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H. B. No. 339
Representative Merrin

A BILL

To amend sections 167.03, 1751.32, 1751.53,
1751.69, 1751.74, 1751.84, 1753.31, 3901.045,
3901.13, 3901.25, 3901.41, 3901.45, 3901.811,
3901.87, 3901.88, 3901.90, 3902.08, 3903.01,
3903.50, 3903.52, 3903.56, 3903.71, 3903.724,
3903.728, 3903.7211, 3903.74, 3904.01, 3904.02,
3904.16, 3905.051, 3905.062, 3905.063, 3905.14,
3905.84, 3905.85, 3906.11, 3907.03, 3907.07,
3909.04, 3911.09, 3911.20, 3911.24, 3913.11,
3913.22, 3913.40, 3915.05, 3915.053, 3915.073,
3915.13, 3916.01, 3916.171, 3916.18, 3919.14,
3921.13, 3921.191, 3922.11, 3922.14, 3922.17,
3923.01, 3923.02, 3923.04, 3923.19, 3923.38,
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3929.011, 3929.04, 3930.10, 3931.02, 3931.03,
3931.99, 3933.01, 3933.02, 3935.06, 3935.10,
3935.12, 3935.13, 3935.14, 3935.99, 3937.10,
3937.182, 3941.46, 3951.04, 3951.06, 3951.10,
3951.99, 3953.01, 3953.07, 3953.14, 3953.29,
3956.01, 3956.09, 3956.10, 3959.01, 3960.07,
3964.19, 3999.16, 3999.41, 4509.41, and 4509.67
and to repeal sections 3941.47, 3941.48,
3941.49, and 3941.52 of the Revised Code to
enact the "Insurance Code Correction Act" to
make technical and corrective changes to the
laws governing insurance.

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

Section 1. That sections 167.03, 1751.32, 1751.53,
1751.69, 1751.74, 1751.84, 1753.31, 3901.045, 3901.13, 3901.25,
3901.41, 3901.45, 3901.811, 3901.87, 3901.88, 3901.90, 3902.08,
3903.01, 3903.50, 3903.52, 3903.56, 3903.71, 3903.724, 3903.728,
3903.7211, 3903.74, 3904.01, 3904.02, 3904.16, 3905.051,
3905.062, 3905.063, 3905.14, 3905.84, 3905.85, 3906.11, 3907.03,
3907.07, 3909.04, 3911.09, 3911.20, 3911.24, 3913.11, 3913.22,
3913.40, 3915.05, 3915.053, 3915.073, 3915.13, 3916.01,
3916.171, 3916.18, 3919.14, 3921.13, 3921.191, 3922.11, 3922.14,
3922.17, 3923.01, 3923.021, 3923.04, 3923.19, 3923.38, 3923.39,
3923.53, 3923.55, 3923.56, 3923.60, 3923.65, 3923.82, 3923.85,
3925.09, 3927.08, 3929.011, 3929.04, 3930.10, 3931.02, 3931.03,
3931.99, 3933.01, 3933.02, 3935.06, 3935.10, 3935.12, 3935.13,
3935.14, 3935.99, 3937.10, 3937.182, 3941.46, 3951.04, 3951.06,
3951.10, 3951.99, 3953.01, 3953.07, 3953.14, 3953.29, 3956.01,
3956.09, 3956.10, 3959.01, 3960.07, 3964.19, 3999.16, 3999.41,
4509.41, and 4509.67 of the Revised Code be amended to read as
follows:

Sec. 167.03. (A) The council shall have the power to:

(1) Study such area governmental problems common to two or
more members of the council as it deems appropriate, including
but not limited to matters affecting health, safety, welfare,
education, economic conditions, and regional development;
(2) Promote cooperative arrangements and coordinate action among its members, and between its members and other agencies of local or state governments, whether or not within Ohio, and the federal government;

(3) Make recommendations for review and action to the members and other public agencies that perform functions within the region;

(4) Promote cooperative agreements and contracts among its members or other governmental agencies and private persons, corporations, or agencies;

(5) Operate a public safety answering point in accordance with Chapter 128. of the Revised Code;

(6) Perform planning directly by personnel of the council, or under contracts between the council and other public or private planning agencies.

(B) The council may:

(1) Review, evaluate, comment upon, and make recommendations, relative to the planning and programming, and the location, financing, and scheduling of public facility projects within the region and affecting the development of the area;

(2) Act as an areawide agency to perform comprehensive planning for the programming, locating, financing, and scheduling of public facility projects within the region and affecting the development of the area and for other proposed land development or uses, which projects or uses have public metropolitan wide or interjurisdictional significance;

(3) Act as an agency for coordinating, based on...
metropolitan wide comprehensive planning and programming, local public policies, and activities affecting the development of the region or area.

(C) The council may, by appropriate action of the governing bodies of the members, perform such other functions and duties as are performed or capable of performance by the members and necessary or desirable for dealing with problems of mutual concern.

(D) The authority granted to the council by this section or in any agreement by the members thereof shall not displace any existing municipal, county, regional, or other planning commission or planning agency in the exercise of its statutory powers.

(E) A council, with an educational service center as its fiscal agent, that is established to provide health care benefits to the council members' officers and employees and their dependents may contract to administer and coordinate a self-funded health benefit program of a nonprofit corporation organized under Chapter 1702. of the Revised Code. A council operating a program under this division that does not act as an administrator as defined in section 3959.01 of the Revised Code does not constitute engaging in the business of insurance and is not subject to the insurance laws of this state.

Sec. 1751.32. Each health insuring corporation, annually, on or before the first day of March, shall file a report with the superintendent of insurance, covering the preceding calendar year.

The report shall be verified by an officer of the health insuring corporation, shall be in the form the superintendent
prescribes, and shall include:

(A) A financial statement of the health insuring corporation, including its balance sheet and receipts and disbursements for the preceding year, which reflect, at a minimum:

(1) All premium rate and other payments received for health care services rendered;

(2) Expenditures with respect to all categories of providers, facilities, insurance companies, and other persons engaged to fulfill obligations of the health insuring corporation arising out of its health care policies, contracts, certificates, and agreements;

(3) Expenditures for capital improvements or additions thereto, including, but not limited to, construction, renovation, or purchase of facilities and equipment.

(B) A description of the enrollee population and composition, group and nongroup;

(C) A summary of enrollee written complaints and their disposition;

(D) A statement of the number of subscriber policies, contracts, certificates, and agreements that have been terminated by action of the health insuring corporation, including the number of enrollees affected;

(E) A summary of the information compiled pursuant to division (B)(A)(5) of section 1751.04 of the Revised Code;

(F) A current report of the names and addresses of the persons responsible for the conduct of the affairs of the health insuring corporation as required by section 1751.03 of the
Revised Code. Additionally, the report shall include the amount of wages, expense reimbursements, and other payments to these persons for services to the health insuring corporation, and shall include a full disclosure of the financial interests related to the operations of the health insuring corporation acquired by these persons during the preceding year.

(G) An actuarial opinion in the form prescribed by the superintendent by rule;

(H) Any other information relating to the performance of the health insuring corporation that is necessary to enable the superintendent to carry out the superintendent's duties under this chapter.

Sec. 1751.53. (A) As used in this section:

(1) "Group contract" means a group health insuring corporation contract covering employees that meets either of the following conditions:

(a) The contract was issued by an entity that, on June 4, 1997, holds a certificate of authority or license to operate under Chapter 1738. or 1742. of the Revised Code, and covers an employee at the time the employee's employment is terminated.

(b) The contract is delivered, issued for delivery, or renewed in this state after June 4, 1997, and covers an employee at the time the employee's employment is terminated.

(2) "Eligible employee" means an employee to whom all of the following apply:

(a) The employee has been continuously covered under a group contract or under the contract and any prior similar group coverage replaced by the contract, during the entire three-month
period preceding the termination of the employee's employment.

(b) The employee did not voluntarily terminate the employee's employment and the termination of employment is not a result of any gross misconduct on the part of the employee.

(c) The employee is not, and does not become, covered by or eligible for coverage by medicare.

(d) The employee is not, and does not become, covered by or eligible for coverage by any other insured or uninsured arrangement that provides hospital, surgical, or medical coverage for individuals in a group and under which the employee was not covered immediately prior to the termination of employment. A person eligible for continuation of coverage under this section, who is also eligible for coverage under section 3923.123 of the Revised Code, may elect either coverage, but not both. A person who elects continuation of coverage may elect any coverage available under section 3923.123 of the Revised Code upon the termination of the continuation of coverage.

(B) A group contract shall provide that any eligible employee may continue the coverage under the contract, for the employee and the employee's eligible dependents, for a period of twelve months after the date that the group coverage would otherwise terminate by reason of the termination of the employee's employment. Each certificate of coverage issued to employees under the contract shall include a notice of the employee's privilege of continuation.

(C) All of the following apply to the continuation of group coverage required under division (B) of this section:

(1) Continuation need not include any supplemental health care services benefits or specialty health care services
benefits provided by the group contract.

(2) The employer shall notify the employee of the right of continuation at the time the employer notifies the employee of the termination of employment. The notice shall inform the employee of the amount of contribution required by the employer under division (C)(4) of this section.

(3) The employee shall file a written election of continuation with the employer and pay the employer the first contribution required under division (C)(4) of this section. The request and payment must be received by the employer no later than the earlier of any of the following dates:

(a) Thirty-one days after the date on which the employee's coverage would otherwise terminate;

(b) Ten days after the date on which the employee's coverage would otherwise terminate, if the employer has notified the employee of the right of continuation prior to this date;

(c) Ten days after the employer notifies the employee of the right of continuation, if the notice is given after the date on which the employee's coverage would otherwise terminate.

(4) The employee must pay to the employer, on a monthly basis, in advance, the amount of contribution required by the employer. The amount required shall not exceed the group rate for the insurance being continued under the policy on the due date of each payment.

(5) The employee's privilege to continue coverage and the coverage under any continuation ceases if any of the following occurs:

(a) The employee ceases to be an eligible employee under
division (A)(2)(c) or (d) of this section;

(b) A period of twelve months expires after the date that the employee’s coverage under the group contract would otherwise have terminated because of the termination of employment;

(c) The employee fails to make a timely payment of a required contribution, in which event the coverage shall cease at the end of the coverage for which contributions were made;

(d) The group contract is terminated, or the employer terminates participation under the contract, unless the employer replaces the coverage by similar coverage under another contract or other group health arrangement. If the employer replaces the contract with similar group health coverage, all of the following apply:

(i) The member shall be covered under the replacement coverage, for the balance of the period that the member would have remained covered under the terminated coverage if it had not been terminated.

(ii) The minimum level of benefits under the replacement coverage shall be the applicable level of benefits of the contract replaced reduced by any benefits payable under the contract replaced.

(iii) The contract replaced shall continue to provide benefits to the extent of its accrued liabilities and extensions of benefits as if the replacement had not occurred.

(D) This section does not apply to any group contract offering only supplemental health care services or specialty health care services.

(E) An employer shall notify the health insuring
corporation if the employee elects continuation of coverage under this section. The health insuring corporation may require the employer to provide documentation if the employee elects continuation of coverage and is seeking premium assistance for the continuation of coverage under the "American Recovery and Investment Act of 2009," Pub. L. No. 111-5, 123 Stat. 115. The director superintendent of insurance shall publish guidance for employers and health insuring corporations regarding the contents of such documentation.

**Sec. 1751.69.** (A) As used in this section, "cost sharing" means the cost to an individual insured under an individual or group health insuring corporation policy, contract, or agreement according to any coverage limit, copayment, coinsurance, deductible, or other out-of-pocket expense requirements imposed by the policy, contract, or agreement.

(B) Notwithstanding section 3901.71 of the Revised Code and subject to division (D) of this section, no individual or group health insuring corporation policy, contract, or agreement providing basic health care services or prescription drug services that is delivered, issued for delivery, or renewed in this state, if the policy, contract, or agreement provides coverage for cancer chemotherapy treatment, shall fail to comply with either of the following:

(1) The policy, contract, or agreement shall not provide coverage or impose cost sharing for a prescribed, orally administered cancer medication on a less favorable basis than the coverage it provides or cost sharing it imposes for intraveneously administered or injected cancer medications.

(2) The policy, contract, or agreement shall not comply with division (B)(1) of this section by imposing an increase in
cost sharing solely for orally administered, intravenously administered, or injected cancer medications.

(C) Notwithstanding any provision of this section to the contrary, an individual or group health insuring corporation policy, contract, or agreement shall be deemed to be in compliance with this section if the cost sharing imposed under such a policy, contract, or agreement for orally administered cancer treatments does not exceed one hundred dollars per prescription fill. The cost-sharing limit of one hundred dollars per prescription fill shall apply to a high deductible plan, as defined in 26 U.S.C. 223, or a catastrophic plan, as defined in 42 U.S.C. 18022, only after the deductible has been met.

(D) The prohibitions in division (B) of this section do not preclude an individual or group health insuring corporation policy, contract, or agreement from requiring an enrollee to obtain prior authorization before orally administered cancer medication is dispensed to the enrollee.

(E) A health insuring corporation that offers coverage for basic health care services is not required to comply with division (B) of this section if all of the following apply:

1. The health insuring corporation submits documentation certified by an independent member of the American academy of actuaries to the superintendent of insurance showing that compliance with division (B)(1) of this section for a period of at least six months independently caused the health insuring corporation's costs for claims and administrative expenses for the coverage of basic health care services to increase by more than one per cent per year.
(2) The health insuring corporation submits a signed letter from an independent member of the American academy of actuaries to the superintendent of insurance opining that the increase in costs described in division (E)(1) of this section could reasonably justify an increase of more than one per cent in the annual premiums or rates charged by the health insuring corporation for the coverage of basic health care services.

(3)(a) The superintendent of insurance makes the following determinations from the documentation and opinion submitted pursuant to divisions (E)(1) and (2) of this section:

(i) Compliance with division (B)(1) of this section for a period of at least six months independently caused the health insuring corporation's costs for claims and administrative expenses for the coverage of basic health care services to increase more than one per cent per year.

(ii) The increase in costs reasonably justifies an increase of more than one per cent in the annual premiums or rates charged by the health insuring corporation for the coverage of basic health care services.

(b) Any determination made by the superintendent under division (E)(3) of this section is subject to Chapter 119. of the Revised Code.

Sec. 1751.74. (A) To implement a quality assurance program required by section [1751.73 1751.73] of the Revised Code, a health insuring corporation shall do both of the following:

(1) Develop and maintain the appropriate infrastructure and disclosure systems necessary to measure and report, on a regular basis, the quality of health care services provided to enrollees, based on a systematic collection, analysis, and
reporting of relevant data. The health insuring corporation shall assure that a committee that includes participating physicians have the opportunity to participate in developing, implementing, and evaluating the quality assurance program and all other programs implemented by the health insuring corporation that relate to the utilization of health care services. A committee that includes participating physicians shall also have the opportunity to participate in the derivation of data assessments, statistical analyses, and outcome interpretations from programs monitoring the utilization of health care services.

(2) Develop and maintain an organizational program for designing, measuring, assessing, and improving the processes and outcomes of health care.

(B) A quality assurance program shall:

(1) Establish an internal system capable of identifying opportunities to improve health care, which system is structured to identify practices that result in improved health care outcomes, to identify problematic utilization patterns, and to identify those providers that may be responsible for either exemplary or problematic patterns. The quality assurance program shall use the findings generated by the system to work on a continuing basis with participating providers and other staff to improve the quality of health care services provided to enrollees.

(2) Develop a written statement of its objectives, lines of authority and accountability, evaluation tools, and performance improvement activities;

(3) Require an annual effectiveness review of the program;
(4) Provide a description of how the health insuring corporation intends to do all of the following:

(a) Analyze both processes and outcomes of health care, including focused review of individual cases as appropriate, to discern the causes of variation;

(b) Identify the targeted diagnoses and treatments to be reviewed by the quality assurance program each year, based on consideration of practices and diagnoses that affect a substantial number of the health insuring corporation's enrollees or that could place enrollees at serious risk;

(c) Use a range of appropriate methods to analyze quality of health care, including collection and analysis of information on over-utilization and under-utilization of health care services; evaluation of courses of treatment and outcomes based on current medical research, knowledge, standards, and practice guidelines; and collection and analysis of information specific to enrollees or providers;

(d) Compare quality assurance program findings with past performance, internal goals, and external standards;

(e) Measure the performance of participating providers and conduct peer review activities;

(f) Utilize treatment protocols and practice parameters developed with appropriate clinical input;

(g) Implement improvement strategies related to quality assurance program findings;

(h) Evaluate periodically, but not less than annually, the effectiveness of the improvement strategies.

Sec. 1751.84. (A) Notwithstanding section 3901.71 of the
Revised Code, each individual and group health insuring corporation policy, contract, or agreement providing basic health care services that is delivered, issued for delivery, or renewed in this state shall provide coverage for the screening, diagnosis, and treatment of autism spectrum disorder. A health insuring corporation shall not terminate an individual's coverage, or refuse to deliver, execute, issue, amend, adjust, or renew coverage to an individual solely because the individual is diagnosed with or has received treatment for an autism spectrum disorder. Nothing in this section shall be applied to nongrandfathered plans in the individual and small group markets or to medicare supplement, accident-only, specified disease, hospital indemnity, disability income, long-term care, or other limited benefit hospital insurance policies. Except as otherwise provided in division (B) of this section, coverage under this section shall not be subject to dollar limits, deductibles, or coinsurance provisions that are less favorable to an enrollee than the dollar limits, deductibles, or coinsurance provisions that apply to substantially all medical and surgical benefits under the policy, contract, or agreement.

(B) Benefits provided under this section shall cover, at minimum, all of the following:

(1) For speech and language therapy or occupational therapy for an enrollee under the age of fourteen that is performed by a licensed therapist, twenty visits per year for each service;

(2) For clinical therapeutic intervention for an enrollee under the age of fourteen that is provided by or under the supervision of a professional who is licensed, certified, or registered by an appropriate agency of this state to perform
such services in accordance with a health treatment plan, twenty hours per week;

(3) For mental or behavioral health outpatient services for an enrollee under the age of fourteen that are performed by a licensed psychologist, psychiatrist, or physician providing consultation, assessment, development, or oversight of treatment plans, thirty visits per year.

(C)(1) Except as provided in division (C)(2) of this section, this section shall not be construed as limiting benefits that are otherwise available to an individual under a policy, contract, or agreement.

(2) A policy, contract, or agreement shall stipulate that coverage provided under this section be contingent upon both of the following:

(a) The covered individual receiving prior authorization for the services in question;

(b) The services in question being prescribed or ordered by either a developmental pediatrician or a psychologist trained in autism.

(D)(1) Except for inpatient services, if an enrollee is receiving treatment for an autism spectrum disorder, a health insuring corporation may review the treatment plan annually, unless the health insuring corporation and the enrollee's treating physician or psychologist agree that a more frequent review is necessary.

(2) Any such agreement as described in division (D)(1) of this section shall apply only to a particular enrollee being treated for an autism spectrum disorder and shall not apply to all individuals being treated for autism spectrum disorder by a
physician or psychologist.

(3) The health insuring corporation shall cover the cost of obtaining any review or treatment plan.

(E) This section shall not be construed as affecting any obligation to provide services to an enrollee under an individualized family service plan, an individualized education program, or an individualized service plan.

(F) As used in this section:

(1) "Applied behavior analysis" means the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior.

(2) "Autism spectrum disorder" means any of the pervasive developmental disorders or autism spectrum disorder as defined by the most recent edition of the diagnostic and statistical manual of mental disorders published by the American psychiatric association available at the time an individual is first evaluated for suspected developmental delay.

(3) "Clinical therapeutic intervention" means therapies supported by empirical evidence, which include, but are not limited to, applied behavioral analysis, that satisfy both of the following:

(a) Are necessary to develop, maintain, or restore, to the maximum extent practicable, the function of an individual;

(b) Are provided by or under the supervision of any of the following:
(i) A certified Ohio behavior analyst as defined in section 4783.01 of the Revised Code;

(ii) An individual licensed under Chapter 4732. of the Revised Code to practice psychology;

(iii) An individual licensed under Chapter 4757. of the Revised Code to practice professional counseling, social work, or marriage and family therapy.

(4) "Diagnosis of autism spectrum disorder" means medically necessary assessments, evaluations, or tests to diagnose whether an individual has an autism spectrum disorder.

(5) "Pharmacy care" means medications prescribed by a licensed physician and any health-related services considered medically necessary to determine the need or effectiveness of the medications.

(6) "Psychiatric care" means direct or consultative services provided by a psychiatrist licensed in the state in which the psychiatrist practices.

(7) "Psychological care" means direct or consultative services provided by a psychologist licensed in the state in which the psychologist practices.

(8) "Therapeutic care" means services provided by a speech therapist, occupational therapist, or physical therapist licensed or certified in the state in which the person practices.

(9) "Treatment for autism spectrum disorder" means evidence-based care and related equipment prescribed or ordered for an individual diagnosed with an autism spectrum disorder by
a licensed physician who is a developmental pediatrician or a
licensed psychologist trained in autism who determines the care
to be medically necessary, including any of the following:

(a) Clinical therapeutic intervention;

(b) Pharmacy care;

(c) Psychiatric care;

(d) Psychological care;

(e) Therapeutic care.

(G) If any provision of this section or the application
thereof to any person or circumstances is for any reason held to
be invalid, the remainder of the section and the application of
such remainder to other persons or circumstances shall not be
affected thereby.

Sec. 1753.31. As used in sections 1753.31 to 1753.43 of
the Revised Code:

(A) "Adjusted RBC report" means an RBC report that has
been adjusted by the superintendent of insurance in accordance
with division (C) of section 1753.32 of the Revised Code.

(B) "Authorized control level RBC" means the number
determined under the risk-based capital formula in accordance
with the RBC instructions.

(C) "Company action level RBC" means the product of 2.0
and a health insuring corporation's authorized control level
RBC.

(D) "Corrective order" means an order issued by the
superintendent of insurance specifying corrective actions that
the superintendent determines are required.
(E) "Domestic health insuring corporation" means a health insuring corporation domiciled in this state.

(F) "Foreign health insuring corporation" means a health insuring corporation holding a certificate of authority under chapter 1751. of the Revised Code that is domiciled outside of this state.

(G) "Mandatory control level RBC" means the product of .70 and a health insuring corporation's authorized control level RBC.

(H) "NAIC" means the national association of insurance commissioners.

(I) "Net worth" means statutory capital and surplus.

(J) "RBC" means risk-based capital.

(K) "RBC instructions" means the RBC report, including risk-based capital instructions, as adopted by the NAIC and as amended by the NAIC from time to time in accordance with the procedures adopted by the NAIC. "RBC instructions" also includes any modifications adopted by the superintendent of insurance, as the superintendent considers to be necessary.

(L) "RBC level" means a health insuring corporation's action level RBC, regulatory action level RBC, authorized control level RBC, or mandatory control level RBC.

(M) "RBC plan" means a comprehensive financial plan containing the elements specified in division (B) of section 1753.33 of the Revised Code.

(N) "RBC report" means the report required by section 1753.32 of the Revised Code.
(O) "Regulatory action level RBC" means the product of 1.5 and a health insuring corporation's authorized control level RBC.

(P) "Revised RBC plan" means an RBC plan rejected by the superintendent of insurance and then revised by a health insuring corporation with or without incorporating the superintendent's recommendations.

(Q) "Total adjusted capital" means the sum of both of the following:

1. A health insuring corporation's net worth as determined in accordance with the statutory accounting applicable to the annual financial statements required to be filed under section 1751.32 of the Revised Code;

2. Such other items, if any, as the RBC instructions may provide.

Sec. 3901.045. (A) The superintendent of insurance may receive documents and information, including otherwise confidential or privileged documents and information, from local, state, federal, and international regulatory and law enforcement agencies, from local, state, and federal prosecutors, and from the national association of insurance commissioners and its affiliates and subsidiaries, provided that the superintendent maintains as confidential or privileged any document or information received with notice or the understanding that the document or information is confidential or privileged under the laws of the jurisdiction that is the source of the document or information.

(B) The superintendent may also receive documents and information, including otherwise confidential or privileged
documents and information, from the chief deputy rehabilitator,
the chief deputy liquidator, other deputy rehabilitators and
liquidators, and from any other person employed by, or acting on
behalf of, the superintendent pursuant to Chapter 3901. or 3903.
of the Revised Code, provided that the superintendent maintains
as confidential or privileged any document or information
received with the notice or understanding that the document or
information is confidential or privileged, except that the
superintendent may share and disclose such a document or
information when authorized by other sections of the Revised
Code.

(C) The superintendent has the authority to maintain as
confidential or privileged the documents and information
received pursuant to this section.

(D) The superintendent's authority to receive documents
and information under this section, from the persons and subject
to the conditions listed in this section, is not limited in any
way by section 1751.19, 3901.36, 3901.44, 3901.48, 3901.70,
3903.11, 3903.722, 3903.7211, 3903.88, 3905.492, 3905.50,
3922.21, or 3999.36 of the Revised Code.

Sec. 3901.13. Whenever the superintendent of insurance has
reason to believe that there is a violation of section 3901.11
or 3901.12 of the Revised Code, the superintendent shall
serve upon the insurers and directors a notice of a hearing
before the superintendent to be held not less than thirty days
after the service of such notice, and requiring such insurers
and directors to show cause why an order should not be made by
the superintendent directing such insurers and directors to
cease and desist from such violation. All such hearings shall be
conducted in accordance with sections 119.01 to 119.13.
If, upon such hearing, the superintendent finds that there has been a violation of section 3901.11 or 3901.12 of the Revised Code, the superintendent shall issue and cause to be served upon such insurers and directors an order reciting the facts found by him, setting forth the respects in which there has been a violation, and directing such insurers and directors to cease and desist from such violation.

Any such order of the superintendent shall be subject to judicial review in accordance with sections 119.01 to 119.13, inclusive, of the Revised Code. A violation of any such order is, subject to said judicial review, deemed a violation as contemplated by section 3901.16 or 3901.17 of the Revised Code.

Sec. 3901.25. If after thirty days following the giving of the notice mentioned in section 3901.24 of the Revised Code such insurer has failed to cease making, issuing, or circulating such false misrepresentations or causing the same to be made, issued, or circulated in this state, and if the superintendent of insurance has reason to believe that a proceeding by him in respect to such matters would be to the interest of the public, and that such insurer is issuing or delivering contracts of insurance to residents of this state or collecting premiums on such contracts or doing any of the acts enumerated in section 3901.26 of the Revised Code, the superintendent shall take action against such insurer under sections 3901.19 to 3901.26, inclusive, of the Revised Code.

Sec. 3901.41. (A) As used in this section:

(1) "Automated transaction" has the same meaning as in section 1306.01 of the Revised Code, and includes electronic
transactions between two or more persons conducting business pursuant to the laws of this state relating to insurance.

(2) "Contact point" means any electronic identification to which messages can be sent, including, but not limited to, any of the following:

(a) An electronic mail address;
(b) An instant message identity;
(c) A wireless telephone number, or any other personal electronic communication device;
(d) A facsimile number.

(3) "Insured" means a certificate holder, contract owner, customer, policyholder, or subscriber as those terms are used in the laws of this state relating to insurance.

(4) "Insurer" has the same meaning as in section 3901.32 of the Revised Code.

(5) "Laws of this state relating to insurance" has the same meaning as in section 3901.04 of the Revised Code.

(6) " Personally identifiable information" means any individually identifiable information gathered in connection with an insurance transaction, including a person's name, address, social security number, and banking information.

(7) "Secure web site" means a web site that meets both of the following criteria:

(a) The web site uses the hypertext transfer protocol secure communication protocol or other equally secure communication protocol.
(b) The web site requires a person to enter a unique user
credential to access personally identifiable information for
which the person has the legal right to access.

(B) Notwithstanding any laws of this state relating to
insurance, sections 1306.01 to 1306.23 of the Revised Code, the
"Uniform Electronics Transactions Act," apply to the business of
insurance in this state.

(C)(1) If an insured agrees to conduct the business of
insurance via an automated transaction, any information issued
or delivered in writing may be issued or delivered
electronically to a contact point provided by the insured, as
long as both of the following apply:

(a) The transmission of information is in compliance with
sections 1306.07 and 1306.14 of the Revised Code.

(b) The details of the automated transaction are fully
disclosed to the insured in the application, policy,
certificate, contract of insurance, or by another method that
ensures notice to the insured. An insurer's form used only to
notify an insured of and obtain consent for an automated
transaction does not need to be approved or accepted by the
superintendent of insurance.

(2)(a) Except for notices of cancellation, nonrenewal, or
termination, an insurer may deliver information via a secure web
site if the insurer sends an electronic notice to a contact
point and the electronic notice includes a hyperlink to the
secure web site.

(b) If an insurer uses a secure web site to deliver
changes in terms or conditions in an insured's policy,
certificate, or contract of insurance, including any
endorsements or amendments, the electronic notice to the
insured's contact point shall include all of the following:

(i) A list or summary of the changes;

(ii) A link to the complete document located on the insurer's secure web site;

(iii) The following or substantially similar statement displayed in a prominent manner:

"There are changes in the terms or conditions of your policy, certificate, or contract of insurance."

(3) At a minimum, the details of the automated transaction shall include all of the following:

(a) A clear and conspicuous statement informing the insured of any right or option of the insured to receive a record on paper;

(b) The right of the insured to withdraw the insured's consent, and any consequences or fees if the insured withdraws consent;

(c) A description of the procedures the insured must use to withdraw consent and to update the insured's contact point.

(4) Agreement to participate in a part of an automated transaction shall not be used to confirm the insured's consent to transact the entire business of insurance pursuant to this section.

(5) A withdrawal of consent by an insured shall be effective within a reasonable time period, not to exceed ten business days after the receipt of the withdrawal by the insurer.

(D) The insurer shall send all notices of cancellation,
nonrenewal, termination, or changes in the terms or conditions
of the policy, certificate, or contract of insurance to the last
known contact point supplied by the insured. If the insurer has
knowledge that the insured's contact point is no longer valid,
the insurer shall send the information via regular mail to the
last known address furnished to the insurer by the insured.

(E) Any insurer conducting the business of insurance via
an automated transaction shall allow the insurer's insureds who
agree to participate in an automated transaction the option to
withdraw consent from participating in the automated
transaction.

(F) Notwithstanding any laws or regulations of this state
relating to insurance, any policy, certificate, or contract of
insurance, including any endorsements or amendments, that do not
contain personally identifiable information may be posted to the
insurer's web site in lieu of any other method of delivery. If
the insurer elects to post any policy, certificate, or contract
of insurance to the insurer's web site, all of the following
shall apply:

(1) The policy, certificate, or contract of insurance is
readily accessible by the insured and, once the policy,
certificate, or contract of insurance is no longer used by the
insurer in this state, it is stored in a readily accessible
archive;

(2) The policy, certificate, or contract of insurance is
posted in such a manner that the insured can easily identify the
insured's applicable policy, certificate, or contract and print
or download the insured's documents without charge and without
the use of any special program or application that is not
readily available to the public without charge;
(3) The insurer provides written notice at the time of issuance of the initial policy, certificate, contract, or any renewal forms of a method by which the insured may obtain upon request a paper or electronic copy of their policy, certificate, or contract without charge;

(4) The insurer clearly identifies the applicable policy, endorsements, amendments, certificate, or contract of insurance purchased by the insured on any declaration page, certificate of insurance, summary of benefits, or other evidence of coverage issued to the insured;

(5) The insurer gives notice, in the manner it customarily communicates with an insured, of any changes to the policy, certificate, or contract of insurance, including any endorsements or amendments, and of the insured's right to obtain upon request a paper or electronic copy of the policy, endorsements, or amendments without charge.

(G) Notwithstanding any other section of Title XXXIX or Chapters 1739. or 1751. of the Revised Code or rules adopted thereunder to the contrary, an insurer may deliver any notices, documents, or information to an insured via an automated transaction pursuant to this section.

(H) This section does not supersede any time periods, filing requirements, or content of notices, documents, notices to insureds' agents required pursuant to sections 3937.25, 3937.26, and 3937.27 of the Revised Code, or information otherwise required by a law other than this section relating to insurance. This section does not apply to disclosures through electronic media of certificates, explanation of benefit statements, and other mandated materials under the "Employee Retirement Income Security Act of 1974," 88 Stat. 829, 29 U.S.C.
1001, as amended, and any regulation adopted thereunder.

(I) If the consent of an insured to receive certain notices, documents, or information in an electronic form is on file with an insurer before the effective date of this section—September 4, 2014, if the consent was not accompanied by the details of the automated transaction described in division (C) (3) of this section, and if, pursuant to this section, an insurer intends to deliver additional notices, documents, or information to that insured in an electronic form, then, prior to delivering or at the time of delivering such additional notice, documents, or information electronically, the insurer shall notify the insured of the details of the automated transaction in compliance with division (C)(3) of this section.

(J) The superintendent of insurance may adopt rules in accordance with Chapter 119. of the Revised Code as the superintendent considers necessary to carry out the purposes of this section.

Sec. 3901.45. (A) As used in sections 3901.45 and 3901.46 of the Revised Code:

(1) "AIDS," "HIV," "AIDS-related condition," and "HIV test" have the same meanings as in section 3701.24 of the Revised Code.

(2) "Insurer" means any person authorized to engage in the business of life or sickness and accident insurance under Title XXXIX of the Revised Code or any person or governmental entity providing health services coverage for individuals on a self-insurance basis.

(3) "Group policy" means, with respect to life insurance, a policy covering more than twenty-five individuals and issued
pursuant to section 3917.01 of the Revised Code, and with
respect to sickness and accident insurance, a policy covering
more than twenty-five individuals and issued pursuant to section
3923.11, 3923.12, or 3923.13 of the Revised Code. "Group policy"
includes a certificate of life or sickness and accident
insurance covering more than twenty-five individuals under a
group policy issued to a multiple employer trust.

(4) "Individual policy" means, with respect to life
insurance and sickness and accident insurance, a policy other
than a group policy, except that "individual policy" also
includes all of the following:

(a) The coverage under a group policy of an individual who
seeks to become a member of an insured group after having
deprecated a previous offer of coverage under the group policy;

(b) An individual who seeks life insurance coverage under
a group policy in excess of the maximum coverage available under
the policy without evidence of insurability;

(c) A certificate of life or sickness and accident
insurance covering no more than twenty-five individuals under a
group policy issued to a multiple employer trust.

(B) In processing an application for an individual policy
of life or sickness and accident insurance or in determining
insurability of an applicant, no insurer shall:

(1) Take into consideration an applicant's sexual
orientation;

(2) Make any inquiry toward determining an applicant's
sexual orientation or direct any person who provides services to
the insurer to investigate an applicant's sexual orientation;
(3) Make a decision adverse to the applicant based on entries in medical records or other reports that show that the applicant has sought an HIV test, consultation regarding the possibility of developing AIDS or an AIDS-related condition, or counseling for concerns related to AIDS from health care professionals unless there has been a diagnosis, confirmed by a positive HIV test, of AIDS or an AIDS-related condition or the applicant has been treated for either.

(C)(1) In developing and asking questions regarding medical histories and lifestyles of applicants for life or sickness and accident insurance and in assessing the answers, an insurer shall not ask questions designed to ascertain the sexual orientation of the applicant nor use factors such as marital status, living arrangements, occupation, gender, medical history, beneficiary designation, or zip code or other geographic designation to aid in ascertaining the applicant's sexual orientation.

(2) An insurer may ask the applicant if he the applicant has ever been diagnosed as having AIDS or an AIDS-related condition.

(3) An insurer may ask the applicant specifically whether he the applicant has ever had a positive result on an HIV test. "Positive result" means a result interpreted as positive in accordance with guidelines developed by the director of health under division (B)(1)(a) of section 3701.241 of the Revised Code, even though the applicant may have been tested in another state. "Positive result" does not mean an initial positive result that further testing showed to be false.

(4) The insurer shall not ask the applicant whether he the applicant has ever taken an HIV test.
(D)(1) Except as provided in division (D)(2) of this section, no insurer shall cancel a policy of life or sickness and accident insurance, or refuse to renew a policy of life or sickness and accident insurance other than a policy that is renewable at the option of the insurer, based solely on the fact that, after the effective date of the policy, the policyholder is diagnosed as having AIDS, an AIDS-related condition, or an HIV infection.

(2) If a policy of life or sickness and accident insurance provides for a contestability period, an insurer may cancel the policy during the contestability period if the applicant made a false statement in the application with regard to the question of whether the applicant has been diagnosed as having AIDS, an AIDS-related condition, or an HIV infection.

(E) No insurer shall deliver, issue for delivery, or renew a policy of life or sickness and accident insurance that limits benefits or coverage in the event that, after the effective date of the policy, the insured develops AIDS or an AIDS-related condition or receives a positive result on an HIV test.

(F) An insurer is not required to offer coverage under a policy of life or sickness and accident insurance to an individual or group member, or a dependent of an individual or group member, who has AIDS or an AIDS-related condition, or who has had a positive result on an HIV test.

(G) An insurer is not required to continue to provide coverage under a policy of life or sickness and accident insurance to an individual or group member, or a dependent of an individual or group member, if the insurer determines the individual or group member or dependent of the individual or group member knew on the effective date of the policy that--
the individual or group member or dependent of the individual or group member had AIDS, an AIDS-related condition, or a positive result of an HIV test.

(H) A violation of this section is an unfair insurance practice under sections 3901.19 to 3901.26 of the Revised Code.

Sec. 3901.811. (A) Except as provided in division (B) of this section, an auditing entity is subject to all of the following conditions when performing a pharmacy audit in this state:

(1) If it is necessary that the pharmacy audit be performed on the premises of a pharmacy, the auditing entity shall give the pharmacy that is the subject of the audit written notice of the date or dates on which the audit will be performed and the range of prescription numbers from which the auditing entity will select pharmacy records to audit. Notice of the date or dates on which the audit will be performed shall be given not less than ten business days before the date the audit is to commence. Notice of the range of prescription numbers from which the auditing entity will select pharmacy records to audit shall be received by the pharmacy not less than seven business days before the date of the audit is to commence.

(2) The auditing entity shall not include in the pharmacy audit a review of a claim for payment for the provision of dangerous drugs or pharmacy services if the date of the pharmacy's initial submission of the claim for payment occurred more than twenty-four months before the date the audit commences.

(3) Absent an indication that there was an error in the dispensing of a drug, the auditing entity or payer shall not
seek to recoup from the pharmacy that is the subject of the audit any amount that the pharmacy audit identifies as being the result of clerical or recordkeeping errors in the absence of financial harm. For purposes of this provision, an error in the dispensing of a drug is any of the following: selecting an incorrect drug, issuing incorrect directions, or dispensing a drug to the incorrect patient.

(4) The auditing entity shall not use the accounting practice of extrapolation when calculating a monetary penalty to be imposed or amount to be recouped as the result of the pharmacy audit.

(B)(1) The condition in division (A)(1) of this section does not apply if, prior to the audit, the auditing entity has evidence, from its review of claims data, statements, or physical evidence or its use of other investigative methods, indicating that fraud or other intentional or willful misrepresentation exists.

(2) The condition in division (A)(3) of this section does not apply if the auditing entity has evidence, from its review of claims data, statements, or physical evidence or its use of other investigative methods, indicating that fraud or other intentional or willful misrepresentation exists.

(3) Division (A)(4) of this section does not apply when the accounting practice of extrapolation is required by state or federal law.

Sec. 3901.87. (A) No qualified health plan shall provide coverage for a nontherapeutic abortion.

(B) As used in this section:

(1) "Nontherapeutic abortion" has the same meaning as in

(2) "Qualified health plan" means any qualified health plan as defined in section 1301 of the "Patient Protection and Affordable Care Act," 42 U.S.C. 18021, offered in this state through an exchange created under that act.

