

# As Reported by the House Insurance Committee

122nd General Assembly

Regular Session

1997-1998

Sub. S. B. No. 67

Senators Gillmor, Zaleski, Howard, Oelslager, Watts, Latell, Ray, Latta, Drake  
Representatives Van Vyven, Reid, Mottley, Metelsky, Lewis, Garcia, Haines

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## A B I L L

To amend sections 101.271, 124.81, 124.82, 124.822, 1  
124.84, 124.841, 124.92, 124.93, 145.58, 145.581, 2  
305.171, 306.48, 307.86, 339.16, 351.08, 505.60, 3  
742.45, 742.53, 1319.12, 1337.16, 1545.071, 4  
1731.01, 1731.06, 1739.05, 1901.111, 1901.312, 5  
2133.12, 2305.25, 2913.47, 3105.71, 3111.241, 6  
3113.217, 3307.74, 3307.741, 3309.69, 3309.691, 7  
3313.202, 3375.40, 3381.14, 3501.141, 3701.24, 8  
3701.76, 3702.51, 3702.62, 3709.16, 3729.12, 9  
3901.04, 3901.041, 3901.043, 3901.071, 3901.16, 10  
3901.19, 3901.31, 3901.32, 3901.38, 3901.40, 11  
3901.41, 3901.48, 3901.72, 3902.01, 3902.02, 12  
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3923.382, 3923.41, 3923.51, 3923.54, 3923.58, 15  
3924.01, 3924.02, 3924.08, 3924.10, 3924.12, 16  
3924.13, 3924.41, 3924.61, 3924.62, 3924.64, 17  
3924.73, 3929.77, 3956.01, 3959.01, 3999.32, 18  
3999.36, 4582.041, 4582.29, 4715.02, 4719.01, 19  
4729.381, 4731.67, 5111.02, 5111.17, 5111.171, 20  
5111.19, 5111.74, 5115.10, 5119.01, 5119.202, 21  
5505.28, 5505.33, and 5923.051; to enact sections 22  
1751.01 to 1751.08, 1751.11 to 1751.21, 1751.25 to 23  
1751.28, 1751.31 to 1751.36, 1751.38, 1751.40, 24

1751.42, 1751.44 to 1751.48, 1751.51 to 1751.56,	25
1751.59 to 1751.67, 1751.70, and 1751.71; and to	26
repeal sections 1736.01, 1736.02, 1736.03,	27
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1742.29, 1742.30, 1742.301, 1742.31, 1742.32, 58  
1742.33, 1742.34, 1742.341, 1742.35, 1742.36, 59  
1742.37, 1742.38, 1742.39, 1742.40, 1742.41, 60  
1742.42, 1742.43, 1742.44, and 1742.45 of the 61  
Revised Code to provide for the establishment, 62  
operation, and regulation of health insuring 63  
corporations; to repeal the laws governing prepaid 64  
dental plan organizations, medical care 65  
corporations, health care corporations, dental 66  
care corporations, and health maintenance 67  
organizations; to eliminate certain provisions of 68  
this act on and after February 9, 2004, by 69  
repealing section 1751.64 of the Revised Code on 70  
that date; and to declare an emergency. 71

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

**Section 1.** That sections 101.271, 124.81, 124.82, 124.822, 72  
124.84, 124.841, 124.92, 124.93, 145.58, 145.581, 305.171, 306.48, 73  
307.86, 339.16, 351.08, 505.60, 742.45, 742.53, 1319.12, 1337.16, 74  
1545.071, 1731.01, 1731.06, 1739.05, 1901.111, 1901.312, 2133.12, 75  
2305.25, 2913.47, 3105.71, 3111.241, 3113.217, 3307.74, 3307.741, 76  
3309.69, 3309.691, 3313.202, 3375.40, 3381.14, 3501.141, 3701.24, 77  
3701.76, 3702.51, 3702.62, 3709.16, 3729.12, 3901.04, 3901.041, 78  
3901.043, 3901.071, 3901.16, 3901.19, 3901.31, 3901.32, 3901.38, 79  
3901.40, 3901.41, 3901.48, 3901.72, 3902.01, 3902.02, 3902.11, 80  
3902.13, 3904.01, 3905.71, 3923.123, 3923.30, 3923.301, 3923.33, 81  
3923.333, 3923.38, 3923.382, 3923.41, 3923.51, 3923.54, 3923.58, 82  
3924.01, 3924.02, 3924.08, 3924.10, 3924.12, 3924.13, 3924.41, 83  
3924.61, 3924.62, 3924.64, 3924.73, 3929.77, 3956.01, 3959.01, 84  
3999.32, 3999.36, 4582.041, 4582.29, 4715.02, 4719.01, 4729.381, 85  
4731.67, 5111.02, 5111.17, 5111.171, 5111.19, 5111.74, 5115.10, 86

5119.01, 5119.202, 5505.28, 5505.33, and 5923.051 be amended and 87  
sections 1751.01, 1751.02, 1751.03, 1751.04, 1751.05, 1751.06, 88  
1751.07, 1751.08, 1751.11, 1751.12, 1751.13, 1751.14, 1751.15, 89  
1751.16, 1751.17, 1751.18, 1751.19, 1751.20, 1751.21, 1751.25, 90  
1751.26, 1751.27, 1751.28, 1751.31, 1751.32, 1751.33, 1751.34, 91  
1751.35, 1751.36, 1751.38, 1751.40, 1751.42, 1751.44, 1751.45, 92  
1751.46, 1751.47, 1751.48, 1751.51, 1751.52, 1751.53, 1751.54, 93  
1751.55, 1751.56, 1751.59, 1751.60, 1751.61, 1751.62, 1751.63, 94  
1751.64, 1751.65, 1751.66, 1751.67, 1751.70, and 1751.71 of the 95  
Revised Code be enacted to read as follows: 96

**Sec. 101.271.** (A) As used in this section, "medical insurance 97  
premium" means any premium payment made under a contract with an 98  
insurance company, nonprofit health plan, health ~~care~~ insuring 99  
corporation, ~~health maintenance organization~~, or any combination 100  
of such organizations, pursuant to section 124.82 of the Revised 101  
Code. 102

(B) After the general election in each even-numbered year, 103  
the clerk of the senate, with the assistance of the department of 104  
administrative services, shall estimate the cost of the medical 105  
insurance premiums that will be necessary to provide coverage, on 106  
the same basis as for a similarly situated state employee, for 107  
each person who is elected to a term as senator at such election, 108  
or appointed to fill the unexpired portion of any such term, and 109  
any of ~~his~~ the senator's dependents qualified for coverage at the 110  
time ~~he~~ the senator assumes office. Using this estimate, the clerk 111  
shall determine a fixed amount to be paid by the state in equal 112  
monthly installments on behalf of the senator each year of ~~his~~ the 113  
senator's term as a medical insurance premium, but in no event in 114  
an amount to exceed the total premium required in any month by the 115  
contract of the state by the carrier. Any amount not paid in such 116  
a case shall be placed in reserve and applied against any 117

subsequent month's premium up to the full amount thereof until the 118  
entire amount has been paid along with the original estimate for 119  
each month. This fixed amount shall be such that, as nearly as can 120  
be predicted, the sum of the monthly premiums paid for the senator 121  
during ~~his~~ the senator's term shall equal the total amount of 122  
medical insurance premiums that will be paid for such an employee, 123  
as required by section 124.82 of the Revised Code, during that 124  
term. The senator shall pay the difference between the amount so 125  
fixed and the total premium required by the contract of the state 126  
with the carrier. 127

(C) After the general election in each even-numbered year, 128  
the executive secretary of the house of representatives, with the 129  
assistance of the department of administrative services, shall 130  
estimate the cost of the medical insurance premiums that will be 131  
necessary to provide coverage, on the same basis as for a 132  
similarly situated state employee, for each person who is elected 133  
to a term as representative at such election, or appointed to fill 134  
the unexpired portion of any such term, and any of ~~his~~ the 135  
representative's dependents qualified for coverage at the time ~~he~~ 136  
the representative assumes office. Using this estimate, the 137  
executive secretary shall determine a fixed amount to be paid by 138  
the state in equal monthly installments on behalf of the 139  
representative each year of ~~his~~ the representative's term as a 140  
medical insurance premium, but in no event in an amount to exceed 141  
the total premium required in any month by the contract of the 142  
state with the carrier. Any amount not paid in such a case shall 143  
be placed in reserve and applied against any subsequent month's 144  
premium up to the full amount thereof until the entire reserve has 145  
been paid along with the original estimate for each month. This 146  
fixed amount shall be such that, as nearly as can be predicted, 147  
the sum of the monthly premiums paid for the representative during 148  
~~his~~ the representative's term shall equal the total amount of 149  
medical insurance premiums that will be paid for such an employee, 150

as required by section 124.82 of the Revised Code, during that 151  
term. The representative shall pay the difference between the 152  
amount so fixed and the total premium required by the contract of 153  
the state with the carrier. 154

**Sec. 124.81.** (A) Except as provided in division (E) of this 155  
section, the department of administrative services in consultation 156  
with the superintendent of insurance shall negotiate with and, in 157  
accordance with the competitive selection procedures of Chapter 158  
125. of the Revised Code, contract with one or more insurance 159  
companies authorized to do business in this state, for the 160  
issuance of one of the following: 161

(1) A policy of group life insurance covering all state 162  
employees who are paid directly by warrant of the state auditor, 163  
including elected state officials; 164

(2) A combined policy, or coordinated policies of one or more 165  
insurance companies, ~~medical care corporations, health care~~ 166  
~~corporations, dental care corporations,~~ or health maintenance 167  
insuring corporations in combination with one or more insurance 168  
companies providing group life and health, medical, hospital, 169  
dental, or surgical insurance, or any combination thereof, 170  
covering all such employees; 171

(3) A policy that may include, but is not limited to, 172  
hospitalization, surgical, major medical, dental, vision, and 173  
medical care, disability, hearing aids, prescription drugs, group 174  
life, life, sickness, and accident insurance, group legal 175  
services, or a combination of the above benefits for some or all 176  
of the employees paid in accordance with section 124.152 of the 177  
Revised Code and for some or all of the employees listed in 178  
divisions (B)(2) and (4) of section 124.14 of the Revised Code, 179  
and their immediate dependents. 180

(B) If a state employee uses all accumulated sick leave and 181

then goes on an extended medical disability, the policyholder 182  
shall continue at no cost to the employee the coverage of the 183  
group life insurance for such employee for the period of such 184  
extended leave, but not beyond three years. 185

(C) If a state employee insured under a group life insurance 186  
policy as provided in division (A) of this section is laid off 187  
pursuant to section 124.32 of the Revised Code, such employee by 188  
request to the policyholder, made no later than the effective date 189  
of the layoff, may elect to continue the employee's group life 190  
insurance for the one-year period through which the employee may 191  
be considered to be on laid-off status by paying the policyholder 192  
through payroll deduction or otherwise twelve times the monthly 193  
premium computed at the existing average rate for the group life 194  
case for the amount of the employee's insurance thereunder at the 195  
time of the employee's layoff. The policyholder shall pay the 196  
premiums to the insurance company at the time of the next regular 197  
monthly premium payment for the actively insured employees and 198  
furnish the company appropriate data as to such laid-off 199  
employees. At the time an employee receives written notice of a 200  
layoff, the policyholder shall also give such employee written 201  
notice of the opportunity to continue group life insurance in 202  
accordance with this division. When such laid-off employee is 203  
reinstated for active work before the end of the one-year period, 204  
the employee shall be reclassified as insured again as an active 205  
employee under the group and appropriate refunds for the number of 206  
full months of unearned premium payment shall be made by the 207  
policyholder. 208

(D) This section does not affect the conversion rights of an 209  
insured employee when the employee's group insurance terminates 210  
under the policy. 211

(E) Notwithstanding division (A) of this section, the 212  
department may provide benefits equivalent to those that may be 213

paid under a policy issued by an insurance company, or the 214  
department may, to comply with a collectively bargained contract, 215  
enter into an agreement with a jointly administered trust fund 216  
which receives contributions pursuant to a collective bargaining 217  
agreement entered into between this state, or any of its political 218  
subdivisions, and any collective bargaining representative of the 219  
employees of this state or any political subdivision for the 220  
purpose of providing for self-insurance of all risk in the 221  
provision of fringe benefits similar to those that may be paid 222  
pursuant to division (A) of this section, and the jointly 223  
administered trust fund may provide through the self-insurance 224  
method specific fringe benefits as authorized by the rules of the 225  
board of trustees of the jointly administered trust fund. Amounts 226  
from the fund may be used to pay direct and indirect costs that 227  
are attributable to consultants or a third-party administrator and 228  
that are necessary to administer this section. Benefits provided 229  
under this section include, but are not limited to, 230  
hospitalization, surgical care, major medical care, disability, 231  
dental care, vision care, medical care, hearing aids, prescription 232  
drugs, group life insurance, sickness and accident insurance, 233  
group legal services, or a combination of the above benefits, for 234  
the employees and their immediate dependents. 235

(F) Notwithstanding any other provision of the Revised Code, 236  
any public employer, including the state, and any of its political 237  
subdivisions, including, but not limited to, any county, county 238  
hospital, municipal corporation, township, park district, school 239  
district, state institution of higher education, public or special 240  
district, state agency, authority, commission, or board, or any 241  
other branch of public employment, and any collective bargaining 242  
representative of employees of the state or any political 243  
subdivision may agree in a collective bargaining agreement that 244  
any mutually agreed fringe benefit including, but not limited to, 245

hospitalization, surgical care, major medical care, disability, 246  
dental care, vision care, medical care, hearing aids, prescription 247  
drugs, group life insurance, sickness and accident insurance, 248  
group legal services, or a combination thereof, for employees and 249  
their dependents be provided through a mutually agreed upon 250  
contribution to a jointly administered trust fund. Amounts from 251  
the fund may be used to pay direct and indirect costs that are 252  
attributable to consultants or a third-party administrator and 253  
that are necessary to administer this section. The amount, type, 254  
and structure of fringe benefits provided under this division is 255  
subject to the determination of the board of trustees of the 256  
jointly administered trust fund. Notwithstanding any other 257  
provision of the Revised Code, competitive bidding does not apply 258  
to the purchase of fringe benefits for employees under this 259  
division through a jointly administered trust fund. 260

**Sec. 124.82.** (A) Except as provided in division (D) of this 261  
section, the department of administrative services, in 262  
consultation with the superintendent of insurance, shall, in 263  
accordance with competitive selection procedures of Chapter 125. 264  
of the Revised Code, contract with an insurance company or a 265  
~~nonprofit~~ health plan in combination with an insurance company, 266  
authorized to do business in this state, for the issuance of a 267  
policy or contract of health, medical, hospital, dental, or 268  
surgical benefits, or any combination thereof, covering state 269  
employees who are paid directly by warrant of the auditor of 270  
state, including elected state officials. The department may 271  
fulfill its obligation under this division by exercising its 272  
authority under division (A)(2) of section 124.81 of the Revised 273  
Code. 274

(B) The department may, in addition, in consultation with the 275  
superintendent of insurance, negotiate and contract with health 276

~~health care~~ insuring corporations ~~organized~~ holding a certificate of 277  
authority under Chapter ~~1738.~~ 1751. of the Revised Code, in their 278  
approved service areas only, ~~for issuance of any policy or~~ 279  
~~policies or contract or contracts of health, medical, hospital,~~ 280  
~~dental, or surgical benefits, or any combination thereof, or with~~ 281  
~~health maintenance organizations organized under Chapter 1742. of~~ 282  
~~the Revised Code, in their service areas only,~~ for issuance of a 283  
contract or contracts of health care services, covering state 284  
employees who are paid directly by warrant of the auditor of 285  
state, including elected state officials. Except for health ~~care~~ 286  
~~corporation and health maintenance organization plans~~ insuring 287  
corporations, no more than one insurance carrier or ~~nonprofit~~ 288  
health plan, shall be contracted with to provide the same plan of 289  
benefits, provided that: 290

(1) The amount of the premium or cost for such coverage 291  
contributed by the state, for an individual or for an individual 292  
and ~~his~~ the individual's family, does not exceed that same amount 293  
of the premium or cost contributed by the state under division (A) 294  
of this section; 295

(2) The employee be permitted to exercise ~~his~~ the option as 296  
to which plan ~~he~~ the employee will select under division (A) or 297  
(B) of this section, at a set time each year, which time shall be 298  
determined by the department; 299

(3) The health ~~care~~ insuring corporations ~~or the health~~ 300  
~~maintenance organizations~~ do not refuse to accept the employee, or 301  
the employee and ~~his~~ the employee's family, if ~~he~~ the employee 302  
exercises the option to select care provided by the corporations 303  
~~or organizations;~~ 304

(4) The employee may choose participation in only one of the 305  
plans sponsored by the department; 306

(5) The director of health examines and certifies to the 307

department that the quality and adequacy of care rendered by the 308  
health care insuring corporations ~~or the health maintenance~~ 309  
~~organizations~~ meet at least the standards of care provided by 310  
hospitals and physicians in that employee's community, who would 311  
be providing such care as would be covered by a contract awarded 312  
under division (A) of this section. 313

(C) All or any portion of the cost, premium, or charge for 314  
the coverage in divisions (A) and (B) of this section may be paid 315  
in such manner or combination of manners as the department 316  
determines and may include the proration of health care costs, 317  
premiums, or charges for part-time employees. 318

(D) Notwithstanding division (A) of this section, the 319  
department may provide benefits equivalent to those that may be 320  
paid under a policy or contract issued by an insurance company or 321  
a ~~nonprofit~~ health plan pursuant to division (A) of this section. 322

(E) This section does not prohibit the state office of 323  
collective bargaining from entering into an agreement with an 324  
employee representative for the purposes of providing fringe 325  
benefits including, but not limited to, hospitalization, surgical 326  
care, major medical care, disability, dental care, vision care, 327  
medical care, hearing aids, prescription drugs, group life 328  
insurance, sickness and accident insurance, group legal services 329  
or other benefits, or any combination thereof, to employees paid 330  
directly by warrant of the auditor of state through a jointly 331  
administered trust fund. The employer's contribution for the cost 332  
of the benefit care shall be mutually agreed to in the 333  
collectively bargained agreement. The amount, type, and structure 334  
of fringe benefits provided under this division is subject to the 335  
determination of the board of trustees of the jointly administered 336  
trust fund. Notwithstanding any other provision of the Revised 337  
Code, competitive bidding does not apply to the purchase of fringe 338  
benefits for employees under this division when such benefits are 339

provided through a jointly administered trust fund.

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**Sec. 124.822.** (A) The department of administrative services shall require, as a condition of entering into a contract with a health ~~maintenance organization~~ insuring corporation that desires to provide health care services to state employees, including elected public officials, who are paid directly by warrant of the auditor of state and who reside within its approved service area, that the health ~~maintenance organization~~ insuring corporation enroll at least five hundred of such eligible state employees, or at least five per cent of such eligible state employees, whichever is less.

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(B) Division (A) of this section applies only to contracts that are entered into or renewed on or after ~~the effective date of this section~~ JULY 16, 1991.

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**Sec. 124.84.** (A) The department of administrative services, in consultation with the superintendent of insurance and subject to division (D) of this section, shall negotiate and contract with ~~one or more insurance companies, medical or health care insuring corporations, or health maintenance organizations~~ authorized to operate or do business in this state for the purchase of a policy of long-term care insurance covering all state employees who are paid directly by warrant of the auditor of state, including elected state officials. Any policy purchased under this division shall be negotiated and entered into in accordance with the competitive selection procedures specified in Chapter 125. of the Revised Code. As used in this section, "long-term care insurance" has the same meaning as in section 3923.41 of the Revised Code.

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(B) Any elected state official or state employee paid directly by warrant of the auditor of state may elect to

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participate in any long-term care insurance policy purchased under 370  
division (A) of this section and any official or employee who does 371  
so shall be responsible for paying the entire premium charged, 372  
which shall be deducted from the official's or employee's salary 373  
or wage and be remitted by the auditor of state directly to the 374  
insurance company, ~~medical or health care~~ insuring corporation, ~~or~~ 375  
~~health maintenance organization~~. Participation in the policy may 376  
include the dependents and family members of the elected state 377  
official or state employee. 378

If a participant in a long-term care insurance policy leaves 379  
employment, the participant and the participant's dependents and 380  
family members may, at their election, continue to participate in 381  
a policy established under this section in the same manner as if 382  
the participant had not left employment. 383

(C) Any long-term care insurance policy purchased under this 384  
section or section 124.841 or 145.581 of the Revised Code shall 385  
provide for all of the following with respect to the premiums 386  
charged for the policy: 387

(1) They shall be set at the entry age of the official or 388  
employee when first covered by the policy and shall not increase 389  
except as a class during coverage under the policy. 390

(2) They shall be based on the class of all officials or 391  
employees covered by the policy. 392

(3) They shall continue, pursuant to section 145.581 of the 393  
Revised Code, after the retirement of the official or employee who 394  
is covered under the policy, at the rate in effect on the date of 395  
the official's or employee's retirement. 396

(D) Prior to entering into a contract with an insurance 397  
company, ~~medical or health care~~ insuring corporation, ~~or health~~ 398  
~~maintenance organization~~ for the purchase of a long-term care 399  
insurance policy under this section, the department shall request 400

the superintendent of insurance to certify the financial condition 401  
of the company, or corporation, ~~or organization~~. The department 402  
shall not enter into the contract if, according to that 403  
certification, the company, or corporation, ~~or organization~~ is 404  
insolvent, is determined by the superintendent to be potentially 405  
unable to fulfill its contractual obligations, or is placed under 406  
an order of rehabilitation or conservation by a court of competent 407  
jurisdiction or under an order of supervision by the 408  
superintendent. 409

(E) The department shall adopt rules in accordance with 410  
section 111.15 of the Revised Code governing long-term care 411  
insurance purchased under this section. The rules shall establish 412  
methods of payment for participation under this section, which may 413  
include establishment of a payroll deduction plan. 414

**Sec. 124.841.** (A) As used in this section: 415

(1) "Long-term care insurance" has the same meaning as in 416  
section 3923.41 of the Revised Code. 417

(2) "Political subdivision" has the same meaning as in 418  
section 9.833 of the Revised Code. 419

(B) Any political subdivision may negotiate with and may 420  
contract with, one or more insurance companies, ~~medical~~ or health 421  
~~care~~ insuring corporations, ~~or health maintenance organizations~~ 422  
authorized to operate or do business in this state for the 423  
purchase of a policy of long-term care insurance covering all 424  
elected officials and employees of the political subdivision. The 425  
contract may be entered into without competitive bidding. Any 426  
elected official or employee of a political subdivision may elect 427  
to participate in any long-term care insurance policy that the 428  
political subdivision purchases under this division and any 429  
official or employee who does so shall be responsible for paying 430  
the entire premium charged, which shall be deducted from ~~his~~ the 431

official's or employee's salary or wage and be remitted directly 432  
to the insurance company, ~~medical or health care~~ insuring 433  
~~corporation, or health maintenance organization.~~ 434

(C) Any long-term care insurance policy entered into under 435  
this section is subject to division (C) of section 124.84 of the 436  
Revised Code. 437

**Sec. 124.92.** If the superintendent of insurance has approved 438  
all or a portion of a service area expansion of a health 439  
~~maintenance organization~~ insuring corporation into an additional 440  
county or counties, the department of administrative services 441  
shall authorize the ~~organization~~ corporation, at the next open 442  
enrollment period conducted by the department, to participate in 443  
the open enrollment for state employees who reside in the expanded 444  
service area, if both of the following apply: 445

(A) The open enrollment is conducted in accordance with 446  
section ~~1742.12~~ 1751.15 of the Revised Code; 447

(B) Prior to the expansion of the service area, fewer than 448  
two health ~~maintenance organizations~~ insuring corporations were 449  
available to state employees in the county or counties into which 450  
the ~~organization~~ corporation expanded. 451

**Sec. 124.93.** (A) As used in this section, "physician" means 452  
any person who holds a valid certificate to practice medicine and 453  
surgery or osteopathic medicine and surgery issued under Chapter 454  
4731. of the Revised Code. 455

(B) No health ~~maintenance organization~~ insuring corporation 456  
that, on or after ~~the effective date of this section~~ July 1, 1993, 457  
enters into or renews a contract with the department of 458  
administrative services under section 124.82 of the Revised Code 459  
shall, because of a physician's race, color, religion, sex, 460  
national origin, handicap, age, or ancestry, refuse to contract 461

with that physician for the provision of health care services 462  
under that section. 463

Any health ~~maintenance organization~~ insuring corporation that 464  
violates this division is deemed to have engaged in an unlawful 465  
discriminatory practice as defined in section 4112.02 of the 466  
Revised Code and is subject to Chapter 4112. of the Revised Code. 467

(C) Each health ~~maintenance organization~~ insuring corporation 468  
that, on or after ~~the effective date of this section~~ July 1, 1993, 469  
enters into or renews a contract with the department of 470  
administrative services under section 124.82 of the Revised Code 471  
and that refuses to contract with a physician for the provision of 472  
health care services under that section shall provide that 473  
physician with a written notice that clearly explains the reason 474  
or reasons for the refusal. The notice shall be sent to the 475  
physician by regular mail within thirty days after the refusal. 476  
477

Any health ~~maintenance organization~~ insuring corporation that 478  
fails to provide notice in compliance with this division is deemed 479  
to have engaged in an unfair and deceptive act or practice in the 480  
business of insurance as defined in section 3901.21 of the Revised 481  
Code and is subject to sections 3901.19 to 3901.26 of the Revised 482  
Code. 483

**Sec. 145.58.** (A) As used in this section, "ineligible 484  
individual" means all of the following: 485

(1) A former member receiving benefits pursuant to section 486  
145.32, 145.33, 145.331, 145.34, or 145.46 of the Revised Code for 487  
whom eligibility is established more than five years after June 488  
13, 1981, and who, at the time of establishing eligibility, has 489  
accrued less than ten years' service credit, exclusive of credit 490  
obtained pursuant to section 145.297 or 145.298 of the Revised 491  
Code, credit obtained after January 29, 1981, pursuant to section 492

145.293 or 145.301 of the Revised Code, and credit obtained after 493  
May 4, 1992, pursuant to section 145.28 of the Revised Code; 494

(2) The spouse of the former member; 495

(3) The beneficiary of the former member receiving benefits 496  
pursuant to section 145.46 of the Revised Code. 497

(B) The public employees retirement board may enter into 498  
agreements with insurance companies, ~~medical or health care~~ 499  
~~insuring~~ corporations, ~~health maintenance organizations~~, or 500  
government agencies authorized to do business in the state for 501  
issuance of a policy or contract of health, medical, hospital, or 502  
surgical benefits, or any combination thereof, for those 503  
individuals receiving age and service retirement or a disability 504  
or survivor benefit subscribing to the plan, or for PERS retirants 505  
employed under section 145.38 of the Revised Code, for coverage of 506  
benefits in accordance with division (D)(4)(b) of section 145.38 507  
of the Revised Code. Notwithstanding any other provision of this 508  
chapter, the policy or contract may also include coverage for any 509  
eligible individual's spouse and dependent children and for any of 510  
the individual's sponsored dependents as the board determines 511  
appropriate. If all or any portion of the policy or contract 512  
premium is to be paid by any individual receiving age and service 513  
retirement or a disability or survivor benefit, the individual 514  
shall, by written authorization, instruct the board to deduct the 515  
premium agreed to be paid by the individual to the company, 516  
corporation, or agency. 517

The board may contract for coverage on the basis of part or 518  
all of the cost of the coverage to be paid from appropriate funds 519  
of the public employees retirement system. The cost paid from the 520  
funds of the system shall be included in the employer's 521  
contribution rate provided by sections 145.48 and 145.51 of the 522  
Revised Code. The board may by rule provide coverage to ineligible 523

individuals if the coverage is provided at no cost to the 524  
retirement system. The board shall not pay or reimburse the cost 525  
for coverage under this section or section 145.325 of the Revised 526  
Code for any ineligible individual. 527

The board may provide for self-insurance of risk or level of 528  
risk as set forth in the contract with the companies, 529  
corporations, or agencies, and may provide through the 530  
self-insurance method specific benefits as authorized by rules of 531  
the board. 532

(C) If the board provides health, medical, hospital, or 533  
surgical benefits through any means other than a health 534  
~~maintenance organization~~ insuring corporation, it shall offer to 535  
each individual eligible for the benefits the alternative of 536  
receiving benefits through enrollment in a health ~~maintenance~~ 537  
~~organization~~ insuring corporation, if all of the following apply: 538

(1) The health ~~maintenance organization~~ insuring corporation 539  
provides services in the geographical area in which the individual 540  
lives; 541

(2) The eligible individual was receiving health care 542  
benefits through a health maintenance organization or a health 543  
insuring corporation before retirement; 544

(3) The rate and coverage provided by the health ~~maintenance~~ 545  
~~organization~~ insuring corporation to eligible individuals is 546  
comparable to that currently provided by the board under division 547  
(B) of this section. If the rate or coverage provided by the 548  
health ~~maintenance organization~~ insuring corporation is not 549  
comparable to that currently provided by the board under division 550  
(B) of this section, the board may deduct the additional cost from 551  
the eligible individual's monthly benefit. 552

The health ~~maintenance organization~~ insuring corporation 553  
shall accept as an enrollee any eligible individual who requests 554

enrollment. 555

The board shall permit each eligible individual to change 556  
from one plan to another at least once a year at a time determined 557  
by the board. 558

(D) The board shall, beginning the month following receipt of 559  
satisfactory evidence of the payment for coverage, pay monthly to 560  
each recipient of service retirement, or a disability or survivor 561  
benefit under the public employees retirement system who is 562  
eligible for medical insurance coverage under part B of Title 563  
XVIII of "The Social Security Act," 79 Stat. 301 (1965), 42 564  
U.S.C.A. 1395j, as amended, an amount equal to the basic premium 565  
for such coverage, except that the board shall make no such 566  
payment to any ineligible individual. 567

(E) The board shall establish by rule requirements for the 568  
coordination of any coverage, payment, or benefit provided under 569  
this section or section 145.325 of the Revised Code with any 570  
similar coverage, payment, or benefit made available to the same 571  
individual by the police and firemen's disability and pension 572  
fund, state teachers retirement system, school employees 573  
retirement system, or state highway patrol retirement system. 574

(F) The board shall make all other necessary rules pursuant 575  
to the purpose and intent of this section. 576

**Sec. 145.581.** (A) As used in this section: 577

(1) "Long-term care insurance" has the same meaning as in 578  
section 3923.41 of the Revised Code. 579

(2) "Retirement systems" means the public employees 580  
retirement system, the police and firemen's disability and pension 581  
fund, the state teachers retirement system, the school employees 582  
retirement system, and the state highway patrol retirement system. 583

(B) The public employees retirement board shall establish a 584

long-term care insurance program consisting of the programs 585  
authorized by divisions (C) and (D) of this section. Such program 586  
may be established independently or jointly with one or more of 587  
the other retirement systems. If the program is established 588  
jointly, the board shall adopt rules in accordance with section 589  
111.15 of the Revised Code to establish the terms and conditions 590  
of such joint participation. 591

(C) The board shall establish a program under which it makes 592  
long-term care insurance available to any person who participated 593  
in a policy of long-term care insurance for which the state or a 594  
political subdivision contracted under section 124.84 or 124.841 595  
of the Revised Code and is the recipient of a pension, benefit, or 596  
allowance from the system. To implement the program under this 597  
division, the board, subject to division (E) of this section, may 598  
enter into an agreement with the insurance company, ~~medical or~~ 599  
~~health care~~ insuring corporation, ~~health maintenance organization,~~ 600  
or government agency that provided the insurance. The board shall, 601  
under any such agreement, deduct the full premium charged from the 602  
person's benefit, pension, or allowance notwithstanding any 603  
employer agreement to the contrary. 604

Any long-term care insurance policy entered into under this 605  
division is subject to division (C) of section 124.84 of the 606  
Revised Code. 607

(D)(1) The board, subject to division (E) of this section, 608  
shall establish a program under which a recipient of a pension, 609  
benefit, or allowance from the system who is not eligible for such 610  
insurance under division (C) of this section may participate in a 611  
contract for long-term care insurance. Participation may include 612  
the recipient's dependents and family members. 613

(2) The board shall adopt rules in accordance with section 614  
111.15 of the Revised Code governing the program. The rules shall 615

establish methods of payment for participation under this section, 616  
which may include deduction of the full premium charged from a 617  
recipient's pension, benefit, or allowance, or any other method of 618  
payment considered appropriate by the board. 619

(E) Prior to entering into any agreement or contract with an 620  
insurance company, ~~medical or health care~~ insuring corporation, ~~or~~ 621  
~~health maintenance organization~~ for the purchase of, or 622  
participation in, a long-term care insurance policy under this 623  
section, the board shall request the superintendent of insurance 624  
to certify the financial condition of the company, or corporation, 625  
~~or organization~~. The board shall not enter into the agreement or 626  
contract if, according to that certification, the company, or 627  
corporation, ~~or organization~~ is insolvent, is determined by the 628  
superintendent to be potentially unable to fulfill its contractual 629  
obligations, or is placed under an order of rehabilitation or 630  
conservation by a court of competent jurisdiction or under an 631  
order of supervision by the superintendent. 632

**Sec. 305.171.** (A) The board of county commissioners of any 633  
county may contract for, purchase, or otherwise procure and pay 634  
all or any part of the cost of group insurance policies that may 635  
provide benefits including, but not limited to, hospitalization, 636  
surgical care, major medical care, disability, dental care, eye 637  
care, medical care, hearing aids, or prescription drugs, and that 638  
may provide sickness and accident insurance, group legal services, 639  
or group life insurance, or a combination of any of the foregoing 640  
types of insurance or coverage for county officers and employees 641  
and their immediate dependents from the funds or budgets from 642  
which the officers or employees are compensated for services, 643  
issued by an insurance company, ~~a medical care corporation~~ 644  
~~organized under Chapter 1737. of the Revised Code, or a dental~~ 645  
~~care corporation organized under Chapter 1740. of the Revised~~ 646

Code. 647

(B) The board also may negotiate and contract for any plan or 648  
plans of ~~group insurance or~~ health care services with health ~~care~~ 649  
insuring corporations ~~organized~~ holding a certificate of authority 650  
under Chapter ~~1738. 1751.~~ of the Revised Code ~~and health~~ 651  
~~maintenance organizations organized under Chapter 1742. of the~~ 652  
~~Revised Code~~, provided that each officer or employee shall be 653  
permitted to do both of the following: 654

(1) Exercise an option between a plan offered by an insurance 655  
company, ~~medical care corporation, or dental care corporation,~~ and 656  
such plan or plans offered by health ~~care~~ insuring corporations ~~or~~ 657  
~~health maintenance organizations~~ under this division, on the 658  
condition that the officer or employee shall pay any amount by 659  
which the cost of the plan chosen by such officer or employee 660  
pursuant to this division exceeds the cost of the plan offered 661  
under division (A) of this section; 662

(2) Change from one of the plans to another at a time each 663  
year as determined by the board. 664

(C) Section 307.86 of the Revised Code does not apply to the 665  
purchase of benefits for county officers or employees under 666  
divisions (A) and (B) of this section when those benefits are 667  
provided through a jointly administered health and welfare trust 668  
fund in which the county or contracting authority and a collective 669  
bargaining representative of the county employees or contracting 670  
authority agree to participate. 671

(D) The board of trustees of a jointly administered trust 672  
fund that receives contributions pursuant to collective bargaining 673  
agreements entered into between the board of county commissioners 674  
of any county and a collective bargaining representative of the 675  
employees of the county may provide for self-insurance of all risk 676  
in the provision of fringe benefits, and may provide through the 677

self-insurance method specific fringe benefits as authorized by 678  
the rules of the board of trustees of the jointly administered 679  
trust fund. The fringe benefits may include, but are not limited 680  
to, hospitalization, surgical care, major medical care, 681  
disability, dental care, vision care, medical care, hearing aids, 682  
prescription drugs, group life insurance, sickness and accident 683  
insurance, group legal services, or a combination of any of the 684  
foregoing types of insurance or coverage, for employees and their 685  
dependents. 686

(E) The board of county commissioners may provide the 687  
benefits described in divisions (A) to (D) of this section through 688  
an individual self-insurance program or a joint self-insurance 689  
program as provided in section 9.833 of the Revised Code. 690

(F) When a board of county commissioners offers health 691  
benefits authorized under this section to an officer or employee 692  
of the county, the board may offer the benefits through a 693  
cafeteria plan meeting the requirements of section 125 of the 694  
"Internal Revenue Code of 1986," 100 Stat. 2085, 26 U.S.C.A. 125, 695  
as amended, and, as part of that plan, may offer the officer or 696  
employee the option of receiving a cash payment in any form 697  
permissible under such cafeteria plans. A cash payment made to an 698  
officer or employee under this division shall not exceed 699  
twenty-five per cent of the cost of premiums or payments that 700  
otherwise would be paid by the board for benefits for the officer 701  
or employee under a policy or plan. 702

(G) The board of county commissioners may establish a policy 703  
authorizing any county appointing authority to make a cash payment 704  
to any officer or employee in lieu of providing a benefit 705  
authorized under this section if the officer or employee elects to 706  
take the cash payment instead of the offered benefit. A cash 707  
payment made to an officer or employee under this division shall 708  
not exceed twenty-five per cent of the cost of premiums or 709

payments that otherwise would be paid by the board for benefits 710  
for the officer or employee under an offered policy or plan. 711

(H) No cash payment in lieu of a health benefit shall be made 712  
to a county officer or employee under division (F) or (G) of this 713  
section unless the officer or employee signs a statement affirming 714  
that ~~he~~ the officer or employee is covered under another health 715  
insurance or health care policy, contract, or plan, and setting 716  
forth the name of the employer, if any, that sponsors the 717  
coverage, the name of the carrier that provides the coverage, and 718  
the identifying number of the policy, contract, or plan. 719

(I)(1) As used in this division: 720

(a) "County-operated municipal court" and "legislative 721  
authority" have the same meanings as in section 1901.03 of the 722  
Revised Code. 723

(b) "Health care coverage" has the same meaning as in section 724  
1901.111 of the Revised Code. 725

(2) The legislative authority of a county-operated municipal 726  
court, after consultation with the judges, or the clerk and deputy 727  
clerks, of the municipal court, shall negotiate and contract for, 728  
purchase, or otherwise procure, and pay the costs, premiums, or 729  
charges for, group health care coverage for the judges, and group 730  
health care coverage for the clerk and deputy clerks, in 731  
accordance with section 1901.111 or 1901.312 of the Revised Code. 732

**Sec. 306.48.** A regional transit authority may procure and pay 733  
all or any part of the cost of group hospitalization, surgical, 734  
major medical, or sickness and accident insurance or a combination 735  
of any of the foregoing for the officers and employees of the 736  
regional transit authority and their immediate dependents, whether 737  
issued by an insurance company, ~~or nonprofit medical care~~ a health 738  
insuring corporation duly authorized to do business in this state. 739

740

**Sec. 307.86.** Anything to be purchased, leased, leased with an option or agreement to purchase, or constructed, including, but not limited to, any product, structure, construction, reconstruction, improvement, maintenance, repair, or service, except the services of an accountant, architect, attorney at law, physician, professional engineer, construction project manager, consultant, surveyor, or appraiser by or on behalf of the county or contracting authority, as defined in section 307.92 of the Revised Code, at a cost in excess of fifteen thousand dollars, except as otherwise provided in division (D) of section 713.23 and in sections 125.04, 307.022, 307.041, 307.861, 339.05, 340.03, 340.033, 4115.31 to 4115.35, 5119.16, 5513.01, 5543.19, 5713.01, and 6137.05 of the Revised Code, shall be obtained through competitive bidding. However, competitive bidding is not required when:

(A) The board of county commissioners, by a unanimous vote of its members, makes a determination that a real and present emergency exists and such determination and the reasons therefor are entered in the minutes of the proceedings of the board, when:

(1) The estimated cost is less than fifty thousand dollars;  
or

(2) There is actual physical disaster to structures, radio communications equipment, or computers.

Whenever a contract of purchase, lease, or construction is exempted from competitive bidding under division (A)(1) of this section because the estimated cost is less than fifty thousand dollars, but the estimated cost is fifteen thousand dollars or more, the county or contracting authority shall solicit informal estimates from no fewer than three persons who could perform the

contract, before awarding the contract. With regard to each such 770  
contract, the county or contracting authority shall maintain a 771  
record of such estimates, including the name of each person from 772  
whom an estimate is solicited, for no less than one year after the 773  
contract is awarded. 774

(B) The purchase consists of supplies or a replacement or 775  
supplemental part or parts for a product or equipment owned or 776  
leased by the county and the only source of supply for such 777  
supplies, part, or parts is limited to a single supplier. 778

(C) The purchase is from the federal government, state, 779  
another county or contracting authority thereof, a board of 780  
education, township, or municipal corporation. 781

(D) Public social services are purchased for provision by the 782  
county department of human services under section 329.04 of the 783  
Revised Code or program services, such as direct and ancillary 784  
client services, child day-care, case management services, 785  
residential services, and family resource services, are purchased 786  
for provision by a county board of mental retardation and 787  
developmental disabilities under section 5126.05 of the Revised 788  
Code. 789

(E) The purchase consists of human and social services by the 790  
board of county commissioners from nonprofit corporations or 791  
associations under programs which are funded entirely by the 792  
federal government. 793

(F) The purchase consists of any form of an insurance policy 794  
or contract authorized to be issued under Title XXXIX of the 795  
Revised Code or any form of health care ~~contract or plan~~ 796  
authorized to be issued under Chapter ~~1736., 1737., 1740., or~~ 797  
~~1742.~~ 1751. of the Revised Code, or any combination of such 798  
policies, contracts, or plans that the contracting authority is 799  
authorized to purchase, and the contracting authority does all of 800

the following: 801

(1) Determines that compliance with the requirements of this 802  
section would increase, rather than decrease, the cost of such 803  
purchase; 804

(2) Employs a competent consultant to assist the contracting 805  
authority in procuring appropriate coverages at the best and 806  
lowest prices; 807

(3) Requests issuers of such policies, contracts, or plans to 808  
submit proposals to the contracting authority, in a form 809  
prescribed by the contracting authority, setting forth the 810  
coverage and cost of such policies, contracts, or plans as the 811  
contracting authority desires to purchase; 812

(4) Negotiates with such issuers for the purpose of 813  
purchasing such policies, contracts, or plans at the best and 814  
lowest price reasonably possible. 815

(G) The purchase consists of computer hardware, software, or 816  
consulting services that are necessary to implement a computerized 817  
case management automation project administered by the Ohio 818  
prosecuting attorneys association and funded by a grant from the 819  
federal government. 820

(H) Child day-care services are purchased for provision to 821  
county employees. 822

(I)(1) Property, including land, buildings, and other real 823  
property, is leased for offices, storage, parking, or other 824  
purposes and all of the following apply: 825

(a) The contracting authority is authorized by the Revised 826  
Code to lease the property; 827

(b) The contracting authority develops requests for proposals 828  
for leasing the property, specifying the criteria that will be 829  
considered prior to leasing the property, including the desired 830

size and geographic location of the property; 831

(c) The contracting authority receives responses from 832  
prospective lessors with property meeting the criteria specified 833  
in the requests for proposals by giving notice in a manner 834  
substantially similar to the procedures established for giving 835  
notice under section 307.87 of the Revised Code; 836

(d) The contracting authority negotiates with the prospective 837  
lessors to obtain a lease at the best and lowest price reasonably 838  
possible considering the fair market value of the property and any 839  
relocation and operational costs that may be incurred during the 840  
period the lease is in effect. 841

(2) The contracting authority may use the services of a real 842  
estate appraiser to obtain advice, consultations, or other 843  
recommendations regarding the lease of property under this 844  
division. 845

Any issuer of policies, contracts, or plans listed in 846  
division (F) of this section and any prospective lessor under 847  
division (I) of this section may have ~~his~~ the issuer's or 848  
prospective lessor's name and address, or the name and address of 849  
an agent, placed on a special notification list to be kept by the 850  
contracting authority, by sending the contracting authority such 851  
name and address. The contracting authority shall send notice to 852  
all persons listed on the special notification list. Notices shall 853  
state the deadline and place for submitting proposals. The 854  
contracting authority shall mail the notices at least six weeks 855  
prior to the deadline set by the contracting authority for 856  
submitting such proposals. Every five years the contracting 857  
authority may review this list and remove any person from the list 858  
after mailing the person notification of such action. 859

Any contracting authority that negotiates a contract under 860  
division (F) of this section shall request proposals and 861

renegotiate with issuers in accordance with that division at least 862  
every three years from the date of the signing of such a contract. 863

Any consultant employed pursuant to division (F) of this 864  
section and any real estate appraiser employed pursuant to 865  
division (I) of this section shall disclose any fees or 866  
compensation received from any source in connection with that 867  
employment. 868

**Sec. 339.16.** A board of trustees of any county hospital, or 869  
of any county or district tuberculosis hospital, may contract for, 870  
purchase, or otherwise procure on behalf of any or all of its 871  
employees or such employees and their immediate dependents the 872  
following types of fringe benefits: 873

(A) Group or individual insurance contracts which may include 874  
life, sickness, accident, disability, annuities, endowment, 875  
health, medical expense, hospital, dental, surgical and related 876  
coverage or any combination thereof; 877

(B) Group or individual contracts with ~~medical care~~ 878  
~~corporations,~~ health care insuring corporations, ~~dental care~~ 879  
~~corporations,~~ or other providers of professional services, care, 880  
or benefits duly authorized to do business in this state. 881

A board of trustees of any county hospital, or of any county 882  
or district tuberculosis hospital, may contract for, purchase, or 883  
otherwise procure insurance contracts which provide protection for 884  
the trustees and employees against liability, including 885  
professional liability, provided that this section or any 886  
insurance contract issued pursuant to this section shall not be 887  
construed as a waiver of or in any manner affect the immunity of 888  
the hospital or county. 889

All or any portion of the cost, premium, fees, or charges 890  
therefor may be paid in such manner or combination of manners as 891

the board of trustees may determine, including direct payment by  
the employee, and, if authorized in writing by the employee, by  
the board of trustees with moneys made available by deduction from  
or reduction in salary or wages or by the foregoing of a salary or  
wage increase.

Notwithstanding sections 3917.01 and 3917.06 of the Revised  
Code, the board of trustees may purchase group life insurance  
authorized by this section by reason of payment of premiums  
therefor by the board of trustees from its funds, and such group  
life insurance may be issued and purchased if otherwise consistent  
with sections 3917.01 to 3917.06 of the Revised Code.

**Sec. 351.08.** (A) A convention facilities authority may  
procure and pay any or all of the cost of group hospitalization,  
surgical, major medical, sickness and accident insurance, or group  
life insurance, or a combination of any of the foregoing types of  
insurance or coverage for full-time employees and their  
dependents, ~~whether~~ issued by an insurance company ~~or a medical~~  
~~care corporation,~~ duly authorized to do business in this state.

(B) A convention facilities authority also may procure and  
pay any or all of the cost of a plan of group hospitalization,  
surgical, or major medical insurance with a health ~~care~~ insuring  
corporation with a certificate of authority ~~or license~~ issued  
under Chapter ~~1738-~~ 1751. of the Revised Code, provided that each  
full-time employee shall be permitted to:

(1) Exercise an option between a plan offered by an insurance  
company ~~or medical care corporation~~ as provided in division (A) of  
this section and a plan offered by a health ~~care~~ insuring  
corporation under this division, on the condition that the  
full-time employee shall pay the amount by which the cost of the  
plan offered in this division exceeds the cost of the plan offered  
under division (A) of this section; and

(2) Change from one of the two plans to the other at a time 923  
each year as determined by the convention facilities authority. 924

**Sec. 505.60.** (A) The board of township trustees of any 925  
township may procure and pay all or any part of the cost of 926  
insurance policies that may provide benefits for hospitalization, 927  
surgical care, major medical care, disability, dental care, eye 928  
care, medical care, hearing aids, prescription drugs, or sickness 929  
and accident insurance, or a combination of any of the foregoing 930  
types of insurance for township officers and employees. If the 931  
board so procures any such insurance policies, the board shall 932  
provide uniform coverage under these policies for township 933  
officers and full-time township employees and their immediate 934  
dependents and may provide coverage under these policies for 935  
part-time township employees and their immediate dependents, from 936  
the funds or budgets from which the officers or employees are 937  
compensated for services, ~~whether~~ such policies are to be issued 938  
by an insurance company, ~~a medical care corporation organized~~ 939  
~~under Chapter 1737. of the Revised Code, or a dental care~~ 940  
~~corporation organized under Chapter 1740. of the Revised Code~~ duly 941  
authorized to do business in this state. Any township officer or 942  
employee may refuse to accept the insurance coverage without 943  
affecting the availability of such insurance coverage to other 944  
township officers and employees. 945

The board may also contract for group ~~insurance or~~ health 946  
care services with health ~~care~~ insuring corporations ~~organized~~ 947  
holding certificates of authority under Chapter ~~1738.~~ 1751. of the 948  
Revised Code ~~and health maintenance organizations organized under~~ 949  
~~Chapter 1742. of the Revised Code~~ for township officers and 950  
employees. If the board so contracts, it shall provide uniform 951  
coverage under any such contracts for township officers and 952  
full-time township employees and their immediate dependents and 953

may provide coverage under such contracts for part-time township 954  
employees and their immediate dependents, provided that each 955  
officer and employee so covered is permitted to: 956

(1) Choose between a plan offered by an insurance company, 957  
~~medical care corporation, or dental care corporation~~ and a plan 958  
offered by a health ~~care~~ insuring corporation ~~or health~~ 959  
~~maintenance organization~~, and provided further that the officer or 960  
employee pays any amount by which the cost of the plan chosen ~~by~~ 961  
~~him~~ exceeds the cost of the plan offered by the board under this 962  
section; 963

(2) Change ~~his~~ the choice made under division (A) of this 964  
section at a time each year as determined in advance by the board. 965

An addition of a class or change of definition of coverage to 966  
the plan offered by the board may be made at any time that it is 967  
determined by the board to be in the best interest of the 968  
township. If the total cost to the township of the revised plan 969  
for any trustee's coverage does not exceed that cost under the 970  
plan in effect during the prior policy year, the revision of the 971  
plan does not cause an increase in that trustee's compensation. 972

The board may provide the benefits authorized under this 973  
section, without competitive bidding, by contributing to a health 974  
and welfare trust fund administered through or in conjunction with 975  
a collective bargaining representative of the township employees. 976

The board may also provide the benefits described in this 977  
section through an individual self-insurance program or a joint 978  
self-insurance program as provided in section 9.833 of the Revised 979  
Code. 980

(B) A board of township trustees may procure and pay all or 981  
any part of the cost of group life insurance to insure the lives 982  
of officers and full-time employees of the township. The amount of 983  
group life insurance coverage provided by the board to insure the 984

lives of officers of the township shall not exceed fifty thousand 985  
dollars per officer. 986

(C) If a board of township trustees fails to pay one or more 987  
premiums for a policy, contract, or plan of insurance or health 988  
care services authorized by division (A) of this section and the 989  
failure causes a lapse, cancellation, or other termination of 990  
coverage under the policy, contract, or plan, it may reimburse a 991  
township officer or employee for, or pay on behalf of the officer 992  
or employee, any expenses incurred that would have been covered 993  
under the policy, contract, or plan. 994

(D) As used in this section, "part-time township employee" 995  
means a township employee who is hired with the expectation that 996  
the employee will work not more than one thousand five hundred 997  
hours in any year. 998

**Sec. 742.45.** (A) The board of trustees of the police and 999  
firemen's disability and pension fund may enter into an agreement 1000  
with insurance companies, ~~medical or health care~~ insuring 1001  
corporations, ~~health maintenance organizations,~~ or government 1002  
agencies authorized to do business in the state for issuance of a 1003  
policy or contract of health, medical, hospital, or surgical 1004  
benefits, or any combination thereof, for those individuals 1005  
receiving service or disability pensions or survivor benefits 1006  
subscribing to the plan. Notwithstanding any other provision of 1007  
this chapter, the policy or contract may also include coverage for 1008  
any eligible individual's spouse and dependent children and for 1009  
any of the eligible individual's sponsored dependents as the board 1010  
considers appropriate. 1011

If all or any portion of the policy or contract premium is to 1012  
be paid by any individual receiving a service, disability, or 1013  
survivor pension or benefit, the individual shall, by written 1014  
authorization, instruct the board to deduct from the individual's 1015

benefit the premium agreed to be paid by the individual to the 1016  
company, corporation, or agency. 1017

The board may contract for coverage on the basis of part or 1018  
all of the cost of the coverage to be paid from appropriate funds 1019  
of the police and firemen's disability and pension fund. The cost 1020  
paid from the funds of the police and firemen's disability and 1021  
pension fund shall be included in the employer's contribution 1022  
rates provided by sections 742.33 and 742.34 of the Revised Code. 1023

The board may provide for self-insurance of risk or level of 1024  
risk as set forth in the contract with the companies, 1025  
corporations, or agencies, and may provide through the 1026  
self-insurance method specific benefits as authorized by the rules 1027  
of the board. 1028

(B) If the board provides health, medical, hospital, or 1029  
surgical benefits through any means other than a health 1030  
~~maintenance organization~~ insuring corporation, it shall offer to 1031  
each individual eligible for the benefits the alternative of 1032  
receiving benefits through enrollment in a health ~~maintenance~~ 1033  
~~organization~~ insuring corporation, if all of the following apply: 1034

(1) The health ~~maintenance organization~~ insuring corporation 1035  
provides health care services in the geographical area in which 1036  
the individual lives; 1037

(2) The eligible individual was receiving health care 1038  
benefits through a health ~~maintenance organization~~ or a health 1039  
insuring corporation before retirement; 1040

(3) The rate and coverage provided by the health ~~maintenance~~ 1041  
~~organization~~ insuring corporation to eligible individuals is 1042  
comparable to that currently provided by the board under division 1043  
(A) of this section. If the rate or coverage provided by the 1044  
health ~~maintenance organization~~ insuring corporation is not 1045  
comparable to that currently provided by the board under division 1046

(A) of this section, the board may deduct the additional cost from 1047  
the eligible individual's monthly benefit. 1048

The health ~~maintenance organization~~ insuring corporation 1049  
shall accept as an enrollee any eligible individual who requests 1050  
enrollment. 1051

The board shall permit each eligible individual to change 1052  
from one plan to another at least once a year at a time determined 1053  
by the board. 1054

(C) The board shall, beginning the month following receipt of 1055  
satisfactory evidence of the payment for coverage, pay monthly to 1056  
each recipient of service, disability, or survivor benefits under 1057  
the police and firemen's disability and pension fund who is 1058  
eligible for medical insurance coverage under part B of "The 1059  
Social Security Amendments of 1965," 79 Stat. 301, 42 U.S.C.A. 1060  
1395j, as amended, an amount equal to the basic premiums for such 1061  
coverage. 1062

(D) The board shall establish by rule requirements for the 1063  
coordination of any coverage, payment, or benefit provided under 1064  
this section with any similar coverage, payment, or benefit made 1065  
available to the same individual by the public employees 1066  
retirement system, state teachers retirement system, school 1067  
employees retirement system, or state highway patrol retirement 1068  
system. 1069

(E) The board shall make all other necessary rules pursuant 1070  
to the purpose and intent of this section. 1071

**Sec. 742.53.** (A) As used in this section: 1072

(1) "Long-term care insurance" has the same meaning as in 1073  
section 3923.41 of the Revised Code. 1074

(2) "Retirement systems" has the same meaning as in division 1075  
(A) of section 145.581 of the Revised Code. 1076

(B) The board of trustees of the police and firemen's disability and pension fund shall establish a program under which members of the fund, employers on behalf of members, and persons receiving service or disability pensions or survivor benefits are permitted to participate in contracts for long-term care insurance. Participation may include dependents and family members. If a participant in a contract for long-term care insurance leaves ~~his~~ employment, ~~he~~ the participant and ~~his~~ the participant's dependents and family members may, at their election, continue to participate in a program established under this section in the same manner as if ~~he~~ the participant had not left ~~his~~ employment, except that no part of the cost of the insurance shall be paid by ~~his~~ the participant's former employer.

Such program may be established independently or jointly with one or more of the other retirement systems.

(C) The fund may enter into an agreement with insurance companies, ~~medical or health care~~ insuring corporations, ~~health maintenance organizations,~~ or government agencies authorized to do business in the state for issuance of a long-term care ~~insurance~~ policy or contract. However, prior to entering into such an agreement with an insurance company, ~~medical or health care~~ insuring corporation, ~~or health maintenance organization,~~ the fund shall request the superintendent of insurance to certify the financial condition of the company, or corporation, ~~or organization~~. The fund shall not enter into the agreement if, according to that certification, the company, or corporation, ~~or organization~~ is insolvent, is determined by the superintendent to be potentially unable to fulfill its contractual obligations, or is placed under an order of rehabilitation or conservation by a court of competent jurisdiction or under an order of supervision by the superintendent.

(D) The board shall adopt rules in accordance with section

111.15 of the Revised Code governing the program. The rules shall  
establish methods of payment for participation under this section,  
which may include establishment of a payroll deduction plan under  
section 742.56 of the Revised Code, deduction of the full premium  
charged from a person's service or disability pension or survivor  
benefit, or any other method of payment considered appropriate by  
the board. If the program is established jointly with one or more  
of the other retirement systems, the rules also shall establish  
the terms and conditions of such joint participation.

**Sec. 1319.12.** (A)(1) As used in this section, "collection  
agency" means any person who, for compensation, contingent or  
otherwise, or for other valuable consideration, offers services to  
collect an alleged debt asserted to be owed to another.

(2) "Collection agency" does not mean a person whose  
collection activities are confined to and directly related to the  
operation of another business, including, but not limited to, the  
following:

(a) Any bank, including the trust department of a bank, trust  
company, savings and loan association, savings bank, credit union,  
or fiduciary as defined in section 1339.03 of the Revised Code,  
except those that own or operate a collection agency;

(b) Any real estate broker, real estate salesperson, limited  
real estate broker, or limited real estate salesperson, as these  
persons are defined in section 4735.01 of the Revised Code;

(c) Any retail seller collecting its own accounts;

(d) Any insurance company authorized to do business in this  
state under Title XXXIX of the Revised Code or a health  
~~maintenance organization~~ insuring corporation authorized to  
operate in this state under Chapter ~~1742.~~ 1751. of the Revised  
Code;

(e) Any public officer or judicial officer acting under order	1139
of a court;	1140
(f) Any licensee as defined either in section 1321.01 or	1141
1321.71 of the Revised Code, or any registrant as defined in	1142
section 1321.51 of the Revised Code;	1143
(g) Any public utility.	1144
(B) A collection agency with a place of business in this	1145
state may take assignment of another person's accounts, bills, or	1146
other evidences of indebtedness in its own name for the purpose of	1147
billing, collecting, or filing suit in its own name as the real	1148
party in interest.	1149
(C) No collection agency shall commence litigation for the	1150
collection of an assigned account, bill, or other evidence of	1151
indebtedness unless it has taken the assignment in accordance with	1152
all of the following requirements:	1153
(1) The assignment was voluntary, properly executed, and	1154
acknowledged by the person transferring title to the collection	1155
agency.	1156
(2) The collection agency did not require the assignment as a	1157
condition to listing the account, bill, or other evidence of	1158
indebtedness with the collection agency for collection.	1159
(3) The assignment was manifested by a written agreement	1160
separate from and in addition to any document intended for the	1161
purpose of listing the account, bill, or other evidence of	1162
indebtedness with the collection agency. The written agreement	1163
must state the effective date of the assignment and the	1164
consideration paid or given, if any, for the assignment, and must	1165
expressly authorize the collection agency to refer the assigned	1166
account, bill, or other evidence of indebtedness to an attorney	1167
admitted to the practice of law in this state for the commencement	1168

of litigation. The written agreement must also disclose that the  
collection agency may, for purposes of filing an action,  
consolidate the assigned account, bill, or other evidence of  
indebtedness with those of other creditors against an individual  
debtor or co-debtors.

(4) Upon the effective date of the assignment to the  
collection agency, the creditor's account maintained by the  
collection agency in connection with the assigned account, bill,  
or other evidence of indebtedness was canceled.

(D) A collection agency shall commence litigation for the  
collection of an assigned account, bill, or other evidence of  
indebtedness in a court of competent jurisdiction located in the  
county in which the debtor resides, or in the case of co-debtors,  
a county in which at least one of the co-debtors resides.

(E) No collection agency shall commence any litigation  
authorized by this section unless the agency appears by an  
attorney admitted to the practice of law in this state.

(F) This section does not affect the powers and duties of any  
person described in division (A)(2) of this section.

