division (B) of that section. As 1508
used in this division, "employee," "employer," and "physician" 1509
have the same meanings as in section 2305.33 of the Revised 1510
Code. 1511

(21) The violation of section 3701.79 of the Revised Code 1512
or of any abortion rule adopted by the director of health 1513
pursuant to section 3701.341 of the Revised Code; 1514

(22) Any of the following actions taken by an agency 1515
responsible for authorizing, certifying, or regulating an 1516
individual to practice a health care occupation or provide 1517
health care services in this state or another jurisdiction, for 1518
any reason other than the nonpayment of fees: the limitation, 1519
revocation, or suspension of an individual's license to 1520
practice; acceptance of an individual's license surrender; 1521
denial of a license; refusal to renew or reinstate a license; 1522
imposition of probation; or issuance of an order of censure or 1523
other reprimand; 1524

(23) The violation of section 2919.12 of the Revised Code 1525
or the performance or inducement of an abortion upon a pregnant 1526

woman with actual knowledge that the conditions specified in 1527
division (B) of section 2317.56 of the Revised Code have not 1528
been satisfied or with a heedless indifference as to whether 1529
those conditions have been satisfied, unless an affirmative 1530
defense as specified in division (H) (2) of that section would 1531
apply in a civil action authorized by division (H) (1) of that 1532
section; 1533

(24) The revocation, suspension, restriction, reduction, 1534
or termination of clinical privileges by the United States 1535
department of defense or department of veterans affairs or the 1536
termination or suspension of a certificate of registration to 1537
prescribe drugs by the drug enforcement administration of the 1538
United States department of justice; 1539

(25) Termination or suspension from participation in the 1540
medicare or medicaid programs by the department of health and 1541
human services or other responsible agency for any act or acts 1542
that also would constitute a violation of division (B) (2), (3), 1543
(6), (8), or (19) of this section; 1544

(26) Impairment of ability to practice according to 1545
acceptable and prevailing standards of care because of habitual 1546
or excessive use or abuse of drugs, alcohol, or other substances 1547
that impair ability to practice. 1548

For the purposes of this division, any individual 1549
authorized to practice by this chapter accepts the privilege of 1550
practicing in this state subject to supervision by the board. By 1551
filing an application for or holding a license or certificate to 1552
practice under this chapter, an individual shall be deemed to 1553
have given consent to submit to a mental or physical examination 1554
when ordered to do so by the board in writing, and to have 1555
waived all objections to the admissibility of testimony or 1556

examination reports that constitute privileged communications. 1557

If it has reason to believe that any individual authorized 1558
to practice by this chapter or any applicant for licensure or 1559
certification to practice suffers such impairment, the board may 1560
compel the individual to submit to a mental or physical 1561
examination, or both. The expense of the examination is the 1562
responsibility of the individual compelled to be examined. Any 1563
mental or physical examination required under this division 1564
shall be undertaken by a treatment provider or physician who is 1565
qualified to conduct the examination and who is chosen by the 1566
board. 1567

Failure to submit to a mental or physical examination 1568
ordered by the board constitutes an admission of the allegations 1569
against the individual unless the failure is due to 1570
circumstances beyond the individual's control, and a default and 1571
final order may be entered without the taking of testimony or 1572
presentation of evidence. If the board determines that the 1573
individual's ability to practice is impaired, the board shall 1574
suspend the individual's license or certificate or deny the 1575
individual's application and shall require the individual, as a 1576
condition for initial, continued, reinstated, or renewed 1577
licensure or certification to practice, to submit to treatment. 1578

Before being eligible to apply for reinstatement of a 1579
license or certificate suspended under this division, the 1580
impaired practitioner shall demonstrate to the board the ability 1581
to resume practice in compliance with acceptable and prevailing 1582
standards of care under the provisions of the practitioner's 1583
license or certificate. The demonstration shall include, but 1584
shall not be limited to, the following: 1585