Sec. 3901.88. The superintendent of insurance shall conduct an actuarial study on the costs of all health care mandates under state law that apply to individual and group health insurance plans that are not subject to the "Employee Retirement Income Security Act of 1974," 29 U.S.C. 1001, et seq. This study shall be delivered electronically to the governor, the senate president, and the speaker of the house not later than two years after the effective date of this section April 6, 2017.

Sec. 3901.90. The superintendent of insurance, in consultation with the director of mental health and addiction services, shall develop consumer and payer education on mental health and addiction services insurance parity and establish and promote a consumer hotline to collect information and help consumers understand and access their insurance benefits.

The department of insurance and the department of mental health and addiction services shall jointly report annually on the department's efforts, which shall include information on consumer and payer outreach activities and identification of trends and barriers to access and coverage in this state. The departments shall submit the report to the general assembly, the joint medicaid oversight committee, and the governor, not later than the thirtieth day of January of each year.

Sec. 3902.08. (A) Except as provided in section 3902.03 of
the Revised Code, sections 3902.01 to 3902.08 of the Revised Code apply to all policy forms filed on or after three years after the effective date of sections 3902.01 to 3902.08 of the Revised Code January 9, 1983. No policy form shall be delivered or issued for delivery in this state on or after five years after the effective date of sections 3902.01 to 3902.08 of the Revised Code January 9, 1985 unless approved by the superintendent of insurance, or permitted to be issued, pursuant to sections 3902.01 to 3902.08 of the Revised Code. Any policy form that has been approved or permitted to be issued prior to five years after the effective date of sections 3902.01 to 3902.08 of the Revised Code January 9, 1985, and that meets the standards set by sections 3902.01 to 3902.08 of the Revised Code need not be refiled for approval, but may continue to be lawfully delivered or issued for delivery in this state upon the filing with the superintendent of a list of such forms identified by form number and accompanied by a certificate as to each such form in the manner provided in division (D) of section 3902.05–3902.04 of the Revised Code.

(B) The superintendent may, in his discretion, extend the dates in division (A) of this section.

Sec. 3903.01. As used in sections 3903.01 to 3903.59 of the Revised Code:

(A) "Admitted assets" means investment in assets which will be admitted by the superintendent of insurance pursuant to the law of this state.

(B) "Affiliate" has the same meaning as "affiliate of" or "affiliated with," as defined in section 3901.32 of the Revised Code.
(C) "Assets" means all property, real and personal, of every nature and kind whatsoever or any interest therein.

(D) "Ancillary state" means any state other than a domiciliary state.

(E) "Commodity contract" means any of the following:

1. A contract for the purchase or sale of a commodity for future delivery on, or subject to the rules of, a board of trade designated as a contract market by the commodity futures trading commission under the "Commodity Exchange Act," 7 U.S.C. 1 et seq., as amended, or a board of trade outside the United States;

2. An agreement that is subject to regulation under section 19 of the "Commodity Exchange Act," 7 U.S.C. 23, as amended, and that is commonly known to the commodities trade as a margin account, margin contract, leverage account, or lever contract;

3. An agreement or transaction that is subject to regulation under section 4c(b) of the "Commodity Exchange Act," 7 U.S.C. 6c(b), as amended, and that is commonly known to the commodities trade as a commodity option;

4. Any combination of agreements or transactions described in division (E) of this section;

5. Any option to enter into an agreement or transaction described in division (E) of this section.

(F) "Creditor" means a person having any claim, whether matured or unmatured, liquidated or unliquidated, secured or unsecured, absolute, fixed, or contingent.

(G) "Delinquency proceeding" means any proceeding commenced against an insurer for the purpose of liquidating,
rehabilitating, reorganizing, or conserving the insurer, and any summary proceeding under section 3903.09 or 3903.10 of the Revised Code. "Formal delinquency proceeding" means any liquidation or rehabilitation proceeding.

(H) "Doing business" includes any of the following acts, whether effected by mail or otherwise:

(1) The issuance or delivery of contracts of insurance to persons resident in this state;

(2) The solicitation of applications for such contracts, or other negotiations preliminary to the execution of such contracts;

(3) The collection of premiums, membership fees, assessments, or other consideration for such contracts;

(4) The transaction of matters subsequent to execution of such contracts and arising out of them;

(5) Operating under a license or certificate of authority, as an insurer, issued by the department of insurance.

(I) "Domiciliary state" means the state in which an insurer is incorporated or organized, or, in the case of an alien insurer, its state of entry.

(J) "Fair consideration" is given for property or obligation when either of the following apply:

(1) When in exchange for such property or obligation, as a fair equivalent therefor, and in good faith, property is conveyed, services are rendered, an obligation is incurred, or an antecedent debt is satisfied;

(2) When such property or obligation is received in good
faith to secure a present advance or antecedent debt in an amount not disproportionately small as compared to the value of the property or obligation obtained.


(L) "Foreign country" means any other jurisdiction not in any state.

(M) "Forward contract" has the same meaning as in the federal "Deposit Insurance Act," 64 Stat. 884, 12 U.S.C. 1821(e)(8)(D), as now and hereafter amended.

(N) "Guaranty association" means the Ohio insurance guaranty association created by section 3955.06 of the Revised Code and any other similar entity hereafter created by the general assembly for the payment of claims of insolvent insurers. "Foreign guaranty association" means any similar entities now in existence in or hereafter created by the legislature of any other state.

(O) "Insolvency" or "insolvent" means:

(1) For an insurer issuing only assessable fire insurance policies either of the following:

(a) The inability to pay any obligation within thirty days after it becomes payable;

(b) If an assessment is made within thirty days after such date, the inability to pay the obligation thirty days following the date specified in the first assessment notice issued after the date of loss.

(2) For any other insurer, that it is unable to pay its
obligations when they are due, or when its admitted assets do not exceed its liabilities plus the greater of either of the following:

(a) Any capital and surplus required by law for its organization;

(b) The total par or stated value of its authorized and issued capital stock.

(3) As to any insurer licensed to do business in this state as of the effective date of sections 3903.01 to 3903.59 of the Revised Code that does not meet the standard established under division (N)(O)(2) of this section, the term "insolvency" or "insolvent" means, for a period not to exceed three years from the effective date of sections 3903.01 to 3903.59 of the Revised Code, that it is unable to pay its obligations when they are due or that its admitted assets do not exceed its liabilities plus any required capital contribution ordered by the superintendent under provisions of Title XXXIX of the Revised Code.

(4) For purposes of divisions (N)(O)(2) to (4) of this section, "liabilities" includes, but is not limited to, reserves required by statute or by rules of the superintendent or specific requirements imposed by the superintendent upon a subject company at the time of admission or subsequent thereto.

(P) "Insurer" means any person who has done, purports to do, is doing, or is licensed to do an insurance business, and is or has been subject to the authority of, or to liquidation, rehabilitation, reorganization, supervision, or conservation by, any insurance commissioner, superintendent, or equivalent official. For purposes of sections 3903.01 to 3903.59 of the Revised Code, that it is unable to pay its obligations when they are due or that its admitted assets do not exceed its liabilities plus any required capital contribution ordered by the superintendent under provisions of Title XXXIX of the Revised Code.
Revised Code, any other persons included under section 3903.03 of the Revised Code are deemed to be insurers.

(Q) "Netting agreement" means:

(1) A contract or agreement, including a master agreement, and any terms and conditions incorporated by reference in such a contract or agreement, that provides for the netting, liquidation, setoff, termination, acceleration, or close out under or in connection with a qualified financial contract, or any present or future payment or delivery obligations or entitlements under a qualified financial contract, including liquidation or close-out values relating to those obligations or entitlements;

(2) A master agreement, together with all schedules, confirmations, definitions, and addenda to the agreement and transactions under the agreement, which shall be treated as one netting agreement, and any bridge agreement for one or more master agreements;

(3) Any security agreement or arrangement, credit support document, or guarantee or reimbursement obligation related to any contract or agreement described in division (P)(Q) of this section.

Any contract or agreement described in division (P)(Q) of this section relating to agreements or transactions that are not qualified financial contracts shall be deemed to be a netting agreement only with respect to those agreements or transactions that are qualified financial contracts.

(R) "Preferred claim" means any claim with respect to which the terms of sections 3903.01 to 3903.59 of the Revised Code accord priority of payment from the assets of the insurer.
"Qualified financial contract" means any commodity contract, forward contract, repurchase agreement, securities contract, swap agreement, and any similar agreement that the superintendent may determine by rule or order to be a qualified financial contract for purposes of this chapter.

"Reciprocal state" means any state other than this state in which in substance and effect division (A) of section 3903.18, and sections 3903.52, 3903.53, and 3903.55 to 3903.57 of the Revised Code are in force, in which provisions are in force requiring that the superintendent or equivalent official be the receiver, liquidator, rehabilitator, or conservator of a delinquent insurer, and in which some provision exists for the avoidance of fraudulent conveyances and preferential transfers.

"Repurchase agreement" has the same meaning as in the federal "Deposit Insurance Act," 64 Stat. 884, 12 U.S.C. 1821(e) (8)(D), as now and hereafter amended.

"Secured claim" means any claim secured by mortgage, trust deed, security agreement, pledge, deposit as security, escrow, or otherwise, but not including special deposit claims or claims against assets. The term also includes claims which have become liens upon specific assets by reason of judicial process.

"Securities contract" has the same meaning as in the federal "Deposit Insurance Act," 64 Stat. 884, 12 U.S.C. 1821(e) (8)(D), as now and hereafter amended.

"Special deposit claim" means any claim secured by a deposit made pursuant to statute for the security or benefit of a limited class or classes of persons, but not including any claim secured by assets.
"State" has the meaning set forth in division (G) of section 1.59 of the Revised Code.

"Superintendent" or "superintendent of insurance" means the superintendent of insurance of this state, or, when the context requires, the superintendent or commissioner of insurance, or equivalent official, of another state.

"Swap agreement" has the same meaning as in the federal "Deposit Insurance Act," 64 Stat. 884, 12 U.S.C. 1821(e)(8)(D), as now and hereafter amended.

"Transfer" includes the sale and every other and different mode, direct or indirect, of disposing of or of parting with property or with an interest in property, or with the possession of property or of fixing a lien upon property or upon an interest in property, absolutely or conditionally, voluntarily, or by or without judicial proceedings. The retention of a security title to property delivered to a debtor shall be deemed a transfer suffered by the debtor.

Sec. 3903.50. (A) If a domiciliary liquidator has not been appointed, the superintendent of insurance may file a complaint in the court of common pleas for an order directing the superintendent to act as conservator to conserve the property of an alien insurer not domiciled in this state or a foreign insurer on any one or more of the following grounds:

(1) Any of the grounds in section 3903.12 of the Revised Code;

(2) That any of its property has been sequestered by official action in its domiciliary state, or in any other state;

(3) That enough of its property has been sequestered in a foreign country to give reasonable cause to fear that the
insurer is or may become insolvent;

(4) That its certificate of authority to do business in this state has been revoked or none was ever issued and that there are residents of this state with outstanding claims or outstanding policies.

(B) When an order is sought under division (A) of this section, the court shall cause the insurer to be given such notice and time to respond thereto as is reasonable under the circumstances.

(C) The court may issue the order in whatever terms it considers appropriate. Persons dealing with the property of the insurer are charged with notice of a judgment ordering the supervisor/superintendent to act as conservator under this section from the time when the judgment is filed under Civil Rule 58, or a certified copy of the judgment is filed under Civil Rule 3(F), with the clerk of the court of common pleas of the county in which the principal business of the company is located or the county in which its principal office or place of business is located.

(D) The conservator may at any time file a motion for and the court may grant an order under section 3903.51 of the Revised Code to liquidate assets of a foreign or alien insurer under conservation, or, if appropriate, for an order under section 3903.53 of the Revised Code to be appointed ancillary receiver.

(E) The conservator may at any time move the court for an order terminating conservation of an insurer. If the court finds that the conservation is no longer necessary, it shall order that the insurer be restored to possession of its property and
the control of its business. The court may also make such finding and issue such order at any time upon motion of any interested party, but if such motion is denied all costs shall be assessed against the party.

Sec. 3903.52. (A) The domiciliary liquidator of an insurer domiciled in a reciprocal state shall, except as to special deposits and security on secured claims under division (C) of section 3903.53 of the Revised Code, be vested by operation of law with the title to all of the assets, property, contracts, and rights of action, agents' balances, and all of the books, accounts, and other records of the insurer located in this state. The date of vesting shall be the date of the filing of the complaint or petition, if that date is specified by the domiciliary law for the vesting of property in the domiciliary state. Otherwise, the date of vesting shall be the date of entry of the order directing possession to be taken. The domiciliary liquidator shall have the immediate right to recover balances due from agents and to obtain possession of the books, accounts, and other records of the insurer located in this state. He also shall have the right to recover all other assets of the insurer located in this state, subject to section 3903.53 of the Revised Code.

(B) If a domiciliary liquidator is appointed for an insurer not domiciled in a reciprocal state, the superintendent of insurance shall be vested by operation of law with the title to all of the property, contracts, and rights of action, and all of the books, accounts, and other records of the insurer located in this state, at the same time that the domiciliary liquidator is vested with title in the domicile. The superintendent may file a complaint for a conservation or liquidation order under section 3903.50 or 3903.51 of the Revised Code, or for an
ancillary receivership under section 3903.53 of the Revised Code, or after approval by the court may transfer title to the domiciliary liquidator, as the interests of justice and the equitable distribution of the assets require.

(C) Claimants residing in this state may file claims with the liquidator or ancillary receiver, if any, in this state or with the domiciliary liquidator, if the domiciliary law permits. The claims must be filed on or before the last date fixed for the filing of claims in the domiciliary liquidation proceedings.

**Sec. 3903.56.** (A) In a liquidation proceeding in a reciprocal state against an insurer domiciled in that state, claimants against the insurer who reside within this state may file claims either with the ancillary receiver, if any, in this state, or with the domiciliary liquidator. Claims must be filed on or before the last dates fixed for the filing of claims in the domiciliary liquidation proceeding.

(B) Claims belonging to claimants residing in this state may be proved either in the domiciliary state under the law of that state, or in ancillary proceedings, if any, in this state. If a claimant elects to prove his claim in this state, he shall file his claim with the liquidator in the manner provided in sections 3903.35 and 3903.36 of the Revised Code. The ancillary receiver shall make a recommendation to the court as under section 3903.43 of the Revised Code. He shall also arrange a date for hearing if necessary under section 3903.39 of the Revised Code and shall give notice to the liquidator in the domiciliary state, either by certified mail or by personal service at least forty days prior to the date set for hearing. If the domiciliary liquidator, within thirty days
after the giving of such notice, gives notice in writing to the ancillary receiver and to the claimant, either by certified mail or by personal service, of his intention to contest the claim, he shall be entitled to appear or to be represented in any proceeding in this state involving the adjudication of the claim.

(C) The final allowance of the claim by the courts of this state shall be accepted as conclusive as to amount and as to priority against special deposits or other security located in this state.

Sec. 3903.71. If it appears to the superintendent of insurance upon satisfactory evidence that the affairs of an insurance company, partnership, association, or reciprocal insurance exchange, not organized under the laws of this state, are such that any of the following conditions exist, he shall suspend the authority granted to such company to do business in this state:

(A) It cannot meet the current applicable requirements for incorporation and commencement of the business of insurance in this state;

(B) It has commenced, or has attempted to commence, any voluntary liquidation or dissolution proceeding, or any proceeding to procure the appointment of a receiver, liquidator, rehabilitor, sequestrator, conservator, or similar officer for itself;

(C) It is the subject of liquidation or dissolution proceedings undertaken by another state, or any other proceeding undertaken by another state to procure the appointment of a
receiver, liquidator, rehabilitor, sequestrator, conservator, or similar officer;

(D) Its ratio of premium writings to surplus and capital are unreasonable as determined by the superintendent of insurance;

(E) Its further transaction of business would be hazardous to its policyholders, contract holders, or the public as shown by the following conduct, but not necessarily limited to only the following:

(1) Its investments are made so as to make unavailable within a reasonable time sufficient moneys to meet promptly any demand which might in the ordinary course of business be properly made against it;

(2) Any of its officers or directors have embezzled, sequestered, or wrongfully diverted any of its assets;

(3) It has willfully violated its charter or any law of this state.

If no demand for a hearing is made by the suspended company within thirty days after suspension, such suspension shall become a revocation of the authority to transact the business of insurance in this state. Any such hearing shall be held in compliance with sections 119.01 to 119.13 of the Revised Code. If during such hearing, satisfactory evidence of any of the enumerated conditions of this section is found to exist, the superintendent shall revoke the authority to transact the business of insurance in this state.

Sec. 3903.724. (A) This section shall determine the calendar year statutory valuation interest rates (VIR) used in determining the minimum standard for the valuation of all of the
following:

(1) Life insurance policies issued on or after January 1, 1989;

(2) Individual annuity and pure endowment contracts issued on or after January 1, 1989;

(3) Annuities and pure endowments purchased on or after January 1, 1989, under group annuity and pure endowment contracts;

(4) The net increase, if any, in amounts held under a guaranteed interest contract in a calendar year after January 1, 1989.

(B) The calendar year statutory valuation interest rates shall be calculated as follows and the results rounded to the nearest one-quarter of one per cent:

(1)(a) For life insurance, by adding three per cent to the result of multiplying W (the applicable weighting factor) by R(sub-1) minus three per cent (where R(sub-1) is the lesser of the reference interest rate and nine per cent) and also adding the result of multiplying one-half of the weighting factor by R(sub-2) minus nine per cent (where R(sub-2) is the greater of the reference interest rate and nine per cent), expressed as follows:

\[ \text{VIR} = .03 + W (R_{sub-1} - .03) + \frac{W}{2}(R_{sub-2} - .09). \]

(b) Provided that if the calendar year statutory valuation interest rate for a life insurance policy issued in any calendar year determined in accordance with this division does not differ from the calendar year valuation interest rate for similar policies issued in the preceding calendar year by at least one-
half of one per cent, the calendar year valuation interest rate for the policy shall be equal to the calendar year valuation interest rate for the preceding calendar year. The calendar year statutory valuation interest rate shall be determined for 1980 and for each subsequent year prior to the operative date of the valuation manual.

(2) For all single premium immediate annuities and for annuity benefits involving life contingencies arising from other annuities with cash settlement options and from guaranteed interest contracts with cash settlement options by adding to three per cent the result of multiplying $W$ (the applicable weighting factor) by $R$ minus three per cent (where $R$ is the reference interest rate), expressed as follows:

\[
VIR = .03 + W(R - .03).
\]

(3) Except as provided in division (B)(2) of this section, for other annuities with cash settlement options and guaranteed interest contracts with cash settlement options, valued on an issue year basis, the life insurance formula stated in division (B)(1) of this section shall apply to all annuity and guaranteed interest contracts with guarantee durations in excess of ten years and the formula for single premium immediate annuities stated in division (B)(2) of this section shall apply to annuities and guaranteed interest contracts with guarantee duration of ten years or less.

(4) For other annuities with no cash settlement options and for guaranteed interest contracts with no cash settlement options, the formula for single premium immediate annuities stated in division (B)(2) of this section shall apply.

(5) For other annuities with cash settlement options and
guaranteed interest contracts with cash settlement options, valued on a change in fund basis, the formula for single premium immediate annuities stated in division (B)(2) of this section shall apply.

(C) For life insurance, the guarantee duration is the maximum number of years the life insurance can remain in force on a basis guaranteed in the policy or under an option to convert to a plan of life insurance with premium rates or nonforfeiture values, or both, guaranteed in the policy.

(D) The weighting factors for the formulas prescribed in division (B) of this section are shown in the following table:

<table>
<thead>
<tr>
<th>A</th>
<th>Weighting Factors for Life Insurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>B</td>
<td>Guarantee Duration (Years)</td>
</tr>
<tr>
<td>C</td>
<td>10 or less</td>
</tr>
<tr>
<td>D</td>
<td>More than 10, but not more than 20</td>
</tr>
<tr>
<td>E</td>
<td>More than 20</td>
</tr>
</tbody>
</table>

(E) The weighting factor for single premium immediate annuities and for annuity benefits involving life contingencies arising from other annuity and guaranteed interest contracts with cash settlement options is .80.

(F) Weighting factors for all other annuity and guaranteed interest contracts vary with the type of plan and guarantee
duration. The types of plans are as follows:

(1) A plan type A is one in which funds may not be withdrawn or may be withdrawn in only one of three ways:

(a) With an adjustment to reflect changes in interest rates or asset values since receipt of the funds by the company;

(b) Without such adjustment but in installments over five or more years;

(c) As an immediate life annuity.

(2) A plan type B is one in which the funds may not be withdrawn before the expiration of the interest rate guarantee unless an adjustment is made to reflect changes in interest rates or asset values since receipt of the funds by the company or unless they are withdrawn in installments over five or more years. At the end of the interest rate guarantee, funds may be withdrawn in a single sum or in installments over less than five years without adjustment.

(3) A plan type C is one in which the funds may be withdrawn before the end of the interest rate guarantee in a single sum or in installments over less than five years without adjustment to reflect changes in interest rates or asset values since receipt of the funds by the company or subject only to a fixed surrender charge stipulated in the contract as a percentage of the fund.

(4) The guarantee duration for an annuity or guaranteed interest contract with cash settlement options is the number of years for which the contract guarantees interest rates in excess of the calendar year valuation interest rate for life insurance policies with guarantee duration in excess of twenty years. The guarantee duration for annuity and guaranteed interest contracts
without cash settlement options is the number of years from the
date of issue or date of purchase to the date annuity benefits
are scheduled to commence.

(5) Annuity and guaranteed interest contracts with cash
settlement options may be valued on an issue year basis or on a
change in fund basis. Annuity and guaranteed interest contracts
without cash settlement options must be valued on an issue year
basis. As used in this division, an issue year basis of
valuation refers to a valuation basis under which the interest
rate used to determine the minimum valuation standard for the
entire duration of the annuity or guaranteed interest contract
is the calendar year valuation interest rate for the year of
issue or year of purchase of the annuity or guaranteed interest
contract, and the change in fund basis of valuation refers to a
valuation basis under which the interest rate used to determine
the minimum valuation standard applicable to each change in the
fund held under the annuity or guaranteed interest contract is
the calendar year valuation interest rate for the year of the
change in the fund.

(6) Weighting factors for other annuities and for
guaranteed interest contracts, except as stated in division (E)
of this section, are specified below.

(a) For annuity and guaranteed interest contracts valued
on an issue year basis:

Weighting Factors for Annuities and Guaranteed Interest
Contracts

1  2  3  4
<table>
<thead>
<tr>
<th>A</th>
<th>Weighting Factor for Plan Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>B</td>
<td>Guarantee Duration (Years)</td>
</tr>
<tr>
<td>C</td>
<td>5 or less</td>
</tr>
<tr>
<td>D</td>
<td>More than 5, but not more than 10</td>
</tr>
<tr>
<td>E</td>
<td>More than 10, but not more than 20</td>
</tr>
<tr>
<td>F</td>
<td>More than 20</td>
</tr>
</tbody>
</table>

(b) For annuities and guaranteed interest contracts valued on a change in fund basis, the factors shown in division (F)(6) of this section increased by the following amounts:

(i) For plan type A, .15;

(ii) For plan type B, .25;

(iii) For plan type C, .05.

(c) For annuities and guaranteed interest contracts valued on an issue year basis, other than those with no cash settlement options, that do not guarantee interest on considerations received more than one year after issue or purchase and for annuities and guaranteed interest contracts valued on a change in fund basis that do not guarantee interest rates on considerations received more than twelve months beyond the valuation date, the factors shown in item (F)(6)(a) or derived in item (F)(6)(b) increased by .05 for all plan types.

(G) The reference interest rate is determined by comparing the monthly average of the composite yield of the monthly average on seasoned corporate bonds, as published by Moody's investors service, inc. for the applicable time period, as
prescribed below:

(1) The reference interest rate for all life insurance is the lesser of such average over the thirty-six month period and such average over the twelve-month period ending on the thirtieth day of June of the calendar year preceding the year of issue.

(2) The reference interest rate for annuity and guaranteed interest contracts with cash settlement options, except single premium immediate annuities and annuity benefits involving life contingencies arising from other annuity and guaranteed interest contracts with cash settlement options, valued on an issue year basis with guarantee durations in excess of ten years, is the lesser of such average over the thirty-six month period and such average over the twelve-month period ending on the thirtieth day of June of the calendar year of issue or purchase.

(3) The reference interest rate for other annuities with cash settlement options and guaranteed interest contracts with cash settlement options, valued on a year of issue basis, except as stated in division (G)(6) of this section, with guarantee duration of ten years or less, such average over the twelve-month period ending on the thirtieth day of June of the calendar year of issue or purchase.

(4) The reference interest rate for other annuities with no cash settlement options and for guaranteed interest contracts with no cash settlement options, such average over the twelve-month period ending on the thirtieth day of June of the calendar year of issue or purchase.

(5) The reference interest rate for all other annuity and guaranteed interest contracts with cash settlement options
valued on a change in fund basis is such average over the

(6) The reference interest rate for all single premium immediate annuities and annuity benefits involving life contingencies arising from other annuity and guaranteed interest contracts with cash settlement options is such average over the twelve-month period ending on the thirtieth day of June of the calendar year in which a change in the fund occurs.

(7) If such corporate bond rate average is no longer published or the national association of insurance commissioners determines that such average is no longer appropriate, the superintendent may by rule approve the use of any alternative method for the determination of the reference interest rate adopted by the commissioners.

Sec. 3903.728. (A) For policies issued on or after the operative date of the valuation manual, the standard prescribed in the valuation manual is the minimum standard of valuation required under division (B) of section 3903.721 of the Revised Code, except as provided under divisions (E) and (G) of this section.

(B) The operative date of the valuation manual is January 1 of the first calendar year following the first July 1 as of which all of the following have occurred:

(1) The valuation manual has been adopted by the national association of insurance commissioners by an affirmative vote of at least forty-two members, or three-fourths of the members voting, whichever is greater.

(2) The standard valuation law, as amended by the national
association of insurance commissioners in 2009, or legislation including substantially similar terms and provisions, has been enacted by states representing greater than seventy-five per cent of the direct premiums written as reported in one or more of the following annual statements submitted for 2008: life, accident, and health annual statements; health annual statements; or fraternal annual statements.

(3) The standard valuation law, as amended by the national association of insurance commissioners in 2009, or legislation including substantially similar terms and provisions, has been enacted by at least forty-two of the following fifty-five jurisdictions: the fifty states of the United States, American Samoa, the American Virgin Islands, the District of Columbia, Guam, and Puerto Rico.

(C) Unless a change in the valuation manual specifies a later effective date, changes to the valuation manual shall be effective on January 1 following the date when all of the following have occurred:

(1) The change to the valuation manual has been adopted by the national association of insurance commissioners by an affirmative vote representing both of the following:

(a) At least three-fourths of the members of the national association of insurance commissioners voting, but not less than a majority of the total membership;

(b) Members of the national association of insurance commissioners representing jurisdictions totaling greater than seventy-five per cent of the direct premiums written as reported in one or more of the following annual statements most recently available prior to the vote in division (C)(1)(a) of this
section: life, accident, and health annual statements; health annual statements; or fraternal annual statements.

(D) The valuation manual shall specify all of the following:

(1) Minimum valuation standards for and definitions of the policies or contracts subject to division (B) of section 3903.721 of the Revised Code. The minimum valuation standards shall be:

(a) The commissioners reserve valuation method for life insurance contracts, other than annuity contracts, subject to division (B) of section 3903.721 of the Revised Code;

(b) The commissioners annuity reserve valuation method for annuity contracts subject to division (B) of section 3903.721 of the Revised Code;

(c) Minimum reserves for all other policies or contracts subject to division (B) of section 3903.721 of the Revised Code.

(2) Which policies or contracts or types of policies or contracts are subject to the requirements of a principle-based valuation in division (A) of section 3903.729 of the Revised Code and the minimum valuation standards consistent with those requirements.

(3) For policies and contracts subject to a principle-based valuation under section 3903.729 of the Revised Code:

(a) Requirements for the format of reports to the superintendent under division (B)(3) of section 3903.729 of the Revised Code that shall include information necessary to determine if the valuation is appropriate and in compliance with sections 3903.72 to 3903.7211 of the Revised Code.
(b) Assumptions for risks over which the company does not have significant control or influence.

(c) Procedures for corporate governance and oversight of the actuarial function, and a process for appropriate waiver or modification of such procedures.

(4) For policies not subject to a principle-based valuation under section 3903.729 of the Revised Code, the minimum valuation standard, which shall be or do either of the following:

(a) Be consistent with the minimum standard of valuation prior to the operative date of the valuation manual;

(b) Develop reserves that quantify the benefits and guarantees, and the funding, associated with the contracts and their risks at a level of conservatism that reflects conditions that include unfavorable events that have a reasonable probability of occurring.

(5) Other requirements, including those relating to reserve methods, models for measuring risk, generation of economic scenarios, assumptions, margins, use of company experience, risk measurement, disclosure, certifications, reports, actuarial opinions and memorandums, transition rules, and internal controls;

(6) The data and form of the data required under section 3903.7210 of the Revised Code, with whom the data must be submitted, and other requirements specified by the superintendent, which may include data analyses and reporting of analyses.

(E) In the absence of a specific valuation requirement or if a specific valuation requirement in the valuation manual is
not, in the opinion of the superintendent, in compliance with sections 3903.72 to 3903.7211 of the Revised Code, then the company shall, with respect to such requirements, comply with minimum valuation standards prescribed in rules adopted by the superintendent.

(F) The superintendent may engage a qualified actuary, at the expense of the company, to perform an actuarial examination of the company and opine on the appropriateness of any reserve assumption or method used by the company, or to review and opine on a company's compliance with any requirement set forth in sections 3903.72 to 3903.7211 of the Revised Code. The superintendent may rely upon the opinion, regarding provisions contained within sections 3903.72 to 3903.7211 of the Revised Code, of a qualified actuary engaged by the insurance commissioner of another state, district, or territory of the United States. As used in this division, the term "engage" includes employment and contracting.

(G) The superintendent may require a company to change any assumption or method that in the opinion of the superintendent is necessary in order to comply with the requirements of the valuation manual or sections 3903.72 to 3903.7211 of the Revised Code, and the company shall adjust the reserves as required by the superintendent. The superintendent may take other disciplinary action as permitted under applicable laws.

Sec. 3903.7211. (A) As used in this section:

(1) "Confidential information" means all of the following:

(a) A memorandum in support of an opinion submitted under sections 3903.722 and 3903.726 of the Revised Code and any other documents, materials, and other information, including all
working papers, and copies thereof, created, produced, or
obtained by or disclosed to the superintendent or any other
person in connection with such memorandum.

(b)(i) Except as provided in division (A)(1)(b)(ii) of
this section, all documents, materials, and other information,
including all working papers, and copies thereof, created,
produced, or obtained by or disclosed to the superintendent or
any other person in the course of an examination made under
division (F) of section 3903.728 of the Revised Code.

(ii) If an examination report or other material prepared
in connection with an examination made under section 3901.07 of
the Revised Code is not held as private and confidential
information under that section, an examination report or other
material prepared in connection with an examination made under
division (F) of section 3903.728 of the Revised Code shall not
be considered confidential information to the same extent as if
such examination report or other material had been prepared
under section 3901.07 of the Revised Code.

(c) Any reports, documents, materials, and other
information developed by a company in support of, or in
connection with, an annual certification by the company under
division (B)(2) of section 3903.729 of the Revised Code
evaluating the effectiveness of the company's internal controls
with respect to a principle-based valuation and any other
documents, materials, and other information, including all
working papers, and copies thereof, created, produced, or
obtained by or disclosed to the superintendent or any other
person in connection with such reports, documents, materials,
and other information;

(d) Any principle-based valuation report developed under
division (B)(3) of section 3903.729 of the Revised Code and any other documents, materials, and other information, including all working papers, and copies thereof, created, produced, or obtained by or disclosed to the superintendent or any other person in connection with such report;

(e) Any documents, materials, data, and other information submitted by a company under section 3903.7210 of the Revised Code, referred to collectively as "experience data," and any other documents, materials, data, and other information, including all working papers, and copies thereof, created or produced in connection with such experience data, in each case that include any potentially company-identifying or personally identifiable information, that is provided to or obtained by the superintendent, which when combined with any experience data is referred to as "experience materials," and any other documents, materials, data, and other information, including all working papers, and copies thereof, created, produced, or obtained by or disclosed to the superintendent or any other person in connection with such experience materials.

(2) "Regulatory agency," "law enforcement agency," and the "national association of insurance commissioners" includes their employees, agents, consultants, and contractors.

(B)(1) Except as provided in division (B)(2) of this section and as otherwise provided in this section, a company's confidential information is confidential by law and privileged, is not a public record under section 149.43 of the Revised Code, shall not be subject to subpoena, and shall not be subject to discovery or admissible in evidence in any private civil action. Except as otherwise provided in this section, neither the superintendent nor any person who received confidential
information while acting under the superintendent's authority shall be permitted or required to testify in any private civil action concerning that confidential information.

(2) The superintendent is authorized to use the confidential information in the furtherance of any regulatory or legal action brought against the company as a part of the superintendent's official duties.

(C)(1) In order to assist in the performance of the superintendent's duties, the superintendent may share confidential information with all of the following:

(a) Other state, federal, and international regulatory agencies;

(b) The national association of insurance commissioners and its affiliates and subsidiaries;

(c) The actuarial board for counseling and discipline, or its successor, in the case of confidential information specified in divisions (A)(1)(a) and (d) of this section only, upon a request stating that the confidential information is required for the purpose of professional disciplinary proceedings;

(d) State, federal, and international law enforcement officials.

(2) The superintendent may share confidential information as specified in divisions (C)(1)(a) through (d) of this section only if the recipient agrees, and has the legal authority to agree, to maintain the confidentiality and privileged status of such documents, materials, data, and other information in the same manner and to the same extent as required for the superintendent.
(D) The superintendent may receive documents, materials, data, and other information, including otherwise confidential and privileged documents, materials, data, or information, from the national association of insurance commissioners and its affiliates and subsidiaries, from regulatory or law enforcement officials of other foreign or domestic jurisdictions, and from the actuarial board for counseling and discipline or its successor. The superintendent shall maintain as confidential or privileged any document, material, data, or other information received with notice or the understanding that it is confidential or privileged under the laws of the jurisdiction that is the source of the document, material, data, or other information.

(E) The superintendent may enter into agreements governing sharing and use of information consistent with this section.

(F) No waiver of any applicable privilege or claim of confidentiality in the confidential information shall occur as a result of disclosure to the superintendent under this section or as a result of sharing as authorized in division (C) of this section.

(G) A privilege established under the law of any state or jurisdiction that is substantially similar to the privilege established under this section shall be available and enforced in any proceeding in, and in any court of, this state.

(H) Notwithstanding divisions (B) to (G) of this section, any confidential information specified in divisions (A)(1)(a) and (d) of this section are subject to all of the following:

(I) The confidential information may be subject to subpoena for the purpose of defending an action seeking damages.
from the appointed actuary submitting the related memorandum in support of an opinion submitted under sections 3903.722 and 3903.726 of the Revised Code or principle-based valuation report developed under division (B)(3) of section 3903.729 of the Revised Code by reason of an action required by sections 3903.72 to 3903.7211 of the Revised Code or by rules adopted pursuant to those sections.

(2) The confidential information may otherwise be released by the superintendent with the written consent of the company.

(3) Once any portion of a memorandum in support of an opinion submitted under section 3903.722 and or 3903.726 of the Revised Code or a principle-based valuation report developed under division (B)(3) of section 3903.729 of the Revised Code is cited by the company in its marketing or is publicly volunteered to or before a governmental agency other than a state insurance department or is released by the company to the news media, all portions of that memorandum or report shall no longer be confidential.

Sec. 3903.74. If any company, corporation, or association required by law to make a deposit with the superintendent of insurance, or other state officer, to secure the contracts or of such company, corporation, or association, or for any other purpose, fails to pay any of its liabilities upon such contracts, or other obligations, according to the terms thereof after the liability thereon has been determined, or if such company, corporation, or association, having ceased to do business within this state, leaves unpaid any such liability or has become insolvent, the attorney general, on behalf of the superintendent, or such other officer, and upon the application of any person entitled to participate in such
deposit, or the proceeds arising therefrom, shall commence a civil action in the court of common pleas of Franklin county, making the company, corporation, or association a party defendant, to determine the rights of all parties claiming any interest in such deposit, to subject the deposit to the payment or satisfaction of all liabilities, and to distribute such fund among the persons entitled thereto.

Sec. 3904.01. As used in sections 3904.01 to 3904.22 of the Revised Code:

(A)(1) "Adverse underwriting decision" means any of the following actions with respect to insurance transactions involving life, health, or disability insurance coverage that is individually underwritten:

(a) A declination of insurance coverage;

(b) A termination of insurance coverage;

(c) Failure of an agent to apply for insurance coverage with a specific insurance institution that the agent represents and that is requested by an applicant;

(d) An offer to insure at higher than standard rates.

(2) Notwithstanding division (A)(1) of this section, none of the following actions is an adverse underwriting decision, but the insurance institution or agent responsible for their occurrence shall nevertheless provide the applicant or policyholder with the specific reason or reasons for their occurrence:

(a) The termination of an individual policy form on a class or statewide basis;

(b) A declination of insurance coverage solely because the
coverage is not available on a class or statewide basis;

(c) The rescission of a policy.

(B) "Affiliate" or "affiliated" means a person that directly, or indirectly through one or more intermediaries, controls, is controlled by, or is under common control with another person.

(C) "Agent" means a person licensed under Chapter 3905. of the Revised Code to negotiate or solicit applications for a policy or contract of life, health, or disability insurance.

(D) "Applicant" means any person that seeks to contract for life, health, or disability insurance coverage other than a person seeking group insurance that is not individually underwritten.

(E) "Consumer report" means any written, oral, or other communication of information bearing on a natural person's credit worthiness, credit standing, credit capacity, character, general reputation, personal characteristics, or mode of living that is used or expected to be used in connection with a life, health, or disability insurance transaction.

(F) "Consumer reporting agency" means any person that does all of the following:

(1) Regularly engages, in whole or in part, in the practice of assembling or preparing consumer reports for a monetary fee;

(2) Obtains information primarily from sources other than insurance institutions;

(3) Furnishes consumer reports to other persons.
(G) "Control," including the terms "controlled by" or "under common control with," means the possession, direct or indirect, of the power to direct or cause the direction of the management and policies of a person, whether through the ownership of voting securities, by contract other than a commercial contract for goods or nonmanagement services, or otherwise, unless the power is the result of an official position with or corporate office held by the person.

(H) "Declination of insurance coverage" means a denial, in whole or in part, by an insurance institution or agent of requested insurance coverage.

(I) "Individual" means any natural person who in connection with life, health, or disability insurance:

(1) Is a past, present, or proposed principal insured or certificate holder;

(2) Is a past, present, or proposed policy owner;

(3) Is a past or present applicant;

(4) Is a past or present claimant;

(5) Derived, derives, or is proposed to derive insurance coverage under an insurance policy or certificate subject to sections 3904.01 to 3904.22 of the Revised Code.

(J) "Institutional source" means any person or governmental entity that provides information about an individual to an agent, insurance institution, or insurance support organization, other than any of the following:

(1) An agent;

(2) The individual who is the subject of the information;
(3) A natural person acting in a personal capacity rather than in a business or professional capacity.

(K) "Insurance institution" means any corporation, association, partnership, fraternal benefit society, or other person engaged in the business of life, health, or disability insurance, including health insuring corporations. "Insurance institution" does not include agents or insurance support organizations.