(G) Nothing in this section relieves a collection agency from  
complying with the "Fair Debt Collection Practices Act," 91 Stat.  
874 (1977), 15 U.S.C. 1692, as amended, or deprives any debtor of  
the right to assert defenses as provided in section 1317.031 of  
the Revised Code and 16 C.F.R. 433, as amended.

(H) For purposes of filing an action, a collection agency  
that has taken an assignment or assignments pursuant to this  
section may consolidate the assigned accounts, bills, or other  
evidences of indebtedness of one or more creditors against an  
individual debtor or co-debtors. Each separate assigned account,  
bill, or evidence of indebtedness must be separately identified  
and pled in any consolidated action authorized by this section. If

a debtor or co-debtor raises a good faith dispute concerning any 1200  
account, bill, or other evidence of indebtedness, the court shall 1201  
separate each disputed account, bill, or other evidence of 1202  
indebtedness from the action and hear the disputed account, bill, 1203  
or other evidence of indebtedness on its own merits in a separate 1204  
action. The court shall charge the filing fee of the separate 1205  
action to the losing party. 1206

**Sec. 1337.16.** (A) No physician, health care facility, other 1207  
health care provider, person authorized to engage in the business 1208  
of insurance in this state under Title XXXIX of the Revised Code, 1209  
~~medical care corporation,~~ health care insuring corporation, ~~health~~ 1210  
~~maintenance organization,~~ other health care plan, or legal entity 1211  
that is self-insured and provides benefits to its employees or 1212  
members shall require an individual to create or refrain from 1213  
creating a durable power of attorney for health care, or shall 1214  
require an individual to revoke or refrain from revoking a durable 1215  
power of attorney for health care, as a condition of being 1216  
admitted to a health care facility, being provided health care, 1217  
being insured, or being the recipient of benefits. 1218

(B)(1) Subject to division (B)(2) of this section, an 1219  
attending physician of a principal or a health care facility in 1220  
which a principal is confined may refuse to comply or allow 1221  
compliance with the instructions of an attorney in fact under a 1222  
durable power of attorney for health care on the basis of a matter 1223  
of conscience or on another basis. An employee or agent of an 1224  
attending physician of a principal or of a health care facility in 1225  
which a principal is confined may refuse to comply with the 1226  
instructions of an attorney in fact under a durable power of 1227  
attorney for health care on the basis of a matter of conscience. 1228

(2)(a) An attending physician of a principal who, or health 1229  
care facility in which a principal is confined that, is not 1230

willing or not able to comply or allow compliance with the 1231  
instructions of an attorney in fact under a durable power of 1232  
attorney for health care to use or continue, or to withhold or 1233  
withdraw, health care that were given under division (A) of 1234  
section 1337.13 of the Revised Code, or with any probate court 1235  
reevaluation order issued pursuant to division (D)(6) of this 1236  
section, shall not prevent or attempt to prevent, or unreasonably 1237  
delay or attempt to unreasonably delay, the transfer of the 1238  
principal to the care of a physician who, or a health care 1239  
facility that, is willing and able to so comply or allow 1240  
compliance. 1241

(b) If the instruction of an attorney in fact under a durable 1242  
power of attorney for health care that is given under division (A) 1243  
of section 1337.13 of the Revised Code is to use or continue 1244  
life-sustaining treatment in connection with a principal who is in 1245  
a terminal condition or in a permanently unconscious state, the 1246  
attending physician of the principal who, or the health care 1247  
facility in which the principal is confined that, is not willing 1248  
or not able to comply or allow compliance with that instruction 1249  
shall use or continue the life-sustaining treatment or cause it to 1250  
be used or continued until a transfer as described in division 1251  
(B)(2)(a) of this section is made. 1252

(C) Sections 1337.11 to 1337.17 of the Revised Code and a 1253  
durable power of attorney for health care created under section 1254  
1337.12 of the Revised Code do not affect or limit the authority 1255  
of a physician or a health care facility to provide or not to 1256  
provide health care to a person in accordance with reasonable 1257  
medical standards applicable in an emergency situation. 1258

(D)(1) If the attending physician of a principal and one 1259  
other physician who examines the principal determine that ~~he~~ the 1260  
principal is in a terminal condition or in a permanently 1261  
unconscious state, if the attending physician additionally 1262

determines that the principal has lost the capacity to make 1263  
informed health care decisions for ~~himself~~ the principal and that 1264  
there is no reasonable possibility that the principal will regain 1265  
the capacity to make informed health care decisions for ~~himself~~ 1266  
the principal, and if the attorney in fact under the principal's 1267  
durable power of attorney for health care makes a health care 1268  
decision pertaining to the use or continuation, or the withholding 1269  
or withdrawal, of life-sustaining treatment, the attending 1270  
physician shall do all of the following: 1271

(a) Record the determinations and health care decision in the 1272  
principal's medical record; 1273

(b) Make a good faith effort, and use reasonable diligence, 1274  
to notify the appropriate individual or individuals, in accordance 1275  
with the following descending order of priority, of the 1276  
determinations and health care decision: 1277

(i) If any, the guardian of the principal. This division does 1278  
not permit or require the appointment of a guardian for the 1279  
principal. 1280

(ii) The principal's spouse; 1281

(iii) The principal's adult children who are available within 1282  
a reasonable period of time for consultation with the principal's 1283  
attending physician; 1284

(iv) The principal's parents; 1285

(v) An adult sibling of the principal or, if there is more 1286  
than one adult sibling, a majority of the principal's adult 1287  
siblings who are available within a reasonable period of time for 1288  
such consultation. 1289

(c) Record in the principal's medical record the names of the 1290  
individual or individuals notified pursuant to division (D)(1)(b) 1291  
of this section and the manner of notification; 1292

(d) Afford time for the individual or individuals notified 1293  
pursuant to division (D)(1)(b) of this section to object in the 1294  
manner described in division (D)(3)(a) of this section. 1295

(2)(a) If, despite making a good faith effort, and despite 1296  
using reasonable diligence, to notify the appropriate individual 1297  
or individuals described in division (D)(1)(b) of this section, 1298  
the attending physician cannot notify the individual or 1299  
individuals of the determinations and health care decision because 1300  
the individual or individuals are deceased, cannot be located, or 1301  
cannot be notified for some other reason, the requirements of 1302  
divisions (D)(1)(b), (c), and (d) of this section and, except as 1303  
provided in division (D)(3)(b) of this section, the provisions of 1304  
divisions (D)(3) to (6) of this section shall not apply in 1305  
connection with the principal. However, the attending physician 1306  
shall record in the principal's medical record information 1307  
pertaining to the reason for the failure to provide the requisite 1308  
notices and information pertaining to the nature of the good faith 1309  
effort and reasonable diligence used. 1310

(b) The requirements of divisions (D)(1)(b), (c), and (d) of 1311  
this section and, except as provided in division (D)(3)(b) of this 1312  
section, the provisions of divisions (D)(3) to (6) of this section 1313  
shall not apply in connection with the principal if only one 1314  
individual would have to be notified pursuant to division 1315  
(D)(1)(b) of this section and that individual is the attorney in 1316  
fact under the durable power of attorney for health care. However, 1317  
the attending physician of the principal shall record in the 1318  
principal's medical record information indicating that no notice 1319  
was given pursuant to division (D)(1)(b) of this section because 1320  
of the provisions of division (D)(2)(b) of this section. 1321

(3)(a) Within forty-eight hours after receipt of a notice 1322  
pursuant to division (D)(1) of this section, any individual so 1323  
notified shall advise the attending physician of the principal 1324

whether ~~he~~ the individual objects on a basis specified in division 1325  
(D)(4)(c) of this section. If an objection as described in that 1326  
division is communicated to the attending physician, then, within 1327  
two business days after the communication, the individual shall 1328  
file a complaint as described in division (D)(4) of this section 1329  
in the probate court of the county in which the principal is 1330  
located. If the individual fails to so file a complaint, ~~his~~ the 1331  
individual's objections as described in division (D)(4)(c) of this 1332  
section shall be considered to be void. 1333

(b) Within forty-eight hours after the priority individual or 1334  
any member of a priority class of individuals receives a notice 1335  
pursuant to division (D)(1) of this section or within forty-eight 1336  
hours after information pertaining to an unnotified priority 1337  
individual or unnotified priority class of individuals is recorded 1338  
in a principal's medical record pursuant to division (D)(2)(a) or 1339  
(b) of this section, the individual or a majority of the 1340  
individuals in the next class of individuals that pertains to the 1341  
principal in the descending order of priority set forth in 1342  
divisions (D)(1)(b)(i) to (v) of this section shall advise the 1343  
attending physician of the principal whether ~~he~~ the individual or 1344  
~~they~~ majority object on a basis specified in division (D)(4)(c) of 1345  
this section. If an objection as described in that division is 1346  
communicated to the attending physician, then, within two business 1347  
days after the communication, the objecting individual or majority 1348  
shall file a complaint as described in division (D)(4) of this 1349  
section in the probate court of the county in which the principal 1350  
is located. If the objecting individual or majority fails to file 1351  
a complaint, ~~his or their~~ the objections as described in division 1352  
(D)(4)(c) of this section shall be considered to be void. 1353

(4) A complaint of an individual that is filed in accordance 1354  
with division (D)(3)(a) of this section or of an individual or 1355  
majority of individuals that is filed in accordance with division 1356

(D)(3)(b) of this section shall satisfy all of the following:	1357
(a) Name any health care facility in which the principal is confined;	1358 1359
(b) Name the principal, <del>his</del> <u>the principal's</u> attending physician, and the consulting physician associated with the determination that the principal is in a terminal condition or in a permanently unconscious state;	1360 1361 1362 1363
(c) Indicate whether the plaintiff or plaintiffs object on one or more of the following bases:	1364 1365
(i) To the attending physician's determination that the principal has lost the capacity to make informed health care decisions for <del>himself</del> <u>the principal</u> ;	1366 1367 1368
(ii) To the attending physician's determination that there is no reasonable possibility that the principal will regain the capacity to make informed health care decisions for <del>himself</del> <u>the principal</u> ;	1369 1370 1371 1372
(iii) That, in exercising <del>his</del> <u>the attorney in fact's</u> authority, the attorney in fact is not acting consistently with the desires of the principal or, if the desires of the principal are unknown, in the best interest of the principal;	1373 1374 1375 1376
(iv) That the durable power of attorney for health care has expired or otherwise is no longer effective;	1377 1378
(v) To the attending physician's and consulting physician's determinations that the principal is in a terminal condition or in a permanently unconscious state;	1379 1380 1381
(vi) That the attorney in fact's health care decision pertaining to the use or continuation, or the withholding or withdrawal, of life-sustaining treatment is not authorized by the durable power of attorney for health care or is prohibited under section 1337.13 of the Revised Code;	1382 1383 1384 1385 1386

(vii) That the durable power of attorney for health care was 1387  
executed when the principal was not of sound mind or was under or 1388  
subject to duress, fraud, or undue influence; 1389

(viii) That the durable power of attorney for health care 1390  
otherwise does not substantially comply with section 1337.12 of 1391  
the Revised Code. 1392

(d) Request the probate court to issue one or more of the 1393  
following types of orders: 1394

(i) An order to the attending physician to reevaluate, in 1395  
light of the court proceedings, the determination that the 1396  
principal has lost the capacity to make informed health care 1397  
decisions for ~~himself~~ the principal, the determination that the 1398  
principal is in a terminal condition or in a permanently 1399  
unconscious state, or the determination that there is no 1400  
reasonable possibility that the principal will regain the capacity 1401  
to make informed health care decisions for ~~himself~~ the principal; 1402

(ii) An order to the attorney in fact to act consistently 1403  
with the desires of the principal or, if the desires of the 1404  
principal are unknown, in the best interest of the principal in 1405  
exercising ~~his~~ the attorney in fact's authority, or to make only 1406  
health care decisions pertaining to life-sustaining treatment that 1407  
are authorized by the durable power of attorney for health care 1408  
and that are not prohibited under section 1337.13 of the Revised 1409  
Code; 1410

(iii) An order invalidating the durable power of attorney for 1411  
health care because it has expired or otherwise is no longer 1412  
effective, it was executed when the principal was not of sound 1413  
mind or was under or subject to duress, fraud, or undue influence, 1414  
or it otherwise does not substantially comply with section 1337.12 1415  
of the Revised Code. 1416

(e) Be accompanied by an affidavit of the plaintiff or 1417

1418 plaintiffs that includes averments relative to whether ~~he~~ the  
1419 plaintiff is an individual or ~~they~~ the plaintiffs are individuals  
1420 as described in division (D)(1)(b)(i), (ii), (iii), (iv), or (v)  
1421 of this section and to the factual basis for ~~his~~ the plaintiff's  
1422 or ~~their~~ the plaintiffs' objections;

(f) Name any individuals who were notified by the attending 1423  
physician in accordance with division (D)(1)(b) of this section 1424  
and who are not joining in the complaint as plaintiffs; 1425

(g) Name, in the caption of the complaint, as defendants the 1426  
attending physician of the principal, the attorney in fact under 1427  
the durable power of attorney for health care, the consulting 1428  
physician associated with the determination that the principal is 1429  
in a terminal condition or in a permanently unconscious state, any 1430  
health care facility in which the principal is confined, and any 1431  
individuals who were notified by the attending physician in 1432  
accordance with division (D)(1)(b) of this section and who are not 1433  
joining in the complaint as plaintiffs. 1434

(5) Notwithstanding any contrary provision of the Revised 1435  
Code or of the Rules of Civil Procedure, the state and persons 1436  
other than an objecting individual as described in division 1437  
(D)(3)(a) of this section, other than an objecting individual or 1438  
majority of individuals as described in division (D)(3)(b) of this 1439  
section, and other than persons described in division (D)(4)(g) of 1440  
this section are prohibited from commencing a civil action under 1441  
division (D) of this section and from joining or being joined as 1442  
parties to an action commenced under division (D) of this section, 1443  
including joining by way of intervention. 1444

(6)(a) A probate court in which a complaint as described in 1445  
division (D)(4) of this section is filed within the period 1446  
specified in division (D)(3)(a) or (b) of this section shall 1447  
conduct a hearing on the complaint after a copy of it and a notice 1448

of the hearing have been served upon the defendants. The clerk of  
the probate court in which the complaint is filed shall cause the  
complaint and the notice of the hearing to be so served in  
accordance with the Rules of Civil Procedure, which service shall  
be made, if possible, within three days after the filing of the  
complaint. The hearing shall be conducted at the earliest possible  
time, but no later than the third business day after such service  
has been completed. Immediately following the hearing, the court  
shall enter on its journal its determination whether a requested  
order will be issued.

(b) If the health care decision of the attorney in fact  
authorized the use or continuation of life-sustaining treatment  
and if the plaintiff or plaintiffs requested a reevaluation order  
to the attending physician of the principal or an order to the  
attorney in fact as described in division (D)(4)(d)(i) or (ii) of  
this section, the court shall issue the requested order only if it  
finds that the plaintiff or plaintiffs have established a factual  
basis for the objection or objections involved by clear and  
convincing evidence and, if applicable, to a reasonable degree of  
medical certainty and in accordance with reasonable medical  
standards.

(c) If the health care decision of the attorney in fact  
authorized the withholding or withdrawal of life-sustaining  
treatment and if the plaintiff or plaintiffs requested a  
reevaluation order to the attending physician of the principal or  
an order to the attorney in fact as described in division  
(D)(4)(d)(i) or (ii) of this section, the court shall issue the  
requested order only if it finds that the plaintiff or plaintiffs  
have established a factual basis for the objection or objections  
involved by a preponderance of the evidence and, if applicable, to  
a reasonable degree of medical certainty and in accordance with  
reasonable medical standards.

(d) If the plaintiff or plaintiffs requested an invalidation order as described in division (D)(4)(d)(iii) of this section, the court shall issue the order only if it finds that the plaintiff or plaintiffs have established a factual basis for the objection or objections involved by clear and convincing evidence.

(e) If the court issues a reevaluation order to the principal's attending physician pursuant to division (D)(6)(b) or (c) of this section, the attending physician shall make the requisite reevaluation. If, after doing so, the attending physician again determines that the principal has lost the capacity to make informed health care decisions for ~~himself~~ the principal, that the principal is in a terminal condition or in a permanently unconscious state, or that there is no reasonable possibility that the principal will regain the capacity to make informed health care decisions for ~~himself~~ the principal, the attending physician shall notify the court in writing of the determination and comply with division (B)(2) of this section.

(E)(1) In connection with the provision of comfort care in a manner consistent with divisions (C) and (E) of section 1337.13 of the Revised Code to a principal who is in a terminal condition or in a permanently unconscious state, nothing in sections 1337.11 to 1337.17 of the Revised Code precludes the attending physician of the principal who carries out the responsibility to provide comfort care to the principal in good faith and while acting within the scope of ~~his~~ the attending physician's authority from prescribing, dispensing, administering, or causing to be administered any particular medical procedure, treatment, intervention, or other measure to the principal, including, but not limited to, prescribing, dispensing, administering, or causing to be administered by judicious titration or in another manner any form of medication, for the purpose of diminishing ~~his~~ the principal's pain or discomfort and not for the purpose of

postponing or causing ~~his~~ the principal's death, even though the 1513  
medical procedure, treatment, intervention, or other measure may 1514  
appear to hasten or increase the risk of the principal's death. In 1515  
connection with the provision of comfort care in a manner 1516  
consistent with divisions (C) and (E) of section 1337.13 of the 1517  
Revised Code to a principal who is in a terminal condition or in a 1518  
permanently unconscious state, nothing in sections 1337.11 to 1519  
1337.17 of the Revised Code precludes health care personnel acting 1520  
under the direction of the principal's attending physician who 1521  
carry out the responsibility to provide comfort care to the 1522  
principal in good faith and while acting within the scope of their 1523  
authority from dispensing, administering, or causing to be 1524  
administered any particular medical procedure, treatment, 1525  
intervention, or other measure to the principal, including, but 1526  
not limited to, dispensing, administering, or causing to be 1527  
administered by judicious titration or in another manner any form 1528  
of medication, for the purpose of diminishing ~~his~~ the principal's 1529  
pain or discomfort and not for the purpose of postponing or 1530  
causing ~~his~~ the principal's death, even though the medical 1531  
procedure, treatment, intervention, or other measure may appear to 1532  
hasten or increase the risk of the principal's death. 1533

(2) If, at any time, a priority individual or any member of a 1534  
priority class of individuals under division (D)(1)(b) of this 1535  
section or if, at any time, the individual or a majority of the 1536  
individuals in the next class of individuals that pertains to the 1537  
principal in the descending order of priority set forth in that 1538  
division, believes in good faith that both of the following 1539  
circumstances apply, the priority individual, the member of the 1540  
priority class of individuals, or the individual or majority of 1541  
individuals in the next class of individuals that pertains to the 1542  
principal may commence an action in the probate court of the 1543  
county in which a principal who is in a terminal condition or 1544  
permanently unconscious state is located for the issuance of an 1545

order mandating the use or continuation of comfort care in 1546  
connection with the principal in a manner that is consistent with 1547  
sections 1337.11 to 1337.17 of the Revised Code: 1548

(a) Comfort care is not being used or continued in connection 1549  
with the principal. 1550

(b) The withholding or withdrawal of the comfort care is 1551  
contrary to sections 1337.11 to 1337.17 of the Revised Code. 1552

(F) Except as provided in divisions (D) and (E) of this 1553  
section in connection with principals who are in a terminal 1554  
condition or in a permanently unconscious state, sections 1337.11 1555  
to 1337.17 of the Revised Code do not authorize the commencement 1556  
of any civil action in a probate court or court of common pleas 1557  
for the purpose of obtaining an order relative to a health care 1558  
decision made by an attorney in fact under a durable power of 1559  
attorney for health care. 1560

(G) A durable power of attorney for health care, or other 1561  
document, that is similar to a durable power of attorney for 1562  
health care authorized by sections 1337.11 to 1337.17 of the 1563  
Revised Code, that is or has been executed under the law of 1564  
another state prior to, on, or after October 10, 1991, and that 1565  
substantially complies with that law or with sections 1337.11 to 1566  
1337.17 of the Revised Code shall be considered to be valid for 1567  
purposes of those sections. 1568

**Sec. 1545.071.** The board of park commissioners of any park 1569  
district may procure and pay all or any part of the cost of group 1570  
insurance policies that may provide benefits for hospitalization, 1571  
surgical care, major medical care, disability, dental care, eye 1572  
care, medical care, hearing aids, or prescription drugs, or 1573  
sickness and accident insurance or a combination of any of the 1574  
foregoing types of insurance or coverage for park district 1575

officers and employees and their immediate dependents issued by an 1576  
insurance company, ~~a medical care corporation organized under~~ 1577  
~~Chapter 1737. of the Revised Code, or a dental care corporation~~ 1578  
~~organized under Chapter 1740. of the Revised Code~~ duly authorized 1579  
to do business in this state. 1580

The board may procure and pay all or any part of the cost of 1581  
group life insurance to insure the lives of park district 1582  
employees. 1583

The board also may contract for group ~~insurance or~~ health 1584  
care services with health ~~care~~ insuring corporations ~~organized~~ 1585  
holding a certificate of authority under Chapter ~~1738.~~ 1751. of 1586  
the Revised Code and ~~health maintenance organizations organized~~ 1587  
~~under Chapter 1742. of the Revised Code~~ provided that each officer 1588  
or employee is permitted to: 1589

(A) Choose between a plan offered by an insurance company, 1590  
~~medical care corporation, or dental care corporation~~ and a plan 1591  
offered by a health ~~care~~ insuring corporation ~~or health~~ 1592  
~~maintenance organization~~ and provided further that the officer or 1593  
employee pays any amount by which the cost of the plan chosen by 1594  
~~him~~ the officer or employee exceeds the cost of the plan offered 1595  
by the board under this section; 1596

(B) Change ~~his~~ the choice made under division (A) of this 1597  
section at a time each year as determined in advance by the board. 1598

Any appointed member of the board of park commissioners and 1599  
the spouse and dependent children of the member may be covered, at 1600  
the option and expense of the member, as a noncompensated employee 1601  
of the park district under any benefit plan described in division 1602  
(A) of this section. The member shall pay to the park district the 1603  
amount certified to it by the benefit provider as the provider's 1604  
charge for the coverage the member has chosen under division (A) 1605  
of this section. Payments for coverage shall be made, in advance, 1606

in a manner prescribed by the board. The member's exercise of an  
option to be covered under this section shall be in writing,  
announced at a regular public meeting of the board, and recorded  
as a public record in the minutes of the board.

The board may provide the benefits authorized in this section  
by contributing to a health and welfare trust fund administered  
through or in conjunction with a collective bargaining  
representative of the park district employees.

The board may provide the benefits described in this section  
through an individual self-insurance program or a joint  
self-insurance program as provided in section 9.833 of the Revised  
Code.

**Sec. 1731.01.** As used in this chapter:

(A) "Alliance" or "small employer health care alliance" means  
an existing or newly created organization that has been granted a  
certificate of authority by the superintendent of insurance under  
section 1731.021 of the Revised Code and that is either of the  
following:

(1) A chamber of commerce, trade association, professional  
organization, or any other organization that has all of the  
following characteristics:

(a) Is a nonprofit corporation or association;

(b) Has members that include or are exclusively small  
employers;

(c) Sponsors or is part of a program to assist such small  
employer members to obtain coverage for their employees under one  
or more health benefit plans;

(d) Is not directly or indirectly controlled, through voting  
membership, representation on its governing board, or otherwise,

by any insurance company, person, firm, or corporation that sells insurance, any provider, or by persons who are officers, trustees, or directors of such enterprises, or by any combination of such enterprises or persons.

(2) A nonprofit corporation controlled by one or more organizations described in division (A)(1) of this section.

(B) "Alliance program" or "alliance health care program" means a program sponsored by a small employer health care alliance that assists small employer members of such small employer health care alliance or any other small employer health care alliance to obtain coverage for their employees under one or more health benefit plans, and that includes at least one agreement between a small employer health care alliance and an insurer that contains the insurer's agreement to offer and sell one or more health benefit plans to such small employers and contains all of the other features required under section 1731.04 of the Revised Code.

(C) "Eligible employees, retirees, their dependents, and members of their families," as used together or separately, means the active employees of a small employer, or retired former employees of a small employer or predecessor firm or organization, their dependents or members of their families, who are eligible for coverage under the terms of the applicable alliance program.

(D) "Enrolled small employer" or "enrolled employer" means a small employer that has obtained coverage for its eligible employees from an insurer under an alliance program.

(E) "Health benefit plan" means any hospital or medical expense policy of insurance or a health care plan provided by an insurer, including a health ~~maintenance organization~~ insuring corporation plan and a ~~preferred provider organization plan~~, provided by or through an insurer, or any combination thereof. "Health benefit plan" does not include any of the following:

(1) A policy covering only accident, credit, dental, 1668  
disability income, long-term care, hospital indemnity, medicare 1669  
supplement, specified disease, or vision care, ~~or coverage issued~~ 1670  
~~by a health care corporation~~, except where any of the foregoing is 1671  
offered as an addition, indorsement, or rider to a health benefit 1672  
plan; 1673

(2) Coverage issued as a supplement to liability insurance, 1674  
insurance arising out of a workers' compensation or similar law, 1675  
automobile medical-payment insurance, or insurance under which 1676  
benefits are payable with or without regard to fault and which is 1677  
statutorily required to be contained in any liability insurance 1678  
policy or equivalent self-insurance; 1679

(3) Coverage issued by a health insuring corporation 1680  
authorized to offer supplemental health care services only. 1681

(F) "Insurer" means an insurance company authorized to do the 1682  
business of sickness and accident insurance in this state or, for 1683  
the purposes of this chapter, a health ~~maintenance organization~~ 1684  
insuring corporation authorized to issue health ~~benefit care~~ plans 1685  
in this state. 1686

(G) "Participants" or "beneficiaries" means those eligible 1687  
employees, retirees, their dependents, and members of their 1688  
families who are covered by health benefit plans provided by an 1689  
insurer to enrolled small employers under an alliance program. 1690

(H) "Provider" means a hospital, urgent care facility, 1691  
nursing home, physician, podiatrist, dentist, pharmacist, 1692  
chiropractor, certified registered nurse anesthetist, dietitian, 1693  
~~health maintenance organization~~, or other health care provider 1694  
licensed by this state, or group of such health care providers. 1695

(I) "Qualified alliance program" means an alliance program 1696  
under which health care benefits are provided to two thousand five 1697  
hundred or more participants. 1698

(J) "Small employer," regardless of its definition in any other chapter of the Revised Code, in this chapter means an employer that employs no more than one hundred fifty full-time employees, at least a majority of whom are employed at locations within this state.

(1) For this purpose:

(a) Each entity that is controlled by, controls, or is under common control with, one or more other entities shall, together with such other entities, be considered to be a single employer.

(b) "Full-time employee" means a person who normally works at least twenty-five hours per week and at least forty weeks per year for the employer.

(c) An employer will be treated as having one hundred fifty or fewer full-time employees on any day if, during the prior calendar year or any twelve consecutive months during the twenty-four full months immediately preceding that day, the mean number of full-time employees employed by the employer does not exceed one hundred fifty.

(2) An employer that qualifies as a small employer for purposes of becoming an enrolled small employer continues to be treated as a small employer for purposes of this chapter until such time as it fails to meet the conditions described in division (J)(1) of this section for any period of thirty-six consecutive months after first becoming an enrolled small employer, unless earlier disqualified under the terms of the alliance program.

**Sec. 1731.06.** (A) No health benefit plan offered or provided by an insurer to a small employer under a qualified alliance program is subject to any law that does any of the following:

(1) Inhibits the insurer from selectively contracting with

providers or groups of providers with respect to health care	1729
service or benefits;	1730
(2) Imposes any restrictions on the ability of the insurer to	1731
negotiate with providers regarding the level or method of	1732
reimbursing for care or services;	1733
(3) Requires the insurer either to include a specific	1734
provider or class of providers, or to exclude any class of	1735
providers that are generally authorized by law to provide such	1736
care, in connection with health care services or benefits under	1737
such health benefit plan;	1738
(4) Limits the financial incentives that a health benefit	1739
plan may require a beneficiary to pay when a nonplan provider is	1740
used on a nonemergency basis;	1741
(5) Prohibits utilization review of any or all treatments and	1742
conditions;	1743
(6) Requires the use of specified standards of health care	1744
practice in such reviews or requires the disclosure of the	1745
specific criteria used in such reviews;	1746
(7) Requires payments to providers for the expenses of	1747
responding to utilization review requests;	1748
(8) Imposes liability for delays in performing such review.	1749
(B) Notwithstanding division (A) of this section, every	1750
health benefit plan offered or provided by an insurer, other than	1751
a health <del>maintenance organization</del> <u>insuring corporation</u> , to a small	1752
employer under a qualified alliance program is subject to sections	1753
3923.23, 3923.231, 3923.232, 3923.233, and 3923.234 of the Revised	1754
Code and any other provision of the Revised Code that requires the	1755
reimbursement, utilization, or consideration of a specific	1756
category of licensed or certified health care practitioner.	1757

**Sec. 1739.05.** (A) A multiple employer welfare arrangement 1758  
that is created pursuant to sections 1739.01 to 1739.22 of the 1759  
Revised Code and that operates a group self-insurance program may 1760  
be established only if any of the following applies: 1761

(1) The arrangement has and maintains a minimum enrollment of 1762  
three hundred employees of two or more employers. 1763

(2) The arrangement has and maintains a minimum enrollment of 1764  
three hundred self-employed individuals. 1765

(3) The arrangement has and maintains a minimum enrollment of 1766  
three hundred employees or self-employed individuals in any 1767  
combination of divisions (A)(1) and (2) of this section. 1768

(B) A multiple employer welfare arrangement that is created 1769  
pursuant to sections 1739.01 to 1739.22 of the Revised Code and 1770  
that operates a group self-insurance program shall comply with all 1771  
laws applicable to self-funded programs in this state, including 1772  
sections 3901.04, 3901.041, 3901.19 to 3901.26, 3901.38, 3901.40, 1773  
3901.45, 3901.46, 3902.01 to 3902.14, 3923.30, 3923.301, and 1774  
3923.38 of the Revised Code. 1775

(C) A multiple employer welfare arrangement created pursuant 1776  
to sections 1739.01 to 1739.22 of the Revised Code shall solicit 1777  
enrollments only through agents or solicitors licensed pursuant to 1778  
Chapter 3905. of the Revised Code to sell or solicit sickness and 1779  
accident insurance. 1780

(D) A multiple employer welfare arrangement created pursuant 1781  
to sections 1739.01 to 1739.22 of the Revised Code shall provide 1782  
benefits only to individuals who are members, employees of 1783  
members, or the dependents of members or employees, or are 1784  
eligible for continuation of coverage under section ~~1742.34~~ 1785  
1751.53 or 3923.38 of the Revised Code or under Title X of the 1786  
"Consolidated Omnibus Budget Reconciliation Act of 1985," 100 1787

Stat. 227, 29 U.S.C.A. 1161, as amended.	1788
Sec. 1751.01. <u>As used in this chapter:</u>	1789
<u>(A) "Basic health care services" means the following services</u>	1790
<u>when medically necessary:</u>	1791
<u>(1) Physician's services, except when such services are</u>	1792
<u>supplemental under division (B) of this section;</u>	1793
<u>(2) Inpatient hospital services;</u>	1794
<u>(3) Outpatient medical services;</u>	1795
<u>(4) Emergency health services;</u>	1796
<u>(5) Urgent care services;</u>	1797
<u>(6) Diagnostic laboratory services and diagnostic and</u>	1798
<u>therapeutic radiologic services;</u>	1799
<u>(7) Preventive health care services, including, but not</u>	1800
<u>limited to, voluntary family planning services, infertility</u>	1801
<u>services, periodic physical examinations, prenatal obstetrical</u>	1802
<u>care, and well-child care.</u>	1803
<u>"Basic health care services" does not include experimental</u>	1804
<u>procedures.</u>	1805
<u>A health insuring corporation shall not offer coverage for a</u>	1806
<u>health care service, defined as a basic health care service by</u>	1807
<u>this division, unless it offers coverage for all listed basic</u>	1808
<u>health care services. However, THIS REQUIREMENT DOES NOT APPLY TO</u>	1809
<u>THE COVERAGE OF BENEFICIARIES ENROLLED IN TITLE XVIII OF THE</u>	1810
<u>"SOCIAL SECURITY ACT," 49 STAT. 620 (1935), 42 U.S.C.A. 301, AS</u>	1811
<u>AMENDED, PURSUANT TO A MEDICARE RISK CONTRACT OR MEDICARE COST</u>	1812
<u>CONTRACT, OR TO THE COVERAGE OF BENEFICIARIES ENROLLED IN THE</u>	1813
<u>FEDERAL EMPLOYEE HEALTH BENEFITS PROGRAM PURSUANT TO 5 U.S.C.A.</u>	1814
<u>8905, OR TO THE COVERAGE OF BENEFICIARIES ENROLLED IN TITLE XIX OF</u>	1815
<u>THE "SOCIAL SECURITY ACT," 49 STAT. 620 (1935), 42 U.S.C.A. 301,</u>	1816
<u>AS AMENDED, KNOWN AS THE MEDICAL ASSISTANCE PROGRAM OR MEDICAID,</u>	1817

PROVIDED BY THE OHIO DEPARTMENT OF HUMAN SERVICES UNDER CHAPTER 1818  
5111. OF THE REVISED CODE, OR TO THE COVERAGE OF BENEFICIARIES 1819  
UNDER ANY FEDERAL HEALTH CARE PROGRAM REGULATED BY A FEDERAL 1820  
REGULATORY BODY. 1821

(B) "Supplemental health care services" means any health care 1822  
services other than basic health care services that a health 1823  
insuring corporation may offer, alone or in combination with 1824  
either basic health care services or other supplemental health 1825  
care services, and includes: 1826

(1) Services of facilities for intermediate or long-term 1827  
care, or both; 1828

(2) Dental care services; 1829

(3) Vision care and optometric services including lenses and 1830  
frames; 1831

(4) Podiatric care or foot care services; 1832

(5) Mental health services including psychological services; 1833

(6) Short-term outpatient evaluative and crisis-intervention 1834  
mental health services; 1835

(7) Medical or psychological treatment and referral services 1836  
for alcohol and drug abuse or addiction; 1837

(8) Home health services; 1838

(9) Prescription drug services; 1839

(10) Nursing services; 1840

(11) Services of a dietitian licensed under Chapter 4759. of 1841  
the Revised Code; 1842

(12) Physical therapy services; 1843

(13) Chiropractic services; 1844

(14) Any other category of services approved by the 1845

<u>superintendent of insurance.</u>	1846
<u>(C) "SPECIALTY HEALTH CARE SERVICES" MEANS ONE OF THE</u>	1847
<u>SUPPLEMENTAL HEALTH CARE SERVICES LISTED IN DIVISION (B)(1) TO</u>	1848
<u>(13) OF THIS SECTION, WHEN PROVIDED BY A HEALTH INSURING</u>	1849
<u>CORPORATION ON AN OUTPATIENT-ONLY BASIS AND NOT IN COMBINATION</u>	1850
<u>WITH OTHER SUPPLEMENTAL HEALTH CARE SERVICES.</u>	1851
<u>(D) "CLOSED PANEL PLAN" MEANS A HEALTH CARE PLAN THAT</u>	1852
<u>REQUIRES ENROLLEES TO USE PARTICIPATING PROVIDERS.</u>	1853
<u>(E) "COMPENSATION" MEANS REMUNERATION FOR THE PROVISION OF</u>	1854
<u>HEALTH CARE SERVICES, DETERMINED ON OTHER THAN A FEE-FOR-SERVICE</u>	1855
<u>OR DISCOUNTED-FEE-FOR-SERVICE BASIS.</u>	1856
<u>(F) "Contractual periodic prepayment" means the formula for</u>	1857
<u>determining the premium rate for all subscribers of a health</u>	1858
<u>insuring corporation.</u>	1859
<u>(G) "Corporation" means a corporation formed under Chapter</u>	1860
<u>1701. or 1702. of the Revised Code or the similar laws of another</u>	1861
<u>state.</u>	1862
<u>(H) "Emergency health services" means those health care</u>	1863
<u>services that must be available on a seven-days-per-week,</u>	1864
<u>twenty-four-hours-per-day basis in order to prevent jeopardy to an</u>	1865
<u>enrollee's health status that would occur if such services were</u>	1866
<u>not received as soon as possible, and includes, where appropriate,</u>	1867
<u>provisions for transportation and indemnity payments or service</u>	1868
<u>agreements for out-of-area coverage.</u>	1869
<u>(I) "Enrollee" means any natural person who is entitled to</u>	1870
<u>receive health care benefits provided by a health insuring</u>	1871
<u>corporation.</u>	1872
<u>(J) "Evidence of coverage" means any certificate, agreement,</u>	1873
<u>policy, or contract issued to a subscriber that sets out the</u>	1874
<u>coverage and other rights to which such person is entitled under a</u>	1875

health care plan. 1876

(K) "Health care facility" means any facility, except a health care practitioner's office, that provides preventive, diagnostic, therapeutic, acute convalescent, rehabilitation, mental health, mental retardation, intermediate care, or skilled nursing services. 1877  
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(L) "Health care services" means any services involved in or incident to the furnishing of preventive, diagnostic, therapeutic, or rehabilitative care. 1882  
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(M) "Health delivery network" means any group of providers or health care facilities, or both, or any representative thereof, that have entered into an agreement to offer health care services in a panel rather than on an individual basis. 1885  
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(N) "Health insuring corporation" means a corporation, as defined in division (G) of this section, that, pursuant to a policy, contract, certificate, or agreement, pays for, reimburses, or provides, delivers, arranges for, or otherwise makes available, basic health care services, supplemental health care services, or SPECIALTY HEALTH CARE SERVICES, OR A COMBINATION OF BASIC HEALTH CARE SERVICES AND EITHER SUPPLEMENTAL HEALTH CARE SERVICES OR SPECIALTY health care services, through either an open panel plan or a closed panel plan. 1889  
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"Health insuring corporation" does not include a limited liability company formed pursuant to Chapter 1705. of the Revised Code, a corporation formed by or on behalf of a political subdivision or a department, office, or institution of the state, OR A public entity FORMED BY OR ON BEHALF OF A BOARD OF COUNTY COMMISSIONERS, A COUNTY BOARD OF MENTAL RETARDATION AND DEVELOPMENTAL DISABILITIES, AN ALCOHOL AND DRUG ADDICTION SERVICES BOARD, A BOARD OF ALCOHOL, DRUG ADDICTION, AND MENTAL HEALTH SERVICES, OR A COMMUNITY MENTAL HEALTH BOARD, AS THOSE TERMS ARE 1898  
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USED IN CHAPTERS 340. and 5126. OF THE REVISED CODE. EXCEPT AS 1907  
PROVIDED BY DIVISION (D) OF SECTION 1751.02 of the Revised Code, 1908  
or as otherwise provided by law, no board, commission, agency, or 1909  
other entity under the control of a political subdivision may 1910  
accept insurance risk in providing for health care services. 1911  
However, nothing in this division shall be construed as 1912  
prohibiting such entities from purchasing the services of a health 1913  
insuring corporation or a third-party administrator licensed under 1914  
Chapter 3959. of the Revised Code. 1915

(Q) "Intermediary organization" means a health delivery 1916  
network or other entity that contracts with licensed health 1917  
insuring corporations or self-insured employers, or both, to 1918  
provide health care services, and that enters into contractual 1919  
arrangements with other entities for the provision of health care 1920  
services for the purpose of fulfilling the terms of its contracts 1921  
with the health insuring corporations and self-insured employers. 1922

(P) "Intermediate care" means residential care above the 1923  
level of room and board for patients who require personal 1924  
assistance and health-related services, but who do not require 1925  
skilled nursing care. 1926

(O) "Medical record" means the personal information that 1927  
relates to an individual's physical or mental condition, medical 1928  
history, or medical treatment. 1929

(R)(1) "OPEN PANEL PLAN" MEANS A HEALTH CARE PLAN THAT 1930  
PROVIDES INCENTIVES FOR ENROLLEES TO USE PARTICIPATING PROVIDERS 1931  
AND THAT ALSO ALLOWS ENROLLEES TO USE PROVIDERS THAT ARE NOT 1932  
PARTICIPATING PROVIDERS. 1933

(2) NO HEALTH INSURING CORPORATION MAY OFFER AN OPEN PANEL 1934  
PLAN, UNLESS THE HEALTH INSURING CORPORATION IS ALSO LICENSED AS 1935  
AN INSURER UNDER TITLE XXXIX OF THE REVISED CODE, the health 1936  
insuring corporation, on the effective date of this section, holds 1937

a certificate of authority or license to operate under Chapter 1938  
1736. or 1740. of the Revised Code, OR AN INSURER LICENSED UNDER 1939  
TITLE XXXIX OF THE REVISED CODE IS RESPONSIBLE FOR THE 1940  
OUT-OF-NETWORK RISK AS EVIDENCED BY both an evidence of coverage 1941  
filing under section 1751.11 of the Revised Code and a policy and 1942  
certificate filing under section 3923.02 of the Revised Code. 1943

(S) "Person" has the same meaning as in section 1.59 of the 1944  
Revised Code, and, unless the context otherwise requires, includes 1945  
any insurance company holding a certificate of authority under 1946  
Title XXXIX of the Revised Code, any subsidiary and affiliate of 1947  
an insurance company, and any government agency. 1948

(T) "Premium rate" MEANS ANY SET FEE REGULARLY PAID BY A 1949  
SUBSCRIBER TO A HEALTH INSURING CORPORATION. A "premium rate" DOES 1950  
NOT INCLUDE A ONE-TIME MEMBERSHIP FEE, AN ANNUAL ADMINISTRATIVE 1951  
FEE, OR A NOMINAL ACCESS FEE, PAID TO A MANAGED HEALTH CARE SYSTEM 1952  
UNDER WHICH THE RECIPIENT OF HEALTH CARE SERVICES REMAINS SOLELY 1953  
RESPONSIBLE FOR ANY CHARGES ACCESSED FOR THOSE SERVICES BY THE 1954  
PROVIDER OR HEALTH CARE FACILITY. 1955

(U) "Primary care provider" means a provider that is 1956  
designated by a health insuring corporation to supervise, 1957  
coordinate, or provide initial care or continuing care to an 1958  
enrollee, and that may be required by the health insuring 1959  
corporation to initiate a referral for specialty care and to 1960  
maintain supervision of the health care services rendered to the 1961  
enrollee. 1962

(V) "Provider" means any natural person or partnership of 1963  
natural persons who are licensed, certified, accredited, or 1964  
otherwise authorized in this state to furnish health care 1965  
services, or any professional association organized under Chapter 1966  
1785. of the Revised Code, provided that nothing in this chapter 1967  
or other provisions of law shall be construed to preclude a health 1968  
insuring corporation, health care practitioner, or organized 1969

health care group associated with a health insuring corporation 1970  
from employing nurse practitioners, dietitians, physicians' 1971  
assistants, dental assistants, dental hygienists, optometric 1972  
technicians, or other allied health personnel who are licensed, 1973  
certified, accredited, or otherwise authorized in this state to 1974  
furnish health care services. 1975

(W) "PROVIDER SPONSORED ORGANIZATION" MEANS A CORPORATION, AS 1976  
DEFINED IN DIVISION (G) OF THIS SECTION, THAT IS AT LEAST EIGHTY 1977  
PER CENT OWNED OR CONTROLLED BY ONE OR MORE HOSPITALS, AS DEFINED 1978  
IN SECTION 3727.01 OF THE REVISED CODE, OR ONE OR MORE PHYSICIANS 1979  
LICENSED TO PRACTICE MEDICINE OR SURGERY OR OSTEOPATHIC MEDICINE 1980  
AND SURGERY UNDER CHAPTER 4731. OF THE REVISED CODE, OR ANY 1981  
COMBINATION OF SUCH PHYSICIANS AND HOSPITALS. SUCH CONTROL IS 1982  
PRESUMED TO EXIST IF AT LEAST EIGHTY PER CENT OF THE VOTING RIGHTS 1983  
OR GOVERNANCE RIGHTS OF A PROVIDER SPONSORED ORGANIZATION ARE 1984  
DIRECTLY OR INDIRECTLY OWNED, CONTROLLED, OR OTHERWISE HELD BY ANY 1985  
COMBINATION OF THE PHYSICIANS AND HOSPITALS DESCRIBED IN THIS 1986  
DIVISION. 1987

(X) "Solicitation document" means the written materials 1988  
provided to prospective subscribers or enrollees, or both, and 1989  
used for advertising and marketing to induce enrollment in the 1990  
health care plans of a health insuring corporation. 1991

(Y) "Subscriber" means a person who is responsible for making 1992  
payments to a health insuring corporation for participation in a 1993  
health care plan, or an enrollee whose employment or other status 1994  
is the basis of eligibility for enrollment in a health insuring 1995  
corporation. 1996

(Z) "Urgent care services" means those health care services 1997  
that are appropriately provided for an unforeseen condition of a 1998  
kind that usually requires medical attention without delay but 1999  
that does not pose a threat to the life, limb, or permanent health 2000  
of the injured or ill person, and may include such health care 2001

services provided out of the health insuring corporation's 2002  
approved service area pursuant to indemnity payments or service 2003  
agreements. 2004

Sec. 1751.02. (A) Notwithstanding any law in this state to 2005  
the contrary, any corporation, as defined in section 1751.01 of 2006  
the Revised Code, may apply to the superintendent of insurance for 2007  
a certificate of authority to establish and operate a health 2008  
insuring corporation. IF THE CORPORATION APPLYING FOR A 2009  
CERTIFICATE OF AUTHORITY IS A FOREIGN CORPORATION DOMICILED IN A 2010  
STATE WITHOUT LAWS SIMILAR TO THOSE OF THIS CHAPTER, THE 2011  
CORPORATION must form a domestic CORPORATION to apply for, obtain, 2012  
and maintain A CERTIFICATE OF AUTHORITY under this chapter. 2013

(B) No person shall establish, operate, or perform the 2014  
services of a health insuring corporation in this state without 2015  
obtaining a certificate of authority under this chapter. 2016

(C) Except as provided by division (D) of this section, no 2017  
political subdivision or department, office, or institution of 2018  
this state, or corporation formed by or on behalf of any political 2019  
subdivision or department, office, or institution of this state, 2020  
shall establish, operate, or perform the services of a health 2021  
insuring corporation. Nothing in this section shall be construed 2022  
to preclude a board of county commissioners, a county board of 2023  
mental retardation and developmental DISABILITIES, AN alcohol and 2024  
drug addiction services board, a board of alcohol, drug addiction, 2025  
and mental HEALTH services, or a community mental health board, or 2026  
a public entity formed by or on behalf of any of these boards, 2027  
from using managed care techniques in carrying out the board's or 2028  
public entity's duties pursuant to the requirements of Chapters 2029  
307., 329., 340., and 5126. of the Revised Code. However, no such 2030  
board or public entity may operate so as to compete in the private 2031  
sector with HEALTH insuring corporations holding certificates of 2032  
authority under this chapter. 2033

(D) A corporation formed by or on behalf of a publicly owned, operated, or funded hospital or health care facility may apply to the superintendent for a certificate of authority under division (A) of this section to establish and operate a health insuring corporation. 2034  
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(E) A health insuring corporation shall operate in this state in compliance with this chapter and with sections 3702.51 to 3702.62 of the Revised Code, and shall operate in conformity with its filings with the superintendent under this chapter, including filings made pursuant to sections 1751.03, 1751.11, 1751.12, and 1751.31 of the Revised Code. 2039  
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(F) AN INSURER LICENSED UNDER TITLE XXXIX OF THE REVISED CODE NEED NOT OBTAIN A CERTIFICATE OF AUTHORITY AS A HEALTH INSURING CORPORATION TO OFFER AN OPEN PANEL PLAN AS LONG AS THE PROVIDERS AND HEALTH CARE FACILITIES PARTICIPATING IN THE OPEN PANEL PLAN RECEIVE THEIR COMPENSATION DIRECTLY FROM THE INSURER. IF THE PROVIDERS AND HEALTH CARE FACILITIES PARTICIPATING IN THE OPEN PANEL PLAN RECEIVE THEIR COMPENSATION FROM ANY PERSON OTHER THAN THE INSURER, OR IF THE INSURER OFFERS A CLOSED PANEL PLAN, THE INSURER MUST OBTAIN A CERTIFICATE OF AUTHORITY AS A HEALTH INSURING CORPORATION. 2045  
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(G) An intermediary organization need not obtain a certificate of authority as a health insuring corporation, regardless of the method of reimbursement to the intermediary organization, as long as a health insuring corporation or a self-insured employer maintains the ultimate responsibility to assure delivery of all health care services required by the contract between the health insuring corporation and the subscriber and the laws of this state or between the self-insured employer and its employees. 2055  
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Nothing in this section shall be construed to require any 2064

health care facility, provider, health delivery network, or 2065  
intermediary organization that contracts with a health insuring 2066  
corporation or self-insured employer, regardless of the method of 2067  
reimbursement to the health care facility, provider, health 2068  
delivery network, or intermediary organization, to obtain a 2069  
certificate of authority as a health insuring corporation under 2070  
this chapter, unless otherwise provided, in the case of contracts 2071  
with a self-insured employer, by operation of the "Employee 2072  
Retirement Income Security Act of 1974," 88 Stat. 829, 29 U.S.C.A. 2073  
1001, as amended. 2074

(H) Any health delivery network doing business in this state 2075  
that is not required to obtain a certificate of authority under 2076  
this chapter shall certify to the superintendent annually, not 2077  
later than the first day of July, and shall provide a statement 2078  
signed by the highest ranking official which includes the 2079  
following information: 2080

(1) The health delivery network's full name and the address 2081  
of its principal place of business; 2082

(2) A statement that the health delivery network is not 2083  
required to obtain a certificate of authority under this chapter 2084  
to conduct its business. 2085

(I) THE SUPERINTENDENT SHALL NOT ISSUE A CERTIFICATE OF 2086  
AUTHORITY TO A HEALTH INSURING CORPORATION THAT IS A PROVIDER 2087  
SPONSORED ORGANIZATION UNLESS ALL HEALTH CARE PLANS TO BE OFFERED 2088  
BY THE HEALTH INSURING CORPORATION PROVIDE BASIC HEALTH CARE 2089  
SERVICES. Substantially all of the physicians and hospitals with 2090  
ownership or control of the provider sponsored organization, as 2091  
defined in division (W) of section 1751.01 of the Revised Code, 2092  
shall also be participating providers for the provision of basic 2093  
health care services for health care plans offered by the provider 2094  
sponsored organization. IF A HEALTH INSURING CORPORATION THAT IS A 2095

PROVIDER SPONSORED ORGANIZATION OFFERS HEALTH CARE PLANS THAT DO 2096  
NOT PROVIDE BASIC HEALTH CARE SERVICES, THE HEALTH INSURING 2097  
CORPORATION SHALL BE DEEMED, FOR PURPOSES OF SECTION 1751.35 OF 2098  
THE REVISED CODE, TO HAVE FAILED TO SUBSTANTIALLY COMPLY WITH THIS 2099  
CHAPTER. 2100

Except as specifically provided in this division and in 2101  
division (C) of section 1751.28 of the Revised Code, the 2102  
provisions of this chapter shall apply to all health insuring 2103  
corporations that are provider sponsored organizations in the same 2104  
manner that these provisions apply to all health insuring 2105  
corporations that are not provider sponsored organizations. 2106

(J) Nothing in this section shall be construed to apply to 2107  
any multiple employer welfare arrangement operating pursuant to 2108  
Chapter 1739. Of the Revised Code. 2109

(K) Any person who violates division (B) of this section, and 2110  
any health delivery network that fails to comply with division (H) 2111  
of this section, is subject to the penalties set forth in section 2112  
1751.45 of the Revised Code. 2113

Sec. 1751.03. (A) Each application for a certificate of 2114  
authority under this chapter shall be verified by an officer or 2115  
authorized representative of the applicant, shall be in a format 2116  
prescribed by the superintendent of insurance, and shall set forth 2117  
or be accompanied by the following: 2118

(1) A certified copy of the applicant's articles of 2119  
incorporation and all amendments to the articles of incorporation; 2120

(2) A copy of any regulations adopted for the government of 2121  
the corporation, any bylaws, and any similar documents, and a copy 2122  
of all amendments to these regulations, bylaws, and documents. The 2123  
corporate secretary shall certify that these regulations, bylaws, 2124  
documents, and amendments have been properly adopted or approved. 2125

2126

(3) A list of the names, addresses, and official positions of the persons responsible for the conduct of the applicant, including all members of the board, the principal officers, and the person responsible for completing or filing financial statements with the department of insurance, accompanied by a completed original biographical affidavit and release of information for each of these persons on forms acceptable to the department; 2127  
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(4) A full and complete disclosure of the extent and nature of any contractual or other financial arrangement between the applicant and any provider or a person listed in division (A)(3) of this section, including, but not limited to, a full and complete disclosure of the financial interest held by any such provider or person in any health care facility, provider, or insurer that has entered into a financial relationship with the health insuring corporation; 2135  
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(5) A description of the applicant, its facilities, and its personnel, including, but not limited to, the location, hours of operation, and telephone numbers of all contracted facilities; 2143  
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(6) The applicant's projected annual enrollee population over a three-year period; 2146  
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(7) A clear and specific description of the health care plan or plans to be used by the applicant, including a description of the proposed providers, procedures for accessing care, and the form of all proposed and existing contracts relating to the administration, delivery, or financing of health care services; 2148  
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(8) A copy of each type of evidence of coverage and identification card or similar document to be issued to subscribers; 2153  
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(9) A copy of each type of individual or group policy, contract, or agreement to be used; 2156  
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<u>(10) The schedule of the proposed contractual periodic</u>	2158
<u>prepayments or premium rates, or both, accompanied by appropriate</u>	2159
<u>supporting data;</u>	2160
<u>(11) A financial plan which provides a three-year projection</u>	2161
<u>of operating results, including the projected expenses, income,</u>	2162
<u>and sources of working capital;</u>	2163
<u>(12) The enrollee complaint procedure to be utilized as</u>	2164
<u>required under section 1751.19 of the Revised Code;</u>	2165
<u>(13) A description of the procedures and programs to be</u>	2166
<u>implemented on an ongoing basis to assure the quality of health</u>	2167
<u>care services delivered to enrollees;</u>	2168
<u>(14) A statement describing the geographic area or areas to</u>	2169
<u>be served, by county;</u>	2170
<u>(15) A copy of all solicitation documents;</u>	2171
<u>(16) A balance sheet and other financial statements showing</u>	2172
<u>the applicant's assets, liabilities, income, and other sources of</u>	2173
<u>financial support;</u>	2174
<u>(17) A description of the nature and extent of any</u>	2175
<u>reinsurance program to be implemented, and a demonstration that</u>	2176
<u>errors and omission insurance and, if appropriate, fidelity</u>	2177
<u>insurance, will be in place upon the applicant's receipt of a</u>	2178
<u>certificate of authority;</u>	2179
<u>(18) Copies of all proposed or in force related-party or</u>	2180
<u>intercompany agreements with an explanation of the financial</u>	2181
<u>impact of these agreements on the applicant. If the applicant</u>	2182
<u>intends to enter into a contract for managerial or administrative</u>	2183
<u>services, with either an affiliated or an unaffiliated person, the</u>	2184
<u>applicant shall provide a copy of the contract and a detailed</u>	2185
<u>description of the person to provide these services. The</u>	2186
<u>description shall include that person's experience in managing or</u>	2187

<u>administering health care plans, a copy of that person's most</u>	2188
<u>recent audited financial statement, and a completed biographical</u>	2189
<u>affidavit on a form acceptable to the superintendent for each of</u>	2190
<u>that person's principal officers and board members and for any</u>	2191
<u>additional employee to be directly involved in providing</u>	2192
<u>managerial or administrative services to the health insuring</u>	2193
<u>corporation. If the person to provide managerial or administrative</u>	2194
<u>services is affiliated with the health insuring corporation, the</u>	2195
<u>contract must provide for payment for services based on actual</u>	2196
<u>costs.</u>	2197
<u>(19) A statement from the applicant's board that the admitted</u>	2198
<u>assets of the applicant have not been and will not be pledged or</u>	2199
<u>hypothecated;</u>	2200
<u>(20) A statement from the applicant's board that the</u>	2201
<u>applicant will submit monthly financial statements during the</u>	2202
<u>first year of operations;</u>	2203
<u>(21) The name and address of the applicant's Ohio statutory</u>	2204
<u>agent for service of process, notice, or demand;</u>	2205
<u>(22) Copies of all documents the applicant filed with the</u>	2206
<u>secretary of state;</u>	2207
<u>(23) The location of those books and records of the applicant</u>	2208
<u>that must be maintained in Ohio;</u>	2209
<u>(24) The applicant's federal identification number, corporate</u>	2210
<u>address, and mailing address;</u>	2211
<u>(25) An internal and external organizational chart;</u>	2212
<u>(26) A list of the assets representing the initial net worth</u>	2213
<u>of the applicant;</u>	2214
<u>(27) If the applicant has a parent company, the parent</u>	2215
<u>company's guaranty, on a form acceptable to the superintendent,</u>	2216
<u>that the applicant will maintain Ohio's minimum net worth. If no</u>	2217

parent company exists, a statement regarding the availability of 2218  
future funds if needed. 2219

(28) The names and addresses of the applicant's actuary and 2220  
external auditors; 2221

(29) IF THE APPLICANT IS A FOREIGN CORPORATION, A COPY OF THE 2222  
MOST RECENT FINANCIAL STATEMENTS FILED WITH THE INSURANCE 2223  
REGULATORY AGENCY IN THE APPLICANT'S STATE OF DOMICILE; 2224

(30) IF THE APPLICANT IS A FOREIGN CORPORATION, A STATEMENT 2225  
FROM THE INSURANCE REGULATORY AGENCY OF THE APPLICANT'S STATE OF 2226  
DOMICILE STATING THAT THE REGULATORY AGENCY HAS NO OBJECTION TO 2227  
THE APPLICANT APPLYING FOR AN OHIO LICENSE AND THAT THE APPLICANT 2228  
IS IN GOOD STANDING IN THE APPLICANT'S STATE OF DOMICILE; 2229

(31) Any other information that the superintendent may 2230  
require. 2231

(B)(1) A health insuring corporation, unless otherwise 2232  
provided for in this chapter, shall file a timely notice with the 2233  
superintendent describing any change to the corporation's articles 2234  
of incorporation or regulations, or any major modification to its 2235  
operations as set out in the information required by division (A) 2236  
of this section that affects any of the following: 2237

(a) The solvency of the health insuring corporation; 2238

(b) The health insuring corporation's continued provision of 2239  
services that it has contracted to provide; 2240

(c) The manner in which the health insuring corporation 2241  
conducts its business. 2242

(2) If the change or modification is to be the result of an 2243  
action to be taken by the health insuring corporation, the notice 2244  
shall be filed with the superintendent prior to the health 2245  
insuring corporation taking the action. The action shall be deemed 2246  
approved if the superintendent does not disapprove it within sixty 2247

days of filing. 2248

(C)(1) No health insuring corporation shall expand its 2249  
approved service area until a copy of the request for expansion, 2250  
accompanied by documentation of the network of providers, 2251  
enrollment projections, plan of operation, and any other changes 2252  
have been filed with the superintendent. 2253

(2) Within ten calendar days after receipt of a complete 2254  
filing under division (C)(1) of this section, the superintendent 2255  
shall refer the appropriate jurisdictional issues to the director 2256  
of health pursuant to section 1751.04 of the Revised Code. 2257

(3) Within seventy-five days after the superintendent's 2258  
receipt of a complete filing under division (C)(1) of this 2259  
section, the superintendent shall determine whether the plan for 2260  
expansion is lawful, fair, and reasonable. The superintendent may 2261  
not make a determination until the superintendent has received the 2262  
director's certification of compliance, which the director shall 2263  
furnish within forty-five days after referral under division 2264  
(C)(2) of this section. The director shall not certify that the 2265  
requirements of section 1751.04 of the Revised Code are not met, 2266  
unless the applicant has been given an opportunity for a hearing 2267  
as provided in division (D) of section 1751.04 of the Revised 2268  
Code. The forty-five-day and seventy-five-day review periods 2269  
provided for in division (C)(3) of this section shall cease to run 2270  
as of the date on which the notice of the applicant's right to 2271  
request a hearing is mailed and shall remain suspended until the 2272  
director issues a final certification. 2273

(4) If the superintendent has not approved or disapproved all 2274  
or a portion of a service area expansion within the 2275  
seventy-five-day period provided for in division (C)(3) of this 2276  
section, the filing shall be deemed approved. 2277