(a) Certification from a treatment provider approved under 1586

section 4731.25 of the Revised Code that the individual has 1587
successfully completed any required inpatient treatment; 1588

(b) Evidence of continuing full compliance with an 1589
aftercare contract or consent agreement; 1590

(c) Two written reports indicating that the individual's 1591
ability to practice has been assessed and that the individual 1592
has been found capable of practicing according to acceptable and 1593
prevailing standards of care. The reports shall be made by 1594
individuals or providers approved by the board for making the 1595
assessments and shall describe the basis for their 1596
determination. 1597

The board may reinstate a license or certificate suspended 1598
under this division after that demonstration and after the 1599
individual has entered into a written consent agreement. 1600

When the impaired practitioner resumes practice, the board 1601
shall require continued monitoring of the individual. The 1602
monitoring shall include, but not be limited to, compliance with 1603
the written consent agreement entered into before reinstatement 1604
or with conditions imposed by board order after a hearing, and, 1605
upon termination of the consent agreement, submission to the 1606
board for at least two years of annual written progress reports 1607
made under penalty of perjury stating whether the individual has 1608
maintained sobriety. 1609

(27) A second or subsequent violation of section 4731.66 1610
or 4731.69 of the Revised Code; 1611

(28) Except as provided in division (N) of this section: 1612

(a) Waiving the payment of all or any part of a deductible 1613
or copayment that a patient, pursuant to a health insurance or 1614
health care policy, contract, or plan that covers the 1615

individual's services, otherwise would be required to pay if the 1616
waiver is used as an enticement to a patient or group of 1617
patients to receive health care services from that individual; 1618

(b) Advertising that the individual will waive the payment 1619
of all or any part of a deductible or copayment that a patient, 1620
pursuant to a health insurance or health care policy, contract, 1621
or plan that covers the individual's services, otherwise would 1622
be required to pay. 1623

(29) Failure to use universal blood and body fluid 1624
precautions established by rules adopted under section 4731.051 1625
of the Revised Code; 1626

(30) Failure to provide notice to, and receive 1627
acknowledgment of the notice from, a patient when required by 1628
section 4731.143 of the Revised Code prior to providing 1629
nonemergency professional services, or failure to maintain that 1630
notice in the patient's medical record; 1631

(31) Failure of a physician supervising a physician 1632
assistant to maintain supervision in accordance with the 1633
requirements of Chapter 4730. of the Revised Code and the rules 1634
adopted under that chapter; 1635

(32) Failure of a physician or podiatrist to enter into a 1636
standard care arrangement with a clinical nurse specialist, 1637
certified nurse-midwife, or certified nurse practitioner with 1638
whom the physician or podiatrist is in collaboration pursuant to 1639
section 4731.27 of the Revised Code or failure to fulfill the 1640
responsibilities of collaboration after entering into a standard 1641
care arrangement; 1642

(33) Failure to comply with the terms of a consult 1643
agreement entered into with a pharmacist pursuant to section 1644

4729.39 of the Revised Code; 1645

(34) Failure to cooperate in an investigation conducted by 1646
the board under division (F) of this section, including failure 1647
to comply with a subpoena or order issued by the board or 1648
failure to answer truthfully a question presented by the board 1649
in an investigative interview, an investigative office 1650
conference, at a deposition, or in written interrogatories, 1651
except that failure to cooperate with an investigation shall not 1652
constitute grounds for discipline under this section if a court 1653
of competent jurisdiction has issued an order that either 1654
quashes a subpoena or permits the individual to withhold the 1655
testimony or evidence in issue; 1656

(35) Failure to supervise an oriental medicine 1657
practitioner or acupuncturist in accordance with Chapter 4762. 1658
of the Revised Code and the board's rules for providing that 1659
supervision; 1660

(36) Failure to supervise an anesthesiologist assistant in 1661
accordance with Chapter 4760. of the Revised Code and the 1662
board's rules for supervision of an anesthesiologist assistant; 1663