(L)(1) "Insurance support organization" means any person that regularly engages, in whole or in part, in the practice of assembling or collecting information about natural persons for the primary purpose of providing the information to an insurance institution or agent for insurance transactions, including both of the following:

(a) The furnishing of consumer reports or investigative consumer reports to an insurance institution or agent for use in connection with an insurance transaction;

(b) The collection of personal information from insurance institutions, agents, or other insurance support organizations for the purpose of detecting or preventing fraud, material misrepresentation, or material nondisclosure in connection with insurance underwriting or insurance claim activity.

(2) Notwithstanding division (L)(1) of this section, agents, government institutions, insurance institutions, medical care institutions, and medical professionals are not "insurance support organizations" for purposes of sections 3904.01 to 3904.22 of the Revised Code.

(M) "Insurance transaction" means any transaction involving life, health, or disability insurance primarily for
personal, family, or household needs rather than business or professional needs and entailing either the determination of an individual's eligibility for a life, health, or disability insurance coverage, benefit, or payment, or the servicing of a life, health, or disability insurance application, policy, contract, or certificate.

(N) "Investigative consumer report" means a consumer report or portion thereof in which information about a natural person's character, general reputation, personal characteristics, or mode of living is obtained through personal interviews with the person's neighbors, friends, associates, acquaintances, or others who may have knowledge concerning such items of information.

(O) "Medical care institution" means any facility or institution that is licensed to provide health care services to natural persons, including home-health agencies, hospitals, medical clinics, public health agencies, rehabilitation agencies, and skilled nursing facilities.

(P) "Medical professional" means any person licensed or certified to provide health care services to natural persons, including a chiropractor, clinical dietitian, clinical psychologist, dentist, nurse, occupational therapist, optometrist, pharmacist, physical therapist, physician, podiatrist, psychiatric social worker, and speech therapist.

(Q) "Medical record information" means personal information that relates to an individual's physical or mental condition, medical history, or medical treatment and that is obtained from a medical professional or medical care institution, from the individual, or from the individual's spouse, parent, or legal guardian.
(R) "Personal information" means any individually identifiable information gathered in connection with an insurance transaction from which judgments can be made about an individual's character, habits, avocations, finances, occupation, general reputation, credit, health, or any other personal characteristics. "Personal information" includes an individual's name and address and medical record information but does not include privileged information.

(S) "Policyholder" means any person that is a present owner of individual life, health, or disability insurance, or a present certificate holder under group life, health, or disability insurance that is individually underwritten.

(T) "Pretext interview" means an interview whereby a person, in an attempt to obtain information about a natural person, performs one or more of the following acts:

1. Pretends to be someone the interviewer is not;
2. Pretends to represent a person the interviewer is not in fact representing;
3. Misrepresents the true purpose of the interview;
4. Refuses to identify self upon request.

(U) "Privileged information" means any individually identifiable information that relates to a claim for life, health, or disability insurance benefits or a civil or criminal proceeding involving an individual, and that is collected in connection with, or in reasonable anticipation of, a claim for life, health, or disability insurance benefits or civil or criminal proceeding involving an individual. However, information otherwise meeting the requirements of this division shall nevertheless be considered personal information if it is
disclosed in violation of section 3904.13 of the Revised Code.

(V) "Termination of insurance coverage" or "termination of an insurance policy" means either a cancellation or nonrenewal of a life, health, or disability insurance policy, in whole or in part, for any reason other than the failure to pay a premium as required by the policy.

(W) "Unauthorized insurer" means an insurance institution that has not been granted a certificate of authority by the superintendent of insurance to transact the business of life, health, or disability insurance in this state.

Sec. 3904.02. (A) The obligations of sections 3904.01 to 3904.22 of the Revised Code apply to those insurance institutions, agents, or insurance support organizations that, on or after the effective date of these sections June 29, 1995, do either of the following:

(1) Collect, receive, or maintain information in connection with insurance transactions that pertains to natural persons who are residents of this state;

(2) Engage in insurance transactions with applicants, individuals, or policyholders who are residents of this state.

(B) The rights granted by sections 3904.01 to 3904.22 of the Revised Code extend to both of the following persons who are residents of this state:

(1) Natural persons who are the subject of information collected, received, or maintained in connection with insurance transactions;

(2) Applicants, individuals, or policyholders who engage in or seek to engage in insurance transactions.
(C) For purposes of this section, a person is considered a resident of this state if the person's last known mailing address, as shown in the records of the insurance institution, agent, or insurance support organization, is located in this state.

Sec. 3904.16. (A) Whenever the superintendent of insurance has reason to believe that an insurance institution, agent, or insurance support organization has been or is engaged in conduct in this state that violates sections 3904.01 to 3904.22 of the Revised Code, or if the superintendent believes that an insurance support organization has been or is engaged in conduct outside this state that has an effect on a person residing in this state and that violates these sections, the superintendent shall issue and serve upon such insurance institution, agent, or insurance support organization a statement of charges and notice of hearing to be held at a time and place fixed in the notice. The date for such hearing shall be not less than thirty days after the date of service.

(B) At the time and place fixed for such hearing, the insurance institution, agent, or insurance support organization charged shall have an opportunity to answer the charges against it and present evidence on its behalf. Upon good cause shown, the superintendent shall permit any adversely affected person to intervene, appear, and be heard at such hearing by counsel or in person.

(C) At any hearing conducted pursuant to this section, the superintendent may administer oaths, examine, and cross-examine witnesses and receive oral and documentary evidence. The superintendent may subpoena witnesses, compel their attendance, and require the production of books, papers, records,
correspondence and other documents that are relevant to the hearing. A stenographic record of the hearing shall be made upon the request of any party or at the discretion of the superintendent. If no stenographic record is made and if judicial review is sought, the superintendent shall prepare a statement of the evidence for use on the review. Hearings conducted under this section are governed by the same rules of evidence and procedure applicable to administrative proceedings conducted under Chapter 119. of the Revised Code.

(D) Statements of charges, notices, orders, and other processes of the superintendent under sections 3904.01 to 3904.22 of the Revised Code may be served by anyone authorized to act on behalf of the superintendent. Service of process may be completed in the manner provided by law for service of process in civil actions or by registered mail. A copy of the statement of charges, notice, order or other process shall be provided to the person or persons whose rights under these sections have been allegedly violated. A verified return setting forth the manner of service, or return postcard receipt in the case of registered mail, is sufficient proof of service.

Sec. 3905.051. (A) As used in this section:

(A) (1) "Applicant" means a natural person applying for either of the following:

(1) (a) A resident license as an insurance agent or surety bail bond agent;

(2) (b) An additional line of authority under an existing resident insurance agent license if a criminal record check has not been obtained within the last twelve months for insurance license purposes.
(B) "Fingerprint" means an impression of the lines on
the finger taken for the purpose of identification. The
impression may be electronic or converted to an electronic
format.

(C) Each applicant shall consent to a criminal record
check in accordance with this section and shall submit a full
set of fingerprints to the superintendent of insurance for that
purpose.

(D) The superintendent of insurance shall request the
superintendent of the bureau of criminal identification and
investigation to conduct a criminal records check based on the
applicant's fingerprints. The superintendent of insurance shall
request that criminal record information from the federal bureau
of investigation be obtained as part of the criminal records
check.

(E) The superintendent of insurance may contract for
the collection and transmission of fingerprints authorized under
this section. The superintendent may order the fee for
collecting and transmitting fingerprints to be payable directly
to the contractor by the applicant. The superintendent may agree
to a reasonable fingerprinting fee to be charged by the
contractor. Any fee required under this section shall be paid by
the applicant.

(F) The superintendent may receive criminal record
information directly in lieu of the bureau of criminal
identification and investigation that submitted the fingerprints
to the federal bureau of investigation.

(G) The superintendent shall treat and maintain an
applicant's fingerprints and any criminal record information
obtained under this section as confidential and shall apply security measures consistent with the criminal justice information services division of the federal bureau of investigation standards for the electronic storage of fingerprints and necessary identifying information and limit the use of records solely to the purposes authorized by this section. The fingerprints and any criminal record information are not subject to subpoena other than one issued pursuant to a criminal investigation, are confidential by law and privileged, are not subject to discovery, and are not admissible in any private civil action.

(G) This section does not apply to an agent applying for renewal of an existing resident or nonresident license in this state.

Sec. 3905.062. (A) As used in this section:

(1) "Customer" means a person who purchases portable electronics or services.

(2) "Enrolled customer" means a customer who elects coverage under a portable electronics insurance policy issued to a vendor of portable electronics by an insurer.

(3) "Endorsee" means an employee or authorized representative of a vendor authorized to sell or offer portable electronics insurance.

(4) "Location" means any physical location in this state or any web site, call center site, or similar location directed to residents of this state.

(5) "Portable electronics" means a personal, self-contained, battery-operated electronic communication, viewing, listening, recording, gaming, computing, or global positioning
device that is easily carried by an individual, including a cellular or satellite telephone; pager; personal global positioning satellite unit; portable computer; portable audio listening, video viewing or recording device; digital camera; video camcorder; portable gaming system; docking station; automatic answering device; and any other similar device, and any accessory related to the use of the device.

(6) "Portable electronics insurance" means insurance providing coverage for the repair or replacement of portable electronics, which may be offered on a month-to-month or other periodic basis as a group or master commercial inland marine policy issued to a vendor by an insurer, and may cover portable electronics against loss, theft, inoperability due to mechanical failure, malfunction, damage, or other applicable perils. "Portable electronics insurance" does not mean any of the following:

(a) A consumer goods service contract governed by section 3905.423 of the Revised Code;

(b) A policy of insurance covering a seller's or a manufacturer's obligations under a warranty;

(c) A homeowner's, renter's, private passenger automobile, commercial multi-peril, or similar insurance policy.

(7) "Portable electronics transaction" means the sale or lease of portable electronics by a vendor to a customer or the sale of a service related to the use of portable electronics by a vendor to a customer.

(8) "Supervising entity" means an insurer or a business entity licensed as an insurance agent under section 3905.06 of the Revised Code that is appointed by an insurer to supervise
the administration of a portable electronics insurance program.

(9) "Vendor" means a person in the business of engaging in portable electronics transactions directly or indirectly.

(B)(1) Except as provided in division (B)(2) of this section, no vendor or vendor's employee shall offer, sell, solicit, or place portable electronics insurance unless the vendor is licensed under section 3905.06 or 3905.07 of the Revised Code with a portable electronics insurance line of authority.

(2) Any vendor offering or selling portable electronics insurance on or before the effective date of this section March 22, 2012, that wishes to continue offering or selling that insurance shall apply for a license within ninety days after the superintendent of insurance makes the application available.

(C)(1) The superintendent shall issue a resident business entity license to a vendor under section 3905.06 of the Revised Code if the vendor satisfies the requirements of sections 3905.05 and 3905.06 of the Revised Code, except that the application for a portable electronics insurance license shall satisfy the following additional requirements:

(a) The application shall include the location of the vendor's home office.

(b) If the application requires the vendor to designate an individual or entity as a responsible insurance agent, that agent shall not be required to be an employee of the applicant and may be the supervising entity or an individual agent who is an employee of the supervising entity.

(c) If the vendor derives less than fifty per cent of the vendor's revenue from the sale of portable electronics
insurance, the application for a portable electronics insurance license may require the vendor to provide the name, residence address, and other information required by the superintendent for one employee or officer of the vendor who is designated by the vendor as the person responsible for the vendor's compliance with the requirements of this chapter.

(d) If the vendor derives fifty per cent or more of the vendor's revenue from the sale of portable electronics insurance, the application may require the information listed under division (C)(1)(c) of this section for all owners with at least ten per cent interest or voting interest, partners, officers, and directors of the vendor, or members or managers of a vendor that is a limited liability company.

(2) The superintendent shall issue a nonresident business entity license to a vendor if the vendor satisfies the requirements of section 3905.07 of the Revised Code. However, if the nonresident vendor's home state does not issue a limited lines license for portable electronics insurance, the nonresident vendor may apply for a resident license under section 3905.06 of the Revised Code in the same manner and with the same rights and privileges as if the vendor were a resident of this state.

(D) The holder of a limited lines license may not sell, solicit, or negotiate insurance on behalf of any insurer unless appointed to represent that insurer under section 3905.20 of the Revised Code.

(E) Division (B)(34) of section 3905.14 of the Revised Code shall not apply to portable electronics vendors or the vendors' endorsees.
(F)(1) A vendor may authorize any endorsee of the vendor to sell or offer portable electronics insurance to a customer at any location at which the vendor engages in portable electronics transactions.

(2) An endorsee is not required to be licensed as an insurance agent under this chapter if the vendor is licensed under this section and the insurer issuing the portable electronics insurance either directly supervises or appoints a supervising entity to supervise the administration of the portable electronics insurance program including development of a training program for endorsees in accordance with division (G) of this section.

(3) No endorsee shall do any of the following:

(a) Advertise, represent, or otherwise represent the endorsee's self as an insurance agent licensed under section 3905.06 of the Revised Code;

(b) Offer, sell, or solicit the purchase of portable electronics insurance except in conjunction with and incidental to the sale or lease of portable electronics;

(c) Make any statement or engage in any conduct, express or implied, that would lead a customer to believe any of the following:

(i) That the insurance policies offered by the endorsee provide coverage not already provided by a customer's homeowner's insurance policy, renter's insurance policy, or by another source of coverage;

(ii) That the purchase by the customer of portable electronics insurance is required in order to purchase or lease portable electronics or services from the portable electronics
(iii) That the portable electronics vendor or its endorsee is qualified to evaluate the adequacy of the customer's existing insurance coverage.

(G) Each vendor, or the supervising entity to that vendor, shall provide a training and education program for all endorsee who sell or offer portable electronics insurance. The program may be provided as a web-based training module or in any other electronic or recorded video form. The training and education program shall meet all of the following minimum standards:

(1) The training shall be delivered to each endorsee of each vendor who sells or offers portable electronics insurance and the endorsee shall complete the training;

(2) If the training is conducted in an electronic form, the supervising entity shall implement a supplemental education program regarding portable electronics insurance that is conducted and overseen by employees of the supervising entity who are licensed as insurance agents under section 3905.06 of the Revised Code;

(3) The training and education program shall include basic information about portable electronics insurance and information concerning all of the following prohibited actions of endorsee:

(a) No endorsee shall advertise, represent, or otherwise represent the endorsee's self as a licensed insurance agent.

(b) No endorsee shall offer, sell, or solicit the purchase of portable electronics insurance except in conjunction with and incidental to the sale or lease of portable electronics.

(c) No endorsee shall make any statement or engage in any

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conduct, express or implied, that would lead a customer to believe any of the following:

(i) That the insurance policies offered by the endorsee provide coverage not already provided by a customer's homeowner's insurance policy, renter's insurance policy, or by another source of coverage;

(ii) That the purchase by the customer of portable electronics insurance is required in order to purchase or lease portable electronics or services from the portable electronics vendor;

(iii) That the portable electronics vendor or its endorsees are qualified to evaluate the adequacy of the customer's existing insurance coverage.

(H) A supervising entity appointed to supervise the administration of a portable electronics insurance program under division (F)(2) of this section shall maintain a registry of locations supervised by that entity that are authorized to sell or solicit portable electronics insurance in this state. The supervising entity shall make the registry available to the superintendent upon request by the superintendent if the superintendent provides ten days' notice to the vendor or supervising entity.

(I) At every location where a vendor offers portable electronics insurance to customers, the vendor shall provide brochures or other written materials to prospective customers that include all of the following:

(1) A summary of the material terms of the insurance coverage, including all of the following:

(a) The identity of the insurer;
(b) The identity of the supervising entity;

(c) The amount of any applicable deductible and how it is to be paid;

(d) Benefits of the coverage;

(e) Key terms and conditions of coverage such as whether portable electronics may be replaced with a similar make and model, replaced with a reconditioned device, or repaired with nonoriginal manufacturer parts or equipment.

(2) A summary of the process for filing a claim, including a description of how to return portable electronics equipment and the maximum fee applicable if a customer fails to comply with any equipment return requirements;

(3) A disclosure that portable electronics insurance may provide a duplication of coverage already provided by a customer's homeowner's insurance policy, renter's insurance policy, or other source of coverage;

(4) A disclosure that the enrollment by the customer in a portable electronics insurance program is not required to purchase or lease portable electronics or services;

(5) A disclosure that neither the endorsee nor the vendor is qualified to evaluate the adequacy of the customer's existing insurance coverage;

(6) A disclosure that the customer may cancel enrollment for coverage under a portable electronics insurance policy at any time and receive a refund of any applicable premium.

(J)(1) The charges for portable electronics insurance may be billed and collected by the vendor of portable electronics, and the vendor may receive compensation for performing billing
and collection services, if either of the following conditions are met:

(a) If the charge to the customer for coverage is not included in the cost associated with the purchase or lease of portable electronics or related services, the charge for coverage is separately itemized on the customer's bill.

(b) If the charge to the customer for coverage is included in the cost associated with the purchase or lease of portable electronics or related services, the vendor clearly and conspicuously discloses to the customer that the charge for portable electronics insurance coverage is included with the charge for portable electronics or related services.

(2) All funds received by a vendor from a customer for the sale of portable electronics insurance shall be considered funds held in trust by the vendor in a fiduciary capacity for the benefit of the insurer. Vendors that bill and collect such charges are not required to maintain those funds in a segregated account if the vendor is authorized by the insurer to hold those funds in an alternate manner and the vendor remits the amount of the charges to the supervising entity within sixty days after receiving the charges.

(K)(1) Except as otherwise provided in divisions (K)(2) and (3) of this section, an insurer may terminate or otherwise change the terms and conditions of a policy of portable electronics insurance only upon providing the vendor policyholder and enrolled customers with at least sixty days' prior notice. If the insurer changes the terms and conditions, the insurer shall promptly provide the vendor policyholder with a revised policy or endorsement and each enrolled customer with a revised certificate, endorsement, updated brochure, or other
evidence indicating that a change in the terms and conditions has occurred and a summary of material changes.

(2) An insurer may terminate an enrolled customer's enrollment under a portable electronics insurance policy upon fifteen days' prior notice for discovery of fraud or material misrepresentation in obtaining coverage or in the presentation of a claim under the policy.

(3) An insurer may immediately terminate an enrolled customer's enrollment under a portable electronics insurance policy for any of the following reasons:

(a) The enrolled customer fails to pay the required premium;

(b) The enrolled customer ceases to have an active service plan, if applicable, with the vendor of portable electronics;

(c) The enrolled customer exhausts the aggregate limit of liability, if any, under the terms of the portable electronics insurance policy and the insurer sends notice of termination to the customer within thirty calendar days after exhaustion of the limit. However, if the insurer does not send the notice within the thirty-day time frame, enrollment shall continue notwithstanding the aggregate limit of liability until the insurer sends notice of termination to the enrolled customer.

(4) If a portable electronics insurance policy is terminated by a vendor policyholder, the vendor policyholder shall provide notice to each enrolled customer advising the customer of the termination of the policy and the effective date of the termination. The written notice shall be mailed or delivered to the customer at least thirty days prior to the termination.
(5) Notice required pursuant to this section shall be provided in writing, either via mail or by electronic means.

(a) If notice is provided via mail, it shall be mailed or delivered to the vendor at the vendor's mailing address and to all affected enrolled customers at the last known mailing addresses of those customers on file with the insurer. The insurer or vendor of portable electronics shall maintain proof of mailing in a form authorized or accepted by the United States postal service or other commercial mail delivery service.

(b) If notice is provided electronically, it shall be transmitted via facsimile or electronic mail to the vendor at the vendor's facsimile number or electronic mail address and to all affected enrolled customers at the last known facsimile numbers or electronic mail addresses of those customers on file with the insurer. The insurer or vendor shall maintain proof that the notice was sent.

(L) An enrolled customer may cancel the enrolled customer's coverage under a portable electronics insurance policy at any time. Upon cancellation, the insurer shall refund any applicable unearned premium.

(M) A license issued pursuant to this section shall authorize the vendor and its endorsees to engage only in those activities that are expressly permitted by this section.

(N)(1) If a vendor or a vendor's endorsee violates any provision of this section, the superintendent may revoke or suspend the license issued or impose any other sanctions provided under section 3905.14 of the Revised Code.

(2) If any provision of this section is violated by a vendor or a vendor's endorsee at a particular location,
superintendent may issue a cease and desist order to a  
particular location, or take any other administrative action  
authorized in section 3901.22 and division (D) of section  
3905.14 of the Revised Code.

(3) If any person violates division (B) or (F)(3) of this  
section, the superintendent may issue a cease and desist order  
in addition to taking any other administrative action provided  
for in sections 3901.22 and division (D) of section 3905.14 of  
the Revised Code.

(4) If the superintendent determines that a violation of  
this section or section 3905.14 of the Revised Code has  
occeded, the superintendent may assess a civil penalty in  
amount not exceeding twenty-five thousand dollars per violation  
and an administrative fee to cover the expenses incurred by the  
department in the administrative action, including costs  
incurred in the investigation and hearing process.

(O) The superintendent may adopt rules implementing this  
section.

Sec. 3905.063. (A) As used in this section:

(1) "Customer" means a person who obtains the use of  
storage space from a self-service storage facility under the  
terms of a self-storage rental agreement.

(2) "Endorsee" means an employee or authorized  
representative of a self-service storage facility authorized to  
sell or offer self-service storage insurance.

(3) "Enrolled customer" means a customer who elects  
coverage under a self-service storage insurance policy issued to  
a self-service storage facility by an insurer or a policy issued  
directly to a customer from an insurer.
(4) "Location" means any physical location in this state or any web site, call center site, or similar location directed to residents of this state.

(5) "Owner" means the owner, operator, property management company, lessor, or sublessor of a self-service storage facility. "Owner" does not mean an occupant.

(6) "Personal property" means moveable property not affixed to land, and includes goods, merchandise, furniture, and household items.

(7)(a) "Self-service storage insurance" means insurance providing coverage for the loss of, or damage to, tangible personal property that is contained in storage space or in transit during a self-service storage rental agreement period, which may be offered on a month-to-month or other periodic basis under an individual policy, or as a group, commercial, or master policy issued to a self-service storage facility to provide insurance for the self-service storage facility's customers.

(b) "Self-service storage insurance" does not mean any of the following:

(i) A consumer goods service contract governed by section 3905.423 of the Revised Code;

(ii) A policy of insurance covering a seller's or a manufacturer's obligations under a warranty;

(iii) A homeowner's, renter's, private passenger automobile, or similar insurance policy.

(8) "Self-service storage rental agreement" means a written agreement containing the terms and conditions governing the use of storage space provided by a self-service storage
facility.

(9) "Supervising entity" means an insurer or a business entity licensed as an insurance agent under section 3905.06 or 3905.07 of the Revised Code that is appointed by an insurer to supervise the administration of self-service storage insurance.

(B)(1) Except as provided in division (B)(2) of this section, no self-service storage facility or self-service storage facility's endorsee shall offer, sell, solicit, or place self-service storage insurance unless the self-service storage facility is licensed under section 3905.06 or 3905.07 of the Revised Code with a self-service storage insurance line of authority and the offer, sale, solicitation, or placement is incidental to the lease of self-service storage.

(2) Any self-service storage facility offering or selling self-service storage insurance on or before the effective date of this section, March 23, 2015, that wishes to continue offering or selling that insurance shall apply for a license within ninety days after the superintendent of insurance makes the application available.

(C)(1) The superintendent shall issue a resident insurance license to a self-service storage facility under section 3905.06 of the Revised Code if the self-service storage facility satisfies the requirements of sections 3905.05 and 3905.06 of the Revised Code, except that the application for a self-service storage insurance license shall satisfy the following additional requirements:

(a) The application shall include the location, including the address for each location, of the self-service storage facility's home office and any location at which the facility
engages in self-service storage transactions.

(b) If the application requires the self-service storage facility to designate an individual or entity as a responsible insurance agent, that agent shall not be required to be an employee of the applicant and may be an individual agent who is an employee of the supervising entity.

(c) If the self-service storage facility derives less than fifty per cent of the self-service storage facility's revenue from the sale of self-service storage insurance, the application for a self-service storage insurance license may require the self-service storage facility to provide the name, residence address, and other information required by the superintendent for one employee or officer of the self-service storage facility who is designated by the self-service storage facility as the person responsible for the self-service storage facility's compliance with the requirements of this chapter.

(d) If the self-service storage facility derives fifty per cent or more of the self-service storage facility's revenue from the sale of self-service storage insurance, the application may require the information listed under division (C)(1)(c) of this section for all owners with at least ten per cent interest or voting interest, partners, officers, and directors of the self-service storage facility, or members or managers of a self-service storage facility that is a limited liability company.

(2) The superintendent shall issue a nonresident insurance agent license to a self-service storage facility if the self-service storage facility satisfies the requirements of section 3905.07 of the Revised Code. However, if the nonresident self-service storage facility's home state does not issue a limited lines license for self-service storage insurance, the
nonresident self-service storage facility may apply for a
resident license under sections 3905.05 and 3905.06 of the
Revised Code in the same manner and with the same rights and
privileges as if the self-service storage facility were a
resident of this state.

(D) The holder of a limited lines license may not sell,
solicit, or negotiate insurance on behalf of any insurer unless
appointed to represent that insurer under section 3905.20 of the
Revised Code.

(E) Division (B)(34) of section 3905.14 of the Revised
Code shall not apply to the self-service storage facility or the
self-service storage facility's endorsees.

(F) If insurance is required as a condition of a self-
service storage rental agreement, the requirement may be
satisfied by the customer's purchase of self-service storage
insurance that is sold, solicited, or negotiated by the self-
service storage facility or presentation to the self-service
storage facility of evidence of other applicable insurance
coverage.

Evidence of applicable insurance coverage includes a
representation by a licensed Ohio insurance agent that the
customer satisfies the requirements of this division.

(G)(1) A self-service storage facility may authorize any
endorssee of the self-service storage facility to sell or offer
self-service storage insurance to a customer at any location at
which the self-service storage facility engages in self-service
storage transactions.

(2) An endorssee is not required to be licensed as an
insurance agent under this chapter if the self-service storage

facility is licensed under this section and the insurer issuing the self-service storage insurance either directly supervises or appoints a supervising entity to supervise the administration of the self-service storage insurance including development of a training program for endorsees in accordance with division (H) of this section.

(3) No endorsee shall do any of the following:

(a) Advertise, represent, or otherwise represent the endorsee's self as an insurance agent licensed under section 3905.06 or 3905.07 of the Revised Code;

(b) Offer, sell, or solicit the purchase of self-service storage insurance except in conjunction with and incidental to the sale or lease of self-service storage;

(c) Make any statement or engage in any conduct, express or implied, that would lead a customer to believe either of the following:

(i) That, if insurance is required as a condition of a self-service storage rental agreement, the purchase by the customer of self-service storage insurance offered by the self-service storage facility is the only method by which that condition may be met;

(ii) That the self-service storage facility or its endorsees are qualified to evaluate the adequacy of the customer's existing insurance coverage.

(4) An endorsee shall disclose that self-service storage insurance may duplicate coverage already provided under a customer's homeowner's insurance policy, renter's insurance policy, or other coverage.
(H) Each self-service storage facility, or the supervising entity to that self-service storage facility, shall provide a training and education program for all endorsees who sell or offer self-service storage insurance. The program may be provided as a web-based training module or in any other electronic or recorded video form. The training and education program shall meet all of the following minimum standards:

(1) The training shall be delivered to each endorsee of each self-service storage facility who sells or offers self-service storage insurance and the endorsee shall complete the training.

(2) If the training is conducted in an electronic form, the supervising entity shall implement a supplemental education program regarding self-service storage insurance that is conducted and overseen by employees of the supervising entity who are licensed as insurance agents under section 3905.06 or 3905.07 of the Revised Code.

(3) The training and education program shall include basic information about self-service storage insurance and information concerning all of the following prohibited actions of endorsees:

(a) No endorsee shall advertise, represent, or otherwise represent the endorsee's self as a licensed insurance agent.

(b) No endorsee shall offer, sell, or solicit the purchase of self-service storage insurance except in conjunction with and incidental to the rental of a storage space by the self-service storage facility.

(c) No endorsee shall make any statement or engage in any conduct, express or implied, that would lead a customer to believe any of the following:
(i) That the insurance policies offered by the endorsee provide coverage not already provided by a customer's homeowner's insurance policy, renter's insurance policy, or by another source of coverage;

(ii) That, if insurance is required as a condition of a self-service storage rental agreement, the purchase by the customer of self-service storage insurance offered by the self-service storage facility is the only method by which that condition may be met;

(iii) That the self-service storage facility or its endorsees are qualified to evaluate the adequacy of the customer's existing insurance coverage.

(I) A supervising entity appointed to supervise the administration of self-service storage insurance under division (G)(2) of this section shall maintain a registry of locations supervised by that entity that are authorized to sell or solicit self-service storage insurance in this state and the endorsees at each location. The supervising entity shall make the registry available to the superintendent upon request.

(J)(1) At every location where a self-service storage facility offers self-service storage insurance to customers, the self-service storage facility shall provide brochures or other written materials to prospective customers that include all of the following:

(a) A summary of the material terms of the insurance coverage, including all of the following:

(i) The identity of the insurer;

(ii) The identity of the supervising entity;
(iii) The amount of any applicable deductible and how it is to be paid;

(iv) Benefits of the coverage;

(v) Key terms and conditions of coverage.

(b) A summary of the process for filing a claim;

(c) A disclosure that self-service storage insurance may provide a duplication of coverage already provided by a customer's homeowner's insurance policy, renter's insurance policy, or other source of coverage;

(d) A disclosure that, if insurance is required as a condition of a self-service storage rental agreement, the requirement may be satisfied by either of the following:

(i) The customer's purchase of self-service storage insurance that is sold, solicited, or negotiated by the self-service storage facility;

(ii) The customer's presentation to the self-service storage facility of evidence of other applicable insurance coverage such as a representation by a licensed Ohio insurance agent that the customer satisfies the coverage requirement;

(e) A disclosure that neither the endorsee nor the self-service storage facility is qualified to evaluate the adequacy of the customer's existing insurance coverage;

(f) A disclosure that the customer may cancel enrollment for coverage under a self-service storage insurance policy at any time and receive a refund of any applicable premium.

(2) A self-service storage facility shall provide to every customer who purchases self-service storage insurance a
certificate that is evidence of the coverage.

(K)(1) The charges for self-service storage insurance may be billed and collected by the self-service storage facility, and the self-service storage facility may receive compensation for performing billing and collection services, if either of the following conditions are met:

(a) If the charge to the customer for coverage is not included in the cost associated with the purchase or lease of self-service storage or related services, the charge for coverage is separately itemized on the customer’s bill.

(b) If the charge to the customer for coverage is included in the cost associated with the lease of self-service storage, the self-service storage facility clearly and conspicuously discloses to the customer that the charge for self-service storage insurance coverage is included with the lease for self-service storage.

(2) All funds received by a self-service storage facility from a customer for the sale of self-service storage insurance shall be considered funds held in trust by the self-service storage facility in a fiduciary capacity for the benefit of the insurer. Self-service storage facilities that bill and collect such charges are not required to maintain those funds in a segregated account if the self-service storage facility is authorized by the insurer to hold those funds in an alternate manner and the self-service storage facility remits the amount of the charges to the supervising entity within sixty days after receiving the charges.

(L)(1) Except as otherwise provided in divisions (L)(2) and (3) of this section, an insurer may terminate or otherwise
change the terms and conditions of a policy of self-service
storage insurance only upon providing the self-service storage
facility policyholder and enrolled customers with at least sixty
days' prior notice. If the insurer changes the terms and
conditions, the insurer shall promptly provide the self-service
storage facility policyholder with a revised policy or
endorsement and each enrolled customer with a revised
certificate, endorsement, updated brochure, or other evidence
indicating that a change in the terms and conditions has
occurred and a summary of material changes.

(2) An insurer may terminate an enrolled customer's
enrollment under a self-service storage insurance policy upon
fifteen days' prior notice for discovery of fraud or material
misrepresentation in obtaining coverage or in the presentation
of a claim under the policy.

(3) An insurer may immediately terminate an enrolled
customer's enrollment under a self-service storage insurance
policy for any of the following reasons:

(a) The enrolled customer fails to pay the required
premium;

(b) The enrolled customer ceases to have an active lease
at the self-service storage facility;

(c) The enrolled customer exhausts the aggregate limit of
liability, if any, under the terms of the self-service storage
insurance policy and the insurer sends notice of termination to
the customer within thirty calendar days after exhaustion of the
limit. However, if the insurer does not send the notice within
the thirty-day time frame, enrollment shall continue
notwithstanding the aggregate limit of liability until the
insurer sends notice of termination to the enrolled customer.

(4) If a self-service storage insurance policy is terminated by a self-service storage facility policyholder, the self-service storage facility policyholder shall provide notice to each enrolled customer advising the customer of the termination of the policy and the effective date of the termination. The written notice shall be sent by mail, electronic mail, or delivery to the customer at least thirty days prior to the termination.

(5) Notice required pursuant to this section may be sent by any of the following methods:

   (a) Electronically, in accordance with section 3901.41 of the Revised Code;

   (b) Via ordinary, registered, or certified mail, return receipt requested and postage prepaid;

   (c) By overnight delivery using a nationally recognized carrier.

(M) An enrolled customer may cancel the enrolled customer's coverage under a self-service storage insurance policy at any time. Upon cancellation, the insurer shall refund any applicable unearned premium.

(N) A license issued pursuant to this section shall authorize the self-service storage facility and its endorses to engage only in those activities that are expressly permitted by this section.

(O)(1) If a self-service storage facility or a self-service storage facility's endorsee violates any provision of this section, the superintendent may revoke or suspend the
license issued or impose any other sanctions provided under section 3905.14 of the Revised Code.

(2) If any provision of this section is violated by a self-service storage facility, a self-service storage facility's endorsee at a particular location, a supervising entity, or an agent, the facility, endorsed, supervising entity, or agent is deemed to have engaged in an unfair and deceptive act or practice in the business of insurance under sections 3901.19 to 3901.26 of the Revised Code.

(3) If the superintendent determines that a violation of this section or section 3905.14 of the Revised Code has occurred, the superintendent may assess a civil penalty in an amount not exceeding twenty-five thousand dollars per violation and an administrative fee to cover the expenses incurred by the department in the administrative action, including costs incurred in the investigation and hearing process.

(P)(1) Notwithstanding any other provision of law, if a self-service storage facility's insurance-related activities, and those of its endorsees, employees, and authorized representatives, are limited to offering and disseminating self-service storage insurance on behalf of and under the direction of a limited lines self-service storage insurance agent that meets the requirements of this section, the facility is authorized to offer and disseminate insurance and receive related compensation for these services if the self-service storage facility is registered by the limited lines self-service storage insurance agent as described in division (I) of this section. Any compensation paid to a self-service storage facility's endorsee, employee, or authorized representative for the services described in this section shall be incidental to
the endorsee's, employee's, or authorized representative's
overall compensation and not based primarily on the number of
customers who purchase self-service storage insurance coverage.

(2) Nothing in this section shall be construed to prohibit
payment of compensation to a self-service storage facility or
its employees, endorseees, or authorized representatives for
activities under the limited lines self-service storage
insurance agent's license that are incidental to the overall
compensation of the self-service storage facility or the
employees, endorseees, or authorized representatives of the
facility.

(3) All costs paid or charged to a consumer for the
purchase of self-service storage insurance or related services,
including compensation to the self-service storage facility,
shall be separately itemized on the customer's bill.

(Q) The superintendent may adopt rules implementing this
section.

Sec. 3905.14. (A) As used in sections 3905.14 to 3905.16
of the Revised Code:

(1) "Insurance agent" includes a limited lines insurance
agent, surety bail bond agent, and surplus line broker.

(2) "Refusal to issue or renew" means the decision of the
superintendent of insurance not to process either the initial
application for a license as an agent or the renewal of such a
license.

(3) "Revocation" means the permanent termination of all
authority to hold any license as an agent in this state.

(4) "Surrender for cause" means the voluntary termination
of all authority to hold any license as an agent in this state, in lieu of a revocation or suspension order.

(5) "Suspension" means the termination of all authority to hold any license as an agent in this state, for either a specified period of time or an indefinite period of time and under any terms or conditions determined by the superintendent.

(B) The superintendent may suspend, revoke, or refuse to issue or renew any license of an insurance agent, assess a civil penalty, or impose any other sanction or sanctions authorized under this chapter, for one or more of the following reasons:

(1) Providing incorrect, misleading, incomplete, or materially untrue information in a license or appointment application;

(2) Violating or failing to comply with any insurance law, rule, subpoena, consent agreement, or order of the superintendent or of the insurance authority of another state;

(3) Obtaining, maintaining, or attempting to obtain or maintain a license through misrepresentation or fraud;

(4) Improperly withholding, misappropriating, or converting any money or property received in the course of doing insurance business;

(5) Intentionally misrepresenting the terms, benefits, value, cost, or effective dates of any actual or proposed insurance contract or application for insurance;

(6) Having been convicted of or pleaded guilty or no contest to a felony regardless of whether a judgment of conviction has been entered by the court;

(7) Having been convicted of or pleaded guilty or no
contest to a misdemeanor that involves the misuse or theft of money or property belonging to another, fraud, forgery, dishonest acts, or breach of a fiduciary duty, that is based on any act or omission relating to the business of insurance, securities, or financial services, or that involves moral turpitude regardless of whether a judgment has been entered by the court;

(8) Having admitted to committing, or having been found to have committed, any insurance unfair trade act or practice or insurance fraud;

(9) Using fraudulent, coercive, or dishonest practices, or demonstrating incompetence, untrustworthiness, or financial irresponsibility, in the conduct of business in this state or elsewhere;

(10) Having an insurance agent license, or its equivalent, denied, suspended, or revoked in any other state, province, district, or territory;

(11) Forging or causing the forgery of an application for insurance or any document related to or used in an insurance transaction;

(12) Improperly using notes, any other reference material, equipment, or devices of any kind to complete an examination for an insurance agent license;

(13) Knowingly accepting insurance business from an individual who is not licensed;

(14) Failing to comply with any official invoice, notice, assessment, or order directing payment of federal, state, or local income tax, state or local sales tax, or workers' compensation premiums;
(15) Failing to timely submit an application for insurance. For purposes of division (B)(15) of this section, a submission is considered timely if it occurs within the time period expressly provided for by the insurer, or within seven days after the insurance agent accepts a premium or an order to bind coverage from a policyholder or applicant for insurance, whichever is later.