(5) Disapproval of all or a portion of the filing shall be 2278

effected by written notice, which shall state the grounds for the 2279  
order of disapproval and shall be given in accordance with Chapter 2280  
119. of the Revised Code. 2281

Sec. 1751.04. (A) Upon the receipt by the superintendent of 2282  
insurance of a complete application for a certificate of authority 2283  
to establish or operate a health insuring corporation, which 2284  
application sets forth or is accompanied by the information and 2285  
documents required by division (A) of section 1751.03 of the 2286  
Revised Code, the superintendent shall transmit copies of the 2287  
application and accompanying documents to the director of health. 2288

(B) The director shall review the application and 2289  
accompanying documents and make findings as to whether the 2290  
applicant for a certificate of authority has done all of the 2291  
following with respect to any basic health care services and 2292  
supplemental health care services to be furnished: 2293

(1) Demonstrated the willingness and potential ability to 2294  
ensure that all basic health care services and supplemental health 2295  
care services described in the evidence of coverage will be 2296  
provided to all its enrollees as promptly as is appropriate and in 2297  
a manner that assures continuity; 2298

(2) Made effective arrangements to ensure that its enrollees 2299  
have reliable access to qualified providers in those specialties 2300  
that are generally available in the geographic area or areas to be 2301  
served by the applicant and that are necessary to provide all 2302  
basic health care services and supplemental health care services 2303  
described in the evidence of coverage; 2304

(3) Made appropriate arrangements for the availability of 2305  
short-term health care services in emergencies within the 2306  
geographic area or areas to be served by the applicant, 2307  
twenty-four hours per day, seven days per week, and for the 2308  
provision of adequate coverage whenever an out-of-area emergency 2309

<u>arises;</u>	2310
<u>(4) Made appropriate arrangements for an ongoing evaluation</u>	2311
<u>and assurance of the quality of health care services provided to</u>	2312
<u>enrollees and the adequacy of the personnel, facilities, and</u>	2313
<u>equipment by or through which the services are rendered;</u>	2314
<u>(5) Developed a procedure to gather and report statistics</u>	2315
<u>relating to the cost and effectiveness of its operations, the</u>	2316
<u>pattern of utilization of its services, and the quality,</u>	2317
<u>availability, and accessibility of its services.</u>	2318
<u>(C) Within ninety days of the director's receipt of the</u>	2319
<u>application for issuance of a certificate of authority, the</u>	2320
<u>director shall certify to the superintendent whether or not the</u>	2321
<u>applicant meets the requirements of division (B) of this section</u>	2322
<u>and sections 3702.51 to 3702.62 of the Revised Code. If the</u>	2323
<u>director certifies that the applicant does not meet these</u>	2324
<u>requirements, the director shall specify in what respects it is</u>	2325
<u>deficient. However, the director shall not certify that the</u>	2326
<u>requirements of this section are not met unless the applicant has</u>	2327
<u>been given an opportunity for a hearing.</u>	2328
<u>(D) If the applicant requests a hearing, the director shall</u>	2329
<u>hold a hearing before certifying that the applicant does not meet</u>	2330
<u>the requirements of this section. The hearing shall be held in</u>	2331
<u>accordance with Chapter 119. of the Revised Code.</u>	2332
<u>(E) The ninety-day review period provided for under division</u>	2333
<u>(C) of this section shall cease to run as of the date on which the</u>	2334
<u>notice of the applicant's right to request a hearing is mailed and</u>	2335
<u>shall remain suspended until the director issues a final</u>	2336
<u>certification order.</u>	2337
<u>Sec. 1751.05. (A) The superintendent of insurance shall issue</u>	2338
<u>or deny a certificate of authority to establish or operate a</u>	2339
<u>health insuring corporation to any corporation filing an</u>	2340

application pursuant to section 1751.03 of the Revised Code within 2341  
forty-five days of the superintendent's receipt of the 2342  
certification from the director of health under division (C) of 2343  
section 1751.04 of the Revised Code. A certificate of authority 2344  
shall be issued upon payment of the application fee prescribed in 2345  
section 1751.44 of the Revised Code if the superintendent is 2346  
satisfied that the following conditions are met: 2347

(1) The persons responsible for the conduct of the affairs of 2348  
the applicant are competent, trustworthy, and possess good 2349  
reputations. 2350

(2) THE DIRECTOR CERTIFIES, IN ACCORDANCE WITH DIVISION (C) 2351  
OF SECTION 1751.04 OF THE REVISED CODE, THAT THE ORGANIZATION'S 2352  
PROPOSED PLAN OF OPERATION MEETS THE REQUIREMENTS OF DIVISION (B) 2353  
OF THAT SECTION AND SECTIONS 3702.51 TO 3702.62 OF THE REVISED 2354  
CODE. IF, AFTER THE DIRECTOR HAS CERTIFIED COMPLIANCE, THE 2355  
APPLICATION IS AMENDED IN A MANNER THAT AFFECTS ITS APPROVAL UNDER 2356  
SECTION 1751.04 OF THE REVISED CODE, THE SUPERINTENDENT SHALL 2357  
REQUEST THE DIRECTOR TO REVIEW AND RECERTIFY THE AMENDED PLAN OF 2358  
OPERATION. WITHIN FORTY-FIVE DAYS OF RECEIPT OF THE AMENDED PLAN 2359  
FROM THE SUPERINTENDENT, THE DIRECTOR SHALL CERTIFY TO THE 2360  
SUPERINTENDENT, PURSUANT TO SECTION 1751.04 OF THE REVISED CODE, 2361  
WHETHER OR NOT THE AMENDED PLAN MEETS THE REQUIREMENTS OF SECTION 2362  
1751.04 OF THE REVISED CODE. THE SUPERINTENDENT'S FORTY-FIVE-DAY 2363  
REVIEW PERIOD SHALL CEASE TO RUN AS OF THE DATE ON WHICH THE 2364  
AMENDED PLAN IS TRANSMITTED TO THE DIRECTOR AND SHALL REMAIN 2365  
SUSPENDED UNTIL THE SUPERINTENDENT RECEIVES A NEW CERTIFICATION 2366  
FROM THE DIRECTOR. 2367

(3) The applicant constitutes an appropriate mechanism to 2368  
effectively provide or arrange for the provision of the basic 2369  
health care services, supplemental health care services, or 2370  
specialty health care services to be provided to enrollees. 2371

(4) The applicant is financially responsible, complies with 2372

section 1751.28 of the Revised Code, and may reasonably be 2373  
expected to meet its obligations to enrollees and prospective 2374  
enrollees. In making this determination, the superintendent may 2375  
consider: 2376

(a) The financial soundness of the applicant's arrangements 2377  
for health care services, including the applicant's proposed 2378  
contractual periodic prepayments or premiums and the use of 2379  
copayments or deductibles; 2380

(b) The adequacy of working capital; 2381

(c) Any agreement with an insurer, a government, or any other 2382  
person for insuring the payment of the cost of health care 2383  
services or providing for automatic applicability of an 2384  
alternative coverage in the event of discontinuance of the health 2385  
insuring corporation's operations; 2386

(d) Any agreement with providers or health care facilities 2387  
for the provision of health care services; 2388

(e) Any deposit of securities submitted in accordance with 2389  
section 1751.27 of the Revised Code as a guarantee that the 2390  
obligations will be performed. 2391

(5) The applicant has submitted documentation of an 2392  
arrangement to provide health care services to its enrollees until 2393  
the expiration of the enrollees' contracts with the applicant if a 2394  
health care plan or the operations of the health insuring 2395  
corporation are discontinued prior to the expiration of the 2396  
enrollees' contracts. An arrangement to provide health care 2397  
services may be made by using any one, or any combination, of the 2398  
following methods: 2399

(a) The maintenance of insolvency insurance; 2400

(b) A provision in contracts with providers and health care 2401  
facilities, BUT NO HEALTH INSURING CORPORATION SHALL RELY SOLELY 2402

<u>ON SUCH A PROVISION FOR MORE THAN thirty DAYS;</u>	2403
<u>(c) An agreement with other health insuring corporations or</u>	2404
<u>insurers, providing enrollees with automatic conversion rights</u>	2405
<u>upon the discontinuation of a health care plan or the health</u>	2406
<u>insuring corporation's operations;</u>	2407
<u>(d) Such other methods as approved by the superintendent.</u>	2408
<u>(6) Nothing in the applicant's proposed method of operation,</u>	2409
<u>as shown by the information submitted pursuant to section 1751.03</u>	2410
<u>of the Revised Code or by independent investigation, will cause</u>	2411
<u>harm to an enrollee or to the public at large, as determined by</u>	2412
<u>the superintendent.</u>	2413
<u>(7) Any deficiencies certified by the director have been</u>	2414
<u>corrected.</u>	2415
<u>(8) The applicant has deposited securities as set forth in</u>	2416
<u>section 1751.27 of the Revised Code.</u>	2417
<u>(B) If an applicant elects to fulfill the requirements of</u>	2418
<u>division (A)(5) of this section through an agreement with other</u>	2419
<u>health insuring corporations or insurers, the agreement shall</u>	2420
<u>require those health insuring corporations or insurers to give</u>	2421
<u>thirty days' notice to the superintendent prior to cancellation or</u>	2422
<u>discontinuation of the agreement for any reason.</u>	2423
<u>(C) A certificate of authority shall be denied only after</u>	2424
<u>compliance with the requirements of section 1751.36 of the Revised</u>	2425
<u>Code.</u>	2426
<u>Sec. 1751.06. Upon obtaining a certificate of authority as</u>	2427
<u>required under this chapter, a health insuring corporation may do</u>	2428
<u>all of the following:</u>	2429
<u>(A) Enroll individuals and their dependents in either of the</u>	2430
<u>following circumstances:</u>	2431
<u>(1) The individual resides in the approved service area.</u>	2432

(2) The individual's place of employment is located in the 2433  
approved service area and the individual has agreed to receive 2434  
health care services in accordance with the evidence of coverage. 2435

(B) Contract with providers and health care facilities for 2436  
the health care services to which enrollees are entitled under the 2437  
terms of the health insuring corporation's health care contracts; 2438

(C) Contract with insurance companies authorized to do 2439  
business in this state for insurance, indemnity, or reimbursement 2440  
against the cost of providing emergency and nonemergency health 2441  
care services for enrollees, subject to the provisions set forth 2442  
in this chapter and the limitations set forth in the Revised Code; 2443

(D) Contract with any person pursuant to the requirements of 2444  
division (A)(18) of section 1751.03 of the Revised Code for 2445  
managerial or administrative services, or for data processing, 2446  
actuarial analysis, billing services, or any other services 2447  
authorized by the superintendent of insurance. However, a health 2448  
insuring corporation shall not enter into a contract for any of 2449  
the services listed in this division with an insurance company 2450  
that is not authorized to engage in the business of insurance in 2451  
this state. 2452

(E) Accept from governmental agencies, private agencies, 2453  
corporations, associations, groups, individuals, or other persons, 2454  
payments covering all or part of the costs of planning, 2455  
development, construction, and the provision of health care 2456  
services; 2457

(F) Purchase, lease, construct, renovate, operate, or 2458  
maintain health care facilities, and their ancillary equipment, 2459  
and any property necessary in the transaction of the business of 2460  
the health insuring corporation. 2461

Nothing in this section shall be construed as prohibiting a 2462  
health insuring corporation without other commercial enrollment 2463

from contracting solely with federal health care programs 2464  
regulated by federal regulatory bodies. 2465

Nothing in this section shall be construed to limit the 2466  
authority of a health insuring corporation to perform those 2467  
functions not otherwise prohibited by law. 2468

Sec. 1751.07. Any trustee, director, officer, or employee of 2469  
a health insuring corporation who receives, collects, disburses, 2470  
or invests funds in connection with the activities of the health 2471  
insuring corporation shall be responsible for such funds in a 2472  
fiduciary relationship to the corporation. 2473

Sec. 1751.08. (A) Except as otherwise specifically provided 2474  
in this chapter or Title XXXIX of the Revised Code, provisions of 2475  
Title XXXIX of the Revised Code shall not be applicable to any 2476  
health insuring corporation holding a certificate of authority 2477  
under this chapter. This division shall not apply to an insurer 2478  
licensed and regulated pursuant to Title XXXIX of the Revised Code 2479  
except with respect to its health insuring corporation activities 2480  
authorized and regulated pursuant to this chapter. 2481

(B) For the purpose of clarifying jurisdiction under the 2482  
"Bankruptcy Reform Act of 1978," 92 Stat. 2549, 11 U.S.C.A. 101, 2483  
and in recognition of the right of this state to regulate domestic 2484  
insurance companies under the "McCarran-Ferguson Act," 59 Stat. 33 2485  
(1945), 15 U.S.C.A. 1011, a health insuring corporation is deemed 2486  
to be a domestic insurance company. 2487

(C) Solicitation of enrollees by a health insuring 2488  
corporation holding a certificate of authority under this chapter, 2489  
or its representatives, shall not be construed to violate any 2490  
provision of law relating to solicitation or advertising by health 2491  
professionals. 2492

(D) Any health insuring corporation holding a certificate of 2493  
authority under this chapter shall not be considered to be 2494

practicing medicine.

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Sec. 1751.11. (A) Every subscriber of a health insuring corporation is entitled to an evidence of coverage for the health care plan under which health care benefits are provided.

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(B) Every subscriber of a health insuring corporation that offers basic health care services is entitled to an identification card or similar document that specifies the health insuring corporation's name as stated in its articles of incorporation, and any trade or fictitious names used by the health insuring corporation. The identification card or document shall list at least one telephone number that provides the subscriber with access to health care on a twenty-four-hour-per-day, seven-day-per-week basis.

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(C) No evidence of coverage, or amendment to the evidence of coverage, shall be delivered, issued for delivery, renewed, or used, until the form of the evidence of coverage or amendment has been filed by the health insuring corporation with the superintendent of insurance. If the superintendent does not disapprove the evidence of coverage or amendment within sixty days after it is filed it shall be deemed approved, unless the superintendent sooner gives approval for the evidence of coverage or amendment. With respect to an amendment to an approved evidence of coverage, the superintendent only may disapprove provisions amended or added to the evidence of coverage. If the superintendent determines within the sixty-day period that any evidence of coverage or amendment fails to meet the requirements of this section, the superintendent shall so notify the health insuring corporation and it shall be unlawful for the health insuring corporation to use such evidence of coverage or amendment. At any time, the superintendent, upon at least thirty days' written notice to a health insuring corporation, may withdraw an approval, deemed or actual, of any evidence of

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coverage or amendment on any of the grounds stated in this 2527  
section. Such disapproval shall be effected by a written order, 2528  
which shall state the grounds for disapproval and shall be issued 2529  
in accordance with Chapter 119. of the Revised Code. 2530

(D) No evidence of coverage or amendment shall be delivered, 2531  
issued for delivery, renewed, or used: 2532

(1) If it contains provisions or statements that are 2533  
inequitable, untrue, misleading, or deceptive; 2534

(2) Unless it contains a clear, concise, and complete 2535  
statement of the following: 2536

(a) The health care services and insurance or other benefits, 2537  
if any, to which the enrollee is entitled under the health care 2538  
plan; 2539

(b) Any exclusions or limitations on the health care 2540  
services, type of health care services, benefits, or type of 2541  
benefits to be provided, including copayments or deductibles; 2542

(c) THE ENROLLEE'S PERSONAL FINANCIAL OBLIGATION FOR 2543  
NON-COVERED SERVICES; 2544

(d) Where and in what manner general information and 2545  
information as to how services may be obtained is available, 2546  
including the telephone number; 2547

(e) The premium rate with respect to individual and 2548  
conversion contracts, and relevant copayment provisions with 2549  
respect to all contracts. THE STATEMENT OF THE PREMIUM rate, 2550  
HOWEVER, MAY BE CONTAINED IN A SEPARATE INSERT. 2551

(f) The method utilized by the health insuring corporation 2552  
for resolving enrollee complaints. 2553

(3) Unless it provides for the continuation of an enrollee's 2554  
coverage, in the event that the enrollee's coverage under the 2555  
policy, contract, certificate, or agreement terminates while the 2556

enrollee is receiving inpatient care in a hospital. This 2557  
continuation of coverage shall terminate at the earliest 2558  
occurrence of any of the following: 2559

(a) The enrollee's discharge from the hospital; 2560

(b) The determination by the enrollee's attending physician 2561  
that inpatient care is no longer medically indicated for the 2562  
enrollee; 2563

(c) The enrollee's reaching the limit for contractual 2564  
benefits. 2565

(4) Unless it contains a provision that states, in substance, 2566  
that the health insuring corporation is not a member of any 2567  
guaranty fund, and that in the event of the health insuring 2568  
corporation's insolvency, the enrollee is protected only to the 2569  
extent that the hold harmless provision required by section 2570  
1751.13 of the Revised Code applies to the health care services 2571  
rendered; 2572

(5) Unless it contains a provision that states, in substance, 2573  
that in the event of the insolvency of the health insuring 2574  
corporation, the enrollee may be financially responsible for 2575  
health care services rendered by a provider or health care 2576  
facility that is not under contract to the health insuring 2577  
corporation, whether or not the health insuring corporation 2578  
authorized the use of the provider or health care facility. 2579

(E) Notwithstanding division (D) of this section, a health 2580  
insuring corporation may use an evidence of coverage that provides 2581  
for the coverage of beneficiaries enrolled in Title XVIII of the 2582  
"Social Security Act," 49 Stat. 620 (1935), 42 U.S.C.A. 301, as 2583  
amended, pursuant to a medicare risk contract or medicare cost 2584  
contract, or an evidence of coverage that provides for the 2585  
coverage of beneficiaries enrolled in the federal employees health 2586  
benefits program pursuant to 5 U.S.C.A. 8905, or an evidence of 2587

coverage that provides for the coverage of beneficiaries enrolled 2588  
in Title XIX of the "Social Security Act," 49 Stat. 620 (1935), 42 2589  
U.S.C.A. 301, as amended, known as the medical assistance program 2590  
or medicaid, provided by the Ohio department of human services 2591  
under Chapter 5111. of the Revised Code, or an evidence of 2592  
coverage that provides for the coverage of beneficiaries under any 2593  
other federal health care program regulated by a federal 2594  
regulatory body, if both of the following apply: 2595

(1) The evidence of coverage has been approved by the United 2596  
States department of health and human services, the United States 2597  
office of personnel management, or the Ohio department of human 2598  
services. 2599

(2) The evidence of coverage is filed with the superintendent 2600  
of insurance prior to use and is accompanied by documentation of 2601  
approval from the United States department of health and human 2602  
services, the United States office of personnel management, or the 2603  
Ohio department of human services. 2604

Sec. 1751.12. (A)(1) No contractual periodic prepayment and 2605  
no premium rate for nongroup and conversion policies for health 2606  
care services, or any amendment to them, may be used by any health 2607  
insuring corporation at any time until the contractual periodic 2608  
prepayment and premium rate, or amendment, have been filed with 2609  
the superintendent of insurance, and shall not be effective until 2610  
the expiration of sixty days after their filing unless the 2611  
superintendent sooner gives approval. The superintendent shall 2612  
disapprove the filing, if the superintendent determines within the 2613  
sixty-day period that the contractual periodic prepayment or 2614  
premium rate, or amendment, is not in accordance with sound 2615  
actuarial principles or is not reasonably related to the 2616  
applicable coverage and characteristics of the applicable class of 2617  
enrollees. The superintendent shall notify the health insuring 2618  
corporation of the disapproval, and it shall thereafter be 2619

unlawful for the health insuring corporation to use the 2620  
contractual periodic prepayment or premium rate, or amendment. 2621

(2) NO CONTRACTUAL PERIODIC PREPAYMENT FOR GROUP POLICIES FOR 2622  
HEALTH CARE SERVICES SHALL BE USED UNTIL THE CONTRACTUAL PERIODIC 2623  
PREPAYMENT HAS BEEN FILED WITH THE SUPERINTENDENT. THE 2624  
SUPERINTENDENT MAY REJECT A FILING MADE UNDER DIVISION (A)(2) OF 2625  
THIS SECTION AT ANY TIME, WITH AT LEAST THIRTY DAYS' WRITTEN 2626  
NOTICE TO A HEALTH INSURING CORPORATION, IF THE CONTRACTUAL 2627  
PERIODIC PREPAYMENT IS NOT in accordance with sound actuarial 2628  
principles or is not reasonably related to the applicable coverage 2629  
and characteristics of the applicable class of enrollees. 2630

(3) At any time, the superintendent, upon at least thirty 2631  
days' written notice to a health insuring corporation, may 2632  
withdraw the approval given under division (A)(1) of this section, 2633  
deemed or actual, of any contractual periodic prepayment or 2634  
premium rate, or amendment, based on information that either of 2635  
the following applies: 2636

(a) The contractual periodic prepayment or premium rate, or 2637  
amendment, is not in accordance with sound actuarial principles. 2638

(b) The contractual periodic prepayment or premium rate, or 2639  
amendment, is not reasonably related to the applicable coverage 2640  
and characteristics of the applicable class of enrollees. 2641

(4) Any disapproval under division (A)(1) of this section, 2642  
ANY REJECTION OF A FILING MADE UNDER DIVISION (A)(2) OF THIS 2643  
SECTION, or any withdrawal of approval under division (A)(3) of 2644  
this section, shall be effected by a written notice, which shall 2645  
state the specific basis for the disapproval, rejection, or 2646  
withdrawal and shall be issued in accordance with Chapter 119. of 2647  
the Revised Code. 2648

(B) Notwithstanding division (A) of this section, a health 2649  
insuring corporation may use a contractual periodic prepayment or 2650

premium rate for policies used for the coverage of beneficiaries 2651  
enrolled in Title XVIII of the "Social Security Act," 49 Stat. 620 2652  
(1935), 42 U.S.C.A. 301, as amended, pursuant to a medicare risk 2653  
contract or medicare cost contract, or for policies used for the 2654  
coverage of beneficiaries enrolled in the federal employees health 2655  
benefits program pursuant to 5 U.S.C.A. 8905, or for policies used 2656  
for the coverage of beneficiaries enrolled in Title XIX of the 2657  
"Social Security Act," 49 Stat. 620 (1935), 42 U.S.C.A. 301, as 2658  
amended, known as the medical assistance program or medicaid, 2659  
provided by the Ohio department of human services under Chapter 2660  
5111. of the Revised Code, or for policies used for the coverage 2661  
of beneficiaries under any other federal health care program 2662  
regulated by a federal regulatory body, if both of the following 2663  
apply: 2664

(1) The contractual periodic prepayment or premium rate has 2665  
been approved by the United States department of health and human 2666  
services, the United States office of personnel management, or the 2667  
Ohio department of human services. 2668

(2) The contractual periodic prepayment or premium rate is 2669  
filed with the superintendent prior to use and is accompanied by 2670  
documentation of approval from the United States department of 2671  
health and human services, the United States office of personnel 2672  
management, or the Ohio department of human services. 2673

(C) The administrative expense portion of all contractual 2674  
periodic prepayment or premium rate filings submitted to the 2675  
superintendent for review must reflect the actual cost of 2676  
administering the product. The superintendent may require that the 2677  
administrative expense portion of the filings be itemized and 2678  
supported. 2679

(D)(1) Copayments and deductibles must be reasonable and must 2680  
not be a barrier to the necessary utilization of services by 2681  
enrollees. 2682

(2) A health insuring corporation may not impose copayment charges on basic health care services that exceed thirty per cent of the total cost of providing any single covered health care service, except for emergency health services and urgent care services. The total cost of providing a health care service is the cost to the health insuring corporation of providing the health care service to the enrollee as reduced by any applicable provider discount. AN OPEN PANEL PLAN MAY NOT IMPOSE COPAYMENTS ON OUT-OF-NETWORK BENEFITS THAT EXCEED FIFTY PER CENT OF THE TOTAL COST OF PROVIDING ANY SINGLE COVERED HEALTH CARE SERVICE.

(3) To ensure that copayments are not a barrier to the utilization of basic health care services, a health insuring corporation may not impose, in any contract year, on any subscriber or enrollee, copayments that exceed two hundred per cent of the total annual premium rate to the subscriber or enrollees. This limitation of two hundred per cent does not include any reasonable copayments that are not a barrier to the necessary utilization of health care services by enrollees and that are imposed on physician office visits, emergency health services, urgent care services, supplemental health care services, or specialty health care services.

(E) A health insuring corporation shall not impose lifetime maximums on basic health care services. However, a health insuring corporation may establish a benefit limit for inpatient hospital services that are provided pursuant to a policy, contract, certificate, or agreement for supplemental health care services.

Sec. 1751.13. (A)(1) A health insuring corporation shall, either directly or indirectly, enter into contracts for the provision of health care services with a sufficient number and types of providers and health care facilities to ensure that all covered health care services will be accessible to enrollees from

a contracted provider or health care facility. 2715

(2) When a health insuring corporation is unable to provide a covered health care service from a contracted provider or health care facility, the health insuring corporation must provide that health care service from a noncontracted provider or health care facility consistent with the terms of the enrollee's policy, contract, certificate, or agreement. The health insuring corporation shall either ensure that the health care service be provided at no greater cost to the enrollee than if the enrollee had obtained the health care service from a contracted provider or health care facility, or make other arrangements acceptable to the superintendent of insurance. 2716  
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(3) Nothing in this section shall prohibit a health insuring corporation from entering into contracts with out-of-state providers or health care facilities that are licensed, certified, accredited, or otherwise authorized in that state. 2727  
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(B)(1) A health insuring corporation shall, either directly or indirectly, enter into contracts with all providers and health care facilities through which health care services are provided to its enrollees. 2731  
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(2) A health insuring corporation, upon written request, shall assist its contracted providers in finding stop-loss or reinsurance carriers. 2735  
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(C) A health insuring corporation shall file an annual certificate with the superintendent certifying that all provider contracts and contracts with health care facilities through which health care services are being provided contain the following: 2738  
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(1) A description of the method by which the provider or health care facility will be notified of the specific health care services for which the provider or health care facility will be responsible, including any limitations or conditions on such 2742  
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services; 2746

(2) The specific hold harmless provision specifying 2747  
protection of enrollees set forth as follows: 2748

"[Provider/Health Care Facility] agrees that in no event, 2749  
including but not limited to nonpayment by the health insuring 2750  
corporation, insolvency of the health insuring corporation, or 2751  
breach of this agreement, shall [Provider/Health Care Facility] 2752  
bill, charge, collect a deposit from, seek remuneration or 2753  
reimbursement from, or have any recourse against, a subscriber, 2754  
enrollee, person to whom health care services have been provided, 2755  
or person acting on behalf of the covered enrollee, for health 2756  
care services provided pursuant to this agreement. This does not 2757  
prohibit [Provider/Health Care Facility] from collecting 2758  
co-insurance, deductibles, or copayments as specifically provided 2759  
in the evidence of coverage, or fees for uncovered health care 2760  
services delivered on a fee-for-service basis to persons 2761  
referenced above, nor from any recourse against the health 2762  
insuring corporation or its successor." 2763

(3) Provisions requiring the provider or health care facility 2764  
to continue to provide covered health care services to enrollees 2765  
in the event of the health insuring corporation's insolvency or 2766  
discontinuance of operations. THE PROVISIONS SHALL REQUIRE THE 2767  
PROVIDER OR HEALTH CARE FACILITY TO CONTINUE TO PROVIDE COVERED 2768  
HEALTH CARE SERVICES TO ENROLLEES AS NEEDED TO COMPLETE ANY 2769  
MEDICALLY NECESSARY PROCEDURES COMMENCED BUT UNFINISHED AT THE 2770  
TIME OF THE HEALTH INSURING CORPORATION'S INSOLVENCY OR 2771  
DISCONTINUANCE OF OPERATIONS. IF AN ENROLLEE IS RECEIVING 2772  
NECESSARY INPATIENT CARE AT A HOSPITAL, THE PROVISIONS MAY LIMIT 2773  
THE REQUIRED PROVISION OF COVERED HEALTH CARE SERVICES RELATING TO 2774  
THAT INPATIENT CARE IN ACCORDANCE WITH DIVISION (D)(3) OF SECTION 2775  
1751.11 OF THE REVISED CODE, AND MAY ALSO LIMIT SUCH REQUIRED 2776  
PROVISION OF COVERED HEALTH CARE SERVICES TO THE PERIOD ENDING 2777

<u>THIRTY DAYS AFTER THE HEALTH INSURING CORPORATION'S INSOLVENCY OR</u>	2778
<u>DISCONTINUANCE OF OPERATIONS.</u>	2779
THE PROVISIONS REQUIRED BY DIVISION (C)(3) OF THIS SECTION	2780
SHALL NOT REQUIRE ANY PROVIDER OR HEALTH CARE FACILITY TO CONTINUE	2781
TO PROVIDE ANY COVERED HEALTH CARE SERVICE AFTER THE OCCURRENCE OF	2782
ANY OF THE FOLLOWING:	2783
(a) THE END OF THE THIRTY-DAY PERIOD FOLLOWING THE ENTRY OF A	2784
LIQUIDATION ORDER UNDER CHAPTER 3903. OF THE REVISED CODE;	2785
(b) THE END OF THE ENROLLEE'S PERIOD OF COVERAGE FOR A	2786
CONTRACTUAL PREPAYMENT OR PREMIUM;	2787
(c) THE ENROLLEE OBTAINS EQUIVALENT COVERAGE WITH ANOTHER	2788
HEALTH INSURING CORPORATION OR INSURER, OR THE ENROLLEE'S EMPLOYER	2789
OBTAINS SUCH COVERAGE FOR THE ENROLLEE;	2790
(d) THE ENROLLEE OR THE ENROLLEE'S EMPLOYER TERMINATES	2791
COVERAGE UNDER THE CONTRACT;	2792
(e) A LIQUIDATOR EFFECTS A TRANSFER OF THE HEALTH INSURING	2793
CORPORATION'S OBLIGATIONS UNDER THE CONTRACT UNDER DIVISION (A)(8)	2794
OF SECTION 3903.21 OF THE REVISED CODE.	2795
(4) <u>A provision clearly stating the rights and</u>	2796
<u>responsibilities of the health insuring corporation, and of the</u>	2797
<u>contracted providers and health care facilities, with respect to</u>	2798
<u>administrative policies and programs, including, but not limited</u>	2799
<u>to, payments systems, utilization review, quality assessment and</u>	2800
<u>improvement programs, credentialing, confidentiality requirements,</u>	2801
<u>and any applicable federal or state programs.</u>	2802
(5) <u>A provision regarding the availability and</u>	2803
<u>confidentiality of those health records maintained by providers</u>	2804
<u>and health care facilities to monitor and evaluate the quality of</u>	2805
<u>care, to conduct evaluations and audits, and to determine on a</u>	2806
<u>concurrent or retrospective basis the necessity of and</u>	2807

appropriateness of health care services provided to enrollees. The 2808  
provision shall include terms requiring the provider or health 2809  
care facility to make these health records available to 2810  
appropriate state and federal authorities involved in assessing 2811  
the quality of care or in investigating the grievances or 2812  
complaints of enrollees, and requiring the provider or health care 2813  
facility to comply with applicable state and federal laws related 2814  
to the confidentiality of medical or health records. 2815

(6) A provision that states that contractual rights and 2816  
responsibilities may not be assigned or delegated by the provider 2817  
or health care facility without the prior written consent of the 2818  
health insuring corporation; 2819

(7) A provision requiring the provider or health care 2820  
facility to maintain adequate professional liability and 2821  
malpractice insurance. The provision shall also require the 2822  
provider or health care facility to notify the health insuring 2823  
corporation not more than ten days after the provider's or health 2824  
care facility's receipt of notice of any reduction or cancellation 2825  
of such coverage. 2826

(8) A provision requiring the provider or health care 2827  
facility to observe, protect, and promote the rights of enrollees 2828  
as patients; 2829

(9) A provision requiring the provider or health care 2830  
facility to provide health care services without discrimination on 2831  
the basis of a patient's participation in the health care plan, 2832  
age, sex, ethnicity, religion, sexual preference, health status, 2833  
or disability, and without regard to the source of payments made 2834  
for health care services rendered to a patient. This requirement 2835  
shall not apply to circumstances when the provider or health care 2836  
facility appropriately does not render services due to limitations 2837  
arising from the provider's or health care facility's lack of 2838  
training, experience, or skill, or due to licensing restrictions. 2839

(10) A provision containing the specifics of any obligation on the provider or health care facility to provide, or to arrange for the provision of, covered health care services twenty-four hours per day, seven days per week; 2840  
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(11) A provision setting forth procedures for the resolution of disputes arising out of the contract; 2844  
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(12) A provision stating that the hold harmless provision required by division (C)(2) of this section shall survive the termination of the contract with respect to services covered and provided under the contract during the time the contract was in effect, regardless of the reason for the termination, including the insolvency of the health insuring corporation; 2846  
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(13) A provision requiring those terms that are used in the contract and that are defined by this chapter, be used in the contract in a manner consistent with those definitions. 2852  
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(D) No health insuring corporation contract with a provider or health care facility shall do either of the following: 2855  
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(1) Offer an inducement to the provider or health care facility, directly or indirectly, to reduce or limit medically necessary health care services to a covered enrollee; 2857  
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(2) Penalize a provider or health care facility that assists an enrollee to seek a reconsideration of the health insuring corporation's decision to deny or limit benefits to the enrollee. 2860  
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(E) Any contract between a health insuring corporation and an intermediary organization shall clearly specify that the health insuring corporation must approve or disapprove the participation of any provider or health care facility with which the intermediary organization contracts. 2863  
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(F) If an intermediary organization that is not a health delivery network contracting solely with self-insured employers 2868  
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subcontracts with a provider or health care facility, the 2870  
subcontract with the provider or health care facility shall do all 2871  
of the following: 2872

(1) Contain the provisions required by divisions (C) and (G) 2873  
of this section, as made applicable to an intermediary 2874  
organization, without the inclusion of inducements or penalties 2875  
described in division (D) of this section; 2876

(2) Acknowledge that the health insuring corporation is a 2877  
third-party beneficiary to the agreement; 2878

(3) Acknowledge the health insuring corporation's role in 2879  
approving the participation of the provider or health care 2880  
facility, pursuant to division (E) of this section. 2881

(G) Any provider contract or contract with a health care 2882  
facility shall clearly specify the health insuring corporation's 2883  
statutory responsibility to monitor and oversee the offering of 2884  
covered health care services to its enrollees. 2885

(H)(1) A health insuring corporation shall maintain its 2886  
provider contracts and its contracts with health care facilities 2887  
at one or more of its places of business in this state, and shall 2888  
provide copies of these contracts to facilitate regulatory review 2889  
upon written notice by the superintendent of insurance. 2890

(2) Any contract with an intermediary organization shall 2891  
include provisions requiring the intermediary organization to 2892  
provide the superintendent with regulatory access to all books, 2893  
records, financial information, and documents related to the 2894  
provision of health care services to subscribers and enrollees 2895  
under the contract. The contract shall require the intermediary 2896  
organization to maintain such books, records, financial 2897  
information, and documents at its principal place of business in 2898  
this state and to preserve them for at least three years in a 2899  
manner that facilitates regulatory review. 2900

(I) A health insuring corporation shall provide notice of the termination of any contract with a primary care physician or hospital. 2901  
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(J) Divisions (A) and (B) of this section do not apply to any health insuring corporation that, on the effective date of this section, holds a certificate of authority or license to operate under Chapter 1740. of the Revised Code. 2904  
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Sec. 1751.14. (A) Any policy, contract, or agreement for health care services authorized by this chapter that is issued, delivered, or renewed in this state and that provides that coverage of an unmarried dependent child will terminate upon attainment of the limiting age for dependent children specified in the policy, contract, or agreement, shall also provide in substance that attainment of the limiting age shall not operate to terminate the coverage of the child if the child is and continues to be both: 2908  
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(1) Incapable of self-sustaining employment by reason of mental retardation or physical handicap; 2917  
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(2) Primarily dependent upon the subscriber for support and maintenance. 2919  
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(B) Proof of incapacity and dependence for purposes of division (A) of this section shall be furnished to the health insuring corporation within thirty-one days of the child's attainment of the limiting age. Upon request, but not more frequently than annually, the health insuring corporation may require proof satisfactory to it of the continuance of such incapacity and dependency. 2921  
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(C) Nothing in this section shall be construed to require a health insuring corporation to cover a dependent child who is mentally retarded or physically handicapped if the policy, contract, or agreement is underwritten on evidence of insurability 2928  
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based on health factors set forth in the application, or if the 2932  
dependent child does not satisfy the conditions of the policy, 2933  
contract, or agreement as to any requirement for evidence of 2934  
insurability or any other provision of the policy, contract, or 2935  
agreement, satisfaction of which is required for coverage 2936  
thereunder to take effect. In any such case, the terms of the 2937  
policy, contract, or agreement shall apply with regard to the 2938  
coverage or exclusion of the dependent from such coverage. 2939

(D) This section does not apply to any health insuring 2940  
corporation, policy, contract, or agreement offering only 2941  
supplemental health care services or specialty health care 2942  
services. 2943

Sec. 1751.15. (A) After a health insuring corporation has 2944  
furnished, directly or indirectly, basic health care services for 2945  
a period of twenty-four months, and if it currently meets the 2946  
financial requirements set forth in section 1751.28 of the Revised 2947  
Code and had net income as reported to the superintendent of 2948  
insurance for at least one of the preceding four calendar 2949  
quarters, it shall hold an annual open enrollment period of not 2950  
less than thirty days during its month of licensure. 2951

(B) During the open enrollment period described in division 2952  
(A) of this section, the health insuring corporation shall accept 2953  
applicants and their dependents in the order in which they apply 2954  
for enrollment and in accordance with any of the following: 2955

(1) Up to its capacity, as determined by the health insuring 2956  
corporation subject to review by the superintendent; 2957

(2) If less than its capacity, one per cent of the health 2958  
insuring corporation's total number of subscribers residing in 2959  
this state as of the immediately preceding thirty-first day of 2960  
December. 2961

(C) Where a health insuring corporation demonstrates to the 2962

<u>satisfaction of the superintendent that such open enrollment would</u>	2963
<u>jeopardize its economic viability, the superintendent may do any</u>	2964
<u>of the following:</u>	2965
<u>(1) Waive the requirement for open enrollment;</u>	2966
<u>(2) Impose a limit on the number of applicants and their</u>	2967
<u>dependents that must be enrolled;</u>	2968
<u>(3) Authorize such underwriting restrictions upon open</u>	2969
<u>enrollment as are necessary to do any of the following:</u>	2970
<u>(a) Preserve its financial stability;</u>	2971
<u>(b) Prevent excessive adverse selection;</u>	2972
<u>(c) Avoid unreasonably high or unmarketable charges for</u>	2973
<u>coverage of health care services.</u>	2974
<u>(D)(1) A request to the superintendent under division (C) of</u>	2975
<u>this section for any restriction, limit, or waiver during an open</u>	2976
<u>enrollment period must be accompanied by supporting documentation,</u>	2977
<u>including financial data. In reviewing the request, the</u>	2978
<u>superintendent may consider various factors, including the size of</u>	2979
<u>the health insuring corporation, the health insuring corporation's</u>	2980
<u>net worth and profitability, the health insuring corporation's</u>	2981
<u>delivery system structure, and the effect on profitability of</u>	2982
<u>prior open enrollments.</u>	2983
<u>(2) Any action taken by the superintendent under division (C)</u>	2984
<u>of this section shall be effective for a period of not more than</u>	2985
<u>one year. At the expiration of such time, a new demonstration of</u>	2986
<u>the health insuring corporation's need for the restriction, limit,</u>	2987
<u>or waiver shall be made before a new restriction, limit, or waiver</u>	2988
<u>is granted by the superintendent.</u>	2989
<u>(3) Irrespective of the granting of any restriction, limit,</u>	2990
<u>or waiver by the superintendent, a health insuring corporation may</u>	2991
<u>reject an applicant or a dependent of the applicant during its</u>	2992

<u>open enrollment period if the applicant or dependent:</u>	2993
(a) <u>Was eligible for and was covered under any</u>	2994
<u>employer-sponsored health care coverage, or if employer-sponsored</u>	2995
<u>health care coverage was available at the time of open enrollment;</u>	2996
(b) <u>Is eligible for conversion or continuation coverage under</u>	2997
<u>state or federal law;</u>	2998
(c) <u>Is eligible for medicare, and the health insuring</u>	2999
<u>corporation does not have an agreement on appropriate payment</u>	3000
<u>mechanisms with the governmental agency administering the medicare</u>	3001
<u>program.</u>	3002
(E) <u>A health insuring corporation shall not be required</u>	3003
<u>either to enroll applicants or their dependents who are confined</u>	3004
<u>to a health care facility because of chronic illness, permanent</u>	3005
<u>injury, or other infirmity that would cause economic impairment to</u>	3006
<u>the health insuring corporation if such applicants or their</u>	3007
<u>dependents were enrolled or to make the effective date of benefits</u>	3008
<u>for applicants or their dependents enrolled under this section</u>	3009
<u>earlier than ninety days after the date of enrollment.</u>	3010
(F) <u>A health insuring corporation shall not be required to</u>	3011
<u>cover the fees or costs, or both, for any basic health care</u>	3012
<u>service related to a transplant of a body organ if the transplant</u>	3013
<u>occurs within one year after the effective date of an enrollee's</u>	3014
<u>coverage under this section. This limitation on coverage does not</u>	3015
<u>apply to a newly born child who meets the requirements for</u>	3016
<u>coverage under section 1751.61 of the Revised Code.</u>	3017
(G) <u>Each health insuring corporation required to hold an open</u>	3018
<u>enrollment pursuant to division (A) of this section shall file</u>	3019
<u>with the superintendent, not later than sixty days prior to the</u>	3020
<u>commencement of the proposed open enrollment period, the following</u>	3021
<u>documents:</u>	3022

<u>(1) The proposed public notice of open enrollment;</u>	3023
<u>(2) The evidence of coverage approved pursuant to section 1751.11 of the Revised Code that will be used during open enrollment;</u>	3024 3025 3026
<u>(3) The contractual periodic prepayment and premium rate approved pursuant to section 1751.12 of the Revised Code that will be applicable during open enrollment;</u>	3027 3028 3029
<u>(4) Any solicitation document approved pursuant to section 1751.31 of the Revised Code to be sent to applicants, including the application form that will be used during open enrollment;</u>	3030 3031 3032
<u>(5) A list of the proposed dates of publication of the public notice, and the names of the newspapers in which the notice will appear;</u>	3033 3034 3035
<u>(6) Any request for a restriction, limit, or waiver with respect to the open enrollment period, along with any supporting documentation.</u>	3036 3037 3038
<u>(H)(1) An open enrollment period shall not satisfy the requirements of this section unless the health insuring corporation provides adequate public notice in accordance with divisions (H)(2) and (3) of this section. No public notice shall be used until the form of the public notice has been filed by the health insuring corporation with the superintendent. If the superintendent does not disapprove the public notice within sixty days after it is filed, it shall be deemed approved, unless the superintendent sooner gives approval for the public notice. If the superintendent determines within this sixty-day period that the public notice fails to meet the requirements of this section, the superintendent shall so notify the health insuring corporation and it shall be unlawful for the health insuring corporation to use the public notice. Such disapproval shall be effected by a written order, which shall state the grounds for disapproval and shall be</u>	3039 3040 3041 3042 3043 3044 3045 3046 3047 3048 3049 3050 3051 3052 3053

issued in accordance with Chapter 119. of the Revised Code.

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(2) A public notice pursuant to division (H)(1) of this section shall be published in at least one newspaper of general circulation in each county in the health insuring corporation's service area, at least once in each of the two weeks immediately preceding the month in which the open enrollment is to occur and in each week of that month, or until the enrollment limitation is reached, whichever occurs first. The notice published during the last week of open enrollment shall appear not less than five days before the end of the open enrollment period. It shall be at least two newspaper columns wide or two and one-half inches wide, whichever is larger. The first two lines of the text shall be published in not less than twelve-point, boldface type. The remainder of the text of the notice shall be published in not less than eight-point type. The entire public notice shall be surrounded by a continuous black line not less than one-eighth of an inch wide.

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(3) The following information shall be included in the public notice provided under division (H)(2) of this section:

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(a) The dates that open enrollment will be held and the date coverage obtained under the open enrollment will become effective;

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(b) Notice that an applicant or the applicant's dependents will not be denied coverage during open enrollment because of a preexisting health condition, but that some limitations and restrictions may apply;

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(c) The address where a person may obtain an application;

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(d) The telephone number that a person may call to request an application or to ask questions;

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(e) The date the first payment will be due;

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(f) The actual rates or range of rates that will be 3084  
applicable for applicants; 3085

(g) Any limitation granted by the superintendent on the 3086  
number of applications that will be accepted by the health 3087  
insuring corporation. 3088

(4) Within thirty days after the end of an open enrollment 3089  
period, the health insuring corporation shall submit to the 3090  
superintendent proof of publication for the public notices, and 3091  
shall report the total number of applicants and their dependents 3092  
enrolled during the open enrollment period. 3093

(I)(1) No health insuring corporation may employ any scheme, 3094  
plan, or device that restricts the ability of any person to enroll 3095  
during open enrollment. 3096

(2) No health insuring corporation may require enrollment to 3097  
be made in person. Every health insuring corporation shall permit 3098  
application for coverage by mail. A representative of the health 3099  
insuring corporation may visit an applicant who has submitted an 3100  
application by mail, in order to explain the operations of the 3101  
health insuring corporation and to answer any questions the 3102  
applicant may have. Every health insuring corporation shall make 3103  
open enrollment applications and solicitation documents readily 3104  
available to any potential applicant who requests such material. 3105

(J) An application postmarked on the last day of an open 3106  
enrollment period shall qualify as a valid application, regardless 3107  
of the date on which it is received by the health insuring 3108  
corporation. 3109

(K) This section does not apply to any health insuring 3110  
corporation that offers only supplemental health care services or 3111  
specialty health care services, or to any health insuring 3112  
corporation that offers plans only through Title XVIII or Title 3113  
XIX of the "Social Security Act," 49 Stat. 620 (1935), 42 U.S.C.A. 3114

301, as amended, and that has no other commercial enrollment, or 3115  
to any health insuring corporation that offers plans only through 3116  
other federal health care programs regulated by federal regulatory 3117  
bodies and that has no other commercial enrollment. 3118

Sec. 1751.16. (A) Except as provided in division (F) of this 3119  
section, every group contract issued by a health insuring 3120  
corporation shall provide an option for conversion to an 3121  
individual contract issued on a direct-payment basis to any 3122  
subscriber covered by the group contract who terminates employment 3123  
or membership in the group, unless: 3124

(1) Termination of the conversion option or contract is based 3125  
upon nonpayment of premium after reasonable notice in writing has 3126  
been given by the health insuring corporation to the subscriber. 3127

(2) The subscriber is, or is eligible to be, covered for 3129  
benefits at least comparable to the group contract under any of 3130  
the following: 3131

(a) Title XVIII of the "Social Security Act," 49 Stat. 620 3132  
(1935), 42 U.S.C.A. 301, as amended; 3133

(b) Any act of congress or law under this or any other state 3134  
of the United States providing coverage at least comparable to the 3135  
benefits under division (A)(2)(a) of this section; 3136

(c) Any policy of insurance or health care plan providing 3137  
coverage at least comparable to the benefits under division 3138  
(A)(2)(a) of this section. 3139

(B) The direct-payment contract offered by the health 3140  
insuring corporation pursuant to division (A) of this section 3141  
shall provide benefits comparable to the benefits being provided 3142  
by any of the individual contracts then being issued to individual 3143  
subscribers by the health insuring corporation. The contract may 3144

contain a coordination of benefits provision as approved by the 3145  
superintendent of insurance. 3146

(C) The option for conversion shall be available: 3147

(1) Upon the death of the subscriber, to the surviving spouse 3148  
with respect to the spouse or dependents who were then covered by 3149  
the group contract; 3150

(2) To a child solely with respect to the child upon the 3151  
child's attaining the limiting age of coverage under the group 3152  
contract while covered as a dependent under the contract; 3153

(3) Upon the divorce, dissolution, or annulment of the 3154  
marriage of the subscriber, to the divorced spouse, or, in the 3155  
event of annulment, to the former spouse of the subscriber. 3156

(D) No health insuring corporation shall do any of the 3157  
following: 3158

(1) Use age as the basis for refusing to renew a converted 3159  
contract; 3160

(2) Require a subscriber to produce evidence of insurability 3161  
in order to exercise the option for conversion provided by this 3162  
section; 3163

(3) Include preexisting condition limitations in a converted 3164  
contract. 3165

(E) Written notice of the conversion option provided by this 3166  
section shall be given to the subscriber by the health insuring 3167  
corporation by mail. The notice shall be sent to the subscriber's 3168  
address in the records of the employer upon receipt of notice from 3169  
the employer of the event giving rise to the conversion option. If 3170  
the subscriber has not received notice of the conversion privilege 3171  
at least fifteen days prior to the expiration of the thirty-day 3172  
conversion period, then the subscriber shall have an additional 3173  
period within which to exercise the privilege. This additional 3174

period shall expire fifteen days after the subscriber receives 3175  
notice, but in no event shall the period extend beyond sixty days 3176  
after the expiration of the thirty-day conversion period. 3177  
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(F) This section does not apply to any group contract 3179  
offering only supplemental health care services or specialty 3180  
health care services. 3181

Sec. 1751.17. (A) As used in this section, "nongroup 3182  
contract" means a contract issued by a health insuring corporation 3183  
to an individual who makes direct application for coverage under 3184  
the contract and who, if required by the health insuring 3185  
corporation, submits to medical underwriting. "Nongroup contract" 3186  
does not include group conversion coverage, coverage obtained 3187  
through open enrollment, or coverage issued on the basis of 3188  
membership in a group. 3189

(B) Except as provided in division (C) of this section, every 3190  
nongroup contract that is issued by a health insuring corporation 3191  
and that makes available basic health care services shall provide 3192  
an option for conversion to a contract issued on a direct-payment 3193  
basis to an enrollee covered by the nongroup contract. The option 3194  
for conversion shall be available: 3195

(1) Upon the death of the subscriber, to the surviving spouse 3196  
with respect to the spouse or dependents who were then covered by 3197  
the nongroup contract; 3198

(2) Upon the divorce, dissolution, or annulment of the 3199  
marriage of the subscriber, to the divorced spouse, or, in the 3200  
event of annulment, to the former spouse of the subscriber; 3201

(3) To a child solely with respect to the child, upon the 3202  
child's attaining the limiting age of coverage under the nongroup 3203  
contract while covered as a dependent under the contract. 3204

(C) The direct payment contract offered pursuant to division 3205

(B) of this section shall not be made available to an enrollee if 3206  
any of the following applies: 3207

(1) The enrollee is, or is eligible to be, covered for 3208  
benefits at least comparable to the nongroup contract under any of 3209  
the following: 3210

(a) The medical assistance program under Chapter 5111. of the 3211  
Revised Code; 3212

(b) Title XVIII of the "Social Security Act," 49 Stat. 620 3213  
(1935), 42 U.S.C.A. 301, as amended; 3214

(c) Any act of congress or law under this or any other state 3215  
of the United States providing coverage at least comparable to the 3216  
benefits offered under division (C)(1)(a) or (b) of this section. 3217

(2) The nongroup contract under which the enrollee was 3218  
covered was terminated due to nonpayment of a premium rate. 3219

(3) The enrollee is eligible for group coverage provided by, 3220  
or available through, an employer or association and the group 3221  
coverage provides benefits comparable to the benefits provided 3222  
under a direct payment contract. 3223

(D) The direct payment contract offered pursuant to division 3224  
(B) of this section shall provide benefits that are at least 3225  
comparable to the benefits provided by the nongroup contract under 3226  
which the enrollee was covered at the time of the occurrence of 3227  
any of the events set forth in division (B) of this section. The 3228  
coverage provided under the direct payment contract shall be 3229  
continuous, provided that the enrollee makes the required premium 3230  
rate payment within the thirty-day period immediately following 3231  
the occurrence of the event, and may be terminated for nonpayment 3232  
of any required premium rate payment. 3233

(E) The evidence of coverage of every nongroup contract shall 3234  
contain notice that an option for conversion to a contract issued 3235

on a direct-payment basis is available, in accordance with this 3236  
section, to any enrollee covered by the contract. 3237

(F) Benefits otherwise payable to an enrollee under a direct 3238  
payment contract shall be reduced by the amount of any benefits 3239  
available to the enrollee under any applicable group health 3240  
insuring corporation contract or group sickness and accident 3241  
insurance policy. 3242

(G) Nothing in this section shall be construed as requiring a 3243  
health insuring corporation to offer nongroup contracts. 3244

(H) This section does not apply to any nongroup contract 3245  
offering only supplemental health care services or specialty 3246  
health care services. 3247

Sec. 1751.18. (A)(1) No health insuring corporation shall 3248  
cancel or fail to renew the coverage of a subscriber or enrollee 3249  
because of the subscriber's or enrollee's health status or 3250  
requirement for health care services, or for any other reason 3251  
designated under rules adopted by the superintendent of insurance. 3252

(2) Unless otherwise required by state or federal law, no 3253  
health insuring corporation, or health care facility or provider 3254  
through which the health insuring corporation has made 3255  
arrangements to provide health care services, shall discriminate 3256  
against any individual with regard to enrollment, disenrollment, 3257  
or the quality of health care services rendered, on the basis of 3258  
the individual's race, color, sex, age, religion, state of health, 3259  
or status as a recipient of medicare or medical assistance under 3260  
Title XVIII or XIX of the "Social Security Act," 49 Stat. 620 3261  
(1935), 42 U.S.C.A. 301, as amended. However, a health insuring 3262  
corporation shall not be required to accept a recipient of 3263  
medicare or medical assistance, if an agreement has not been 3264  
reached on appropriate payment mechanisms between the health 3265  
insuring corporation and the governmental agency administering 3266

these programs. Further, except during a period of open enrollment 3267  
under section 1751.15 of the Revised Code, a health insuring 3268  
corporation may reject an applicant for nongroup enrollment on the 3269  
basis of the state of health of the applicant. 3270

(B) A health insuring corporation may cancel or decide not to 3271  
renew the coverage of a subscriber or enrollee for any of the 3272  
following reasons: 3273

(1) Failure of the subscriber or enrollee to pay, or to have 3274  
paid on the subscriber's or enrollee's behalf, the required 3275  
premium rate or other charge; 3276

(2) Fraud or forgery; 3277

(3) Any material misrepresentation on the application for 3278  
coverage; 3279

(4) The subscriber's or enrollee's permitting the use of an 3280  
identification card or similar documents by another person, 3281  
allowing that person to receive services for which that person is 3282  
not entitled; 3283

(5) The subscriber's or enrollee's inability to establish or 3284  
maintain a provider-patient relationship with any provider 3285  
associated with the health insuring corporation, which inability 3286  
may include the subscriber's or enrollee's disruptive or abusive 3287  
behavior toward providers or the staff of the health care plan. 3288

(C) A subscriber or enrollee may appeal any action or 3289  
decision of the health insuring corporation under division (B) of 3290  
this section. To appeal, the subscriber or enrollee may submit a 3291  
written complaint to the health insuring corporation pursuant to 3292  
section 1751.19 of the Revised Code. The subscriber or enrollee 3293  
may, within thirty days after receiving a written response from 3294  
the health insuring corporation, appeal the health insuring 3295  
corporation's action or decision to the superintendent. 3296

Sec. 1751.19. (A) A health insuring corporation shall 3297  
establish and maintain a complaint system that has been approved 3298  
by the superintendent of insurance to provide adequate and 3299  
reasonable procedures for the expeditious resolution of written 3300  
complaints initiated by subscribers or enrollees concerning any 3301  
matter relating to services provided, directly or indirectly, by 3302  
the health insuring corporation, including, but not limited to, 3303  
claims regarding the scope of coverage for health care services, 3304  
and denials, cancellations, or nonrenewals of coverage. 3305

(B) A health insuring corporation shall provide a timely 3306  
written response to each written complaint it receives. Responses 3307  
to written complaints relating to quality or appropriateness of 3308  
care shall set forth a statement informing the complainant in 3309  
detail of any rights the complainant may have to submit such 3310  
complaint to any professional peer review organization or health 3311  
insuring corporation peer review committee that has been set up to 3312  
monitor the quality or appropriateness of provider services 3313  
rendered. Such statement shall set forth the name of the peer 3314  
review organization or health insuring corporation peer review 3315  
committee, its address, telephone number, and any other pertinent 3316  
data that will enable the complainant to seek further independent 3317  
review of the complaint. Such appeal shall not be made to the peer 3318  
review corporation or health insuring corporation peer review 3319  
committee until the complaint system of the health insuring 3320  
corporation has been exhausted. 3321

(C) Copies of complaints and responses, including medical 3322  
records related to those complaints, shall be available to the 3323  
superintendent and the director of health for inspection for three 3324  
years. Any document or information provided to the superintendent 3325  
pursuant to this division that contains a medical record is 3326  
confidential, and is not a public record subject to section 149.43 3327  
of the Revised Code. 3328

(D) A health insuring corporation shall establish and 3329  
maintain a procedure to accept complaints over the telephone or in 3330  
person. These complaints are not subject to the reporting 3331  
requirement under division (C) of section 1751.32 of the Revised 3332  
Code. 3333

Sec. 1751.20. (A) No health insuring corporation, or agent, 3334  
employee, or representative of a health insuring corporation, 3335  
shall use any advertisement or solicitation document, or shall 3336  
engage in any activity, that is unfair, untrue, misleading, or 3337  
deceptive. 3338

(B) No health insuring corporation shall use a name that is 3339  
deceptively similar to the name or description of any insurance or 3340  
surety corporation doing business in this state. 3341

(C) All solicitation documents, advertisements, evidences of 3342  
coverage, and enrollee identification cards used by a health 3343  
insuring corporation shall contain the health insuring 3344  
corporation's name. The use of a trade name, an insurance group 3345  
designation, the name of a parent company, the name of a division 3346  
of an affiliated insurance company, a service mark, a slogan, a 3347  
symbol, or other device, without the name of the health insuring 3348  
corporation as stated in its articles of incorporation, shall not 3349  
satisfy this requirement if the usage would have the capacity and 3350  
tendency to mislead or deceive persons as to the true identity of 3351  
the health insuring corporation. 3352

(D) No solicitation document or advertisement used by a 3353  
health insuring corporation shall contain any words, symbols, or 3354  
physical materials that are so similar in content, phraseology, 3355  
shape, color, or other characteristic to those used by an agency 3356  
of the federal government or this state, that prospective 3357  
enrollees may be led to believe that the solicitation document or 3358  
advertisement is connected with an agency of the federal 3359

government or this state.

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(E) THIS SECTION DOES NOT APPLY TO THE COVERAGE OF  
BENEFICIARIES ENROLLED IN TITLE XVIII OF THE "SOCIAL SECURITY  
ACT," 49 STAT. 620 (1935), 42 U.S.C.A. 301, AS AMENDED, PURSUANT  
TO A MEDICARE RISK CONTRACT OR MEDICARE COST CONTRACT, OR TO THE  
COVERAGE OF BENEFICIARIES ENROLLED IN THE FEDERAL EMPLOYEE HEALTH  
BENEFITS PROGRAM PURSUANT TO 5 U.S.C.A. 8905, OR TO THE COVERAGE  
OF BENEFICIARIES ENROLLED IN TITLE XIX OF THE "SOCIAL SECURITY  
ACT," 49 STAT. 620 (1935), 42 U.S.C.A. 301, AS AMENDED, KNOWN AS  
THE MEDICAL ASSISTANCE PROGRAM OR MEDICAID, PROVIDED BY THE OHIO  
DEPARTMENT OF HUMAN SERVICES UNDER CHAPTER 5111. OF THE REVISED  
CODE, OR TO THE COVERAGE OF BENEFICIARIES UNDER ANY FEDERAL HEALTH  
CARE PROGRAM REGULATED BY A FEDERAL REGULATORY BODY.

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Sec. 1751.21. (A) A peer review committee of a hospital or  
other health care facility or provider, or of an intermediary  
organization or health delivery network, with which a health  
insuring corporation has a contract for health care services may  
provide to a peer review committee of the health insuring  
corporation any information, documents, testimony, or other  
records relating to any matter that is the subject of evaluation  
or review by the peer review committees, if consent is provided by  
the health care facility and any physician or other provider whose  
professional qualifications or activities are the subject of  
evaluation or review.

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(B) Any immunity from liability for damages that is provided  
under section 2305.25 of the Revised Code and that would otherwise  
apply with respect to the conduct of any peer review committee  
described in division (A) of this section shall continue to apply,  
notwithstanding the provision of information as permitted under  
division (A) of this section.