(37) Assisting suicide, as defined in section 3795.01 of 1664
the Revised Code; 1665

(38) Failure to comply with the requirements of section 1666
2317.561 of the Revised Code; 1667

(39) Failure to supervise a radiologist assistant in 1668
accordance with Chapter 4774. of the Revised Code and the 1669
board's rules for supervision of radiologist assistants; 1670

(40) Performing or inducing an abortion at an office or 1671
facility with knowledge that the office or facility fails to 1672
post the notice required under section 3701.791 of the Revised 1673

Code;	1674
(41) Failure to comply with the standards and procedures	1675
established in rules under section 4731.054 of the Revised Code	1676
for the operation of or the provision of care at a pain	1677
management clinic;	1678
(42) Failure to comply with the standards and procedures	1679
established in rules under section 4731.054 of the Revised Code	1680
for providing supervision, direction, and control of individuals	1681
at a pain management clinic;	1682
(43) Failure to comply with the requirements of section	1683
4729.79 or 4731.055 of the Revised Code, unless the state board	1684
of pharmacy no longer maintains a drug database pursuant to	1685
section 4729.75 of the Revised Code;	1686
(44) Failure to comply with the requirements of section	1687
2919.171, 2919.202, or 2919.203 of the Revised Code or failure	1688
to submit to the department of health in accordance with a court	1689
order a complete report as described in section 2919.171 or	1690
2919.202 of the Revised Code;	1691
(45) Practicing at a facility that is subject to licensure	1692
as a category III terminal distributor of dangerous drugs with a	1693
pain management clinic classification unless the person	1694
operating the facility has obtained and maintains the license	1695
with the classification;	1696
(46) Owning a facility that is subject to licensure as a	1697
category III terminal distributor of dangerous drugs with a pain	1698
management clinic classification unless the facility is licensed	1699
with the classification;	1700
(47) Failure to comply with the requirement regarding	1701
maintaining notes described in division (B) of section 2919.191	1702

of the Revised Code or failure to satisfy the requirements of 1703
section 2919.191 of the Revised Code prior to performing or 1704
inducing an abortion upon a pregnant woman; 1705

(48) Failure to comply with the requirements in section 1706
3719.061 of the Revised Code before issuing for a minor a 1707
prescription for an opioid analgesic, as defined in section 1708
3719.01 of the Revised Code; 1709

(49) Failure to comply with the requirements of section 1710
4731.30 of the Revised Code or rules adopted under section 1711
4731.301 of the Revised Code when recommending treatment with 1712
medical marijuana; 1713

(50) Practicing at a facility, clinic, or other location 1714
that is subject to licensure as a category III terminal 1715
distributor of dangerous drugs with an office-based opioid 1716
treatment classification unless the person operating that place 1717
has obtained and maintains the license with the classification; 1718

(51) Owning a facility, clinic, or other location that is 1719
subject to licensure as a category III terminal distributor of 1720
dangerous drugs with an office-based opioid treatment 1721
classification unless that place is licensed with the 1722
classification; 1723

(52) A pattern of continuous or repeated violations of 1724
division (E) (2) or (3) of section 3963.02 of the Revised Code. 1725

(C) Disciplinary actions taken by the board under 1726
divisions (A) and (B) of this section shall be taken pursuant to 1727
an adjudication under Chapter 119. of the Revised Code, except 1728
that in lieu of an adjudication, the board may enter into a 1729
consent agreement with an individual to resolve an allegation of 1730
a violation of this chapter or any rule adopted under it. A 1731

consent agreement, when ratified by an affirmative vote of not 1732
fewer than six members of the board, shall constitute the 1733
findings and order of the board with respect to the matter 1734
addressed in the agreement. If the board refuses to ratify a 1735
consent agreement, the admissions and findings contained in the 1736
consent agreement shall be of no force or effect. 1737