(16) Failing to disclose to an applicant for insurance or policyholder upon accepting a premium or an order to bind coverage from the applicant or policyholder, that the person has not been appointed by the insurer;

(17) Having any professional license or financial industry regulatory authority registration suspended or revoked or having been barred from participation in any industry;

(18) Having been subject to a cease and desist order or permanent injunction related to mishandling of funds or breach of fiduciary responsibilities or for unlicensed or unregistered activities;

(19) Causing or permitting a policyholder or applicant for insurance to designate the insurance agent or the insurance agent's spouse, parent, child, or sibling as the beneficiary of a policy or annuity sold by the insurance agent or of a policy or annuity for which the agent, at any time, was designated as the agent of record, unless the insurance agent or a relative of the insurance agent is the insured or applicant;

(20) Causing or permitting a policyholder or applicant for insurance to designate the insurance agent or the insurance agent's spouse, parent, child, or sibling as the owner or beneficiary of a trust funded, in whole or in part, by a policy
or annuity sold by the insurance agent or by a policy or annuity for which the agent, at any time, was designated as the agent of record, unless the insurance agent or a relative of the insurance agent is the insured or applicant;

(21) Failing to provide a written response to the department of insurance within twenty-one calendar days after receipt of any written inquiry from the department, unless a reasonable extension of time has been requested of, and granted by, the superintendent or the superintendent's designee;

(22) Failing to appear to answer questions before the superintendent after being notified in writing by the superintendent of a scheduled interview, unless a reasonable extension of time has been requested of, and granted by, the superintendent or the superintendent's designee;

(23) Transferring or placing insurance with an insurer other than the insurer expressly chosen by the applicant for insurance or policyholder without the consent of the applicant or policyholder or absent extenuating circumstances;

(24) Failing to inform a policyholder or applicant for insurance of the identity of the insurer or insurers, or the identity of any other insurance agent or licensee known to be involved in procuring, placing, or continuing the insurance for the policyholder or applicant, upon the binding of the coverage;

(25) In the case of an agent that is a business entity, failing to report an individual licensee's violation to the department when the violation was known or should have been known by one or more of the partners, officers, managers, or members of the business entity;

(26) Submitting or using a document in the conduct of the
business of insurance when the person knew or should have known  
that the document contained a writing that was forged as defined  
in section 2913.01 of the Revised Code;  

(27) Misrepresenting the person's qualifications, status  
or relationship to another person, agency, or entity, or using  
in any way a professional designation that has not been  
conferred upon the person by the appropriate accrediting  
organization;  

(28) Obtaining a premium loan or policy surrender or  
causing a premium loan or policy surrender to be made to or in  
the name of an insured or policyholder without that person's  
knowledge and written authorization;  

(29) Using paper, software, or any other materials of or  
provided by an insurer after the insurer has terminated the  
authority of the licensee, if the use of such materials would  
cause a reasonable person to believe that the licensee was  
acting on behalf of or otherwise representing the insurer;  

(30) Soliciting, procuring an application for, or placing,  
either directly or indirectly, any insurance policy when the  
person is not authorized under this chapter to engage in such  
activity;  

(31) Soliciting, selling, or negotiating any product or  
service that offers benefits similar to insurance but is not  
regulated by the superintendent, without fully disclosing,  
orally and in writing, to the prospective purchaser that the  
product or service is not insurance and is not regulated by the  
superintendent;  

(32) Failing to fulfill a refund obligation to a  
policyholder or applicant in a timely manner. For purposes of
division (B)(32) of this section, a rebuttable presumption
exists that a refund obligation is not fulfilled in a timely
manner unless it is fulfilled within one of the following time
periods:

(a) Thirty days after the date the policyholder,
applicant, or insurer takes or requests action resulting in a
refund;

(b) Thirty days after the date of the insurer's refund
check, if the agent is expected to issue a portion of the total
refund;

(c) Forty-five days after the date of the agent's
statement of account on which the refund first appears.

The presumption may be rebutted by proof that the
policyholder or applicant consented to the delay or agreed to
permit the agent to apply the refund to amounts due for other
coverages.

(33) With respect to a surety bail bond agent license,
rebating or offering to rebate, or unlawfully dividing or
offering to divide, any commission, premium, or fee;

(34) Using a license for the principal purpose of
procuring, receiving, or forwarding applications for insurance
of any kind, other than life, or soliciting, placing, or
effecting such insurance directly or indirectly upon or in
connection with the property of the licensee or that of
relatives, employers, employees, or that for which they or the
licensee is an agent, custodian, vendor, bailee, trustee, or
payee;

(35) In the case of an insurance agent that is a business
entity, using a life license for the principal purpose of
soliciting or placing insurance on the lives of the business entity's officers, employees, or shareholders, or on the lives of relatives of such officers, employees, or shareholders, or on the lives of persons for whom they, their relatives, or the business entity is agent, custodian, vendor, bailee, trustee, or payee;

(36) Offering, selling, soliciting, or negotiating policies, contracts, agreements, or applications for insurance, or annuities providing fixed, variable, or fixed and variable benefits, or contractual payments, for or on behalf of any insurer or multiple employer welfare arrangement not authorized to transact business in this state, or for or on behalf of any spurious, fictitious, nonexistent, dissolved, inactive, liquidated or liquidating, or bankrupt insurer or multiple employer welfare arrangement;

(37) In the case of a resident business entity, failing to be qualified to do business in this state under Title XVII of the Revised Code, failing to be in good standing with the secretary of state, or failing to maintain a valid appointment of statutory agent with the secretary of state;

(38) In the case of a nonresident agent, failing to maintain licensure as an insurance agent in the agent's home state for the lines of authority held in this state;

(39) Knowingly aiding and abetting another person or entity in the violation of any insurance law of this state or the rules adopted under it.

(C) Before denying, revoking, suspending, or refusing to issue any license or imposing any penalty under this section, the superintendent shall provide the licensee or applicant with
notice and an opportunity for hearing as provided in Chapter 119. of the Revised Code, except as follows:

(1)(a) Any notice of opportunity for hearing, the hearing officer's findings and recommendations, or the superintendent's order shall be served by certified mail at the last known address of the licensee or applicant. Service shall be evidenced by return receipt signed by any person.

For purposes of this section, the "last known address" is the residential address of a licensee or applicant, or the principal-place-of-business address of a business entity, that is contained in the licensing records of the department.

(b) If the certified mail envelope is returned with an endorsement showing that service was refused, or that the envelope was unclaimed, the notice and all subsequent notices required by Chapter 119. of the Revised Code may be served by ordinary mail to the last known address of the licensee or applicant. The mailing shall be evidenced by a certificate of mailing. Service is deemed complete as of the date of such certificate provided that the ordinary mail envelope is not returned by the postal authorities with an endorsement showing failure of delivery. The time period in which to request a hearing, as provided in Chapter 119. of the Revised Code, begins to run on the date of mailing.

(c) If service by ordinary mail fails, the superintendent may cause a summary of the substantive provisions of the notice to be published once a week for three consecutive weeks in a newspaper of general circulation in the county where the last known place of residence or business of the party is located. The notice is considered served on the date of the third publication.
(d) Any notice required to be served under Chapter 119. of the Revised Code shall also be served upon the party's attorney by ordinary mail if the attorney has entered an appearance in the matter.

(e) The superintendent may, at any time, perfect service on a party by personal delivery of the notice by an employee of the department.

(f) Notices regarding the scheduling of hearings and all other matters not described in division (C)(1)(a) of this section shall be sent by ordinary mail to the party and to the party's attorney.

(2) Any subpoena for the appearance of a witness or the production of documents or other evidence at a hearing, or for the purpose of taking testimony for use at a hearing, shall be served by certified mail, return receipt requested, by an attorney or by an employee of the department designated by the superintendent. Such subpoenas shall be enforced in the manner provided in section 119.09 of the Revised Code. Nothing in this section shall be construed as limiting the superintendent's other statutory powers to issue subpoenas.

(D) If the superintendent determines that a violation described in this section has occurred, the superintendent may take one or more of the following actions:

(1) Assess a civil penalty in an amount not exceeding twenty-five thousand dollars per violation;

(2) Assess administrative costs to cover the expenses incurred by the department in the administrative action, including costs incurred in the investigation and hearing processes. Any costs collected shall be paid into the state
treasury to the credit of the department of insurance operating fund created in section 3901.021 of the Revised Code.

(3) Suspend all of the person's licenses for all lines of insurance for either a specified period of time or an indefinite period of time and under such terms and conditions as the superintendent may determine;

(4) Permanently revoke all of the person's licenses for all lines of insurance;

(5) Refuse to issue a license;

(6) Refuse to renew a license;

(7) Prohibit the person from being employed in any capacity in the business of insurance and from having any financial interest in any insurance agency, company, surety bail bond business, or third-party administrator in this state. The superintendent may, in the superintendent's discretion, determine the nature, conditions, and duration of such restrictions.

(8) Order corrective actions in lieu of or in addition to the other penalties listed in division (D) of this section. Such an order may provide for the suspension of civil penalties, license revocation, license suspension, or refusal to issue or renew a license if the licensee complies with the terms and conditions of the corrective action order.

(9) Accept a surrender for cause offered by the licensee, which shall be for at least five years and shall prohibit the licensee from seeking any license authorized under this chapter during that time period. A surrender for cause shall be in lieu of revocation or suspension and may include a corrective action order as provided in division (D)(8) of this section.
(E) The superintendent may consider the following factors in denying a license, imposing suspensions, revocations, fines, or other penalties, and issuing orders under this section:

(1) Whether the person acted in good faith;

(2) Whether the person made restitution for any pecuniary losses suffered by other persons as a result of the person's actions;

(3) The actual harm or potential for harm to others;

(4) The degree of trust placed in the person by, and the vulnerability of, persons who were or could have been adversely affected by the person's actions;

(5) Whether the person was the subject of any previous administrative actions by the superintendent;

(6) The number of individuals adversely affected by the person's acts or omissions;

(7) Whether the person voluntarily reported the violation, and the extent of the person's cooperation and acceptance of responsibility;

(8) Whether the person obstructed or impeded, or attempted to obstruct or impede, the superintendent's investigation;

(9) The person's efforts to conceal the misconduct;

(10) Remedial efforts to prevent future violations;

(11) If the person was convicted of a criminal offense, the nature of the offense, whether the conviction was based on acts or omissions taken under any professional license, whether the offense involved the breach of a fiduciary duty, the amount of time that has passed, and the person's activities subsequent
to the conviction;

(12) Such other factors as the superintendent determines to be appropriate under the circumstances.

(F)(1) A violation described in division (B)(1), (2), (3), (4), (5), (6), (7), (8), (9), (10), (11), (12), (13), (14), (16), (17), (18), (19), (20), (22), (23), (24), (25), (26), (27), (28), (29), (30), (31), (32), (33), (34), (35), and/or (36) of this section is a class A offense for which the superintendent may impose any penalty set forth in division (D) of this section.

(2) A violation described in division (B)(15) or (21) of this section, or a failure to comply with section 3905.061, 3905.071, or 3905.22 of the Revised Code, is a class B offense for which the superintendent may impose any penalty set forth in division (D)(1), (2), (8), or (9) of this section.

(3) If the superintendent determines that a violation described in division (B)(36) of this section has occurred, the superintendent shall impose a minimum of a two-year suspension on all of the person's licenses for all lines of insurance.

(G) If a violation described in this section has caused, is causing, or is about to cause substantial and material harm, the superintendent may issue an order requiring that person to cease and desist from engaging in the violation. Notice of the order shall be mailed by certified mail, return receipt requested, or served in any other manner provided for in this section, immediately after its issuance to the person subject to the order and to all persons known to be involved in the violation. The superintendent may thereafter publicize or otherwise make known to all interested parties that the order
has been issued.

The notice shall specify the particular act, omission, practice, or transaction that is subject to the cease-and-desist order and shall set a date, not more than fifteen days after the date of the order, for a hearing on the continuation or revocation of the order. The person shall comply with the order immediately upon receipt of notice of the order.

The superintendent may, upon the application of a party and for good cause shown, continue the hearing. Chapter 119. of the Revised Code applies to such hearings to the extent that that chapter does not conflict with the procedures set forth in this section. The superintendent shall, within fifteen days after objections are submitted to the hearing officer's report and recommendation, issue a final order either confirming or revoking the cease-and-desist order. The final order may be appealed as provided under section 119.12 of the Revised Code.

The remedy under this division is cumulative and concurrent with the other remedies available under this section.

(H) If the superintendent has reasonable cause to believe that an order issued under this section has been violated in whole or in part, the superintendent may request the attorney general to commence and prosecute any appropriate action or proceeding in the name of the state against such person.

The court may, in an action brought pursuant to this division, impose any of the following:

(1) For each violation, a civil penalty of not more than twenty-five thousand dollars;

(2) Injunctive relief;
(3) Restitution;

(4) Any other appropriate relief.

(I) With respect to a surety bail bond agent license:

(1) Upon the suspension or revocation of a license, or the eligibility of a surety bail bond agent to hold a license, the superintendent likewise may suspend or revoke the license or eligibility of any surety bail bond agent who is employed by or associated with that agent and who knowingly was a party to the act that resulted in the suspension or revocation.

(2) The superintendent may revoke a license as a surety bail bond agent if the licensee is adjudged bankrupt.

(J) Nothing in this section shall be construed to create or imply a private cause of action against an agent or insurer.

Sec. 3905.84. No person shall act in the capacity of a surety bail bond agent, or perform any of the functions, duties, or powers prescribed for surety bail bond agents under sections 3905.83 to 3905.95 of the Revised Code, unless that person is qualified, licensed, and appointed as provided in those sections.

Sec. 3905.85. (A)(1) An individual who applies for a license as a surety bail bond agent shall submit an application for the license in a manner prescribed by the superintendent of insurance. The application shall be accompanied by a one-hundred-fifty-dollar fee and a statement that gives the applicant's name, age, residence, present occupation, occupation for the five years next preceding the date of the application, and such other information as the superintendent may require.

(2) An applicant for an individual resident license shall
also submit to a criminal records check pursuant to section 3905.051 of the Revised Code.

(B)(1) The superintendent shall issue to an applicant an individual resident license that states in substance that the person is authorized to do the business of a surety bail bond agent, if the superintendent is satisfied that all of the following apply:

(a) The applicant is eighteen years of age or older.

(b) The applicant's home state is Ohio.

(c) The applicant is a person of high character and integrity.

(d) The applicant has not committed any act that is grounds for the refusal to issue, suspension of, or revocation of a license under section 3905.14 of the Revised Code.

(e) The applicant is a United States citizen or has provided proof of having legal authorization to work in the United States.

(f) The applicant has successfully completed the educational requirements set forth in section 3905.04 of the Revised Code and passed the examination required by that section.

(2) The superintendent shall issue to an applicant an individual nonresident license that states in substance that the person is authorized to do the business of a surety bail bond agent, if the superintendent is satisfied that all of the following apply:

(a) The applicant is eighteen years of age or older.
(b) The applicant is currently licensed as a resident in another state and is in good standing in the applicant's home state for surety bail bond or is qualified for the same authority.

(c) The applicant is a person of high character and integrity.

(d) The applicant has not committed any act that is grounds for the refusal to issue, suspension of, or revocation of a license under section 3905.14 of the Revised Code.

(3) The superintendent shall issue an applicant a resident business entity license that states in substance that the person is authorized to do the business of a surety bail bond agent if the superintendent is satisfied that all of the following apply:

(a) The applicant has submitted an application for the license in a manner prescribed by the superintendent and the one-hundred-fifty-dollar application fee.

(b) The applicant either is domiciled in this state or maintains its principal place of business in this state.

(c) The applicant has designated an individual licensed surety bail bond agent who will be responsible for the applicant's compliance with the insurance laws of this state.

(d) The applicant has not committed any act that is grounds for the refusal to issue, suspension of, or revocation of a license under section 3905.14 of the Revised Code.

(e) The applicant is authorized to do business in this state by the secretary of state if so required under the applicable provisions of Title XVII of the Revised Code.

(f) The applicant has submitted any other documents
requested by the superintendent.

(4) The superintendent shall issue an applicant a nonresident business entity license that states in substance that the person is authorized to do the business of a surety bail bond agent if the superintendent is satisfied that all of the following apply:

(a) The applicant has submitted an application for the license in a manner prescribed by the superintendent and the one-hundred-fifty-dollar application fee.

(b) The applicant is currently licensed and is in good standing in the applicant's home state with surety bail bond authority.

(c) The applicant has designated an individual licensed surety bail bond agent who will be responsible for the applicant's compliance with the insurance laws of this state.

(d) The applicant has not committed any act that is grounds for the refusal to issue, suspension of, or revocation of a license under section 3905.14 of the Revised Code.

(e) The applicant has submitted any other documents requested by the superintendent.

(C) A resident and nonresident surety bail bond agent license issued pursuant to this section authorizes the holder, when appointed by an insurer, to execute or countersign bail bonds in connection with judicial proceedings and to receive money or other things of value for those services. However, the holder shall not execute or deliver a bond during the first one hundred eighty days after the license is initially issued. This restriction does not apply with respect to license renewals or any license issued under divisions (B)(3) and (4) of this
section.

(D) The superintendent may refuse to renew a surety bail bond agent's license as provided in division (B) of section 3905.88 of the Revised Code, and may suspend, revoke, or refuse to issue or renew such a license as provided in section 3905.14 of the Revised Code.

If the superintendent refuses to issue such a license based in whole or in part upon the written response to a criminal records check completed pursuant to division (A) of this section, the superintendent shall send a copy of the response that was transmitted to the superintendent to the applicant at the applicant's home address upon the applicant's submission of a written request to the superintendent.

(E) Any person licensed as a surety bail bond agent may surrender the person's license in accordance with section 3905.16 of the Revised Code.

(F)(1) A person seeking to renew a surety bail bond agent license shall apply annually for a renewal of the license on or before the last day of February. Applications shall be submitted to the superintendent on forms prescribed by the superintendent. Each application shall be accompanied by a one-hundred-fifty-dollar renewal fee.

(2) To be eligible for renewal, an individual applicant shall complete the continuing education requirements pursuant to section 3905.88 of the Revised Code prior to the renewal date.

(3) If an applicant submits a completed renewal application, qualifies for renewal pursuant to divisions (F)(1) and (2) of this section, and has not committed any act that is a ground for the refusal to issue, suspension of, or revocation of...
a license under section 3905.14 or sections 3905.83 to 3905.99 of the Revised Code, the superintendent shall renew the applicant's surety bail bond insurance agent license.

(4) If an individual or business entity does not apply for the renewal of the individual or business entity's license on or before the license renewal date specified in division (F)(1) of this section, the individual or business entity may submit a late renewal application along with all applicable fees required under this chapter prior to the last day of March following the renewal date. The superintendent shall renew the license of an applicant that submits a late renewal application if the applicant satisfies all of the following conditions:

(a) The applicant submits a completed renewal application.

(b) The applicant pays the one-hundred-fifty-dollar renewal fee.

(c) The applicant pays the late renewal fee established by the superintendent.

(d) The applicant provides proof of compliance with the continuing education requirements pursuant to section 3905.88 of the Revised Code.

(e) The applicant has not committed any act that is grounds for the refusal to issue, suspension of, or revocation of a license under section 3905.14 or sections 3905.83 to 3905.99 of the Revised Code.

(5) A license issued under this section that is not renewed on or before its late renewal date specified in division (F)(4) of this section is automatically suspended for nonrenewal effective the first day of April.
(6) If a license is suspended for nonrenewal pursuant to division (F)(5) of this section, the individual or business entity is eligible to apply for reinstatement of the license within the twelve-month period following the date by which the license should have been renewed by complying with the reinstatement procedure established by the superintendent and paying all applicable fees required under this chapter.

(7) A license that is suspended for nonrenewal that is not reinstated pursuant to division (F)(6) of this section automatically is canceled unless the superintendent is investigating any allegations of wrongdoing by the agent or has initiated proceedings under Chapter 119. of the Revised Code. In that case, the license automatically is canceled after the completion of the investigation or proceedings unless the superintendent revokes the license.

(G) The superintendent may prescribe the forms to be used as evidence of the issuance of a license under this section. The superintendent shall require each licensee to acquire, from a source designated by the superintendent, a wallet identification card that includes the licensee's photograph and any other information required by the superintendent. The licensee shall keep the wallet identification card on the licensee's person while engaging in the bail bond business.

(H)(1) The superintendent of insurance shall not issue or renew the license of a business entity organized under the laws of this or any other state unless the business entity is qualified to do business in this state under the applicable provisions of Title XVII of the Revised Code.

(2) The failure of a business entity to be in good standing with the secretary of state or to maintain a valid
appointment of statutory agent is grounds for suspending, revoking, or refusing to renew its license.

(3) By applying for a surety bail bond agent license under this section, an individual or business entity consents to the jurisdiction of the courts of this state.

(I) A surety bail bond agent licensed pursuant to this section is an officer of the court.

(J) Any fee collected under this section shall be paid into the state treasury to the credit of the department of insurance operating fund created by section 3901.021 of the Revised Code.

Sec. 3906.11. (A) An insurer investing under this chapter shall maintain assets in an amount equivalent to the sum of its liabilities and its minimum financial security benchmark at all times.

(B) Assets invested under this chapter may be counted toward satisfaction of the minimum asset requirement only so far as they are invested in compliance with this chapter and any applicable rules adopted, or orders issued, by the superintendent pursuant to this chapter.

(C) The amount of admitted assets used to calculate the minimum asset requirement shall be reduced by the amount of the liability recorded on an insurer's statutory balance sheet for all of the following:

(1) The return of acceptable collateral received in a reverse repurchase transaction or a securities lending transaction;

(2) Cash received in a dollar roll transaction;
(3) Other amounts reported as borrowed money.

(D) Assets other than invested assets may be counted toward satisfaction of the minimum asset requirement at admitted annual financial statement value. However, loans to officers or directors or their immediate families shall not be counted toward the satisfaction of the minimum asset requirement.

(E) An investment held as an admitted asset by an insurer on the effective date of this section September 4, 2014, that qualified under the applicable insurance investment law of this state shall remain qualified as an admitted asset under this chapter.

(F) Notwithstanding any provision of this chapter to the contrary, an asset acquired in the bona fide enforcement of creditors' rights or in bona fide workouts or settlements of disputed claims may be counted toward the minimum asset requirement for five years if the asset is real property and three years if the asset is not real property.

(G) The superintendent may determine an insurer to be financially hazardous under section 3903.09 of the Revised Code if either of the following apply:

(1) The insurer does not own the amount of assets needed to meet its minimum asset requirement.

(2) The insurer is unable to apply the amount of assets needed to meet its minimum asset requirement toward compliance with this chapter.

Sec. 3907.03. When the articles of incorporation are filed in the office of the secretary of state under section 3907.02 of the Revised Code, and the name assumed by the company is not so nearly similar to that of any other company organized in this
state as to lead to confusion or uncertainty on the part of the public, the secretary of state shall submit them to the attorney general for examination. If such articles are found by the attorney general to be in accordance with sections 3907.01 to 3907.21, inclusive, of the Revised Code, and not inconsistent with the constitution and laws of the United States and of this state, the attorney general shall certify to and deliver them to the secretary of state, who shall cause them, together with the certificate of the attorney general, to be recorded in a book kept for that purpose. Upon application of the signers of such articles of incorporation, the secretary of state shall furnish to them a certified copy of such articles and certificates.

Sec. 3907.07. Any legal reserve life insurance company organized under the laws of this state may invest its capital in the stocks, bonds, or mortgages authorized by section 3907.05 of the Revised Code, and may change and invest it or any part thereof in like manner. No company shall commence business until it has deposited with the superintendent of insurance at least one hundred thousand dollars, in such stocks, bonds, or mortgages, made or assigned to the superintendent in trust for the purposes mentioned in sections 3907.01 to 3907.21, inclusive, of the Revised Code. When a mortgage of real estate is assigned to the superintendent, the assignment shall be immediately entered in the records of the county in which the real estate is situated, and the fee for its recording shall be paid by the company.

The superintendent shall hold such securities as security for policyholders in the company. As long as any company depositing such securities remains solvent, the superintendent shall permit it to collect the interest or
dividends on the securities, and from time to time to withdraw them, or a part thereof, on depositing with him the superintendent other securities of the kinds named in section 3907.05 of the Revised Code, and of equal value with those withdrawn.

In case a company making or maintaining such deposit with the superintendent, through inadvertence or by reason of not having securities in such denominations as to make the exact sum of one hundred thousand dollars, deposits securities in excess of the requirement, such excess shall be held in trust for the company and not for the benefit of policyholders, and shall be returned to the company making the deposit on its demand.

Sec. 3909.04. Every life insurance company organized by act of congress or under the laws of another state of the United States shall file with the superintendent of insurance a certified copy of its charter, or deed of settlement, together with a statement, under the oath of the president, vice-president, or other chief officer or manager, and the secretary of the company, stating the name of the company, the place where it is located, and the amount of its capital, with a detailed statement of all the facts required in the annual statement of companies organized under sections 3907.01 to 3907.21, inclusive, of the Revised Code, except as to the statement required by division (N) of section 3907.19 of the Revised Code, which statement shall be filed by such company only when required by the superintendent for purposes of actual valuation, as provided by the insurance laws of this state. The statement also shall include a copy of its last annual report, if any was made.

Sec. 3911.09. (A) Any person may procure, authorize
procurement of, or effect an insurance on the person's life, for any definite period of time or for the term of the person's natural life, to inure to the benefit of the person's spouse and children, or either, or other persons dependent upon such person, or an institution or entity described in division (B)(1) of this section, or any creditor the person causes to be appointed and provided for in the policy.

(B)(1) Any religious, charitable, scientific, literary, educational, or other institution or entity that is described in section 170, 501(c)(3), 2055, or 2522 of the "Internal Revenue Code of 1986," 100 Stat. 2085, 26 U.S.C.A. 170, 501, 2055, 2522, as amended, may be the owner of, or may be designated beneficiary in, any policy of life insurance issued upon the life or lives of one or more individuals. Any such institution or entity has an insurable interest in the life of each insured and is entitled to enforce all rights and collect all benefits to which it is entitled pursuant to the policy.

(2) With respect to any policy of life insurance delivered or issued for delivery in this state before the effective date of this amendment July 8, 1992, and in which any institution or entity described in division (B)(1) of this section has been designated owner of or beneficiary, the institution or entity has an insurable interest in the life of each insured and is entitled to enforce all rights and collect all benefits to which it is entitled pursuant to the policy.

(3) With respect to any transfer of ownership or designation of beneficiary executed before the effective date of this amendment July 8, 1992, and in which any institution or entity described in division (B)(1) of this section has been designated owner or beneficiary, the institution or entity has
an insurable interest in the life of each insured and is entitled to enforce all rights and collect all benefits to which it is entitled pursuant to the policy under which the transfer or designation was executed.

Sec. 3911.20. No life insurance company doing business in this state, whether on the group insurance or any other plan, shall make or permit any distinction or discrimination in favor of individuals between insured persons of the same class and equal expectation of life in the amount or payment of premiums, or in rates charged for policies of insurance, or in the dividends or other benefits payable thereon, or in any other of the terms and conditions of the contracts it makes. No such company, or any agent thereof, shall make any contract of insurance or agreement as to such contract, other than as plainly expressed in the policy issued thereon.

No life insurance company doing business in this state, or any officer, agent, employee, or representative thereof, nor any other person, shall pay, allow, or give, or offer to pay, allow, or give, directly or indirectly, as an inducement to insurance, nor shall any person, partnership, or corporation knowingly receive as such inducement to insurance, any rebate of premium payable on the policy or any special favor or advantage in the dividends or other benefits to accrue thereon, or any special advantage in the date of a policy or date of the issue thereof, or any valuable consideration or inducement. Nor shall such company or person give, receive, sell, or purchase, or offer to give, receive, sell, or purchase, as inducements to insurance or in connection therewith, any stocks, bonds, or other obligations or securities of any insurance company or other corporation, association, partnership, or individual, or any dividends or profits to accrue thereon, or any paid employment or contract
for service of any kind, or anything of value; nor shall such
company or person give or offer to give, or enter into any
separate agreement promising to secure, as an inducement or
consideration for insurance, the loan of any money, either
directly or indirectly, or any contract for services; nor shall
such company or person require as a condition of or in
connection with the granting of a loan, that the applicant or
borrower or any other person, either directly or indirectly,
acquire a policy of life or accident and health insurance from
any particular company, agent, or person.

No person shall receive or accept from any company, agent,
subagent, or any other person any such rebate of premium payable
on the policy, or any special favor or advantage in the dividend
or other benefits to accrue thereon, or any valuable
consideration or inducement not specified in the policy of
insurance. No person shall be excused from testifying or from
producing any books, papers, contracts, agreements, or documents
at the trial of any other person charged with violation of this
section, upon the ground that such testimony or evidence may
tend to incriminate, but no person shall be prosecuted or
subjected to any penalty or forfeiture on account of any
transaction, matter, or thing concerning which the person so
testifies or produces evidence, and no testimony so given or
produced shall be received against him upon any
criminal investigation or proceeding involving rebates or
violation of insurance laws.

This section does not prohibit any company issuing
nonparticipating life insurance from paying bonuses to
policyholders or otherwise abating their premiums out of surplus
accumulated from nonparticipating insurance; nor does it
prohibit any company which transacts industrial insurance on the
weekly payment plan from returning to policyholders, who have
made premium payments for a period of at least one year directly
to the company at its home or district offices, a percentage of
the premium which the company would have paid for the weekly
collection of such payments.

In so far as it is adaptable to the conduct of such
business, this section is also applicable to the sale and
purchase of annuities by and from life insurance companies.

Sec. 3911.24. Upon the conviction of any person, firm,
association, or life insurance company for violating section
3911.23 of the Revised Code, the superintendent of insurance
shall revoke the license of such person, firm, association, or
life insurance company for not less than one year.

The superintendent, when he has good
reason to believe that any company or association writing life
insurance in this state, on any plan, is knowingly permitting
any of its agents or representatives to violate section 3911.23
of the Revised Code, shall give such company or association
notice of a hearing in accordance with sections 119.01 to
119.13, inclusive, Chapter 119, of the Revised Code, upon the
charge of knowingly permitting said section to be violated, and,
if he finds said company or association
guilty of the offense, he shall revoke its
license.

Sec. 3913.11. (A) A domestic mutual life insurance company
may become a stock life insurance company, pursuant to sections
3913.11 to 3913.13 of the Revised Code, provided that the
company have unassigned surplus at least equal to the capital
and surplus required under section 3907.05 of the Revised Code
for a life insurance company to commence business in this state,
that such conversion will benefit the company, that adequate provision for protection of the policyholders' interests is made, and that such conversion is not inequitable, unreasonable, or contrary to law. "Policyholder", as used in sections 3913.11 to 3913.13 of the Revised Code, means a policyholder as defined in section 3913.10 of the Revised Code and the qualifications for voting shall be as provided in that section.

(B) The board of directors of a mutual life insurance company desiring to become a stock life insurance company shall, by a majority vote, adopt a resolution stating the reason it believes such conversion would be of benefit to the company and its policyholders, and setting forth a plan of conversion and explanation thereof, a schedule of the steps to be followed in effecting the conversion, and a statement of the organization of the new company and its capitalization, including the number of shares of capital stock and the price per share for which the stock is to be issued. Five certified copies of such resolution shall be filed with the superintendent of insurance, together with the following:

(1) A copy of the charter or articles of incorporation of the company, together with the proposed articles of incorporation of the new company;

(2) Complete annual financial statements of the company for the five accounting periods immediately preceding the date of the resolution, based on generally recognized insurance accounting principles;

(3) A draft of the prospectus to be sent to the policyholders, which shall contain a full disclosure of the details of the proposed conversion;
(4) Such other and further statements, affidavits, books, records, papers, information, and data, as the superintendent may require.

(C) Within thirty days of the filing of the resolution and supporting documents and information required by division (B) of this section, the superintendent shall review them, and if it appears on their face that such conversion meets the requirements contained in division (A) of this section, the superintendent shall order an examination of the company. If he finds that such conversion does not meet the requirements contained in division (A), he shall issue a written order prohibiting the conversion, stating in detail the reasons therefor. The company may, within thirty days after issuance of such order of prohibition, submit modifications to the proposed conversion, and if he finds that the conversion as so modified meets the requirements contained in division (A), he shall rescind his prior order and order an examination of the company. The examination conducted pursuant to this section shall be such as is necessary to verify that such conversion will meet the requirements contained in division (A). The expenses of such examination shall be paid by the company.

(D) Upon completion of the examination, the superintendent shall appoint an appraisal committee, consisting of a fellow of the society of actuaries, an attorney at law, and a person who by reason of knowledge and experience is specially qualified in the valuation of insurance companies. No member of such committee shall have any direct or indirect interest in the company's affairs, nor shall any member be an employee of the department of insurance. Each such appraiser shall receive
reasonable compensation for the appraiser's services, plus reasonable expenses, as approved by the superintendent, which compensation and expenses shall be paid by the company. The appraisal committee shall determine the value of the company as of the date of the examination conducted pursuant to this section, taking into consideration the admitted and non-admitted assets, reserves, and other liabilities, equity in unearned premium reserves, the value of the agency plant, the value of insurance in force, and any other factor affecting the value of the company.

The appraisal committee shall confirm or modify the determination of the board of directors as to the consideration to be given to each policyholder, including, if applicable, the number of shares of the new corporation and establish the priority rights for subscription to any additional shares that may be issued to each policyholder pursuant to section 3913.12 of the Revised Code. Certified copies of the report of the appraisers shall be filed with the superintendent and sent to the company.

(E) Within sixty days after the appraisal committee files its report with the superintendent, the company shall call a meeting of policyholders. Notice of the time and place of such meeting shall be sent by mail to each policyholder at his the policyholder's post office address as it appears on the books of the company, and to the superintendent, at least thirty days prior to such meeting. Such notice shall include a copy of the prospectus required under division (B)(3) of this section as approved by the superintendent, a summary of the examination approved by the superintendent, a uniform ballot for voting on the question of conversion, together with a postage prepaid envelope for the return of such ballot, a copy or summary of the
report of the appraisal committee, a statement of the consideration to be given to the policyholder, including, if applicable, the number of shares of the new company to be issued to the policyholder and the priority rights of the policyholder for subscription to any additional shares that may be issued, and a statement that if the conversion is approved by the policyholders, the superintendent will fix a time and place for a public hearing on such conversion not more than sixty days after the date of such meeting. The superintendent shall appoint sufficient inspectors to conduct the voting at said meeting and to determine all questions concerning the verification of ballots, the qualifications of voters, and the canvass of the vote. The inspectors shall certify to the superintendent and to the company the result of such proceedings. Voting at such meeting may be in person, by proxy, or by mail as provided in this division. All necessary expenses incurred by the department in connection with such meeting, and certified by the superintendent, shall be paid by the company.

(F) If such conversion is approved at such meeting by the affirmative vote of a majority of the policyholders of such company voting at the meeting, the superintendent shall fix the time and place for a public hearing not more than sixty days after the date of such meeting. Otherwise, the superintendent shall issue an order prohibiting the conversion. Notice of the time and place of such hearing shall be published once each week for two consecutive weeks in a newspaper of general circulation in the county where the home office of the company is located, and in Franklin county, and the last such publication shall be at least fifteen days prior to the date of such hearing. The expenses of publication of notice shall be paid by the company. At such hearing, the superintendent shall hear any person
adversely affected by the conversion, who may present the person's position, arguments, or contentions, offer and examine witnesses, and present evidence tending to show that such conversion does not meet the requirements contained in division (A) of this section. If the superintendent finds that such conversion meets such requirements, the superintendent shall issue a written order accepting the report of the appraisal committee and authorizing the conversion. Otherwise, the superintendent shall issue such order as is appropriate to his findings.

(G) At or after the issuance of the order authorizing the conversion, the articles of incorporation of the new company as approved by the superintendent shall be filed with the secretary of state. When such articles of incorporation of the new company are filed and accepted by the secretary of state, the mutual life insurance company shall become a stock life insurance company, and all property of every description and every interest therein, and all obligations of, belonging to, or due the mutual company shall thereafter be considered vested in the stock company without further act or deed. The stock insurance company shall be liable for all obligations of the mutual company and any claim existing or action or proceeding pending by or against the company may be prosecuted to judgment, with right of appeal as in other cases, as if such conversion had not taken place. All rights of creditors, and all liens upon the property of the mutual company shall be preserved unimpaired, limited in lien to the property affected by such liens immediately prior to the effective date of the conversion.

The directors and officers of the mutual company shall serve as the directors and officers of the new company, until new directors and officers have been duly elected and qualified.
pursuant to the articles of incorporation and by-laws of the new company, and as otherwise provided by law.

(H) Upon the conversion becoming effective pursuant to division (G) of this section, the new company shall forthwith proceed with winding up the affairs of the mutual company, and with the issuance of stock and priority rights in accordance with section 3913.12 of the Revised Code. Within six months after such effective date of the conversion, the new company shall file with the superintendent a written report containing such information as the superintendent may require to fully apprise him the superintendent of the status of the conversion and whether it has been or is being carried out in accordance with its terms and according to law.

Sec. 3913.22. (A) In effecting a conversion of a mutual insurance company into a stock insurance corporation pursuant to sections 3913.20 to 3913.23, inclusive, of the Revised Code, each mutual policyholder is entitled to such shares of stock of the new corporation as his the policyholder's equitable share of the value of the mutual company will purchase. If such equitable share of the value of the mutual company entitles a policyholder to a fractional share of stock, he the policyholder shall have the option of receiving the value of such fractional share in cash or of purchasing such additional fraction as will entitle him the policyholder to a full share. If the initial issue of stock to the new corporation exceeds the number of shares to which the mutual policyholders are entitled in the aggregate, each mutual policyholder is also entitled to preemptive rights in subscribing to his the policyholder's proportionate number of shares of such excess.

(B) The value of the company is the value as determined by
the appraisal committee pursuant to division (D) of section 3913.21 of the Revised Code, and approved by the superintendent of insurance. The equitable share of the value of the company held by each mutual policyholder shall be determined as follows:

(1) By the ratio which the total net premiums paid, in respect to his the policyholder's mutual policy or policies in force on the date of the examination conducted pursuant to division (C) of section 3913.21 of the Revised Code, within the period including the five accounting periods preceding the date of such examination and including the time from the end of the last such accounting period to the date of the examination, bears to the total net premiums paid in the same period in respect to all mutual policies of the company in force on the date of such examination; or

(2) If the company is a perpetual deposit insurance company, by the ratio which each mutual policyholder's premium deposit bears to the total premium deposits held by the company, provided that, if the company has held the premium deposit for less than five years, the equitable share of each mutual policyholder is ten per cent of such ratio for each full six month period said deposit has been held by the company. As used in this section, "net premium" means gross premium less return premium and dividends paid.

(C) Shares shall be issued to the owner or owners of a mutual policy in force on the date of the examination conducted pursuant to division (C) of section 3913.21 of the Revised Code, as such owner or owners appear on the face of the policy. If ownership of a policy has been assigned by a writing absolute on its face to an assignee other than the mutual company, and such assignment is in effect and on file at the principal office of
the new corporation on the date shares are issued the assignee shall be deemed the owner of the policy.

(D) From and after the date of issuance of shares to a policyholder pursuant to sections 3913.20 to 3913.24, inclusive, of the Revised Code, the policyholder's ownership interest in the company as a mutual policyholder terminates, and such ownership interest shall thenceforth be represented solely by the shares of stock in the new corporation issued to the policyholder, but no other rights or liabilities of the policyholder arising under the policy are affected by such issuance of stock.

Sec. 3913.40. (A) Any insurer, including any fraternal benefit society, that is organized under the laws of another state and is admitted to transact the business of insurance in this state may become a domestic insurer by complying with all of the requirements of law relative to the organization and licensing of a domestic insurer of the same type and by designating its principal place of business at a place in this state. Such a domestic insurer shall be issued like certificates and licenses to transact business in this state, is subject to the jurisdiction of this state, and shall be recognized as an insurer formed under the laws of this state as of the date of its original incorporation in its original domiciliary state. The superintendent of insurance shall approve any proposed transfer of domicile under this division unless the superintendent determines that the transfer is not in the interest of policyholders of this state.

(B) Any domestic insurer, upon the approval of the superintendent, may transfer its domicile to any other state in which it is admitted to transact the business of insurance. Upon
such a transfer, the insurer shall cease to be a domestic insurer, and shall be admitted to this state if qualified as a foreign insurer. The superintendent shall approve any proposed transfer of domicile under this division unless the superintendent determines that the transfer is not in the interest of policyholders of this state.

(C)(1) With respect to any insurer, including any fraternal benefit society, that is licensed to transact the business of insurance in this state and that transfers its domicile to this or any other state by merger, consolidation, or any other lawful method, both of the following apply:

(a) The certificate of authority, appointments and licenses, rates, and other items as allowed by the superintendent that are in existence at the time of the transfer shall continue in effect upon the transfer if the insurer remains qualified to transact the business of insurance in this state.

(b) All outstanding policies shall remain in effect and need not be endorsed as to the new name of the company or its new location unless so ordered by the superintendent.

(2) Every transferring insurer as described in division (C)(1) of this section shall file new policy forms with the superintendent on or before the effective date of the transfer, but may use existing policy forms with appropriate endorsements if allowed by, and under such conditions as are approved by, the superintendent. Every such insurer shall notify the superintendent of the details of the proposed transfer, and shall file promptly any resulting amendments to corporate documents filed or required to be filed with the superintendent.
(D) Nothing in this section or any other provision of the Revised Code prohibits an insurer from transferring its domicile to this state because its charter, bylaws, or any other organizational document contains characteristics of both a mutual insurance company and a stock insurance company.