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(C) The information, documents, testimony, or other records

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described in division (A) of this section, if otherwise protected 3391  
under section 2305.251 of the Revised Code, shall not be construed 3392  
as being available for discovery or for use in any civil action 3393  
solely on the basis that they were provided by the peer review 3394  
committee as permitted under division (A) of this section. 3395

Sec. 1751.25. The funds of a health insuring corporation 3396  
shall be invested only in securities or other investments or 3397  
assets that constitute permissible investments under section 3398  
1751.26 or 3925.08 of the Revised Code. 3399

Sec. 1751.26. (A) For purposes of this section, real estate 3400  
used for "the accommodation of the health insuring corporation's 3401  
business operations" includes the health insuring corporation's 3402  
home office, branch office, medical facilities, and field office 3403  
operations. 3404

(B) No health insuring corporation shall purchase, hold, or 3405  
convey real estate, or any interest in real estate, to be used as 3406  
an investment for the production of income, to be developed for 3407  
the production of income, or to be otherwise used for purposes 3408  
other than the accommodation of the health insuring corporation's 3409  
business operations, without the prior approval of the 3410  
superintendent of insurance. 3411

(C)(1) No health insuring corporation shall invest, without 3412  
the prior approval of the superintendent, an amount that exceeds 3413  
forty per cent of its admitted assets as of the immediately 3414  
preceding thirty-first day of December in real estate used for the 3415  
accommodation of the health insuring corporation's business 3416  
operations from which the health insuring corporation provides 3417  
health care services. 3418

(2) No health insuring corporation shall invest, without the 3419  
prior approval of the superintendent, an amount that exceeds 3420  
twenty-five per cent of its admitted assets as of the immediately 3421

preceding thirty-first day of December in real estate used for the 3422  
accommodation of the health insuring corporation's business 3423  
operations from which the health insuring corporation does not 3424  
provide health care services. 3425

Sec. 1751.27. (A) Each health insuring corporation holding a 3426  
certificate of authority to operate in this state shall have 3427  
deposited securities with the superintendent of insurance or an 3428  
approved custodian in the amount required by this division. 3429

(1) Each health insuring corporation authorized to provide 3430  
basic health care services shall maintain a deposit of not less 3431  
than two hundred fifty thousand dollars. 3432

(2) Each health insuring corporation authorized to provide 3433  
only supplemental health care services shall maintain a deposit of 3434  
not less than one hundred fifty thousand dollars. 3435

(3) EACH HEALTH INSURING CORPORATION AUTHORIZED TO PROVIDE 3436  
ONLY SPECIALTY HEALTH CARE SERVICES SHALL MAINTAIN A DEPOSIT OF 3437  
NOT LESS THAN SEVENTY-FIVE THOUSAND DOLLARS. 3438

(4) Each health insuring corporation authorized to provide 3439  
both basic health care services and supplemental health care 3440  
services shall maintain a deposit of not less than four hundred 3441  
thousand dollars. 3442

(5) EACH HEALTH INSURING CORPORATION AUTHORIZED TO PROVIDE 3443  
BOTH BASIC HEALTH CARE SERVICES AND SPECIALTY HEALTH CARE SERVICES 3444  
SHALL MAINTAIN A DEPOSIT OF NOT LESS THAN THREE HUNDRED 3445  
TWENTY-FIVE THOUSAND DOLLARS. 3446

(B) The securities deposited under division (A) of this 3447  
section shall be held as security for the fulfillment of the 3448  
obligations of the health insuring corporation to its enrollees 3449  
under this chapter. 3450

(C) The interest from the deposit made under division (A) of 3451

this section shall accrue to the health insuring corporation that 3452  
made the deposit. The deposit shall be considered to be an 3453  
admitted asset of the health insuring corporation. 3454

(D) The superintendent shall adopt rules setting forth the 3455  
qualifications and responsibilities of an approved custodian. 3456

Sec. 1751.28. (A) As used in this section: 3457

(1) "Admitted assets" includes the investments authorized by 3458  
section 1751.25 of the Revised Code, and, in addition to these 3459  
investments, only the following: 3460

(a) Petty cash and other cash funds that are in the health 3461  
insuring corporation's principal office or any official branch 3462  
office and that are under the control of the corporation; 3463

(b) Immediately withdrawable funds on deposit in demand 3464  
accounts in a bank or trust company, or similar funds that are 3465  
actually in the health insuring corporation's principal office or 3466  
any official branch office at statement date and that are in 3467  
transit to the bank or trust company with authentic deposit credit 3468  
given prior to the close of business on the fifth bank business 3469  
day following the statement date; 3470

(c) The amount fairly estimated as recoverable on cash 3471  
deposited in a bank or trust company the operations of which have 3472  
been suspended or for which a receiver has been appointed, if 3473  
qualifying under this section prior to the suspension of 3474  
operations of or the appointment of a receiver for the bank or 3475  
trust company; 3476

(d) Bills and accounts receivable collateralized by 3477  
securities of the kind in which the health insuring corporation 3478  
may invest; 3479

(e) Premiums receivable from groups or individuals that are 3480  
not more than ninety days past due; 3481

(f) <u>Accounts receivable that are not more than ninety days past due;</u>	3482
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(g) <u>Amounts due under reinsurance arrangements from insurance companies authorized to do business in this state;</u>	3484
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(h) <u>Tax refunds due from the United States or any state;</u>	3486
(i) <u>The interest accrued on mortgage loans that conform to section 3925.08 of the Revised Code, not exceeding on an individual loan an aggregate amount of one year's total due and accrued interest;</u>	3487
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(j) <u>The rents accrued and owing to the health insuring corporation on real and personal property, directly or beneficially owned, not exceeding on each individual property the amount of one year's total due and accrued rent;</u>	3491
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(k) <u>Interest or rents accrued on conditional sales agreements, security interests, chattel mortgages, and real or personal property under lease to other corporations, that conform to section 3925.08 of the Revised Code, not exceeding on any individual investment the amount of one year's total due and accrued interest or rent;</u>	3495
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(l) <u>The fixed and required interest due and accrued on bonds and other similar evidences of indebtedness, that conform to section 3925.08 of the Revised Code, and not in default;</u>	3501
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(m) <u>Dividends receivable on shares of stock that conform to section 3925.08 Of the Revised Code, provided that the market price taken for valuation purposes does not include the value of the dividend;</u>	3504
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(n) <u>The interest or dividends due and payable, but not credited, on deposits in banks and trust companies or on accounts with savings and loan associations;</u>	3508
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(o) <u>Interest accrued on secured loans that conform to section</u>	3511

<u>3925.08 of the Revised Code, not exceeding the amount of one</u>	3512
<u>year's interest on any loan;</u>	3513
(p) <u>Interest accrued on tax anticipation warrants;</u>	3514
(g) <u>The amortized value of electronic computer or data</u>	3515
<u>processing machines or systems purchased for use in connection</u>	3516
<u>with the business of the health insuring corporation, including</u>	3517
<u>software purchased and developed specifically for the use and</u>	3518
<u>purposes of the corporation;</u>	3519
(r) <u>The cost of furniture, equipment, and medical equipment,</u>	3520
<u>less accumulated depreciation on the furniture and equipment to be</u>	3521
<u>applied pro rata over a period not to exceed five years, and of</u>	3522
<u>medical and pharmaceutical supplies, that are under the control of</u>	3523
<u>the health insuring corporation, provided these assets do not</u>	3524
<u>exceed fifteen per cent of admitted assets;</u>	3525
(s) <u>Amounts due from affiliates to the extent that the</u>	3526
<u>affiliate has liquid assets with which to pay the balance and</u>	3527
<u>maintain its accounts on a current basis. Any amount outstanding</u>	3528
<u>more than three months shall be considered not current.</u>	3529
(2) <u>"Liabilities" means the liabilities of the health</u>	3530
<u>insuring corporation as determined by the superintendent of</u>	3531
<u>insurance.</u>	3532
(B) <u>All admitted assets of a health insuring corporation must</u>	3533
<u>be held in the health insuring corporation's name and must be free</u>	3534
<u>and clear of any encumbrances, pledges, or hypothecation.</u>	3535
(C)(1) <u>Every health insuring corporation authorized to</u>	3536
<u>provide basic health care services, which health insuring</u>	3537
<u>corporation is not a provider sponsored organization, shall</u>	3538
<u>maintain total admitted assets equal to at least one hundred ten</u>	3539
<u>per cent of the liabilities of the corporation. However, at no</u>	3540
<u>time shall the corporation's net worth be less than one million</u>	3541
<u>two hundred thousand dollars.</u>	3542

(2) Every health insuring corporation authorized to provide 3543  
only supplemental health care services shall maintain total 3544  
admitted assets equal to at least one hundred ten per cent of the 3545  
liabilities of the corporation. However, at no time shall the 3546  
corporation's net worth be less than five hundred thousand 3547  
dollars. 3548

(3) EVERY HEALTH INSURING CORPORATION AUTHORIZED TO PROVIDE 3549  
ONLY SPECIALTY HEALTH CARE SERVICES SHALL MAINTAIN TOTAL ADMITTED 3550  
ASSETS EQUAL TO AT LEAST ONE HUNDRED TEN PER CENT OF THE 3551  
LIABILITIES OF THE CORPORATION. HOWEVER, AT NO TIME SHALL THE 3552  
CORPORATION'S NET WORTH BE LESS THAN TWO HUNDRED FIFTY THOUSAND 3553  
DOLLARS. 3554

(4) Every health insuring corporation authorized to provide 3555  
both basic health care services and supplemental health care 3556  
services, which health insuring corporation is not a provider 3557  
sponsored organization, shall maintain total admitted assets equal 3558  
to at least one hundred ten per cent of the liabilities of the 3559  
corporation. However, at no time shall the corporation's net worth 3560  
be less than one million seven hundred thousand dollars. 3561

(5) EVERY HEALTH INSURING CORPORATION AUTHORIZED TO PROVIDE 3562  
BOTH BASIC HEALTH CARE SERVICES AND SPECIALTY HEALTH CARE 3563  
SERVICES, which health insuring corporation is not a provider 3564  
sponsored organization, shall MAINTAIN TOTAL ADMITTED ASSETS EQUAL 3565  
TO AT LEAST ONE HUNDRED TEN PER CENT OF THE LIABILITIES OF THE 3566  
CORPORATION. HOWEVER, AT NO TIME SHALL THE CORPORATION'S NET WORTH 3567  
BE LESS THAN ONE MILLION four HUNDRED FIFTY THOUSAND DOLLARS. 3568

(6) EVERY HEALTH INSURING CORPORATION AUTHORIZED TO PROVIDE 3570  
BASIC HEALTH CARE SERVICES, WHICH HEALTH INSURING CORPORATION IS A 3571  
PROVIDER SPONSORED ORGANIZATION, SHALL MAINTAIN TOTAL ADMITTED 3572  
ASSETS EQUAL TO AT LEAST ONE HUNDRED TEN PER CENT OF THE 3573

LIABILITIES OF THE CORPORATION. HOWEVER, AT NO TIME SHALL THE 3574  
CORPORATION'S NET WORTH BE LESS THAN ONE MILLION DOLLARS. 3575

(7) EVERY HEALTH INSURING CORPORATION AUTHORIZED TO PROVIDE 3576  
BOTH BASIC HEALTH CARE SERVICES AND SUPPLEMENTAL HEALTH CARE 3577  
SERVICES, WHICH HEALTH INSURING CORPORATION IS A PROVIDER 3578  
SPONSORED ORGANIZATION, SHALL MAINTAIN TOTAL ADMITTED ASSETS EQUAL 3579  
TO AT LEAST ONE HUNDRED TEN PER CENT OF THE LIABILITIES OF THE 3580  
CORPORATION. HOWEVER, AT NO TIME SHALL THE CORPORATION'S NET WORTH 3581  
BE LESS THAN ONE MILLION FIVE HUNDRED THOUSAND DOLLARS. 3582

(8) EVERY HEALTH INSURING CORPORATION AUTHORIZED TO PROVIDE 3583  
BOTH BASIC HEALTH CARE SERVICES AND SPECIALTY HEALTH CARE 3584  
SERVICES, WHICH HEALTH INSURING CORPORATION IS A PROVIDER 3585  
SPONSORED ORGANIZATION, SHALL MAINTAIN TOTAL ADMITTED ASSETS EQUAL 3586  
TO AT LEAST ONE HUNDRED TEN PER CENT OF THE LIABILITIES OF THE 3587  
CORPORATION. HOWEVER, AT NO TIME SHALL THE CORPORATION'S NET WORTH 3588  
BE LESS THAN ONE MILLION TWO HUNDRED FIFTY THOUSAND DOLLARS. 3589

(D) The admitted value of any real estate owned by a health 3590  
insuring corporation, whether used for the accommodation of the 3591  
health insuring corporation's business operations or otherwise, 3592  
shall be the original cost plus the cost of improvements, less 3593  
encumbrances and accumulated depreciation. 3594

(E) The net worth otherwise required by this section shall be 3595  
reduced by an amount representing credit given to reserve 3596  
liabilities when a health insuring corporation carries reinsurance 3597  
with an admitted reinsurer. However, such an amount shall not 3598  
affect the minimum amounts set forth in this section and section 3599  
1751.27 Of the Revised Code. 3600

Sec. 1751.31. (A) Any changes in a health insuring 3601  
corporation's solicitation document shall be filed with the 3602  
superintendent of insurance. The superintendent, within sixty days 3603  
of filing, may disapprove any solicitation document or amendment 3604

to it on any of the grounds stated in this section. Such 3605  
disapproval shall be effected by written notice to the health 3606  
insuring corporation. The notice shall state the grounds for 3607  
disapproval and shall be issued in accordance with Chapter 119. of 3608  
the Revised Code. 3609

(B) The solicitation document shall contain all information 3610  
necessary to enable a consumer to make an informed choice as to 3611  
whether or not to enroll in the health insuring corporation. The 3612  
information shall include a specific description of the health 3613  
care services to be available and the approximate number and type 3614  
of full-time equivalent medical practitioners. The information 3615  
shall be presented in the solicitation document in a manner that 3616  
is clear, concise, and intelligible to prospective applicants in 3617  
the proposed service area. 3618

(C) Every potential applicant whose subscription to a health 3619  
care plan is solicited shall receive, at or before the time of 3620  
solicitation, a solicitation document approved by the 3621  
superintendent. 3622

(D) Notwithstanding division (A) of this section, a health 3623  
insuring corporation may use a solicitation document that the 3624  
corporation uses in connection with policies for beneficiaries of 3625  
Title XVIII of the "Social Security Act," 49 Stat. 620 (1935), 42 3626  
U.S.C.A. 301, as amended, pursuant to a medicare risk contract or 3627  
medicare cost contract, or for policies for beneficiaries of the 3628  
federal employees health benefits program pursuant to 5 U.S.C.A. 3629  
8905, or for policies for beneficiaries of Title XIX of the 3630  
"Social Security Act," 49 Stat. 620 (1935), 42 U.S.C.A. 301, as 3631  
amended, known as the medical assistance program or medicaid, 3632  
provided by the Ohio department of human services under Chapter 3633  
5111. of the Revised Code, or for policies for beneficiaries of 3634  
any other federal health care program regulated by a federal 3635  
regulatory body, if both of the following apply: 3636

(1) The solicitation document has been approved by the United States department of health and human services, the United States office of personnel management, or the Ohio department of human services. 3637  
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(2) The solicitation document is filed with the superintendent of insurance prior to use and is accompanied by documentation of approval from the United States department of health and human services, the United States office of personnel management, or the Ohio department of human services. 3641  
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(E) No health insuring corporation, or its agents or representatives, shall use monetary or other valuable consideration, engage in misleading or deceptive practices, or make untrue, misleading, or deceptive representations to induce enrollment. Nothing in this division shall prohibit incentive forms of remuneration such as commission sales programs for the health insuring corporation's employees and agents. 3646  
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(F) Any person obligated for any part of a premium rate in connection with an enrollment agreement, in addition to any right otherwise available to revoke an offer, may cancel such agreement within seventy-two hours after having signed the agreement or offer to enroll. Cancellation occurs when written notice of the cancellation is given to the health insuring corporation or its agents or other representatives. A notice of cancellation mailed to the health insuring corporation shall be considered to have been filed on its postmark date. 3653  
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(G) NOTHING IN THIS SECTION SHALL PROHIBIT HEALTHY LIFESTYLE PROGRAMS. 3662  
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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 and the director of health, covering the preceding calendar year. 3664  
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The report shall be verified by an officer of the health insuring corporation, shall be in the form the superintendent prescribes, and shall include: 3668  
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(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: 3671  
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(1) All premium rate and other payments received for health care services rendered; 3674  
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(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; 3676  
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(3) Expenditures for capital improvements or additions thereto, including, but not limited to, construction, renovation, or purchase of facilities and equipment. 3681  
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(B) A description of the enrollee population and composition, group and nongroup; 3684  
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(C) A summary of enrollee written complaints and their disposition; 3686  
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(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; 3688  
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(E) A summary of the information compiled pursuant to division (B)(5) of section 1751.04 of the Revised Code; 3692  
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(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, 3694  
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expense reimbursements, and other payments to these persons for 3698  
services to the health insuring corporation, and shall include a 3699  
full disclosure of the financial interests related to the 3700  
operations of the health insuring corporation acquired by these 3701  
persons during the preceding year. 3702

(G) An audit report certified by an independent certified 3703  
public accountant in the form prescribed by the superintendent by 3704  
rule; 3705

(H) An actuarial opinion in the form prescribed by the 3706  
superintendent by rule; 3707

(I) Any other information relating to the performance of the 3708  
health insuring corporation that is necessary to enable the 3709  
superintendent to carry out the superintendent's duties under this 3710  
chapter. 3711

Sec. 1751.33. (A) Each health insuring corporation shall 3712  
provide to its subscribers, by mail, a description of the health 3713  
insuring corporation, its method of operation, its service area, 3714  
its most recent provider list, and its complaint procedure 3715  
established pursuant to section 1751.19 of the Revised Code. A 3716  
health insuring corporation providing basic health care services 3717  
or supplemental health care services shall provide this 3718  
information annually. A health insuring corporation providing only 3719  
specialty health care services shall provide this information 3720  
biennially. 3721

(B) Each health insuring corporation, upon the request of a 3722  
subscriber, shall make available its most recent statutory 3723  
financial statement. 3724

Sec. 1751.34. (A) Each health insuring corporation and each 3725  
applicant for a certificate of authority under this chapter shall 3726  
be subject to examination by the superintendent of insurance in 3727  
accordance with section 3901.07 of the Revised Code. Section 3728

3901.07 of the Revised Code shall govern every aspect of the 3729  
examination, including the circumstances under and frequency with 3730  
which it is conducted, the authority of the superintendent and any 3731  
examiner or other person appointed by the superintendent, the 3732  
liability for the assessment of expenses incurred in conducting 3733  
the examination, and the remittance of the assessment to the 3734  
superintendent's examination fund. 3735

(B) The director of health shall make an examination 3736  
concerning the matters subject to the director's consideration in 3737  
section 1751.04 of the Revised Code as often as the director 3738  
considers it necessary for the protection of the interests of the 3739  
people of this state, but not less frequently than once every 3740  
three years. The expenses of such examinations shall be assessed 3741  
against the health insuring corporation being examined in the 3742  
manner in which expenses of examinations are assessed against an 3743  
insurance company under section 3901.07 of the Revised Code. 3744

(C) An examination, pursuant to section 3901.07 of the 3745  
Revised Code, of an insurance company holding a certificate of 3746  
authority under this chapter to organize and operate a health 3747  
insuring corporation shall include an examination of the health 3748  
insuring corporation pursuant to this section and the examination 3749  
shall satisfy the requirements of divisions (A) and (B) of this 3750  
section. 3751

(D) The superintendent may conduct market conduct 3752  
examinations pursuant to section 3901.011 of the Revised Code of 3753  
any health insuring corporation as often as the superintendent 3754  
considers it necessary for the protection of the interests of 3755  
subscribers and enrollees. The expenses of such market conduct 3756  
examinations shall be assessed against the health insuring 3757  
corporation being examined. All costs, assessments, or fines 3758  
collected under this division shall be paid into the state 3759  
treasury to the credit of the department of insurance operating 3760

<u>fund.</u>	3761
Sec. 1751.35. (A) <u>The superintendent of insurance may suspend or revoke any certificate of authority issued to a health insuring corporation under this chapter if the superintendent finds that:</u>	3762 3763 3764 3765
(1) <u>The health insuring corporation is operating in contravention of its articles of incorporation, its health care plan or plans, or in a manner contrary to that described in and reasonably inferred from any other information submitted under section 1751.03 of the Revised Code, unless amendments to such submissions have been filed and have taken effect in compliance with this chapter.</u>	3766 3767 3768 3769 3770 3771 3772
(2) <u>The health insuring corporation fails to issue evidences of coverage in compliance with the requirements of section 1751.11 of the Revised Code.</u>	3773 3774 3775
(3) <u>The contractual periodic prepayments or premium rates used do not comply with the requirements of section 1751.12 of the Revised Code.</u>	3776 3777 3778
(4) <u>The health insuring corporation enters into a contract, agreement, or other arrangement with any health care facility or provider, that does not comply with the requirements of section 1751.13 of the Revised Code, or the corporation fails to provide an annual certificate as required by section 1751.13 of the Revised Code.</u>	3779 3780 3781 3782 3783 3784
(5) <u>The director of health has certified, after a hearing conducted in accordance with Chapter 119. of the Revised Code, that the health insuring corporation no longer meets the requirements of section 1751.04 of the Revised Code.</u>	3785 3786 3787 3788
(6) <u>The health insuring corporation is no longer financially responsible and may reasonably be expected to be unable to meet</u>	3789 3790

<u>its obligations to enrollees or prospective enrollees.</u>	3791
<u>(7) The health insuring corporation has failed to implement</u>	3792
<u>the complaint system that complies with the requirements of</u>	3793
<u>section 1751.19 of the Revised Code.</u>	3794
<u>(8) The health insuring corporation, or any agent or</u>	3795
<u>representative of the corporation, has advertised, merchandised,</u>	3796
<u>or solicited on its behalf in contravention of the requirements of</u>	3797
<u>section 1751.31 of the Revised Code.</u>	3798
<u>(9) The health insuring corporation has unlawfully</u>	3799
<u>discriminated against any enrollee or prospective enrollee with</u>	3800
<u>respect to enrollment, disenrollment, or price or quality of</u>	3801
<u>health care services.</u>	3802
<u>(10) The continued operation of the health insuring</u>	3803
<u>corporation would be hazardous or otherwise detrimental to its</u>	3804
<u>enrollees.</u>	3805
<u>(11) The health insuring corporation has submitted false</u>	3806
<u>information in any filing or submission required under this</u>	3807
<u>chapter or any rule adopted under this chapter.</u>	3808
<u>(12) The health insuring corporation has otherwise failed to</u>	3809
<u>substantially comply with this chapter or any rule adopted under</u>	3810
<u>this chapter.</u>	3811
<u>(13) The health insuring corporation is not operating a</u>	3812
<u>health care plan.</u>	3813
<u>(B) A certificate of authority shall be suspended or revoked</u>	3814
<u>only after compliance with the requirements of Chapter 119. of the</u>	3815
<u>Revised Code.</u>	3816
<u>(C) When the certificate of authority of a health insuring</u>	3817
<u>corporation is suspended, the health insuring corporation, during</u>	3818
<u>the period of suspension, shall not enroll any additional</u>	3819
<u>subscribers or enrollees except newborn children or other newly</u>	3820

acquired dependents of existing subscribers or enrollees, and 3821  
shall not engage in any advertising or solicitation whatsoever. 3822

(D) When the certificate of authority of a health insuring 3823  
corporation is revoked, the health insuring corporation, following 3824  
the effective date of the order of revocation, shall conduct no 3825  
further business except as may be essential to the orderly 3826  
conclusion of the affairs of the health insuring corporation. The 3827  
health insuring corporation shall engage in no further advertising 3828  
or solicitation whatsoever. The superintendent, by written order, 3829  
may permit such further operation of the health insuring 3830  
corporation as the superintendent may find to be in the best 3831  
interest of enrollees, to the end that enrollees will be afforded 3832  
the greatest practical opportunity to obtain continuing health 3833  
care coverage. 3834

Sec. 1751.36. (A) When the superintendent of insurance has 3835  
cause to believe that grounds for the denial of an application for 3836  
a certificate of authority exist, or that grounds for the 3837  
suspension or revocation of a certificate of authority exist, the 3838  
superintendent shall notify the applicant or health insuring 3839  
corporation and the director of health in writing, specifically 3840  
stating the grounds for the denial, suspension, or revocation and 3841  
setting a date of at least thirty days after the notification for 3842  
a hearing on the matter. 3843

(B) The recommendations and findings of the director of 3844  
health with respect to matters subject to the director's 3845  
consideration under section 1751.04 of the Revised Code, provided 3846  
in connection with any decision regarding the denial, suspension, 3847  
or revocation of a certificate of authority, shall be reviewed and 3848  
considered by the superintendent. After the hearing authorized by 3849  
division (A) of this section, or upon the failure of the applicant 3850  
or health insuring corporation to appear at the hearing, the 3851  
superintendent shall take such action as in accordance with law 3852

and the evidence. The action shall be set out in written findings 3853  
which shall be mailed to the applicant or health insuring 3854  
corporation with a copy to the director of health. The action of 3855  
the superintendent is subject to review in accordance with Chapter 3856  
119. of the Revised Code, except that a certification by the 3857  
director under division (D) of section 1751.04 or division (A)(5) 3858  
of section 1751.35 of the Revised Code that was made in accordance 3859  
with Chapter 119. of the Revised Code shall be final as to the 3860  
matters certified. 3861

(C) Chapter 119. of the Revised Code applies to proceedings 3862  
under this section to the extent that it is not in conflict with 3863  
divisions (A) and (B) of this section. 3864

Sec. 1751.38. (A) As used in this section, "agent" means a 3865  
person appointed by a health insuring corporation to engage in the 3866  
solicitation or enrollment of subscribers or enrollees. 3867

(B) Agents of health insuring corporations shall be licensed 3868  
pursuant to section 3905.01 or 3905.18 of the Revised Code. 3869

(C) Sections 3905.01, 3905.03, 3905.05, 3905.16 to 3905.18, 3870  
3905.181, 3905.19, 3905.23, 3905.40, 3905.41, 3905.42, 3905.46 to 3871  
3905.48, 3905.481, 3905.482, 3905.486, 3905.49, 3905.50, 3905.71 3872  
to 3905.79, and 3905.99 Of the Revised Code shall apply to health 3873  
insuring corporations and the agents of health insuring 3874  
corporations in the same manner in which these sections apply to 3875  
insurers and agents of insurers. 3876

Sec. 1751.40. (A) NOTWITHSTANDING ANY PROVISION OF TITLE 3877  
XXXIX OF THE REVISED CODE, any insurance company holding a 3878  
certificate of authority issued pursuant to Title XXXIX of the 3879  
Revised Code, or any corporation that is a subsidiary or affiliate 3880  
of the insurance company, may apply for and obtain a certificate 3881  
of authority to organize and operate a health insuring corporation 3882  
in compliance with this chapter. Notwithstanding any other law 3883

that may be inconsistent with this division, any two or more such 3884  
insurance companies, or subsidiaries or affiliates thereof, may 3885  
jointly organize and operate a health insuring corporation under 3886  
this chapter. The business of insurance is deemed to include the 3887  
providing of health care by a health insuring corporation owned or 3888  
operated by an insurance company or a subsidiary or affiliate of 3889  
an insurance company. 3890

(B) Notwithstanding any provision of any insurance laws of 3891  
this state, an insurance company may contract with a health 3892  
insuring corporation to provide insurance or similar protection 3893  
against the cost of care provided through health insuring 3894  
corporations and to provide coverage in the event of the failure 3895  
of the health insuring corporation to meet its obligations. The 3896  
enrollees of a health insuring corporation constitute a 3897  
permissible group under such laws. Among other things, under such 3898  
contracts, the insurer may make benefit payments to health 3899  
insuring corporations for health care services rendered by 3900  
facilities and providers pursuant to a health care plan. 3901

Sec. 1751.42. Any rehabilitation, liquidation, supervision, 3902  
or conservation of a health insuring corporation shall be deemed 3903  
to be the rehabilitation, liquidation, supervision, or 3904  
conservation of an insurance company and shall be conducted under 3905  
the supervision of the superintendent of insurance pursuant to 3906  
Chapter 3903. of the Revised Code. 3907

Sec. 1751.44. (A) Each health insuring corporation shall pay 3908  
to the superintendent of insurance the following fees: 3909

(1) For filing an application for a certificate of authority, 3910  
fifteen hundred dollars; 3911

(2) For filing a request for a service area expansion under 3912  
section 1751.03 of the Revised Code, three hundred dollars; 3913

(3) For filing a major modification under section 1751.03 of 3914

the Revised Code, three hundred dollars; 3915

(4) For filing each annual report, twenty-five dollars; 3916

(5) For all other required filings for which no filing fee is 3917  
otherwise provided for by this chapter, fifty dollars. 3918

(B) All fees collected under this section shall be paid into 3919  
the state treasury to the credit of the department of insurance 3920  
operating fund. 3921

Sec. 1751.45. (A) In lieu of the suspension or revocation of 3922  
a certificate of authority under section 1751.35 of the Revised 3923  
Code, the superintendent of insurance, pursuant to an adjudication 3924  
hearing initiated and conducted in accordance with Chapter 119. of 3925  
the Revised Code, or by consent of the health insuring corporation 3926  
without an adjudication hearing, may levy an administrative 3927  
penalty. The administrative penalty shall be in an amount 3928  
determined by the superintendent, BUT THE ADMINISTRATIVE PENALTY 3929  
SHALL NOT EXCEED ONE HUNDRED THOUSAND DOLLARS PER VIOLATION. 3930  
ADDITIONALLY, THE SUPERINTENDENT MAY require the health insuring 3931  
corporation to correct any deficiency that may be the basis for 3932  
the suspension or revocation of the health insuring corporation's 3933  
certificate of authority. All penalties collected shall be paid 3934  
into the state treasury to the credit of the department of 3935  
insurance operating fund. 3936

(B) If the superintendent or the director of health for any 3937  
reason has cause to believe that any violation of this chapter has 3938  
occurred or is threatened, the superintendent or the director may 3939  
give notice to the health insuring corporation and to the 3940  
representatives or other persons who appear to be involved in the 3941  
suspected violation to arrange a conference with the suspected 3942  
violators or their authorized representatives for the purpose of 3943  
attempting to ascertain the facts relating to the suspected 3944  
violation, and, if it appears that any violation has occurred or 3945

is threatened, to arrive at an adequate and effective means of 3946  
correcting or preventing the violation. 3947

Proceedings under this division shall not be covered by any 3948  
formal procedural requirements, and may be conducted in the manner 3949  
the superintendent or the director of health may consider 3950  
appropriate under the circumstances. 3951

(C)(1) The superintendent may issue an order directing a 3952  
health insuring corporation or a representative of the health 3953  
insuring corporation to cease and desist from engaging in any act 3954  
or practice in violation of this chapter. Within thirty days after 3955  
service of the order to cease and desist, the respondent may 3956  
request a hearing on the question of whether acts or practices in 3957  
violation of this chapter have occurred. Such hearings shall be 3958  
conducted in accordance with Chapter 119. of the Revised Code and 3959  
judicial review shall be available as provided by that chapter. 3960

(2) If the superintendent has reasonable cause to believe 3961  
that an order issued pursuant to this division has been violated 3962  
in whole or in part, the superintendent may request the attorney 3963  
general to commence and prosecute any appropriate action or 3964  
proceeding in the name of the state against the violators in the 3965  
court of common pleas of Franklin county. The court in any such 3966  
action or proceeding may levy civil penalties, not to exceed one 3967  
hundred thousand dollars per violation, in addition to any other 3968  
appropriate relief, including requiring a violator to pay the 3969  
expenses reasonably incurred by the superintendent in enforcing 3970  
the order. The penalties and fees collected under this division 3971  
shall be paid into the state treasury to the credit of the 3972  
department of insurance operating fund. 3973

Sec. 1751.46. (A) The superintendent of insurance and the 3974  
director of health may contract with qualified persons to make 3975  
recommendations concerning the determinations required to be made 3976

by the superintendent or the director relative to an expansion of 3977  
a service area pursuant to division (C) of section 1751.03 of the 3978  
Revised Code, an application for a certificate of authority 3979  
pursuant to sections 1751.04 and 1751.05 of the Revised Code, a 3980  
contractual periodic prepayment or premium rate pursuant to 3981  
section 1751.12 of the Revised Code, and an examination pursuant 3982  
to division (B) of section 1751.34 of the Revised Code. The 3983  
recommendations may be accepted in full or in part, or may be 3984  
rejected, by the superintendent or director. 3985

(B) No qualified person placed on contract by the 3986  
superintendent or the director pursuant to division (A) of this 3987  
section shall have a conflict of interest with the department of 3988  
insurance, the department of health, or the health insuring 3989  
corporation. 3990

Sec. 1751.47. (A) The superintendent of insurance shall adopt 3991  
the forms, instructions, and manuals prescribed by the national 3992  
association of insurance commissioners for the preparation and 3993  
filing of statutory financial statements and other financial 3994  
information. However, the superintendent may by rule adopt 3995  
modifications to such prescribed forms, instructions, and manuals 3996  
as the superintendent considers to be necessary. 3997

(B) For purposes of preparing statutory financial statements 3998  
and other financial information involving circumstances not 3999  
addressed by the forms, instructions, and manuals prescribed by 4000  
the national association of insurance commissioners, the 4001  
superintendent may determine accounting practices and methods to 4002  
be used by health insuring corporations. 4003

(C) The superintendent shall furnish each domestic health 4004  
insuring corporation a copy of the forms for the filing of those 4005  
statutory financial statements and other financial information as 4006  
the corporation is required to file with the superintendent. 4007

Sec. 1751.48. (A) The superintendent of insurance may adopt 4008  
rules as are necessary to carry out the provisions of this 4009  
chapter. These rules shall be adopted in accordance with Chapter 4010  
119. of the Revised Code. 4011

(B) The director of health may make recommendations to the 4012  
superintendent for rules that are necessary to enable the director 4013  
to carry out the director's responsibilities under this chapter, 4014  
including rules that prescribe standards relating to the 4015  
requirements set forth in division (B) of section 1751.04 of the 4016  
Revised Code. In adopting any rules pertaining to the director's 4017  
responsibilities, the superintendent shall consider the 4018  
recommendations of the director. 4019

Sec. 1751.51. If a health care plan of a health insuring 4020  
corporation covers health care services that may be legally 4021  
performed by a class of providers referred to in section 3923.23 4022  
or 3923.231 of the Revised Code but would restrict an enrollee's 4023  
ability to receive these health care services from members of that 4024  
class in any manner that differs from an enrollee's ability under 4025  
the health care plan to receive these health care services from 4026  
any other class of providers that may legally perform these health 4027  
care services, then the health insuring corporation shall do both 4028  
of the following: 4029

(A) Set forth, within any evidence of coverage pertaining to 4030  
the health care plan, under a heading that reads "Restrictions on 4031  
Choice of Providers," a clear, concise, and complete statement of 4032  
the restriction that conforms to the requirements of section 4033  
1751.11 of the Revised Code; 4034

(B) Set forth, within any solicitation document pertaining to 4035  
the health care plan and within any solicitation materials 4036  
pertaining to the health care plan that the health insuring 4037  
corporation provides to any employer or any employee benefit fund, 4038

under a heading that reads "Restrictions on Choice of Providers," 4039  
a clear, concise, and complete statement of the restriction, such 4040  
statement being subject to prior approval by the superintendent of 4041  
insurance in accordance with the same form and content 4042  
requirements that are specified in section 1751.11 of the Revised 4043  
Code with regard to evidence of coverage. 4044

Sec. 1751.52. (A) All applications, filings, and reports 4045  
required under this chapter shall be treated as public documents 4046  
after the date the application, filing, or report becomes 4047  
effective, regardless of the application of the Uniform Trade 4048  
Secrets Act set forth in sections 1333.61 to 1333.69 of the 4049  
Revised Code. 4050

(B) Any data or information pertaining to the diagnosis, 4051  
treatment, or health of any enrollee or applicant for enrollment 4052  
that is obtained by the health insuring corporation from the 4053  
enrollee or applicant, or from any health care facility or 4054  
provider, shall be held in confidence and shall not be disclosed 4055  
to any person except under one of the following circumstances: 4056

(1) To the extent that it may be necessary to carry out the 4057  
purposes of this chapter; 4058

(2) Upon the express consent of the enrollee or applicant; 4059

(3) Pursuant to statute or court order for the production of 4060  
evidence; 4061

(4) In the event of claim litigation between such person and 4062  
the health insuring corporation wherein such data or information 4063  
is pertinent. 4064

(C) A health insuring corporation shall be entitled to claim 4065  
any statutory privileges against disclosure under division (B) of 4066  
this section that the facility or provider who furnished the data 4067  
or information to the health insuring corporation is entitled to 4068

claim. 4069

Sec. 1751.53. (A) As used in this section: 4070

(1) "Group contract" means a group health insuring 4071  
corporation contract covering employees that meets either of the 4072  
following conditions: 4073

(a) The contract was issued by an entity that, on the 4074  
effective date of this section, holds a certificate of authority 4075  
or license to operate under Chapter 1738. or 1742. of the Revised 4076  
Code, and covers an employee at the time the employee's employment 4077  
is terminated. 4078

(b) The contract is delivered, issued for delivery, or 4079  
renewed in this state after the effective date of this section and 4080  
covers an employee at the time the employee's employment is 4081  
terminated. 4082

(2) "Eligible employee" means an employee to whom all of the 4083  
following apply: 4084

(a) The employee has been continuously covered under a group 4085  
contract or under the contract and any prior similar group 4086  
coverage replaced by the contract, during the entire three-month 4087  
period preceding the termination of the employee's employment. 4088

(b) The employee is entitled, at the time of the termination 4089  
of this employment, to unemployment compensation benefits under 4090  
Chapter 4141. of the Revised Code. 4091

(c) The employee is not, and does not become, covered by or 4092  
eligible for coverage by medicare under Title XVIII of the "Social 4093  
Security Act, "49 Stat. 620 (1935), 42 U.S.C.A. 301, as amended. 4094

(d) The employee is not, and does not become, covered by or 4095  
eligible for coverage by any other insured or uninsured 4096  
arrangement that provides hospital, surgical, or medical coverage 4097  
for individuals in a group and under which the employee was not 4098

covered immediately prior to the termination of employment. A 4099  
person eligible for continuation of coverage under this section, 4100  
who is also eligible for coverage under section 3923.123 of the 4101  
Revised Code, may elect either coverage, but not both. A person 4102  
who elects continuation of coverage may elect any coverage 4103  
available under section 3923.123 of the Revised Code upon the 4104  
termination of the continuation of coverage. 4105

(B) A group contract shall provide that any eligible employee 4106  
may continue the coverage under the contract, for the employee and 4107  
the employee's eligible dependents, for a period of six months 4108  
after the date that the group coverage would otherwise terminate 4109  
by reason of the termination of the employee's employment. Each 4110  
certificate of coverage issued to employees under the contract 4111  
shall include a notice of the employee's privilege of 4112  
continuation. 4113

(C) All of the following apply to the continuation of group 4114  
coverage required under division (B) of this section: 4115

(1) Continuation need not include any supplemental health 4116  
care services benefits or specialty health care services benefits 4117  
provided by the group contract. 4118

(2) The employer shall notify the employee of the right of 4119  
continuation at the time the employer notifies the employee of the 4120  
termination of employment. The notice shall inform the employee of 4121  
the amount of contribution required by the employer under division 4122  
(C)(4) of this section. 4123

(3) The employee shall file a written election of 4124  
continuation with the employer and pay the employer the first 4125  
contribution required under division (C)(4) of this section. The 4126  
request and payment must be received by the employer no later than 4127  
the earlier of any of the following dates: 4128

(a) Thirty-one days after the date on which the employee's 4129

coverage would otherwise terminate; 4130

(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; 4131  
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(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. 4134  
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(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. 4137  
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(5) The employee's privilege to continue coverage and the coverage under any continuation ceases if any of the following occurs: 4142  
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(a) The employee ceases to be an eligible employee under division (A)(2)(c) or (d) of this section; 4145  
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(b) A period of six months expires after the date that the employee's coverage under the group contract would otherwise have terminated because of the termination of employment; 4147  
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(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; 4150  
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(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: 4153  
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(i) The member shall be covered under the replacement 4159

coverage, for the balance of the period that the member would have 4160  
remained covered under the terminated coverage if it had not been 4161  
terminated. 4162

(ii) The minimum level of benefits under the replacement 4163  
coverage shall be the applicable level of benefits of the contract 4164  
replaced reduced by any benefits payable under the contract 4165  
replaced. 4166

(iii) The contract replaced shall continue to provide 4167  
benefits to the extent of its accrued liabilities and extensions 4168  
of benefits as if the replacement had not occurred. 4169

(D) This section does not apply to any group contract 4170  
offering only supplemental health care services or specialty 4171  
health care services. 4172

Sec. 1751.54. (A) As used in this section: 4173

(1) "Eligible person" means any person who, at the time a 4174  
reservist is called or ordered to active duty, is covered under a 4175  
group contract and is either of the following: 4176

(a) An employee who is a reservist called or ordered to 4177  
active duty; 4178

(b) The spouse or a dependent child of an employee described 4179  
in division (A)(1)(a) of this section. 4180

(2) "Group contract" includes any group health insuring 4181  
corporation contract that satisfies all of the following: 4182

(a) The contract is delivered, issued for delivery, or 4183  
renewed in this state on or after the effective date of this 4184  
section. 4185

(b) The contract covers employees for health care services, 4186  
including basic health care services. 4187

(c) The contract is in effect and covers an eligible person 4188  
at the time a reservist is called or ordered to active duty. 4189

(3) "Reservist" means a member of a reserve component of the 4190  
armed forces of the United States. "Reservist" includes a member 4191  
of the Ohio national guard and the Ohio air national guard. 4192

(B) Every group contract shall provide that any eligible 4193  
person may continue the coverage under the contract for a period 4194  
of eighteen months after the date on which the coverage would 4195  
otherwise terminate because the reservist is called or ordered to 4196  
active duty. 4197

(C)(1) An eligible person may extend the eighteen-month 4198  
period of continuation of coverage to a thirty-six-month period of 4199  
continuation of coverage, if any of the following occurs during 4200  
the eighteen-month period: 4201

(a) The death of the reservist; 4202

(b) The divorce or separation of a reservist from the 4203  
reservist's spouse; 4204

(c) The cessation of dependency of a child pursuant to the 4205  
terms of the contract. 4206

(2) The thirty-six-month period of continuation of coverage 4207  
is deemed to begin on the date on which the coverage would 4208  
otherwise terminate because the reservist is called or ordered to 4209  
active duty. 4210

(3) The employer may begin the thirty-six-month period on the 4211  
date of any occurrence described in division (C)(1) of this 4212  
section. 4213

(D) All of the following apply to any continuation of 4214  
coverage, or the extension of any continuation of coverage, 4215  
provided under division (B) or (C) of this section: 4216

(1) The continuation of coverage shall provide the same 4217  
benefits as those provided to any similarly situated eligible 4218  
person who is covered under the same group contract and an 4219

employee who has not been called or ordered to active duty. 4220

(2) An employer shall notify each employee of the right of continuation of coverage at the time of employment. At the time the reservist is called or ordered to active duty, the employer shall notify each eligible person of the requirements for the continuation of coverage. 4221  
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(3) Each certificate of coverage issued by a health insuring corporation to an employee under the group contract shall include a notice of the eligible person's right of continuation of coverage. 4226  
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(4) An eligible person shall file a written election of continuation of coverage with the employer and pay the employer the first contribution required under division (D)(5) of this section. The written election and payment must be received by the employer no later than thirty-one days after the date on which the eligible person's coverage would otherwise terminate. If the employer notifies the eligible person of the right of continuation of coverage after the date on which the eligible person's coverage would otherwise terminate, the written election and payment must be received by the employer no later than thirty-one days after the date of the notification. 4230  
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(5)(a) Except as provided in division (D)(5)(b) of this section, the eligible person shall pay to the employer, on a monthly basis and in advance, the amount of contribution required by the employer. The amount shall not exceed one hundred two per cent of the group rate for the coverage being continued under the group contract on the due date of each payment. 4241  
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(b) The employer may pay a portion or all of the eligible person's contribution. 4247  
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(E) The eligible person's right to any continuation of coverage, or the extension of any continuation of coverage, 4249  
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provided under division (B) or (C) of this section ceases on the 4251  
date on which any of the following occurs: 4252

(1) The eligible person, whether as an employee or otherwise, 4253  
becomes covered by another group contract or other group health 4254  
plan or arrangement that does not contain any exclusion or 4255  
limitation with respect to any preexisting condition of that 4256  
eligible person. For purposes of division (E)(1) of this section, 4257  
a group contract or other group health plan or arrangement does 4258  
not include the civilian health and medical program of the 4259  
uniformed services as defined in Public Law 99-661, 100 Stat. 3898 4260  
(1986), 10 U.S.C.A. 1072. 4261

(2) The period of either eighteen months provided under 4262  
division (B) of this section or thirty-six months provided under 4263  
division (C) of this section expires. 4264

(3) The eligible person fails to make a timely payment of a 4265  
required contribution, in which case the coverage ceases at the 4266  
end of the period of coverage for which contributions were made. 4267

(4) The group contract, or participation under the group 4268  
contract, is terminated, unless the employer, in accordance with 4269  
division (F) of this section, replaces the coverage with similar 4270  
coverage under another group contract or other group health plan 4271  
or arrangement. 4272

(F) If the employer replaces the group contract with similar 4273  
coverage as described in division (E)(4) of this section, both of 4274  
the following apply: 4275

(1) The eligible person is covered under the replacement 4276  
coverage for the balance of the period that the person would have 4277  
remained covered under the terminated coverage if it had not been 4278  
terminated. 4279

(2) The level of benefits under the replacement coverage is 4280

the same as the level of benefits provided to any similarly 4281  
situated eligible person who is covered under the group contract 4282  
and an employee who has not been called or ordered to active duty. 4283

(G) Upon the reservist's release from active duty and the 4284  
reservist's return to employment for the employer by whom the 4285  
reservist was employed at the time the reservist was called or 4286  
ordered to active duty, both of the following apply: 4287

(1) Every eligible person is entitled, without any waiting 4288  
period, to coverage under the employer's group contract that is in 4289  
effect at the time of the reservist's return to employment. 4290

(2) Every eligible person is entitled to all benefits under 4291  
the group contract described in division (G)(1) of this section 4292  
from the date of the original coverage under the contract. 4293

(H)(1) No health insuring corporation shall fail to provide 4294  
for a continuation of coverage, or an extension of a continuation 4295  
of coverage, in a group contract as required by and in accordance 4296  
with the terms and conditions set forth under this section. 4297

(2) No health insuring corporation shall fail to issue a 4298  
certificate of coverage in compliance with division (D)(3) of this 4299  
section. 4300

(3) No employer shall fail to provide an employee or eligible 4301  
person with notice of the right to a continuation of coverage 4302  
under a group contract in accordance with division (D)(2) of this 4303  
section. 4304

(I) Whoever violates division (H)(1), (2), or (3) of this 4305  
section is deemed to have engaged in an unfair and deceptive act 4306  
or practice in the business of insurance under sections 3901.19 to 4307  
3901.26 of the Revised Code. 4308

(J) This section does not apply to any group contract that is 4309  
subject to section 5923.051 of the Revised Code. 4310

(K) This section does not apply to any group contract 4311  
offering only supplemental health care services or specialty 4312  
health care services. 4313

Sec. 1751.55. A health insuring corporation policy, contract, 4314  
or agreement shall not be construed to exclude illness or injury 4315  
upon the ground that the subscriber might have elected to have 4316  
such illness or injury covered by workers' compensation under 4317  
division (A)(3) of section 4123.01 of the Revised Code unless the 4318  
policy, contract, or agreement clearly excludes work or 4319  
occupational related illness or injury, or the policy, contract, 4320  
or agreement, or a separate writing signed by the subscriber, 4321  
informs the subscriber that such coverage is excluded and may be 4322  
available to the subscriber under workers' compensation as the 4323  
sole proprietor of a business, a member of a partnership, or an 4324  
officer of a family farm corporation. 4325

Sec. 1751.56. (A) No individual or group health insuring 4326  
corporation policy, contract, or agreement shall be delivered, 4327  
issued for delivery, or renewed in this state, if the policy, 4328  
contract, or agreement excludes or reduces the benefits payable to 4329  
or on behalf of an insured because benefits are also payable or 4330  
have been paid under a supplemental sickness and accident 4331  
insurance policy to which all of the following apply: 4332

(1) The policy covers a specified disease or a limited plan 4333  
of coverage. 4334

(2) The policy is specifically designed, advertised, 4335  
represented, and sold as a supplement to other basic sickness and 4336  
accident insurance coverage. 4337

(3) The entire premium for the policy is paid by the insured, 4338  
the insured's family, or the insured's guardian. 4339

(B) This section applies to supplemental sickness and 4340  
accident insurance policies irrespective of the mode or channel of 4341

premium payment to the insurer or of any reduction in the premium 4342  
by virtue of the insured's membership in any health insuring 4343  
corporation or the insured's status as an employee. 4344

Sec. 1751.59. (A) No individual or group health insuring 4345  
corporation policy, contract, or agreement providing family 4346  
coverage may be delivered, issued for delivery, or renewed in this 4347  
state, unless the policy, contract, or agreement covers adopted 4348  
children of the subscriber on the same basis as other dependents. 4349

(B) The coverage required by this section is subject to the 4350  
requirements and restrictions set forth in section 3924.51 of the 4351  
Revised Code. Coverage for dependent children living outside the 4352  
health insuring corporation's approved service area must be 4353  
provided if a court order requires the subscriber to provide 4354  
health care coverage. 4355

Sec. 1751.60. (A) Except as provided for in divisions (E) and 4356  
(F) of this section, every provider or health care facility that 4357  
contracts with a health insuring corporation to provide health 4358  
care services to the health insuring corporation's enrollees or 4359  
subscribers shall seek compensation for covered services solely 4360  
from the health insuring corporation and not, under any 4361  
circumstances, from the enrollees or subscribers, except for 4362  
approved deductibles and copayments. 4363

(B) No subscriber or enrollee of a health insuring 4364  
corporation is liable to any contracting provider or health care 4365  
facility for the cost of any covered health care services, if the 4366  
subscriber or enrollee has acted in accordance with the evidence 4367  
of coverage. 4368

(C) Except as provided for in divisions (E) and (F) of this 4369  
section, every contract between a health insuring corporation and 4370  
provider or health care facility shall contain a provision 4371  
approved by the superintendent of insurance requiring the provider 4372

or health care facility to seek compensation solely from the 4373  
health insuring corporation and not, under any circumstances, from 4374  
the subscriber or enrollee, except for approved deductibles and 4375  
copayments. 4376

(D) Nothing in this section shall be construed as preventing 4377  
a provider or health care facility from billing the enrollee or 4378  
subscriber of a health insuring corporation for noncovered 4379  
services. 4380

(E) Upon application by a health insuring corporation and a 4381  
provider or health care facility, the superintendent may waive the 4382  
requirements of divisions (A) and (C) of this section when, in 4383  
addition to the reserve requirements contained in section 1751.28 4384  
of the Revised Code, the health insuring corporation provides 4385  
sufficient assurances to the superintendent that the provider or 4386  
health care facility has been provided with financial guarantees. 4387  
No waiver of the requirements of divisions (A) and (C) of this 4388  
section is effective as to enrollees or subscribers for whom the 4389  
health insuring corporation is compensated under a provider 4390  
agreement or risk contract entered into pursuant to Chapter 5111. 4391  
or 5115. of the Revised Code. 4392

(F) The requirements of divisions (A) to (C) of this section 4393  
apply only to health care services provided to an enrollee or 4394  
subscriber prior to the effective date of a termination of a 4395  
contract between the health insuring corporation and the provider 4396  
or health care facility. 4397

Sec. 1751.61. (A) Each individual or group evidence of 4398  
coverage that is delivered, issued for delivery, or renewed by a 4399  
health insuring corporation in this state, and that provides 4400  
coverage for family members of a subscriber, also shall provide 4401  
that coverage applicable to children is payable from the moment of 4402  
birth with respect to a newly born child of the subscriber or 4403

subscriber's spouse. 4404

(B) Coverage for a newly born child is effective for a period of thirty-one days from the date of birth. 4405  
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(C) To continue coverage for a newly born child beyond the thirty-one day period described in division (B) of this section, the subscriber shall notify the health insuring corporation within that period. 4407  
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(D) If payment of a specific premium rate is required to provide coverage under this section for an additional child, the evidence of coverage may require the subscriber to make this payment to the health insuring corporation within the thirty-one day period described in division (B) of this section in order to continue the coverage beyond that period. 4411  
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Sec. 1751.62. (A) As used in this section, "screening mammography" means a radiologic examination utilized to detect unsuspected breast cancer at an early stage in an asymptomatic woman and includes the x-ray examination of the breast using equipment that is dedicated specifically for mammography, including the x-ray tube, filter, compression device, screens, film, and cassettes, and that has an average radiation exposure delivery of less than one rad mid-breast. "Screening mammography" includes two views for each breast. The term also includes the professional interpretation of the film. 4417  
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"Screening mammography" does not include diagnostic mammography. 4427  
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(B) Every individual or 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 benefits for the expenses of both of the following: 4429  
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(1) Screening mammography to detect the presence of breast 4434

cancer in adult women; 4435

(2) Cytologic screening for the presence of cervical cancer. 4436

(C) The benefits provided under division (B)(1) of this 4437  
section shall cover expenses in accordance with all of the 4438  
following: 4439

(1) If a woman is at least thirty-five years of age but under 4440  
forty years of age, one screening mammography; 4441

(2) If a woman is at least forty years of age but under fifty 4442  
years of age, either of the following: 4443

(a) One screening mammography every two years; 4444

(b) If a licensed physician has determined that the woman has 4445  
risk factors to breast cancer, one screening mammography every 4446  
year. 4447

(3) If a woman is at least fifty years of age but under 4448  
sixty-five years of age, one screening mammography every year. 4449

(D)(1) The benefits provided under division (B)(1) of this 4450  
section shall not exceed eighty-five dollars per year unless a 4451  
lower amount is established pursuant to a provider contract. 4452

(2) The benefit paid in accordance with division (D)(1) of 4453  
this section shall constitute full payment. No institutional or 4454  
professional health care provider shall seek or receive 4455  
remuneration in excess of the payment made in accordance with 4456  
division (D)(1) of this section, except for approved deductibles 4457  
and copayments. 4458

(E) The benefits provided under division (B)(1) of this 4459  
section shall be provided only for screening mammographies that 4460  
are performed in a health care facility or mobile mammography 4461  
screening unit that is accredited under the American college of 4462  
radiology mammography accreditation program or in a hospital as 4463  
defined in section 3727.01 of the Revised Code. 4464

(F) The benefits provided under divisions (B)(1) and (2) of this section shall be provided according to the terms of the subscriber contract. 4465  
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(G) The benefits provided under division (B)(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. 4468  
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Sec. 1751.63. Sections 3923.41 to 3923.48 of the Revised Code apply to every health insuring corporation that offers long-term care and that holds a certificate of authority under this chapter. 4473  
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Sec. 1751.64. (A) As used in this section, "genetic screening or testing" means a laboratory test of a person's genes or chromosomes for abnormalities, defects, or deficiencies, including carrier status, that are linked to physical or mental disorders or impairments, or that indicate a susceptibility to illness, disease, or other disorders, whether physical or mental, which test is a direct test for abnormalities, defects, or deficiencies, and not an indirect manifestation of genetic disorders. 4477  
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(B) No health insuring corporation, in processing an application for coverage for health care services under an individual or group health insuring corporation policy, contract, or agreement or in determining insurability under such a policy, contract, or agreement, shall do any of the following: 4485  
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(1) Require an individual seeking coverage to submit to genetic screening or testing; 4491  
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(2) Take into consideration, other than in accordance with division (F) of this section, the results of genetic screening or testing; 4493  
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<u>(3) Make any inquiry to determine the results of genetic screening or testing;</u>	4496
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<u>(4) Make a decision adverse to the applicant based on entries in medical records or other reports of genetic screening or testing.</u>	4498
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	4500
<u>(C) In developing and asking questions regarding medical histories of applicants for coverage under an individual or group health insuring corporation policy, contract, or agreement, no health insuring corporation shall ask for the results of genetic screening or testing or ask questions designed to ascertain the results of genetic screening or testing.</u>	4501
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<u>(D) No health insuring corporation shall cancel or refuse to issue or renew coverage for health care services based on the results of genetic screening or testing.</u>	4507
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<u>(E) No health insuring corporation shall deliver, issue for delivery, or renew an individual or group policy, contract, or agreement in this state that limits benefits based on the results of genetic screening or testing.</u>	4510
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<u>(F) A health insuring corporation may consider the results of genetic screening or testing if the results are voluntarily submitted by an applicant for coverage or renewal of coverage and the results are favorable to the applicant.</u>	4514
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<u>(G) A violation of this section is an unfair and deceptive act or practice in the business of insurance under sections 3901.19 to 3901.26 of the Revised Code.</u>	4518
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	4520
Sec. 1751.65. <u>(A) As used in this section, "genetic screening or testing" means a laboratory test of a person's genes or chromosomes for abnormalities, defects, or deficiencies, including carrier status, that are linked to physical or mental disorders or impairments, or that indicate a susceptibility to illness,</u>	4521
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disease, or other disorders, whether physical or mental, which 4526  
test is a direct test for abnormalities, defects, or deficiencies, 4527  
and not an indirect manifestation of genetic disorders. 4528

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(B) Upon the repeal of section 1751.64 of the Revised Code, 4530  
no health insuring corporation shall do either of the following: 4531

(1) Consider, in a manner adverse to an applicant or insured, 4532  
any information obtained from genetic screening or testing 4533  
conducted prior to the repeal of section 1751.64 of the Revised 4534  
Code in processing an application for coverage for health care 4535  
services under an individual or group policy, contract, or 4536  
agreement or in determining insurability under such a policy, 4537  
contract, or agreement; 4538

(2) Inquire, directly or indirectly, into the results of 4539  
genetic screening or testing conducted prior to the repeal of 4540  
section 1751.64 of the Revised Code, or use such information, in 4541  
whole or in part, to cancel, refuse to issue or renew, or limit 4542  
benefits under, an individual or group policy, contract, or 4543  
agreement. 4544

(C) Any health insuring corporation that has engaged in, is 4545  
engaged in, or is about to engage in a violation of division (B) 4546  
of this section is subject to the jurisdiction of the 4547  
superintendent of insurance under section 3901.04 of the Revised 4548  
Code. 4549

Sec. 1751.66. (A) No individual or group health insuring 4550  
corporation policy, contract, or agreement that provides coverage 4551  
for prescription drugs shall limit or exclude coverage for any 4552  
drug approved by the United States food and drug administration on 4553  
the basis that the drug has not been approved by the United States 4554  
food and drug administration for the treatment of the particular 4555  
indication for which the drug has been prescribed, provided the 4556

drug has been recognized as safe and effective for treatment of 4557  
that indication in one or more of the standard medical reference 4558  
compendia specified in division (B)(1) of this section or in 4559  
medical literature that meets the criteria specified in division 4560  
(B)(2) of this section. 4561

(B)(1) The compendia accepted for purposes of division (A) of 4562  
this section are the following: 4563

(a) The "AMA drug evaluations," a publication of the American 4564  
medical association; 4565

(b) The "AHFS (American hospital formulary service) drug 4566  
information," a publication of the American society of health 4567  
system pharmacists; 4568

(c) "Drug information for the health care provider," a 4569  
publication of the United States pharmacopoeia convention. 4570

(2) Medical literature may be accepted for purposes of 4571  
division (A) of this section only if all of the following apply: 4572

(a) Two articles from major peer-reviewed professional 4573  
medical journals have recognized, based on scientific or medical 4574  
criteria, the drug's safety and effectiveness for treatment of the 4575  
indication for which it has been prescribed; 4576

(b) No article from a major peer-reviewed professional 4577  
medical journal has concluded, based on scientific or medical 4578  
criteria, that the drug is unsafe or ineffective or that the 4579  
drug's safety and effectiveness cannot be determined for the 4580  
treatment of the indication for which it has been prescribed; 4581

(c) Each article meets the uniform requirements for 4582  
manuscripts submitted to biomedical journals established by the 4583  
international committee of medical journal editors or is published 4584  
in a journal specified by the United States department of health 4585  
and human services pursuant to Section 1861(t)(2)(B) of the 4586