A telephone conference call may be utilized for 1738
ratification of a consent agreement that revokes or suspends an 1739
individual's license or certificate to practice or certificate 1740
to recommend. The telephone conference call shall be considered 1741
a special meeting under division (F) of section 121.22 of the 1742
Revised Code. 1743

If the board takes disciplinary action against an 1744
individual under division (B) of this section for a second or 1745
subsequent plea of guilty to, or judicial finding of guilt of, a 1746
violation of section 2919.123 of the Revised Code, the 1747
disciplinary action shall consist of a suspension of the 1748
individual's license or certificate to practice for a period of 1749
at least one year or, if determined appropriate by the board, a 1750
more serious sanction involving the individual's license or 1751
certificate to practice. Any consent agreement entered into 1752
under this division with an individual that pertains to a second 1753
or subsequent plea of guilty to, or judicial finding of guilt 1754
of, a violation of that section shall provide for a suspension 1755
of the individual's license or certificate to practice for a 1756
period of at least one year or, if determined appropriate by the 1757
board, a more serious sanction involving the individual's 1758
license or certificate to practice. 1759

(D) For purposes of divisions (B) (10), (12), and (14) of 1760
this section, the commission of the act may be established by a 1761

finding by the board, pursuant to an adjudication under Chapter 1762
119. of the Revised Code, that the individual committed the act. 1763
The board does not have jurisdiction under those divisions if 1764
the trial court renders a final judgment in the individual's 1765
favor and that judgment is based upon an adjudication on the 1766
merits. The board has jurisdiction under those divisions if the 1767
trial court issues an order of dismissal upon technical or 1768
procedural grounds. 1769

(E) The sealing of conviction records by any court shall 1770
have no effect upon a prior board order entered under this 1771
section or upon the board's jurisdiction to take action under 1772
this section if, based upon a plea of guilty, a judicial finding 1773
of guilt, or a judicial finding of eligibility for intervention 1774
in lieu of conviction, the board issued a notice of opportunity 1775
for a hearing prior to the court's order to seal the records. 1776
The board shall not be required to seal, destroy, redact, or 1777
otherwise modify its records to reflect the court's sealing of 1778
conviction records. 1779

(F) (1) The board shall investigate evidence that appears 1780
to show that a person has violated any provision of this chapter 1781
or any rule adopted under it. Any person may report to the board 1782
in a signed writing any information that the person may have 1783
that appears to show a violation of any provision of this 1784
chapter or any rule adopted under it. In the absence of bad 1785
faith, any person who reports information of that nature or who 1786
testifies before the board in any adjudication conducted under 1787
Chapter 119. of the Revised Code shall not be liable in damages 1788
in a civil action as a result of the report or testimony. Each 1789
complaint or allegation of a violation received by the board 1790
shall be assigned a case number and shall be recorded by the 1791
board. 1792

(2) Investigations of alleged violations of this chapter 1793
or any rule adopted under it shall be supervised by the 1794
supervising member elected by the board in accordance with 1795
section 4731.02 of the Revised Code and by the secretary as 1796
provided in section 4731.39 of the Revised Code. The president 1797
may designate another member of the board to supervise the 1798
investigation in place of the supervising member. No member of 1799
the board who supervises the investigation of a case shall 1800
participate in further adjudication of the case. 1801

(3) In investigating a possible violation of this chapter 1802
or any rule adopted under this chapter, or in conducting an 1803
inspection under division (E) of section 4731.054 of the Revised 1804
Code, the board may question witnesses, conduct interviews, 1805
administer oaths, order the taking of depositions, inspect and 1806
copy any books, accounts, papers, records, or documents, issue 1807
subpoenas, and compel the attendance of witnesses and production 1808
of books, accounts, papers, records, documents, and testimony, 1809
except that a subpoena for patient record information shall not 1810
be issued without consultation with the attorney general's 1811
office and approval of the secretary and supervising member of 1812
the board. 1813