(E) The superintendent, in accordance with Chapter 119. of the Revised Code, may adopt rules to carry out the purposes of this section.

Sec. 3915.05. No policy of life insurance shall be issued or delivered in this state or be issued by a life insurance company organized under the laws of this state unless such policy contains:

(A) A provision that all premiums shall be payable in advance, either at the home office of the company or to an agent of the company, upon delivery of a receipt signed by one or more of the officers named in the policy;

(B) A provision for a grace of one month for the payment of every premium after the first, which extension period may be subject to an interest charge and during which month the insurance shall continue in force, which provision may contain a stipulation that if the insured dies during the month of grace the overdue premium will be deducted in any settlement under the policy;

(C) A provision that the policy and the application therefor, a copy of which application must be indorsed on the policy, shall constitute the entire contract between the parties and shall be incontestable after it has been in force during the lifetime of the insured for a period of not more than two years from its date, except for nonpayment of premiums, except for
violations of the conditions relating to naval or military
service in time of war or to aeronautics, and except at the
option of the company, with respect to provisions relative to
benefits in the event of total and permanent disability and
provisions which grant additional insurance specifically against
death by accident or by accidental means;

(D) A provision that all statements made by the insured in
the application shall, in the absence of fraud, be deemed
representations and not warranties;

(E) A provision that if the age of the insured has been
understated the amount payable under the policy shall be such as
the premium would have purchased at the correct age;

(F) A provision that the policy shall participate in the
surplus of the company and that, beginning not later than the
end of the third policy year, the company will annually
determine and account for the portion of the divisible surplus
accruing on the policy, and that the owner of the policy has the
right each year to have the current dividend arising from such
participation paid in cash or applied to the purchase of paid-up
additions, and if the policy provides other dividend options, it
shall further provide that if the owner of the policy does not
elect any such other option the dividend shall be applied to the
purchase of paid-up additions.

In lieu of such provision, the policy may contain a
provision that:

(1) The policy shall participate in the surplus of the
company;

(2) Beginning not later than the end of the fifth policy
year, the company will determine and account for the portion of
the divisible surplus accruing on the policy;

(3) The owner of the policy has the right to have the current dividend arising from such participation paid in cash;

(4) Such accounting and payment shall be had at periods of not more than five years, at the option of the policyholder.

Renewable term policies of ten years or less may provide that the surplus accruing to such policies shall be determined and apportioned each year after the second policy year and accumulated during each renewal period, and that at the end of any renewal period, on renewal of the policy by the insured, the company shall apply the accumulated surplus as an annuity for the next succeeding renewal term in the reduction of premiums.

The provisions described in this division are not required in nonparticipating policies.

(G) A provision that after three full years' premiums have been paid, the company, at any time while the policy is in force, will advance, on proper assignment of the policy and on the sole security thereof, at a rate of interest calculated pursuant to section 3915.051 of the Revised Code, a sum equal to, or at the option of the owner of the policy, less than, the amount required by section 3915.08 of the Revised Code under the conditions specified in said section, and that the company will deduct from such loan value any indebtedness not already deducted in determining such value and any unpaid balance of the premium for the current policy year, and may collect interest in advance on the loan to the end of the current policy year. It shall be further stipulated in the policy that failure to repay any such advance or to pay interest does not avoid the policy unless the total indebtedness thereon to the company
equals or exceeds such loan value at the time of such failure nor until one month after notice has been mailed by the company to the last known address of insured and of the assignee.

No conditions, other than as provided in this division or in section 3915.08 of the Revised Code, shall be exacted as a prerequisite to any such advance.

This provision is not required in term insurance nor does it apply to any form of insurance granted as a nonforfeiture benefit.

(H) A provision for nonforfeiture benefits and cash surrender values in accordance with the requirements of section 3915.06, 3915.07, or 3915.071 of the Revised Code;

(I) Except for policies which guarantee unscheduled changes in benefits upon the happening of specified events or upon the exercise of an option without change to a new policy, a table showing in figures the loan values and the options available under the policies each year upon default in premium payments, during at least the first twenty years of the policy;

(J) A provision that if, in the event of default in premium payments, the value of the policy is applied to the purchase of other insurance, and if such insurance is in force and the original policy has not been surrendered to the company and canceled, the policy may be reinstated within three years from such default, upon evidence of insurability satisfactory to the company and payment of arrears of premiums with interest;

(K) A provision that when a policy becomes a claim by the death of the insured, settlement shall be made upon receipt of due proof of death, or not later than two months after receipt of such proof;
(L) A table showing the amounts of installments in which the policy provides its proceeds may be payable;

(M) A title on its face and back, correctly describing such policy.

Any of the provisions described in this section or portions thereof, relating to premiums not applicable to single premium policies, shall to that extent not be incorporated in such policies.

Sec. 3915.053. (A)(1) Except as provided in division (A) (2) of this section, this section shall apply to any individual life insurance policy insuring the life of a reservist, as defined in section 3923.381 of the Revised Code, who is on active duty pursuant to an executive order of the president of the United States, an act of the congress of the United States, or section 5919.29 or 5923.21 of the Revised Code, if the life insurance policy meets both of the following conditions:

(a) The policy has been in force for at least one hundred eighty days.

(b) The policy has been brought within the "Servicemembers Civil Relief Act," 117 Stat. 2835 (2003), 50 U.S.C. App. 541, et seq.

(2) This section does not apply to any policy that was cancelled or that had lapsed for the nonpayment of premiums prior to the commencement of the insured's period of military service.

(B) An individual life insurance policy described in division (A) of this section shall not lapse or be forfeited for the nonpayment of premiums during a reservist's period of military service or during the two-year period subsequent to the
end of the reservist's period of military service.

(C) This section does not limit a life insurance company's enforcement of provisions in the insured's policy relating to naval or military service in time of war.

Sec. 3915.073. (A) This section shall be known as the standard nonforfeiture law for individual deferred annuities.

(B) This section does not apply to any reinsurance, group annuity purchased under a retirement plan or plan of deferred compensation established or maintained by an employer, including a partnership or sole proprietorship, or by an employee organization, or by both, other than a plan providing individual retirement accounts or individual retirement annuities under section 408 of the Internal Revenue Code of 1954, 26 U.S.C.A. 408, as amended, premium deposit fund, variable annuity, investment annuity, immediate annuity, any deferred annuity contract after annuity payments have commenced, or reversionary annuity, nor to any contract which is delivered outside this state through an agent or other representative of the company issuing the contract.

(C) No contract of annuity, except as stated in division (B) of this section, shall be delivered or issued for delivery in this state unless the contract contains in substance the following provisions, or corresponding provisions that in the opinion of the superintendent of insurance are at least as favorable to the contract owners, relative to the cessation of payment of consideration under the contract:

(1) That upon cessation of payment of considerations under a contract, or upon the written request of the contract owner, the company shall grant a paid-up annuity benefit on a plan
stipulated in the contract of such value as is specified in divisions (E), (F), (G), (H), and (J) of this section;

(2) If a contract provides for a lump sum settlement at maturity, or at any other time, that upon surrender of the contract at or prior to the commencement of any annuity payments, the company shall pay in lieu of any paid-up annuity benefit a cash surrender benefit of such amount as is specified in divisions (E), (F), (H), and (J) of this section. The company may reserve the right to defer the payment of such cash surrender benefit for a period not to exceed six months after demand therefor with surrender of the contract. The deferral is contingent upon the company's conveyance of a written request for the deferral to the superintendent and the company's receipt of written approval from the superintendent for the deferral. The request shall address the necessity and equitability to all contract owners of the deferral.

(3) A statement of the mortality table, if any, and interest rates used in calculating any minimum paid-up annuity, cash surrender, or death benefits that are guaranteed under the contract, together with sufficient information to determine the amounts of such benefits;

(4) A statement that any paid-up annuity, cash surrender, or death benefits that may be available under the contract are not less than the minimum benefits required by any statute of the state in which the contract is delivered and an explanation of the manner in which such benefits are altered by the existence of any additional amounts credited by the company to the contract, any indebtedness to the company on the contract, or any prior withdrawals from or partial surrenders of the contract.
Notwithstanding the requirements of this section, any deferred annuity contract may provide that if no considerations have been received under a contract for a period of two full years and the portion of the paid-up annuity benefit at maturity on the plan stipulated in the contract arising from considerations paid prior to such period would be less than twenty dollars monthly, the company may at its option terminate such contract by payment in cash of the then present value of such portion of the paid-up annuity benefit, calculated on the basis of the mortality table, if any, and interest rate specified in the contract for determining the paid-up annuity benefit, and by such payment shall be relieved of any further obligation under such contract.

(D) The minimum values as specified in divisions (E), (F), (G), (H), and (J) of this section of any paid-up annuity, cash surrender, or death benefits available under an annuity contract shall be based upon minimum nonforfeiture amounts as defined in this division.

(1)(a) The minimum nonforfeiture amount at any time at or prior to the commencement of any annuity payments shall be equal to an accumulation up to such time at rates of interest determined in accordance with division (D)(2) of this section of the net considerations, determined in accordance with division (D)(1)(b) of this section, paid prior to such time, decreased by the sum of:

(i) Any prior withdrawals from or partial surrenders of the contract, accumulated at rates of interest determined in accordance with division (D)(2) of this section;

(ii) An annual contract charge of fifty dollars, accumulated at rates of interest determined in accordance with
division (D)(2) of this section;

(iii) Any premium tax paid by the company for the contract, accumulated at rates of interest determined in accordance with division (D)(2) of this section;

(iv) The amount of any indebtedness to the company on the contract, including interest due and accrued.

(b) The net considerations for a given contract year used to define the minimum nonforfeiture amount shall be an amount equal to eighty-seven and one-half per cent of the gross considerations credited to the contract during that contract year.

(2)(a) The interest rate used in determining minimum nonforfeiture amounts under divisions (D)(1) to (4) of this section shall be an annual rate of interest determined as the lesser of three per cent per annum or the following, which shall be specified in the contract if the interest rate will be reset:

(i) The five-year constant maturity treasury rate reported by the federal reserve as of a date or an average over a period, rounded to the nearest one-twentieth of one per cent, specified in the contract, no longer than fifteen months prior to the contract issue date or the redetermination date specified in division (D)(2)(b) of this section;

(ii) Reduced by one hundred twenty-five basis points;

(iii) Where the resulting interest rate shall not be less than one per cent.

(b) The interest rate determined under division (D)(2)(a) of this section shall apply for an initial period and may be redetermined for additional periods. The redetermination date,
basis and period, if any, shall be stated in the contract. The basis is the date or average over a specified period that produces the value of the five-year constant maturity treasury rate to be used at each redetermination date.

(3) During the period or term that a contract provides substantive participation in an equity-indexed benefit, the contract may provide for an increase in the reduction described in division (D)(2)(a)(ii) of this section by a maximum of one hundred basis points to reflect the value of the equity-indexed benefit. The present value at the contract issue date, and at each redetermination date thereafter, of the additional reduction shall not exceed the market value of the benefit. The superintendent may require a demonstration that the present value of the additional reduction does not exceed the market value of the benefit. If the demonstration is not acceptable to the superintendent, the superintendent may disallow or limit the additional reduction.

(4) The superintendent may adopt rules to implement division (D)(3) of this section and to provide for further adjustments to the calculation of minimum nonforfeiture amounts for contracts that provide substantive participation in an equity-indexed benefit and for other contracts for which the superintendent determines adjustments are justified.

(E) Any paid-up annuity benefit available under a contract shall be such that its present value on the date annuity payments are to commence is at least equal to the minimum nonforfeiture amount on that date. Such present value shall be computed using the mortality table, if any, and the interest rate specified in the contract for determining the minimum paid-up annuity benefits guaranteed in the contract.
(F) For contracts which provide cash surrender benefits, such cash surrender benefits available prior to maturity shall not be less than the present value as of the date of surrender of that portion of the maturity value of the paid-up annuity benefit that would be provided under the contract at maturity arising from considerations paid prior to the time of cash surrender reduced by the amount appropriate to reflect any prior withdrawals from or partial surrenders of the contract, such present value being calculated on the basis of an interest rate not more than one per cent higher than the interest rate specified in the contract for accumulating the net considerations to determine such maturity value, decreased by the amount of any indebtedness to the company on the contract, including interest due and accrued, and increased by any existing additional amounts credited by the company to the contract. In no event shall any cash surrender benefit be less than the minimum nonforfeiture amount at that time. The death benefit under such contracts shall be at least equal to the cash surrender benefit.

(G) For contracts that do not provide cash surrender benefits, the present value of any paid-up annuity benefit available as a nonforfeiture option at any time prior to maturity shall not be less than the present value of that portion of the maturity value of the paid-up annuity benefit provided under the contract arising from considerations paid prior to the time the contract is surrendered in exchange for, or changed to, a deferred paid-up annuity, such present value being calculated for the period prior to the maturity date on the basis of the interest rate specified in the contract for accumulating the net considerations to determine such maturity value, and increased by any existing additional amounts credited
by the company to the contract. For contracts that do not provide any death benefits prior to the commencement of any annuity payments, such present values shall be calculated on the basis of such interest rate and the mortality table specified in the contract for determining the maturity value of the paid-up annuity benefit. However, in no event shall the present value of a paid-up annuity benefit be less than the minimum nonforfeiture amount at that time.

(H) For the purpose of determining the benefits calculated under divisions (F) and (G) of this section, in the case of annuity contracts under which an election may be made to have annuity payments commence at optional maturity dates, the maturity date shall be deemed to be the latest date for which election shall be permitted by the contract, but shall not be deemed to be later than the anniversary of the contract next following the annuitant's seventieth birthday or the tenth anniversary of the contract, whichever is later.

(I) Any contract that does not provide cash surrender benefits or does not provide death benefits at least equal to the minimum nonforfeiture amount prior to the commencement of any annuity payments shall include a statement in a prominent place in the contract that such benefits are not provided.

(J) Any paid-up annuity, cash surrender, or death benefits available at any time, other than on the contract anniversary under any contract with fixed scheduled considerations, shall be calculated with allowance for the lapse of time and the payment of any scheduled considerations beyond the beginning of the contract year in which cessation of payment of considerations under the contract occurs.

(K) For any contract that provides, within the same
contract by rider or supplemental contract provision, both
annuity benefits and life insurance benefits that are in excess
of the greater of cash surrender benefits or a return of the
gross considerations with interest, the minimum nonforfeiture
benefit shall be equal to the sum of the minimum nonforfeiture
benefits for the annuity portion and the minimum nonforfeiture
benefits, if any, for the life insurance portion computed as if
each portion were a separate contract. Notwithstanding the
provisions of divisions (E), (F), (G), (H), and (J) of this
section, additional benefits payable:

(1) In the event of total and permanent disability;
(2) As reversionary annuity or deferred reversionary
annuity benefits; or
(3) As other policy benefits additional to life insurance,
endowment and annuity benefits, and considerations for all such
additional benefits shall be disregarded in ascertaining the
minimum nonforfeiture amounts, paid-up annuity, cash surrender,
and death benefits that may be required by this section.

The inclusion of such additional benefits shall not be
required in any paid-up benefits, unless such additional
benefits separately would require minimum nonforfeiture amounts,
paid-up annuity, cash surrender, and death benefits.

(L) The superintendent may adopt rules in accordance with
Chapter 119. of the Revised Code to implement this section.

Sec. 3915.13. No life insurance company nor any of its
agents shall knowingly make, issue, or deliver in this state any
policy or contract of life insurance which purports to be issued
or to take effect as of a date more than three six months before
the application therefor was made, if thereby the premium on
such policy or contract is reduced below the premium which would be payable thereon, as determined by the nearest birthday of the insured at the time when such application was made. In determining the date when an application was made, under this section the date of execution of the application or the date of medical examination, where such examination is required, whichever is later, shall govern.

This section does not prohibit the exchange, alteration, or conversion of any policy of life or endowment insurance or any annuity in the manner provided by section 3915.12 of the Revised Code, nor does it invalidate any contract made in violation of this section.

Sec. 3916.01. As used in this chapter:

(A) "Advertising" means any written, electronic, or printed communication or any communication by means of recorded telephone messages or transmitted on radio, television, the internet, or similar communications media, including, but not limited to, film strips, motion pictures, and videos, that is published, disseminated, circulated, or placed directly or indirectly before the public in this state for the purpose of creating an interest in or inducing a person to purchase or sell, assign, devise, bequest, or transfer the death benefit or ownership of a policy pursuant to a viatical settlement contract.

(B) "Business of viatical settlements" means an activity involved, but not limited to, in the offering, solicitation, negotiation, procurement, effectuation, purchasing, investing, financing, monitoring, tracking, underwriting, selling, transferring, assigning, pledging, or hypothecating or in any other manner acquiring an interest in a policy by means of
viatical settlement contracts.

(C) "Chronically ill" means having been certified within the preceding twelve-month period by a licensed health professional as:

(1) Being unable to perform, without substantial assistance from another individual, at least two activities of daily living, including, but not limited to, eating, toileting, transferring, bathing, dressing, or continence for at least ninety days due to a loss of functional capacity; or

(2) Requiring substantial supervision to protect the individual from threats to health and safety due to severe cognitive impairment; or

(3) Having a level of disability similar to that described in division (C)(1) of this section, as determined under regulations prescribed by the United States secretary of the treasury in consultation with the United States secretary of health and human services.

(D) "Escrow agent" means an independent third-party person who, pursuant to a written agreement signed by the viatical settlement provider and viator, provides escrow services related to the acquisition of a policy pursuant to a viatical settlement contract. "Escrow agent" does not include any person associated with, affiliated with, or under the control of a person licensed under this chapter or described in division (C) of section 3916.02 of the Revised Code.

(E)(1) "Financing entity" means an underwriter, placement agent, lender, purchaser of securities, purchaser of a policy from a viatical settlement provider, credit enhancer, or any other person that has a direct ownership interest in a policy.
that is the subject of a viatical settlement contract and to which both of the following apply:

(a) Its principal activity related to the transaction is providing funds to effect the business of viatical settlements or the purchase of one or more viaticated policies.

(b) It has an agreement in writing with one or more licensed viatical settlement providers to finance the acquisition of viatical settlement contracts.

(2) "Financing entity" does not include a non-accredited investor or viatical settlement purchaser.

(F) "Recklessly" has the same meaning as in section 2901.22 of the Revised Code.

(G) "Defraud" has the same meaning as in section 2913.01 of the Revised Code.

(H) "Life expectancy" means an opinion or evaluation as to how long a particular person is going to live.

(I) Notwithstanding section 1.59 of the Revised Code, "person" means a natural person or a legal entity, including, but not limited to, an individual, partnership, limited liability company, limited liability partnership, association, trust, business trust, or corporation.

(J) "Policy" means an individual or group policy, group certificate, or other contract or arrangement of life insurance affecting the rights of a resident of this state or bearing a reasonable relation to this state, regardless of whether delivered or issued for delivery in this state.

(K) "Related provider trust" means a titling trust or any other trust established by a licensed viatical settlement
provider or a financing entity for the sole purpose of holding
ownership or beneficial interest in purchased policies in
connection with a financing transaction, provided that the trust
has a written agreement with the licensed viatical settlement
provider under which the licensed viatical settlement provider
is responsible for ensuring compliance with all statutory and
regulatory requirements and under which the trust agrees to make
all records and files related to viatical settlement
transactions available to the superintendent of insurance as if
those records and files were maintained directly by the licensed
viatical settlement provider.

(L) "Special purpose entity" means a corporation,
partnership, trust, limited liability company or other similar
entity formed solely for one of the following purposes:

(i) To provide access, either directly or indirectly, to
institutional capital markets for a financing entity or licensed
viatical settlement provider;

(ii) In connection with a transaction in which the
securities in the special purpose entity are acquired by
qualified institutional buyers.

(M) "Terminally ill" means certified by a physician as
having an illness or physical condition that can reasonably be
expected to result in death in twenty-four months or less.

(N) "Viatical settlement broker" means a person that, on
behalf of a viator and for a fee, commission, or other valuable
consideration, offers or attempts to negotiate viatical
settlements between a viator and one or more viatical settlement
providers or viatical settlement brokers. "Viatical settlement
broker" does not include an attorney, a certified public

accountant, or a financial planner accredited by a nationally recognized accreditation agency, who is retained to represent the viator, whose compensation is not paid directly or indirectly by the viatical settlement provider or purchaser.

(O)(1) "Viatical settlement contract" means any of the following:

(a) A written agreement between a viator and a viatical settlement provider that establishes the terms under which compensation or anything of value, that is less than the expected death benefit of the policy is or will be paid in return for the viator's present or future assignment, transfer, sale, release, devise, or bequest of the death benefit or ownership of any portion of the policy or any beneficial interest in the policy or its ownership;

(b) The transfer or acquisition for compensation or anything of value for ownership or beneficial interest in a trust or an interest in another person that owns such a policy if the trust or other person was formed or availed of for the principal purpose of acquiring one or more life insurance policies;

(c) A premium finance loan made for a policy by a lender to a viator on, before, or after the date of issuance of the policy in either of the following situations:

(i) The viator or the insured receives a guarantee of the viatical settlement value of the policy.

(ii) The viator or the insured agrees on, before, or after the issuance of the policy to sell the policy or any portion of the policy's death benefit.

(2) "Viatical settlement contracts" include but are not
limited to contracts that are commonly termed "life settlement contracts" and "senior settlement contracts."

(3) "Viatical settlement contract" does not include any of the following unless part of a plan, scheme, device, or artifice to avoid the application of this chapter:

(a) A policy loan or accelerated death benefit made by the insurer pursuant to the policy's terms whether issued with the original policy or a rider;

(b) Loan proceeds that are used solely to pay premiums for the policy and the costs of the loan including interest, arrangement fees, utilization fees and similar fees, closing costs, legal fees and expenses, trustee fees and expenses, and third-party collateral provider fees and expenses, including fees payable to letter of credit issuers;

(c) A loan made by a regulated financial institution in which the lender takes an interest in a policy solely to secure repayment of a loan or, if there is a default on the loan and the policy is transferred, the transfer of such a policy by the lender, provided that neither the default itself nor the transfer is pursuant to an agreement or understanding with any other person for the purpose of evading regulation under this chapter;

(d) A premium finance loan made by a lender that does not violate sections 1321.71 to 1321.83 of the Revised Code, if the premium finance loan is not described in division (O)(1)(c) of this section;

(e) An agreement where all parties are closely related to the insured by blood or law or have a lawful substantial economic interest in the continued life, health, and bodily
safety of the person insured, or are persons or trusts established primarily for the benefit of such parties;

(f) Any designation, consent, or agreement by an insured who is an employee of an employer in connection with the purchase by the employer, or trust established by the employer, of life insurance on the life of the employee as described in section 3911.091 of the Revised Code;

(g) Any business succession planning arrangement including, but not limited to all of the following if the arrangements are bona fide arrangements:

(i) An arrangement between one or more shareholders in a corporation or between a corporation and one or more of its shareholders or one or more persons or trusts established by its shareholders;

(ii) An arrangement between one or more partners in a partnership or between a partnership and one or more of its partners or one or more trusts established by its partners;

(iii) An arrangement between one or more members in a limited liability company or between a limited liability company and one or more of its members or one or more trusts established by its members.

(h) An agreement entered into by a service recipient, a trust established by the service recipient and a service provider, or a trust established by the service provider who performs significant services for the service recipient's trade or business;

(i) An arrangement or agreement with a special purpose entity;
(j) Any other contract, transaction, or arrangement exempted from the definition of viatical settlement contract by rule adopted by the superintendent based on the superintendent's determination that the contract, transaction, or arrangement is not of the type regulated by this chapter.

(P)(1) "Viatical settlement provider" means a person, other than a viator, that enters into or effectuates a viatical settlement contract.

(2) "Viatical settlement provider" does not include any of the following:

(a) A bank, savings bank, savings and loan association, credit union, or other regulated financial institution that takes an assignment of a policy solely as a collateral for a loan;

(b) A premium finance company exempted under section 1321.72 of the Revised Code from the licensure requirements of section 3921.73 of the Revised Code that takes an assignment of a policy solely as collateral for a premium finance loan;

(c) The issuer of a policy;

(d) An individual who enters into or effectuates not more than one viatical settlement contract in any calendar year for the transfer of life insurance policies for any value less than the expected death benefit;

(e) An authorized or eligible insurer that provides stop loss coverage or financial guarantee insurance to a viatical settlement provider, purchaser, financing entity, special purpose entity, or related provider trust;

(f) A financing entity;
(g) A special purpose entity;

(h) A related provider trust;

(i) A viatical settlement purchaser;

(j) Any other person the superintendent determines is not consistent with the definition of viatical settlement provider.

(Q) "Viaticated policy" means a policy that has been acquired by a viatical settlement provider pursuant to a viatical settlement contract.

(R) "Viator" means the owner of a policy or a certificate holder under a group policy that has not previously been viaticated who, in return for compensation or anything of value that is less than the expected death benefit of the policy or certificate, assigns, transfers, sells, releases, devises, or bequests the death benefit or ownership of any portion of the policy or certificate of insurance. For the purposes of this chapter, a "viator" is not limited to an owner of a policy or a certificate holder under a group policy insuring the life of an individual who is terminally or chronically ill except where specifically addressed. "Viator" does not include any of the following:

(1) A licensee under this chapter;

(2) A qualified institutional buyer;

(3) A financing entity;

(4) A special purpose entity;

(5) A related provider trust.

(S) "Viatical settlement purchaser" means a person who provides a sum of money as consideration for a policy or an
interest in the death benefits of a policy from a viatical
settlement provider that is the subject of a viatical settlement
contract, or a person who owns, acquires, or is entitled to a
beneficial interest in a trust or person that owns a viatical
settlement contract or is the beneficiary of a policy that is
the subject of a viatical settlement contract, for the purpose
of deriving an economic benefit. "Viatical settlement purchaser"
does not include any of the following:

(1) A licensee under this chapter;

(2) A qualified institutional buyer;

(3) A financing entity;

(4) A special purpose entity;

(5) A related provider trust.

(T) "Qualified institutional buyer" has the same meaning
as in 17 C.F.R. 230.144A as that regulation exists on the
effective date of this amendment September 11, 2008.

(U) "Licensee" means a person licensed as a viatical
settlement provider or viatical settlement broker under this
chapter.

(V) "NAIC" means the national association of insurance
commissioners.

(X) "Regulated financial institution" means a bank, a
savings association, or credit union operating under authority
granted by the superintendent of financial institutions, the
regulatory authority of any other state of the United States,
the office of thrift supervision, the national credit union
administration, or the office of the comptroller of the
currency.
(W)(1) "Stranger-originated life insurance," or "STOLI," means a practice, arrangement, or agreement initiated at or prior to the issuance of a policy that includes both of the following:

(a) The purchase or acquisition of a policy primarily benefiting one or more persons who, at the time of issuance of the policy, lack insurable interest in the person insured under the policy;

(b) The transfer at any time of the legal or beneficial ownership of the policy or benefits of the policy or both, in whole or in part, including through an assumption or forgiveness of a loan to fund premiums.

(2) "Stranger-originated life insurance" also includes trusts or other persons that are created to give the appearance of insurable interest and are used to initiate one or more policies for investors but violate insurable interest laws and the prohibition against wagering on life.

(3) "Stranger-originated life insurance" does not include viatical settlement transactions specifically described in division (O)(3) of this section.

Sec. 3916.171. (A) No person shall commit a fraudulent viatical settlement act.

(B) All of the following acts are fraudulent viatical settlement acts when committed by any person who, knowingly and with intent to defraud and for the purpose of depriving another of property or for pecuniary gain, commits, or permits any of its employees or its agents to commit them:

(1) Presenting, causing to be presented, or preparing with knowledge or belief that it will be presented to or by a
viatical settlement provider, viatical settlement broker, life expectancy provider, viatical settlement purchaser, financing entity, insurer, insurance broker, insurance agent, or any other person, any false material information, or concealing any material information, as part of, in support of, or concerning a fact material to, one or more of the following:

(a) An application for the issuance of a viatical settlement contract or a policy;

(b) The underwriting of a viatical settlement contract or a policy;

(c) A claim for payment or benefit pursuant to a viatical settlement contract or a policy;

(d) Any premiums paid on a policy;

(e) Any payments and changes in ownership or beneficiary made in accordance with the terms of a viatical settlement contract or a policy;

(f) The reinstatement or conversion of a policy;

(g) The solicitation, offer, effectuation, or sale of a viatical settlement contract or a policy;

(h) The issuance of written evidence of a viatical settlement contract or a policy;

(i) A financing transaction;

(j) Any application for or the existence of or any payments related to a loan secured directly or indirectly by any interest in a policy.

(2) Failing to disclose to the insurer, where the insurer has requested such disclosure, that the prospective insured has
undergone a life expectancy evaluation by any person or entity other than the insurer or its authorized representatives in connection with the application, underwriting, and issuance of the policy.

(3) In the furtherance of a fraud or to prevent the detection of a fraud, doing any of the following:

(a) Removing, concealing, altering, destroying, or sequestering from the superintendent of insurance the assets or records of a licensee or another person engaged in the business of viatical settlements;

(b) Misrepresenting or concealing the financial condition of a licensee, financing entity, insurer, or any other person;

(c) Transacting the business of viatical settlements in violation of any law of this state requiring a license, certificate of authority, or other legal authority for the transaction of the business of viatical settlements;

(d) Filing with the superintendent of insurance or the chief insurance regulatory official of another jurisdiction a document containing false information or otherwise concealing from the superintendent any information about a material fact.

(4) Recklessly entering into, negotiating, brokering, or otherwise dealing in a viatical settlement contract involving a policy that was obtained by presenting false, deceptive, or misleading information of any fact material to the policy, or by concealing information concerning any fact material to the policy, for the purpose of misleading and with the intent to defraud the issuer of the policy, the viatical settlement provider, or the viator;

(5) Committing any embezzlement, theft, misappropriation,
or conversion of moneys, funds, premiums, credits, or other property of a viatical settlement provider, insurer, insured, viator, policyowner, or any other person engaged in the business of viatical settlements or insurance;

(6) Employing any plan, financial structure, device, scheme, or artifice to defraud in the business of viatical settlements;

(7) Misrepresenting the state of residence or facilitating the change of the state in which a person owns a policy or the state of residency of a viator to a state or jurisdiction that does not have laws similar to this chapter for the express purposes of evading or avoiding the provisions of this chapter;

(8) In the solicitation, application, or issuance of a policy, employing any device, scheme, or artifice in violation of sections 3911.09 or 3911.091 of the Revised Code;

(9) Engaging in any conduct related to a viatical settlement contract if the person knows or should have known that the intent of the transaction was to avoid the disclosure and notice requirements of section 3916.06 of the Revised Code;

(10) Entering into a premium finance agreement with any person pursuant to which the person will receive, directly or indirectly, any proceeds, fees, or other considerations from the policy, the owner of the policy, the issuer of the policy, or from any other person with respect to the premium finance agreement or any viatical settlement contract, or from any transaction related to the policy, that are in addition to the amount required to pay the principal, interest, costs, and expenses related to the policy premiums pursuant to the premium finance agreement or subsequent sale of the agreement. Any
payments, charges, fees, or other amounts in addition to the amounts required to pay the principal, interest, costs, and expenses related to policy premiums paid under the premium finance agreement shall be remitted to the original owner of the policy or, if the owner is not living at the time of the determination of the overpayment, to the estate of the owner.

(11) With respect to any viatical settlement contract or a policy, for a viatical settlement broker or an agent registered under this chapter as operating as a viatical settlement broker to knowingly solicit an offer from, effectuate a viatical settlement with, or make a sale to any viatical settlement provider, viatical settlement purchaser, financing entity, or related provider trust that is controlling, controlled by, or under common control with such viatical settlement broker or registered agent unless both of the following are true:

(a) The viatical settlement broker or agent disclosed that affiliation to the viator.

(b) The viatical settlement broker or agent is controlled by or under common control with a person that is regulated under the "Securities Act of 1933" or the "Securities Act of 1934," 15 U.S.C. 77a et seq., as amended.

(12) With respect to any viatical settlement contract or a policy, for a viatical settlement provider to knowingly enter into a viatical settlement contract with a viator if, in connection with such viatical settlement contract, anything of value will be paid to a viatical settlement broker or an agent registered under this chapter as operating as a viatical settlement broker that is controlling, controlled by, or under common control with such viatical settlement provider or the viatical settlement purchaser, financing entity, or related
provider trust that is involved in such viatical settlement contract unless both of the following are true:

(a) The viatical settlement broker or agent disclosed that affiliation to the viator.

(b) The viatical settlement broker or agent is controlled by or under common control with a person that is regulated under the "Securities Act of 1933" or the "Securities Act of 1934," 15 U.S.C. 77a et seq., as amended.

(13) Issuing, soliciting, marketing, or otherwise promoting the purchase of a policy for the purpose of or with emphasis on settling the policy;

(14) Issuing or using a pattern of false, misleading, or deceptive life expectancies;

(15) Issuing, soliciting, marketing, or otherwise promoting stranger-originated life insurance;

(16) Attempting to commit, assisting, aiding or abetting in the commission of, or conspiracy to commit any act or omission specified in divisions (B)(1) to (15) of this section.

Sec. 3916.18. (A)(1) No person shall knowingly or intentionally interfere with the enforcement of the provisions of this chapter or investigations of suspected or actual violations of this chapter.

(2) No person in the business of viatical settlements shall knowingly or intentionally permit any person convicted of a felony involving dishonesty or breach of trust to participate in the business of viatical settlements.

(B)(1) Each viatical settlement contract and each application for a viatical settlement, regardless of the form of
transmission, shall contain the following statement or a substantially similar statement:

"Any person who knowingly presents false information in an application for insurance or viatical settlement contract is guilty of a crime and may be subject to fines and imprisonment."

(2) The lack of a statement as required in division (B)(1) of this section does not constitute a defense in any prosecution for a fraudulent viatical settlement act.

(C)(1) Every person engaged in the business of viatical settlements having knowledge or a reasonable belief that a fraudulent viatical settlement act is being, will be, or has been committed shall provide to the superintendent of insurance the information required by the superintendent. The person shall provide the information in a manner prescribed by the superintendent.

(2) Every person having knowledge or a reason to believe that a fraudulent viatical settlement act is being, will be, or has been committed may provide to the superintendent the information required by the superintendent. The person shall provide the information under this division in a manner prescribed by the superintendent.

(3) Any life insurer that has a good faith belief that a person is participating or has participated in a stranger-originated life insurance transaction shall report the person to the superintendent in a form and manner prescribed by the superintendent. Upon receipt of the insurer's report, the superintendent shall conduct an investigation to determine whether there is probable cause, based on the totality of the facts and circumstances that the person has or had
engaged in a stranger-originated life insurance transaction. If the superintendent finds probable cause, the superintendent shall do one of the following:

(a) If the person is licensed or regulated by the department of insurance, the superintendent shall provide the person an opportunity for notice and hearing pursuant to Chapter 119. of the Revised Code. If the person waives or does not request a hearing pursuant to Chapter 119. of the Revised Code, or a hearing is held and the person is found to have participated in one or more stranger-originated life insurance transactions, the superintendent shall publish the order on the department's web site, and shall notify each insurance company licensed in this state that the person has been adjudicated as having participated in one or more stranger-originated life insurance transactions.

(b) If the person is not licensed or regulated by the department, the superintendent shall provide the superintendent's findings to the appropriate licensing or regulatory authority.

(D)(1) No civil liability shall be imposed on, and no cause of action shall arise from, a person's furnishing information concerning suspected, anticipated, or completed fraudulent viatical settlement acts or suspected or completed fraudulent insurance acts, if the information is provided to or received from any of the following:

(a) The superintendent, or the superintendent's employees, agents, or representatives;

(b) Law enforcement or regulatory officials of this state, another state, the United States, or a political subdivision of
this state or another state, or any employee, agent, or representative of any of those officials;

(c) A person involved in the prevention and detection of fraudulent viatical settlement acts or any agent, employee, or representative of any person so involved;

(d) The NAIC, financial industry regulatory authority (FINRA), the north American securities administrators association (NASAA), any employee, agent, or representative of any of those associations, or other regulatory body overseeing life insurance, viatical settlements, securities, or investment fraud;

(e) The life insurer that issued the policy covering the life of the insured.

(2) The immunity provided in division (D)(1) of this section shall not apply to any statement made with actual malice. In an action brought against a person for filing a report or furnishing other information concerning a fraudulent viatical settlement act, the party bringing the action shall plead specifically any allegation that the immunity provided in division (D)(1) of this section does not apply because the person filing the report or furnishing the information did so with actual malice.

(3) If a person is the prevailing party in a civil action for libel, slander, or any other relevant tort arising out of activities in carrying out the provisions of this chapter, if the prevailing party is a person identified in division (D)(1) of this section and the immunity described in that division applies to the person, and if the party who brought the action was not substantially justified in doing so, the person who is
the prevailing party is entitled to an award of attorney's fees and costs arising out of the action. However, the person is not entitled to an award of attorney's fees if the person provided information about the person's own fraudulent viatical settlement acts. For purposes of this division, an action is "substantially justified" if it had a reasonable basis in law or fact at the time that it was initiated.

(4) This section does not abrogate or modify any common law or statutory privilege or immunity enjoyed by a person described in division (D)(1) of this section.

(E)(1) The documents and evidence provided pursuant to division (D) of this section or obtained by the superintendent in an investigation of any suspected or actual fraudulent viatical settlement act is privileged and confidential, is not a public record open for inspection under section 149.43 of the Revised Code, and is not subject to discovery or subpoena in a civil or criminal action.

(2) Division (E)(1) of this section does not prohibit release by the superintendent of any document or evidence obtained in an investigation of suspected or actual fraudulent viatical settlement acts, in any of the following manners or circumstances:

(a) In any administrative or judicial proceeding to enforce any laws administered by the superintendent;

(b) To any law enforcement or regulatory agency of this state, another state, the United States, or a political subdivision of this state or another state, to an organization established for the purpose of detecting and preventing fraudulent viatical settlement acts, or to the NAIC;
(c) At the discretion of the superintendent, to a person in the business of viatical settlements that is aggrieved by a fraudulent viatical settlement act.

(3) Release of documents and evidence under division (E) (2) of this section does not abrogate or modify the privilege granted in division (E)(1) of this section.

(F) The provisions of this chapter do not do any of the following:

(1) Preempt the authority or relieve the duty of any other law enforcement or regulatory agencies to investigate, examine, or prosecute suspected violations of law;

(2) Prevent or prohibit a person from disclosing voluntarily any information concerning fraudulent viatical settlement acts to a law enforcement or regulatory agency other than the department of insurance;

(3) Limit any power granted elsewhere by the law of this state to the superintendent or an insurance fraud unit to investigate and examine possible violations of law and to take appropriate action against wrongdoers.