"Social Security Act," 107 Stat. 591 (1993), 42 U.S.C. 1395 4587  
(x)(t)(2)(B), as amended, as accepted peer-reviewed medical 4588  
literature. 4589

(C) Coverage of a drug required by division (A) of this 4590  
section includes medically necessary services associated with the 4591  
administration of the drug. 4592

(D) Division (A) of this section shall not be construed to do 4593  
any of the following: 4594

(1) Require coverage for any drug if the United States food 4595  
and drug administration has determined its use to be 4596  
contraindicated for the treatment of the particular indication for 4597  
which the drug has been prescribed; 4598

(2) Require coverage for experimental drugs not approved for 4599  
any indication by the United States food and drug administration; 4600

(3) Alter any law with regard to provisions limiting the 4601  
coverage of drugs that have not been approved by the United States 4602  
food and drug administration; 4603

(4) Require reimbursement or coverage for any drug not 4604  
included in the drug formulary or list of covered drugs specified 4605  
in a health insuring corporation contract; 4606

(5) Prohibit a health insuring corporation from limiting or 4607  
excluding coverage of a drug, provided that the decision to limit 4608  
or exclude coverage of the drug is not based primarily on the 4609  
coverage of drugs required by this section. 4610

(E) This section applies only to health insuring corporation 4611  
policies, contracts, and agreements that are described in division 4612  
(A) of this section and that are delivered, issued for delivery, 4613  
or renewed in this state on or after July 1, 1997. 4614

Sec. 1751.67. (A) EACH INDIVIDUAL OR GROUP HEALTH INSURING 4615  
CORPORATION POLICY, CONTRACT, OR AGREEMENT DELIVERED, ISSUED FOR 4616

DELIVERY, OR RENEWED IN THIS STATE THAT PROVIDES MATERNITY 4617  
BENEFITS SHALL PROVIDE COVERAGE OF INPATIENT CARE AND FOLLOW-UP 4618  
CARE FOR A MOTHER AND HER NEWBORN AS FOLLOWS: 4619

(1) THE POLICY, CONTRACT, OR AGREEMENT SHALL COVER A MINIMUM 4620  
OF FORTY-EIGHT HOURS OF INPATIENT CARE FOLLOWING A NORMAL VAGINAL 4621  
DELIVERY AND A MINIMUM OF NINETY-SIX HOURS OF INPATIENT CARE 4622  
FOLLOWING A CESAREAN DELIVERY. SERVICES COVERED AS INPATIENT CARE 4623  
SHALL INCLUDE MEDICAL, EDUCATIONAL, AND ANY OTHER SERVICES THAT 4624  
ARE CONSISTENT WITH THE INPATIENT CARE RECOMMENDED IN THE 4625  
PROTOCOLS AND GUIDELINES DEVELOPED BY NATIONAL ORGANIZATIONS THAT 4626  
REPRESENT PEDIATRIC, OBSTETRIC, AND NURSING PROFESSIONALS. 4627

(2) THE POLICY, CONTRACT, OR AGREEMENT SHALL COVER A 4628  
PHYSICIAN-DIRECTED SOURCE OF FOLLOW-UP CARE. SERVICES COVERED AS 4629  
FOLLOW-UP CARE SHALL INCLUDE PHYSICAL ASSESSMENT OF THE MOTHER AND 4630  
NEWBORN, PARENT EDUCATION, ASSISTANCE AND TRAINING IN BREAST OR 4631  
BOTTLE FEEDING, ASSESSMENT OF THE HOME SUPPORT SYSTEM, PERFORMANCE 4632  
OF ANY MEDICALLY NECESSARY AND APPROPRIATE CLINICAL TESTS, AND ANY 4633  
OTHER SERVICES THAT ARE CONSISTENT WITH THE FOLLOW-UP CARE 4634  
RECOMMENDED IN THE PROTOCOLS AND GUIDELINES DEVELOPED BY NATIONAL 4635  
ORGANIZATIONS THAT REPRESENT PEDIATRIC, OBSTETRIC, AND NURSING 4636  
PROFESSIONALS. THE COVERAGE SHALL APPLY TO SERVICES PROVIDED IN A 4637  
MEDICAL SETTING OR THROUGH HOME HEALTH CARE VISITS. THE COVERAGE 4638  
SHALL APPLY TO A HOME HEALTH CARE VISIT ONLY IF THE PROVIDER WHO 4639  
CONDUCTS THE VISIT IS KNOWLEDGEABLE AND EXPERIENCED IN MATERNITY 4640  
AND NEWBORN CARE. 4641

WHEN A DECISION IS MADE IN ACCORDANCE WITH DIVISION (B) OF 4642  
THIS SECTION TO DISCHARGE A MOTHER OR NEWBORN PRIOR TO THE 4643  
EXPIRATION OF THE APPLICABLE NUMBER OF HOURS OF INPATIENT CARE 4644  
REQUIRED TO BE COVERED, THE COVERAGE OF FOLLOW-UP CARE SHALL APPLY 4645  
TO ALL FOLLOW-UP CARE THAT IS PROVIDED WITHIN FORTY-EIGHT HOURS 4646  
AFTER DISCHARGE. WHEN A MOTHER OR NEWBORN RECEIVES AT LEAST THE 4647  
NUMBER OF HOURS OF INPATIENT CARE REQUIRED TO BE COVERED, THE 4648

COVERAGE OF FOLLOW-UP CARE SHALL APPLY TO FOLLOW-UP CARE THAT IS 4649  
DETERMINED TO BE MEDICALLY NECESSARY BY THE PROVIDER RESPONSIBLE 4650  
FOR DISCHARGING THE MOTHER OR NEWBORN. 4651

(B) ANY DECISION TO SHORTEN THE LENGTH OF INPATIENT STAY TO 4652  
LESS THAN THAT SPECIFIED UNDER DIVISION (A)(1) OF THIS SECTION 4653  
SHALL BE MADE BY THE PHYSICIAN ATTENDING THE MOTHER OR NEWBORN, 4654  
EXCEPT THAT IF A NURSE-MIDWIFE IS ATTENDING THE MOTHER IN 4655  
COLLABORATION WITH A PHYSICIAN, THE DECISION MAY BE MADE BY THE 4656  
NURSE-MIDWIFE. DECISIONS REGARDING EARLY DISCHARGE SHALL BE MADE 4657  
ONLY AFTER CONFERRING WITH THE MOTHER OR A PERSON RESPONSIBLE FOR 4658  
THE MOTHER OR NEWBORN. FOR PURPOSES OF THIS DIVISION, A PERSON 4659  
RESPONSIBLE FOR THE MOTHER OR NEWBORN MAY INCLUDE A PARENT, 4660  
GUARDIAN, OR ANY OTHER PERSON WITH AUTHORITY TO MAKE MEDICAL 4661  
DECISIONS FOR THE MOTHER OR NEWBORN. 4662

(C)(1) NO HEALTH INSURING CORPORATION MAY DO EITHER OF THE 4663  
FOLLOWING: 4664

(a) TERMINATE THE PARTICIPATION OF A PROVIDER OR HEALTH CARE 4665  
FACILITY IN AN INDIVIDUAL OR GROUP HEALTH CARE PLAN SOLELY FOR 4666  
MAKING RECOMMENDATIONS FOR INPATIENT OR FOLLOW-UP CARE FOR A 4667  
PARTICULAR MOTHER OR NEWBORN THAT ARE CONSISTENT WITH THE CARE 4668  
REQUIRED TO BE COVERED BY THIS SECTION; 4669

(b) ESTABLISH OR OFFER MONETARY OR OTHER FINANCIAL INCENTIVES 4670  
FOR THE PURPOSE OF ENCOURAGING A PERSON TO DECLINE THE INPATIENT 4671  
OR FOLLOW-UP CARE REQUIRED TO BE COVERED BY THIS SECTION. 4672  
4673

(2) WHOEVER VIOLATES DIVISION (C)(1)(a) OR (b) OF THIS 4674  
SECTION HAS ENGAGED IN AN UNFAIR AND DECEPTIVE ACT OR PRACTICE IN 4675  
THE BUSINESS OF INSURANCE UNDER SECTIONS 3901.19 TO 3901.26 OF THE 4676  
REVISED CODE. 4677

(D) THIS SECTION DOES NOT DO ANY OF THE FOLLOWING: 4678

(1) REQUIRE A POLICY, CONTRACT, OR AGREEMENT TO COVER 4679

INPATIENT OR FOLLOW-UP CARE THAT IS NOT RECEIVED IN ACCORDANCE 4680  
WITH THE POLICY'S, CONTRACT'S, OR AGREEMENT'S TERMS PERTAINING TO 4681  
THE PROVIDERS AND FACILITIES FROM WHICH AN INDIVIDUAL IS 4682  
AUTHORIZED TO RECEIVE HEALTH CARE SERVICES; 4683

(2) REQUIRE A MOTHER OR NEWBORN TO STAY IN A HOSPITAL OR 4684  
OTHER INPATIENT SETTING FOR A FIXED PERIOD OF TIME FOLLOWING 4685  
DELIVERY; 4686

(3) REQUIRE A CHILD TO BE DELIVERED IN A HOSPITAL OR OTHER 4687  
INPATIENT SETTING; 4688

(4) AUTHORIZE A NURSE-MIDWIFE TO PRACTICE BEYOND THE 4689  
AUTHORITY TO PRACTICE NURSE-MIDWIFERY IN ACCORDANCE WITH CHAPTER 4690  
4723. OF THE REVISED CODE; 4691

(5) ESTABLISH MINIMUM STANDARDS OF MEDICAL DIAGNOSIS, CARE, 4692  
OR TREATMENT FOR INPATIENT OR FOLLOW-UP CARE FOR A MOTHER OR 4693  
NEWBORN. A DEVIATION FROM THE CARE REQUIRED TO BE COVERED UNDER 4694  
THIS SECTION SHALL NOT, SOLELY ON THE BASIS OF THIS SECTION, GIVE 4695  
RISE TO A MEDICAL CLAIM OR TO DERIVATIVE CLAIMS FOR RELIEF, AS 4696  
THOSE TERMS ARE DEFINED IN SECTION 2305.11 OF THE REVISED CODE. 4697

Sec. 1751.70. (A) An employee of the state, of any political 4698  
subdivision of the state, or of any institution supported in whole 4699  
or in part by the state, may authorize the deduction from the 4700  
employee's salary or wages of the amount of the employee's premium 4701  
rate to any health insuring corporation holding a certificate of 4702  
authority pursuant to this chapter. The employee's authorization 4703  
shall be evidenced by approval of the head of the department, 4704  
division, office, or institution in which the employee is 4705  
employed. 4706

(B) In the case of employees of the state, the employee's 4707  
authorization shall be directed to and filed with the director of 4708  
administrative services. In the case of employees of a political 4709  
subdivision, the employee's authorization shall be directed to and 4710

filed with the fiscal officer of such political subdivision. In 4711  
the case of employees of any institution supported in whole or in 4712  
part by the state, the employee's authorization shall be directed 4713  
to and filed with the fiscal officer of such institution. 4714

(C) Upon the filing of the employee's authorization in 4715  
accordance with division (B) of this section, the director or 4716  
fiscal officer shall provide for payment to the health insuring 4717  
corporation referred to in the employee's authorization, for the 4718  
amount covering the sum of the deductions thereby authorized. 4719

Sec. 1751.71. Each health insuring corporation subject to 4720  
this chapter may accept from governmental agencies, or from 4721  
private persons, payments covering all or part of the cost of 4722  
policies, contracts, and agreements entered into between the 4723  
health insuring corporation and its subscribers or groups of 4724  
subscribers. 4725

**Sec. 1901.111.** (A) As used in this section, "health care 4726  
coverage" means sickness and accident insurance or other coverage 4727  
of hospitalization, surgical care, major medical care, disability, 4728  
dental care, eye care, medical care, hearing aids, and 4729  
prescription drugs, or any combination of those benefits or 4730  
services. 4731

(B) The legislative authority, after consultation with the 4732  
judges of the municipal court, shall negotiate and contract for, 4733  
purchase, or otherwise procure group health care coverage for the 4734  
judges and their spouses and dependents from insurance companies 4735  
authorized to engage in the business of insurance in this state 4736  
under Title XXXIX of the Revised Code, ~~medical care corporations~~ 4737  
~~organized under Chapter 1737. of the Revised Code,~~ or health care 4738  
insuring corporations organized holding certificates of authority 4739  
under Chapter ~~1738.~~ 1751. of the Revised Code, ~~or health~~ 4740  
~~maintenance organizations organized under Chapter 1742. of the~~ 4741

~~Revised Code~~, except that if the county or municipal corporation 4742  
served by the legislative authority provides group health care 4743  
coverage for its employees, the group health care coverage 4744  
required by this section shall be provided, if possible, through 4745  
the policy or plan under which the group health care coverage is 4746  
provided for the county or municipal corporation employees. 4747

(C) The portion of the costs, premiums, or charges for the 4748  
group health care coverage procured pursuant to division (B) of 4749  
this section that is not paid by the judges of the municipal 4750  
court, or all of the costs, premiums, or charges for the group 4751  
health care coverage if the judges will not be paying any such 4752  
portion, shall be paid as follows: 4753

(1) If the municipal court is a county-operated municipal 4754  
court, the portion of the costs, premiums, or charges or all of 4755  
the costs, premiums, or charges shall be paid out of the treasury 4756  
of the county. 4757

(2) If the municipal court is not a county-operated municipal 4758  
court, the portion of the costs, premiums, or charges or all of 4759  
the costs, premiums, or charges shall be paid in three-fifths and 4760  
two-fifths shares from the city treasury and appropriate county 4761  
treasuries as described in division (C) of section 1901.11 of the 4762  
Revised Code. The three-fifths share of a city treasury is subject 4763  
to apportionment under section 1901.026 of the Revised Code. 4764  
4765

**Sec. 1901.312.** (A) As used in this section, "health care 4766  
coverage" has the same meaning as in section 1901.111 of the 4767  
Revised Code. 4768

(B) The legislative authority, after consultation with the 4769  
clerk and deputy clerks of the municipal court, shall negotiate 4770  
and contract for, purchase, or otherwise procure group health care 4771  
coverage for the clerk and deputy clerks and their spouses and 4772

dependents from insurance companies authorized to engage in the 4773  
business of insurance in this state under Title XXXIX of the 4774  
Revised Code, ~~medical care corporations organized under Chapter~~ 4775  
~~1737. of the Revised Code, or health care insuring corporations~~ 4776  
~~organized holding certificates of authority under Chapter 1738.~~ 4777  
~~1751. of the Revised Code, or health maintenance organizations~~ 4778  
~~organized under Chapter 1742. of the Revised Code,~~ except that if 4779  
the county or municipal corporation served by the legislative 4780  
authority provides group health care coverage for its employees, 4781  
the group health care coverage required by this section shall be 4782  
provided, if possible, through the policy or plan under which the 4783  
group health care coverage is provided for the county or municipal 4784  
corporation employees. 4785

(C) The portion of the costs, premiums, or charges for the 4786  
group health care coverage procured pursuant to division (B) of 4787  
this section that is not paid by the clerk and deputy clerks of 4788  
the municipal court, or all of the costs, premiums, or charges for 4789  
the group health care coverage if the clerk and deputy clerks will 4790  
not be paying any such portion, shall be paid as follows: 4791

(1) If the municipal court is a county-operated municipal 4792  
court, the portion of the costs, premiums, or charges or all of 4793  
the costs, premiums, or charges shall be paid out of the treasury 4794  
of the county. 4795

(2)(a) If the municipal court is not a county-operated 4796  
municipal court, the portion of the costs, premiums, or charges in 4797  
connection with the clerk or all of the costs, premiums, or 4798  
charges in connection with the clerk shall be paid in three-fifths 4799  
and two-fifths shares from the city treasury and appropriate 4800  
county treasuries as described in division (C) of section 1901.31 4801  
of the Revised Code. The three-fifths share of a city treasury is 4802  
subject to apportionment under section 1901.026 of the Revised 4803  
Code. 4804

(b) If the municipal court is not a county-operated municipal court, the portion of the costs, premiums, or charges in connection with the deputy clerks or all of the costs, premiums, or charges in connection with the deputy clerks shall be paid from the city treasury and shall be subject to apportionment under section 1901.026 of the Revised Code.

(D) This section does not apply to the clerk of the Auglaize county, Hamilton county, Portage county, or Wayne county municipal court, if health care coverage is provided to the clerk by virtue of ~~his~~ the clerk's employment as the clerk of the court of common pleas of Auglaize county, Hamilton county, Portage county, or Wayne county.

**Sec. 2133.12.** (A) The death of a qualified patient or other patient resulting from the withholding or withdrawal of life-sustaining treatment in accordance with this chapter does not constitute a suicide, aggravated murder, murder, or any other homicide offense for any purpose.

(B)(1) The execution of a declaration shall not do either of the following:

(a) Affect the sale, procurement, issuance, or renewal of any policy of life insurance or annuity, notwithstanding any term of a policy or annuity to the contrary;

(b) Be deemed to modify or invalidate the terms of any policy of life insurance or annuity that is in effect on October 10, 1991.

(2) Notwithstanding any term of a policy of life insurance or annuity to the contrary, the withholding or withdrawal of life-sustaining treatment from an insured, qualified patient or other patient in accordance with this chapter shall not impair or invalidate any policy of life insurance or annuity.

(3) Notwithstanding any term of a policy or plan to the contrary, the use or continuation, or the withholding or withdrawal, of life-sustaining treatment from an insured, qualified patient or other patient in accordance with this chapter shall not impair or invalidate any policy of health insurance or any health care benefit plan.

(4) No physician, health care facility, other health care provider, person authorized to engage in the business of insurance in this state under Title XXXIX of the Revised Code, ~~medical care corporation~~, health ~~care~~ insuring corporation, ~~health maintenance organization~~, other health care plan, legal entity that is self-insured and provides benefits to its employees or members, or other person shall require any individual to execute or refrain from executing a declaration, or shall require an individual to revoke or refrain from revoking a declaration, as a condition of being insured or of receiving health care benefits or services.

(C)(1) This chapter does not create any presumption concerning the intention of an individual who has revoked or has not executed a declaration with respect to the use or continuation, or the withholding or withdrawal, of life-sustaining treatment if ~~he~~ the individual should be in a terminal condition or in a permanently unconscious state at any time.

(2) This chapter does not affect the right of a qualified patient or other patient to make informed decisions regarding the use or continuation, or the withholding or withdrawal, of life-sustaining treatment as long as ~~he~~ the qualified patient or other patient is able to make those decisions.

(3) This chapter does not require a physician, other health care personnel, or a health care facility to take action that is contrary to reasonable medical standards.

(4) This chapter and, if applicable, a declaration do not

affect or limit the authority of a physician or a health care  
facility to provide or not to provide life-sustaining treatment to  
a person in accordance with reasonable medical standards  
applicable in an emergency situation.

(D) Nothing in this chapter condones, authorizes, or approves  
of mercy killing, assisted suicide, or euthanasia.

(E)(1) This chapter does not affect the responsibility of the  
attending physician of a qualified patient or other patient, or  
other health care personnel acting under the direction of the  
patient's attending physician, to provide comfort care to the  
patient. Nothing in this chapter precludes the attending physician  
of a qualified patient or other patient who carries out the  
responsibility to provide comfort care to the patient in good  
faith and while acting within the scope of ~~his~~ the attending  
physician's authority from prescribing, dispensing, administering,  
or causing to be administered any particular medical procedure,  
treatment, intervention, or other measure to the patient,  
including, but not limited to, prescribing, dispensing,  
administering, or causing to be administered by judicious  
titration or in another manner any form of medication, for the  
purpose of diminishing ~~his~~ the qualified patient's or other  
patient's pain or discomfort and not for the purpose of postponing  
or causing ~~his~~ the qualified patient's or other patient's death,  
even though the medical procedure, treatment, intervention, or  
other measure may appear to hasten or increase the risk of the  
patient's death. Nothing in this chapter precludes health care  
personnel acting under the direction of the patient's attending  
physician who carry out the responsibility to provide comfort care  
to the patient in good faith and while acting within the scope of  
their authority from dispensing, administering, or causing to be  
administered any particular medical procedure, treatment,  
intervention, or other measure to the patient, including, but not

limited to, dispensing, administering, or causing to be 4898  
administered by judicious titration or in another manner any form 4899  
of medication, for the purpose of diminishing ~~his~~ the qualified 4900  
patient's or other patient's pain or discomfort and not for the 4901  
purpose of postponing or causing ~~his~~ the qualified patient's or 4902  
other patient's death, even though the medical procedure, 4903  
treatment, intervention, or other measure may appear to hasten or 4904  
increase the risk of the patient's death. 4905

(2)(a) If, at any time, a person described in division 4906  
(A)(2)(a)(i) of section 2133.05 of the Revised Code or the 4907  
individual or a majority of the individuals in either of the first 4908  
two classes of individuals that pertain to a declarant in the 4909  
descending order of priority set forth in division (A)(2)(a)(ii) 4910  
of section 2133.05 of the Revised Code believes in good faith that 4911  
both of the following circumstances apply, the person or the 4912  
individual or majority of individuals in either of the first two 4913  
classes of individuals may commence an action in the probate court 4914  
of the county in which a declarant who is in a terminal condition 4915  
or permanently unconscious state is located for the issuance of an 4916  
order mandating the use or continuation of comfort care in 4917  
connection with the declarant in a manner that is consistent with 4918  
division (E)(1) of this section: 4919

(i) Comfort care is not being used or continued in connection 4920  
with the declarant. 4921

(ii) The withholding or withdrawal of the comfort care is 4922  
contrary to division (E)(1) of this section. 4923

(b) If a declarant did not designate in ~~his~~ the declarant's 4924  
declaration a person as described in division (A)(2)(a)(i) of 4925  
section 2133.05 of the Revised Code and if, at any time, a 4926  
priority individual or any member of a priority class of 4927  
individuals under division (A)(2)(a)(ii) of section 2133.05 of the 4928  
Revised Code or, at any time, the individual or a majority of the 4929

individuals in the next class of individuals that pertains to the 4930  
declarant in the descending order of priority set forth in that 4931  
division believes in good faith that both of the following 4932  
circumstances apply, the priority individual, the member of the 4933  
priority class of individuals, or the individual or majority of 4934  
individuals in the next class of individuals that pertains to the 4935  
declarant may commence an action in the probate court of the 4936  
county in which a declarant who is in a terminal condition or 4937  
permanently unconscious state is located for the issuance of an 4938  
order mandating the use or continuation of comfort care in 4939  
connection with the declarant in a manner that is consistent with 4940  
division (E)(1) of this section: 4941

(i) Comfort care is not being used or continued in connection 4942  
with the declarant. 4943

(ii) The withholding or withdrawal of the comfort care is 4944  
contrary to division (E)(1) of this section. 4945

(c) If, at any time, a priority individual or any member of a 4946  
priority class of individuals under division (B) of section 4947  
2133.08 of the Revised Code or, at any time, the individual or a 4948  
majority of the individuals in the next class of individuals that 4949  
pertains to the patient in the descending order of priority set 4950  
forth in that division believes in good faith that both of the 4951  
following circumstances apply, the priority individual, the member 4952  
of the priority class of individuals, or the individual or 4953  
majority of individuals in the next class of individuals that 4954  
pertains to the patient may commence an action in the probate 4955  
court of the county in which a patient as described in division 4956  
(A) of section 2133.08 of the Revised Code is located for the 4957  
issuance of an order mandating the use or continuation of comfort 4958  
care in connection with the patient in a manner that is consistent 4959  
with division (E)(1) of this section: 4960

(i) Comfort care is not being used or continued in connection 4961

with the patient.	4962
(ii) The withholding or withdrawal of the comfort care is	4963
contrary to division (E)(1) of this section.	4964
<b>Sec. 2305.25.</b> (A) No health care entity and no individual who	4965
is a member of or works on behalf of any of the following boards	4966
or committees of a health care entity or of any of the following	4967
corporations shall be liable in damages to any person for any	4968
acts, omissions, decisions, or other conduct within the scope of	4969
the functions of the board, committee, or corporation:	4970
(1) A peer review committee of a hospital, a nonprofit health	4971
care corporation which is a member of the hospital or of which the	4972
hospital is a member, or a community mental health center;	4973
	4974
(2) A board or committee of a hospital or of a nonprofit	4975
health care corporation which is a member of the hospital or of	4976
which the hospital is a member reviewing professional	4977
qualifications or activities of the hospital medical staff or	4978
applicants for admission to the medical staff;	4979
(3) A utilization committee of a state or local society	4980
composed of doctors of medicine or doctors of osteopathic medicine	4981
and surgery or doctors of podiatric medicine;	4982
(4) A peer review committee of nursing home providers or	4983
administrators, including a corporation engaged in performing the	4984
functions of a peer review committee of nursing home providers or	4985
administrators, or a corporation engaged in the functions of	4986
another type of peer review or professional standards review	4987
committee;	4988
(5) A peer review committee, professional standards review	4989
committee, or arbitration committee of a state or local society	4990
composed of doctors of medicine, doctors of osteopathic medicine	4991

and surgery, doctors of dentistry, doctors of optometry, doctors  
of podiatric medicine, psychologists, or registered pharmacists;

(6) A peer review committee of a health ~~maintenance~~  
~~organization~~ insuring corporation that has at least a two-thirds  
majority of member physicians in active practice and that conducts  
professional credentialing and quality review activities involving  
the competence or professional conduct of health care providers,  
which conduct adversely affects, or could adversely affect, the  
health or welfare of any patient. For purposes of this division,  
"health ~~maintenance organization~~ insuring corporation" includes  
wholly owned subsidiaries of a health ~~maintenance organization~~  
insuring corporation.

(7) A peer review committee of any insurer authorized under  
Title XXXIX of the Revised Code to do the business of sickness and  
accident insurance in this state that has at least a two-thirds  
majority of physicians in active practice and that conducts  
professional credentialing and quality review activities involving  
the competence or professional conduct of health care providers,  
which conduct adversely affects, or could adversely affect, the  
health or welfare of any patient;

(8) A peer review committee of any insurer authorized under  
Title XXXIX of the Revised Code to do the business of sickness and  
accident insurance in this state that has at least a two-thirds  
majority of physicians in active practice and that conducts  
professional credentialing and quality review activities involving  
the competence or professional conduct of a health care facility  
that has contracted with the insurer to provide health care  
services to insureds, which conduct adversely affects, or could  
adversely affect, the health or welfare of any patient;

(9) A quality assurance committee of a state correctional  
institution operated by the department of rehabilitation and

correction; 5023

(10) A quality assurance committee of the central office of 5024  
the department of rehabilitation and correction or department of 5025  
mental health. 5026

(11) A peer review committee of an insurer authorized under 5027  
Title XXXIX of the Revised Code to do the business of medical 5028  
professional liability insurance in this state and that conducts 5029  
professional quality review activities involving the competence or 5030  
professional conduct of health care providers, which conduct 5031  
adversely affects, or could affect, the health or welfare of any 5032  
patient; 5033

(12) A peer review committee of a health care entity. 5034

(B)(1) A hospital shall be presumed to not be negligent in 5035  
the credentialing of a qualified person if the hospital proves by 5036  
a preponderance of the evidence that at the time of the alleged 5037  
negligent credentialing of the qualified person it was accredited 5038  
by the joint commission on accreditation of health care 5039  
organizations, the American osteopathic association, or the 5040  
national committee for quality assurance. 5041

(2) The presumption that a hospital is not negligent as 5042  
provided in division (B)(1) of this section may be rebutted only 5043  
by proof, by a preponderance of the evidence, of any of the 5044  
following: 5045

(a) The credentialing and review requirements of the 5046  
accrediting organization did not apply to the hospital, the 5047  
qualified person, or the type of professional care that is the 5048  
basis of the claim against the hospital. 5049

(b) The hospital failed to comply with all material 5050  
credentialing and review requirements of the accrediting 5051  
organization that applied to the qualified person. 5052

(c) The hospital, through its medical staff executive committee or its governing body and sufficiently in advance to take appropriate action, knew that a previously competent qualified person with staff privileges at the hospital had developed a pattern of incompetence that indicated that the qualified person's privileges should have been limited prior to treating the plaintiff at the hospital.

(d) The hospital, through its medical staff executive committee or its governing body and sufficiently in advance to take appropriate action, knew that a previously competent qualified person with staff privileges at the hospital would provide fraudulent medical treatment but failed to limit the qualified person's privileges prior to treating the plaintiff at the hospital.

(3) If the plaintiff fails to rebut the presumption provided in division (B)(1) of this section, upon the motion of the hospital, the court shall enter judgment in favor of the hospital on the claim of negligent credentialing.

(C) Nothing in this section otherwise shall relieve any individual or health care entity from liability arising from treatment of a patient. Nothing in this section shall be construed as creating an exception to section 2305.251 of the Revised Code.

(D) No person who provides information under this section without malice and in the reasonable belief that the information is warranted by the facts known to the person shall be subject to suit for civil damages as a result of providing the information.

(E) For purposes of this section:

(1) "Peer review committee" means a utilization review committee, quality assurance committee, quality improvement committee, tissue committee, credentialing committee, or other

committee that conducts professional credentialing and quality review activities involving the competence or professional conduct of health care practitioners.

(2) "Health care entity" means a government entity, a for-profit or nonprofit corporation, a limited liability company, a partnership, a professional corporation, a state or local society as described in division (A)(3) of this section, or other health care organization, including, but not limited to, health care entities described in division (A) of this section, whether acting on its own behalf or on behalf of or in affiliation with other health care entities, that conducts, as part of its purpose, professional credentialing or quality review activities involving the competence or professional conduct of health care practitioners or providers.

(3) "Hospital" means either of the following:

(a) An institution that has been registered or licensed by the Ohio department of health as a hospital;

(b) An entity, other than an insurance company authorized to do business in this state, that owns, controls, or is affiliated with an institution that has been registered or licensed by the Ohio department of health as a hospital.

(4) "Qualified person" means a member of the medical staff of a hospital or a person who has professional privileges at a hospital pursuant to section 3701.351 of the Revised Code.

(F) This section shall be considered to be purely remedial in its operation and shall be applied in a remedial manner in any civil action in which this section is relevant, whether the civil action is pending in court or commenced on or after the effective date of this section, regardless of when the cause of action accrued and notwithstanding any other section of the Revised Code or prior rule of law of this state.

Sec. 2913.47. (A) As used in this section: 5115

(1) "Data" has the same meaning as in section 2913.01 of the 5116  
Revised Code and additionally includes any other representation of 5117  
information, knowledge, facts, concepts, or instructions that are 5118  
being or have been prepared in a formalized manner. 5119

(2) "Deceptive" means that a statement, in whole or in part, 5120  
would cause another to be deceived because it contains a 5121  
misleading representation, withholds information, prevents the 5122  
acquisition of information, or by any other conduct, act, or 5123  
omission creates, confirms, or perpetuates a false impression, 5124  
including, but not limited to, a false impression as to law, 5125  
value, state of mind, or other objective or subjective fact. 5126

(3) "Insurer" means any person that is authorized to engage 5127  
in the business of insurance in this state under Title XXXIX of 5128  
the Revised Code~~+,~~ the Ohio fair plan underwriting association 5129  
created under section 3929.43 of the Revised Code~~+,~~ any ~~prepaid~~ 5130  
~~dental plan, medical care corporation,~~ health care insuring 5131  
~~corporation, dental care corporation, or health maintenance~~ 5132  
~~organization;~~ and any legal entity that is self-insured and 5133  
provides benefits to its employees or members. 5134

(4) "Policy" means a policy, certificate, contract, or plan 5135  
that is issued by an insurer. 5136

(5) "Statement" includes, but is not limited to, any notice, 5137  
letter, or memorandum; proof of loss; bill of lading; receipt for 5138  
payment; invoice, account, or other financial statement; estimate 5139  
of property damage; bill for services; diagnosis or prognosis; 5140  
prescription; hospital, medical, or dental chart or other record; 5141  
x-ray, photograph, videotape, or movie film; test result; other 5142  
evidence of loss, injury, or expense; computer-generated document; 5143  
and data in any form. 5144

(B) No person, with purpose to defraud or knowing that the person is facilitating a fraud, shall do either of the following:

(1) Present to, or cause to be presented to, an insurer any written or oral statement that is part of, or in support of, an application for insurance, a claim for payment pursuant to a policy, or a claim for any other benefit pursuant to a policy, knowing that the statement, or any part of the statement, is false or deceptive;

(2) Assist, aid, abet, solicit, procure, or conspire with another to prepare or make any written or oral statement that is intended to be presented to an insurer as part of, or in support of, an application for insurance, a claim for payment pursuant to a policy, or a claim for any other benefit pursuant to a policy, knowing that the statement, or any part of the statement, is false or deceptive.

(C) Whoever violates this section is guilty of insurance fraud. Except as otherwise provided in this division, insurance fraud is a misdemeanor of the first degree. If the amount of the claim that is false or deceptive is five hundred dollars or more and is less than five thousand dollars, insurance fraud is a felony of the fifth degree. If the amount of the claim that is false or deceptive is five thousand dollars or more and is less than one hundred thousand dollars, insurance fraud is a felony of the fourth degree. If the amount of the claim that is false or deceptive is one hundred thousand dollars or more, insurance fraud is a felony of the third degree.

(D) This section shall not be construed to abrogate, waive, or modify division (A) of section 2317.02 of the Revised Code.

**Sec. 3105.71.** (A) If a party to an action for divorce, annulment, dissolution of marriage, or legal separation was the

named insured or subscriber under, or the policyholder, 5175  
certificate holder, or contract holder of, a policy, contract, or 5176  
plan of health insurance that provided health insurance coverage 5177  
for ~~his~~ that party's spouse and dependents immediately prior to 5178  
the filing of the action, that party shall not cancel or otherwise 5179  
terminate or cause the termination of such coverage for which the 5180  
spouse and dependents would otherwise be eligible until the court 5181  
determines that the party is no longer responsible for providing 5182  
such health insurance coverage for ~~his~~ that party's spouse and 5183  
dependents. 5184

(B) If the party responsible for providing health insurance 5185  
coverage for ~~his~~ that party's spouse and dependents under division 5186  
(A) of this section fails to provide that coverage in accordance 5187  
with that division, the court shall issue an order that includes 5188  
all of the following: 5189

(1) A requirement that the party make payment to ~~his~~ that 5190  
party's spouse in the amount of any premium ~~he~~ that party failed 5191  
to pay or contribution ~~he~~ that party failed to make that resulted 5192  
in ~~his~~ that party's failure to provide health insurance coverage 5193  
in compliance with division (A) of this section; 5194

(2) A requirement that the party make payment to ~~his~~ that 5195  
party's spouse for reimbursement of any hospital, surgical, and 5196  
medical expenses incurred as a result of ~~his~~ that party's failure 5197  
to comply with division (A) of this section; 5198

(3) A requirement that, if the party fails to comply with 5199  
divisions (B)(1) and (2) of this section, the employer of the 5200  
party deduct from the party's earnings an amount necessary to make 5201  
any payments required under divisions (B)(1) and (2) of this 5202  
section. 5203

(C) If the party responsible for providing health insurance 5204  
coverage for ~~his~~ that party's spouse and dependents under division 5205

(A) of this section cancels or otherwise terminates or causes the 5206  
termination of such coverage for which the spouse and dependents 5207  
would otherwise be eligible, the spouse may apply to the insurer, 5208  
health ~~maintenance organization~~ insuring corporation, or other 5209  
third-party payer that provided the coverage for a policy or 5210  
contract of health insurance. The spouse and dependents shall have 5211  
the same rights and be subject to the same limitations as a person 5212  
applying for or covered under a converted or separate policy under 5213  
section 3923.32 of the Revised Code upon the divorce, annulment, 5214  
dissolution of marriage, or the legal separation of the spouse 5215  
from the named insured. 5216

**Sec. 3111.241.** (A) As used in this section, "insurer" means 5217  
any person that is authorized to engage in the business of 5218  
insurance in this state under Title XXXIX of the Revised Code; ~~and~~ 5219  
any ~~prepaid dental plan, medical care corporation,~~ health care 5220  
insuring corporation, ~~dental care corporation, or health~~ 5221  
~~maintenance organization;~~ and any legal entity that is 5222  
self-insured and provides benefits to its employees or members. 5223

(B) If an administrative officer of a child support 5224  
enforcement agency issues an administrative support order under 5225  
section 3111.20, 3111.21, or 3111.22 of the Revised Code, in 5226  
addition to any requirements in those sections, the agency also 5227  
shall issue a separate order that includes all of the following: 5228

(1) A requirement that the obligor under the child support 5229  
order obtain health insurance coverage for the children who are 5230  
the subject of the administrative child support order from an 5231  
insurer that provides a group health insurance or health care 5232  
policy, contract, or plan that is specified in the order and a 5233  
requirement that the obligor, no later than thirty days after the 5234  
issuance of the order under division (B)(1) of this section, 5235  
furnish written proof to the child support enforcement agency that 5236

the required health insurance coverage has been obtained, if that  
coverage is available at a reasonable cost through a group health  
insurance or health care policy, contract, or plan offered by the  
obligor's employer or through any other group health insurance or  
health care policy, contract, or plan available to the obligor and  
if health insurance coverage for the children is not available for  
a more reasonable cost through a group health insurance or health  
care policy, contract, or plan available to the obligee under the  
administrative child support order;

(2) If the obligor is required under division (B)(1) of this  
section to obtain health insurance coverage for the children who  
are the subject of the administrative child support order, a  
requirement that the obligor supply the obligee with information  
regarding the benefits, limitations, and exclusions of the health  
insurance coverage, copies of any insurance forms necessary to  
receive reimbursement, payment, or other benefits under the health  
insurance coverage, and a copy of any necessary insurance cards, a  
requirement that the obligor submit a copy of the administrative  
order issued pursuant to division (B) of this section to the  
insurer at the time that the obligor makes application to enroll  
the children in the health insurance or health care policy,  
contract, or plan, and a requirement that the obligor, no later  
than thirty days after the issuance of the administrative order  
under division (B)(2) of this section, furnish written proof to  
the child support enforcement agency that division (B)(2) of this  
section has been complied with;

(3) A requirement that the obligee under the administrative  
child support order obtain health insurance coverage for the  
children who are the subject of the administrative child support  
order from an insurer that provides a group health insurance or  
health care policy, contract, or plan that is specified in the  
administrative order and a requirement that the obligee, no later

than thirty days after the issuance of the administrative order 5269  
under division (B)(1) of this section, furnish written proof to 5270  
the child support enforcement agency that the required health 5271  
insurance coverage has been obtained, if that coverage is 5272  
available through a group health insurance or health care policy, 5273  
contract, or plan offered by the obligee's employer or through any 5274  
other group health insurance or health care policy, contract, or 5275  
plan available to the obligee and if that coverage is available at 5276  
a more reasonable cost than health insurance coverage for the 5277  
children through a group health insurance or health care policy, 5278  
contract, or plan available to the obligor; 5279

(4) If the obligee is required under division (B)(3) of this 5280  
section to obtain health insurance coverage for the children who 5281  
are the subject of the administrative child support order, a 5282  
requirement that the obligee submit a copy of the administrative 5283  
order issued pursuant to division (B) of this section to the 5284  
insurer at the time that the obligee makes application to enroll 5285  
the children in the health insurance or health care policy, 5286  
contract, or plan; 5287

(5) A list of the group health insurance and health care 5288  
policies, contracts, and plans that the child support enforcement 5289  
agency determines are available at a reasonable cost to the 5290  
obligor or to the obligee and the name of the insurer that issues 5291  
each policy, contract, or plan; 5292

(6) A statement setting forth the name, address, and 5293  
telephone number of the individual who is to be reimbursed for 5294  
out-of-pocket medical, optical, hospital, dental, or prescription 5295  
expenses paid for each child who is the subject of the 5296  
administrative child support order and a statement that the 5297  
insurer that provides the health insurance coverage for the 5298  
children may continue making payment for medical, optical, 5299  
hospital, dental, or prescription services directly to any health 5300

care provider in accordance with the applicable health insurance 5301  
or health care policy, contract, or plan; 5302

(7) A requirement that the obligor and the obligee designate 5303  
the children who are the subject of the administrative child 5304  
support order as covered dependents under any health insurance or 5305  
health care policy, contract, or plan for which they contract; 5306

(8) A requirement that the obligor, the obligee, or both of 5307  
them under a formula established by the child support enforcement 5308  
agency pay copayment or deductible costs required under the health 5309  
insurance or health care policy, contract, or plan that covers the 5310  
children; 5311

(9) If health insurance coverage for the children who are the 5312  
subject of the administrative order is not available at a 5313  
reasonable cost through a group health insurance or health care 5314  
policy, contract, or plan offered by the obligor's employer or 5315  
through any other group health insurance or health care policy, 5316  
contract, or plan available to the obligor and is not available at 5317  
a reasonable cost through a group health insurance or health care 5318  
policy, contract, or plan offered by the obligee's employer or 5319  
through any other group health insurance or health care policy, 5320  
contract, or plan available to the obligee, a requirement that the 5321  
obligor and the obligee share liability for the cost of the 5322  
medical and health care needs of the children who are the subject 5323  
of the administrative order, under an equitable formula 5324  
established by the agency, and a requirement that if, after the 5325  
issuance of the order, health insurance coverage for the children 5326  
who are the subject of the administrative order becomes available 5327  
at a reasonable cost through a group health insurance or health 5328  
care policy, contract, or plan offered by the obligor's or 5329  
obligee's employer or through any other group health insurance or 5330  
health care policy, contract, or plan available to the obligor or 5331  
obligee, the obligor or obligee to whom the coverage becomes 5332

available immediately inform the agency of that fact. 5333

(10) A notice that, if the obligor is required under 5334  
divisions (B)(1) and (2) of this section to obtain health 5335  
insurance coverage for the children who are the subject of the 5336  
administrative child support order and if the obligor fails to 5337  
comply with the requirements of those divisions, the child support 5338  
enforcement agency immediately shall issue an administrative order 5339  
to the employer of the obligor, upon written notice from the child 5340  
support enforcement agency, requiring the employer to take 5341  
whatever action is necessary to make application to enroll the 5342  
obligor in any available group health insurance or health care 5343  
policy, contract, or plan with coverage for the children who are 5344  
the subject of the administrative child support order, to submit a 5345  
copy of the administrative order issued pursuant to division (B) 5346  
of this section to the insurer at the time that the employer makes 5347  
application to enroll the children in the health insurance or 5348  
health care policy, contract, or plan, and, if the obligor's 5349  
application is accepted, to deduct any additional amount from the 5350  
obligor's earnings necessary to pay any additional cost for that 5351  
health insurance coverage; 5352

(11) A notice that during the time that an order under this 5353  
section is in effect, the employer of the obligor is required to 5354  
release to the obligee or the child support enforcement agency 5355  
upon written request any necessary information on the health 5356  
insurance coverage of the obligor, including, but not limited to, 5357  
the name and address of the insurer and any policy, contract, or 5358  
plan number, and to otherwise comply with this section and any 5359  
court order issued under this section; 5360

(12) A statement setting forth the full name and date of 5361  
birth of each child who is the subject of the administrative child 5362  
support order; 5363

(13) A requirement that the obligor and the obligee comply 5364  
with any requirement described in division (B)(1), (2), (3), (4), 5365  
or (7) of this section that is contained in the order issued under 5366  
this section no later than thirty days after the issuance of the 5367  
order. 5368

(C) If an administrative officer of a child support 5369  
enforcement agency issues an administrative support order under 5370  
section 3111.20, 3111.21, or 3111.22 of the Revised Code, the 5371  
child support enforcement agency, in addition to any requirements 5372  
in those sections and in lieu of an order issued under division 5373  
(B) of this section, may issue a separate order requiring both the 5374  
obligor and the obligee to obtain health insurance coverage for 5375  
the children who are the subject of the administrative child 5376  
support order, if health insurance coverage is available for the 5377  
children and if the agency determines that the coverage is 5378  
available at a reasonable cost to both the obligor and the obligee 5379  
and that the dual coverage by both parents would provide for 5380  
coordination of medical benefits without unnecessary duplication 5381  
of coverage. If the agency issues an order under this division, it 5382  
shall include in the order any of the requirements, notices, and 5383  
information set forth in divisions (B)(1) to (13) of this section 5384  
that are applicable. 5385

(D) Any administrative order issued under this section shall 5386  
be binding upon the obligor and the obligee, their employers, and 5387  
any insurer that provides health insurance coverage for either of 5388  
them or their children. The agency shall send a copy of any 5389  
administrative order issued under this section that contains any 5390  
requirement or notice described in division (B)(1), (2), (3), (4), 5391  
(7), (8), or (10) of this section by ordinary mail to the obligor, 5392  
the obligee, and any employer that is subject to the 5393  
administrative order. The agency shall send a copy of any 5394  
administrative order issued under this section that contains any 5395

requirement contained in division (B)(9) of this section by 5396  
ordinary mail to the obligor and obligee. 5397

(E) If an obligor does not comply with any administrative 5398  
order issued under this section that contains any requirement or 5399  
notice described in division (B)(1), (2), (4), (7), (8), or (10) 5400  
of this section within thirty days after the administrative order 5401  
is issued, the child support enforcement agency shall notify the 5402  
court of common pleas of the county in which the agency is located 5403  
in writing of the failure of the obligor to comply with the 5404  
administrative order. Upon receipt of the notice from the agency, 5405  
the court shall issue an order to the employer of the obligor 5406  
requiring the employer to take whatever action is necessary to 5407  
make application to enroll the obligor in any available group 5408  
health insurance or health care policy, contract, or plan with 5409  
coverage for the children who are the subject of the 5410  
administrative child support order, to submit a copy of the 5411  
administrative order issued pursuant to division (B) of this 5412  
section to the insurer at the time that the employer makes 5413  
application to enroll the children in the health insurance or 5414  
health care policy, contract, or plan, and, if the obligor's 5415  
application is accepted, to deduct from the wages or other income 5416  
of the obligor the cost of the coverage for the children. Upon 5417  
receipt of any court order under this division, the employer shall 5418  
take whatever action is necessary to comply with the court order. 5419

During the time that any administrative or court order issued 5420  
under this section is in effect and after the employer has 5421  
received a copy of the administrative or court order, the employer 5422  
of the obligor who is the subject of the administrative or court 5423  
order shall comply with the administrative or court order and, 5424  
upon request from the obligee or agency, shall release to the 5425  
obligee and the child support enforcement agency all information 5426  
about the obligor's health insurance coverage that is necessary to 5427

ensure compliance with this section or any administrative or court 5428  
order issued under this section, including, but not limited to, 5429  
the name and address of the insurer and any policy, contract, or 5430  
plan number. Any information provided by an employer pursuant to 5431  
this division shall be used only for the purpose of the 5432  
enforcement of an administrative or court order issued under this 5433  
section. 5434

Any employer who receives a copy of an administrative or 5435  
court order issued under this section shall notify the child 5436  
support enforcement agency of any change in or the termination of 5437  
the obligor's health insurance coverage that is maintained 5438  
pursuant to an order issued under this section. 5439

(F) Any insurer that receives a copy of an administrative 5440  
order issued under this section shall comply with this section and 5441  
any administrative order issued under this section, regardless of 5442  
the residence of the children. If an insurer provides health 5443  
insurance coverage for the children who are the subject of an 5444  
administrative child support order in accordance with an order 5445  
issued under this section, the insurer shall reimburse the parent, 5446  
who is designated to receive reimbursement in the administrative 5447  
order issued under this section, for covered out-of-pocket 5448  
medical, optical, hospital, dental, or prescription expenses 5449  
incurred on behalf of the children subject to the administrative 5450  
order. 5451

(G) If an obligee under an administrative child support order 5452  
is eligible for medical assistance under Chapter 5111. or 5115. of 5453  
the Revised Code and the obligor has obtained health insurance 5454  
coverage pursuant to an administrative order issued under division 5455  
(B) of this section, the obligee shall notify any physician, 5456  
hospital, or other provider of medical services for which medical 5457  
assistance is available of the name and address of the obligor's 5458  
insurer and of the number of the obligor's health insurance or 5459

health care policy, contract, or plan. Any physician, hospital, or  
other provider of medical services for which medical assistance is  
available under Chapter 5111. or 5115. of the Revised Code who is  
notified under this division of the existence of a health  
insurance or health care policy, contract, or plan with coverage  
for children who are eligible for medical assistance first shall  
bill the insurer for any services provided for those children. If  
the insurer fails to pay all or any part of a claim filed under  
this division by the physician, hospital, or other medical  
services provider and the services for which the claim is filed  
are covered by Chapter 5111. or 5115. of the Revised Code, the  
physician, hospital, or other medical services provider shall bill  
the remaining unpaid costs of the services in accordance with  
Chapter 5111. or 5115. of the Revised Code.

(H) Any obligor who fails to comply with an administrative  
order issued under this section is liable to the obligee for any  
medical expenses incurred as a result of the failure to comply  
with the administrative order.

(I) Nothing in this section shall be construed to require an  
insurer to accept for enrollment any child who does not meet the  
underwriting standards of the health insurance or health care  
policy, contract, or plan for which application is made.

(J) If any person fails to comply with an administrative  
order issued under this section, the agency may bring an action  
under section 3111.242 of the Revised Code in the juvenile court  
of the county in which the agency is located requesting the court  
to find the obligor or any other person in contempt pursuant to  
section 2705.02 of the Revised Code.

**Sec. 3113.217.** (A) As used in this section:

(1) "Obligor," "obligee," and "child support enforcement

agency" have the same meanings as in section 3113.21 of the Revised Code. 5490  
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(2) "Insurer" means any person that is authorized to engage in the business of insurance in this state under Title XXXIX of the Revised Code; ~~any prepaid dental plan, medical care corporation, health care~~ insuring corporation, ~~dental care corporation, or health maintenance organization;~~ and any legal entity that is self-insured and provides benefits to its employees or members. 5492  
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(B) In any action or proceeding in which a child support order is issued or modified on or after July 1, 1990, under Chapter 3115. or section 2151.23, 2151.231, 2151.33, 2151.36, 2151.49, 3105.18, 3105.21, 3109.05, 3109.19, 3111.13, 3113.04, 3113.07, 3113.216, or 3113.31 of the Revised Code, the child support enforcement agency shall determine whether the obligor or obligee has satisfactory health insurance coverage, other than medical assistance under Title XIX of the "Social Security Act," 49 Stat. 620 (1935), 42 U.S.C. 301, as amended, for the children who are the subject of the child support order. If the agency determines that neither the obligor nor the obligee has satisfactory health insurance coverage for the children, it shall file a motion with the court requesting the court to issue an order in accordance with divisions (C) to (K) of this section. 5499  
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(C) In any action or proceeding in which a child support order is issued or modified on or after July 1, 1990, under Chapter 3115. or section 2151.23, 2151.231, 2151.33, 2151.36, 2151.49, 3105.18, 3105.21, 3109.05, 3109.19, 3111.13, 3113.04, 3113.07, 3113.216, or 3113.31 of the Revised Code, in addition to any requirements in those sections, the court also shall issue a separate order that includes all of the following: 5513  
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(1) A requirement that the obligor under the child support 5520

order obtain health insurance coverage for the children who are 5521  
the subject of the child support order from an insurer that 5522  
provides a group health insurance or health care policy, contract, 5523  
or plan that is specified in the order and a requirement that the 5524  
obligor, no later than thirty days after the issuance of the order 5525  
under division (C)(1) of this section, furnish written proof to 5526  
the child support enforcement agency that the required health 5527  
insurance coverage has been obtained, if that coverage is 5528  
available at a reasonable cost through a group health insurance or 5529  
health care policy, contract, or plan offered by the obligor's 5530  
employer or through any other group health insurance or health 5531  
care policy, contract, or plan available to the obligor and if 5532  
health insurance coverage for the children is not available for a 5533  
more reasonable cost through a group health insurance or health 5534  
care policy, contract, or plan available to the obligee under the 5535  
child support order; 5536

(2) If the obligor is required under division (C)(1) of this 5537  
section to obtain health insurance coverage for the children who 5538  
are the subject of the child support order, a requirement that the 5539  
obligor supply the obligee with information regarding the 5540  
benefits, limitations, and exclusions of the health insurance 5541  
coverage, copies of any insurance forms necessary to receive 5542  
reimbursement, payment, or other benefits under the health 5543  
insurance coverage, and a copy of any necessary insurance cards, a 5544  
requirement that the obligor submit a copy of the court order 5545  
issued pursuant to division (C) of this section to the insurer at 5546  
the time that the obligor makes application to enroll the children 5547  
in the health insurance or health care policy, contract, or plan, 5548  
and a requirement that the obligor, no later than thirty days 5549  
after the issuance of the order under division (C)(2) of this 5550  
section, furnish written proof to the child support enforcement 5551  
agency that division (C)(2) of this section has been complied 5552

with; 5553

(3) A requirement that the obligee under the child support 5554  
order obtain health insurance coverage for the children who are 5555  
the subject of the child support order from an insurer that 5556  
provides a group health insurance or health care policy, contract, 5557  
or plan that is specified in the order and a requirement that the 5558  
obligee, no later than thirty days after the issuance of the order 5559  
under division (C)(1) of this section, furnish written proof to 5560  
the child support enforcement agency that the required health 5561  
insurance coverage has been obtained, if that coverage is 5562  
available through a group health insurance or health care policy, 5563  
contract, or plan offered by the obligee's employer or through any 5564  
other group health insurance or health care policy, contract, or 5565  
plan available to the obligee and if that coverage is available at 5566  
a more reasonable cost than health insurance coverage for the 5567  
children through a group health insurance or health care policy, 5568  
contract, or plan available to the obligor; 5569

(4) If the obligee is required under division (C)(3) of this 5570  
section to obtain health insurance coverage for the children who 5571  
are the subject of the child support order, a requirement that the 5572  
obligee submit a copy of the court order issued pursuant to 5573  
division (C) of this section to the insurer at the time that the 5574  
obligee makes application to enroll the children in the health 5575  
insurance or health care policy, contract, or plan; 5576

(5) A list of the group health insurance and health care 5577  
policies, contracts, and plans that the court determines are 5578  
available at a reasonable cost to the obligor or to the obligee 5579  
and the name of the insurer that issues each policy, contract, or 5580  
plan; 5581

(6) A statement setting forth the name, address, and 5582  
telephone number of the individual who is to be reimbursed for 5583

out-of-pocket medical, optical, hospital, dental, or prescription 5584  
expenses paid for each child who is the subject of the support 5585  
order and a statement that the insurer that provides the health 5586  
insurance coverage for the children may continue making payment 5587  
for medical, optical, hospital, dental, or prescription services 5588  
directly to any health care provider in accordance with the 5589  
applicable health insurance or health care policy, contract, or 5590  
plan; 5591

(7) A requirement that the obligor and the obligee designate 5592  
the children who are the subject of the child support order as 5593  
covered dependents under any health insurance or health care 5594  
policy, contract, or plan for which they contract; 5595

(8) A requirement that the obligor, the obligee, or both of 5596  
them under a formula established by the court pay co-payment or 5597  
deductible costs required under the health insurance or health 5598  
care policy, contract, or plan that covers the children; 5599

(9) If health insurance coverage for the children who are the 5600  
subject of the order is not available at a reasonable cost through 5601  
a group health insurance or health care policy, contract, or plan 5602  
offered by the obligor's employer or through any other group 5603  
health insurance or health care policy, contract, or plan 5604  
available to the obligor and is not available at a reasonable cost 5605  
through a group health insurance or health care policy, contract, 5606  
or plan offered by the obligee's employer or through any other 5607  
group health insurance or health care policy, contract, or plan 5608  
available to the obligee, a requirement that the obligor and the 5609  
obligee share liability for the cost of the medical and health 5610  
care needs of the children who are the subject of the order, under 5611  
an equitable formula established by the court, and a requirement 5612  
that if, after the issuance of the order, health insurance 5613  
coverage for the children who are the subject of the order becomes 5614  
available at a reasonable cost through a group health insurance or 5615

health care policy, contract, or plan offered by the obligor's or 5616  
obligee's employer or through any other group health insurance or 5617  
health care policy, contract, or plan available to the obligor or 5618  
obligee, the obligor or obligee to whom the coverage becomes 5619  
available immediately inform the court of that fact. 5620

(10) A notice that, if the obligor is required under 5621  
divisions (C)(1) and (2) of this section to obtain health 5622  
insurance coverage for the children who are the subject of the 5623  
child support order and if the obligor fails to comply with the 5624  
requirements of those divisions, the court immediately shall issue 5625  
an order to the employer of the obligor, upon written notice from 5626  
the child support enforcement agency, requiring the employer to 5627  
take whatever action is necessary to make application to enroll 5628  
the obligor in any available group health insurance or health care 5629  
policy, contract, or plan with coverage for the children who are 5630  
the subject of the child support order, to submit a copy of the 5631  
court order issued pursuant to division (C) of this section to the 5632  
insurer at the time that the employer makes application to enroll 5633  
the children in the health insurance or health care policy, 5634  
contract, or plan, and, if the obligor's application is accepted, 5635  
to deduct any additional amount from the obligor's earnings 5636  
necessary to pay any additional cost for that health insurance 5637  
coverage; 5638

(11) A notice that during the time that an order under this 5639  
section is in effect, the employer of the obligor is required to 5640  
release to the obligee or the child support enforcement agency 5641  
upon written request any necessary information on the health 5642  
insurance coverage of the obligor, including, but not limited to, 5643  
the name and address of the insurer and any policy, contract, or 5644  
plan number, and to otherwise comply with this section and any 5645  
court order issued under this section; 5646

(12) A statement setting forth the full name and date of 5647

birth of each child who is the subject of the child support order; 5648

(13) A requirement that the obligor and the obligee comply 5649  
with any requirement described in division (C)(1), (2), (3), (4), 5650  
or (7) of this section that is contained in the order issued under 5651  
this section no later than thirty days after the issuance of the 5652  
order. 5653

(D) In any action in which a child support order is issued or 5654  
modified on or after July 1, 1990, under Chapter 3115. or section 5655  
2151.23, 2151.231, 2151.33, 2151.36, 2151.49, 3105.18, 3105.21, 5656  
3109.05, 3109.19, 3111.13, 3113.04, 3113.07, 3113.216, or 3113.31 5657  
of the Revised Code, the court, in addition to any requirements in 5658  
those sections and in lieu of an order issued under division (C) 5659  
of this section, may issue a separate order requiring both the 5660  
obligor and the obligee to obtain health insurance coverage for 5661  
the children who are the subject of the child support order, if 5662  
health insurance coverage is available for the children and if the 5663  
court determines that the coverage is available at a reasonable 5664  
cost to both the obligor and the obligee and that the dual 5665  
coverage by both parents would provide for coordination of medical 5666  
benefits without unnecessary duplication of coverage. If the court 5667  
issues an order under this division, it shall include in the order 5668  
any of the requirements, notices, and information set forth in 5669  
divisions (C)(1) to (13) of this section that are applicable. 5670  
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(E) Any order issued under this section shall be binding upon 5672  
the obligor and the obligee, their employers, and any insurer that 5673  
provides health insurance coverage for either of them or their 5674  
children. The court shall send a copy of any order issued under 5675  
this section that contains any requirement or notice described in 5676  
division (C)(1), (2), (3), (4), (7), (8), or (10) of this section 5677  
by ordinary mail to the obligor, the obligee, and any employer 5678  
that is subject to the order. The court shall send a copy of any 5679

order issued under this section that contains any requirement 5680  
contained in division (C)(9) of this section by ordinary mail to 5681  
the obligor and obligee. 5682

(F) If an obligor does not comply with any order issued under 5683  
this section that contains any requirement or notice described in 5684  
division (C)(1), (2), (4), (7), (8), or (10) of this section 5685  
within thirty days after the order is issued, the child support 5686  
enforcement agency shall notify the court in writing of the 5687  
failure of the obligor to comply with the order. Upon receipt of 5688  
the notice from the agency, the court shall issue an order to the 5689  
employer of the obligor requiring the employer to take whatever 5690  
action is necessary to make application to enroll the obligor in 5691  
any available group health insurance or health care policy, 5692  
contract, or plan with coverage for the children who are the 5693  
subject of the child support order, to submit a copy of the court 5694  
order issued pursuant to division (C) of this section to the 5695  
insurer at the time that the employer makes application to enroll 5696  
the children in the health insurance or health care policy, 5697  
contract, or plan, and, if the obligor's application is accepted, 5698  
to deduct from the wages or other income of the obligor the cost 5699  
of the coverage for the children. Upon receipt of any order under 5700  
this division, the employer shall take whatever action is 5701  
necessary to comply with the order. 5702

During the time that any order issued under this section is 5703  
in effect and after the employer has received a copy of the order, 5704  
the employer of the obligor who is the subject of the order shall 5705  
comply with the order and, upon request from the obligee or 5706  
agency, shall release to the obligee and the child support 5707  
enforcement agency all information about the obligor's health 5708  
insurance coverage that is necessary to ensure compliance with 5709  
this section or any order issued under this section, including, 5710  
but not limited to, the name and address of the insurer and any 5711

policy, contract, or plan number. Any information provided by an 5712  
employer pursuant to this division shall be used only for the 5713  
purpose of the enforcement of an order issued under this section. 5714

Any employer who receives a copy of an order issued under 5715  
this section shall notify the child support enforcement agency of 5716  
any change in or the termination of the obligor's health insurance 5717  
coverage that is maintained pursuant to an order issued under this 5718  
section. 5719

(G) Any insurer that receives a copy of an order issued under 5720  
this section shall comply with this section and any order issued 5721  
under this section, regardless of the residence of the children. 5722  
If an insurer provides health insurance coverage for the children 5723  
who are the subject of a child support order in accordance with an 5724  
order issued under this section, the insurer shall reimburse the 5725  
parent, who is designated to receive reimbursement in the order 5726  
issued under this section, for covered out-of-pocket medical, 5727  
optical, hospital, dental, or prescription expenses incurred on 5728  
behalf of the children subject to the order. 5729

(H) If an obligee under a child support order is eligible for 5730  
medical assistance under Chapter 5111. or 5115. of the Revised 5731  
Code and the obligor has obtained health insurance coverage 5732  
pursuant to an order issued under division (C) of this section, 5733  
the obligee shall notify any physician, hospital, or other 5734  
provider of medical services for which medical assistance is 5735  
available of the name and address of the obligor's insurer and of 5736  
the number of the obligor's health insurance or health care 5737  
policy, contract, or plan. Any physician, hospital, or other 5738  
provider of medical services for which medical assistance is 5739  
available under Chapter 5111. or 5115. of the Revised Code who is 5740  
notified under this division of the existence of a health 5741  
insurance or health care policy, contract, or plan with coverage 5742  
for children who are eligible for medical assistance first shall 5743

bill the insurer for any services provided for those children. If 5744  
the insurer fails to pay all or any part of a claim filed under 5745  
this division by the physician, hospital, or other medical 5746  
services provider and the services for which the claim is filed 5747  
are covered by Chapter 5111. or 5115. of the Revised Code, the 5748  
physician, hospital, or other medical services provider shall bill 5749  
the remaining unpaid costs of the services in accordance with 5750  
Chapter 5111. or 5115. of the Revised Code. 5751

(I) Any obligor who fails to comply with an order issued 5752  
under this section is liable to the obligee for any medical 5753  
expenses incurred as a result of the failure to comply with the 5754  
order. 5755

(J) Whoever violates an order issued under this section may 5756  
be punished as for contempt under Chapter 2705. of the Revised 5757  
Code. If an obligor is found in contempt under that chapter for 5758  
failing to comply with an order issued under this section and if 5759  
the obligor previously has been found in contempt under that 5760  
chapter, the court shall consider the obligor's failure to comply 5761  
with the court's order as a change in circumstances for the 5762  
purpose of modification of the amount of support due under the 5763  
child support order that is the basis of the order issued under 5764  
this section. 5765

(K) Nothing in this section shall be construed to require an 5766  
insurer to accept for enrollment any child who does not meet the 5767  
underwriting standards of the health insurance or health care 5768  
policy, contract, or plan for which application is made. 5769

(L) Notwithstanding section 3109.01 of the Revised Code, if a 5770  
court issues an order under this section requiring a parent to 5771  
obtain health insurance coverage for the children who are the 5772  
subject of a child support order, the order shall remain in effect 5773  
beyond the child's eighteenth birthday as long as the child 5774

continuously attends on a full-time basis any recognized and 5775  
accredited high school. Any parent ordered to obtain health 5776  
insurance coverage for the children who are the subject of a child 5777  
support order shall continue to obtain the coverage for the 5778  
children under the order, including during seasonal vacation 5779  
periods, until the order terminates. 5780

**Sec. 3307.74.** (A) The state teachers retirement board may 5781  
enter into an agreement with insurance companies, ~~medical or~~ 5782  
health ~~care~~ insuring corporations, ~~health maintenance~~ 5783  
~~organizations,~~ or government agencies authorized to do business in 5784  
the state for issuance of a policy or contract of health, medical, 5785  
hospital, or surgical benefits, or any combination thereof, for 5786  
those individuals receiving service retirement or a disability or 5787  
survivor benefit subscribing to the plan. Notwithstanding any 5788  
other provision of this chapter, the policy or contract may also 5789  
include coverage for any eligible individual's spouse and 5790  
dependent children and for any of the individual's sponsored 5791  
dependents as the board considers appropriate. If all or any 5792  
portion of the policy or contract premium is to be paid by any 5793  
individual receiving service retirement or a disability or 5794  
survivor benefit, the individual shall, by written authorization, 5795  
instruct the board to deduct the premium agreed to be paid by the 5796  
individual to the companies, ~~associations,~~ corporations, or 5797  
agencies. 5798

The board may contract for coverage on the basis of part or 5799  
all of the cost of the coverage to be paid from appropriate funds 5800  
of the state teachers retirement system. The cost paid from the 5801  
funds of the system shall be included in the employer's 5802  
contribution rate provided by section 3307.53 of the Revised Code. 5803

The board may provide for self-insurance of risk or level of 5804  
risk as set forth in the contract with the companies, 5805

corporations, or agencies, and may provide through the 5806  
self-insurance method specific benefits as authorized by the rules 5807  
of the board. 5808

(B) If the board provides health, medical, hospital, or 5809  
surgical benefits through any means other than a health 5810  
~~maintenance organization~~ insuring corporation, it shall offer to 5811  
each individual eligible for the benefits the alternative of 5812  
receiving benefits through enrollment in a health ~~maintenance~~ 5813  
~~organization~~ insuring corporation, if all of the following apply: 5814

(1) The health ~~maintenance organization~~ insuring corporation 5815  
provides health care services in the geographical area in which 5816  
the individual lives; 5817

(2) The eligible individual was receiving health care 5818  
benefits through a health maintenance organization or a health 5819  
insuring corporation before retirement; 5820

(3) The rate and coverage provided by the health ~~maintenance~~ 5821  
~~organization~~ insuring corporation to eligible individuals is 5822  
comparable to that currently provided by the board under division 5823  
(A) of this section. If the rate or coverage provided by the 5824  
health ~~maintenance organization~~ insuring corporation is not 5825  
comparable to that currently provided by the board under division 5826  
(A) of this section, the board may deduct the additional cost from 5827  
the eligible individual's monthly benefit. 5828

The health ~~maintenance organization~~ insuring corporation 5829  
shall accept as an enrollee any eligible individual who requests 5830  
enrollment. 5831

The board shall permit each eligible individual to change 5832  
from one plan to another at least once a year at a time determined 5833  
by the board. 5834

(C) The board shall, beginning the month following receipt of 5835

satisfactory evidence of the payment for coverage, make a monthly  
payment to each recipient of service retirement, or a disability  
or survivor benefit under the state teachers retirement system who  
is eligible for insurance coverage under part B of "The Social  
Security Amendments of 1965," 79 Stat. 301, 42 U.S.C.A. 1395j, as  
amended. The payment shall be the lesser of an amount equal to the  
basic premium for such coverage, or an amount equal to the basic  
premium in effect on April 10, 1991.