(a) Before issuance of a subpoena for patient record 1814
information, the secretary and supervising member shall 1815
determine whether there is probable cause to believe that the 1816
complaint filed alleges a violation of this chapter or any rule 1817
adopted under it and that the records sought are relevant to the 1818
alleged violation and material to the investigation. The 1819
subpoena may apply only to records that cover a reasonable 1820
period of time surrounding the alleged violation. 1821

(b) On failure to comply with any subpoena issued by the 1822

board and after reasonable notice to the person being 1823
subpoenaed, the board may move for an order compelling the 1824
production of persons or records pursuant to the Rules of Civil 1825
Procedure. 1826

(c) A subpoena issued by the board may be served by a 1827
sheriff, the sheriff's deputy, or a board employee designated by 1828
the board. Service of a subpoena issued by the board may be made 1829
by delivering a copy of the subpoena to the person named 1830
therein, reading it to the person, or leaving it at the person's 1831
usual place of residence, usual place of business, or address on 1832
file with the board. When serving a subpoena to an applicant for 1833
or the holder of a license or certificate issued under this 1834
chapter, service of the subpoena may be made by certified mail, 1835
return receipt requested, and the subpoena shall be deemed 1836
served on the date delivery is made or the date the person 1837
refuses to accept delivery. If the person being served refuses 1838
to accept the subpoena or is not located, service may be made to 1839
an attorney who notifies the board that the attorney is 1840
representing the person. 1841

(d) A sheriff's deputy who serves a subpoena shall receive 1842
the same fees as a sheriff. Each witness who appears before the 1843
board in obedience to a subpoena shall receive the fees and 1844
mileage provided for under section 119.094 of the Revised Code. 1845

(4) All hearings, investigations, and inspections of the 1846
board shall be considered civil actions for the purposes of 1847
section 2305.252 of the Revised Code. 1848

(5) A report required to be submitted to the board under 1849
this chapter, a complaint, or information received by the board 1850
pursuant to an investigation or pursuant to an inspection under 1851
division (E) of section 4731.054 of the Revised Code is 1852

confidential and not subject to discovery in any civil action. 1853

The board shall conduct all investigations or inspections 1854
and proceedings in a manner that protects the confidentiality of 1855
patients and persons who file complaints with the board. The 1856
board shall not make public the names or any other identifying 1857
information about patients or complainants unless proper consent 1858
is given or, in the case of a patient, a waiver of the patient 1859
privilege exists under division (B) of section 2317.02 of the 1860
Revised Code, except that consent or a waiver of that nature is 1861
not required if the board possesses reliable and substantial 1862
evidence that no bona fide physician-patient relationship 1863
exists. 1864

The board may share any information it receives pursuant 1865
to an investigation or inspection, including patient records and 1866
patient record information, with law enforcement agencies, other 1867
licensing boards, and other governmental agencies that are 1868
prosecuting, adjudicating, or investigating alleged violations 1869
of statutes or administrative rules. An agency or board that 1870
receives the information shall comply with the same requirements 1871
regarding confidentiality as those with which the state medical 1872
board must comply, notwithstanding any conflicting provision of 1873
the Revised Code or procedure of the agency or board that 1874
applies when it is dealing with other information in its 1875
possession. In a judicial proceeding, the information may be 1876
admitted into evidence only in accordance with the Rules of 1877
Evidence, but the court shall require that appropriate measures 1878
are taken to ensure that confidentiality is maintained with 1879
respect to any part of the information that contains names or 1880
other identifying information about patients or complainants 1881
whose confidentiality was protected by the state medical board 1882
when the information was in the board's possession. Measures to 1883

ensure confidentiality that may be taken by the court include 1884
sealing its records or deleting specific information from its 1885
records. 1886

(6) On a quarterly basis, the board shall prepare a report 1887
that documents the disposition of all cases during the preceding 1888
three months. The report shall contain the following information 1889
for each case with which the board has completed its activities: 1890