(G)(1) Viatical settlement providers and viatical settlement brokers shall adopt and have in place antifraud initiatives reasonably calculated to detect, prosecute, and prevent fraudulent viatical settlement acts. At the discretion of the superintendent, the superintendent may order, or a viatical settlement provider or viatical settlement broker may request and the superintendent may grant, any modifications of the following required initiatives described in divisions (G)(1) (a) and (b) of this section that are necessary to ensure an effective antifraud program. The modifications may be more or
less restrictive than the required initiatives so long as the modifications may reasonably be expected to accomplish the purpose of this section. Antifraud initiatives under this division shall include all of the following:

(a) Fraud investigators, who may be licensed viatical settlement provider or licensed viatical settlement broker employees or independent contractors;

(b) An antifraud plan that includes, but is not limited to, all of the following:

(i) A description of the procedures for detecting and investigating possible fraudulent viatical settlement acts and procedures for resolving material inconsistencies between medical records and insurance applications;

(ii) A description of the procedures for reporting possible fraudulent viatical settlement acts to the superintendent;

(iii) A description of the plan for antifraud education and training of underwriters and other personnel;

(iv) A description or chart outlining the organizational arrangement of the antifraud personnel who are responsible for the investigation and reporting of possible fraudulent viatical settlement acts and investigating unresolved material inconsistencies between medical records and insurance applications;

(v) A description of the procedures used to perform initial and continuing review of the accuracy of life expectancies used in connection with a viatical settlement contract.
(2) The superintendent, by rule adopted in accordance with Chapter 119. of the Revised Code, may require that antifraud plans required under division (G)(1) of this section be submitted to the superintendent. If the superintendent requires that antifraud plans be submitted to the superintendent, the plans so submitted are privileged and confidential, are not a public record open for inspection under section 149.43 of the Revised Code, and are not subject to discovery or subpoena in a civil or criminal action.

(H) No insurer that issued a policy being viaticated shall be responsible, under this chapter, for any act or omission of a viatical settlement broker or viatical settlement provider arising out of or in connection with the viatical settlement transaction unless the insurer receives compensation for the placement of a viatical settlement contract from the viatical settlement provider or viatical settlement broker in connection with the viatical settlement contract.

Sec. 3919.14. A company or association organized under section 3919.01 of the Revised Code amending its articles of incorporation and its constitution and bylaws is subject to sections 3919.11 and 3919.12 of the Revised Code as to its organization and government, and it shall make separate annual statements to the superintendent of insurance of the business transacted by it under the assessment plan, as required by section 3919.11 to 3919.15, inclusive, of the Revised Code, or for the purpose of and of the business transacted by it under the level premium or legal reserve plan, as required by section 3907.19 of the Revised Code.

Sec. 3921.13. (A) A domestic fraternal benefit society may, by a reinsurance agreement, cede any individual risk or
risks in whole or in part to an insurer, other than another fraternal benefit society, having the power to make such reinsurance and authorized to do business in this state, or if not so authorized, one which is approved by the superintendent of insurance; however, no society may reinsure substantially all of its insurance in force without the written permission of the superintendent. It may take credit for the reserves on the ceded risks to the extent reinsured, but no credit shall be allowed as an admitted asset or as a deduction from liability, to a ceding society for reinsurance made, ceded, renewed, or otherwise becoming effective after January 1, 1997, unless the reinsurance is payable by the assuming insurer on the basis of the liability of the ceding society under the contract or contracts reinsured without diminution because of the insolvency of the ceding society.

(B) Notwithstanding division (A) of this section, a society may reinsure the risks of another society in a consolidation or merger approved by the superintendent under section 3921.14 of the Revised Code.

(C) A society with assets of less than five billion dollars that provides contract benefits of major medical, medicare supplemental, or long-term care pursuant to division (A)(5) of section 3921.16 of the Revised Code shall reinsure not less than fifty per cent of the risk arising from those contracts if the society's risk-based capital is less than three hundred per cent.

Sec. 3921.191. (A) A fraternal benefit society shall provide an applicant for contractual benefits a disclosure statement at the time of sale substantially as follows:

"........... (Name of the fraternal benefit society) IS
LICENSED TO DO BUSINESS IN THE STATE OF OHIO. AS A ........
(not-for-profit, tax-exempt, self-governing, or membership
organization), FRATERNAL BENEFIT SOCIETIES ARE NOT INCLUDED IN
THE OHIO GUARANTY ASSOCIATION. THIS MEANS THAT FRATERNAL BENEFIT
SOCIETIES CANNOT BE ASSESSED FOR THE INSOLVENCY OF OTHER LIFE
INSURERS OR OTHER FRATERNAL BENEFIT SOCIETIES. BY LAW, A
FRATERNAL BENEFIT SOCIETY IS RESPONSIBLE FOR ITS OWN SOLVENCY.
IF THERE IS AN IMPAIRMENT OF RESERVES, A CERTIFICATE HOLDER MAY
BE ASSESSED A PROPORTIONATE SHARE OF THE IMPAIRMENT. THIS
PROCESS IS DESCRIBED IN THE CERTIFICATE ISSUED BY THE SOCIETY."

(B) The statement must be signed by the applicant and
maintained in the certificate or contract file by the fraternal
benefit society. The statement may be part of the society's
membership application or certificate or policy application.

(C) This section is applicable only to new business
written by a fraternal benefit society after the effective date
of this section September 6, 2012.

Sec. 3922.11. (A) The superintendent of insurance shall
establish and maintain a system for receiving and reviewing
requests for external review for adverse benefit determinations
where the determination by the health plan issuer was based on a
contractual issue and did not involve a medical judgment or a
determination based on any medical information, except for
emergency services, as specified in division (C) of section
3922.05 of the Revised Code.

(B) A health plan issuer shall submit a request for
external review pursuant to division (B) or (C) of section
3922.05 of the Revised Code to the superintendent, in accordance
with any associated rules, policies, or procedures adopted by
the superintendent of insurance.
(C) On receipt of a request from a health plan issuer, the superintendent shall consider whether the health care service is a service covered under the terms of the covered person's policy, contract, certificate, or agreement, except that the superintendent shall not conduct a review under this section unless the covered person has exhausted the health plan issuer's internal appeal process, pursuant to sections 3922.03 and 3922.04 of the Revised Code. The health plan issuer and covered person shall provide the superintendent with any information required by the superintendent that is in their possession and is germane to the review.

(D) Unless the superintendent is not able to do so because making the determination requires a medical judgment or a determination based on medical information, the superintendent shall determine whether the health care service at issue is a service covered under the terms of the covered person's contract, policy, certificate, or agreement. The superintendent shall notify the covered person and the health plan issuer of the superintendent's determination.

(E) If the superintendent notifies the health plan issuer that making the determination requires a medical judgment or a determination based on medical information, the health plan issuer shall initiate an external review under this chapter.

(F) If the superintendent determines that the health service is a covered service, the health plan issuer shall cover the service.

(G) If the superintendent determines that the health care service is not a covered service, the health plan issuer is not required to cover the service or afford the covered person an
external review by an independent review organization.

Sec. 3922.14. (A) To be accredited by the superintendent of insurance to conduct external reviews under section 3922.13 of the Revised Code, in addition to the requirements provided in section 3922.13 of the Revised Code and any associated rules adopted by the superintendent, an independent review organization shall do all of the following:

(1) Develop and maintain written policies and procedures that govern all aspects of both the standard external review process and the expedited external review process set forth in this chapter, including a quality assurance mechanism that does all of the following:

(a) Ensures that external reviews are conducted within the time frames prescribed under this chapter and that the required notices are provided in a timely manner;

(b) Ensures the selection of qualified and impartial clinical reviewers to conduct external reviews on behalf of the independent review organization;

(c) Ensures that chosen clinical reviewers are suitably matched according to their area of expertise to specific cases and that the independent review organization employs or contracts with an adequate number of clinical reviewers to meet this requirement;

(d) Ensures the confidentiality of medical and treatment records and clinical review criteria;

(e) Ensures that any person employed by, or who is under contract with, the independent review organization adheres to the requirements of this chapter.
(2) Maintain a toll-free telephone service to receive information on a twenty-four-hour-a-day, seven-days-a-week basis related to external reviews that is capable of accepting, recording, and providing appropriate instruction to incoming telephone callers during other than normal business hours;

(3) Agree to maintain and provide to the superintendent, upon request and in accordance with any associated rules, policies, or procedures adopted by the superintendent of insurance, the information prescribed in section 3922.17 of the Revised Code.

(B) An independent review organization may not own or control, be a subsidiary of or in any way be owned or controlled by, or exercise control with a health plan issuer, a national, state, or local trade association of health plan issuers, or a national, state, or local trade association of health care providers.

(C)(1) Neither the independent review organization selected to conduct the external review nor any clinical reviewer assigned by the independent organization to conduct the external review may have a material, professional, familial, or financial affiliation with any of the following:

(a) The health plan issuer that is the subject of the external review, or any officer, director, or management employee of the health plan issuer;

(b) The covered person whose treatment is the subject of the external review;

(c) The health care provider, or the health care provider's medical group or independent practice association, recommending the health care service or treatment that is the
subject of the external review;

(d) The facility at which the recommended health care service would be provided;

(e) The developer or manufacturer of the principal drug, device, procedure, or other therapy being recommended for the covered person whose treatment is the subject of the external review.

(2) The superintendent may make a determination as to whether an independent review organization or a clinical reviewer of the independent review organization has a material professional, familial, or financial conflict of interest for purposes of division (C)(1) of this section. In making this determination, the superintendent may take into consideration situations where an independent review organization, or a clinical reviewer, may have an apparent conflict of interest, but that the characteristics of the relationship or connection in question are such that they do not fall under the definition of conflict of interest provided under division (D)(1) of this section. If the superintendent determines that a conflict of interest exists, the superintendent shall disallow an independent review organization or a clinical reviewer from conducting the external review in question. Such determinations related to conflicts of interest are the sole discretion of the superintendent of insurance.

(D)(1) An independent review organization that is accredited by a nationally recognized private accrediting entity that has independent review accreditation standards that the superintendent has determined are equivalent to or exceed the minimum qualifications of this section shall be presumed in compliance with this section to be eligible for accreditation by
the superintendent under section 3922.13 of the Revised Code.

(2) The superintendent shall initially review and periodically review the independent review organization accreditation standards of a nationally recognized private accrediting entity to determine whether the entity's standards are, and continue to be, equivalent to or exceed the minimum qualifications established under this section. The superintendent may accept a review conducted by the national association of insurance commissioners for the purpose of the determination under this division.

(3) Upon request, a nationally recognized, private accrediting entity shall make its current independent review organization accreditation standards available to the superintendent or the national association of insurance commissioners in order for the superintendent to determine if the entity's standards are equivalent to or exceed the minimum qualifications established under this section. The superintendent may exclude any private accrediting entity that is not reviewed by the national association of insurance commissioners.

(E) An independent review organization shall be unbiased in its review of adverse benefit determinations and shall establish and maintain written procedures to ensure that it is unbiased.

Sec. 3922.17. (A)(1) An independent review organization assigned pursuant to sections 3922.08, 3922.09, or 3922.10 of the Revised Code to conduct an external review shall maintain written records in accordance with the associated rules established by the superintendent, in the aggregate by state,
and by the health plan issuer, on all external reviews requested and conducted during a calendar year.

Each independent review organization shall submit this information to the superintendent, upon request, in a report in the format specified by the superintendent that shall include, in the aggregate by state and for each health plan issuer, all of the following:

(a) The total number of requests for external review;

(b) The number of requests for external review resolved and, of those resolved, the number upholding and the number reversing an adverse benefit determination;

(c) The average length of time for a resolution;

(d) A summary of the types of requested health care services or cases for which an external review was sought;

(e) The number of external reviews that were terminated as the result of a reconsideration by the health plan issuer of an adverse benefit determination after the receipt of additional information from the covered person under section 3922.05 of the Revised Code;

(f) The costs associated with external reviews, including the amounts charged by the independent review organization to conduct the reviews;

(g) The medical specialty, or the type, of clinical reviewer used to conduct each external review, as related to the specific medical condition of the covered person;

(h) Any other information the superintendent may request or require.
(2) The independent review organization shall retain the written records required under division (A)(1) of this section for at least three years.

(B) A health plan issuer shall maintain written records on all requests made for an external review under this chapter and shall provide all such information as required by any associated rules, policies, or procedures adopted by the superintendent of insurance. A health plan issuer shall maintain written records on all requests for external review for at least three years.

(C) The superintendent shall compile and annually publish the information collected under this section and report the information to the governor, the speaker and minority leader of the house of representatives, the president and minority leader of the senate, and the chairs and ranking minority members of the house and senate committees with jurisdiction over health and insurance issues.

Sec. 3923.01. As used in this chapter, "policy of sickness and accident insurance" includes any policy, contract, or certificate of insurance against loss or expense resulting from the sickness of the insured, or from the bodily injury or death of the insured by accident, or both, that is delivered, issued for delivery, renewed, or used in this state on or after the date occurring six months after the effective date of this amendment November 24, 1995.

Sec. 3923.021. (A) As used in this section:

(1) "Benefits provided are not unreasonable in relation to the premium charged" means the rates were calculated in accordance with sound actuarial principles.

(2) "Individual policy of sickness and accident insurance"
includes sickness and accident insurance made available by
insurers in the individual market to individuals, with or
without family members or dependents, through group policies
issued to one or more associations or entities.

(B) With respect to any filing, made pursuant to section
3923.02 of the Revised Code, of any premium rates for any
individual policy of sickness and accident insurance or
certificates made available by an insurer to individuals in the
individual market through a group policy or for any indorsement
or rider pertaining thereto, the superintendent of insurance
may, within thirty days after filing:

(1) Disapprove such filing after finding that the benefits
provided are unreasonable in relation to the premium charged.
Such disapproval shall be effected by written order of the
superintendent, a copy of which shall be mailed to the insurer
that has made the filing. In the order, the superintendent shall
specify the reasons for the disapproval and state that a hearing
will be held within fifteen days after requested in writing by
the insurer. If a hearing is so requested, the superintendent
shall also give such public notice as the superintendent
considers appropriate. The superintendent, within fifteen days
after the commencement of any hearing, shall issue a written
order, a copy of which shall be mailed to the insurer that has
made the filing, either affirming the prior disapproval or
approving such filing after finding that the benefits provided
are not unreasonable in relation to the premium charged.

(2) Set a date for a public hearing to commence no later
than forty days after the filing. The superintendent shall give
the insurer making the filing twenty days' written notice of the
hearing and shall give such public notice as the superintendent
considers appropriate. The superintendent, within twenty days after the commencement of a hearing, shall issue a written order, a copy of which shall be mailed to the insurer that has made the filing, either approving such filing if the superintendent finds that the benefits provided are not unreasonable in relation to the premium charged, or disapproving such filing if the superintendent finds that the benefits provided are unreasonable in relation to the premium charged. This division does not apply to any insurer organized or transacting the business of insurance under Chapter 3907. or 3909. of the Revised Code.

(3) Take no action, in which case such filing shall be deemed to be approved and shall become effective upon the thirty-first day after such filing, unless the superintendent has previously given to the insurer a written approval.

(C) At any time after any filing has been approved pursuant to this section, the superintendent may, after a hearing of which at least twenty days' written notice has been given to the insurer that has made such filing and for which such public notice as the superintendent considers appropriate has been given, withdraw approval of such filing after finding that the benefits provided are unreasonable in relation to the premium charged. Such withdrawal of approval shall be effected by written order of the superintendent, a copy of which shall be mailed to the insurer that has made the filing, which shall state the ground for such withdrawal and the date, not less than forty days after the date of such order, when the withdrawal of approval shall become effective.

(D) The superintendent may retain at the insurer's expense such attorneys, actuaries, accountants, and other experts not
otherwise a part of the superintendent's staff as shall be reasonably necessary to assist in the preparation for and conduct of any public hearing under this section. The expense for retaining such experts and the expenses of the department of insurance incurred in connection with such public hearing shall be assessed against the insurer in an amount not to exceed one one-hundredth of one per cent of the sum of premiums earned plus net realized investment gain or loss of such insurer as reflected in the most current annual statement on file with the superintendent. Any person retained shall be under the direction and control of the superintendent and shall act in a purely advisory capacity.

Sec. 3923.04. Except as provided in section 3923.07 of the Revised Code, every policy of sickness and accident insurance delivered, issued for delivery, or used in this state shall contain the standard provisions specified in this section in the words in which the same appear in this section. Such standard provisions shall be preceded individually by the caption appearing in this section or, at the option of the insurer, by such appropriate individual or group captions or subcaptions as the superintendent of insurance may approve.

(A) A provision as follows: Entire contract; changes. This policy, including the indorsements and the attached papers, if any, constitutes the entire contract of insurance. No change in this policy shall be valid until approved by an executive officer of the insurer and unless such approval be indorsed hereon or attached hereto. No agent has authority to change this policy or to waive any of its provisions.

No statement made by an applicant for a policy of sickness and accident insurance not included therein shall avoid the
policy or be used to deny any claim thereunder or be used in any legal proceeding thereunder.

(B) A provision in two parts as follows: Time limit on certain defenses.

(1) After two years from the date of issue of this policy no misstatements, except fraudulent misstatements, made by the applicant in the application for this policy shall be used to void this policy or to deny a claim for loss incurred or disability (as defined in this policy) commencing after the expiration of such two -year period.

The policy provision in division (B)(1) of this section shall not be so construed as to affect any legal requirements for avoidance of a policy or denial of a claim during such initial two-year period, nor to limit the application of divisions (A), (B), (C), (D), and (E) of section 3923.05 of the Revised Code in the event of misstatement with respect to age, occupation, or other insurance.

A policy which the insured has the right to continue in force subject to its terms by the timely payment of premiums until at least age fifty, or a policy issued after the insured has attained age forty-four and which the insured has the right to continue in force subject to its terms by the timely payment of premiums for at least five years from its date of issue, may contain, in lieu of the foregoing policy provision in division (B)(1) of this section, a provision, from which the clause in parentheses may be omitted at the insurer's option, under the caption Incontestable, as follows: After this policy has been in force for a period of two years during the lifetime of the insured (excluding any period during which the insured is disabled), it shall become incontestable as to the statements
contained in the application.

(2) No claim for loss incurred or disability (as defined in this policy) commencing after two years from the date of issue of this policy shall be reduced or denied on the ground that a disease or physical condition not excluded from coverage by name or specific description effective on the date of loss had existed prior to the effective date of coverage of this policy.

No chronic disease or chronic physical condition may be excluded from the coverage of a policy of sickness insurance or from the sickness insurance coverage of a policy of sickness and accident insurance except by name or specific description.

(C) A provision as follows: Grace period. A grace period of 10 days will be granted for the payment of each premium falling due after the first premium, during which grace period this policy shall continue in force.

The insurer shall insert in the blank space in the policy provision in division (C) of this section a number not smaller than seven for weekly premium policies or ten for monthly premium policies or thirty-one for all other policies.

A policy in which the insurer reserves the right to refuse any renewal shall contain a provision, at the beginning of the policy provision in division (C) of this section, as follows: Unless not less than five days prior to the premium due date the insurer has delivered to the insured or has mailed to the insured’s last address as shown by the records of the insurer written notice of its intention not to renew this policy beyond the period for which the premium has been accepted. Each such policy, other than an accident insurance only policy, shall
provide in substance, in a provision thereof or in an
endorsement thereon or in a rider attached thereto, that the
insurer may not refuse renewal of the policy before the first
anniversary, or between anniversaries, of its date of issue, and
that any non-renewal of the policy by the insurer or insured
shall be without prejudice to any claim originating prior to the
effective date of non-renewal.

(D) A provision as follows: Reinstatement. If any renewal
premium be not paid within the time granted the insured for
payment, a subsequent acceptance of premium by the insurer or by
any agent duly authorized by the insurer to accept such premium,
without requiring in connection therewith an application for
reinstatement, shall reinstate this policy. If the insurer or
such agent requires an application for reinstatement and issues
a conditional receipt for the premium tendered, this policy will
be reinstated upon approval of such application by the insurer
or, lacking such approval, upon the forty-fifth day following
the date of such conditional receipt unless the insurer has
previously notified the insured in writing of its disapproval of
such application. The reinstated policy shall cover only loss
resulting from such accidental injury as may be sustained after
the date of reinstatement and loss due to such sickness as may
begin more than ten days after such date. In all other respects
the insured and insurer shall have the same rights thereunder as
they had under this policy immediately before the due date of
the defaulted premium, subject to any provisions indorsed hereon
or attached hereto in connection with the reinstatement. Any
premium accepted in connection with a reinstatement shall be
applied to a period for which premium has not been previously
paid, but not to any period more than sixty days prior to the
date of reinstatement.
The last sentence of the policy provision in division (D) of this section may be omitted from any policy which the insured has the right to continue in force subject to its terms by the timely payment of premiums until at least age fifty or from any policy issued after the insured has attained age forty-four and which the insured has the right to continue in force subject to its terms by the timely payment of premiums for at least five years from its date of issue.

(E) A provision as follows: Notice of claim. Written notice of claim must be given to the insurer within twenty days after the occurrence or commencement of any loss covered by this policy, or as soon thereafter as is reasonably possible. Notice given by or on behalf of the insured or the beneficiary to the insurer at ........ or to any authorized agent of the insurer, with information sufficient to identify the insured, shall be deemed notice to the insurer.

The insurer shall insert in the blank space in the policy provision in division (E) of this section the location of such office as it may desire to designate for the purpose of notice.

In a policy providing a loss of time benefit which may be payable for at least two years, an insurer may insert, between the first and second sentences of the policy provision in division (E) of this section, a provision as follows:

Subject to the qualifications set forth below, if the insured suffers loss of time on account of disability for which indemnity may be payable for at least two years, the insured shall, at least once in every six months after having given notice of claim, give to the insurer notice of continuance of said disability, except in the event of legal incapacity. The period of six months following any filing of proof by the
insured or any payment by the insurer on account of such claim
or any denial of liability in whole or in part by the insurer
shall be excluded in applying this provision. Delay in giving of
such notice shall not impair the insured’s right to any
indemnity which would otherwise have accrued during the period
of six months preceding the date on which such notice is
actually given.

(F) A provision as follows: Claim forms. The insurer, upon
receipt of a notice of claim, will furnish to the claimant such
forms as are usually furnished by it for filing proofs of loss.
If such forms are not furnished within fifteen days after the
giving of such notice the claimant shall be deemed to have
complied with the requirements of this policy as to proof of
loss upon submitting, within the time fixed in this policy for
filing proofs of loss, written proof covering the occurrence,
the character and the extent of the loss for which claim is
made.

(G) A provision as follows: Proofs of loss. Written proof
of loss must be furnished to the insurer at its office in case
of claim for loss for which this policy provides any periodic
payment contingent upon continuing loss within ninety days after
the termination of the period for which the insurer is liable
and in case of claim for any other loss within ninety days after
the date of such loss. Failure to furnish such proof within the
time required shall not invalidate nor reduce any claim if it
was not reasonably possible to give proof within such time,
provided such proof is furnished as soon as reasonably possible
and in no event, except in the absence of legal capacity, later
than one year from the time proof is otherwise required.

(H) A provision as follows: Time of payment of claims.
Indemnities payable under this policy for any loss, other than loss for which this policy provides any periodic payment, will be paid immediately upon, or within thirty days after, receipt of due written proof of such loss. Subject to due written proof of loss, all accrued indemnities for loss for which this policy provides periodic payment will be paid ....... and any balance remaining unpaid upon the termination of liability will be paid immediately upon receipt of due written proof.

The insurer shall insert in the blank space in the provision in division (H) of this section a period for payment which must not be less frequently than monthly. The insurer may at its option omit from the provision in division (H) of this section ", or within thirty days after,.".

(I) A provision as follows: Payment of claims. Indemnity for loss of life will be payable in accordance with the beneficiary designation and the provisions respecting such payment which may be prescribed herein and effective at the time of payment. If no such designation or provision is then effective, such indemnity shall be payable to the estate of the insured. Any other accrued indemnities unpaid at the insured's death may, at the option of the insurer, be paid either to such beneficiary or to such estate. All other indemnities will be payable to the insured.

The insurer may at its option add at the end of the provision in division (I) of this section, the following provisions or either of the following provisions:

(1) If any indemnity of this policy shall be payable to the estate of the insured, or to an insured or beneficiary who is a minor or otherwise not competent to give a valid release, the insurer may pay such indemnity, up to an amount not
exceeding .......... dollars, to any relative by blood or
connection by marriage of the insured or beneficiary who is
deemed by the insurer to be equitably entitled thereto. Any
payment made by the insurer in good faith pursuant to this
provision shall fully discharge the insurer to the extent of
such payment.

(2) Subject to any written direction of the insured in the
application or otherwise all or a portion of any indemnities
provided by this policy on account of hospital, nursing,
medical, or surgical services may, at the insurer's option and
unless the insured requests otherwise in writing not later than
the time of filing proofs of such loss, be paid directly to the
hospital or person rendering such services; but it is not
required that the services be rendered by a particular hospital
or person.

The insurer shall insert in the blank space in the policy
provision in division [I][I](1) of this section an amount which
shall not exceed one thousand dollars.

(J) A provision as follows: Physical examination and
autopsy. The insurer at its own expense shall have the right and
opportunity to examine the person of the insured when and as
often as it may reasonably require during the pendency of a
claim hereunder and to make an autopsy in case of death where it
is not forbidden by law.

(K) A provision as follows: Legal actions. No action at
law or in equity shall be brought to recover on this policy
prior to the expiration of sixty days after written proof of
loss has been furnished in accordance with the requirements of
this policy. No such action shall be brought after the
expiration of three years after the time written proof of loss


is required to be furnished.

(L) A provision as follows: Change of beneficiary. Unless the insured makes an irrevocable designation of beneficiary, the right to change of beneficiary is reserved to the insured and the consent of the beneficiary or beneficiaries shall not be requisite to surrender or assignment of this policy or to any change of beneficiary or beneficiaries, or to any other changes in this policy.

The insurer may at its option omit from the provision in division (L) of this section the following: Unless the insured makes an irrevocable designation of beneficiary.

(M) A provision, which shall be contained in the policy or in an indorsement thereon or in a rider attached thereto, as follows: Cancellation by the insured. Non-cancellation by the insurer. The insured may cancel this policy at any time by written notice delivered or mailed to the insurer, effective upon receipt or on such later date as may be specified in such notice. In the event of cancellation, the insurer will return promptly the unearned portion of any premium paid. The earned premium shall be computed by the use of the short-rate table last filed with the state official having supervision of insurance in the state where the insured resided when this policy was issued. Cancellation shall be without prejudice to any claim originating prior to the effective date of cancellation. The insurer may not cancel this policy. This provision nullifies any other provision, contained in this policy or in any indorsement hereon or in any rider attached hereto, which provides for cancellation of this policy by the insurer or by the insured.

Sec. 3923.19. (A) Benefits under all policies of sickness
and accident insurance are not liable to attachment or other process, or to be taken, appropriated, or applied by any legal or equitable process or by operation of law, either before or after payment of the benefits, to pay any liabilities of the person insured under any such policy to the extent that the benefits are reasonably necessary for the support of the debtor and any dependents of the debtor.

When a policy provides for a lump sum payment because of a dismemberment or other loss insured, the payment is exempt from execution by the insured's creditors.

(B)(1) A payment under a stock bonus, pension, profit-sharing, profit-sharing, annuity, or similar plan or contract on account of illness, disability, death, age, or length of service, to the extent reasonably necessary for the support of the person who is the beneficiary of the plan or party to the contract and any dependents of the person, is not liable to attachment or other process, or to be taken, appropriated, or applied by any legal or equitable process or by operation of law, either before or after payment of the benefits, to pay any liabilities of the person unless all of the following apply:

(a) The plan or contract was established by or under the auspices of an insider that employed the person at the time the person's rights under the plan or contract arose.

(b) The payment is on account of age or length of service.

(c) The plan or contract does not qualify under section 401(a), 403(a), 403(b), or 408 of the Internal Revenue Code of 1986, 100 Stat. 2085, 26 U.S.C. 1, as amended.

(2) When a plan or contract provides for a lump sum
payment because of a dismemberment or other loss covered by the plan or contract, the payment is exempt from execution by the person's creditors.

**Sec. 3923.38.** (A) As used in this section:

(1) "Group policy" includes any group sickness and accident policy or contract delivered, issued for delivery, or renewed in this state on or after June 28, 1984, and any private or public employer self-insurance plan or other plan that provides, or provides payment for, health care benefits for employees resident in this state other than through an insurer or health insuring corporation, to which both of the following apply:

(a) The policy insures employees for hospital, surgical, or major medical insurance on an expense incurred or service basis, other than for specified diseases or for accidental injuries only.

(b) The policy is in effect and covers an eligible employee at the time the employee's employment is terminated.

(2) "Eligible employee" includes only an employee to whom all of the following apply:

(a) The employee has been continuously insured under a group policy or under the policy and any prior similar group coverage replaced by the policy, during the entire three-month period preceding the termination of the employee's employment.

(b) The employee did not voluntarily terminate the employee's employment and the termination of employment is not a result of any gross misconduct on the part of the employee.

(c) The employee is not, and does not become, covered by
or eligible for coverage by medicare under Title XVIII of the Social Security Act, as amended.

(d) The employee is not, and does not become, covered by or eligible for coverage by any other insured or uninsured arrangement that provides hospital, surgical, or medical coverage for individuals in a group and under which the person was not covered immediately prior to such termination. A person eligible for continuation of coverage under this section, who is also eligible for coverage under section 3923.123 of the Revised Code, may elect either coverage, but not both. A person who elects continuation of coverage may elect any coverage available under section 3923.123 of the Revised Code upon the termination of the continuation of coverage.

(3) "Group rate" means, in the case of an employer self-insurance or other health benefits plan, the average monthly cost per employee, over a period of at least twelve months, of the operation of the plan that would represent a group insurance rate if the same coverage had been provided under a group sickness and accident insurance policy.

(B) A group policy shall provide that any eligible employee may continue the employee's hospital, surgical, and medical insurance under the policy, for the employee and the employee's eligible dependents, for a period of twelve months after the date that the insurance coverage would otherwise terminate by reason of the termination of the employee's employment. Each certificate of coverage, or other notice of coverage, issued to employees under the policy shall include a notice of the employee's privilege of continuation.

(C) All of the following apply to the continuation of coverage required under division (B) of this section:
(1) Continuation need not include dental, vision care, or any other benefits provided under the policy in addition to its hospital, surgical, or major medical benefits.

(2) The employer shall notify the employee of the right of continuation at the time the employer notifies the employee of the termination of employment. The notice shall inform the employee of the amount of contribution required by the employer under division (C)(4) of this section.

(3) The employee shall file a written election of continuation with the employer and pay the employer the first contribution required under division (C)(4) of this section. The request and payment must be received by the employer no later than the earlier of any of the following dates:

(a) Thirty-one days after the date on which the employee's coverage would otherwise terminate;

(b) Ten days after the date on which the employee's coverage would otherwise terminate, if the employer has notified the employee of the right of continuation prior to such date;

(c) Ten days after the employer notifies the employee of the right of continuation, if the notice is given after the date on which the employee's coverage would otherwise terminate.

(4) The employee must pay to the employer, on a monthly basis, in advance, the amount of contribution required by the employer. The amount required shall not exceed the group rate for the insurance being continued under the policy on the due date of each payment.

(5) The employee's privilege to continue coverage and the coverage under any continuation ceases if any of the following occurs:
(a) The employee ceases to be an eligible employee under division (A)(2)(c) or (d) of this section;

(b) A period of twelve months expires after the date that the employee's insurance under the policy would otherwise have terminated because of the termination of employment;

(c) The employee fails to make a timely payment of a required contribution, in which event the coverage shall cease at the end of the coverage for which contributions were made;

(d) The policy is terminated, or the employer terminates participation under the policy, unless the employer replaces the coverage by similar coverage under another group policy or other group health arrangement.

If the employer replaces the policy with similar group health coverage, all of the following apply:

(i) The member shall be covered under the replacement coverage, for the balance of the period that the member would have remained covered under the terminated coverage if it had not been terminated.

(ii) The minimum level of benefits under the replacement coverage shall be the applicable level of benefits of the policy replaced reduced by any benefits payable under the policy replaced.

(iii) The policy replaced shall continue to provide benefits to the extent of its accrued liabilities and extensions of benefits as if the replacement had not occurred.

(D) This section does not apply to an employer's self-insurance plan if federal law supersedes, preempts, prohibits, or otherwise precludes its application to such plans.
(E) An employer shall notify the insurer if the employee elects continuation of coverage under this section. The insurer may require the employer to provide documentation if the employee elects continuation of coverage and is seeking premium assistance for the continuation of coverage under the "American Recovery and Investment Act of 2009," Pub. L. No. 111-5, 123 Stat. 115. The director of insurance shall publish guidance for employers and insurers regarding the contents of such documentation.

Sec. 3923.39. (A) As used in this section:

(1) "Consolidated corporation" means any mutual insurance company that merged or consolidated with a hospital service association.

(2) "Individual policy" means a policy other than a policy issued pursuant to section 3923.11, 3923.12, or 3923.13 of the Revised Code.

(3) "Individual policyholder" means a person who is an insured under an individual policy.

(4) "Cancel" means any cancellation, denial of renewal, lapse, or other termination of coverage of an individual policyholder of a consolidated corporation on the ground of nonpayment of a policy payment.

(5) "Notice of cancellation" means a notice by a consolidated corporation of an intention to cancel an individual policy on the ground of nonpayment of a policy payment.

(6) "Extenuating circumstances" means circumstances that excuse an individual policyholder's failure to pay a policy payment after the mailing of a notice of cancellation under this section and include, but are not limited to, any of the...
following:

(a) Hospitalization;

(b) Incapacity or incompetency;

(c) Continuous absence from the address to which the notice was addressed for a period of time, including the date on which the notice was delivered to the address, of not more than sixty days from the date on which the notice was mailed.

(7) "Medicare supplement policy" has the same meaning as in section 3923.33 of the Revised Code.

(B) If a consolidated corporation does not receive a policy payment due from a policyholder on an individual policy on or before the due date shown on a billing mailed to the policyholder, the consolidated corporation may cancel the policyholder's coverage by mailing a notice of cancellation to the policyholder at his last known address.

No cancellation for nonpayment of a policy payment shall take effect until not less than fifteen days have passed since the date of mailing of a notice of cancellation.

An individual policyholder whose coverage is terminated for nonpayment may apply for reinstatement of coverage within sixty days after the date the notice of cancellation is mailed. The consolidated corporation shall reinstate the coverage, continuous from the date of cancellation, if it determines that the policyholder's failure to pay was due to extenuating circumstances, and the policyholder pays the payment required for reinstatement of coverage. A consolidated corporation shall establish an appeals procedure that will enable the policyholder to present the reasons why the consolidated corporation should reconsider the cancellation and reinstate the coverage.
The notice of cancellation shall advise the policyholder of the policyholder's rights to appeal the cancellation of coverage and of the amount of payment that will be required to reinstate the coverage.

(C) No individual policyholder of a consolidated corporation shall be billed either by a hospital or the consolidated corporation for rendered health care services adjudged unnecessary by a utilization review mechanism recognized by the consolidated corporation or the hospital, provided such individual policyholder has acted in good faith. The contract between the consolidated corporation and the hospital may specify the conditions under which the consolidated corporation or the hospital shall sustain the loss of revenue.

(D) Notwithstanding the provisions of section 3941.47 of the Revised Code, a medicare supplement policy issued or renewed by a consolidated corporation to an individual policyholder may not provide for the denial or reduction of benefits under such policy when services are provided at or by a hospital which does not have a contractual relationship with such consolidated corporation.

Sec. 3923.53. (A) Every public employee benefit plan that is established or modified in this state shall provide benefits for the expenses of both of the following:

(1) Screening mammography to detect the presence of breast cancer in adult women;

(2) Cytologic screening for the presence of cervical cancer.

(B) The benefits provided under division (A)(1) of this section shall cover expenses in accordance with all of the
following:

(1) If a woman is at least thirty-five years of age but under forty years of age, one screening mammography;

(2) If a woman is at least forty years of age but under fifty years of age, either of the following:
   (a) One screening mammography every two years;
   (b) If a licensed physician has determined that the woman has risk factors to breast cancer, one screening mammography every year.

(3) If a woman is at least fifty years of age but under sixty-five years of age, one screening mammography every year.

(C) As used in this division, "medicare reimbursement rate" means the reimbursement rate paid in this state under the medicare program for screening mammography that does not include digitization or computer-aided detection, regardless of whether the actual benefit includes digitization or computer-aided detection.

(1) Subject to divisions (C)(2) and (3) of this section, if a provider, hospital, or other health care facility provides a service that is a component of the screening mammography benefit in division (B)(A)(1) of this section and submits a separate claim for that component, a separate payment shall be made to the provider, hospital, or other health care facility in an amount that corresponds to the ratio paid by medicare in this state for that component.

(2) Regardless of whether separate payments are made for the benefit provided under division (A)(1) of this section, the total benefit for a screening mammography shall not exceed one
hundred thirty per cent of the medicare reimbursement rate in this state for screening mammography. If there is more than one medicare reimbursement rate in this state for screening mammography or a component of a screening mammography, the reimbursement limit shall be one hundred thirty per cent of the lowest medicare reimbursement rate in this state.

(3) The benefit paid in accordance with division (C)(1) of this section shall constitute full payment. No provider, hospital, or other health care facility shall seek or receive compensation in excess of the payment made in accordance with division (C)(1) of this section, except for approved deductibles and copayments.

(D) The benefits provided under division (A)(1) of this section shall be provided only for screening mammographies that are performed in a facility or mobile mammography screening unit that is accredited under the American college of radiology mammography accreditation program or in a hospital as defined in section 3727.01 of the Revised Code.

(E) The benefits provided under division (A)(2) of this section shall be provided only for cytologic screenings that are processed and interpreted in a laboratory certified by the college of American pathologists or in a hospital as defined in section 3727.01 of the Revised Code.

Sec. 3923.55. (A) As used in this section and section 3923.56 of the Revised Code:

(1) "Child health supervision services" means periodic review of a child's physical and emotional status performed by a physician, by a health care professional under the supervision of a physician, or, in the case of hearing screening, by an
individual acting in accordance with section 3701.505 of the Revised Code.

(2) "Periodic review" means a review performed in accordance with the recommendations of the American academy of pediatrics and includes a history, complete physical examination, developmental assessment, anticipatory guidance, appropriate immunizations, and laboratory tests.

(3) "Physician" means a person authorized under Chapter 4731. of the Revised Code to practice medicine and surgery or osteopathic medicine and surgery.

(B) Notwithstanding section 3901.71 of the Revised Code, each policy of individual or group sickness and accident insurance delivered, issued for delivery, or renewed in this state on or after the effective date of this amendment November 24, 1995, that provides coverage for family members of the insured shall provide, with respect to that coverage, that any benefits applicable for children shall include benefits for child health supervision services from the moment of birth until age nine.

(C) A policy that provides the benefits described in division (B) of this section may limit the benefits to cover only the expenses of child health supervision services that are performed by one physician or by a health care professional under the supervision of one physician during the course of any one visit.

(D) Copayments and deductibles shall be reasonable and shall not be a barrier to the necessary utilization of child health supervision services by covered persons.

(E) Benefits for child health supervision services that
are provided to a child during the period from birth to age one shall not exceed a maximum limit of five hundred dollars, including benefits for the hearing screening required by the program established under section 3701.504 of the Revised Code. The benefits for the hearing screening shall not exceed a maximum limit of seventy-five dollars. Benefits for child health supervision services that are provided to a child during any year thereafter shall not exceed a maximum limit of one hundred fifty dollars per year.

(F) This section does not apply to any policy that provides coverage for specific diseases or accidents only, or to any hospital indemnity, medicare supplement, or other policy that offers only supplemental benefits.

Sec. 3923.56. (A) Notwithstanding section 3901.71 of the Revised Code, each employee benefit plan established or maintained in this state on or after the effective date of this amendment November 24, 1995, that provides coverage for family members of the employee shall provide, with respect to that coverage, that any benefits applicable for children shall include benefits for child health supervision services from the moment of birth until age nine.

(B) A plan that provides the benefits described in division (A) of this section may limit the benefits to cover only the expenses of child health supervision services that are performed by one physician or by a health care professional under the supervision of one physician during the course of any one visit.

(C) Copayments and deductibles shall be reasonable and shall not be a barrier to the necessary utilization of child health supervision services by covered persons.
(D) Benefits for child health supervision services that are provided to a child during the period from birth to age one shall not exceed a maximum limit of five hundred dollars, including benefits for the hearing screening required by the program established under section 3701.504 of the Revised Code. The benefits for the hearing screening shall not exceed a maximum limit of seventy-five dollars. Benefits for child health supervision services that are provided to a child during any year thereafter shall not exceed a maximum limit of one hundred fifty dollars per year.