(D) The board shall establish by rule requirements for the  
coordination of any coverage, payment, or benefit provided under  
this section or section 3307.405 of the Revised Code with any  
similar coverage, payment, or benefit made available to the same  
individual by the public employees retirement system, police and  
firemen's disability and pension fund, school employees retirement  
system, or state highway patrol retirement system.

(E) The board shall make all other necessary rules pursuant  
to the purpose and intent of this section.

**Sec. 3307.741.** The state teachers retirement board shall  
establish a program under which members of the retirement system,  
employers on behalf of members, and persons receiving service,  
disability, or survivor benefits are permitted to participate in  
contracts for long-term health care insurance. Participation may  
include dependents and family members. If a participant in a  
contract for long-term care insurance leaves ~~his~~ employment, ~~he~~  
the participant and ~~his~~ the participant's dependents and family  
members may, at their election, continue to participate in a  
program established under this section in the same manner as if ~~he~~  
the participant had not left ~~his~~ employment, except that no part  
of the cost of the insurance shall be paid by ~~his~~ the  
participant's former employer.

Such program may be established independently or jointly with

one or more of the other retirement systems. For purposes of this 5867  
section, "retirement systems" has the same meaning as in division 5868  
(A) of section 145.581 of the Revised Code. 5869

The board may enter into an agreement with insurance 5870  
companies, ~~medical or health care~~ insuring corporations, ~~health~~ 5871  
~~maintenance organizations,~~ or government agencies authorized to do 5872  
business in the state for issuance of a long-term care insurance 5873  
policy or contract. However, prior to entering into such an 5874  
agreement with an insurance company, ~~medical or health care~~ 5875  
insuring corporation, ~~or health maintenance organization,~~ the 5876  
board shall request the superintendent of insurance to certify the 5877  
financial condition of the company, or corporation, ~~or~~ 5878  
~~organization~~. The board shall not enter into the agreement if, 5879  
according to that certification, the company, or corporation, ~~or~~ 5880  
~~organization~~ is insolvent, is determined by the superintendent to 5881  
be potentially unable to fulfill its contractual obligations, or 5882  
is placed under an order of rehabilitation or conservation by a 5883  
court of competent jurisdiction or under an order of supervision 5884  
by the superintendent. 5885

The board shall adopt rules in accordance with section 111.15 5886  
of the Revised Code governing the program. The rules shall 5887  
establish methods of payment for participation under this section, 5888  
which may include establishment of a payroll deduction plan under 5889  
section 3307.281 of the Revised Code, deduction of the full 5890  
premium charged from a person's service, disability, or survivor 5891  
benefit, or any other method of payment considered appropriate by 5892  
the board. If the program is established jointly with one or more 5893  
of the other retirement systems, the rules also shall establish 5894  
the terms and conditions of such joint participation. 5895

**Sec. 3309.69.** (A) As used in this section, "ineligible 5896  
individual" means all of the following: 5897

(1) A former member receiving benefits pursuant to section 5898  
3309.34, 3309.35, 3309.36, 3309.38, or 3309.381 of the Revised 5899  
Code for whom eligibility is established more than five years 5900  
after June 13, 1981, and who, at the time of establishing 5901  
eligibility, has accrued less than ten years of service credit, 5902  
exclusive of credit obtained after January 29, 1981, pursuant to 5903  
sections 3309.021, 3309.301, 3309.31, and 3309.33 of the Revised 5904  
Code; 5905

(2) The spouse of the former member; 5906

(3) The beneficiary of the former member receiving benefits 5907  
pursuant to section 3309.46 of the Revised Code. 5908

(B) The school employees retirement board may enter into an 5909  
agreement with insurance companies, ~~medical or health care~~ 5910  
insuring corporations, ~~health maintenance organizations,~~ or 5911  
government agencies authorized to do business in the state for 5912  
issuance of a policy or contract of health, medical, hospital, or 5913  
surgical benefits, or any combination thereof, for those 5914  
individuals receiving service retirement or a disability or 5915  
survivor benefit subscribing to the plan and their eligible 5916  
dependents. 5917

If all or any portion of the policy or contract premium is to 5918  
be paid by any individual receiving service retirement or a 5919  
disability or survivor benefit, the person shall, by written 5920  
authorization, instruct the board to deduct the premiums agreed to 5921  
be paid by the individual to the companies, corporations, or 5922  
agencies. 5923

The board may contract for coverage on the basis of part or 5924  
all of the cost of the coverage to be paid from appropriate funds 5925  
of the school employees retirement system. The cost paid from the 5926  
funds of the system shall be included in the employer's 5927  
contribution rate provided by sections 3309.49 and 3309.491 of the 5928

Revised Code. The board shall not pay or reimburse the cost for  
health care under this section or section 3309.375 of the Revised  
Code for any ineligible individual.

The board may provide for self-insurance of risk or level of  
risk as set forth in the contract with the companies,  
corporations, or agencies, and may provide through the  
self-insurance method specific benefits as authorized by the rules  
of the board.

(C) If the board provides health, medical, hospital, or  
surgical benefits through any means other than a health  
~~maintenance organization~~ insuring corporation, it shall offer to  
each individual eligible for the benefits the alternative of  
receiving benefits through enrollment in a health ~~maintenance~~  
~~organization~~ insuring corporation, if all of the following apply:

(1) The health ~~maintenance organization~~ insuring corporation  
provides health care services in the geographical area in which  
the individual lives;

(2) The eligible individual was receiving health care  
benefits through a health maintenance organization or a health  
insuring corporation before retirement;

(3) The rate and coverage provided by the health ~~maintenance~~  
~~organization~~ insuring corporation to eligible individuals is  
comparable to that currently provided by the board under division  
(B) of this section. If the rate or coverage provided by the  
health ~~maintenance organization~~ insuring corporation is not  
comparable to that currently provided by the board under division  
(B) of this section, the board may deduct the additional cost from  
the eligible individual's monthly benefit.

The health ~~maintenance organization~~ insuring corporation  
shall accept as an enrollee any eligible individual who requests  
enrollment.

The board shall permit each eligible individual to change 5960  
from one plan to another at least once a year at a time determined 5961  
by the board. 5962

(D) The board shall, beginning the month following receipt of 5963  
satisfactory evidence of the payment for coverage, make a monthly 5964  
payment to each recipient of service retirement, or a disability 5965  
or survivor benefit under the school employees retirement system 5966  
who is eligible for insurance coverage under part B of "The Social 5967  
Security Amendments of 1965," 79 Stat. 301, 42 U.S.C.A. 1395j, as 5968  
amended, except that the board shall make no such payment to any 5969  
ineligible individual. The amount of the payment shall be the 5970  
lesser of an amount equal to the basic premium for such coverage, 5971  
or an amount equal to the basic premium in effect on January 1, 5972  
1988. 5973

(E) The board shall establish by rule requirements for the 5974  
coordination of any coverage, payment, or benefit provided under 5975  
this section or section 3309.375 of the Revised Code with any 5976  
similar coverage, payment, or benefit made available to the same 5977  
individual by the public employees retirement system, police and 5978  
firemen's disability and pension fund, state teachers retirement 5979  
system, or state highway patrol retirement system. 5980

(F) The board shall make all other necessary rules pursuant 5981  
to the purpose and intent of this section. 5982

**Sec. 3309.691.** The school employees retirement board shall 5983  
establish a program under which members of the retirement system, 5984  
employers on behalf of members, and persons receiving service, 5985  
disability, or survivor benefits are permitted to participate in 5986  
contracts for long-term health care insurance. Participation may 5987  
include dependents and family members. If a participant in a 5988  
contract for long-term care insurance leaves ~~his~~ employment, ~~he~~ 5989  
the participant and ~~his~~ the participant's dependents and family 5990

members may, at their election, continue to participate in a 5991  
program established under this section in the same manner as if ~~he~~ 5992  
the participant had not left ~~his~~ employment, except that no part 5993  
of the cost of the insurance shall be paid by ~~his~~ the 5994  
participant's former employer. 5995

Such program may be established independently or jointly with 5996  
one or more of the other retirement systems. For purposes of this 5997  
section, "retirement systems" has the same meaning as in division 5998  
(A) of section 145.581 of the Revised Code. 5999

The board may enter into an agreement with insurance 6000  
companies, ~~medical or health care~~ insuring corporations, ~~health~~ 6001  
~~maintenance organizations,~~ or government agencies authorized to do 6002  
business in the state for issuance of a long-term care insurance 6003  
policy or contract. However, prior to entering into such an 6004  
agreement with an insurance company, ~~medical or health care~~ 6005  
insuring corporation, ~~or health maintenance organization,~~ the 6006  
board shall request the superintendent of insurance to certify the 6007  
financial condition of the company, or corporation, ~~or~~ 6008  
~~organization~~. The board shall not enter into the agreement if, 6009  
according to that certification, the company, or corporation, ~~or~~ 6010  
~~organization~~ is insolvent, is determined by the superintendent to 6011  
be potentially unable to fulfill its contractual obligations, or 6012  
is placed under an order of rehabilitation or conservation by a 6013  
court of competent jurisdiction or under an order of supervision 6014  
by the superintendent. 6015

The board shall adopt rules in accordance with section 111.15 6016  
of the Revised Code governing the program. The rules shall 6017  
establish methods of payment for participation under this section, 6018  
which may include establishment of a payroll deduction plan under 6019  
section 3309.27 of the Revised Code, deduction of the full premium 6020  
charged from a person's service, disability, or survivor benefit, 6021

or any other method of payment considered appropriate by the 6022  
board. If the program is established jointly with one or more of 6023  
the other retirement systems, the rules also shall establish the 6024  
terms and conditions of such joint participation. 6025

**Sec. 3313.202.** (A) The board of education of a school 6026  
district may procure and pay all or part of the cost of group term 6027  
life, hospitalization, surgical care, or major medical insurance, 6028  
disability, dental care, vision care, medical care, hearing aids, 6029  
prescription drugs, sickness and accident insurance, group legal 6030  
services, or a combination of any of the foregoing types of 6031  
insurance or coverage, whether issued by an insurance company or a 6032  
~~medical care corporation, health care insuring corporation, dental~~ 6033  
~~care corporation, or health maintenance organization~~ duly licensed 6034  
by this state, covering the teaching or nonteaching employees of 6035  
the school district, or a combination of both, or the dependent 6036  
children and spouses of such employees, provided if such coverage 6037  
affects only the teaching employees of the district such coverage 6038  
shall be with the consent of a majority of such employees of the 6039  
school district, or if such coverage affects only the nonteaching 6040  
employees of the district such coverage shall be with the consent 6041  
of a majority of such employees. If such coverage is proposed to 6042  
cover all the employees of a school district, both teaching and 6043  
nonteaching employees, such coverage shall be with the consent of 6044  
a majority of all the employees of a school district. A board of 6045  
education shall continue to carry, on payroll records, all school 6046  
employees whose sick leave accumulation has expired, or who are on 6047  
a disability leave of absence or an approved leave of absence, for 6048  
the purpose of group term life, hospitalization, surgical, major 6049  
medical, or any other insurance. A board of education may pay all 6050  
or part of such coverage except when such employees are on an 6051  
approved leave of absence, or on a disability leave of absence for 6052  
that period exceeding two years. As used in this section, 6053

"teaching employees" means any person employed in the public 6054  
schools of this state in a position for which the person is 6055  
required to have a certificate or license pursuant to sections 6056  
3319.22 to 3319.31 of the Revised Code. "Nonteaching employees" as 6057  
used in this section means any person employed in the public 6058  
schools of the state in a position for which the person is not 6059  
required to have a certificate or license issued pursuant to 6060  
sections 3319.22 to 3319.31 of the Revised Code. 6061

(B) The board of education of a school district may enter 6062  
into an agreement with a jointly administered trust fund which 6063  
receives contributions pursuant to a collective bargaining 6064  
agreement entered into between the board and any collective 6065  
bargaining representative of the employees of the board for the 6066  
purpose of providing for self-insurance of all risk in the 6067  
provision of fringe benefits similar to those that may be paid 6068  
pursuant to division (A) of this section, and may provide through 6069  
the self-insurance method specific fringe benefits as authorized 6070  
by the rules of the board of trustees of the jointly administered 6071  
trust fund. Benefits provided under this section include, but are 6072  
not limited to, hospitalization, surgical care, major medical 6073  
care, disability, dental care, vision care, medical care, hearing 6074  
aids, prescription drugs, group life insurance, sickness and 6075  
accident insurance, group legal services, or a combination of the 6076  
above benefits, for the employees and their dependents. 6077

(C) Notwithstanding any other provision of the Revised Code, 6078  
the board of education and any collective bargaining 6079  
representative of employees of the board may agree in a collective 6080  
bargaining agreement that any mutually agreed fringe benefit, 6081  
including, but not limited to, hospitalization, surgical care, 6082  
major medical care, disability, dental care, vision care, medical 6083  
care, hearing aids, prescription drugs, group life insurance, 6084  
sickness and accident insurance, group legal services, or a 6085

combination thereof, for employees and their dependents be 6086  
provided through a mutually agreed upon contribution to a jointly 6087  
administered trust fund. The amount, type, and structure of fringe 6088  
benefits provided under this division are subject to the 6089  
determination of the board of trustees of the jointly administered 6090  
trust fund. Notwithstanding any other provision of the Revised 6091  
Code, competitive bidding does not apply to the purchase of fringe 6092  
benefits for employees under this division through a jointly 6093  
administered trust fund. 6094

(D) Any elected or appointed member of the board of education 6095  
and the dependent children and spouse of the member may be 6096  
covered, at the option of the member, as an employee of the school 6097  
district under any benefit plan adopted under this section. The 6098  
member shall pay to the school district the amount certified for 6099  
that coverage under division (D)(1) or (2) of this section. 6100  
Payments for such coverage shall be made, in advance, in a manner 6101  
prescribed by the board. The member's exercise of an option to be 6102  
covered under this section shall be in writing, announced at a 6103  
regular public meeting of the board, and recorded as a public 6104  
record in the minutes of the board. 6105

For the purposes of determining the cost to board members 6106  
under this division: 6107

(1) In the case of a benefit plan purchased under division 6108  
(A) of this section, the provider of the benefits shall certify to 6109  
the board the provider's charge for coverage under each option 6110  
available to employees under that benefit plan; 6111

(2) In the case of benefits provided under division (B) or 6112  
(C) of this section, the board of trustees of the jointly 6113  
administered trust fund shall certify to the board of education 6114  
the trustees' charge for coverage under each option available to 6115  
employees under each benefit plan. 6116

(E) The board may provide the benefits described in this 6117  
section through an individual self-insurance program or a joint 6118  
self-insurance program as provided in section 9.833 of the Revised 6119  
Code. 6120

**Sec. 3375.40.** Each board of library trustees appointed 6121  
pursuant to sections 3375.06, 3375.10, 3375.12, 3375.15, 3375.22, 6122  
and 3375.30 of the Revised Code may: 6123

(A) Hold title to and have the custody of all real and 6124  
personal property of the free public library under its 6125  
jurisdiction; 6126

(B) Expend for library purposes, and in the exercise of the 6127  
power enumerated in this section, all moneys, whether derived from 6128  
the county library and local government support fund or otherwise, 6129  
credited to the free public library under its jurisdiction and 6130  
generally do all things it considers necessary for the 6131  
establishment, maintenance, and improvement of the public library 6132  
under its jurisdiction; 6133

(C) Purchase, lease, construct, remodel, renovate, or 6134  
otherwise improve, equip, and furnish buildings or parts of 6135  
buildings and other real property, and purchase, lease, or 6136  
otherwise acquire motor vehicles and other personal property, 6137  
necessary for the proper maintenance and operation of the free 6138  
public libraries under its jurisdiction, and pay the costs thereof 6139  
in installments or otherwise. Financing of these costs may be 6140  
provided through the issuance of notes, through an installment 6141  
sale, or through a lease-purchase agreement. Any such notes shall 6142  
be issued pursuant to section 3375.404 of the Revised Code. 6143

(D) Purchase, lease, lease with an option to purchase, or 6144  
erect buildings or parts of buildings to be used as main 6145  
libraries, branch libraries, or library stations pursuant to 6146

section 3375.41 of the Revised Code; 6147

(E) Establish and maintain a main library, branches, library 6148  
stations, and traveling library service within the territorial 6149  
boundaries of the subdivision or district over which it has 6150  
jurisdiction of free public library service; 6151

(F) Establish and maintain branches, library stations, and 6152  
traveling library service in any school district, outside the 6153  
territorial boundaries of the subdivision or district over which 6154  
it has jurisdiction of free public library service, upon 6155  
application to and approval of the state library board, pursuant 6156  
to section 3375.05 of the Revised Code; provided the board of 6157  
trustees of any free public library maintaining branches, 6158  
stations, or traveling-book service, outside the territorial 6159  
boundaries of the subdivision or district over which it has 6160  
jurisdiction of free public library service, on September 4, 1947, 6161  
may continue to maintain and operate such branches, stations, and 6162  
traveling library service without the approval of the state 6163  
library board; 6164

(G) Appoint and fix the compensation of all of the employees 6165  
of the free public library under its jurisdiction; pay the 6166  
reasonable cost of tuition for any of its employees who enroll in 6167  
a course of study the board considers essential to the duties of 6168  
the employee or to the improvement of the employee's performance; 6169  
and reimburse applicants for employment for any reasonable 6170  
expenses they incur by appearing for a personal interview; 6171

(H) Make and publish rules for the proper operation and 6172  
management of the free public library and facilities under its 6173  
jurisdiction, including rules pertaining to the provision of 6174  
library services to individuals, corporations, or institutions 6175  
that are not inhabitants of the county; 6176

(I) Establish and maintain a museum in connection with and as 6177

an adjunct to the free public library under its jurisdiction; 6178

(J) By the adoption of a resolution accept any bequest, gift, 6179  
or endowment upon the conditions connected with such bequest, 6180  
gift, or endowment; provided no such bequest, gift, or endowment 6181  
shall be accepted by such board if the conditions thereof remove 6182  
any portion of the free public library under its jurisdiction from 6183  
the control of such board or if such conditions, in any manner, 6184  
limit the free use of such library or any part thereof by the 6185  
residents of the counties in which such library is located; 6186  
6187

(K) At the end of any fiscal year by a two-thirds vote of its 6188  
full membership set aside any unencumbered surplus remaining in 6189  
the general fund of the library under its jurisdiction for any 6190  
purpose including creating or increasing a special building and 6191  
repair fund, or for operating the library or acquiring equipment 6192  
and supplies; 6193

(L) Procure and pay all or part of the cost of group life, 6194  
hospitalization, surgical, major medical, disability benefit, 6195  
dental care, eye care, hearing aids, or prescription drug 6196  
insurance, or a combination of any of the foregoing types of 6197  
insurance or coverage, whether issued by an insurance company, or 6198  
~~nonprofit medical or dental care~~ a health insuring corporation 6199  
duly licensed by the state, covering its employees and in the case 6200  
of hospitalization, surgical, major medical, dental care, eye 6201  
care, hearing aids, or prescription drug insurance, also covering 6202  
the dependents and spouses of such employees, and in the case of 6203  
disability benefits, also covering spouses of such employees. With 6204  
respect to life insurance, coverage for any employee shall not 6205  
exceed the greater of the sum of ten thousand dollars or the 6206  
annual salary of the employee, exclusive of any double indemnity 6207  
clause that is a part of the policy. 6208

(M) Pay reasonable dues and expenses for the free public 6209  
library and library trustees in library associations. 6210

**Sec. 3381.14.** A regional arts and cultural district may 6211  
procure and pay all or any part of the cost of group 6212  
hospitalization, surgical, major medical, or sickness and accident 6213  
insurance or a combination of any of the foregoing for the 6214  
employees of the district and their immediate dependents, whether 6215  
issued by an insurance company, ~~nonprofit medical care~~ or a health 6216  
insuring corporation, ~~or hospital service association~~ duly 6217  
authorized to do business in this state. 6218

**Sec. 3501.141.** (A) The board of elections of any county may 6219  
contract, purchase, or otherwise procure and pay all or any part 6220  
of the cost of group insurance policies that may provide benefits 6221  
for hospitalization, surgical care, major medical care, 6222  
disability, dental care, eye care, medical care, hearing aids, or 6223  
prescription drugs, and that may provide sickness and accident 6224  
insurance, or group life insurance, or a combination of any of the 6225  
foregoing types of insurance or coverage for the full-time 6226  
employees of such board and their immediate dependents, whether 6227  
issued by an insurance company, ~~a health or medical care~~ 6228  
~~corporation, a dental care corporation,~~ or a health ~~maintenance~~ 6229  
~~organization~~ insuring corporation, duly authorized to do business 6230  
in this state. 6231

(B) The board of elections of any county may procure and pay 6232  
all or any part of the cost of group hospitalization, surgical, 6233  
major medical, or sickness and accident insurance or a combination 6234  
of any of the foregoing types of insurance or coverage for the 6235  
members appointed to the board of elections under section 3501.06 6236  
of the Revised Code and their immediate dependents when each 6237  
member's term begins, whether issued by an insurance company or a 6238

health ~~or medical care~~ insuring corporation, duly authorized to do 6239  
business in this state. 6240

**Sec. 3701.24.** (A) As used in this section and sections 6241  
3701.241 to 3701.249 of the Revised Code: 6242

(1) "AIDS" means the illness designated as acquired 6243  
immunodeficiency syndrome. 6244

(2) "HIV" means the human immunodeficiency virus identified 6245  
as the causative agent of AIDS. 6246

(3) "AIDS-related condition" means symptoms of illness 6247  
related to HIV infection, including AIDS-related complex, that are 6248  
confirmed by a positive HIV test. 6249

(4) "HIV test" means any test for the antibody or antigen to 6250  
HIV that has been approved by the director of health under 6251  
division (B) of section 3701.241 of the Revised Code. 6252

(5) "Health care facility" has the same meaning as in section 6253  
~~1742.01~~ 1751.01 of the Revised Code. 6254

(6) "Director" means the director of health or any employee 6255  
of the department of health acting on ~~his~~ the director's behalf. 6256

(7) "Physician" means a person who holds a current, valid 6257  
certificate issued under Chapter 4731. of the Revised Code 6258  
authorizing the practice of medicine or surgery and osteopathic 6259  
medicine and surgery. 6260

(8) "Nurse" means a registered nurse or licensed practical 6261  
nurse who holds a license or certificate issued under Chapter 6262  
4723. of the Revised Code. 6263

(9) "Anonymous test" means an HIV test administered so that 6264  
the individual to be tested can give informed consent to the test 6265  
and receive the results by means of a code system that does not 6266  
link ~~his~~ the identity of the individual tested to the request for 6267

the test or the test results. 6268

(10) "Confidential test" means an HIV test administered so 6269  
that the identity of the individual tested is linked to the test 6270  
but is held in confidence to the extent provided by section 6271  
3701.24 to 3701.248 of the Revised Code. 6272

(11) "Health care provider" means an individual who provides 6273  
diagnostic, evaluative, or treatment services. Pursuant to Chapter 6274  
119. of the Revised Code, the public health council may adopt 6275  
rules further defining the scope of the term "health care 6276  
provider." 6277

(12) "Significant exposure to body fluids" means a 6278  
percutaneous or mucous membrane exposure of an individual to the 6279  
blood, semen, vaginal secretions, or spinal, synovial, pleural, 6280  
peritoneal, pericardial, or amniotic fluid of another individual. 6281

(13) "Emergency medical services worker" means all of the 6282  
following: 6283

(a) A peace officer; 6284

(b) An employee of an emergency medical service organization 6285  
as defined in section 4765.01 of the Revised Code; 6286

(c) A firefighter employed by a political subdivision; 6287

(d) A volunteer firefighter, emergency operator, or rescue 6288  
operator; 6289

(e) An employee of a private organization that renders rescue 6290  
services, emergency medical services, or emergency medical 6291  
transportation to accident victims and persons suffering serious 6292  
illness or injury. 6293

(14) "Peace officer" has the same meaning as in division (A) 6294  
of section 109.71 of the Revised Code, except that it also 6295  
includes a sheriff and the superintendent and troopers of the 6296  
state highway patrol. 6297

(B) Boards of health, health authorities or officials, and  
physicians in localities in which there are no health authorities  
or officials, shall report promptly to the department of health  
the existence of any one of the following diseases:

(1) Asiatic cholera;

(2) Yellow fever;

(3) Diphtheria;

(4) Typhus or typhoid fever;

(5) Any other contagious or infectious diseases that the  
public health council specifies.

(C) Persons designated by rule adopted by the public health  
council under section 3701.241 of the Revised Code shall report  
promptly every case of AIDS, every AIDS-related condition, and  
every confirmed positive HIV test to the department of health on  
forms and in a manner prescribed by the director. In each county  
the director shall designate the health commissioner of a health  
district in the county to receive the reports.

Information reported under this division that identifies an  
individual is confidential and may be released only with the  
written consent of the individual except as the director  
determines necessary to ensure the accuracy of the information, as  
necessary to provide treatment to the individual, as ordered by a  
court pursuant to section 3701.243 or 3701.247 of the Revised  
Code, or pursuant to a search warrant or a subpoena issued by or  
at the request of a grand jury, prosecuting attorney, city  
director of law or similar chief legal officer of a municipal  
corporation, or village solicitor, in connection with a criminal  
investigation or prosecution. Information that does not identify  
an individual may be released in summary, statistical, or other  
form.

Sec. 3701.76. (A) The director of health shall establish and 6328  
maintain a statewide public information campaign on the effects of 6329  
diethylstilbestrol or other nonsteroidal synthetic estrogens for 6330  
the purpose of educating the public concerning the potential 6331  
hazards related to exposure to diethylstilbestrol or other 6332  
nonsteroidal synthetic estrogens and encouraging persons exposed 6333  
to diethylstilbestrol or other nonsteroidal synthetic estrogens, 6334  
including those exposed before birth, to seek medical attention 6335  
for the identification and treatment of any conditions resulting 6336  
from this exposure. 6337

(B) The director shall maintain a registry of hospitals, 6338  
clinics, physicians, or other health care providers to whom ~~he~~ the 6339  
director shall refer persons who make inquiries to the department 6340  
of health regarding possible exposure to diethylstilbestrol or 6341  
other nonsteroidal synthetic estrogens. In order to be eligible 6342  
for listing in the registry, a health care provider shall make an 6343  
application to the director, and shall have the necessary 6344  
experience, facilities, and equipment to make examinations for 6345  
possible effects of diethylstilbestrol or other nonsteroidal 6346  
synthetic estrogens. 6347

(C) The director shall maintain a registry of persons who 6348  
have been exposed to diethylstilbestrol or other nonsteroidal 6349  
synthetic estrogens, including persons exposed before birth, for 6350  
the purpose of studying and monitoring conditions caused by 6351  
exposure to diethylstilbestrol or other nonsteroidal synthetic 6352  
estrogen. No person shall be listed in the registry without ~~his~~ 6353  
the director's consent. 6354

(D) The director shall make an annual report to the general 6355  
assembly on the effectiveness of the programs established under 6356  
this section, and shall make recommendations concerning the 6357  
programs and possible legislation relating to them. 6358

(E) No insurance company doing business under Title XXXIX and  
no health insuring corporation holding a certificate of authority  
~~or license~~ under Chapter ~~1737., 1738., or 1742.~~ 1751. of the  
Revised Code shall cancel or refuse to renew a policy ~~or~~  
~~subscription,~~ contract, certificate, or agreement or limit  
benefits provided under a policy ~~or subscription,~~ contract,  
certificate, or agreement solely because a policyholder,  
subscriber, or applicant for a policy ~~or subscription,~~ contract,  
certificate, or agreement has been exposed to diethylstilbestrol  
or other nonsteroidal synthetic estrogens.

**Sec. 3702.51.** As used in sections 3702.51 to 3702.62 of the  
Revised Code:

(A) "Applicant" means any person that submits an application  
for a certificate of need and who is designated in the application  
as the applicant.

(B) "Person" means any individual, corporation, business  
trust, estate, firm, partnership, association, joint stock  
company, insurance company, government unit, or other entity.

(C) "Certificate of need" means a written approval granted by  
the director of health to an applicant to authorize conducting a  
reviewable activity.

(D) "Health service area" means a geographic region  
designated by the director of health under section 3702.58 of the  
Revised Code.

(E) "Health service" means a clinically related service, such  
as a diagnostic, treatment, rehabilitative, or preventive service.

(F) "Health service agency" means an agency designated to  
serve a health service area in accordance with section 3702.58 of  
the Revised Code.

(G) "Health care facility" means:	6389
(1) A hospital registered under section 3701.07 of the Revised Code;	6390 6391
(2) A nursing home licensed under section 3721.02 of the Revised Code, or by a political subdivision certified under section 3721.09 of the Revised Code;	6392 6393 6394
(3) A county home or a county nursing home as defined in section 5155.31 of the Revised Code that is certified under Title XVIII or XIX of the "Social Security Act," 49 Stat. 620 (1935), 42 U.S.C.A. 301, as amended;	6395 6396 6397 6398
(4) A freestanding dialysis center;	6399
(5) A freestanding inpatient rehabilitation facility;	6400
(6) An ambulatory surgical facility;	6401
(7) A freestanding cardiac catheterization facility;	6402
(8) A freestanding birthing center;	6403
(9) A freestanding or mobile diagnostic imaging center;	6404
(10) A freestanding radiation therapy center.	6405
A health care facility does not include the offices of private physicians and dentists whether for individual or group practice, Christian Science sanitoriums operated or listed and certified by the First Church of Christ, Scientist, Boston, Massachusetts, residential facilities licensed under section 5123.19 of the Revised Code, or habilitation centers certified by the director of mental retardation and developmental disabilities under section 5123.041 of the Revised Code.	6406 6407 6408 6409 6410 6411 6412 6413
(H) "Medical equipment" means a single unit of medical equipment or a single system of components with related functions that is used to provide health services.	6414 6415 6416
(I) "Third-party payer" means a <del>medical care corporation or</del>	6417

health care insuring corporation licensed under Chapter ~~1737. or~~ 6418  
~~1738. 1751.~~ of the Revised Code, a health maintenance organization 6419  
as defined in division (K) of this section, an insurance company 6420  
that issues sickness and accident insurance in conformity with 6421  
Chapter 3923. of the Revised Code, a state-financed health 6422  
insurance program under Chapter 3701., 4123., or 5111. of the 6423  
Revised Code, or any self-insurance plan. 6424

(J) "Government unit" means the state and any county, 6425  
municipal corporation, township, or other political subdivision of 6426  
the state, or any department, division, board, or other agency of 6427  
the state or a political subdivision. 6428

(K) "Health maintenance organization" means a public or 6429  
private organization organized under the law of any state that is 6430  
qualified under section 1310(d) of Title XIII of the "Public 6431  
Health Service Act," 87 Stat. 931 (1973), 42 U.S.C. 300e--9 ~~or~~ 6432  
~~that does all of the following:~~ 6433

~~(1) Provides or otherwise makes available to enrolled 6434  
participants health care services including at least the following 6435  
basic health care services: usual physician services, 6436  
hospitalization, laboratory, x ray, emergency and preventive 6437  
services, and out of area coverage;~~ 6438

~~(2) Is compensated, except for copayments, for the provision 6439  
of basic health care services listed in division (K)(1) of this 6440  
section to enrolled participants by a payment that is paid on a 6441  
periodic basis without regard to the date the health care services 6442  
are provided and that is fixed without regard to the frequency, 6443  
extent, or kind of health service actually provided;~~ 6444

~~(3) Provides physician services primarily either:~~ 6445

~~(a) Directly through physicians who are either employees or 6446  
partners of the organization;~~ 6447

~~(b) Through arrangements with individual physicians or one or 6448~~

~~more groups of physicians organized on a group practice or  
individual practice basis.~~ 6449  
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(L) "Existing health care facility" means a health care 6451  
facility that is licensed or otherwise approved to practice in 6452  
this state, in accordance with applicable law, is staffed and 6453  
equipped to provide health care services, and actively provides 6454  
health services or has not been actively providing health services 6455  
for less than twelve consecutive months. 6456

(M) "State" means the state of Ohio, including, but not 6457  
limited to, the general assembly, the supreme court, the offices 6458  
of all elected state officers, and all departments, boards, 6459  
offices, commissions, agencies, institutions, and other 6460  
instrumentalities of the state of Ohio. "State" does not include 6461  
political subdivisions. 6462

(N) "Political subdivision" means a municipal corporation, 6463  
township, county, school district, and all other bodies corporate 6464  
and politic responsible for governmental activities only in 6465  
geographic areas smaller than that of the state to which the 6466  
sovereign immunity of the state attaches. 6467

(O) "Affected person" means: 6468

(1) An applicant for a certificate of need, including an 6469  
applicant whose application was reviewed comparatively with the 6470  
application in question; 6471

(2) The person that requested the reviewability ruling in 6472  
question; 6473

(3) Any person that resides or regularly uses health care 6474  
facilities within the geographic area served or to be served by 6475  
the health care services that would be provided under the 6476  
certificate of need or reviewability ruling in question; 6477

(4) Any health care facility that is located in the health 6478

service area where the health care services would be provided	6479
under the certificate of need or reviewability ruling in question;	6480
(5) Third-party payers that reimburse health care facilities	6481
for services in the health service area where the health care	6482
services would be provided under the certificate of need or	6483
reviewability ruling in question;	6484
(6) Any other person who testified at a public hearing held	6485
under division (B) of section 3702.52 of the Revised Code or	6486
submitted written comments in the course of review of the	6487
certificate of need application in question.	6488
(P) "Osteopathic hospital" means a hospital registered under	6489
section 3701.07 of the Revised Code that advocates osteopathic	6490
principles and the practice and perpetuation of osteopathic	6491
medicine by doing any of the following:	6492
(1) Maintaining a department or service of osteopathic	6493
medicine or a committee on the utilization of osteopathic	6494
principles and methods, under the supervision of an osteopathic	6495
physician;	6496
(2) Maintaining an active medical staff, the majority of	6497
which is comprised of osteopathic physicians;	6498
(3) Maintaining a medical staff executive committee that has	6499
osteopathic physicians as a majority of its members.	6500
(Q) "Ambulatory surgical facility" has the same meaning as in	6501
section 3702.30 of the Revised Code.	6502
(R) Except as otherwise provided in division (T) of this	6503
section, and until the termination date specified in section	6504
3702.511 of the Revised Code, "reviewable activity" means any of	6505
the following:	6506
(1) The addition by any person of any of the following health	6507
services, regardless of the amount of operating costs or capital	6508

expenditures:	6509
(a) A heart, heart-lung, lung, liver, kidney, bowel, pancreas, or bone marrow transplantation service, a stem cell harvesting and reinfusion service, or a service for transplantation of any other organ unless transplantation of the organ is designated by public health council rule not to be a reviewable activity;	6510 6511 6512 6513 6514 6515
(b) A cardiac catheterization service;	6516
(c) An open-heart surgery service;	6517
(d) Any new, experimental medical technology that is designated by rule of the public health council.	6518 6519
(2) The acceptance of high-risk patients, as defined in rules adopted under section 3702.57 of the Revised Code, by any cardiac catheterization service that was initiated without a certificate of need pursuant to division (R)(3)(b) of the version of this section in effect immediately prior to April 20, 1995;	6520 6521 6522 6523 6524
(3)(a) The establishment, development, or construction of a new health care facility other than a new long-term care facility or a new hospital;	6525 6526 6527
(b) The establishment, development, or construction of a new hospital or the relocation of an existing hospital;	6528 6529
(c) The relocation of hospital beds, other than long-term care, perinatal, or pediatric intensive care beds, into or out of a rural area.	6530 6531 6532
(4)(a) The replacement of an existing hospital;	6533
(b) The replacement of an existing hospital obstetric or newborn care unit or freestanding birthing center.	6534 6535
(5)(a) The renovation of a hospital that involves a capital expenditure, obligated on or after the effective date of this	6536 6537

amendment, of five million dollars or more, not including 6538  
expenditures for equipment, staffing, or operational costs. For 6539  
purposes of division (R)(5)(a) of this section, a capital 6540  
expenditure is obligated: 6541

(i) When a contract enforceable under Ohio law is entered 6542  
into for the construction, acquisition, lease, or financing of a 6543  
capital asset; 6544

(ii) When the governing body of a hospital takes formal 6545  
action to commit its own funds for a construction project 6546  
undertaken by the hospital as its own contractor; 6547

(iii) In the case of donated property, on the date the gift 6548  
is completed under applicable Ohio law. 6549

(b) The renovation of a hospital obstetric or newborn care 6550  
unit or freestanding birthing center that involves a capital 6551  
expenditure of five million dollars or more, not including 6552  
expenditures for equipment, staffing, or operational costs. 6553

(6) Any change in the health care services, bed capacity, or 6554  
site, or any other failure to conduct the reviewable activity in 6555  
substantial accordance with the approved application for which a 6556  
certificate of need was granted, if the change is made prior to 6557  
the date the activity for which the certificate was issued ceases 6558  
to be a reviewable activity; 6559

(7) Any of the following changes in perinatal bed capacity or 6560  
pediatric intensive care bed capacity: 6561

(a) An increase in bed capacity; 6562

(b) A change in service or service-level designation of 6563  
newborn care beds or obstetric beds in a hospital or freestanding 6564  
birthing center, other than a change of service that is provided 6565  
within the service-level designation of newborn care or obstetric 6566  
beds as registered by the department of health; 6567

(c) A relocation of perinatal or pediatric intensive care beds from one physical facility or site to another, excluding the relocation of beds within a hospital or freestanding birthing center or the relocation of beds among buildings of a hospital or freestanding birthing center at the same site.

(8) The expenditure of more than one hundred ten per cent of the maximum expenditure specified in a certificate of need;

(9) Any transfer of a certificate of need issued prior to April 20, 1995, from the person to whom it was issued to another person before the project that constitutes a reviewable activity is completed, any agreement that contemplates the transfer of a certificate of need issued prior to that date upon completion of the project, and any transfer of the controlling interest in an entity that holds a certificate of need issued prior to that date. However, the transfer of a certificate of need issued prior to that date or agreement to transfer such a certificate of need from the person to whom the certificate of need was issued to an affiliated or related person does not constitute a reviewable transfer of a certificate of need for the purposes of this division, unless the transfer results in a change in the person that holds the ultimate controlling interest in the certificate of need.

(10)(a) The acquisition by any person of any of the following medical equipment, regardless of the amount of operating costs or capital expenditure:

(i) A cobalt radiation therapy unit;

(ii) A linear accelerator;

(iii) A gamma knife unit.

(b) The acquisition by any person of medical equipment with a cost of two million dollars or more. The cost of acquiring medical

equipment includes the sum of the following:	6598
(i) The greater of its fair market value or the cost of its lease or purchase;	6599 6600
(ii) The cost of installation and any other activities essential to the acquisition of the equipment and its placement into service.	6601 6602 6603
(11) The addition of another cardiac catheterization laboratory to an existing cardiac catheterization service.	6604 6605
(S) Except as provided in division (T) of this section, "reviewable activity" also means any of the following activities, none of which are subject to a termination date:	6606 6607 6608
(1) The establishment, development, or construction of a new long-term care facility;	6609 6610
(2) The replacement of an existing long-term care facility;	6611
(3) The renovation of a long-term care facility that involves a capital expenditure of two million dollars or more, not including expenditures for equipment, staffing, or operational costs;	6612 6613 6614 6615
(4) Any of the following changes in long-term care bed capacity:	6616 6617
(a) An increase in bed capacity;	6618
(b) A relocation of beds from one physical facility or site to another, excluding the relocation of beds within a long-term care facility or among buildings of a long-term care facility at the same site;	6619 6620 6621 6622
(c) A recategorization of hospital beds registered under section 3701.07 of the Revised Code from another registration category to skilled nursing beds or long-term care beds.	6623 6624 6625
(5) Any change in the health services, bed capacity, or site,	6626

or any other failure to conduct the reviewable activity in 6627  
substantial accordance with the approved application for which a 6628  
certificate of need concerning long-term care beds was granted, if 6629  
the change is made within five years after the implementation of 6630  
the reviewable activity for which the certificate was granted; 6631

(6) The expenditure of more than one hundred ten per cent of 6632  
the maximum expenditure specified in a certificate of need 6633  
concerning long-term care beds; 6634

(7) Any transfer of a certificate of need that concerns 6635  
long-term care beds and was issued prior to April 20, 1995, from 6636  
the person to whom it was issued to another person before the 6637  
project that constitutes a reviewable activity is completed, any 6638  
agreement that contemplates the transfer of such a certificate of 6639  
need upon completion of the project, and any transfer of the 6640  
controlling interest in an entity that holds such a certificate of 6641  
need. However, the transfer of a certificate of need that concerns 6642  
long-term care beds and was issued prior to April 20, 1995, or 6643  
agreement to transfer such a certificate of need from the person 6644  
to whom the certificate was issued to an affiliated or related 6645  
person does not constitute a reviewable transfer of a certificate 6646  
of need for purposes of this division, unless the transfer results 6647  
in a change in the person that holds the ultimate controlling 6648  
interest in the certificate of need. 6649

(T) "Reviewable activity" does not include any of the 6650  
following activities: 6651

(1) Acquisition of computer hardware or software; 6652

(2) Acquisition of a telephone system; 6653

(3) Construction or acquisition of parking facilities; 6654

(4) Correction of cited deficiencies that are in violation of 6655  
federal, state, or local fire, building, or safety laws and rules 6656

and that constitute an imminent threat to public health or safety; 6657  
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(5) Acquisition of an existing health care facility that does 6659  
not involve a change in the number of the beds, by service, or in 6660  
the number or type of health services; 6661

(6) Correction of cited deficiencies identified by 6662  
accreditation surveys of the joint commission on accreditation of 6663  
healthcare organizations or of the American osteopathic 6664  
association; 6665

(7) Acquisition of medical equipment to replace the same or 6666  
similar equipment for which a certificate of need has been issued 6667  
if the replaced equipment is removed from service; 6668

(8) Mergers, consolidations, or other corporate 6669  
reorganizations of health care facilities that do not involve a 6670  
change in the number of beds, by service, or in the number or type 6671  
of health services; 6672

(9) Construction, repair, or renovation of bathroom 6673  
facilities; 6674

(10) Construction of laundry facilities, waste disposal 6675  
facilities, dietary department projects, heating and air 6676  
conditioning projects, administrative offices, and portions of 6677  
medical office buildings used exclusively for physician services; 6678

(11) Acquisition of medical equipment to conduct research 6679  
required by the United States food and drug administration or 6680  
clinical trials sponsored by the national institute of health. Use 6681  
of medical equipment that was acquired without a certificate of 6682  
need under division (T)(11) of this section and for which 6683  
premarket approval has been granted by the United States food and 6684  
drug administration to provide services for which patients or 6685  
reimbursement entities will be charged shall be a reviewable 6686  
activity. 6687

(12) Removal of asbestos from a health care facility.	6688
Only that portion of a project that meets the requirements of division (T) of this section is not a reviewable activity.	6689 6690
(U) "Small rural hospital" means a hospital that is located within a rural area, has fewer than one hundred beds, and to which fewer than four thousand persons were admitted during the most recent calendar year.	6691 6692 6693 6694
(V) "Children's hospital" means any of the following:	6695
(1) A hospital registered under section 3701.07 of the Revised Code that provides general pediatric medical and surgical care, and in which at least seventy-five per cent of annual inpatient discharges for the preceding two calendar years were individuals less than eighteen years of age;	6696 6697 6698 6699 6700
(2) A distinct portion of a hospital registered under section 3701.07 of the Revised Code that provides general pediatric medical and surgical care, has a total of at least one hundred fifty registered pediatric special care and pediatric acute care beds, and in which at least seventy-five per cent of annual inpatient discharges for the preceding two calendar years were individuals less than eighteen years of age;	6701 6702 6703 6704 6705 6706 6707
(3) A distinct portion of a hospital, if the hospital is registered under section 3701.07 of the Revised Code as a children's hospital and the children's hospital meets all the requirements of division (V)(1) of this section.	6708 6709 6710 6711
(W) "Long-term care facility" means any of the following:	6712
(1) A nursing home licensed under section 3721.02 of the Revised Code or by a political subdivision certified under section 3721.09 of the Revised Code;	6713 6714 6715
(2) The portion of any facility, including a county home or county nursing home, that is certified as a skilled nursing	6716 6717

facility or a nursing facility under Title XVIII or XIX of the 6718  
"Social Security Act"; 6719

(3) The portion of any hospital that contains beds registered 6720  
under section 3701.07 of the Revised Code as skilled nursing beds 6721  
or long-term care beds. 6722

(X) "Long-term care bed" means a bed in a long-term care 6723  
facility. 6724

(Y) "Perinatal bed" means a bed in a hospital that is 6725  
registered under section 3701.07 of the Revised Code as a newborn 6726  
care bed or obstetric bed, or a bed in a freestanding birthing 6727  
center. 6728

(Z) "Freestanding birthing center" means any facility in 6729  
which deliveries routinely occur, regardless of whether the 6730  
facility is located on the campus of another health care facility, 6731  
and which is not licensed under Chapter 3711. of the Revised Code 6732  
as a level one, two, or three maternity unit or a limited 6733  
maternity unit. 6734

(AA)(1) "Reviewability ruling" means a ruling issued by the 6735  
director of health under division (A) of section 3702.52 of the 6736  
Revised Code as to whether a particular proposed project is or is 6737  
not a reviewable activity. 6738

(2) "Nonreviewability ruling" means a ruling issued under 6739  
that division that a particular proposed project is not a 6740  
reviewable activity. 6741

(BB)(1) "Metropolitan statistical area" means an area of this 6742  
state designated a metropolitan statistical area or primary 6743  
metropolitan statistical area in United States office of 6744  
management and budget bulletin No. 93-17, June 30, 1993, and its 6745  
attachments. 6746

(2) "Rural area" means any area of this state not located 6747

within a metropolitan statistical area.

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**Sec. 3702.62.** (A) Any action pursuant to section 140.03,  
140.04, 140.05, 307.091, 313.21, 339.01, 339.021, 339.03, 339.06,  
339.08, 339.09, 339.12, 339.14, 339.21, 339.231, 339.24, 339.31,  
339.36, 339.39, 513.05, 513.07, 513.08, 513.081, 513.12, 513.15,  
513.17, 513.171, 749.02, 749.14, 749.16, 749.20, 749.25, 749.28,  
749.35, ~~1742.06~~ 1751.06, or 3707.29 of the Revised Code shall be  
taken in accordance with sections 3702.51 to 3702.61 of the  
Revised Code.

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(B) A nursing home certified as an intermediate care facility  
for the mentally retarded under Title XIX of the "Social Security  
Act," 49 Stat. 620 (1935), 42 U.S.C.A. 301, as amended, that is  
required to apply for licensure as a residential facility under  
section 5123.19 of the Revised Code is not, with respect to the  
portion of the home certified as an intermediate care facility for  
the mentally retarded, subject to sections 3702.51 to 3702.61 of  
the Revised Code.

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**Sec. 3709.16.** The board of health of a city or general health  
district shall determine the duties and fix the salaries of its  
employees.

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No member of the board shall be appointed as health officer  
or ward physician.