(a) The case number assigned to the complaint or alleged 1891
violation; 1892

(b) The type of license or certificate to practice, if 1893
any, held by the individual against whom the complaint is 1894
directed; 1895

(c) A description of the allegations contained in the 1896
complaint; 1897

(d) The disposition of the case. 1898

The report shall state how many cases are still pending 1899
and shall be prepared in a manner that protects the identity of 1900
each person involved in each case. The report shall be a public 1901
record under section 149.43 of the Revised Code. 1902

(G) If the secretary and supervising member determine both 1903
of the following, they may recommend that the board suspend an 1904
individual's license or certificate to practice or certificate 1905
to recommend without a prior hearing: 1906

(1) That there is clear and convincing evidence that an 1907
individual has violated division (B) of this section; 1908

(2) That the individual's continued practice presents a 1909
danger of immediate and serious harm to the public. 1910

Written allegations shall be prepared for consideration by 1911
the board. The board, upon review of those allegations and by an 1912
affirmative vote of not fewer than six of its members, excluding 1913
the secretary and supervising member, may suspend a license or 1914
certificate without a prior hearing. A telephone conference call 1915
may be utilized for reviewing the allegations and taking the 1916
vote on the summary suspension. 1917

The board shall issue a written order of suspension by 1918
certified mail or in person in accordance with section 119.07 of 1919
the Revised Code. The order shall not be subject to suspension 1920
by the court during pendency of any appeal filed under section 1921
119.12 of the Revised Code. If the individual subject to the 1922
summary suspension requests an adjudicatory hearing by the 1923
board, the date set for the hearing shall be within fifteen 1924
days, but not earlier than seven days, after the individual 1925
requests the hearing, unless otherwise agreed to by both the 1926
board and the individual. 1927

Any summary suspension imposed under this division shall 1928
remain in effect, unless reversed on appeal, until a final 1929
adjudicative order issued by the board pursuant to this section 1930
and Chapter 119. of the Revised Code becomes effective. The 1931
board shall issue its final adjudicative order within seventy- 1932
five days after completion of its hearing. A failure to issue 1933
the order within seventy-five days shall result in dissolution 1934
of the summary suspension order but shall not invalidate any 1935
subsequent, final adjudicative order. 1936

(H) If the board takes action under division (B) (9), (11), 1937
or (13) of this section and the judicial finding of guilt, 1938
guilty plea, or judicial finding of eligibility for intervention 1939
in lieu of conviction is overturned on appeal, upon exhaustion 1940

of the criminal appeal, a petition for reconsideration of the 1941
order may be filed with the board along with appropriate court 1942
documents. Upon receipt of a petition of that nature and 1943
supporting court documents, the board shall reinstate the 1944
individual's license or certificate to practice. The board may 1945
then hold an adjudication under Chapter 119. of the Revised Code 1946
to determine whether the individual committed the act in 1947
question. Notice of an opportunity for a hearing shall be given 1948
in accordance with Chapter 119. of the Revised Code. If the 1949
board finds, pursuant to an adjudication held under this 1950
division, that the individual committed the act or if no hearing 1951
is requested, the board may order any of the sanctions 1952
identified under division (B) of this section. 1953

(I) The license or certificate to practice issued to an 1954
individual under this chapter and the individual's practice in 1955
this state are automatically suspended as of the date of the 1956
individual's second or subsequent plea of guilty to, or judicial 1957
finding of guilt of, a violation of section 2919.123 of the 1958
Revised Code. In addition, the license or certificate to 1959
practice or certificate to recommend issued to an individual 1960
under this chapter and the individual's practice in this state 1961
are automatically suspended as of the date the individual pleads 1962
guilty to, is found by a judge or jury to be guilty of, or is 1963
subject to a judicial finding of eligibility for intervention in 1964
lieu of conviction in this state or treatment or intervention in 1965
lieu of conviction in another jurisdiction for any of the 1966
following criminal offenses in this state or a substantially 1967
equivalent criminal offense in another jurisdiction: aggravated 1968
murder, murder, voluntary manslaughter, felonious assault, 1969
kidnapping, rape, sexual battery, gross sexual imposition, 1970
aggravated arson, aggravated robbery, or aggravated burglary. 1971