Sec. 3923.60. (A) Notwithstanding section 3901.71 of the Revised Code, no group or individual policy of sickness and accident insurance that provides coverage for prescription drugs shall limit or exclude coverage for any drug approved by the United States food and drug administration on the basis that the drug has not been approved by the United States food and drug administration for the treatment of the particular indication for which the drug has been prescribed, provided the drug has been recognized as safe and effective for treatment of that indication in one or more of the standard medical reference compendia adopted by the United States department of health and human services under 42 U.S.C. 1395x(t)(2), as amended, or in medical literature that meets the criteria specified in division (B) of this section.

(B) Medical literature may be accepted for purposes of division (A) of this section only if all of the following apply:

(1) Two articles from major peer-reviewed professional medical journals have recognized, based on scientific or medical criteria, the drug's safety and effectiveness for treatment of the indication for which it has been prescribed;
(2) No article from a major peer-reviewed professional medical journal has concluded, based on scientific or medical criteria, that the drug is unsafe or ineffective or that the drug's safety and effectiveness cannot be determined for the treatment of the indication for which it has been prescribed;

(3) Each article meets the uniform requirements for manuscripts submitted to biomedical journals established by the international committee of medical journal editors or is published in a journal specified by the United States department of health and human services pursuant to section 1861(t)(2)(B) of the "Social Security Act," 107 Stat. 591 (1993), 42 U.S.C. 1395x(t)(2)(B), as amended, as acceptable peer-reviewed medical literature.

(C) Coverage of a drug required by division (A) of this section includes medically necessary services associated with the administration of the drug.

(D) Division (A) of this section shall not be construed to do any of the following:

(1) Require coverage for any drug if the United States food and drug administration has determined its use to be contraindicated for the treatment of the particular indication for which the drug has been prescribed;

(2) Require coverage for experimental drugs not approved for any indication by the United States food and drug administration;

(3) Alter any law with regard to provisions limiting the coverage of drugs that have not been approved by the United States food and drug administration;

(4) Require reimbursement or coverage for any drug not
included in the drug formulary or list of covered drugs specified in a policy of sickness and accident insurance;

(5) Prohibit a policy of sickness and accident insurance from limiting or excluding coverage of a drug, provided that the decision to limit or exclude coverage of the drug is not based primarily on the coverage of drugs required by this section.

(E) This section, as amended, applies only to policies of sickness and accident insurance that are described in division (A) of this section and that are delivered, issued for delivery, or renewed in this state on or after the effective date of this amendment December 26, 2011.

Sec. 3923.65. (A) As used in this section:

(1) "Emergency medical condition" means a medical condition that manifests itself by such acute symptoms of sufficient severity, including severe pain, that a prudent layperson with average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in any of the following:

(a) Placing the health of the individual or, with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy;

(b) Serious impairment to bodily functions;

(c) Serious dysfunction of any bodily organ or part.

(2) "Emergency services" means the following:

(a) A medical screening examination, as required by federal law, that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department, to evaluate an emergency
medical condition;

(b) Such further medical examination and treatment that are required by federal law to stabilize an emergency medical condition and are within the capabilities of the staff and facilities available at the hospital, including any trauma and burn center of the hospital.

(B) Every individual or group policy of sickness and accident insurance that provides hospital, surgical, or medical expense coverage shall cover emergency services without regard to the day or time the emergency services are rendered or to whether the policyholder, the hospital's emergency department where the services are rendered, or an emergency physician treating the policyholder, obtained prior authorization for the emergency services.

(C) Every individual policy or certificate furnished by an insurer in connection with any sickness and accident insurance policy shall provide information regarding the following:

(1) The scope of coverage for emergency services;

(2) The appropriate use of emergency services, including the use of the 9-1-1 system and any other telephone access systems utilized to access prehospital emergency services;

(3) Any copayments for emergency services.

(D) This section does not apply to any individual or group policy of sickness and accident insurance covering only accident, credit, dental, disability income, long-term care, hospital indemnity, medicare supplement, medicare, tricare, specified disease, or vision care; coverage under a one-time limited-duration policy that is less than twelve months; coverage issued as a supplement to liability insurance;
insurance arising out of workers' compensation or similar law; automobile medical payment insurance; or insurance under which benefits are payable with or without regard to fault and which is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.

Sec. 3923.82. (A) As used in this section, "health benefit plan" has the same meaning as in section 3924.01 of the Revised Code.

(B) Notwithstanding section 3901.71 of the Revised Code, no health benefit plan or public employee benefit plan shall contain a provision that limits or excludes an insured's coverage under the plan for a loss or expense the insured sustains that is the result of the insured's use of alcohol or other drugs or both and the loss or expense is otherwise covered under the plan.

(C) Nothing in this section shall be construed as doing either of the following:

(1) Requiring coverage for the treatment of alcohol or substance abuse except as otherwise required by law;

(2) Prohibiting the enforcement of an exclusion based on injuries sustained by an insured during the commission of an offense by the insured in which the insured is convicted of or pleads guilty or no contest to a felony.

(D) Not later than four years after the effective date of this section April 7, 2009, the department of insurance shall conduct an analysis of the impact of the requirements of this section on the cost of and coverage provided by health benefit plans in this state and prepare a written report of its findings from the analysis. The department shall submit the report to the
governor and, in accordance with section 101.68 of the Revised Code, to the general assembly.

**Sec. 3923.85.** (A) As used in this section, "cost sharing" means the cost to an individual insured under an individual or group policy of sickness and accident insurance or a public employee benefit plan according to any coverage limit, copayment, coinsurance, deductible, or other out-of-pocket expense requirements imposed by the policy or plan.

(B) Notwithstanding section 3901.71 of the Revised Code and subject to division (D) of this section, no individual or group policy of sickness and accident insurance that is delivered, issued for delivery, or renewed in this state and no public employee benefit plan that is established or modified in this state shall fail to comply with either of the following:

(1) The policy or plan shall not provide coverage or impose cost sharing for a prescribed, orally administered cancer medication on a less favorable basis than the coverage it provides or cost sharing it imposes for intravenously administered or injected cancer medications.

(2) The policy or plan shall not comply with division (B) (1) of this section by imposing an increase in cost sharing solely for orally administered, intravenously administered, or injected cancer medications.

(C) Notwithstanding any provision of this section to the contrary, a policy or plan shall be deemed to be in compliance with this section if the cost sharing imposed under such a policy or plan for orally administered cancer treatments does not exceed one hundred dollars per prescription fill. The cost sharing limit of one hundred dollars per prescription fill shall
apply to a high deductible plan, as defined in 26 U.S.C. 223, or a catastrophic plan, as defined in 42 U.S.C. 18022, only after the deductible has been met.

(D)(1) The prohibitions in division (B) of this section do not preclude an individual or group policy of sickness and accident insurance or public employee benefit plan from requiring an insured or plan member to obtain prior authorization before orally administered cancer medication is dispensed to the insured or plan member.

(2) Division (B) of this section does not apply to the offer or renewal of any individual or group policy of sickness and accident insurance that provides coverage for specific diseases or accidents only, or to any hospital indemnity, medicare supplement, disability income, or other policy that offers only supplemental benefits.

(E) An insurer that offers any sickness and accident insurance or any public employee benefit plan that offers coverage for basic health care services is not required to comply with division (B) of this section if all of the following apply:

(1) The insurer or plan submits documentation certified by an independent member of the American academy of actuaries to the superintendent of insurance showing that compliance with division (B)(1) of this section for a period of at least six months independently caused the insurer or plan’s costs for claims and administrative expenses for the coverage of basic health care services to increase by more than one per cent per year.

(2) The insurer or plan submits a signed letter from an
independent member of the American academy of actuaries to the superintendent of insurance opining that the increase in costs described in division (E)(1) of this section could reasonably justify an increase of more than one per cent in the annual premiums or rates charged by the insurer or plan for the coverage of basic health care services.

(3)(a) The superintendent of insurance makes the following determinations from the documentation and opinion submitted pursuant to divisions (E)(1) and (2) of this section:

(i) Compliance with division (B)(1) of this section for a period of at least six months independently caused the insurer or plan's costs for claims and administrative expenses for the coverage of basic health care services to increase more than one per cent per year.

(ii) The increase in costs reasonably justifies an increase of more than one per cent in the annual premiums or rates charged by the insurer or plan for the coverage of basic health care services.

(b) Any determination made by the superintendent under division (E)(3) of this section is subject to Chapter 119. of the Revised Code.

Sec. 3925.09. No insurance company shall own more than one fourth of the capital stock of a national bank, nor invest in or loan on the stocks and bonds, both included, of any railroad company, to an extent exceeding one fifth of its own capital and surplus, nor in the aggregate shall the investment in and loan on all railroad property exceed one fourth of its own capital and surplus. Not more than one half of its capital and surplus shall be loaned on mortgages of real estate, as provided in
sections section 3925.05 of the Revised Code for the investment thereof, and not more than one tenth of the capital and surplus actually existing of such a company shall be invested in a single mortgage. The current market value of the evidences of indebtedness mentioned in this section, in which the accumulations or surplus money above the capital stock of an insurance company may be loaned or invested, must be at all times during the continuance of the loans at least twenty per cent more than the sum loaned thereon.

Sec. 3927.08. Every insurance company other than a life insurance company, organized by act of congress or under the laws of another state or government, annually, at the time and in the form and manner required of similar companies organized under the laws of this state, shall file a statement of its condition and affairs in the office of the superintendent of insurance. A company organized under or incorporated by a foreign government shall also furnish a supplementary statement for the year ending on the preceding thirty-first day of December, verified by the oath of the manager of such company residing in the United States, which shall comprise a report of its business and affairs in the United States, as required from companies organized in this state, together with any other information that may be required by the superintendent. If such annual statement is satisfactory evidence to the superintendent of the solvency and ability of the company to meet all its engagements at maturity, and that the deposit is maintained as provided by section 3927.06 of the Revised Code, the superintendent shall issue, during the month of January in each year or within sixty days thereafter, renewal certificates of authority to the agent agents of the company, certified copies of which shall be filed in the county recorder's office of each
county in which an agency is located and retained therewith for
a minimum of two years from the date of filing. Such
certificates shall be the authority for such agents to issue new
policies in this state for the ensuing year.

Sec. 3929.011. (A)(1) As a condition of the issuance of a
certificate of authority to transact in this state any of the
kinds of insurance set forth in divisions (A)(1) to (4), (6),
(7), (10) to (13), (16), (17), (18), and (21) to (24) of section
3929.01 of the Revised Code, each stock insurance company shall
have and maintain capital and surplus in the aggregate amount of
not less than two million five hundred thousand dollars, which
amount shall include paid-in-capital of not less than one
million dollars and contributed surplus of not less than one
million dollars.

(2) As a condition of the issuance of a certificate of
authority to transact in this state any of the kinds of
insurance set forth in divisions (A)(1) to (4), (6), (7), (10)
to (13), (16), (17), (18), and (21) to (24) of section 3929.01
of the Revised Code, each insurance company other than a stock
insurance company shall have and maintain surplus in the total
amount of not less than two million five hundred thousand
dollars.

(B)(1) As a condition of the issuance of a certificate of
authority to transact in this state any of the kinds of
insurance set forth in divisions (A)(5), (8), (9), (14), (15),
(19), (20), and (26) of section 3929.01 of the Revised Code,
each stock insurance company shall have and maintain capital and
surplus in the aggregate amount of not less than five million
dollars, which amount shall include paid-in-capital of not less
than one million dollars and contributed surplus of not less
than one million dollars.

(2) As a condition of the issuance of a certificate of authority to transact in this state any of the kinds of insurance set forth in divisions (A)(5), (8), (9), (14), (15), (19), (20), and (26) of section 3929.01 of the Revised Code, each insurance company other than a stock insurance company shall have and maintain surplus in the total amount of not less than five million dollars.

(C)(1) As a condition of the issuance of a certificate of authority to transact in this state the kind of insurance described in division (A)(25) of section 3929.01 of the Revised Code, each stock insurance company shall have and maintain capital and surplus in the aggregate amount of not less than ten million dollars, which amount shall include paid-in-capital of not less than one million dollars and contributed surplus of not less than one million dollars.

(2) As a condition of the issuance of a certificate of authority to transact in this state the kind of insurance described in division (A)(25) of section 3929.01 of the Revised Code, each insurance company other than a stock insurance company shall have and maintain surplus in the total amount of not less than ten million dollars.

(D)(1) As a condition of the issuance of a certificate of authority to transact the business of insurance in this state, each stock insurance company that assumes reinsurance and transacts any of the kinds of insurance set forth in division (A) of section 3929.01 of the Revised Code shall have and maintain capital and surplus in the aggregate amount of not less than ten million dollars, which amount shall include paid-in-capital of not less than one million dollars and contributed surplus of not less than one million dollars.
surplus of not less than one million dollars.

(2) As a condition of the issuance of a certificate of authority to transact the business of insurance in this state, each insurance company other than a stock insurance company that assumes reinsurance and transacts any of the kinds of insurance set forth in division (A) of section 3929.01 of the Revised Code shall have and maintain surplus in the total amount of not less than ten million dollars.

(3) Divisions (D)(1) and (2) of this section do not apply to any insurance company that transacts any of the kinds of insurance set forth in division (A) of section 3929.01 of the Revised Code and that assumes reinsurance only under any of the following circumstances:

(a) Pursuant to a pooling arrangement among members of the same insurance holding company system;

(b) Pursuant to a requirement of any law, rule, or regulation;

(c) If, as of the immediately preceding thirty-first day of December, the aggregate amount of assumed premiums, except those with respect to reinsurance assumed under division (D)(3) (a) or (b) of this section, for that calendar year is less than five hundred thousand dollars.

(E)(1) Except as provided in divisions (E)(2) and (3) of this section, as a condition of the renewal of its certificate of authority to transact in this state any of the kinds of insurance set forth in division (A) of section 3929.01 of the Revised Code, each mutual fire insurance association that, prior to the effective date of this section August 8, 1991, reorganized as a mutual fire insurance company pursuant to
section 3939.10 of the Revised Code shall have and maintain surplus in the total amount of not less than two million five hundred thousand dollars.

(2) If such a company attains the applicable total surplus required under division (B)(2), (C)(2), or (D)(2) of this section, the company, as a condition of the renewal of its certificate of authority to transact that kind of insurance in this state, shall continue to have and maintain the total surplus set forth in that division.

(3) If, as a result of any of the actions described in division (B)(1) of section 3901.321 of the Revised Code, control of such a company is obtained by another person, the company, as a condition of the renewal of its certificate of authority under division (B)(2), (C)(2), or (D)(2) of this section, shall have and maintain the total surplus set forth in that division of this section.

(F) This section applies only to the issuance or renewal of certificates of authority to transact the business of insurance in this state on or after the effective date of this section August 8, 1991.

Sec. 3929.04. In case of the death of any employee by reason of the wrongful or negligent acts of his employer, or negligence or wrongful acts for which said employer is liable, the personal representative of the deceased employee has all the rights and remedies that the employee would have had under section 3929.03 of the Revised Code had death not resulted.

Sec. 3930.10. There shall be no liability imposed on the part of and no cause of action of any nature arises against the
Ohio commercial insurance joint underwriting association, its members, board of governors, agents, or employees, an insurer or its employees, any licensed agent or broker, or the superintendent of insurance or the superintendent's authorized representatives, their members or employees, for any action taken by them in the performance of their powers and duties under sections 3930.03 to 3930.17 of the Revised Code. Any reports and communications in connection therewith are not public records.

Sec. 3931.02. Every attorney under section 3931.01 of the Revised Code shall pay to the superintendent of insurance for the use of the state the following fees:

(A) For filing declaration, twenty-five dollars;

(B) For filing each financial statement required by sections 3931.01 to 3931.13, inclusive, 3931.12 of the Revised Code, twenty dollars;

(C) For filing each certificate of license, and certified copy thereof, two dollars;

(D) For each copy of a paper filed in the superintendent's office, twenty cents per folio;

(E) For affixing the seal of office and certifying any paper, one dollar.

Sec. 3931.03. The attorney under section 3931.01 of the Revised Code shall file with the superintendent of insurance a declaration, verified by the attorney's oath, or, when the attorney is a corporation, by the oath of its authorized officers, setting forth:

(A) The name of the attorney and the name or designation
under which such contracts are issued, which name or designation shall not be so similar to any other name or designation previously adopted by an attorney, or by any insurance organization in the United States, prior to the adoption of such name or designation by the attorney, as to confuse or deceive, unless such other attorney or organization consents thereto in writing;

(B) The location of the principal office;

(C) The kind of insurance to be effected;

(D) A copy of each form of policy, contract, or agreement under or by which such insurance is to be effected;

(E) A copy of the form of power of attorney under which such insurance is to be effected;

(F) The fact that applications have been made for indemnity upon at least seventy-five separate risks, aggregating not less than one and one-half million dollars, represented by executed contracts or bona fide applications to become concurrently effective;

(G) The fact that there is in the possession of such attorney net assets of not less than three hundred thousand dollars, available for the payment of losses;

(H) A financial statement in the form prescribed for the annual statement;

(I) The instrument authorizing service of process as provided for in section 3931.04 of the Revised Code;

(J) A certificate showing compliance with the deposit requirements, if any, applicable to a mutual insurance company authorized to do the kind or kinds of insurance to be effected;
(K) A copy of all bylaws, codes of regulations, any other document wherein the relationships between the subscribers and between the subscribers and the attorney are set forth, and any amendments to any of the foregoing. Any filing made pursuant to this division shall become effective thirty days from the date of filing, unless disapproved by the superintendent. Any action taken by the superintendent under this division may be appealed pursuant to Chapter 119 of the Revised Code.

This division does not apply to filings required pursuant to Chapters 3935. and 3937. of the Revised Code.

Sec. 3931.99. (A) Whoever violates sections 3931.01 to 3931.12, inclusive, of the Revised Code, or fails to comply with any duty imposed upon him by such sections, for which violation or failure no penalty is otherwise provided by law, shall be fined not more than five hundred dollars.

Sec. 3933.01. No corporation, association, or partnership engaged in this state in the guaranty, bonding, surety, or insurance business, other than life insurance, nor any officer, agent, solicitor, employee, or representative thereof, shall pay, allow, or give, or offer to pay, allow, or give, directly or indirectly, as inducements to insurance, and no person shall knowingly receive as an inducement to insurance, any rebate or premium payable on the policy, or any special favor or advantage in the dividends or other benefits to accrue thereon, or any paid employment or contract for services of any kind, or any special advantage in the date of the policy or date of its issue, or any valuable consideration or inducement not plainly specified in the policy or contract of insurance or agreement of indemnity, or give, receive, sell, or purchase, or offer to give, receive, sell, or purchase, as inducements to insurance or
in connection therewith, any stock, bonds, or other obligations of an insurance company or other corporation, association, partnership, or individual.

Sections 3933.01 to 3933.03, inclusive, of the Revised Code do not prevent the payment to an authorized officer, agent, or solicitor of such company, association, or partnership of commissions at customary rates on policies or contracts of insurance effected through him the officer, agent, or solicitor by which he himself the officer, agent, or solicitor is insured, provided such officer, agent, or solicitor holds himself self out as such and has been engaged in such business in good faith for a period of six months prior to any such payment. Such sections do not prohibit a mutual fire insurance company from paying dividends to policyholders at any time after such dividends have been earned.

Sec. 3933.02. No person shall be excused from attending, testifying, or producing any books, papers, or other documents before any court or magistrate having jurisdiction, upon any investigation, proceeding, or trial for a violation of any of sections 3933.01 to 3933.03, inclusive, of the Revised Code, upon the ground that the testimony of evidence, documentary or otherwise, required of him the person may tend to incriminate or degrade him the person. No person shall be prosecuted or subject to any penalty or forfeiture on account of any transaction, matter, or thing concerning which he the person may so testify or produce evidence, documentary or otherwise, except for perjury committed in so testifying.

Sec. 3935.06. A corporation, an unincorporated association, a partnership, or an individual, whether located within or outside this state, may make application to the
superintendent of insurance for license as a rating bureau for such kinds of insurance, or subdivision or class of risk or a part or combination thereof, as are specified in its application and shall file the following therewith:

(A) A copy of its constitution, of its articles of agreement or association or its certificate of incorporation, and of its bylaws, rules, and regulations governing the conduct of its business;

(B) A list of its members and subscribers;

(C) The name and address of a resident of this state upon whom notices or orders of the superintendent, or process affecting such rating bureau, may be served;

(D) A statement of its qualifications as a rating bureau.

If the superintendent finds that the applicant is competent, trustworthy, and otherwise qualified to act as a rating bureau and that its constitution, its articles of agreement or association or certificate of conduct of its business conform to the law, the superintendent shall issue a license specifying the kinds of insurance, or subdivision or class of risk or part or combination thereof, for which the applicant is authorized to act as a rating bureau. Every such application shall be granted or denied in whole or in part by the superintendent within sixty days of the date of its filing with the superintendent. Licenses issued pursuant to this section shall remain in effect for three years unless sooner suspended or revoked by the superintendent. The fee for said license shall be twenty-five dollars. Licenses issued pursuant to this section may be suspended or revoked by the superintendent, after hearing upon notice, in the event the
rating bureau ceases to comply with this division. Every rating bureau shall notify the superintendent promptly of every change in any of the items described in divisions (A), (B), and (C) of this section.

Subject to rules and regulations which have been approved by the superintendent as reasonable, each rating bureau shall permit any insurer, not a member, to be a subscriber to its rating services for any kind of insurance, or subdivision or class of risk or a part or combination thereof, for which it is authorized to act as a rating bureau. Notice of proposed changes in such rules and regulations shall be given to subscribers. Each rating bureau shall furnish its rating services without discrimination to its members and subscribers. The reasonableness of any rule or regulation in its application to subscribers, or the refusal of any rating bureau to admit an insurer as a subscriber, shall at the request of any subscriber or any such insurer, be reviewed by the superintendent at a hearing held upon at least ten days' written notice to such rating bureau and to such subscriber or insurer. If the superintendent finds that such rule or regulation is unreasonable in its application to subscribers, the superintendent shall order that such rule or regulation is not applicable to subscribers. If the rating bureau fails to grant or reject an insurer's application for subscribership within thirty days after it was made, the insurer may request a review by the superintendent as if the application had been rejected. If the superintendent finds that the insurer has been refused admittance to the rating bureau as a subscriber without justification, the superintendent shall order the rating bureau to admit the insurer as a subscriber. If the superintendent finds that the action of the rating bureau was
justified, the superintendent shall make an order affirming its action.

No rating bureau shall adopt any rule which would prohibit or regulate the payment of dividends, savings, or unabsorbed premium deposits allowed or returned by insurers to their policyholders, members, or subscribers.

Co-operation among rating bureaus, or among rating bureaus and insurers, in rate making or in other matters covered by sections 3935.01 to 3935.17, inclusive, of the Revised Code, is authorized, provided the filings resulting from such co-operation are subject to all such sections which are applicable to filings generally. The superintendent may review such co-operative activities and practices and if, after a hearing, the superintendent finds that any such activity or practice is unfair, unreasonable, or otherwise inconsistent with such sections, the superintendent may issue a written order specifying in what respects such activity or practice is unfair, unreasonable, or otherwise inconsistent, and requiring the discontinuance of such activity or practice.

Any rating bureau may provide for the examination of policies, daily reports, binders, renewal certificates, indorsements, or other evidences of insurance, or the cancellation thereof, and may make reasonable rules governing their submission. Such rules shall contain a provision that, in the event any insurer does not within sixty days furnish satisfactory evidence to the rating bureau of the correction of any error or omission previously called to its attention by such rating bureau, the rating bureau shall notify the superintendent thereof. All information submitted for such examination shall be confidential.
Any rating bureau may subscribe for or purchase actuarial, technical, or other services, and such services shall be available to all members and subscribers without discrimination.

Sec. 3935.10. The superintendent of insurance shall promulgate rules and statistical plans, reasonably adopted to each of the rating systems on file with him, which may be modified from time to time and which shall be used thereafter by each insurer in the recording and reporting of its loss and country-wide expense experience, in order that the experience of all insurers may be made available at least annually in such form and detail as is necessary to aid the superintendent in determining whether rating systems comply with the standards set forth in section 3935.03 of the Revised Code. Such rules and plans may also provide for the recording and reporting of expense experience items which are specially applicable to this state and which are not susceptible of determination by a prorating of country-wide expense experience. In promulgating such rules and plans, the superintendent shall give due consideration to the rating systems on file with him and, in order that such rules and plans may be as uniform as is practicable among the several states, to the rules and to the form of the plans used for such rating systems in other states. No insurer need record or report its loss experience on a classification basis that is inconsistent with the rating system filed by it. The superintendent may designate one or more rating bureaus or other agencies to assist him in gathering such experience and making compilations thereof, and such compilations shall be made available, subject to reasonable rules promulgated by the superintendent, to insurers and rating bureaus.

Reasonable rules and plans may be promulgated by the
superintendent for the interchange of data necessary for the
application of rating plans.

In order to further uniform administration of rate
regulatory laws, the superintendent and every insurer and rating
bureau may exchange information and experience data with
insurance supervisory officials, insurers, and rating bureaus in
other states and may consult with them with respect to rate
making and the application of rating systems.

The superintendent may make reasonable rules and
regulations necessary to effectuate sections 3935.01 to 3935.17, inclusive,

Sections 119.01 to 119.13, inclusive, of the Revised Code are applicable to the rule-making functions of the
superintendent under sections 3935.01 to 3935.17, inclusive, of the Revised Code, including appeals from the order of the
superintendent in adopting, amending, or rescinding rules.

Sec. 3935.12. (A) Every group, association, or other
organization of insurers, whether located within or outside this
state, which assists insurers which make their own filings or
rating bureaus in rate making, by the collection and furnishing
of loss or expense statistics, or by the submission of
recommendations, but which does not make filings under sections
3935.01 to 3935.17, inclusive, of the Revised Code, shall be
known as an advisory organization.

(B) Every advisory organization shall file the following
items with the superintendent of insurance:

(1) A copy of its constitution, its articles of agreement
or association or its certificate of incorporation, and of its
bylaws, rules, and regulations governing its activities;
(2) A list of its members;

(3) The name and address of a resident of this state upon whom notices or orders of the superintendent or process issued at his direction may be served;

(4) An agreement that the superintendent may examine such advisory organization in accordance with section 3935.11 of the Revised Code.

(C) If, after a hearing, the superintendent finds that the furnishing of information or assistance to insurers by such advisory organization involves any act or practice which is unfair, unreasonable, or otherwise inconsistent with sections 3935.01 to 3935.17, inclusive, of the Revised Code, he the superintendent may issue a written order specifying in what respects such act or practice is unfair, unreasonable, or otherwise inconsistent with said sections, and requiring the discontinuance of such act or practice.

(D) No insurer which makes its own filings, nor any rating bureau, shall support its filings by statistics or adopt rate-making recommendations furnished to it by an advisory organization which has not complied with this section or with an order of the superintendent involving such statistics or recommendations issued under division (C) of this section. If the superintendent finds such insurer or rating bureau to be in violation of this division, he the superintendent may issue an order requiring the discontinuance of such violation.

Sec. 3935.13. Every group, association, or other organization of insurers which engages in joint underwriting or joint reinsurance shall be subject to regulation with respect to such underwriting or reinsurance as provided in this section,
subject, with respect to joint underwriting, to sections 3935.01 to 3935.17, inclusive, of the Revised Code, and, with respect to joint reinsurance, to sections 3935.11, 3935.14, 3935.16, and 3935.17 of the Revised Code.

If, after a hearing, the superintendent of insurance finds that any activity or practice of any such group, association, or other organization is unfair, unreasonable, or otherwise inconsistent with sections 3935.01 to 3935.17, inclusive, of the Revised Code, he may issue a written order specifying in what respects such activity or practice is unfair, unreasonable, or otherwise inconsistent with said sections and requiring the discontinuance of such activity or practice.

Sec. 3935.14. After the superintendent of insurance makes an order, he shall, not later than the day following the issuance thereof, serve a certified copy of such order upon the parties, together with a statement of the time and method by which an appeal may be perfected. A copy of such order shall be mailed to attorneys of record representing the parties.

Any insurer, advisory organization, or rating bureau, aggrieved by any order or decision of the superintendent made without a hearing, may, within thirty days after notice of the order to the insurer or bureau, make written request to the superintendent for a hearing thereon. The superintendent shall hear such party within twenty days after receipt of such request and shall give not less than ten days' written notice of the time and place of the hearing. Within fifteen days after such hearing the superintendent shall affirm, reverse, or modify his previous action, specifying his reasons therefor. Pending such hearing and decision thereon, the
superintendent may suspend or postpone the effective date of his previous action.

The superintendent may postpone or continue any hearing upon the application of any party or upon his own motion.

Where the record of a hearing may be the basis of an appeal to court, a full and complete stenographic record of the hearing shall be made.

All orders of the superintendent issued pursuant to sections 3935.01 to 3935.17, inclusive, of the Revised Code, other than in adopting, amending, or rescinding rules, shall be governed entirely by said sections.

Any party adversely affected by an order of the superintendent issued pursuant to an adjudication may appeal to the court of common pleas of Franklin county.

Any party desiring to appeal shall file a notice of appeal with the superintendent, setting forth the order appealed from and the grounds of his appeal. A copy of such notice of appeal shall also be filed by the appellant with the court. Such notices of appeal shall be filed within fifteen days after the mailing of the notice of the superintendent's order as provided in this section.

The filing of a notice of appeal shall not automatically operate as a suspension of the order of the superintendent. If it appears to the court that an unusual hardship to the appellant will result from the execution of the superintendent's order pending determination of the appeal, the court may grant a suspension and fix its terms.

Within ten days after receipt of notice of appeal from an
order in any case in which a hearing is required by sections 3935.01 to 3935.17, inclusive, of the Revised Code, the
superintendent shall prepare and certify to the court a complete record of the proceedings in said case. Such record shall be
prepared and transcribed, and the expense thereof shall be taxed as a part of the costs on the appeal. The appellant must provide
security for costs satisfactory to the court of common pleas.
Upon demand by any interested party, the superintendent shall
furnish, at the cost of the party requesting same, a copy of the
stenographic report of testimony offered and evidence submitted
at any hearing and a copy of the complete record.

In the hearing of the appeal the court shall be confined
to the record as certified to it by the superintendent, provided
that the court may grant a request for the admission of
additional evidence when satisfied that such additional evidence is newly discovered and could not with reasonable diligence have
been ascertained prior to the hearing before the superintendent.

The court shall conduct a hearing on such appeal and shall
give preference to all proceedings under sections 3935.01 to
3935.17, inclusive, of the Revised Code, over all other civil
cases, irrespective of the position of any such proceedings on
the calendar of the court. The hearing in the court of common
pleas shall proceed as in the trial of a civil action, and the
court shall determine the rights of the parties in accordance
with the law applicable to such action. At such hearing counsel
may be heard on oral argument, briefs may be submitted, and
evidence introduced if the court has granted a request for the
presentation of additional evidence.

The court may affirm, reverse, vacate, or modify the order
of the superintendent complained of in the appeal, and its order
shall be final and conclusive unless reversed, vacated, or modified on appeal.

The court shall certify its judgment to the superintendent or take such other action in connection therewith as may be required to give its judgment effect.

Sec. 3935.99. (A) Whoever violates sections 3935.01 to 3935.17, inclusive, of the Revised Code, shall be fined not less than fifty nor more than five hundred dollars.

Sec. 3937.10. (A) Every group, association, or other organization of insurers which engages in joint underwriting or joint reinsurance is subject to regulation with respect thereto as provided in this section, subject, with respect to joint underwriting, to sections 3937.01 to 3937.17, inclusive, of the Revised Code, and, with respect to joint reinsurance, to sections 3937.11 and 3937.15 to 3937.17, inclusive, of the Revised Code.

(B) If, after a hearing, the superintendent of insurance finds that any activity or practice of any such group, association, or other organization is unfair, unreasonable, or otherwise inconsistent with sections 3937.01 to 3937.17, inclusive, of the Revised Code, he may issue a written order specifying in what respects such activity or practice is unfair, unreasonable, or otherwise inconsistent with such sections and requiring the discontinuance of such activity or practice.

Sec. 3937.182. (A) As used in this section, "policy" includes an endorsement.

(B) No policy of automobile or motor vehicle insurance that is covered by sections 3937.01 to 3937.17 of the Revised Code...
Code, including, but not limited to, the uninsured motorist coverage, underinsured motorist coverage, or both uninsured and underinsured motorist coverages included in such a policy as authorized by section 3937.18 of the Revised Code, and that is issued by an insurance company licensed to do business in this state, and no other policy of casualty or liability insurance that is covered by sections 3937.01 to 3937.17 of the Revised Code and that is so issued, shall provide coverage for judgments or claims against an insured for punitive or exemplary damages.

(C) This section applies only to policies of automobile, motor vehicle, or other casualty or liability insurance as described in division (B) of this section that are issued or renewed on or after the effective date of this section January 5, 1988.

Sec. 3941.46. Any foreign or alien mutual company licensed in this state which is a party to a merger or consolidation shall on or before the effective date thereof file with the superintendent a copy of the agreement. If the surviving company is, at the effective date of the merger or consolidation, licensed as an insurer in this state its license shall continue in effect as though no merger or consolidation had taken place, and on request the superintendent shall transfer to it any additional licenses issued by this state and then held by any nonsurviving insurer which is a party to the merger or consolidation. Revocation or suspension of any of such licenses shall be made only pursuant to the procedures and on the grounds provided in this code, provided, that an additional ground for revocation or suspension of license shall be that the merger or consolidation may have the effect of substantially lessening competition or tending to create a monopoly as to any line of insurance in this state. On receipt of a copy of the
agreement of merger or consolidation to which this section applies, the superintendent shall determine whether such
revocation or suspension proceedings should be commenced. In making such determination the superintendent may consider any
information on file with any agency, division or department of this or any other state, together with any additional relevant
information which shall be furnished by the company or companies, pursuant to the superintendent's request. A
determination that the merger or consolidation does not violate the additional ground provided in this section shall be
conclusively established by the lapse of three months after the effective date of the merger or consolidation without
commencement of proceedings to revoke or suspend the license or licenses on that ground.

Sec. 3951.04. The superintendent of insurance shall issue certificates of authority to any person, firm, association,
partnership, or corporation making application therefor who is trustworthy and competent to act as a public insurance adjuster in such manner as to safeguard the interest of the public and who have complied with the prerequisites herein described. A certificate of authority issued to a firm, association, partnership, or corporation shall authorize only the members of the firm, association, or partnership or the officers and directors of the corporation, specified in the certificate of authority to act as a public insurance adjuster.

The superintendent shall not issue any certificate of authority to any applicant who is convicted of a felony, or any crime or offense involving fraudulent or dishonest practice or who, within three years preceding the date of filing such application, has been guilty of any practice which would be grounds for suspension or revocation of a certificate of
authority as a public insurance adjuster.

Sec. 3951.06. (A) A fee of one hundred dollars shall be paid to the superintendent by the applicant for a public insurance adjuster's certificate of authority before the initial application is granted. If the applicant is a firm, association, partnership, or corporation, the fee shall be paid for each person specified in the application.

(B) A firm, association, partnership, or corporation to which a certificate of authority has been issued by the superintendent may at any time make an application to the superintendent for the issuance of a supplemental certificate of authority authorizing additional officers or directors of the corporation or members of the firm, association, or partnership to act as a public insurance adjuster, and the superintendent may thereupon issue to such firm, association, partnership, or corporation a supplemental certificate accordingly upon the payment of a fee of fifty dollars for each member or officer or director thereby authorized to act as a public insurance adjuster.

(C) Every public insurance adjuster's certificate of authority shall expire on the thirty-first day of December of the calendar year in which it was issued, and shall be renewed according to the standard renewal procedure of sections 4745.01 to 4745.03, inclusive, of the Revised Code. Every public insurance adjuster's certificate of authority with a payment of a fifty-dollar fee can be renewed for the ensuing year without examination, but if an application for the renewal of such certificate has been filed with the superintendent before January first of any year the certificate of authority sought to be renewed shall continue in full force and effect until the
issuance by the superintendent of the new certificate applied for or until five days after the superintendent has refused to issue a new certificate and has served notice of such refusal on the applicant therefor. Service of such notice shall be made by registered or certified mail directed to the applicant at the place of business specified in the application.

(D) No certificate of authority shall be issued or renewed unless, the applicant is a resident of the state, a lending institution, or a bona fide employee of a lending institution who is authorized to act as a public insurance adjuster in another state on behalf of the lending institution, and there is on file with the superintendent a bond, executed by such applicant and by approved sureties, in the penal sum of one thousand dollars for each person designated in the application, conditioned for the faithful performance by such applicant and by all persons designated in such application, of their duties as public insurance adjusters. Such bond shall be approved as to form by the attorney general and as to sufficiency by the superintendent. Such bond shall be made payable to the state and shall specifically authorize recovery for and on behalf of an injured party of the sum provided therein in case the adjuster has been guilty of fraudulent or dishonest practices in connection with the transaction of business as an adjuster.

Sec. 3951.10. On receipt of a notice pursuant to section 3123.43 of the Revised Code, the superintendent of insurance shall comply with sections 3123.41 to 3123.50 of the Revised Code and any applicable rules adopted under section 3123.63 of the Revised Code with respect to a certificate issued pursuant to this chapter.

Sec. 3951.99. (A) Any person, firm, association,
partnership, or corporation required by sections 3951.01 to
3951.09, inclusive, of the Revised Code, to obtain a certificate
of authority to act as a public insurance adjuster, who adjusts
any insurance losses without previously having obtained the
required certificate of authority or who adjusts any insurance
loss after his the person's, or its the firm's, association's,
partnership's, or corporation's, certificate of authority has
been revoked, shall be fined not less than one hundred nor more
than five hundred dollars for each loss adjusted without such
certificate of authority.

(B) The penalties in division (A) of this section shall
not limit the authority of the superintendent of insurance to
suspend, revoke, or refuse to issue a certificate of authority
for the causes set forth in section 3951.07 of the Revised Code.

Sec. 3953.01. As used in this chapter:

(A) "Title insurance" means insuring, guaranteeing, or
indemnifying owners of real property or others interested in
real property against loss or damage suffered by reason of liens
or encumbrances upon, defect in, or the unmarketability of the
title to the real property, guaranteeing, warranting, or
otherwise insuring by a title insurance company the correctness
of searches relating to the title to real property, or doing any
business in substance equivalent to any of the foregoing.

(B) "The business of title insurance" means the following:

(1) The making as insurer, guarantor, or surety, or
proposing to make as insurer, guarantor, or surety, any contract
or policy of title insurance;

(2) The transacting, or proposing to transact, any phase
of title insurance, including solicitation, negotiation
preliminary to execution, execution of a contract of title insurance, insuring, and transacting matters subsequent to the execution of the contract and arising out of it, including reinsurance;

(3) The doing or proposing to do any business in substance equivalent to any of the foregoing.

(C) "Title insurance company" means any of the following:

(1) Any domestic title guaranty company and domestic title guarantee and trust company to the extent that they are engaged in the business of title insurance;

(2) Any domestic company organized under this chapter for the purpose of insuring titles to real property;

(3) Any title insurance company organized under the laws of another state or foreign government;

(4) Any domestic or foreign company that has the powers and is authorized to insure titles to real estate within this state on December 12, 1967, and that meets the requirements of this chapter.

(D) "Applicants for insurance" includes all those, whether or not a prospective insured, who from time to time apply to a title insurance company or to its agent for title insurance and who at the time of that application are not agents for a title insurance company.