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The board of health of any health district may procure and  
pay all or any part of the cost of group life, hospitalization,  
surgical, major medical, sickness and accident insurance, or a  
combination of any of the foregoing types of insurance or  
coverage, for the health commissioner, the employees of the health  
district, and their immediate dependents, from the funds or  
budgets from which said health commissioner or employees are  
compensated for services, issued by an insurance company or

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~~nonprofit medical care~~ a health insuring corporation duly 6778  
authorized to do business in this state. 6779

Notwithstanding section 3917.01 of the Revised Code, the 6780  
board of health of any health district may purchase group life 6781  
insurance authorized by this section by reason of payment of 6782  
premiums therefor by the board from its funds, and such group life 6783  
insurance may be issued and purchased if otherwise consistent with 6784  
sections 3917.01 to 3917.06 of the Revised Code. 6785

**Sec. 3729.12.** Not later than a date specified by the director 6786  
of health, the Ohio health care data center shall make its first 6787  
submission of a report containing the health care information 6788  
specified in this section to the governor, the speaker of the 6789  
house of representatives, the president of the senate, and the 6790  
chairpersons of the standing committees of the house of 6791  
representatives and the senate that have primary responsibility 6792  
for the consideration of health legislation. Each year thereafter, 6793  
the data center shall submit a report not later than the 6794  
thirty-first day of December. The report shall contain, to the 6795  
extent possible with the data collected under sections 3729.15 to 6796  
3729.45 of the Revised Code, an analysis of all of the following: 6797  
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(A) The one hundred high priority diagnoses and one hundred 6799  
high priority medical procedures that account for eighty per cent 6800  
of public and private health care costs in this state, and 6801  
diagnoses and medical procedures for which a disproportionate 6802  
share of public and private expenditures are consumed relative to 6803  
the total number of diseases diagnosed and medical procedures 6804  
performed; 6805

(B) The relationship between: 6806

(1) Health care costs, access, outcomes, continuity of care, 6807  
and professional practice patterns for selected diseases and 6808

procedures;	6809
(2) An individual's source of payment, age, geographic location, sex, race, and income.	6810 6811
(C) The differences in administrative expenses for delivery of health care in the public sector versus the private sector;	6812 6813
(D)(1) Compared to previous years when appropriate data were collected, the increase in expenditures that has occurred in the public health care programs in each of the following categories:	6814 6815 6816
(a) Long-term care facilities;	6817
(b) Hospital inpatient services;	6818
(c) Hospital outpatient services;	6819
(d) Home-based health care;	6820
(e) Physicians' services;	6821
(f) Allied health services;	6822
(g) Pharmaceuticals;	6823
(h) Durable medical equipment and medical and surgical products;	6824 6825
(i) Mental health services;	6826
(j) Other health services selected by the director of health.	6827 6828
(2) The factors that have contributed to the expenditure increases in each of the categories specified by division (D)(1) of this section.	6829 6830 6831
(E) The extent to which physicians and other health care providers selected by the director participate in public versus private health care programs, and changes in this participation from previous years when appropriate data were collected;	6832 6833 6834 6835
(F) The distribution of emergency medical services among the	6836

population of this state, and the relationship between:	6837
(1) Access to emergency medical services;	6838
(2) An individual's source of payment, age, geographic location, sex, race, and income.	6839 6840
(G) The number of residents of this state who are uninsured or underinsured with respect to health care, the distribution of this population by county, the demographic characteristics, including employment status, of this population, and the changes in those demographic characteristics from previous years when appropriate data were collected;	6841 6842 6843 6844 6845 6846
(H) The percentage of individuals who seek or register for health care services that:	6847 6848
(1) Are diagnosed or treated;	6849
(2) Are denied services;	6850
(3) Receive primary care services from emergency facilities.	6851
(I) The differences between primary care case managed systems and other managed health care reimbursement systems in health care costs and outcomes for one hundred high priority diseases or procedures selected by the director, access to health care, and professional practice patterns and variations, and the factors that contribute to those differences;	6852 6853 6854 6855 6856 6857
(J) The relationship between:	6858
(1) Long-term care facility admission, transfer, and length-of-stay;	6859 6860
(2) An individual's source of payment, age, geographic location, sex, race, and income.	6861 6862
(K) The percentage of hospitals' uncompensated care, including uncompensated care provided by group practices as defined in section 4731.65 of the Revised Code that have one	6863 6864 6865

hundred members or more, that is attributable to each of the	6866
following:	6867
(1) Charity care;	6868
(2) Courtesy care;	6869
(3) Contractual allowances;	6870
(4) The medical assistance program;	6871
(5) The medicare program;	6872
(6) Bad debts.	6873
(L) The relationship between the number and type of	6874
pharmaceutical prescriptions and each of the following:	6875
(1) An individual's source of payment, age, geographic	6876
location, and sex;	6877
(2) Use of a therapeutic formulary by disease category.	6878
(M) The extent to which physicians and other health care	6879
providers selected by the director provide primary care services	6880
to indigent individuals and the type of primary care services	6881
provided;	6882
(N) Public or private provider reimbursement strategies that	6883
have been effective in containing health care costs;	6884
(O) The effectiveness of quality improvement programs	6885
introduced by health care organizations, including health	6886
<del>maintenance organizations</del> <u>insuring corporations</u> and independent	6887
practice associations, or health care plans in improving the	6888
general quality of health care in this state;	6889
(P) The comparison of health care costs, access, outcomes,	6890
continuity of care, and professional practice patterns in this	6891
state with other states and countries;	6892
(Q) State and local statutes, ordinances, or rules that may	6893

contribute to health care cost increases and suggested changes in 6894  
the regulatory framework to reduce costs without adversely 6895  
affecting quality or access; 6896

(R) The increase in health care costs that can be attributed 6897  
to increases in malpractice insurance premiums and increases in 6898  
the practice of defensive medicine; 6899

(S) The total number of visits by medical assistance program 6900  
recipients and medicare beneficiaries to clinics versus primary 6901  
care health care practitioner offices in this state, categorized 6902  
by type of clinic or primary care practitioner and diagnosis; 6903

(T) Variations in treatment, costs, and medical outcome of a 6904  
range of diagnoses selected by the director according to 6905  
practitioner specialty versus primary care case management with 6906  
global fees and comparison of individuals' source of payment, age, 6907  
geographic location, sex, race, and income; 6908

(U) The major components of the cost of long-term care 6909  
facilities and the variations in the costs of the components 6910  
according to diagnosis, the resident's level of functioning, 6911  
facility size and geographic location, and source of payment; 6912

(V) Factors that account for increases in the utilization of 6913  
long-term care facilities in comparison with home and community 6914  
outpatient care; 6915

(W) The effect of health care utilization and costs on the 6916  
general health of residents of this state and the effect of 6917  
~~behaviorial~~ behavioral risk factors, including tobacco use, 6918  
alcohol and substance abuse, lack of exercise, being overweight, 6919  
and other factors selected by the director; 6920

(X) The effect of utilization of preventive health care 6921  
services on health care costs and outcomes, categorized by age, 6922  
occupation, and type of health care coverage; 6923

(Y) The number of individuals in each county who received 6924  
services the previous calendar year from a public health care 6925  
program administered in whole or in part by the department of 6926  
mental retardation and developmental disabilities or a county 6927  
board of mental retardation and developmental disabilities, 6928  
compared to the number of individuals in each county who applied 6929  
and were found eligible for those services that year but did not 6930  
receive them; 6931

(Z) The number of individuals in each county that received 6932  
services the previous calendar year from a public health care 6933  
program administered in whole or in part by the department of 6934  
mental health, a community mental health board, or a board of 6935  
alcohol, drug abuse, and mental health services, compared to the 6936  
number of individuals in each county who applied and were found 6937  
eligible for those services that year but did not receive them. 6938

The report must comply with section 3729.46 of the Revised 6939  
Code. 6940

**Sec. 3901.04.** (A) As used in this section: 6941

(1) "Laws of this state relating to insurance" include but 6942  
are not limited to ~~Chapters 1736., 1737., 1738., 1739.~~ 6943  
~~notwithstanding section 1739.02, 1740., and 1742. Chapter 1751.~~ 6944  
notwithstanding section ~~1742.30~~ 1751.08, Title XXXIX, sections 6945  
5725.18 to 5725.25, and Chapter 5729. of the Revised Code. 6946

(2) "Person" has the meaning defined in division (A) of 6947  
section 3901.19 of the Revised Code. 6948

(B) Whenever it appears to the superintendent of insurance, 6949  
from ~~his~~ the superintendent's files, upon complaint or otherwise, 6950  
that any person has engaged in, is engaged in, or is about to 6951  
engage in any act or practice declared to be illegal or prohibited 6952  
by the laws of this state relating to insurance, or defined as 6953

unfair or deceptive by such laws, or when the superintendent 6954  
believes it to be in the best interest of the public and necessary 6955  
for the protection of the people in this state, the superintendent 6956  
or anyone designated by the superintendent under ~~his~~ the 6957  
superintendent's official seal may do any one or more of the 6958  
following: 6959

(1) Require any person to file with the superintendent, on a 6960  
form that is appropriate for review by the superintendent, an 6961  
original or additional statement or report in writing, under oath 6962  
or otherwise, as to any facts or circumstances concerning the 6963  
person's conduct of the business of insurance within this state 6964  
and as to any other information that the superintendent considers 6965  
to be material or relevant to such business; 6966

(2) Administer oaths, summon and compel by order or subpoena 6967  
the attendance of witnesses to testify in relation to any matter 6968  
which, by the laws of this state relating to insurance, is the 6969  
subject of inquiry and investigation, and require the production 6970  
of any book, paper, or document pertaining to such matter. A 6971  
subpoena, notice, or order under this section may be served by 6972  
certified mail, return receipt requested. If the subpoena, notice, 6973  
or order is returned because of inability to deliver, or if no 6974  
return is received within thirty days of the date of mailing, the 6975  
subpoena, notice, or order may be served by ordinary mail. If no 6976  
return of ordinary mail is received within thirty days after the 6977  
date of mailing, service shall be deemed to have been made. If the 6978  
subpoena, notice, or order is returned because of inability to 6979  
deliver, the superintendent may designate a person or persons to 6980  
effect either personal or residence service upon the witness. 6981  
Service of any subpoena, notice, or order and return may also be 6982  
made in any manner authorized under the Rules of Civil Procedure. 6983  
Such service shall be made by an employee of the department 6984  
designated by the superintendent, a sheriff, a deputy sheriff, an 6985

attorney, or any person authorized by the Rules of Civil Procedure 6986  
to serve process. 6987

In the case of disobedience of any notice, order, or subpoena 6988  
served on a person or the refusal of a witness to testify to a 6989  
matter regarding which ~~he~~ the person may lawfully be interrogated, 6990  
the court of common pleas of the county where venue is 6991  
appropriate, on application by the superintendent, may compel 6992  
obedience by attachment proceedings for contempt, as in the case 6993  
of disobedience of the requirements of a subpoena issued from such 6994  
court, or a refusal to testify therein. Witnesses shall receive 6995  
the fees and mileage allowed by section 2335.06 of the Revised 6996  
Code. All such fees, upon the presentation of proper vouchers 6997  
approved by the superintendent, shall be paid out of the 6998  
appropriation for the contingent fund of the department of 6999  
insurance. The fees and mileage of witnesses not summoned by the 7000  
superintendent or ~~his~~ the superintendent's designee shall not be 7001  
paid by the state. 7002

(3) In a case in which there is no administrative procedure 7003  
available to the superintendent to resolve a matter at issue, 7004  
request the attorney general to commence an action for a 7005  
declaratory judgment under Chapter 2721. of the Revised Code with 7006  
respect to the matter. 7007

(4) Initiate criminal proceedings by presenting evidence of 7008  
the commission of any criminal offense established under the laws 7009  
of this state relating to insurance to the prosecuting attorney of 7010  
any county in which the offense may be prosecuted. At the request 7011  
of the prosecuting attorney, the attorney general may assist in 7012  
the prosecution of the violation with all the rights, privileges, 7013  
and powers conferred by law on prosecuting attorneys including, 7014  
but not limited to, the power to appear before grand juries and to 7015  
interrogate witnesses before grand juries. 7016

**Sec. 3901.041.** The superintendent of insurance shall adopt, 7017  
amend, and rescind rules and make adjudications, necessary to 7018  
discharge ~~his~~ the superintendent's duties and exercise ~~his~~ the 7019  
superintendent's powers, including, but not limited to, ~~his~~ the 7020  
superintendent's duties and powers under ~~Chapters 1737., 1738.,~~ 7021  
~~and 1740.~~ Chapter 1751. and Title XXXIX of the Revised Code, 7022  
subject to ~~sections 119.01 to 119.13~~ Chapter 119. of the Revised 7023  
Code. 7024

**Sec. 3901.043.** The superintendent of insurance may adopt 7025  
rules in accordance with Chapter 119. of the Revised Code to 7026  
establish reasonable fees for any service or transaction performed 7027  
by the department of insurance pursuant to section ~~1738.04,~~ 7028  
~~1742.03~~ 1751.03, 3901.321, 3901.341, 3907.09, 3907.10, 3907.11, 7029  
3907.12, 3911.011, 3913.31, 3915.14, 3917.06, 3918.07, 3923.02, 7030  
3935.04, 3937.03, 3953.28, 3957.12, or 3957.13 of the Revised Code 7031  
or any provision in sections 3913.01 to 3913.23 or in Chapter 7032  
3905. of the Revised Code, if no fee is otherwise provided under 7033  
Title XVII or XXXIX of the Revised Code for such service or 7034  
transaction. Any fee collected pursuant to those rules shall be 7035  
paid into the state treasury to the credit of the department of 7036  
insurance operating fund. 7037

**Sec. 3901.071.** All moneys collected by the superintendent of 7038  
insurance for expenses incurred by ~~him~~ the superintendent in 7039  
conducting examinations pursuant to the Revised Code of the 7040  
financial affairs of any insurance company doing business in this 7041  
state, for which the insurance company examined is required to pay 7042  
the costs, shall be paid to the superintendent. The superintendent 7043  
shall deposit the money in the state treasury to the credit of the 7044  
superintendent's examination fund, which is hereby established. 7045  
Any funds expended or obligated therefrom by the superintendent 7046

shall be expended or obligated solely for defrayment of the costs 7047  
of examinations of the financial affairs of insurance companies 7048  
made by the superintendent pursuant to the Revised Code. For 7049  
purposes of this section, "insurance company" means any domestic 7050  
or foreign stock company, risk retention group, mutual company, 7051  
mutual protective association, fraternal benefit society, 7052  
reciprocal or inter-insurance exchange, ~~nonprofit medical care~~ 7053  
~~corporation,~~ and health care insuring corporation, ~~and nonprofit~~ 7054  
~~dental care corporation,~~ regardless of the type of coverage 7055  
written, benefits provided, or guarantees made by each. 7056

**Sec. 3901.16.** Any association, company, or corporation, 7057  
including a health insuring corporation, which violates any law 7058  
relating to the superintendent of insurance, any provision of 7059  
Chapter 1751. Of the Revised Code, or any insurance law of this 7060  
state, for the violation of which no forfeiture or penalty is 7061  
elsewhere provided in the Revised Code, shall forfeit and pay not 7062  
less than one thousand nor more than ten thousand dollars, to be 7063  
recovered by an action in the name of the state and on collection 7064  
to be paid to the superintendent, who shall pay such sum into the 7065  
state treasury. 7066

**Sec. 3901.19.** As used in sections 3901.19 to 3901.26 of the 7067  
Revised Code: 7068

(A) "Person" means any individual, corporation, association, 7069  
partnership, reciprocal exchange, inter-insurer, fraternal benefit 7070  
society, title guarantee and trust company, ~~prepaid dental plan~~ 7071  
~~organization,~~ ~~medical care corporation,~~ health care insuring 7072  
corporation, ~~dental care corporation,~~ ~~health maintenance~~ 7073  
~~organization incorporated under Chapter 1735., 1736., 1737.,~~ 7074  
~~1738., 1740., or 1742. of the Revised Code,~~ and any other legal 7075  
entity. 7076

(B) "Residents" includes any individual, partnership, or corporation. 7077  
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(C) "Maternity benefits" means those benefits calculated to indemnify the insured for hospital and medical expenses fairly and reasonably associated with a pregnancy and childbirth. 7079  
7080  
7081

(D) "Insurance" includes, but is not limited to, any policy or contract offered, issued, sold, or marketed by an insurer, corporation, association, organization, or entity regulated by the superintendent of insurance or doing business in this state. 7082  
7083  
7084  
7085  
Nothing in any other section of the Revised Code shall be construed to exclude single premium deferred annuities from the regulation of the superintendent under sections 3901.19 to 3901.26 of the Revised Code. 7086  
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**Sec. 3901.31.** (A) Every person who is directly or indirectly the beneficial owner of more than ten per cent of any class of any equity security of a domestic stock insurance company which is not a wholly owned subsidiary of an insurance holding company system or who is a director or officer of such company, shall file with the superintendent of insurance within ten days after ~~he~~ the person becomes such beneficial owner, director, or officer, a statement in such form as the superintendent of insurance may prescribe, of the amount of all equity securities of such company of which ~~he~~ the person is the beneficial owner, and within ten days after the close of each calendar month thereafter, if there has been a change in such ownership during such month, shall file with the superintendent of insurance a statement, in such form as the superintendent of insurance may prescribe, indicating ~~his~~ the person's ownership at the close of the calendar month and such changes in ~~his~~ the person's ownership as have occurred during such calendar month. 7090  
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(B) For the purpose of preventing the unfair use of 7107

information which may have been obtained by such beneficial owner, 7108  
director, or officer by reason of ~~his~~ the beneficial owner's, 7109  
director's, or officer's relationship to such company, any profit 7110  
realized by ~~him~~ the beneficial owner, director, or officer from 7111  
any purchase and sale, or any sale and purchase, of any equity 7112  
security of such company within any period of less than six 7113  
months, unless such security was acquired in good faith in 7114  
connection with a debt previously contracted, shall inure to and 7115  
be recoverable by the company, irrespective of any intention on 7116  
the part of such beneficial owner, director, or officer in 7117  
entering into such transaction of holding the security purchased 7118  
or of not repurchasing the security sold for a period exceeding 7119  
six months. Suit to recover such profit may be instituted at law 7120  
or in equity in any court of competent jurisdiction by the 7121  
company, or by the owner of any security of the company in the 7122  
name and in behalf of the company if the company fails or refuses 7123  
to bring such suit within sixty days after request or fails 7124  
diligently to prosecute the same thereafter; but no such suit 7125  
shall be brought more than two years after the date such profit 7126  
was realized. Division (B) of this section shall not be construed 7127  
to cover any transaction where such beneficial owner was not such 7128  
both at the time of purchase and sale, or the sale and purchase, 7129  
of the security involved, or any transaction or transactions which 7130  
the superintendent of insurance by rules may exempt as not 7131  
comprehended within the purpose of division (B) of this section. 7132

(C) No such beneficial owner, director, or officer, directly 7133  
or indirectly, shall sell any equity security of such company if 7134  
the person selling the security or ~~his~~ the person's principal does 7135  
not own the security sold, or if owning the security, does not 7136  
deliver it against such sale within twenty days thereafter, or 7137  
does not within five days after such sale deposit it in the mails 7138  
or other usual channels of transportation; but no person shall be 7139

deemed to have violated division (C) of this section if ~~he~~ the 7140  
person proves that notwithstanding the exercise of good faith ~~he~~ 7141  
the person was unable to make such delivery or deposit within such 7142  
time, or that to do so would cause undue inconvenience or expense. 7143

(D) A domestic insurance company having at least fifty 7144  
shareholders or any other person soliciting proxies with respect 7145  
to such domestic insurance company shall not solicit voting 7146  
proxies from any shareholder or other person except upon a proxy 7147  
statement and pursuant to a notice of meeting, which statement and 7148  
notice have been submitted to the superintendent of insurance at 7149  
least ten days prior to being mailed to the intended recipients. 7150  
Such proxy statement and notice of meeting shall make such 7151  
disclosures pertinent to the business to be carried on at the 7152  
meeting or meetings with respect to which such proxies are 7153  
solicited and such notices are given as the superintendent by rule 7154  
requires. The superintendent shall retain such proxy material for 7155  
examination by any interested party for at least one year. 7156

(E) Division (B) of this section does not apply to any 7157  
purchase and sale, or sale and purchase, and division (C) of this 7158  
section does not apply to any sale, of an equity security of a 7159  
domestic stock insurance company not then or theretofore held ~~by~~ 7160  
~~him~~ in an investment account, by a dealer in the ordinary course 7161  
of ~~his~~ the dealer's business and incident to the establishment or 7162  
maintenance by ~~him~~ the dealer of a primary or secondary market for 7163  
such security. The superintendent of insurance may, by such rules 7164  
as ~~he~~ the superintendent considers necessary or appropriate in the 7165  
public interest, describe and define the terms and conditions with 7166  
respect to securities held in an investment account and 7167  
transactions made in the ordinary course of business and incident 7168  
to the establishment or maintenance of a primary or secondary 7169  
market. 7170

(F) Divisions (A), (B), and (C) of this section do not apply 7171

to foreign or domestic arbitrage transactions unless made in 7172  
contravention of such rules as the superintendent of insurance may 7173  
adopt in order to carry out the purposes of this section. 7174

(G) "Equity security" when used in this section means any 7175  
stock or similar security; or any security convertible, with or 7176  
without consideration, into such a security, or carrying any 7177  
warrant or right to subscribe to or purchase such a security; or 7178  
any such warrant or right; or any other security which the 7179  
superintendent of insurance determines to be of similar nature and 7180  
considers necessary or appropriate, by such rules as ~~he~~ the 7181  
superintendent may prescribe in the public interest or for the 7182  
protection of investors, to treat as an equity security. 7183

(H) The superintendent of insurance may adopt, amend, and 7184  
rescind rules, pursuant to Chapter 119. of the Revised Code, which 7185  
will enable ~~him~~ the superintendent to carry out the duties imposed 7186  
~~upon him~~ by this section. 7187

(I) This section applies to health insuring corporations in 7188  
the same manner in which this section applies to domestic stock 7189  
insurance companies. 7190

**Sec. 3901.32.** As used in sections 3901.32 to 3901.37 of the 7191  
Revised Code: 7192

(A) "Affiliate of" or "affiliated with" a specific person 7193  
means a person that, directly or indirectly, through one or more 7194  
intermediaries, controls, is controlled by, or is under common 7195  
control with, the person specified. 7196

(B) "Control," including "controlling," "controlled by," and 7197  
"under common control with," means the possession, direct or 7198  
indirect, of the power to direct or cause the direction of the 7199  
management and policies of a person, whether through the ownership 7200  
of voting securities, by contract other than a commercial contract 7201

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. Control shall be presumed to exist if  
any person, directly or indirectly, owns, controls, holds with the  
power to vote, or holds proxies representing, ten per cent or more  
of the voting securities of any other person. This presumption may  
be rebutted by a showing made in the manner provided in division  
(J) of section 3901.33 of the Revised Code that control does not  
exist in fact. The superintendent of insurance may determine,  
after furnishing all persons in interest notice and opportunity to  
be heard and making specific findings of fact to support such  
determination, that control exists in fact, notwithstanding the  
absence of a presumption to that effect.

(C) "Insurance holding company system" means two or more  
affiliated persons, one or more of which is an insurer.

(D) "Insurer" means any person engaged in the business of  
insurance, guaranty, or membership, an inter-insurance exchange, a  
mutual or fraternal benefit society, ~~a prepaid dental plan  
organization, a health maintenance organization, a medical care,  
or a health care, or dental care~~ insuring corporation, excepting  
any agency, authority, or instrumentality of the United States,  
its possessions and territories, the Commonwealth of Puerto Rico,  
the District of Columbia, or a state or political subdivision of a  
state.

(E) "Person" means an individual, a corporation, a  
partnership, an association, a joint stock company, a trust, an  
unincorporated organization, any similar entity, or any  
combination of the foregoing acting in concert.

(F) "Subsidiary" of a specified person is an affiliate  
controlled by such person, directly or indirectly, through one or  
more intermediaries.

(G) "Voting security" includes any security convertible into 7233  
or evidencing a right to acquire a voting security. 7234

**Sec. 3901.38.** (A) As used in this section: 7235

(1) "Beneficiary" means any policyholder, subscriber, member, 7236  
employee, or other person who is eligible for benefits under a 7237  
benefits contract. 7238

(2) "Benefits contract" means a sickness and accident 7239  
insurance policy providing hospital, surgical, or medical expense 7240  
coverage, or a health maintenance organization insuring 7241  
corporation contract, ~~preferred provider organization contract,~~ or 7242  
other policy or agreement under which a third-party payer agrees 7243  
to reimburse for covered health care or dental services rendered 7244  
to beneficiaries, up to the limits and exclusions contained in the 7245  
benefits contract. 7246

(3) "Completed claim" means a proof of loss or a claim for 7247  
payment for health care services which has been submitted to the 7248  
appropriate claims processing office of the third-party payer 7249  
accompanied by sufficient documentation for the third-party payer 7250  
to determine proof of loss and reasonably required by the 7251  
third-party payer to accept or reject the claim. 7252

(4) "Hospital" has the same meaning set forth in section 7253  
3727.01 of the Revised Code. 7254

(5) "Proof of loss" means a claim for payment for health care 7255  
services which has been submitted to the appropriate claims 7256  
processing office of the third-party payer accompanied by 7257  
sufficient documentation for the third-party payer to determine 7258  
benefits payable under the benefits contract and reasonably 7259  
required by the third-party payer to accept or reject the claim. 7260

(6) "Provider" means a hospital, nursing home, physician, 7261  
podiatrist, dentist, pharmacist, chiropractor, or other licensed 7262

health care provider entitled to reimbursement by a third-party	7263
payer for services rendered to a beneficiary under a benefits	7264
contract.	7265
(7) "Reimburse" means indemnify, make payment, or otherwise	7266
accept responsibility for payment for health care services	7267
rendered to a beneficiary, or arrange for the provision of health	7268
care services to a beneficiary.	7269
(8) "Third-party payer" means any of the following:	7270
(a) An insurance company;	7271
(b) A health <del>maintenance organization</del> <u>insuring corporation</u> ;	7272
(c) A preferred provider organization;	7273
(d) A labor organization;	7274
(e) An employer;	7275
(f) <del>A prepaid dental plan organization</del> <u>An intermediary</u>	7276
<u>organization, as defined in section 1751.01 Of the Revised Code,</u>	7277
<u>that is not a health delivery network contracting solely with</u>	7278
<u>self-insured employers;</u>	7279
(g) An administrator subject to sections 3959.01 to 3959.16	7280
of the Revised Code;	7281
(h) A HEALTH DELIVERY NETWORK, AS DEFINED IN SECTION 1751.01	7282
OF THE <u>REVISED CODE</u> ;	7283
<u>(i)</u> Any other person that is obligated pursuant to a benefits	7284
contract to reimburse for covered health care services rendered to	7285
beneficiaries under such contract.	7286
(B)(1) Except as provided in division (B)(2) of this section,	7287
within twenty-four days of the receipt of a completed claim from a	7288
provider or a beneficiary for reimbursement for health care	7289
services rendered by the provider to a beneficiary, a third-party	7290
payer shall, in accordance with division (D) of this section, make	7291

payment of any amount due on such claim. 7292

(2) A third-party payer and a provider may, in negotiating a 7293  
reimbursement contract, agree to any time period by which a 7294  
third-party payer shall, subject to division (D) of this section, 7295  
make payment of any amount due on a completed claim. Nothing in 7296  
this division shall be construed as limiting in any manner the 7297  
application of the requirements of this section to any benefits or 7298  
reimbursement contract. 7299

(3) Any provider or beneficiary aggrieved with respect to any 7300  
act of a third-party payer that such provider or beneficiary 7301  
believes to be a violation of division (B)(1) or (2) of this 7302  
section may file a written complaint with the superintendent of 7303  
insurance. If a series of such complaints is received by the 7304  
superintendent with respect to a particular third-party payer and 7305  
if, after investigation, the superintendent finds that such 7306  
third-party payer has engaged in a series of such violations 7307  
which, taken together, constitute a consistent pattern or a 7308  
practice of such third-party payer to violate division (B)(1) or 7309  
(2) of this section, the superintendent shall issue an order 7310  
requiring such third-party payer to cease and desist from engaging 7311  
in such violations and to pay a late payment penalty as specified 7312  
in divisions (B)(4) and (5) of this section with respect to the 7313  
claims the superintendent finds were not timely paid. In the 7314  
order, the superintendent shall specify the reasons for ~~his~~ the 7315  
superintendent's finding and order and state that a hearing 7316  
conducted pursuant to Chapter 119. of the Revised Code shall be 7317  
held within fifteen days after requested in writing by the 7318  
third-party payer. The provisions of this division (B)(3) of this 7319  
section are in addition to, and not in lieu of, such other 7320  
remedies as providers and beneficiaries may otherwise have by law. 7321

(4)(a) The late payment penalty shall be computed based upon 7322  
the number of days that have elapsed between the date payment is 7323

due in accordance with division (B)(1) or (2) of this section and 7324  
the date payment is actually sent. 7325

(b) The interest rate for determining the amount of the late 7326  
payment penalty shall be the rate agreed to by the provider and 7327  
the third-party payer or the rate specified by and determined in 7328  
accordance with division (A) of section 1343.01 of the Revised 7329  
Code. 7330

(5) A provider and a third-party payer may enter into a 7331  
contractual agreement in which the timing of payments by the 7332  
third-party payer is not directly related to the receipt of a 7333  
completed claim. Such contractual arrangement may include periodic 7334  
interim payment arrangements, capitation payment arrangements, or 7335  
other payment arrangements acceptable to the provider and the 7336  
third-party payer. Except as agreed to under such contract, this 7337  
section does not apply to such payment arrangements. 7338

(6) Any late payment penalty due and payable by a third-party 7339  
payer in accordance with this section shall not be used to reduce 7340  
benefits or payments otherwise payable under a benefits contract. 7341  
7342

(C) No third-party payer shall refuse to process or pay 7343  
within the time period required under division (B)(1) or (2) of 7344  
this section a completed claim submitted by a provider on the 7345  
ground the beneficiary has not been discharged from the hospital 7346  
or the treatment has not been completed, if the submitted claim 7347  
covers services actually rendered and charges actually incurred 7348  
over at least a thirty-day period. 7349  
7350

(D)(1) ~~Notwithstanding~~ NOTWITHSTANDING section 1742.10 or 7351  
division (I)(2) of section 3923.04 of the Revised Code, a 7352  
reimbursement contract entered into or renewed on or after ~~the~~ 7353  
~~effective date of this section~~ JUNE 29, 1988, between a 7354

third-party payer and a hospital shall provide that reimbursement 7355  
for any service provided by a hospital pursuant to a reimbursement 7356  
contract and covered under a benefits contract shall be made 7357  
directly to the hospital. 7358

(2) If the third-party payer and the hospital have not 7359  
entered into a contract regarding the provision and reimbursement 7360  
for covered services, the third-party payer shall accept and honor 7361  
a completed and validly executed assignment of benefits with a 7362  
hospital by a beneficiary, except when the third-party payer has 7363  
notified the hospital in writing of the conditions under which the 7364  
third-party payer will not accept and honor an assignment of 7365  
benefits. Such notice shall be made annually. 7366

(3) A third-party payer may not refuse to accept and honor a 7367  
validly executed assignment of benefits with a hospital pursuant 7368  
to division (D)(2) of this section for medically necessary 7369  
hospital services provided on an emergency basis. 7370

(E) A series of violations which taken together, constitute a 7371  
consistent pattern or a practice of violation of any of the 7372  
provisions of this section is an unfair and deceptive act pursuant 7373  
to sections 3901.19 to 3901.23 of the Revised Code and is subject 7374  
to proceedings pursuant to those sections. 7375

**Sec. 3901.40.** No insurance company, ~~medical care corporation,~~ 7376  
health ~~care~~ insuring corporation, or self-insurance plan, ~~or~~ 7377  
~~dental care corporation~~ authorized to do business in this state 7378  
shall include or provide in its policies or subscriber agreements 7379  
for benefit payments or reimbursement for services in any hospital 7380  
which is not certified or accredited as provided in division (A) 7381  
of section 3727.02 of the Revised Code. No hospital located in 7382  
this state shall charge any insurance company, ~~medical care~~ 7383  
~~corporation,~~ health ~~care~~ insuring corporation, ~~dental care~~ 7384  
~~corporation,~~ federal, state, or local government agency, or person 7385

for any services rendered unless the hospital is certified or 7386  
accredited as provided in division (A) of section 3727.02 of the 7387  
Revised Code. "Hospital" as used in this section means only those 7388  
institutions included within the definition of that term contained 7389  
in section 3727.01 of the Revised Code, and the prohibitions in 7390  
this section do not apply to facilities excluded from that 7391  
definition. 7392

**Sec. 3901.41.** (A) An insurance company licensed to transact 7393  
business in this state, or a health insuring corporation holding a 7394  
certificate of authority under Chapter 1751. Of the Revised Code, 7395  
shall notify the superintendent of insurance and deliver a copy of 7396  
any order or judgment to the superintendent within thirty days of 7397  
the happening in another state of any one or more of the 7398  
following: 7399

(1) Suspension or revocation of its right to transact 7400  
business; 7401

(2) Receipt of an order to show cause why its license should 7402  
not be suspended or revoked; 7403

(3) Imposition of a penalty on it for any violation of the 7404  
insurance laws of such other state. 7405

(B) Whenever the superintendent finds that an insurance 7406  
company or a health insuring corporation has failed to notify the 7407  
superintendent and to deliver a copy of any order or judgment to 7408  
~~him~~ the superintendent pursuant to division (A) of this section, 7409  
~~he~~ the superintendent may order a hearing to be held not less than 7410  
thirty days after the service of notice, to require it to show 7411  
cause why an order should not be made by the superintendent, as a 7412  
result of the violation of division (A) of this section, directing 7413  
the company or corporation to suspend any transaction of business 7414  
in this state or levying a penalty against the company in an 7415

amount not to exceed five hundred dollars. All such hearings shall 7416  
be conducted, and may be appealed, in accordance with ~~sections~~ 7417  
~~119.01 to 119.13~~ Chapter 119. of the Revised Code. 7418

**Sec. 3901.48.** (A) The original work papers of a certified 7419  
public accountant performing an audit of an insurance company or 7420  
health insuring corporation doing business in this state that is 7421  
required by rule or by any section of the Revised Code to file an 7422  
audited financial report with the superintendent of insurance 7423  
shall remain the property of the certified public accountant. Any 7424  
copies of these work papers voluntarily given to the 7425  
superintendent shall be the property of the superintendent. The 7426  
original work papers or any copies of them, whether in possession 7427  
of the certified public accountant or the department of insurance, 7428  
are confidential and are not a public record as defined in section 7429  
149.43 of the Revised Code. The original work papers and any 7430  
copies of them are not subject to subpoena and shall not be made 7431  
public by the superintendent or any other person. However, the 7432  
original work papers and any copies of them may be released by the 7433  
superintendent to the insurance regulatory authority of any other 7434  
state if that authority agrees to maintain the confidentiality of 7435  
the work papers or copies and if the work papers and copies are 7436  
not public records under the laws of that state. 7437

(B) The work papers of the superintendent or of the person 7438  
appointed by ~~him~~ the superintendent, resulting from the conduct of 7439  
an examination made pursuant to section 3901.07 of the Revised 7440  
Code, are confidential and are not a public record as defined in 7441  
section 149.43 of the Revised Code. The original work papers and 7442  
any copies of them are not subject to subpoena and shall not be 7443  
made public by the superintendent or any other person. However, 7444  
the original work papers and any copies of them may be released by 7445  
the superintendent to the insurance regulatory authority of any 7446  
other state if that authority agrees to maintain the 7447

confidentiality of the work papers or copies and if the work 7448  
papers and copies are not public records under the laws of that 7449  
state. 7450

(C) The work papers of the superintendent or of any person 7451  
appointed by the superintendent, resulting from the conduct of a 7452  
performance regulation examination made pursuant to authority 7453  
granted under section 3901.011 of the Revised Code, are 7454  
confidential and are not a public record as defined in section 7455  
149.43 of the Revised Code. The original work papers and any 7456  
copies of them are not subject to subpoena and shall not be made 7457  
public by the superintendent or any other person. However, the 7458  
original work papers and any copies of them may be released by the 7459  
superintendent to the insurance regulatory authority of any other 7460  
state if that authority agrees to maintain the confidentiality of 7461  
the work papers or copies and if the work papers and copies are 7462  
not public records under the laws of that state. 7463

**Sec. 3901.72.** Any person may advance to a domestic insurance 7464  
company or a health ~~maintenance organization~~ insuring corporation 7465  
any sum of money necessary for the purpose of the insurance 7466  
company's or health ~~maintenance organization's~~ insuring 7467  
corporation's business, or to enable the insurance company or 7468  
health ~~maintenance organization~~ insuring corporation to comply 7469  
with any law, or as a cash guarantee fund. Such money, and 7470  
interest agreed upon, not exceeding ten per cent per annum or the 7471  
total of four hundred basis points plus the rate on United States 7472  
treasury notes or bonds closest in maturity to the final repayment 7473  
date of the money so advanced, whichever is greater, shall not be 7474  
a liability or claim against the insurance company or health 7475  
~~maintenance organization~~ insuring corporation, or any of its 7476  
assets, except as provided in this section, and shall be repaid 7477  
only out of the surplus earnings of such insurance company or 7478  
health ~~maintenance organization~~ insuring corporation. Except as 7479

ordered by the superintendent of insurance, no part of the 7480  
principal or interest thereof shall be repaid until the surplus of 7481  
the insurance company or health ~~maintenance organization~~ insuring 7482  
corporation remaining after such repayment is equal in amount to 7483  
the principal of the money so advanced. Such advancement and 7484  
repayment shall be subject to the approval of the superintendent, 7485  
provided that this section shall not affect the power to borrow 7486  
money which any such insurance company or health ~~maintenance~~ 7487  
~~organization~~ insuring corporation possesses under other laws. No 7488  
commission or promotion expenses shall be paid by the insurance 7489  
company or health ~~maintenance organization~~ insuring corporation, 7490  
in connection with the advance of any such money to the insurance 7491  
company or health ~~maintenance organization~~ insuring corporation, 7492  
and the amount of any such unpaid advance shall be reported in 7493  
each annual statement. 7494

**Sec. 3902.01.** (A) The purpose of sections 3902.01 to 3902.08 7495  
of the Revised Code is to establish minimum standards for language 7496  
used in policies and certificates of life insurance and annuities, 7497  
credit life insurance and credit disability insurance, and 7498  
sickness and accident insurance, and subscriber policies or 7499  
certificates of ~~medical care corporations~~, health ~~care~~ insuring 7500  
corporations, ~~dental care corporations~~, and health ~~maintenance~~ 7501  
~~organizations~~, delivered or issued for ~~deliver~~ delivery in this 7502  
state, to facilitate ease of reading by insureds and subscribers. 7503

(B) Sections 3902.01 to 3902.08 of the Revised Code are not 7504  
intended to increase the risk assumed by insurance companies or 7505  
other entities subject to sections 3902.01 to 3902.08 of the 7506  
Revised Code or to supersede their obligation to comply with the 7507  
substance of other applicable insurance laws. Sections 3902.01 to 7508  
3902.08 of the Revised Code are not intended to impede flexibility 7509  
and innovation in the development of policy forms or content, or 7510

to lead to the standardization of policy forms or content. 7511

**Sec. 3902.02.** As used in sections 3902.01 to 3902.08 of the 7512  
Revised Code: 7513

(A) "Policy" or "policy form" means any policy, contract, 7514  
plan or agreement of life insurance and annuities, credit life 7515  
insurance and credit disability insurance, and sickness and 7516  
accident insurance, and subscriber policies, contracts, 7517  
certificates, and agreements of ~~medical care corporations,~~ health 7518  
~~care~~ insuring corporations, ~~dental care corporations, and health~~ 7519  
~~maintenance organizations,~~ delivered or issued for delivery in 7520  
this state by any company subject to sections 3902.01 to 3902.08 7521  
of the Revised Code; any certificate, contract or policy issued by 7522  
a fraternal benefit society; any certificate issued pursuant to a 7523  
group insurance policy delivered or issued for delivery in this 7524  
state; and any evidence of coverage issued by a health ~~maintenance~~ 7525  
~~organization~~ insuring corporation. 7526

(B) "Company" or "insurer" means any entity authorized to do 7527  
the business of life insurance and annuities, sickness and 7528  
accident insurance, credit life insurance, or credit disability 7529  
insurance; a fraternal benefit society; and a ~~medical care~~ 7530  
~~corporation;~~ a health ~~care~~ insuring corporation; ~~a dental care~~ 7531  
~~corporation;~~ and a ~~health maintenance organization.~~ 7532

**Sec. 3902.11.** As used in sections 3902.11 to 3902.14 of the 7533  
Revised Code: 7534

(A) "Beneficiary" has the same meaning as in division (A)(1) 7535  
of section 3901.38 of the Revised Code. 7536

(B) "Plan of health coverage" means any of the following if 7537  
the policy, contract, or agreement contains a coordination of 7538  
benefits provision: 7539

(1) An individual or group sickness and accident insurance 7540  
policy ~~or an individual or group contract of a health maintenance~~ 7541  
~~organization~~, which policy ~~or contract~~ provides for hospital, 7542  
dental, surgical, or medical services; 7543

(2) Any individual or group contract ~~that provides dental~~ 7544  
benefits of a health insuring corporation, which contract provides 7545  
for hospital, dental, surgical, or medical services; 7546

(3) Any other individual or group policy or agreement under 7547  
which a third-party payer provides for hospital, dental, surgical, 7548  
or medical services; 7549

~~(4) An individual or group contract of a health care~~ 7550  
~~corporation.~~ 7551

(C) "Provider" has the same meaning as in division (A)(6) of 7552  
section 3901.38 of the Revised Code. 7553

(D) "Third-party payer" has the same meaning as in division 7554  
(A)(8) of section 3901.38 of the Revised Code, ~~and includes any~~ 7555  
~~health care corporation.~~ 7556

**Sec. 3902.13.** (A) A plan of health coverage determines its 7557  
order of benefits using the first of the following that applies: 7558

(1) A plan that does not coordinate with other plans is 7559  
always the primary plan. 7560

(2) The benefits of the plan that covers a person as an 7561  
employee, member, insured, or subscriber, other than a dependent, 7562  
is the primary plan. The plan that covers the person as a 7563  
dependent is the secondary plan. 7564

(3) When more than one plan covers the same child as a 7565  
dependent of different parents who are not divorced or separated, 7566  
the primary plan is the plan of the parent whose birthday falls 7567  
earlier in the year. The secondary plan is the plan of the parent 7568

whose birthday falls later in the year. If both parents have the  
same birthday, the benefits of the plan that covered the parent  
the longer is the primary plan. The plan that covered the parent  
the shorter time is the secondary plan. If the other plan's  
provision for coordination of benefits does not include the rule  
contained in this division because it is not subject to regulation  
under this division, but instead has a rule based on the gender of  
the parent, and if, as a result, the plans do not agree on the  
order of benefits, the rule of the other plan will determine the  
order of benefits.

(4)(a) Except as provided in division (A)(4)(b) of this  
section, if more than one plan covers a person as a dependent  
child of divorced or separated parents, benefits for the child are  
determined in the following order:

(i) The plan of the parent who is the residential parent and  
legal custodian of the child;

(ii) The plan of the spouse of the parent who is the  
residential parent and legal custodian of the child;

(iii) The plan of the parent who is not the residential  
parent and legal custodian of the child.

(b) If the specific terms of a court decree state that one  
parent is responsible for the health care expenses of the child,  
the plan of that parent is the primary plan. A parent responsible  
for the health care pursuant to a court decree must notify the  
insurer or health ~~maintenance organization~~ insuring corporation of  
the terms of the decree.

(5) The primary plan is the plan that covers a person as an  
employee who is neither laid off or retired, or that employee's  
dependent. The secondary plan is the plan that covers that person  
as a laid-off or retired employee, or that employee's dependent.

(6) If none of the rules in divisions (A)(1), (2), (3), (4), 7599  
and (5) of this section determines the order of benefits, the 7600  
primary plan is the plan that covered an employee, member, 7601  
insured, or subscriber longer. The secondary plan is the plan that 7602  
covered that person the shorter time. 7603

(B) When a plan of health coverage is determined to be a 7604  
secondary plan it acts to provide benefits in excess of those 7605  
provided by the primary plan. 7606

(C) The secondary plan shall not be required to make payment 7607  
in an amount which exceeds the amount it would have paid if it 7608  
were the primary plan, but in no event, when combined with the 7609  
amount paid by the primary plan, shall payments by the secondary 7610  
plan exceed one hundred per cent of expenses allowable under the 7611  
provisions of the applicable policies and contracts. 7612

(D) A third-party payer may require a beneficiary to file a 7613  
claim with the primary plan before it determines the amount of its 7614  
payment obligation, if any, with regard to that claim. 7615

(E) Nothing in this section shall be construed to require a 7616  
plan to make a payment until it determines whether it is the 7617  
primary plan or the secondary plan and what benefits are payable 7618  
under the primary plan. 7619

(F) A plan may obtain any facts and information necessary to 7620  
apply the provisions of this section, or supply this information 7621  
to any other third-party payer or provider, or any agent of such 7622  
third-party payer or provider, without the consent of the 7623  
beneficiary. Each person claiming benefits under the plan shall 7624  
provide any information necessary to apply the provisions of this 7625  
section. 7626

(G) If the amount of payments made by any plan is more than 7627  
should have been paid, the plan may recover the excess from 7628  
whichever party received the excess payment. 7629

(H) No third-party payer shall administer a plan of health coverage delivered, issued for delivery, or renewed on or after June 29, 1988, unless such plan complies with this section.

(I)(1) A third-party payer that is subject to this section and has reason to believe payment has been made by another third-party payer for the same service may request from that third-party payer, and shall be provided by the third-party payer, such data as necessary to determine whether duplicate payment has been made.

(2) A third-party payer that meets the criteria of a secondary payer in accordance with this section may seek repayment of any duplicate payment that may have been made from the person to whom it made payment. If the person who received the duplicate payment is a provider, absent a finding of a court of competent jurisdiction that the provider has engaged in civil or criminal fraudulent activities, the request for the return of any duplicate payment shall be made within three years after the close of the provider's fiscal year in which the duplicate payment has been made.

(J) Nothing in this section shall be construed to affect the prohibition of section 3923.37 of the Revised Code.

(K)(1) No third-party payer shall knowingly fail to comply with the order of benefits as set forth in division (A) of this section.

(2) No primary plan shall direct or encourage an insured to use the benefits of a secondary plan that results in a reduction of payment by such primary plan.

(L) Whoever violates division (K) of this section is deemed to have engaged in an unfair and deceptive insurance act or practice under sections 3901.19 to 3901.26 of the Revised Code, and is subject to proceedings pursuant to those sections.

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;	7720
(2) Is a past, present, or proposed policy owner;	7721
(3) Is a past or present applicant;	7722
(4) Is a past or present claimant;	7723
(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.	7724 7725 7726
(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:	7727 7728 7729 7730
(1) An agent;	7731
(2) The individual who is the subject of the information;	7732
(3) A natural person acting in a personal capacity rather than in a business or professional capacity.	7733 7734
(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 <del>health maintenance organizations, prepaid dental plan organizations, medical care corporations, health care</del> <u>insuring</u> corporations, <del>and dental care corporations</del> . "Insurance institution" does not include agents or insurance support organizations.	7735 7736 7737 7738 7739 7740 7741 7742
(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:	7743 7744 7745 7746 7747 7748

(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. 7780

(P) "Medical professional" means any person licensed or 7781  
certified to provide health care services to natural persons, 7782  
including a chiropractor, clinical dietician, clinical 7783  
psychologist, dentist, nurse, occupational therapist, optometrist, 7784  
pharmacist, physical therapist, physician, podiatrist, psychiatric 7785  
social worker, and speech therapist. 7786

(Q) "Medical record information" means personal information 7787  
that relates to an individual's physical or mental condition, 7788  
medical history, or medical treatment and that is obtained from a 7789  
medical professional or medical care institution, from the 7790  
individual, or from the individual's spouse, parent, or legal 7791  
guardian. 7792

(R) "Personal information" means any individually 7793  
identifiable information gathered in connection with an insurance 7794  
transaction from which judgments can be made about an individual's 7795  
character, habits, avocations, finances, occupation, general 7796  
reputation, credit, health, or any other personal characteristics. 7797  
"Personal information" includes an individual's name and address 7798  
and medical record information but does not include privileged 7799  
information. 7800

(S) "Policyholder" means any person that is a present owner 7801  
of individual life, health, or disability insurance, or a present 7802  
certificate holder under group life, health, or disability 7803  
insurance that is individually underwritten. 7804

(T) "Pretext interview" means an interview whereby a person, 7805  
in an attempt to obtain information about a natural person, 7806  
performs one or more of the following acts: 7807

(1) Pretends to be someone ~~he~~ the interviewer is not; 7808

(2) Pretends to represent a person ~~he~~ the interviewer is not 7809

in fact representing;	7810
(3) Misrepresents the true purpose of the interview;	7811
(4) Refuses to identify <del>himself</del> <u>self</u> upon request.	7812
(U) "Privileged information" means any individually	7813
identifiable information that relates to a claim for life, health,	7814
or disability insurance benefits or a civil or criminal proceeding	7815
involving an individual, and that is collected in connection with,	7816
or in reasonable anticipation of, a claim for life, health, or	7817
disability insurance benefits or civil or criminal proceeding	7818
involving an individual. However, information otherwise meeting	7819
the requirements of this division shall nevertheless be considered	7820
personal information if it is disclosed in violation of section	7821
3904.13 of the Revised Code.	7822
(V) "Termination of insurance coverage" or "termination of an	7823
insurance policy" means either a cancellation or nonrenewal of a	7824
life, health, or disability insurance policy, in whole or in part,	7825
for any reason other than the failure to pay a premium as required	7826
by the policy.	7827
(W) "Unauthorized insurer" means an insurance institution	7828
that has not been granted a certificate of authority by the	7829
superintendent of insurance to transact the business of life,	7830
health, or disability insurance in this state.	7831
<b>Sec. 3905.71.</b> As used in sections 3905.71 to 3905.79 of the	7832
Revised Code:	7833
(A) "Actuary" means a person who is a member in good standing	7834
of the American academy of actuaries.	7835
(B) "Insurer" means any person licensed to do business in	7836
this state under Chapter <del>1736., 1737., 1738., 1740., 1742., 1751.</del>	7837
or 1761. of the Revised Code or Title XXXIX of the Revised Code.	7838
(C) "Laws of this state relating to insurance" has the same	7839

meaning as in section 3901.04 of the Revised Code. 7840

(D)(1) "Managing general agent" means any person that does 7841  
all of the following: 7842

(a) Manages all or part of the insurance business of an 7843  
insurer, including the management of a separate division, 7844  
department, or underwriting office, or negotiates and binds ceding 7845  
reinsurance contracts on behalf of an insurer; 7846

(b) Acts as an agent for the insurer, whether known as a 7847  
managing general agent, manager, or other similar term; 7848

(c) With or without the authority of the insurer, separately 7849  
or together with affiliates, does both of the following: 7850

(i) Produces, directly or indirectly, and underwrites an 7851  
amount of gross direct written premium equal to or more than five 7852  
per cent of the policyholder surplus of the insurer as reported in 7853  
the last annual statement of the insurer in any one year; 7854

(ii) Adjusts or pays claims, or negotiates reinsurance on 7855  
behalf of the insurer. 7856

(2) "Managing general agent" does not include any of the 7857  
following: 7858

(a) An employee of the insurer; 7859

(b) A United States manager of the United States branch of an 7860  
alien insurer; 7861

(c) An underwriting manager that, pursuant to contract, 7862  
manages all or a part of the insurance operations of the insurer, 7863  
is under common control with the insurer, subject to sections 7864  
3901.32 to 3901.37 of the Revised Code, and whose compensation is 7865  
not based on the volume of premiums written; 7866

(d) The attorney authorized by and acting for the subscribers 7867  
of a reciprocal insurer or inter-insurance exchange under powers 7868

of attorney; 7869

(e) An administrator licensed pursuant to Chapter 3959. of 7870  
the Revised Code whose activities on behalf of an insurer are 7871  
limited to administrative services involving underwriting or the 7872  
payment of claims, and do not include the management of all or 7873  
part of the insurance business of the insurer. 7874

(E) "Underwrite" or "underwriting" means the authority to 7875  
accept or reject risk on behalf of an insurer. 7876

**Sec. 3923.123.** (A) As used in this section: 7877

(1) "Association" means a voluntary unincorporated 7878  
association of insurers formed for the sole purpose of enabling 7879  
cooperative action to provide health coverage in accordance with 7880  
this section. 7881

(2) "Insurer" includes any insurance company authorized to do 7882  
the business of sickness and accident insurance in this state, 7883  
~~medical care corporation organized under Chapter 1737. of the~~ 7884  
~~Revised Code, and any health care insuring corporation organized~~ 7885  
~~holding a certificate of authority under Chapter 1738. 1751. of~~ 7886  
the Revised Code, and any health care insuring corporation organized 7887  
~~dental care corporation organized under Chapter~~ 7888  
~~1740. of the Revised Code, or hospital maintenance organization~~ 7889  
~~organized under Chapter 1742. of the Revised Code.~~

(3) "Insured" means a person covered under a group policy or 7890  
contract issued pursuant to this section. 7891

(4) "Qualified unemployed person" means one who became 7892  
unemployed while a resident of this state from employment or 7893  
self-employment and has since been continuously unemployed or is 7894  
employed only so that ~~he~~ the person does not have, or have a right 7895  
to purchase, group health coverage. An individual who is, or who 7896  
becomes, covered by medicare is not a qualified unemployed person. 7897  
A person eligible for coverage under this section, who is also 7898

eligible for continuation of coverage under section ~~1737.30,~~ 7899  
~~1738.26, 1742.34,~~ 1751.53 or 3923.38 of the Revised Code, may 7900  
elect either coverage, but not both. A person who elects 7901  
continuation of coverage under ~~any~~ either of such sections may, 7902  
upon the termination of the continuation of coverage, elect any 7903  
coverage available under this section. 7904

(B) Any insurer may join with one or more other insurers, in 7905  
an association, to offer, sell, and issue to a policyholder or 7906  
subscriber selected by the association a policy or contract of 7907  
group health coverage, covering residents of this state who are 7908  
qualified unemployed persons and the spouses or dependents of such 7909  
residents. The coverage shall be offered, issued, and administered 7910  
in the name of the association. Membership in the association 7911  
shall be open to any insurer and each insurer which participates 7912  
shall be liable for a specified percentage of the risks. The 7913  
policy or contract may be executed on behalf of the association by 7914  
a duly authorized person. 7915

(C) The persons eligible for coverage under the policy or 7916  
contract shall be all residents of this state who are qualified 7917  
unemployed persons and their spouses and dependents, subject to 7918  
reasonable underwriting restrictions to be set forth in the plan 7919  
of the association. The policy or contract may provide basic 7920  
hospital and surgical coverage, basic medical coverage, major 7921  
medical coverage, and any combination of these; provided that it 7922  
shall not be required as a condition for obtaining major medical 7923  
coverage that any basic coverage be taken. 7924

(D) The association shall file with the superintendent of 7925  
insurance any policy, contract, certificate, or other evidence of 7926  
coverage, application, or other forms pertaining to such insurance 7927  
together with the premium rates to be charged therefor. The 7928  
superintendent may approve, disapprove, and withdraw approval of 7929  
the forms in accordance with section 3923.02 of the Revised Code, 7930

or the premium rates if by reasonable assumptions such rates are  
excessive in relation to the benefits provided. In determining  
whether such rates by reasonable assumptions are excessive in  
relation to the benefits provided, the superintendent shall give  
due consideration to past and prospective claim experience, within  
and outside this state, and to fluctuations in such claim  
experience, to a reasonable risk charge, to contribution to  
surplus and contingency funds, to past and prospective expenses,  
both within and outside this state, and to all other relevant  
factors within and outside this state, including any differing  
operating methods of the insurers joining in the issuance of the  
policy or contract. In reviewing the forms the superintendent  
shall not be bound by the requirements of sections 3923.04 to  
3923.07 of the Revised Code with respect to standard provisions to  
be included in sickness and accident policies or forms.

(E) The association may enroll eligible persons for coverage  
under the policy or contract through any person licensed by, or  
authorized under the law of, this state to sell the policies or  
contracts, or to enroll persons in the health plans, of any of the  
insurers participating in the association.

(F) The association shall file annually with the  
superintendent on such date and in such form as ~~he~~ the  
superintendent may prescribe, a financial summary of its  
operations.

(G) The association may sue and be sued in its associate name  
and for such purposes only shall be treated as a domestic  
corporation. Service of process against such association made upon  
a managing agent, any member thereof, or any agent authorized by  
appointment to receive service of process, shall have the same  
force and effect as if such service had been made upon all members  
of the association.

(H) Under any policy issued as provided in this section, the policyholder, or such person as the policyholder shall designate, shall alone be a member of each domestic mutual insurance company joining in the issue of the policy and shall be entitled to one vote by virtue of such policy at the meetings of each such mutual insurance company. Notice of the annual meetings of each such mutual insurance company may be given by written notice to the policyholder or as otherwise prescribed in said policy.

**Sec. 3923.30.** Every person, the state and any of its instrumentalities, any county, township, school district, or other political subdivisions and any of its instrumentalities, and any municipal corporation and any of its instrumentalities, which provides payment for health care benefits for any of its employees resident in this state, which benefits are not provided by contract with an insurer qualified to provide sickness and accident insurance, or a health ~~maintenance organization~~ insuring corporation, shall include the following benefits in its plan of health care benefits commencing on or after January 1, 1979:

(A) If such plan of health care benefits provides payment for the treatment of mental or nervous disorders, then such plan shall provide benefits for services on an outpatient basis for each eligible employee and dependent for mental or emotional disorders, or for evaluations, that are at least equal to the following:

(1) Payments not less than five hundred fifty dollars in a twelve-month period, for services legally performed by or under the clinical supervision of a licensed physician or a licensed psychologist, whether performed in an office, in a hospital, or in a community mental health facility so long as the hospital or community mental health facility is approved by the joint commission on accreditation of hospitals or certified by the

department of mental health as being in compliance with standards 7993  
established under division (I) of section 5119.01 of the Revised 7994  
Code; 7995

(2) Such benefit shall be subject to reasonable limitations, 7996  
and may be subject to reasonable deductibles and co-insurance 7997  
costs. 7998

(3) In order to qualify for participation under this 7999  
division, every facility specified in this division shall have in 8000  
effect a plan for utilization review and a plan for peer review 8001  
and every person specified in this division shall have in effect a 8002  
plan for peer review. Such plans shall have the purpose of 8003  
ensuring high quality patient care and effective and efficient 8004  
utilization of available health facilities and services. 8005

(4) Such payment for benefits shall not be greater than 8006  
usual, customary, and reasonable. 8007

(5) For purposes of this division, "community mental health 8008  
facility" means a facility as defined in section 3923.28 of the 8009  
Revised Code. 8010

(6)(a) Services performed under the clinical supervision of a 8011  
licensed physician or licensed psychologist, in order to be 8012  
reimbursable under the coverage required in division (A) of this 8013  
section, shall meet both of the following requirements: 8014

(i) The services shall be performed in accordance with a 8015  
treatment plan that describes the expected duration, frequency, 8016  
and type of services to be performed; 8017

(ii) The plan shall be reviewed and approved by a licensed 8018  
physician or licensed psychologist every three months. 8019

(b) Payment of benefits for services reimbursable under 8020  
division (A)(6)(a) of the section shall not be restricted to 8021  
services described in the treatment plan or conditioned upon 8022

standards of a licensed physician or licensed psychologist, which 8023  
at least equal the requirements of division (A)(6)(a) of this 8024  
section. 8025

(B) Payment for benefits for alcoholism treatment for 8026  
outpatient, inpatient, and intermediate primary care for each 8027  
eligible employee and dependent that are at least equal to the 8028  
following: 8029

(1) Payments not less than five hundred fifty dollars in a 8030  
twelve-month period for services legally performed by or under the 8031  
clinical supervision of a licensed physician or licensed 8032  
psychologist, whether performed in an office, or in a hospital or 8033  
a community mental health facility or alcoholism treatment 8034  
facility so long as the hospital, community mental health 8035  
facility, or alcoholism treatment facility is approved by the 8036  
joint commission on accreditation of hospitals or certified by the 8037  
department of health; 8038

(2) The benefits provided under this division shall be 8039  
subject to reasonable limitations and may be subject to reasonable 8040  
deductibles and co-insurance costs. 8041

(3) A licensed physician or licensed psychologist shall every 8042  
three months certify a patient's need for continued services 8043  
performed by such facilities. 8044

(4) In order to qualify for participation under this 8045  
division, every facility specified in this division shall have in 8046  
effect a plan for utilization review and a plan for peer review 8047  
and every person specified in this division shall have in effect a 8048  
plan for peer review. Such plans shall have the purpose of 8049  
ensuring high quality patient care and efficient utilization of 8050  
available health facilities and services. Such person or 8051  
facilities shall also have in effect a program of rehabilitation 8052  
or a program of rehabilitation and detoxification. 8053

(5) Nothing in this section shall be construed to require reimbursement for benefits which is greater than usual, customary, and reasonable.

**Sec. 3923.301.** Every person, the state and any of its instrumentalities, any county, township, school district, or other political subdivision and any of its instrumentalities, and any municipal corporation and any of its instrumentalities that provides payment for health care benefits for any of its employees resident in this state, which benefits are not provided by contract with an insurer qualified to provide sickness and accident insurance or a health ~~maintenance organization~~ insuring corporation, and that includes reimbursement for any service that may be legally performed by a certified nurse-midwife who is authorized under section 4723.42 of the Revised Code to practice nurse-midwifery, shall not deny reimbursement to a certified nurse-midwife performing the service if the service is performed in collaboration with a licensed physician. The collaborating physician shall be identified on the claim form.

The cost of collaboration with a certified nurse-midwife by a licensed physician as required under section 4723.43 of the Revised Code is a reimbursable expense.

The division of any reimbursement payment for services performed by a certified nurse-midwife between the nurse-midwife and the nurse-midwife's collaborating physician shall be determined and mutually agreed upon by the certified nurse-midwife and the physician. The division of fees shall not be considered a violation of division (B)(17) of section 4731.22 of the Revised Code. In no case shall the total fees charged exceed the fee the physician would have charged had the physician provided the entire service.

Sec. 3923.33. As used in section 3923.33 and sections 8084  
3923.331 to 3923.339 of the Revised Code: 8085

(A) "Applicant" means: 8086

(1) In the case of an individual medicare supplement policy, 8087  
the person who seeks to contract for insurance benefits; and 8088

(2) In the case of a group medicare supplement policy, the 8089  
proposed certificate holder. 8090

(B) "Certificate" means, for purposes of section 3923.33 and 8091  
sections 3923.331 to 3923.339 of the Revised Code, any certificate 8092  
delivered or issued for delivery in this state under a group 8093  
medicare supplement policy. 8094

(C) "Certificate form" means the form on which the 8095  
certificate is delivered or issued for delivery by the issuer. 8096

(D) "Direct response insurance policy" means a medicare 8097  
supplement policy or certificate marketed without the direct 8098  
involvement of an insurance agent. 8099

(E) "Issuer" includes insurance companies, fraternal benefit 8100  
societies, health ~~maintenance organizations~~ insuring corporations, 8101  
and any other entities delivering or issuing for delivery in this 8102  
state medicare supplement policies or certificates. 8103

(F) "Medicare" means the "Health Insurance for the Aged Act," 8104  
Title XVIII of the Social Security Amendments of 1965, 79 Stat. 8105  
291, 42 U.S.C.A. 1395, as then constituted or later amended. 8106

(G) "Medicare supplement policy" means a group or individual 8107  
policy of sickness and accident insurance or a subscriber contract 8108  
of health ~~maintenance organizations~~ insuring corporations or any 8109  
other issuers, other than a policy issued pursuant to a contract 8110  
under section 1876 of the "Social Security Act," 49 Stat. 620 8111  
(1935), 42 U.S.C.A., 1395mm, as amended, or an issued policy under 8112

any demonstration project specified in 42 U.S.C.A. 1395ss(g)(1), 8113  
which is advertised, marketed, or designed primarily as a 8114  
supplement to reimbursements under medicare for the hospital, 8115  
medical, or surgical expenses of persons eligible for medicare. 8116

(H) "Policy form" means the form on which the policy is 8117  
delivered or issued for delivery by the issuer. 8118

**Sec. 3923.333.** Medicare supplement policies shall return to 8119  
policyholders benefits that are reasonable in relation to the 8120  
premium charged. The superintendent of insurance shall issue 8121  
reasonable rules to establish minimum standards for loss ratios of 8122  
medicare supplement policies on the basis of incurred claims 8123  
experience, or incurred health care expenses where coverage is 8124  
provided by a health ~~maintenance organization~~ insuring corporation 8125  
on a service rather than reimbursement basis, and earned premiums 8126  
in accordance with accepted actuarial principles and practices. 8127

**Sec. 3923.38.** (A) As used in this section: 8128

(1) "Group policy" includes any group sickness and accident 8129  
policy or contract delivered, issued for delivery, or renewed in 8130  
this state on or after June 28, 1984, and any private or public 8131  
employer self-insurance plan or other plan that provides, or 8132  
provides payment for, health care benefits for employees resident 8133  
in this state other than through an insurer, or health care 8134  
insuring corporation, ~~or health maintenance organization~~, to which 8135  
both of the following apply: 8136

(a) The policy insures employees for hospital, surgical, or 8137  
major medical insurance on an expense incurred or service basis, 8138  
other than for specified diseases or for accidental injuries only. 8139

(b) The policy is in effect and covers an eligible employee 8140  
at the time the employee's employment is terminated. 8141

(2) "Eligible employee" includes only an employee to whom all 8142

of the following apply: 8143

(a) The employee has been continuously insured under a group 8144  
policy or under the policy and any prior similar group coverage 8145  
replaced by the policy, during the entire three-month period 8146  
preceding the termination of the employee's employment. 8147

(b) The employee is entitled, at the time of the termination 8148  
of ~~his~~ the employee's employment, to unemployment compensation 8149  
benefits under Chapter 4141. of the Revised Code. 8150

(c) The employee is not, and does not become, covered by or 8151  
eligible for coverage by medicare under Title XVIII of the Social 8152  
Security Act, as amended. 8153

(d) The employee is not, and does not become, covered by or 8154  
eligible for coverage by any other insured or uninsured 8155  
arrangement that provides hospital, surgical, or medical coverage 8156  
for individuals in a group and under which the person was not 8157  
covered immediately prior to such termination. A person eligible 8158  
for continuation of coverage under this section, who is also 8159  
eligible for coverage under section 3923.123 of the Revised Code, 8160  
may elect either coverage, but not both. A person who elects 8161  
continuation of coverage may elect any coverage available under 8162  
section 3923.123 of the Revised Code upon the termination of the 8163  
continuation of coverage. 8164

(3) "Group rate" means, in the case of an employer 8165  
self-insurance or other health benefits plan, the average monthly 8166  
cost per employee, over a period of at least twelve months, of the 8167  
operation of the plan that would represent a group insurance rate 8168  
if the same coverage had been provided under a group sickness and 8169  
accident insurance policy. 8170

(B) A group policy shall provide that any eligible employee 8171  
may continue the employee's hospital, surgical, and medical 8172  
insurance under the policy, for the employee and the employee's 8173

eligible dependents, for a period of six months after the date 8174  
that the insurance coverage would otherwise terminate by reason of 8175  
the termination of ~~his~~ the employee's employment. Each certificate 8176  
of coverage, or other notice of coverage, issued to employees 8177  
under the policy shall include a notice of the employee's 8178  
privilege of continuation. 8179

(C) All of the following apply to the continuation of 8180  
coverage required under division (B) of this section: 8181

(1) Continuation need not include dental, vision care, 8182  
prescription drug benefits, or any other benefits provided under 8183  
the policy in addition to its hospital, surgical, or major medical 8184  
benefits. 8185

(2) The employer shall notify the employee of the right of 8186  
continuation at the time the employer notifies the employee of the 8187  
termination of employment. The notice shall inform the employee of 8188  
the amount of contribution required by the employer under division 8189  
(C)(4) of this section. 8190

(3) The employee shall file a written election of 8191  
continuation with the employer and pay the employer the first 8192  
contribution required under division (C)(4) of this section. The 8193  
request and payment must be received by the employer no later than 8194  
the earlier of any of the following dates: 8195

(a) Thirty-one days after the date on which the employee's 8196  
coverage would otherwise terminate; 8197

(b) Ten days after the date on which the employee's coverage 8198  
would otherwise terminate, if the employer has notified the 8199  
employee of the right of continuation prior to such date; 8200

(c) Ten days after the employer notifies the employee of the 8201  
right of continuation, if the notice is given after the date on 8202  
which the employee's coverage would otherwise terminate. 8203

(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 six 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 ~~he~~ 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 8234  
to the extent of its accrued liabilities and extensions of 8235  
benefits as if the replacement had not occurred. 8236

(D) This section does not apply to an employer's 8237  
self-insurance plan if federal law supersedes, preempts, 8238  
prohibits, or otherwise precludes its application to such plans. 8239

**Sec. 3923.382.** (A) As used in this section: 8240

(1) "Eligible person" means any person who, at the time a 8241  
reservist is called or ordered to active duty, is covered under a 8242  
group plan and is either of the following: 8243

(a) An employee who is a reservist called or ordered to 8244  
active duty; 8245

(b) The spouse or a dependent child of an employee described 8246  
in division (A)(1)(a) of this section. 8247

(2) "Group plan" includes any private or public employer 8248  
self-insurance plan that satisfies all of the following: 8249

(a) The plan is established or modified in this state on or 8250  
after ~~the effective date of this section~~ APRIL 17, 1991. 8251

(b) The plan provides, or provides payment for, health 8252  
benefits for employees resident in this state other than through 8253  
an insurer, or ~~health maintenance organization, health care~~ 8254  
insuring corporation, ~~or medical care corporation.~~ 8255

(c) The plan is in effect and covers an eligible person at 8256  
the time a reservist is called or ordered to active duty. 8257

(3) "Group rate" means the average monthly cost per employee, 8258  
over a period of at least twelve months of the operation of a 8259  
group plan, that would represent a group insurance rate if the 8260  
same coverage had been provided under a group sickness and 8261  
accident insurance policy. 8262

(4) "Reservist" means a member of a reserve component of the  
armed forces of the United States. "Reservist" includes a member  
of the Ohio national guard and the Ohio air national guard.