Continued practice after suspension shall be considered 1972
practicing without a license or certificate. 1973

The board shall notify the individual subject to the 1974
suspension by certified mail or in person in accordance with 1975
section 119.07 of the Revised Code. If an individual whose 1976
license or certificate is automatically suspended under this 1977
division fails to make a timely request for an adjudication 1978
under Chapter 119. of the Revised Code, the board shall do 1979
whichever of the following is applicable: 1980

(1) If the automatic suspension under this division is for 1981
a second or subsequent plea of guilty to, or judicial finding of 1982
guilt of, a violation of section 2919.123 of the Revised Code, 1983
the board shall enter an order suspending the individual's 1984
license or certificate to practice for a period of at least one 1985
year or, if determined appropriate by the board, imposing a more 1986
serious sanction involving the individual's license or 1987
certificate to practice. 1988

(2) In all circumstances in which division (I)(1) of this 1989
section does not apply, enter a final order permanently revoking 1990
the individual's license or certificate to practice. 1991

(J) If the board is required by Chapter 119. of the 1992
Revised Code to give notice of an opportunity for a hearing and 1993
if the individual subject to the notice does not timely request 1994
a hearing in accordance with section 119.07 of the Revised Code, 1995
the board is not required to hold a hearing, but may adopt, by 1996
an affirmative vote of not fewer than six of its members, a 1997
final order that contains the board's findings. In that final 1998
order, the board may order any of the sanctions identified under 1999
division (A) or (B) of this section. 2000

(K) Any action taken by the board under division (B) of
this section resulting in a suspension from practice shall be
accompanied by a written statement of the conditions under which
the individual's license or certificate to practice may be
reinstated. The board shall adopt rules governing conditions to
be imposed for reinstatement. Reinstatement of a license or
certificate suspended pursuant to division (B) of this section
requires an affirmative vote of not fewer than six members of
the board.

(L) When the board refuses to grant or issue a license or
certificate to practice to an applicant, revokes an individual's
license or certificate to practice, refuses to renew an
individual's license or certificate to practice, or refuses to
reinstate an individual's license or certificate to practice,
the board may specify that its action is permanent. An
individual subject to a permanent action taken by the board is
forever thereafter ineligible to hold a license or certificate
to practice and the board shall not accept an application for
reinstatement of the license or certificate or for issuance of a
new license or certificate.

(M) Notwithstanding any other provision of the Revised
Code, all of the following apply:

(1) The surrender of a license or certificate issued under
this chapter shall not be effective unless or until accepted by
the board. A telephone conference call may be utilized for
acceptance of the surrender of an individual's license or
certificate to practice. The telephone conference call shall be
considered a special meeting under division (F) of section
121.22 of the Revised Code. Reinstatement of a license or
certificate surrendered to the board requires an affirmative

vote of not fewer than six members of the board. 2031

(2) An application for a license or certificate made under 2032
the provisions of this chapter may not be withdrawn without 2033
approval of the board. 2034

(3) Failure by an individual to renew a license or 2035
certificate to practice in accordance with this chapter or a 2036
certificate to recommend in accordance with rules adopted under 2037
section 4731.301 of the Revised Code shall not remove or limit 2038
the board's jurisdiction to take any disciplinary action under 2039
this section against the individual. 2040

(4) At the request of the board, a license or certificate 2041
holder shall immediately surrender to the board a license or 2042
certificate that the board has suspended, revoked, or 2043
permanently revoked. 2044