(E) "Risk premium" for title insurance means that portion of the fee charged by a title insurance company, agent of a title insurance company, or approved attorney of a title insurance company to an insured or an applicant for insurance for the assumption by the title insurance company of the risk
created by the issuance of the title insurance policy.

(F) "Fee" for title insurance means the risk premium, abstracting or searching charge, examination charge, and every other charge, exclusive of settlement, closing, or escrow charges, whether denominated premium or otherwise, made by a title insurance company, agent of a title insurance company, or an approved attorney of a title insurance company to an insured or an applicant for insurance for any policy or contract for the issuance of title insurance. "Fee" does not include any charges paid to and retained by an attorney at law or abstractor acting as an independent contractor whether or not the attorney or abstractor is acting as an agent of a title insurance company or an approved attorney and does not include any charges made for special services not constituting title insurance, even though performed in connection with a title insurance policy or contract.

(G) "Approved attorney" means an attorney at law who is not an employee of a title insurance company or a title insurance agent and upon whose examination of title and report on the examination a title insurance company may issue a policy of title insurance.

(H) "Title insurance agent" means a person, partnership, or corporation authorized in writing by a title insurance company to solicit insurance and collect premiums and to issue or countersign policies on its behalf. "Title insurance agent" does not include officers and salaried employees of any title insurance company authorized to do a title insurance business within this state.

(I) "Single insurance risk" means the insured amount of any policy or contract of title insurance issued by a title
insurance company.

(J) "Foreign title insurance company" means a title insurance company organized under the laws of any state or territory of the United States or the District of Columbia.

(K) "Alien title insurance company" means a title insurance company that is incorporated or organized under the laws of any foreign nation or any province or territory of a foreign nation and that is not a foreign title insurance company.

(L) "Non-directed escrow funds" means any funds delivered to a title insurance agent or title insurance company with instructions to hold or disburse the funds pursuant to a transaction in which a title insurance policy will be issued, but without written instructions to either deposit the funds in an account for the benefit of a specific person or to pay the interest earned on the funds to a specific person.

(M) "Business day" means any day, other than a Saturday or Sunday, or a legal holiday, on which a bank, savings and loan association, credit union, or savings bank is open to the public for carrying on substantially all of its functions.

(N) "Housing accommodations" and "restrictive covenant" have the same meanings as in section 4112.01 of the Revised Code.

Sec. 3953.07. No policy or contract of title insurance shall be written unless it is based upon a reasonable examination of the title unless a determination of insurability of title has been made in accordance with sound underwriting practices for title insurance companies and unless, on and after the effective date of this amendment March 30, 1999.
3953.29 of the Revised Code is complied with in connection with registered land. Evidence that a reasonable examination of a title has been made shall be preserved and retained in the files of the title insurance company or its agents for a period of not less than ten years after the policy or contract of title insurance has been issued. This section does not apply to a company assuming no primary liability in a contract of reinsurance and does not apply to a company acting as a coinsurer if one of the other coinsuring companies has complied with this section.

**Sec. 3953.14.** (A) Except as provided in Chapter 3953. of the Revised Code the investments of a title insurance company shall be governed by sections 3925.05 to 3925.21, inclusive, of the Revised Code.

(B) Provided it shall at all times keep at least one hundred thousand dollars invested in the classes of securities authorized for the investment of capital other than title plant and real estate as provided in division (C) of this section, a title insurance company may invest not more than ten per cent of its admitted assets in a title plant without the prior approval of the superintendent. The title plant shall be considered an admitted asset at the fair value thereof. In determining the fair value of a title plant, no value shall be attributed to furniture and fixtures, and the real estate in which the title plant is housed shall be carried as real estate. The value of title abstracts, title briefs, copies of conveyances or other documents, indices, and other records comprising the title plant, shall be determined by considering the expenses incurred in obtaining them, the age thereof, the cost of replacements less depreciation, and all other relevant factors. Once the value of a title plant has been determined, such value may be
increased only by the acquisition of another title plant by purchase, consolidation, or merger; in no event shall the value of the title plant be increased by additions made thereto as part of the normal course of abstracting and insuring titles to real estate. Subject to the above limitations and with the approval of the superintendent of insurance, a title insurance company may enter into agreements with one or more other title insurance companies authorized to do business in this state, whereby such companies shall participate in the ownership, management, and control of a title plant to service the needs of all such companies or such companies may hold stock of a corporation owning and operating a title plant for such purposes; provided that each of the companies participating in the ownership, management, and control of such jointly owned title plant shall keep the sum of one hundred thousand dollars invested as above set forth.

(C) Any title insurance company may purchase, receive, hold, and convey real estate or any interest therein:

(1) Required for its convenient accommodation in the transaction of its business with reasonable regard to future needs;

(2) Acquired in connection with a claim under a policy of title insurance;

(3) Acquired in satisfaction or on account of loans, mortgages, liens, judgments, or decrees, previously owing to it in the course of its business;

(4) Acquired in part payment of the consideration of the sale of real property owned by it if the transaction results in a net reduction in the company's investment in real estate;
(5) Reasonably necessary for the purpose of maintaining or enhancing the sale value of real property previously acquired or held by it under subdivisions (C)(1), (2), (3), or (4) of this division section.

Sec. 3953.29. On and after the effective date of this section March 30, 1999, in connection with any transfer of registered land that occurs on or after that date in accordance with Chapters 5309. and 5310. of the Revised Code, no title insurance company shall write a policy or contract of title insurance that includes any specific reference to any restrictive covenant that appears to apply to the transferred registered land, if any inclusion of the restrictive covenant in a transfer, rental, or lease of housing accommodations, any honoring or exercising of the restrictive covenant, or any attempt to honor or exercise the restrictive covenant constitutes an unlawful discriminatory practice under division (H)(9) of section 4112.02 of the Revised Code. On and after the effective date of this section March 30, 1999, if a policy or contract of title insurance written by a title insurance company in connection with any transfer of registered land that occurs on or after that date in accordance with Chapters 5309. and 5310. of the Revised Code includes a general or catch-all reference to easements, estates, liens, encumbrances, charges, rights, or restrictions of record, the general or catch-all reference shall be regarded by the parties to the transfer of the registered land and their successors in interest and shall be deemed for all legal purposes to refer to and incorporate by reference easements, estates, liens, encumbrances, charges, rights, and restrictions of record other than a restrictive covenant the inclusion of which in a transfer, rental, or lease of housing accommodations, the honoring or exercising of which,
or the attempt to honor or exercise of which constitutes an unlawful discriminatory practice under division (H)(9) of section 4112.02 of the Revised Code.

Sec. 3956.01. As used in this chapter:

(A) "Account" means either of the two accounts created under section 3956.06 of the Revised Code.

(B) "Contractual obligation" means any obligation under a policy, contract, or certificate under a group policy or contract, or portion of the policy or contract, for which coverage is provided under section 3956.04 of the Revised Code.

(C) "Covered policy or contract" means any policy, contract, or group certificate within the scope of section 3956.04 of the Revised Code.

(D) "Impaired insurer" means a member insurer that, after November 20, 1989, is not an insolvent insurer and is placed under an order of rehabilitation or conservation by a court of competent jurisdiction.

(E) "Insolvent insurer" means a member insurer that, after November 20, 1989, is placed under an order of liquidation by a court of competent jurisdiction with a finding of insolvency.

(F)(1) "Member insurer" means any insurer that holds a certificate of authority or is licensed to transact in this state any kind of insurance for which coverage is provided under section 3956.04 of the Revised Code, and includes any insurer whose certificate of authority or license in this state may have been suspended, revoked, not renewed, or voluntarily withdrawn after November 20, 1989.

(2) "Member insurer" does not include any of the
following:

(a) A health insuring corporation;

(b) A fraternal benefit society;

(c) A self-insurance or joint self-insurance pool or plan of the state or any political subdivision of the state;

(d) A mutual protective association;

(e) An insurance exchange;

(f) Any person who qualifies as a "member insurer" under section 3955.01 of the Revised Code and who does not receive premiums on covered policies or contracts;

(g) Any entity similar to any of those described in divisions (F)(2)(a) to (f) of this section.

(3) "Member insurer" includes any insurer that operates any of the entities described in division (F)(2) of this section as a line of business, and not as a separate, affiliated legal entity, and otherwise qualifies as a member insurer.

(G) "Premiums" means amounts received on covered policies or contracts, less premiums, considerations, and deposits returned on the policies or contracts, and less dividends and experience credits on the policies and contracts. "Premiums" does not include either of the following:

(1) Any amounts in excess of one million dollars received on any unallocated annuity contract not issued under a governmental retirement plan established under Section 401, 403(b), or 457 of the "Internal Revenue Code of 1986," 100 Stat. 2085, 26 U.S.C.A. 1, as amended;

(2) Any amounts received for any policies or contracts or
for the portions of any policies or contracts for which coverage is not provided under section 3956.04 of the Revised Code.

Division (G)(2) of this section shall not be construed to require the exclusion, from assessable premiums, of premiums paid for coverages in excess of the interest limitations specified in division (B)(2)(c) of section 3956.04 of the Revised Code or of premiums paid for coverages in excess of the limitations with respect to any one individual, any one participant, or any one contract holder specified in division (C)(2) of section 3956.04 of the Revised Code.

(H) "Resident" means any person who resides in this state at the time a member insurer is determined to be an impaired or insolvent insurer and to whom a contractual obligation is owed. A person may be a resident of only one state, which, in the case of a person other than a natural person, shall be its principal place of business. Citizens of the United States who are either residents of a foreign country or residents of a United States possession, territory, or protectorate that does not have an association similar to the association created by this chapter shall be considered residents of the state of domicile of the insurer that issued the policy or contract.

(I) "Structured settlement annuity" means an annuity purchased in order to fund periodic payments for a plaintiff or other claimant in payment for or with respect to personal injury suffered by the plaintiff or other claimant.

(J) "Subaccount" means any of the three subaccounts created under division (A) of section 3956.06 of the Revised Code.

(K) "Supplemental contract" means any agreement entered into for the distribution of policy or contract proceeds.
(L) "Unallocated annuity contract" means any annuity contract or group annuity certificate that is not issued to and owned by an individual, except to the extent of any annuity benefits guaranteed to an individual by an insurer under that contract or certificate.

Sec. 3956.09. (A) For the purpose of providing the funds necessary to carry out the powers and duties of the Ohio life and health insurance guaranty association, the board of directors shall assess the member insurers, separately for each subaccount or account, at such time and for such amounts as the board finds necessary. Assessments shall be due not less than thirty days after prior written notice to the member insurers and shall accrue interest at ten per cent per year on and after the due date.

(B) There shall be two classes of assessments, as follows:

(1) Class A assessments shall be made for the purpose of meeting administrative and legal costs and other expenses, and the cost of examinations conducted under division (E) of section 3956.12 of the Revised Code. Class A assessments may be made whether or not related to a particular impaired or insolvent insurer.

(2) Class B assessments shall be made to the extent necessary to carry out the powers and duties of the association under section 3956.08 of the Revised Code with regard to an impaired or an insolvent insurer.

(C)(1) The amount of any class A assessment shall be determined by the board and may be made on a pro rata or non-pro rata basis. If pro rata, the board may provide that it be credited against future class B assessments. A non-pro rata
assessment shall not exceed two hundred dollars per member insurer in any one calendar year. The amount of any class B assessment shall be allocated for assessment purposes among the subaccounts and accounts pursuant to an allocation formula which may be based on the premiums or reserves of the impaired or insolvent insurer or on any other standard considered by the board in its sole discretion as being fair and reasonable under the circumstances.

(2) Class B assessments against member insurers for each subaccount or account shall be in the proportion that the premiums received on business in this state by each assessed member insurer on policies or contracts covered by each subaccount or account for the most recent three calendar years for which information is available preceding the year in which the insurer became impaired or insolvent, as the case may be, bears to such premiums received on business in this state for such calendar years by all assessed member insurers.

(3) Assessments for funds to meet the requirements of the association with respect to an impaired or insolvent insurer shall not be made until necessary to implement the purposes of this chapter. Classification of assessments under division (B) of this section and computation of assessments under this division shall be made with a reasonable degree of accuracy, recognizing that exact determinations may not always be possible.

(D) The association may abate or defer, in whole or in part, the assessment of a member insurer if, in the opinion of the board, payment of the assessment would endanger the ability of the member insurer to fulfill its contractual obligations. If an assessment against a member insurer is abated, or deferred in
whole or in part, the amount by which the assessment is abated or deferred may be assessed against the other member insurers in a manner consistent with the basis for assessments set forth in this section. In determining whether the payment of an assessment would endanger the ability of a member insurer to fulfill its contractual obligations, the board shall consider the adequacy of the capital and surplus of the member insurer in relation to the premiums written, the assets, and the reserve liabilities of that member insurer.

(E)(1) The total of all assessments upon a member insurer for the life insurance and annuity account, which includes the life insurance subaccount, the annuity subaccount, and the unallocated annuity subaccount, shall not in any one calendar year exceed two per cent of the insurer's average premiums received per year in this state on the policies and contracts covered by each such subaccount, and for the health insurance account, shall not in any one calendar year exceed two per cent of the insurer's average premiums received per year in this state on the policies and contracts covered by such account, during the three calendar years preceding the year in which the impaired or insolvent insurer or insurers became impaired or insolvent. If the maximum assessment for a subaccount or account, together with the other assets of the association in the subaccount or account, does not provide in any one year in the subaccount or account an amount sufficient to carry out the responsibilities of the association, the necessary additional funds shall be assessed for the subaccount or account as soon thereafter in succeeding years as permitted by division (E) of this section.

(2) If the maximum assessment under division (E)(1) of this section for any subaccount of the life insurance and
annuity account in any succeeding year does not provide an
amount sufficient to carry out the responsibilities of the
association, then pursuant to division (C)(2) of this section,
the board shall allocate the necessary additional amount among
the other subaccounts of the life and annuity account in the
manner set forth in division (E)(1) of this section, but the
maximum assessment for a subaccount shall not exceed one per
cent in any one calendar year.

(3) Where assessments for two or more impaired or
insolvent insurers have been made within the same calendar year,
and the sum of those assessments exceeds the two per cent
calendar year assessment limitation under division (E)(1) of
this section, the board, with the approval of the superintendent
of insurance, may allocate among the accounts of such insurers
the sums assessed within the two per cent limitation.

(F) The board, by an equitable method as established in
the plan of operation, may refund to member insurers, in
proportion to the contribution of each insurer to that
subaccount or account, the amount by which the assets of the
subaccount or account exceed the amount the board finds is
necessary to carry out during the coming year the obligations of
the association with regard to that subaccount or account,
including assets accruing from assignment, subrogation, net
realized gains, and income from investments. A reasonable amount
may be retained in any subaccount or account to provide funds
for the continuing expenses of the association and for future
losses.

(G) A member insurer, in determining its premium rates and
policyowner dividends as to any kind of insurance within the
scope of this chapter, may consider the amount reasonably
necessary to meet its assessment obligations under this section.

(H) The association, upon request, shall issue to an insurer paying an assessment under this section, other than a class A assessment, a certificate of contribution, in a form approved by the superintendent, for the amount of the assessment so paid. All outstanding certificates shall be of equal dignity and priority without reference to amounts or dates of issue. A certificate of contribution may be shown by the insurer in its financial statement as an asset in the form and for the amount, net of any amounts recovered through a tax offset, and for the period of time the superintendent may approve.

(I) Any member insurer that has contributed funds to pay claims of an impaired or insolvent insurer, pursuant to an agreement entered into with the superintendent and approved by the Franklin county court of common pleas during the five years preceding the effective date of this section November 20, 1989, or at any time following the effective date of this section November 20, 1989, shall receive a credit against any assessments levied pursuant to this section, whether the assessments are class A assessments or class B assessments, in the amount of the contribution.

If the amount of the credit exceeds the amount of assessments levied upon a member insurer in any one year, the balance of that credit shall be carried forward to subsequent years and will reduce the amount of future assessments until the total amount of the credit has been applied to the future assessments.

For the purposes of this division, an impaired or insolvent insurer is an insurer that meets the definitions set forth in section 3956.01 of the Revised Code, and any insurer
that would have met these definitions, if it had been in effect at the time of such contribution.

(J) Division (I) of this section does not apply if an insurer has contributed funds pursuant to that division and has offset those contributions against its premium or franchise tax liability pursuant to any provision of the Revised Code authorizing the establishment of a plan for the distribution of voluntary contributions to pay the life, sickness and accident, or annuity claims of residents of this state that are unpaid due to the insolvency of an insolvent insurer.

Sec. 3956.10. (A)(1) The Ohio life and health insurance guaranty association shall submit to the superintendent of insurance a plan of operation and any amendments to the plan necessary or suitable to ensure the fair, reasonable, and equitable administration of the association. The plan of operation and any amendments shall become effective upon the written approval of the superintendent, or unless the superintendent has not disapproved it within thirty days.

(2) If the association fails to submit a suitable plan of operation within six months following the effective date of this section November 20, 1989, or if at any time after that date the association fails to submit suitable amendments to the plan, the superintendent, after notice and hearing, shall adopt reasonable rules that are necessary or advisable to effectuate the provisions of this chapter. The rules shall continue in force until modified by the superintendent or superseded by a plan submitted by the association and approved by the superintendent.

(B) All member insurers shall comply with the plan of operation.
(C) In addition to requirements enumerated elsewhere in this chapter, the plan of operation shall do the following:

(1) Establish procedures for handling the assets of the association;

(2) Establish the amount and method of reimbursing members of the board of directors under section 3956.07 of the Revised Code;

(3) Establish regular places and times for meetings, including but not limited to telephone conference calls, of the board of directors;

(4) Establish procedures for records to be kept of all financial transactions of the association, its agents, and the board of directors;

(5) Establish the procedures whereby selections for the board of directors will be made and submitted to the superintendent;

(6) Establish any additional procedures for assessments under section 3956.09 of the Revised Code, including, but not limited to, allocating sums raised by assessments when two or more insolvencies occur in the same calendar year that are subject to the two per cent calendar year assessment limitation;

(7) Contain additional provisions necessary or proper for the execution of the powers and duties of the association.

(D) The plan of operation may provide that any or all powers and duties of the association, except those under division (O)(3) of section 3956.08 and section 3956.09 of the Revised Code, are delegated to a corporation, association, or other organization that performs or will perform functions
similar to those of the association, or its equivalent, in two or more states. The corporation, association, or organization shall be reimbursed for any payments made on behalf of the association, and shall be paid for its performance of any function of the association. A delegation under this division shall take effect only with the approval of both the board of directors and the superintendent, and may be made only to a corporation, association, or organization that extends protection not substantially less favorable and effective than that provided by this chapter.

Sec. 3959.01. As used in this chapter:

(A) "Administration fees" means any amount charged a covered person for services rendered. "Administration fees" includes commissions earned or paid by any person relative to services performed by an administrator.

(B) "Administrator" means any person who adjusts or settles claims on, residents of this state in connection with life, dental, health, prescription drugs, or disability insurance or self-insurance programs. "Administrator" includes a pharmacy benefit manager. "Administrator" does not include any of the following:

(1) An insurance agent or solicitor licensed in this state whose activities are limited exclusively to the sale of insurance and who does not provide any administrative services;

(2) Any person who administers or operates the workers' compensation program of a self-insuring employer under Chapter 4123. of the Revised Code;

(3) Any person who administers pension plans for the benefit of the person's own members or employees or administers...
pension plans for the benefit of the members or employees of any other person;

(4) Any person that administers an insured plan or a self-insured plan that provides life, dental, health, or disability benefits exclusively for the person's own members or employees;

(5) Any health insuring corporation holding a certificate of authority under Chapter 1751. of the Revised Code or an insurance company that is authorized to write life or sickness and accident insurance in this state.

(C) "Aggregate excess insurance" means that type of coverage whereby the insurer agrees to reimburse the insured employer or trust for all benefits or claims paid during an agreement period on behalf of all covered persons under the plan or trust which exceed a stated deductible amount and subject to a stated maximum.

(D) "Contracted pharmacy" or "pharmacy" means a pharmacy located in this state participating in either the network of a pharmacy benefit manager or in a health care or pharmacy benefit plan through a direct contract or through a contract with a pharmacy services administration organization, group purchasing organization, or another contracting agent.

(E) "Contributions" means any amount collected from a covered person to fund the self-insured portion of any plan in accordance with the plan's provisions, summary plan descriptions, and contracts of insurance.

(F) "Drug product reimbursement" means the amount paid by a pharmacy benefit manager to a contracted pharmacy for the cost of the drug dispensed to a patient and does not include a dispensing or professional fee.

(H) "Fiscal year" means the twelve-month accounting period commencing on the date the plan is established and ending twelve months following that date, and each corresponding twelve-month accounting period thereafter as provided for in the summary plan description.

(I) "Insurer" means an entity authorized to do the business of insurance in this state or, for the purposes of this section, a health insuring corporation authorized to issue health care plans in this state.

(J) "Managed care organization" means an entity that provides medical management and cost containment services and includes a medicaid managed care organization, as defined in section 5167.01 of the Revised Code.

(K) "Maximum allowable cost" means a maximum drug product reimbursement for an individual drug or for a group of therapeutically and pharmaceutically equivalent multiple source drugs that are listed in the United States food and drug administration's approved drug products with therapeutic equivalence evaluations, commonly referred to as the orange book.

(L) "Maximum allowable cost list" means a list of the drugs for which a pharmacy benefit manager imposes a maximum allowable cost.

(M) "Multiple employer welfare arrangement" has the same meaning as in section 1739.01 of the Revised Code.

(N) "Pharmacy benefit manager" means an entity that
contracts with pharmacies on behalf of an employer, a multiple employer welfare arrangement, public employee benefit plan, state agency, insurer, managed care organization, or other third-party payer to provide pharmacy health benefit services or administration. "Pharmacy benefit manager" includes the state pharmacy benefit manager selected under section 5167.24 of the Revised Code.

(O) "Plan" means any arrangement in written form for the payment of life, dental, health, or disability benefits to covered persons defined by the summary plan description and includes a drug benefit plan administered by a pharmacy benefit manager.

(P) "Plan sponsor" means the person who establishes the plan.

(Q) "Self-insurance program" means a program whereby an employer provides a plan of benefits for its employees without involving an intermediate insurance carrier to assume risk or pay claims. "Self-insurance program" includes but is not limited to employer programs that pay claims up to a prearranged limit beyond which they purchase insurance coverage to protect against unpredictable or catastrophic losses.

(R) "Specific excess insurance" means that type of coverage whereby the insurer agrees to reimburse the insured employer or trust for all benefits or claims paid during an agreement period on behalf of a covered person in excess of a stated deductible amount and subject to a stated maximum.

(S) "Summary plan description" means the written document adopted by the plan sponsor which outlines the plan of benefits, conditions, limitations, exclusions, and other pertinent details
relative to the benefits provided to covered persons thereunder.

(T) "Third-party payer" has the same meaning as in section 3901.38 of the Revised Code.

Sec. 3960.07. (A) No purchasing group shall conduct business in this state unless it has done both of the following:

(1) Issued a notice to the superintendent of insurance that does all of the following:

(a) Identifies the state in which the purchasing group is domiciled and all other states in which the group intends to do business;

(b) Specifies the lines and classifications of liability insurance that the purchasing group intends to purchase and specifies the method by which and the person or persons, if any, through whom insurance will be offered to its members whose risks are resident or located in this state;

(c) Identifies the name and domicile of the insurance company from which the purchasing group intends to purchase its insurance;

(d) Identifies the principal place of business of the purchasing group;

(e) Provides any other information that the superintendent may require to verify that the purchasing group is qualified under division (I) of section 3960.01 of the Revised Code.

A purchasing group, within ten days, shall notify the superintendent of any changes in any of the items set forth in division (A)(1) this section.

(2) Registered with the superintendent, paid a filing fee
as determined by the superintendent, and consented to the
exercise of jurisdiction over it by the superintendent and the
courts of this state. The fee shall be paid into the state
treasury to the credit of the department of insurance operating
fund pursuant to section 3901.021 of the Revised Code.

Division (A)(2) of this section does not apply to a
purchasing group to which all of the following apply:

(a) It was domiciled in any state before April 1, 1986,
and on and after October 27, 1986;

(b) It purchased insurance from an insurance carrier
licensed in any state before and after October 27, 1986;

(c) It was a purchasing group meeting the requirements of
the federal "Product Liability Risk Retention Act of 1981," 95

(d) It does not purchase insurance that was not authorized
for purposes of an exemption under that act, as in effect before
October 27, 1986.

(B) Each purchasing group that is required to give notice
pursuant to division (A)(1) of this section also shall furnish
any information that may be required by the superintendent to do
both of the following:

(1) Determine where the purchasing group is located;

(2) Determine appropriate tax treatment.

(C) Within thirty days after the effective date of this
section, any purchasing group that was doing business in this
state prior to the enactment of this section shall furnish
notice to the superintendent pursuant to division (A)(1) of this
section and furnish any information that may be required—
pursuant to division (B) of this section.

(B) Sections 3937.01 to 3937.17 of the Revised Code apply to admitted insurers that provide insurance to purchasing groups.

Sec. 3964.19. (A) As used in sections 3964.19 to 3964.194 of the Revised Code:

(1) "Counterparty" means a special purpose financial captive insurance company's parent or an affiliated entity that is an insurer domiciled in this state that cedes life insurance risks to the special purpose financial captive insurance company pursuant to a special purpose financial captive insurance company contract.

(2) "Insolvency" or "insolvent" means that the special purpose financial captive insurance company is unable to pay its obligations when they are due, unless those obligations are the subject of a bona fide dispute.

(3) "Insurance securitization" means a package of related risk transfer instruments, capital market offerings, and facilitating administrative agreements, for which a special purpose financial captive insurance company obtains proceeds, either directly or indirectly, through the issuance of securities, where the investment risk to the holders of the securities is contingent upon the obligations of the special purpose financial captive insurance company to the counterparty under the special purpose financial captive insurance company contract, in accordance with the transaction terms, and pursuant to this section. This includes situations where the securitization proceeds are held in trust to secure the obligations of the special purpose financial captive insurance
company under one or more special purpose financial captive insurance company contracts.

(4) "Organizational document" means the special purpose financial captive insurance company's articles of incorporation, bylaws, code of regulations, operating agreement, or other foundational documents that establish the special purpose financial captive insurance company as a legal entity.

(5) "Securities" means debt obligations, equity investments, surplus certificates, surplus notes, funding agreements, derivatives, and other legal forms of financial instruments.

(6) "Special purpose financial captive insurance company contract" means a contract between a special purpose financial captive insurance company and a counterparty pursuant to which the special purpose financial captive insurance company agrees to provide insurance or reinsurance protection to the counterparty for risks associated with the counterparty's insurance or reinsurance business, and includes a contract entered into under division (F) of this section.

(7) "Special purpose financial captive insurance company securities" means the securities issued by a special purpose financial captive insurance company.

(B) The requirements of this section shall not apply to a specific special purpose financial captive insurance company if the superintendent finds a specific requirement is inappropriate due to the nature of the risks to be insured by the special purpose financial captive insurance company and if the special purpose financial captive insurance company meets the criteria established by rules and regulations adopted and promulgated by
the superintendent.

(C)(1) A special purpose financial captive insurance company may not issue a contract for assumption of risk or indemnification of loss other than a special purpose financial captive insurance company contract. However, the special purpose financial captive insurance company may cede a risk assumed through a special purpose financial captive insurance company contract to a third-party reinsurer through the purchase of reinsurance or retrocession protection if approved by the superintendent.

(2) A special purpose financial captive insurance company may enter into contracts and conduct other commercial activities related or incidental to and necessary to fulfill the purposes of special purpose financial captive insurance company contracts, insurance securitization, and this section. Those activities may include:

(a) Entering into special purpose financial captive insurance company contracts;

(b) Issuing securities of the special purpose financial captive insurance company in accordance with applicable securities law;

(c) Complying with the terms of special purpose financial captive insurance company contracts or securities;

(d) Entering into trust, swap, tax, administration, reimbursement, or fiscal agent transactions;

(e) Complying with trust indenture, reinsurance, retrocession, and other agreements necessary or incidental to effectuate an insurance securitization in compliance with this section and in the plan of operation considered by the
superintendent under division (F)(5) of section 3964.03 of the Revised Code.

(D)(1) A special purpose financial captive insurance company may issue securities, subject to and in accordance with applicable law, its plan of operation considered by the superintendent under division (E) of section 3964.03 of the Revised Code, and its organizational documents.

(2) A special purpose financial captive insurance company, in connection with the issuance of securities, may enter into and perform all of its obligations under any required contracts to facilitate the issuance of these securities.

(3) The obligation to repay principal or interest, or both, on the securities issued by the special purpose financial captive insurance company shall reflect the risk associated with the obligations of the special purpose financial captive insurance company to the counterparty under the special purpose financial captive insurance company contract.

(E)(1)(a) A special purpose financial captive insurance company may enter into the following types of transactions for the purposes described in division (E)(1)(b) of this section:

(i) Asset management agreements, including swap agreements, guaranteed;

(ii) Guaranteed investment contracts, or other;

(iii) Other transactions with the objective of reducing timing differences in the funding of upfront, or ongoing, transaction expenses, or managing asset, credit, prepayment, or interest rate risk of the investments of the special purpose financial captive insurance company.
(b) The purpose of the transactions described in division (E)(1)(a) of this section shall be any of the following:

(i) To ensure that the investments are sufficient to assure payment or repayment of the securities, and related interest or principal payments, issued pursuant to a special purpose financial captive insurance company insurance securitization transaction or the:

(ii) To ensure that the investments are sufficient to assure payment or repayment of the obligations required under a special purpose financial captive insurance company contract or for any:

(iii) Any other purpose approved by the superintendent.

(2) An asset management agreement shall not be entered into under this section by a special purpose financial captive insurance company unless it has been approved by the superintendent.

(F)(1) If a special purpose financial captive insurance company has entered into a special purpose financial captive insurance company contract with a counterparty and the special purpose financial captive insurance company has conducted an insurance securitization that is made up, in part or in whole, of the risks of that contract, then the special purpose financial captive insurance company may enter into a second contract with the counterparty under which the counterparty is held liable for those losses or other obligations that were securitized.

(2) Such obligations may be funded and secured with assets held in trust for the benefit of the counterparty pursuant to agreements contemplated by this section and invested in a manner
that meet the criteria in sections 3907.14 and 3907.141 of the Revised Code.

(G)(1) A special purpose financial captive insurance company may enter into agreements with affiliated companies and third parties and conduct business necessary to fulfill its obligations and administrative duties incidental to an insurance securitization and a special purpose financial captive insurance company contract entered into under division (F) of this section.

(2) The agreements may include management and administrative services agreements and other allocation and cost sharing agreements, or swap and asset management agreements, or both, or agreements for other contemplated types of transactions provided in this section.

(H) A special purpose financial captive insurance company contract entered into under division (F) of this section shall contain all of the following:

(1) A requirement that the special purpose financial captive insurance company do either of the following:

(a) Enter into a trust agreement specifying what recoverables or reserves, or both, the agreement is to cover and to establish a trust account for the benefit of the counterparty and the security holders;

(b) Establish such other methods of security acceptable to the superintendent.

(2) A stipulation that assets deposited in the trust account shall be valued in accordance with their current fair-market value and shall consist only of investments permitted by sections 3907.14 and 3907.141 of the Revised Code;
(3) A requirement that, if a trust arrangement is used, the special purpose financial captive insurance company, before depositing assets with the trustee, execute assignments, execute endorsements in blank, or take such actions as are necessary to transfer legal title to the trustee of all assets requiring assignment, in order that the counterparty, or the trustee upon the direction of the counterparty, may negotiate whenever necessary the assets without consent or signature from the special purpose financial captive insurance company or another entity;

(4) A stipulation that, if a trust arrangement is used, the special purpose financial captive insurance company and the counterparty agree that the assets in the trust account established pursuant to the contract:

(a) May be withdrawn by the counterparty, or the trustee on its behalf, at any time, but only in accordance with the terms of the contract;

(b) Shall be utilized and applied by the counterparty, without diminution because of insolvency on the part of the counterparty or the special purpose financial captive insurance company, only for the purposes set forth in the credit for reinsurance laws and rules of this state. As used in this division, "counterparty" includes any successor of the counterparty by operation of law, including, subject to the provisions of this section, but without further limitation, any liquidator, rehabilitator, or receiver of the counterparty.

(I) A special purpose financial captive insurance company contract entered into under division (F) of this section may contain provisions that give the special purpose financial captive insurance company the right to seek approval from the
counterparty to withdraw from the trust all or part of the assets, or income from them, contained in the trust and to transfer the assets to the special purpose financial captive insurance company if such provisions comply with the credit for reinsurance laws and rules of this state.

(J)(1) A special purpose financial captive insurance company contract entered into under division (F) of this section, meeting the requirements of this section, shall be granted credit for reinsurance treatment or otherwise qualify as an asset or a reduction from liability for reinsurance ceded by a domestic insurer to a special purpose financial captive insurance company as an assuming insurer for the benefit of the counterparty if both of the following apply:

(a) The assets are held or invested in one or more of the forms allowed in sections 3907.14 and 3907.141 of the Revised Code.

(b) The agreement is in compliance with section 3901.64 of the Revised Code.

(2) The contract shall be granted credit or otherwise qualify as an asset or reduction from liability only to the extent of the value of the assets held in trust for, or letters of credit, that meet the requirements set forth in division (C) of section 3964.05 of the Revised Code, or as approved by the superintendent, for the benefit of the counterparty under the special purpose financial captive insurance company contract.

(K) A special purpose financial captive insurance company may make investments that meet the qualifications set forth in sections 3907.14 and 3907.141 of the Revised Code, however these investments shall not be subject to any limitations contained in
such sections as to invested amounts. The superintendent may prohibit or limit any investment that threatens the solvency or liquidity of a special purpose financial captive insurance company or that is not made in accordance with the approved plan of operation.

**Sec. 3999.16.** No officer, director, trustee, agent, or employee of any insurance company, corporation, or association authorized to transact business in this state shall knowingly use underwriting standards or rates that result in unfair discrimination against any handicapped person. This section does not prevent reasonable classifications of handicapped persons for determining insurance rates.

As used in this section, "handicapped" means a medically diagnosable, abnormal condition which is expected to continue for a considerable length of time, whether correctable or uncorrectable by good medical practice, which can reasonably be expected to limit the person's functional ability, including but not limited to seeing, hearing, thinking, ambulating, climbing, descending, lifting, grasping, sitting, rising, any related function, or any limitation due to weakness or significantly decreased endurance, so that the person cannot perform his everyday routine living and working without significantly increased hardship and vulnerability to what are considered the everyday obstacles and hazards encountered by the nonhandicapped.

**Sec. 3999.41.** (A) Except as provided in division (D) of this section, every insurer, as defined in division (A) of section 3999.36 of the Revised Code, shall adopt an antifraud program and shall specify in a written plan the procedures it will follow when instances of insurance fraud or suspected
insurance fraud are brought to its attention. The insurer shall identify in the written plan the person or persons responsible for the insurer's antifraud program.

(B)(1) An insurer shall develop a written plan required by division (A) of this section within ninety days after obtaining its license to transact business within this state or within ninety days after beginning to engage in the business of insurance within this state and shall thereafter maintain such a written plan.

(2) An insurer engaged in the business of insurance within this state on the effective date of this section March 17, 1998, shall develop a written plan required by division (A) of this section within ninety days after the effective date of this section March 17, 1998, and shall thereafter maintain such a written plan.

(C) If an insurer modifies the procedures it follows for instances of insurance fraud or suspected insurance fraud, or if there is a change in the person or persons responsible for the insurer's antifraud program, the insurer shall modify the written plan it maintains pursuant to this section.

(D) The requirements of this section are not applicable to any insurer identified in division (A) of this section that is not engaged in writing direct insurance in this state.

Sec. 4509.41. (A) Judgments are satisfied for the purpose of sections 4509.01 to 4509.78, inclusive, of the Revised Code, in each of the following cases:

(1) When twenty-five thousand dollars has been credited upon any judgments in excess of that amount because of bodily injury to or death of one person as a result of any one
accident;

(2) When the sum of fifty thousand dollars has been credited upon any judgments in excess of that amount because of bodily injury to or death of two or more persons as the result of any one accident;

(3) When twenty-five thousand dollars has been credited upon any judgments rendered in excess of that amount because of injury to property of others as a result of any one accident.

(B) Payments made in settlements of any claims because of bodily injury, death, or property damage arising from such accident shall be credited in reduction of the amounts provided for in this section.

Sec. 4509.67. (A) The registrar of motor vehicles shall, upon request, consent to the immediate cancellation of any bond or certificate of insurance, or shall direct and the treasurer of state shall return to the person entitled any money or securities deposited under sections 4509.01 to 4509.78 of the Revised Code, as proof of financial responsibility, or the registrar shall waive the requirement of filing proof, in any of the following events:

(1) At any time after three years from the date such proof was required when, during the three years preceding the request, the registrar has not received record of a conviction or bail forfeiture which would require or permit the suspension or revocation of the license, registration or nonresident's operating privilege of the person by or for whom such proof was furnished and the person's motor vehicle registration has not been suspended for a violation of section 4509.101 of the Revised Code;
(2) In the event of the death of the person on whose behalf such proof was filed or the permanent incapacity of such person to operate a motor vehicle;

(3) In the event the person who has given proof surrenders his license and registration to the registrar.

(B) The registrar shall not consent to the cancellation of any bond or the return of any money or securities if any action for damages upon a liability covered by such proof is pending, or any judgment upon such liability is unsatisfied, or in the event the person who has filed such bond or deposited such money or securities has within two years immediately preceding such request been involved as a driver or owner in any motor vehicle accident resulting in injury to the person or property of others. An affidavit of the applicant as to the nonexistence of such facts, or that he has been released from all liability, or has been finally adjudicated not liable, for such injury may be accepted as evidence thereof in the absence of evidence to the contrary in the records of the registrar.

(C) Whenever any person whose proof has been canceled or returned under division (A)(3) of this section applies for a license or registration within a period of three years from the date proof was originally required, any such application shall be refused unless the applicant re-establishes proof of financial responsibility for the remainder of the three-year period.

Section 2. That existing sections 167.03, 1751.32, 1751.53, 1751.69, 1751.74, 1751.84, 1753.31, 3901.045, 3901.13, 3901.25, 3901.41, 3901.45, 3901.811, 3901.87, 3901.88, 3901.90, 3902.08, 3903.01, 3903.50, 3903.52, 3903.56, 3903.71, 3903.724,
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3903.728, 3903.7211, 3903.74, 3904.01, 3904.02, 3904.16, 3905.051, 3905.062, 3905.063, 3905.14, 3905.84, 3905.85, 3906.11, 3907.03, 3907.07, 3909.04, 3911.09, 3911.20, 3911.24, 3913.11, 3913.22, 3913.40, 3915.05, 3915.053, 3915.073, 3915.13, 3916.01, 3916.171, 3916.18, 3919.14, 3921.13, 3921.191, 3922.11, 3922.14, 3922.17, 3923.01, 3923.021, 3923.04, 3923.19, 3923.38, 3923.39, 3923.53, 3923.55, 3923.56, 3923.60, 3923.65, 3923.82, 3923.85, 3925.09, 3927.08, 3929.011, 3929.04, 3930.10, 3931.02, 3931.03, 3931.99, 3933.01, 3933.02, 3935.06, 3935.10, 3935.12, 3935.13, 3935.14, 3935.99, 3937.10, 3937.182, 3941.46, 3951.04, 3951.06, 3951.10, 3951.99, 3953.01, 3953.07, 3953.14, 3953.29, 3956.01, 3956.09, 3956.10, 3959.01, 3960.07, 3964.19, 3999.16, 3999.41, 4509.41, and 4509.67 of the Revised Code are hereby repealed.

Section 3. That sections 3941.47, 3941.48, 3941.49, and 3941.52 of the Revised Code are hereby repealed.