(N) Sanctions shall not be imposed under division (B) (28) 2045
of this section against any person who waives deductibles and 2046
copayments as follows: 2047

(1) In compliance with the health benefit plan that 2048
expressly allows such a practice. Waiver of the deductibles or 2049
copayments shall be made only with the full knowledge and 2050
consent of the plan purchaser, payer, and third-party 2051
administrator. Documentation of the consent shall be made 2052
available to the board upon request. 2053

(2) For professional services rendered to any other person 2054
authorized to practice pursuant to this chapter, to the extent 2055
allowed by this chapter and rules adopted by the board. 2056

(O) Under the board's investigative duties described in 2057
this section and subject to division (F) of this section, the 2058
board shall develop and implement a quality intervention program 2059

designed to improve through remedial education the clinical and 2060
communication skills of individuals authorized under this 2061
chapter to practice medicine and surgery, osteopathic medicine 2062
and surgery, and podiatric medicine and surgery. In developing 2063
and implementing the quality intervention program, the board may 2064
do all of the following: 2065

(1) Offer in appropriate cases as determined by the board 2066
an educational and assessment program pursuant to an 2067
investigation the board conducts under this section; 2068

(2) Select providers of educational and assessment 2069
services, including a quality intervention program panel of case 2070
reviewers; 2071

(3) Make referrals to educational and assessment service 2072
providers and approve individual educational programs 2073
recommended by those providers. The board shall monitor the 2074
progress of each individual undertaking a recommended individual 2075
educational program. 2076

(4) Determine what constitutes successful completion of an 2077
individual educational program and require further monitoring of 2078
the individual who completed the program or other action that 2079
the board determines to be appropriate; 2080

(5) Adopt rules in accordance with Chapter 119. of the 2081
Revised Code to further implement the quality intervention 2082
program. 2083

An individual who participates in an individual 2084
educational program pursuant to this division shall pay the 2085
financial obligations arising from that educational program. 2086

Section 2. That existing sections 1739.05, 1753.09, 2087
3901.21, 3963.01, 3963.02, 3963.03, 4725.19, and 4731.22 of the 2088

Revised Code are hereby repealed. 2089

Section 3. The following represent the General Assembly's 2090
intent and findings: 2091

(A) The provisions of this act seek to prevent health 2092
insuring corporations, vision insurers, vision benefit plans, 2093
and other contracting entities from establishing fee limitations 2094
on vision care services and vision care materials that are not 2095
covered vision services for enrollees under an insurance plan. 2096

(B) Strategies by health insuring corporations, vision 2097
insurers, vision benefit plans, and other contracting entities 2098
to adopt or impose a deductible, copayment, coinsurance, or any 2099
other requirement in such a way as to provide de minimis 2100
reimbursement for services or vision care materials as a method 2101
to avoid the impact of this law is contrary to the spirit and 2102
intent of the General Assembly. 2103

(C) The provisions of this act concerning the declaration 2104
by vision care providers on whether to accept or not accept as 2105
payment an amount set by the contracting entity for vision care 2106
services and vision care materials that are not covered vision 2107
services and the publication of such declaration to enrollees by 2108
health insuring corporations, vision insurers, vision benefit 2109
plans, and other contracting entities, should treat providers 2110
equally regardless of the declaration made and should be 2111
communicated in such a manner as not to imply that the vision 2112
care provider is favored or disfavored based on the declaration. 2113

Section 4. Section 1739.05 of the Revised Code is 2114
presented in this act as a composite of the section as amended 2115
by both Sub. H.B. 463 and Sub. S.B. 319 of the 131st General 2116
Assembly. The General Assembly, applying the principle stated in 2117

division (B) of section 1.52 of the Revised Code that amendments	2118
are to be harmonized if reasonably capable of simultaneous	2119
operation, finds that the composite is the resulting version of	2120
the section in effect prior to the effective date of the section	2121
as presented in this act.	2122