(B) Every group plan shall provide that any eligible person  
may continue the coverage under the plan for a period of eighteen  
months after the date on which the coverage would otherwise  
terminate because the reservist is called or ordered to active  
duty.

(C)(1) An eligible person may extend the eighteen-month  
period of continuation of coverage to a thirty-six-month period of  
continuation of coverage, if any of the following occurs during  
the eighteen-month period:

(a) The death of the reservist;

(b) The divorce or separation of a reservist from the  
reservist's spouse;

(c) The cessation of dependency of a child pursuant to the  
terms of the plan.

(2) The thirty-six-month period of continuation of coverage  
is deemed to begin on the date on which the coverage would  
otherwise terminate because the reservist is called or ordered to  
active duty.

(3) The employer may begin the thirty-six-month period on the  
date of any occurrence described in division (C)(1) of this  
section.

(D) All of the following apply to any continuation of  
coverage, or the extension of any continuation of coverage,  
provided under division (B) or (C) of this section:

(1) The continuation of coverage shall provide the same  
benefits as those provided to any similarly situated eligible  
person who is covered under the same group plan and an employee

who has not been called or ordered to active duty. 8293

(2) An employer shall notify each employee of the right of 8294  
continuation of coverage at the time of employment. At the time 8295  
the reservist is called or ordered to active duty, the employer 8296  
shall notify each eligible person of the requirements for the 8297  
continuation of coverage. 8298

(3) Each certificate or other evidence of coverage issued by 8299  
an employer to an employee under the group plan shall include a 8300  
notice of the eligible person's right of continuation of coverage. 8301

(4) An eligible person shall file a written election of 8302  
continuation of coverage with the employer and pay the employer 8303  
the first contribution required under division (D)(5) of this 8304  
section. The written election and payment must be received by the 8305  
employer no later than thirty-one days after the date on which the 8306  
eligible person's coverage would otherwise terminate. If the 8307  
employer notifies the eligible person of the right of continuation 8308  
of coverage after the date on which the eligible person's coverage 8309  
would otherwise terminate, the written election and payment must 8310  
be received by the employer no later than thirty-one days after 8311  
the date of the notification. 8312

(5)(a) Except as provided in division (D)(5)(b) of this 8313  
section, the eligible person shall pay to the employer, on a 8314  
monthly basis and in advance, the amount of contribution required 8315  
by the employer. The amount shall not exceed one hundred two per 8316  
cent of the group rate for the coverage being continued under the 8317  
group plan on the due date of each payment. 8318

(b) The employer may pay a portion or all of the eligible 8319  
person's contribution. 8320

(E) The eligible person's right to any continuation of 8321  
coverage, or the extension of any continuation of coverage, 8322  
provided under division (B) or (C) of this section ceases on the 8323

date on which any of the following occurs: 8324

(1) The eligible person, whether as an employee or otherwise, 8325  
enrolls in another group plan or other group health plan or 8326  
arrangement that does not contain any exclusion or limitation with 8327  
respect to any preexisting condition of that eligible person. For 8328  
purposes of division (E)(1) of this section, a group plan or other 8329  
group health plan or arrangement does not include the civilian 8330  
health and medical program of the uniformed services as defined in 8331  
Public Law 99-661, 100 Stat. 3898 (1986), 10 U.S.C.A. 1072. 8332

(2) The period of either eighteen months provided under 8334  
division (B) of this section or thirty-six months provided under 8335  
division (C) of this section expires. 8336

(3) The eligible person fails to make a timely payment of a 8337  
required contribution, in which case the coverage ceases at the 8338  
end of the period of coverage for which contributions were made. 8339

(4) The group plan, or participation under the group plan, is 8340  
terminated, unless the employer, in accordance with division (F) 8341  
of this section, replaces the coverage with similar coverage under 8342  
another group plan or other group health plan or arrangement. 8343

(F) If the employer replaces the group plan with similar 8345  
coverage as described in division (E)(4) of this section, both of 8346  
the following apply: 8347

(1) The eligible person is covered under the replacement 8348  
coverage for the balance of the period that ~~he~~ the person would 8349  
have remained covered under the terminated coverage if it had not 8350  
been terminated. 8351

(2) The level of benefits under the replacement coverage is 8352  
the same as the level of benefits provided to any similarly 8353

situated eligible person who is covered under the group plan and 8354  
an employee who has not been called or ordered to active duty. 8355

(G) Upon the reservist's release from active duty and ~~his~~ the 8356  
reservist's return to employment for the employer by whom ~~he~~ the 8357  
reservist was employed at the time ~~he~~ the reservist was called or 8358  
ordered to active duty, both of the following apply: 8359

(1) Every eligible person is entitled, without any waiting 8360  
period, to coverage under the employer's group plan that is in 8361  
effect at the time of the reservist's return to employment. 8362

(2) Every eligible person is entitled to all benefits under 8363  
the group plan described in division (G)(1) of this section from 8364  
the date of the original coverage under the plan. 8365

(H)(1) No employer shall fail to provide for a continuation 8366  
of coverage, or an extension of a continuation of coverage, in a 8367  
group plan as required by and in accordance with the terms and 8368  
conditions set forth under this section. 8369

(2) No employer shall fail to issue a certificate or other 8370  
evidence of coverage in compliance with division (D)(3) of this 8371  
section. 8372

(3) No employer shall fail to provide an employee or eligible 8373  
person with notice of the right to a continuation of coverage 8374  
under a group plan in accordance with division (D)(2) of this 8375  
section. 8376

(I) Whoever violates division (H)(1), (2), or (3) of this 8377  
section is deemed to have engaged in an unfair and deceptive act 8378  
or practice in the business of insurance under sections 3901.19 to 8379  
3901.26 of the Revised Code. 8380

(J) This section does not apply to a group plan under either 8381  
of the following circumstances: 8382

(1) The group plan is subject to section 5923.051 of the 8383

Revised Code. 8384

(2) The application of this section is superseded, preempted, 8385  
prohibited, or otherwise precluded by federal law. 8386

**Sec. 3923.41.** As used in sections 3923.41 to 3923.48 of the 8387  
Revised Code: 8388

(A) "Long-term care insurance" means any insurance policy or 8389  
rider advertised, marketed, offered, or designed to provide 8390  
coverage for not less than one year for each covered person on an 8391  
expense incurred, indemnity, prepaid, or other basis, for one or 8392  
more necessary or medically necessary diagnostic, preventive, 8393  
therapeutic, rehabilitative, maintenance, or personal care 8394  
services, provided in a setting other than an acute care unit of a 8395  
hospital. "Long-term care insurance" includes group and individual 8396  
annuities and life insurance policies or riders that provide 8397  
directly or supplement long-term care benefits, and policies or 8398  
riders that provide for payment of benefits based on cognitive 8399  
impairment or the loss of functional capacity. "Long-term care 8400  
insurance" includes group and individual policies or riders 8401  
whether issued by insurers, fraternal benefit societies, or health 8402  
~~and medical care insuring corporations, prepaid health plans, or~~ 8403  
~~health maintenance organizations.~~ "Long-term care insurance" does 8404  
not include any insurance policy that is offered primarily to 8405  
provide basic medicare supplement coverage, basic hospital expense 8406  
coverage, basic medical-surgical expense coverage, hospital 8407  
confinement indemnity coverage, major medical expense coverage, 8408  
disability income protection coverage, accident only coverage, 8409  
specified disease or specified accident coverage, or limited 8410  
benefit health coverage. 8411

With regard to life insurance, "long-term care insurance" 8412  
does not include life insurance policies that accelerate the death 8413  
benefits specifically for one or more of the qualifying events of 8414

terminal illness, medical conditions requiring extraordinary 8415  
medical intervention, or permanent institutional confinement; that 8416  
provide the option of a lump sum payment for those benefits; and 8417  
in which neither the benefits nor the eligibility for the benefits 8418  
is conditioned upon the receipt of long-term care. 8419

Notwithstanding any other provision contained in sections 8420  
3923.41 to 3923.48 of the Revised Code, any product advertised, 8421  
marketed, or offered as long-term care insurance shall be subject 8422  
to sections 3923.41 to 3923.48 of the Revised Code. 8423

(B) "Applicant" means either of the following: 8424

(1) In the case of an individual long-term care insurance 8425  
policy, the person who seeks to contract for benefits; 8426

(2) In the case of a group long-term care insurance policy, 8427  
the proposed certificate holder. 8428

(C) "Certificate" means any certificate issued under a group 8429  
long-term care insurance policy that has been delivered, issued 8430  
for delivery, or used in or outside this state. 8431

(D) "Group long-term care insurance" means a form of 8432  
long-term care insurance covering any group of two or more 8433  
employees, members, or other persons, with or without one or more 8434  
of their dependents and members of their immediate families. Such 8435  
insurance may be offered to groups without regard to the purpose 8436  
or type of group or the occupation of the employees, members, and 8437  
other persons insured under the policy. 8438

(E) "Policy" means any policy, contract, rider, or 8439  
endorsement delivered, issued for delivery, or used in or outside 8440  
this state by an insurer, fraternal benefit society, or health ~~or~~ 8441  
~~medical care insuring~~ corporation, ~~prepaid health plan, or health~~ 8442  
~~maintenance organization.~~ 8443

**Sec. 3923.51.** (A) As used in this section, "official poverty 8444

line" means the poverty line as defined by the United States 8445  
office of management and budget and revised by the secretary of 8446  
health and human services under 95 Stat. 511, 42 U.S.C.A. 9902, as 8447  
amended. 8448

(B) Every insurer that is authorized to write sickness and 8449  
accident insurance in this state may offer group contracts of 8450  
sickness and accident insurance to any charitable foundation that 8451  
is certified as exempt from taxation under section 501(c)(3) of 8452  
the "Internal Revenue Code of 1986," 100 Stat. 2085, 26 U.S.C.A. 8453  
1, as amended, and that has the sole purpose of issuing 8454  
certificates of coverage under these contracts to persons under 8455  
the age of nineteen who are members of families that have incomes 8456  
that are no greater than three hundred per cent of the official 8457  
poverty line. 8458

(C) Contracts offered pursuant to division (B) of this 8459  
section are not subject to any of the following: 8460

(1) Sections 3923.122, 3923.24, and 3923.29 of the Revised 8461  
Code; 8462

(2) Any other sickness and accident insurance coverage 8463  
required under this chapter on ~~the effective date of this section~~ 8464  
August 3, 1989. Any requirement of sickness and accident insurance 8465  
coverage enacted after that date applies to this section only if 8466  
the subsequent enactment specifically refers to this section. 8467

8468

(3) Chapter ~~1742-~~ 1751. of the Revised Code. 8469

**Sec. 3923.54.** (A) As used in this section, "screening 8470  
mammography" means a radiologic examination utilized to detect 8471  
unsuspected breast cancer at an early stage in asymptomatic women 8472  
and includes the x-ray examination of the breast using equipment 8473  
that is dedicated specifically for mammography including, but not 8474

limited to, the x-ray tube, filter, compression device, screens, 8475  
film, and cassettes, and that has an average radiation exposure 8476  
delivery of less than one rad mid-breast. "Screening mammography" 8477  
includes two views for each breast. The term also includes the 8478  
professional interpretation of the film. 8479

"Screening mammography" does not include diagnostic 8480  
mammography. 8481

(B) Each employer in this state that provides, in whole or in 8482  
part, health care benefits for its employees under a policy of 8483  
sickness and accident insurance issued in accordance with Chapter 8484  
3923. of the Revised Code shall also provide to its employees 8485  
benefits for the expenses of both of the following: 8486

(1) Screening mammography to detect the presence of breast 8487  
cancer in adult women; 8488

(2) Cytologic screening for the presence of cervical cancer. 8489

(C) An employer may comply with division (B) of this section 8490  
in any of the following ways: 8491

(1) By providing the benefits under a health ~~maintenance~~ 8492  
~~organization~~ insuring corporation contract issued in accordance 8493  
with Chapter ~~1742.~~ 1751. of the Revised Code or a policy of 8494  
sickness and accident insurance issued in accordance with Chapter 8495  
3923. of the Revised Code; 8496

(2) By reimbursing the employee for the direct health care 8497  
provider charges associated with receipt of the covered service; 8498

(3) By making any other arrangement that provides the 8499  
benefits described in division (B) of this section. 8500

(D) The benefits provided under division (B)(1) of this 8501  
section shall cover expenses in accordance with all of the 8502  
following: 8503

(1) If a woman is at least thirty-five years of age but under forty years of age, one screening mammography; 8504  
8505

(2) If a woman is at least forty years of age but under fifty years of age, either of the following: 8506  
8507

(a) One screening mammography every two years; 8508

(b) If a licensed physician has determined that the woman has risk factors to breast cancer, one screening mammography every year. 8509  
8510  
8511

(3) If a woman is at least fifty years of age but under sixty-five years of age, one screening mammography every year. 8512  
8513

(E)(1) The benefits provided under division (B)(1) of this section need not exceed eighty-five dollars per year. 8514  
8515

(2) The benefit paid in accordance with division (E)(1) of this section shall constitute full payment. No institutional or professional health care provider shall seek or receive compensation in excess of the payment made in accordance with division (E)(1) of this section, except for approved deductibles and copayments. 8516  
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(F) The benefits provided under division (B)(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. 8522  
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(G) The benefits provided under division (B)(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. 8528  
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Sec. 3923.58. (A) As used in sections 3923.58 and 3923.59 of 8533  
the Revised Code: 8534

(1) "Case characteristics," "eligible employee," "health 8535  
benefit plan," "late enrollee," "MEWA," and "pre-existing 8536  
conditions provision" have the same meanings as in section 3924.01 8537  
of the Revised Code. 8538

(2) "Insurer" means any sickness and accident insurance 8539  
company authorized to issue health benefit plans in this state, or 8540  
MEWA authorized to issue insured health benefit plans in this 8541  
state. "Insurer" does not include any health ~~maintenance~~ 8542  
~~organization~~ insuring corporation that is owned or operated by an 8543  
insurer. 8544

(3) "Small employer" means any person, firm, corporation, or 8545  
partnership actively engaged in business whose total employed work 8546  
force, on at least fifty per cent of its working days during the 8547  
preceding year, consisted of at least two unrelated eligible 8548  
employees but no more than twenty-five eligible employees, the 8549  
majority of whom were employed within this state. In determining 8550  
the number of eligible employees, companies that are affiliated 8551  
companies or that are eligible to file a combined tax return for 8552  
purposes of state taxation shall be considered one employer. In 8553  
determining whether the members of an association are small 8554  
employers, each member of the association shall be considered as a 8555  
separate person, firm, corporation, or partnership. 8556

(4) "Small employer group" means any group consisting of all 8557  
of the eligible employees of a small employer, except those 8558  
employees who are covered, or are eligible for coverage, under any 8559  
other private or public health benefits arrangement, including the 8560  
medicare program established under Title XVIII of the "Social 8561  
Security Act," 49 Stat. 620 (1935), 42 U.S.C.A. 301, as amended, 8562  
or any other act of congress or law of this or any other state of 8563

the United States that provides benefits comparable to the 8564  
benefits provided under this section. 8565

(B) Beginning in January of each year, insurers shall accept 8566  
applicants for open enrollment coverage, as set forth in divisions 8567  
(B)(1) and (2) of this section, in the order in which they apply 8568  
for coverage and subject to the limitation set forth in division 8569  
(G) of this section: 8570

(1) Insurers in the business of issuing health benefit plans 8571  
to small employer groups shall accept small employer groups for 8572  
which coverage is not otherwise available and for whom coverage 8573  
had not been terminated by the employer or by an insurer ~~or~~, 8574  
health maintenance organization, or health insuring corporation 8575  
during the preceding twelve-month period; 8576

(2) Insurers in the business of issuing individual policies 8577  
of sickness and accident insurance as contemplated by section 8578  
3923.021 of the Revised Code, except individual policies issued 8579  
pursuant to section 3923.122 of the Revised Code, shall either 8580  
accept individuals pursuant to the open enrollment requirements of 8581  
section 3941.53 of the Revised Code, if subject to that section, 8582  
or accept for coverage pursuant to this section individuals to 8583  
whom both of the following conditions apply: 8584

(a) The individual is not applying for coverage as an 8585  
employee of an employer, as a member of an association, or as a 8586  
member of any other group. 8587

(b) The individual is not covered, and is not eligible for 8588  
coverage, under any other private or public health benefits 8589  
arrangement, including the medicare program established under 8590  
Title XVIII of the "Social Security Act," 49 Stat. 620 (1935), 42 8591  
U.S.C.A. 301, as amended, or any other act of congress or law of 8592  
this or any other state of the United States that provides 8593  
benefits comparable to the benefits provided under this section, 8594

any medicare supplement policy, or any conversion or continuation 8595  
of coverage policy under state or federal law. 8596

(C) An insurer shall offer to any individual or small 8597  
employer group accepted under this section the small employer 8598  
health care plan established by the board of directors of the Ohio 8599  
small employer health reinsurance program under division (A) of 8600  
section 3924.10 of the Revised Code or a health benefit plan that 8601  
is substantially similar to the small employer health care plan in 8602  
benefit plan design and scope of covered services. 8603

An insurer may offer other health benefit plans in addition 8604  
to, but not in lieu of, the plan required to be offered under this 8605  
division. These additional health benefit plans shall provide, at 8606  
a minimum, the coverage provided by the small employer health care 8607  
plan or any health benefit plan that is substantially similar to 8608  
the small employer health care plan in benefit plan design and 8609  
scope of covered services. 8610

For purposes of this division, the superintendent of 8611  
insurance shall determine whether a health benefit plan is 8612  
substantially similar to the small employer health care plan in 8613  
benefit plan design and scope of covered services. 8614

(D) Health benefit plans issued under this section may 8615  
establish pre-existing conditions provisions that exclude or limit 8616  
coverage for a period of up to twelve months following the 8617  
individual's effective date of coverage and that may relate only 8618  
to conditions during the six months immediately preceding the 8619  
effective date of coverage. However, an insurer may exclude a late 8620  
enrollee for a period of up to eighteen months following the 8621  
individual's date of application for coverage. 8622

(E) Premiums charged to groups or individuals under this 8623  
section may not exceed an amount that is two and one-half times 8624  
the highest rate charged any other group with similar case 8625

characteristics or any other individual to which the insurer is 8626  
currently accepting new business, and for which similar copayments 8627  
and deductibles are applied. 8628

(F) In offering health benefit plans under this section, an 8629  
insurer may require the purchase of health benefit plans that 8630  
condition the reimbursement of health services upon the use of a 8631  
specific network of providers. 8632

(G)(1) In no event shall an insurer be required to accept 8633  
annually under this section either individuals or small employer 8634  
groups that, in the aggregate, would cause the insurer to have a 8635  
total number of new insureds that is more than one-half per cent 8636  
of its total number of insured individuals in this state per year, 8637  
as contemplated by section 3923.021 of the Revised Code, and small 8638  
group certificate holders of health benefit plans in this state 8639  
per year, calculated as of the immediately preceding thirty-first 8640  
day of December and excluding the insurer's medicare supplement 8641  
policies and conversion or continuation of coverage policies under 8642  
state or federal law and any policies described in division (N) of 8643  
this section. If an insurer is subject to, and elects to operate 8644  
under, the individual open enrollment requirements of section 8645  
3941.53 of the Revised Code, in no event shall the insurer be 8646  
required to accept annually under this section small employer 8647  
groups that would cause the insurer to have a total number of new 8648  
insureds that is more than one-half per cent of its total number 8649  
of small group certificate holders calculated as set forth in 8650  
division (G)(1) of this section. 8651

(2) An officer of the insurer shall certify to the department 8652  
of insurance when it has met the enrollment limit set forth in 8653  
division (G)(1) of this section. Upon providing such 8654  
certification, the insurer shall be relieved of its open 8655  
enrollment requirement under this section for the remainder of the 8656  
calendar year. 8657

(H) An insurer shall not be required to accept under this 8658  
section applicants who, at the time of enrollment, are confined to 8659  
a health care facility because of chronic illness, permanent 8660  
injury, or other infirmity that would cause economic impairment to 8661  
the insurer if the applicants were accepted, or to make the 8662  
effective date of benefits for individuals or groups accepted 8663  
under this section earlier than ninety days after the date of 8664  
acceptance. 8665

(I) The requirements of this section do not apply to any 8666  
insurer that is currently in a state of supervision, insolvency, 8667  
or liquidation. If an insurer demonstrates to the satisfaction of 8668  
the superintendent that the requirements of this section would 8669  
place the insurer in a state of supervision, insolvency, or 8670  
liquidation, the superintendent may waive or modify the 8671  
requirements of division (B) or (G) of this section. The actions 8672  
of the superintendent under this division shall be effective for a 8673  
period of not more than one year. At the expiration of such time, 8674  
a new showing of need for a waiver or modification by the insurer 8675  
shall be made before a new waiver or modification is issued or 8676  
imposed. 8677

(J) No hospital, health care facility, or health care 8678  
practitioner, and no person who employs any health care 8679  
practitioner, shall balance bill any individual or dependent of an 8680  
individual or any eligible employee or dependent of an employee 8681  
for any health care supplies or services provided to the 8682  
individual or dependent or the eligible employee or dependent, who 8683  
is insured under a policy or enrolled under a health benefit plan 8684  
issued under this section. The hospital, health care facility, or 8685  
health care practitioner, or any person that employs the health 8686  
care practitioner, shall accept payments made to it by the insurer 8687  
under the terms of the policy or contract insuring or covering 8688  
such individual as payment in full for such health care supplies 8689

or services. 8690

As used in this division, "hospital" has the same meaning as 8691  
in section 3727.01 of the Revised Code; "health care practitioner" 8692  
has the same meaning as in section 4769.01 of the Revised Code; 8693  
and "balance bill" means charging or collecting an amount in 8694  
excess of the amount reimbursable or payable under the policy or 8695  
health care service contract issued to an individual or group 8696  
under this section for such health care supply or service. 8697  
"Balance bill" does not include charging for or collecting 8698  
copayments or deductibles required by the policy or contract. 8699

(K) An insurer shall pay an agent a commission in the amount 8700  
of five per cent of the premium charged for initial placement or 8701  
for otherwise securing the issuance of a policy or contract issued 8702  
to an individual or small employer group under this section, and 8703  
four per cent of the premium charged for the renewal of such a 8704  
policy or contract. The superintendent may adopt, in accordance 8705  
with Chapter 119. of the Revised Code, such rules as are necessary 8706  
to enforce this division. 8707

(L) Except as otherwise provided in this section, sections 8708  
3924.01 to 3924.06 of the Revised Code apply to all health benefit 8709  
plans issued under this section. 8710

(M) Individuals accepted for coverage under this section may 8711  
be issued contracts and certificates subject to the requirements 8712  
of section 3923.12 of the Revised Code. The coverage issued to 8713  
such individuals is not subject to the requirements of section 8714  
3923.021 of the Revised Code. 8715

(N) This section does not apply to any policy that provides 8716  
coverage for specific diseases or accidents only, or to any 8717  
hospital indemnity, medicare supplement, long-term care, 8718  
disability income, one-time-limited-duration policy of no longer 8719  
than six months, or other policy that offers only supplemental 8720

benefits. 8721

**Sec. 3924.01.** As used in sections 3924.01 to 3924.14 of the 8722  
Revised Code: 8723

(A) "Actuarial certification" means a written statement 8724  
prepared by a member of the American academy of actuaries, or by 8725  
any other person acceptable to the superintendent of insurance, 8726  
that states that, based upon the person's examination, a carrier 8727  
offering health benefit plans to small employers is in compliance 8728  
with sections 3924.01 to 3924.14 of the Revised Code. "Actuarial 8729  
certification" shall include a review of the appropriate records 8730  
of, and the actuarial assumptions and methods used by, the carrier 8731  
relative to establishing premium rates for the health benefit 8732  
plans. 8733

(B) "Adjusted average market premium price" means the average 8734  
market premium price as determined by the board of directors of 8735  
the Ohio small employer health reinsurance program either on the 8736  
basis of the arithmetic mean of all carriers' premium rates for an 8737  
SEHC plan sold to groups with similar case characteristics by all 8738  
carriers selling SEHC plans in the state, or on any other 8739  
equitable basis determined by the board. 8740

(C) "Base premium rate" means, as to any health benefit plan 8741  
that is issued by a carrier and that covers at least two but no 8742  
more than fifty employees of a small employer, the lowest premium 8743  
rate for a new or existing business prescribed by the carrier for 8744  
the same or similar coverage under a plan or arrangement covering 8745  
any small employer with similar case characteristics. 8746

(D) "Carrier" means any sickness and accident insurance 8747  
company or health ~~maintenance organization~~ insuring corporation 8748  
authorized to issue health benefit plans in this state or a MEWA. 8749  
A sickness and accident insurance company that owns or operates a 8750

health ~~maintenance organization~~ insuring corporation, either as a 8751  
separate corporation or as a line of business, shall be considered 8752  
as a separate carrier from that health ~~maintenance organization~~ 8753  
insuring corporation for purposes of sections 3924.01 to 3924.14 8754  
of the Revised Code. 8755

(E) "Case characteristics" means, with respect to a small 8756  
employer, the geographic area in which the employees work; the age 8757  
and sex of the individual employees and their dependents; the 8758  
appropriate industry classification as determined by the carrier; 8759  
the number of employees and dependents; and such other objective 8760  
criteria as may be established by the carrier. "Case 8761  
characteristics" does not include claims experience, health 8762  
status, or duration of coverage from the date of issue. 8763

(F) "Dependent" means the spouse or child of an eligible 8764  
employee, subject to applicable terms of the health benefits plan 8765  
covering the employee. 8766

(G) "Eligible employee" means an employee who works a normal 8767  
work week of twenty-five or more hours. "Eligible employee" does 8768  
not include a temporary or substitute employee, or a seasonal 8769  
employee who works only part of the calendar year on the basis of 8770  
natural or suitable times or circumstances. 8771

(H) "Financially impaired" means a program member that, after 8772  
April 14, 1993, is not insolvent but is determined by the 8773  
superintendent to be potentially unable to fulfill its contractual 8774  
obligations, or is placed under an order of rehabilitation or 8775  
conservation by a court of competent jurisdiction or under an 8776  
order of supervision by the superintendent. 8777

(I) "Health benefit plan" means any hospital or medical 8778  
expense policy or certificate or any health plan provided by a 8779  
carrier, that is delivered, issued for delivery, renewed, or used 8780  
in this state on or after the date occurring six months after ~~the~~ 8781

~~effective date of this amendment~~ November 24, 1995. "Health 8782  
benefit plan" does not include policies covering only accident, 8783  
credit, dental, disability income, long-term care, hospital 8784  
indemnity, medicare supplement, specified disease, or vision care; 8785  
coverage under a one-time-limited-duration policy of no longer 8786  
than six months; ~~coverage issued by a health care corporation;~~ 8787  
~~coverage issued by a prepaid dental plan organization solely or in~~ 8788  
~~conjunction with a carrier;~~ coverage issued as a supplement to 8789  
liability insurance; insurance arising out of a workers' 8790  
compensation or similar law; automobile medical-payment insurance; 8791  
or insurance under which benefits are payable with or without 8792  
regard to fault and which is statutorily required to be contained 8793  
in any liability insurance policy or equivalent self-insurance. 8794

(J) "Initial enrollment period" means the thirty-day period 8795  
immediately following any service waiting period established by an 8796  
employer. 8797

(K) "Late enrollee" means an eligible employee or dependent 8798  
who requests enrollment in a small employer's health benefit plan 8799  
following the initial enrollment period provided under the terms 8800  
of the first plan for which the employee or dependent was eligible 8801  
through the small employer, unless any of the following apply: 8802

(1) The individual: 8803

(a) Was covered under another health benefit plan at the time 8804  
the individual was eligible to enroll; 8805

(b) States, at the time of the initial eligibility, that 8806  
coverage under another health benefit plan was the reason for 8807  
declining enrollment; 8808

(c) Has lost coverage under another health benefit plan as a 8809  
result of the termination of employment, a reduction of hours 8810  
worked per week, the termination of the other plan's coverage, 8811  
death of a spouse, or divorce; and 8812

(d) Requests enrollment within thirty days after the 8813  
termination of coverage under another health benefit plan. 8814

(2) The individual is employed by an employer who offers 8815  
multiple health benefit plans and the individual elects a 8816  
different health benefit plan during an open enrollment period. 8817

(3) A court has ordered coverage to be provided for a spouse 8818  
or minor child under a covered employee's plan and a request for 8819  
enrollment is made within thirty days after issuance of the court 8820  
order. 8821

(L) "MEWA" means any "multiple employer welfare arrangement" 8822  
as defined in section 3 of the "Federal Employee Retirement Income 8823  
Security Act of 1974," 88 Stat. 832, 29 U.S.C.A. 1001, as amended, 8824  
except for any arrangement which is fully insured as defined in 8825  
division (b)(6)(D) of section 514 of that act. 8826

(M) "Midpoint rate" means, for small employers with similar 8827  
case characteristics and plan designs and as determined by the 8828  
applicable carrier for a rating period, the arithmetic average of 8829  
the applicable base premium rate and the corresponding highest 8830  
premium rate. 8831

(N) "Pre-existing conditions provision" means a policy 8832  
provision that excludes or limits coverage for charges or expenses 8833  
incurred during a specified period following the insured's 8834  
effective date of coverage as to a condition which, during a 8835  
specified period immediately preceding the effective date of 8836  
coverage, had manifested itself in such a manner as would cause an 8837  
ordinarily prudent person to seek medical advice, diagnosis, care, 8838  
or treatment or for which medical advice, diagnosis, care, or 8839  
treatment was recommended or received, or a pregnancy existing on 8840  
the effective date of coverage. 8841

(O) "Service waiting period" means the period of time after 8842  
employment begins before an eligible employee may enroll in any 8843

applicable health benefit plan offered by the small employer. 8844

(P)(1) "Small employer" means any person, firm, corporation, 8845  
partnership, or association actively engaged in business whose 8846  
total employed work force consisted of, on at least fifty per cent 8847  
of its working days during the preceding year, at least two but no 8848  
more than fifty eligible employees, the majority of whom were 8849  
employed within the state. 8850

(2) In determining the number of eligible employees for 8851  
purposes of division (P)(1) of this section, companies which are 8852  
affiliated companies or which are eligible to file a combined tax 8853  
return for purposes of state taxation shall be considered one 8854  
employer. Except as otherwise specifically provided, provisions of 8855  
sections 3924.01 to 3924.14 of the Revised Code that apply to a 8856  
small employer that has a health benefit plan shall continue to 8857  
apply until the plan anniversary following the date the employer 8858  
no longer meets the requirements of this division. 8859

(Q) "SEHC plan" means an Ohio small employer health care 8860  
plan, which is a health benefit plan for small employers 8861  
established by the board in accordance with section 3924.10 of the 8862  
Revised Code. 8863

**Sec. 3924.02.** (A) An individual or group health benefit plan 8864  
is subject to sections 3924.01 to 3924.14 of the Revised Code if 8865  
it provides health care benefits covering at least two but no more 8866  
than fifty employees of a small employer, and if it meets either 8867  
of the following conditions: 8868

(1) Any portion of the premium or benefits is paid by a small 8869  
employer, or any covered individual is reimbursed, whether through 8870  
wage adjustments or otherwise, by a small employer for any portion 8871  
of the premium. 8872

(2) The health benefit plan is treated by the employer or any 8873

of the covered individuals as part of a plan or program for 8874  
purposes of section 106 or 162 of the "Internal Revenue Code of 8875  
1986," 100 Stat. 2085, 26 U.S.C.A. 1, as amended. 8876

(B) Notwithstanding division (A) of this section, divisions 8877  
(G) to (J) of section 3924.03 of the Revised Code and section 8878  
3924.04 of the Revised Code do not apply to health benefit 8879  
policies that are not sold to owners of small businesses as an 8880  
employment benefit plan. Such policies shall clearly state that 8881  
they are not being sold as an employment benefit plan and that the 8882  
owner of the business is not responsible, either directly or 8883  
indirectly, for paying the premium or benefits. 8884

(C) Every health benefit plan offered or delivered by a 8885  
carrier, other than a health ~~maintenance organization~~ insuring 8886  
corporation, to a small employer is subject to sections 3923.23, 8887  
3923.231, 3923.232, 3923.233, and 3923.234 of the Revised Code and 8888  
any other provision of the Revised Code that requires the 8889  
reimbursement, utilization, or consideration of a specific 8890  
category of a licensed or certified health care practitioner. 8891

(D) Except as expressly provided in sections 3924.01 to 8892  
3924.14 of the Revised Code, no health benefit plan offered to a 8893  
small employer is subject to any of the following: 8894

(1) Any law that would inhibit any carrier from contracting 8895  
with providers or groups of providers with respect to health care 8896  
services or benefits; 8897

(2) Any law that would impose any restriction on the ability 8898  
to negotiate with providers regarding the level or method of 8899  
reimbursing care or services provided under the health benefit 8900  
plan; 8901

(3) Any law that would require any carrier to either include 8902  
a specific provider or class of provider when contracting for 8903  
health care services or benefits, or to exclude any class of 8904

provider that is generally authorized by statute to provide such 8905  
care. 8906

**Sec. 3924.08.** (A) The board of directors of the Ohio small 8907  
employer health reinsurance program shall consist of nine 8908  
appointed members who shall serve staggered terms as determined by 8909  
the initial board for its members and by the plan of operation of 8910  
the program for members of subsequent boards. Within thirty days 8911  
after April 14, 1993, the members of the board shall be appointed, 8912  
as follows: 8913

(1) The chairperson of the senate committee having 8914  
jurisdiction over insurance shall appoint the following members: 8915

(a) Two member carriers that are small employer carriers; 8916

(b) One member carrier that is a health ~~maintenance~~ 8917  
~~organization~~ insuring corporation predominantly in the small 8918  
employer market; 8919

(c) One representative of providers of health care. 8920

(2) The chairperson of the committee in the house of 8921  
representatives having jurisdiction over insurance shall appoint 8922  
the following members: 8923

(a) One member carrier that is a small employer carrier; 8924

(b) One member carrier whose principal health insurance 8925  
business is in the large employer market; 8926

(c) One representative of an employer with fifty or fewer 8927  
employees; 8928

(d) One representative of consumers in this state. 8929

(3) The superintendent shall appoint a representative of a 8930  
member carrier operating in the small employer market who is a 8931  
fellow of the society of actuaries. 8932

The superintendent, a member of the house of representatives 8933  
appointed by the speaker of the house of representatives, and a 8934  
member of the senate appointed by the president of the senate, 8935  
shall be ex-officio members of the board. The membership of all 8936  
boards subsequent to the initial board shall reflect the 8937  
distribution described in division (A) of this section. 8938

The chairperson of the initial board and each subsequent 8939  
board shall represent a small employer member carrier and shall be 8940  
elected by a majority of the voting members of the board. Each 8941  
chairperson shall serve for the maximum duration established in 8942  
the plan of operation. 8943

(B) Within one hundred eighty days after the appointment of 8944  
the initial board, the board shall establish a plan of operation 8945  
and, thereafter, any amendments to the plan that are necessary or 8946  
suitable, to assure the fair, reasonable, and equitable 8947  
administration of the program. The board shall, immediately upon 8948  
adoption, provide to the superintendent copies of the plan of 8949  
operation and all subsequent amendments to it. 8950

(C) The plan of operation shall establish rules, conditions, 8951  
and procedures for all of the following: 8952

(1) The handling and accounting of assets and moneys of the 8953  
program and for an annual fiscal reporting to the superintendent; 8954

(2) Filling vacancies on the board; 8955

(3) Selecting an administering insurer, which shall be a 8956  
carrier as defined in section 3924.01 of the Revised Code, and 8957  
setting forth the powers and duties of the administering insurer; 8958

(4) Reinsuring risks in accordance with sections 3924.07 to 8959  
3924.14 of the Revised Code; 8960

(5) Collecting assessments subject to section 3924.13 of the 8961  
Revised Code from all members to provide for claims reinsured by 8962

the program and for administrative expenses incurred or estimated	8963
to be incurred during the period for which the assessment is made;	8964
(6) Providing protection for carriers from the financial risk	8965
associated with small employers that present poor credit risks;	8966
	8967
(7) Establishing standards for the coverage of small	8968
employers that have a high turnover of employees;	8969
(8) Establishing an appeals process for carriers to seek	8970
relief when a carrier has experienced an unfair share of	8971
administrative and credit risks;	8972
(9) Establishing the adjusted average market premium prices	8973
for use by the SEHC plan for groups of two to twenty-five	8974
employees and for groups of twenty-six to fifty employees that are	8975
offered in the state;	8976
(10) Establishing participation standards at issue and	8977
renewal for reinsured cases;	8978
(11) Reinsuring risks and collecting assessments in	8979
accordance with division (G) of section 3924.11 of the Revised	8980
Code;	8981
(12) Any additional matters as determined by the board.	8982
<b>Sec. 3924.10.</b> (A) The board of directors of the Ohio small	8983
employer health reinsurance program shall design the SEHC plan	8984
which, when offered by a carrier, is eligible for reinsurance	8985
under the program. The board shall establish the form and level of	8986
coverage to be made available by carriers in their SEHC plan. In	8987
designing the plan the board shall also establish benefit levels,	8988
deductibles, coinsurance factors, exclusions, and limitations for	8989
the plan. The forms and levels of coverage established by the	8990
board shall specify which components of a health benefit plan	8991
offered by a small employer carrier may be reinsured. The SEHC	8992

plan is subject to division (C) of section 3924.02 of the Revised Code and to the provisions in Chapters ~~1742-~~ 1751., 3923., and any other chapter of the Revised Code that require coverage or the offer of coverage of a health care service or benefit.

(B) The board shall adopt the SEHC plan within one hundred eighty days after its appointment. The plan may include cost containment features including any of the following:

(1) Utilization review of health care services, including review of the medical necessity of hospital and physician services;

(2) Case management benefit alternatives;

(3) Selective contracting with hospitals, physicians, and other health care providers;

(4) Reasonable benefit differentials applicable to participating and nonparticipating providers;

(5) Employee assistance program options that provide preventive and early intervention mental health and substance abuse services;

(6) Other provisions for the cost-effective management of the plan.

(C) An SEHC plan established for use by health ~~maintenance organizations~~ insuring corporations shall be consistent with the basic method of operation of such ~~organizations~~ corporations.

(D) Each carrier shall certify to the superintendent of insurance, in the form and manner prescribed by the superintendent, that the SEHC plan filed by the carrier is in substantial compliance with the provisions of the board SEHC plan. Upon receipt by the superintendent of the certification, the carrier may use the certified plan.

(E) Each carrier shall, on and after sixty days after the 9023  
date that the program becomes operational and as a condition of 9024  
transacting business in this state, renew coverage provided to any 9025  
individual or group under its SEHC plan. 9026

(F) A carrier shall not be required to renew coverage where 9027  
the superintendent finds that renewal of coverage would place the 9028  
carrier in a financially impaired condition. The superintendent 9029  
shall determine when the carrier is no longer financially impaired 9030  
and is, therefore, subject to the guaranteed renewability 9031  
requirements. 9032

**Sec. 3924.12.** (A) Except as provided in division (B) of this 9033  
section, premium rates charged for coverage reinsured by the Ohio 9034  
small employer health reinsurance program shall be established as 9035  
follows: 9036

(1) For whole group reinsurance coverage, one and one-half 9037  
times the adjusted average market premium price established by the 9038  
program for that classification or group with similar 9039  
characteristics and coverage, with respect to the eligible 9040  
employees of a small employer and their dependents, all of whose 9041  
coverage is reinsured with the program, minus a ceding expense 9042  
factor determined by the board of directors of the program; 9043

(2) For individual reinsurance coverage, five times the 9044  
adjusted average market premium price established by the program 9045  
for an individual in that classification or group with similar 9046  
characteristics and coverage, with respect to an eligible employee 9047  
or ~~his~~ the employee's dependents, minus a ceding expense factor 9048  
determined by the board. 9049

(B) Premium rates charged for reinsurance by the program to a 9050  
health ~~maintenance organization~~ insuring corporation that is 9051  
approved by the secretary of health and human services as a 9052

federally qualified health maintenance organization pursuant to 9053  
the "Social Security Act," 49 Stat. 620 (1935), 42 U.S.C.A. 301, 9054  
as amended, and as such is subject to requirements that limit the 9055  
amount of risk that may be ceded to the program, may be modified 9056  
to reflect the portion of risk that may be ceded to the program. 9057

**Sec. 3924.13.** (A) Following the close of each calendar year, 9058  
the administering insurer of the Ohio small employer health 9059  
reinsurance program shall determine the net premiums, the program 9060  
expenses for administration, and the incurred losses, if any, for 9061  
the year, taking into account investment income and other 9062  
appropriate gains and losses. For purposes of this section, health 9063  
benefit plan premiums earned by MEWAs shall be established by 9064  
adding paid claim losses and administrative expenses of the MEWA. 9065  
Health benefit plan premiums and benefits paid by a carrier that 9066  
are less than an amount determined by the board of directors of 9067  
the program to justify the cost of collection shall not be 9068  
considered for purposes of determining assessments. For purposes 9069  
of this division, "net premiums" means health benefit plan 9070  
premiums, less administrative expense allowances. 9071

(B) Any net loss for the year shall be recouped first by 9072  
assessments of carriers in accordance with this division. 9073  
Assessments shall be apportioned by the board among all carriers 9074  
participating in the program in proportion to their respective 9075  
shares of the total premiums, net of reinsurance premiums paid for 9076  
coverage under this program earned in the state from health 9077  
benefit plans covering small employers that are issued by 9078  
participating members during the calendar year coinciding with or 9079  
ending during the fiscal year of the program, or on any other 9080  
equitable basis reflecting coverage of small employers as may be 9081  
provided in the plan of operation. An assessment shall be made 9082  
pursuant to this division against a health ~~maintenance~~ 9083  
~~organization~~ insuring corporation that is approved by the 9084

secretary of health and human services as a federally qualified 9085  
health maintenance organization pursuant to the "Social Security 9086  
Act," 49 Stat. 620 (1935), 42 U.S.C.A. 301, as amended, subject to 9087  
an assessment adjustment formula adopted by the board for such 9088  
health ~~maintenance organizations~~ insuring corporations that 9089  
recognizes the restrictions imposed on the ~~organizations~~ entities 9090  
by federal law. The adjustment formula shall be adopted by the 9091  
board prior to the first anniversary of the program's operation. 9092  
In no event shall the assessment made pursuant to this division 9093  
exceed, on an annual basis, one per cent of the carrier's Ohio 9094  
small employer group premium as reported on its most recent annual 9095  
statement filed with the superintendent of insurance. If an excess 9096  
is actuarially projected, the superintendent may take any action 9097  
necessary to lower the assessment to the maximum level of one per 9098  
cent. 9099

(C) If assessments exceed actual losses and administrative 9100  
expenses of the program, the excess shall be held at interest and 9101  
used by the board to offset future losses or to reduce program 9102  
premiums. As used in this division, "future losses" includes 9103  
reserves for incurred but not reported claims. 9104

(D) Each carrier's proportion of participation in the program 9105  
shall be determined annually by the board based on annual 9106  
statements and other reports deemed necessary by the board and 9107  
filed by the carrier with the board. MEWAs shall report to the 9108  
board claims payments made and administrative expenses incurred in 9109  
this state on an annual basis on a form prescribed by the 9110  
superintendent. 9111

(E) Provision shall be made in the plan of operation for the 9112  
imposition of an interest penalty for late payment of assessments. 9113

(F) A carrier may seek from the superintendent a deferment, 9114  
in whole or in part, from any assessment issued by the board. The 9115  
superintendent may defer, in whole or in part, the assessment of a 9116

carrier if, in the opinion of the superintendent, payment of the 9117  
assessment would endanger the carrier's ability to fulfill its 9118  
contractual obligations. 9119

(G) In the event an assessment against a carrier is deferred 9120  
in whole or in part, the amount by which the assessment is 9121  
deferred may be assessed against the other carriers in a manner 9122  
consistent with the basis for assessments set forth in this 9123  
section. In such event, the other carriers assessed shall have a 9124  
claim in the amount of the assessment against the carrier 9125  
receiving the deferment. The carrier receiving the deferment shall 9126  
remain liable to the program for the amount deferred. The 9127  
superintendent may attach appropriate conditions to any deferment. 9128

**Sec. 3924.41.** (A) As used in sections 3924.41 and 3924.42 of 9129  
the Revised Code, "health insurer" means any sickness and accident 9130  
~~insurer, health maintenance organization, preferred provider~~ 9131  
~~organization, or health care insuring corporation, medical care~~ 9132  
~~corporation, dental care corporation, or prepaid dental plan~~ 9133  
~~organization.~~ "Health insurer" also includes any group health plan 9134  
as defined in section 607 of the federal "Employee Retirement 9135  
Income Security Act of 1974," 88 Stat. 832, 29 U.S.C.A. 1167. 9136

(B) Notwithstanding any other provision of the Revised Code, 9138  
no health insurer shall take into consideration the availability 9139  
of, or eligibility for, medical assistance in this state under 9140  
Chapter 5111. of the Revised Code or in any other state pursuant 9141  
to Title XIX of the "Social Security Act," 49 Stat. 620 (1935), 42 9142  
U.S.C.A. 301, as amended, when determining an individual's 9143  
eligibility for coverage or when making payments to or on behalf 9144  
of an enrollee, subscriber, policyholder, or certificate holder. 9145

**Sec. 3924.61.** As used in sections 3924.61 to 3924.74 of the 9146

Revised Code: 9147

(A) "Account holder" means the natural person who opens a 9148  
medical savings account or on whose behalf a medical savings 9149  
account is opened. 9150

(B) "Eligible medical expense" means any expense for a 9151  
service rendered by a licensed health care provider or a ~~christian~~ 9152  
~~science~~ Christian Science practitioner, or for an article, device, 9153  
or drug prescribed by a licensed health care provider or provided 9154  
by a ~~christian science~~ Christian Science practitioner, when 9155  
intended for use in the mitigation, treatment, or prevention of 9156  
disease; or premiums paid for comprehensive sickness and accident 9157  
insurance, coverage under a health care plan of a health 9158  
~~maintenance organization~~ insuring corporation organized under 9159  
Chapter ~~1742.~~ 1751. of the Revised Code, long-term care insurance 9160  
as defined in section 3923.41 of the Revised Code, Medicare 9161  
supplemental coverage as defined in section 3923.33 of the Revised 9162  
Code, or payments made pursuant to cost sharing agreements under 9163  
comprehensive sickness and accident plans. An "eligible medical 9164  
expense" does not include expenses otherwise paid or reimbursed, 9165  
including medical expenses paid or reimbursed under an automobile 9166  
or motor vehicle insurance policy, a workers' compensation 9167  
insurance policy or plan, or an employer-sponsored health coverage 9168  
policy, plan, or contract. 9169

(C) "Qualified dependent" means a child of an account holder 9170  
when any of the following applies: 9171

(1) The child is under nineteen years of age, or is under 9172  
twenty-three years of age and a full-time student at an accredited 9173  
college or university; 9174

(2) The child is not self-sufficient due to physical or 9175  
mental disorders or impairments; 9176

(3) The child is legally entitled to the provision of proper 9177  
or necessary subsistence, education, medical care, or other care 9178  
necessary for the child's health, guidance, or well-being and is 9179  
not otherwise emancipated, self-supporting, married, or a member 9180  
of the armed forces of the United States. 9181

**Sec. 3924.62.** (A) A medical savings account may be opened by 9182  
or on behalf of any natural person, to pay the person's eligible 9183  
medical expenses and the eligible medical expenses of that 9184  
person's spouse or qualified dependent. A medical savings account 9185  
may be opened by or on behalf of a person only if that person 9186  
participates in a sickness or accident insurance plan, a plan 9187  
offered by a health ~~maintenance organization~~ insuring corporation 9188  
organized under Chapter ~~1742-~~ 1751, of the Revised Code, or a 9189  
self-funded, employer-sponsored health benefit plan established 9190  
pursuant to the "Employee Retirement Income Security Act of 1974," 9191  
88 Stat. 832, 29 U.S.C.A. 1001, as amended. While the medical 9192  
savings account is open, the account holder shall continue to 9193  
participate in such a plan. 9194

(B) A person who refuses to participate in a policy, plan, or 9195  
contract of health coverage that is funded by the person's 9196  
employer, and who receives additional monetary compensation by 9197  
virtue of refusing that coverage, may not open a medical savings 9198  
account unless the medical savings account also is sponsored by 9199  
the person's employer. 9200

**Sec. 3924.64.** (A) At the time a medical savings account is 9201  
opened, an administrator for the account shall be designated. If 9202  
an employer opens an account for an employee, the employer may 9203  
designate the administrator. If an account is opened by any person 9204  
other than an employer, or if an employer chooses not to designate 9205  
an administrator for an account opened for an employee, the 9206

account holder shall designate the administrator. The 9207  
administrator shall manage the account in a fiduciary capacity for 9208  
the benefit of the account holder. 9209

(B) Medical savings accounts shall be administered by one of 9210  
the following: 9211

(1) A federally or state-chartered bank, savings and loan 9212  
association, savings bank, or credit union; 9213

(2) A trust company authorized to act as a fiduciary; 9214

(3) An insurer authorized under Title XXXIX of the Revised 9215  
Code to engage in the business of sickness and accident insurance; 9216

(4) A dealer or salesperson licensed under Chapter 1707. of 9217  
the Revised Code; 9218

(5) An administrator licensed under Chapter 3959. of the 9219  
Revised Code; 9220

(6) A certified public accountant; 9221

(7) An employer that administers an employee benefit plan 9222  
subject to regulation under the "Employee Retirement Income 9223  
Security Act of 1974," 88 Stat. 829, 29 U.S.C.A. 1001, as amended, 9224  
or that maintains medical savings accounts for its employees; 9225

(8) Health ~~maintenance organizations~~ insuring corporations 9226  
organized under Chapter ~~1742.~~ 1751. of the Revised Code. 9227

(C) Each administrator shall send to the account holder, at 9228  
least annually, a statement setting forth the balance remaining in 9229  
the account holder's account and detailing the activity in the 9230  
account since the last statement was issued. Upon an 9231  
administrator's receipt of a written request from an account 9232  
holder for a current statement, the administrator shall promptly 9233  
send the statement to the account holder. 9234

(D) When an account holder documents to the administrator of 9235

the account the account holder's payment of, or the account 9236  
holder's obligation for, an eligible medical expense for the 9237  
account holder, the account holder's spouse, or qualified 9238  
dependents, the administrator shall reimburse the account holder 9239  
for, or shall pay for, the eligible medical expense with funds 9240  
from the account holder's account, if sufficient funds are 9241  
available in the account holder's account. If there are not 9242  
sufficient funds in the account to fully reimburse the account 9243  
holder or pay the expenses, the administrator shall reimburse the 9244  
account holder or pay the expenses using whatever funds are in the 9245  
account. The reimbursement or payment shall be made within thirty 9246  
days of the administrator's receipt of the documentation. At the 9247  
time of making the reimbursement or payment, the administrator 9248  
shall notify the account holder if the medical expense does not 9249  
count toward meeting the deductible or other obligation for the 9250  
receipt of benefits that is required by the insurer or other 9251  
third-party payer providing health coverage to the account holder. 9252  
The administrator shall keep a record of the amounts disbursed 9253  
from the account for documented eligible medical expenses and of 9254  
the dates on which the expenses were incurred. This record shall 9255  
be made available to any sickness and accident insurer or other 9256  
third-party payer providing health coverage to the account holder, 9257  
for use by the insurer or third-party payer in determining whether 9258  
the account holder has met the deductible or other obligation 9259  
required for the receipt of benefits from the insurer or 9260  
third-party payer. 9261

(E) When an account is opened, the administrator shall give 9262  
written notice to the account holder of the date of the last 9263  
business day of the administrator's business year. 9264

**Sec. 3924.73.** (A) As used in this section: 9265

(1) "Health care insurer" means any person legally engaged in 9266

the business of providing sickness and accident insurance 9267  
contracts in this state, a health ~~maintenance organization~~ 9268  
insuring corporation organized under Chapter ~~1742.~~ 1751. of the 9269  
Revised Code, or any legal entity that is self-insured and 9270  
provides health care benefits to its employees or members. 9271

(2) "Small employer" has the same meaning as in division (P) 9272  
of section 3924.01 of the Revised Code. 9273

(B)(1) Subject to division (B)(2) of this section, nothing in 9274  
sections 3924.61 to 3924.74 of the Revised Code shall be construed 9275  
to limit the rights, privileges, or protections of employees or 9276  
small employers under sections 3924.01 to 3924.14 of the Revised 9277  
Code. 9278

(2) If any account holder enrolls or applies to enroll in a 9279  
policy or contract offered by a health care insurer providing 9280  
sickness and accident coverage that is more comprehensive than, 9281  
and has a deductible amount that is less than, the coverage and 9282  
deductible amount of the policy under which the account holder 9283  
currently is enrolled, the health care insurer to which the 9284  
account holder applies may subject the account holder to the same 9285  
medical review, waiting periods, and underwriting requirements to 9286  
which the health care insurer generally subjects other enrollees 9287  
or applicants, unless the account holder enrolls or applies to 9288  
enroll during a designated period of open enrollment. 9289

**Sec. 3929.77.** The joint underwriting association shall be 9290  
governed by a board of governors consisting of nine members seven 9291  
of whom shall be selected from the members of the joint 9292  
underwriting association and appointed by the superintendent of 9293  
insurance. Five members shall be selected from insurers and 9294  
corporations domiciled in this state. Two members shall be 9295  
selected from insurers and corporations domiciled outside this 9296  
state. One member shall be an insurance agent licensed and writing 9297

insurance in this state. One member shall represent the interests 9298  
of consumers and shall neither be a member of, or associated with, 9299  
a health care provider or profession nor associated with an 9300  
insurance company or ~~an association organized~~ a health insuring 9301  
corporation holding a certificate of authority under Chapter 9302  
~~1737., 1738., or 1740.~~ 1751. of the Revised Code. The directors of 9303  
the stabilization reserve fund shall serve as ex officio members 9304  
of the board of governors. 9305

**Sec. 3956.01.** As used in this chapter: 9306

(A) "Account" means either of the two accounts created under 9307  
section 3956.06 of the Revised Code. 9308

(B) "Contractual obligation" means any obligation under a 9309  
policy, contract, or certificate under a group policy or contract, 9310  
or portion of the policy or contract, for which coverage is 9311  
provided under section 3956.04 of the Revised Code. 9312

(C) "Covered policy or contract" means any policy, contract, 9313  
or group certificate within the scope of section 3956.04 of the 9314  
Revised Code. 9315

(D) "Impaired insurer" means a member insurer that, after ~~the~~ 9316  
~~effective date of this section~~ November 20, 1989, is not an 9317  
insolvent insurer, and to which either of the following applies: 9318

(1) The insurer is considered by the superintendent to be 9319  
potentially unable to fulfill its contractual obligations; 9320

(2) The insurer is placed under an order of rehabilitation or 9321  
conservation by a court of competent jurisdiction. 9322

(E) "Insolvent insurer" means a member insurer that, after 9323  
~~the effective date of this section~~ November 20, 1989, is placed 9324  
under an order of liquidation by a court of competent jurisdiction 9325  
with a finding of insolvency. 9326

(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 ~~the effective date of this section~~ November 20, 1989.

(2) "Member insurer" does not include any of the following:

~~(a) A medical care corporation;~~

~~(b) A health care corporation;~~

~~(c) A dental care corporation;~~

~~(d) A prepaid dental plan;~~

~~(e) A health maintenance organization~~ insuring corporation;

~~(f) A preferred provider organization;~~

~~(g)~~ (b) A fraternal benefit society;

~~(h)~~ (c) A self-insurance or joint self-insurance pool or plan of the state or any political subdivision of the state;

~~(i)~~ (d) A mutual protective association;

~~(j)~~ (e) An insurance exchange;

~~(k)~~ (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;

~~(l)~~ (g) Any entity similar to any of those described in divisions (F)(2)(a) to ~~(k)~~ (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.

(I) "Subaccount" means any of the three subaccounts created under division (A) of section 3956.06 of the Revised Code.

(J) "Supplemental contract" means any agreement entered into for the distribution of policy or contract proceeds.

(K) "Unallocated annuity contract" means any annuity contract 9386  
or group annuity certificate that is not issued to and owned by an 9387  
individual, except to the extent of any annuity benefits 9388  
guaranteed to an individual by an insurer under that contract or 9389  
certificate. 9390

**Sec. 3959.01.** (A) "Administration fees" means any amount 9391  
charged a covered person for services rendered. "Administration 9392  
fees" includes commissions earned or paid by any person relative 9393  
to services performed by an administrator. 9394

(B) "Administrator" means any person who adjusts or settles 9395  
claims on, residents of this state in connection with life, 9396  
dental, health, or disability insurance or self-insurance 9397  
programs. "Administrator" does not include any of the following: 9398

(1) An insurance agent or solicitor licensed in this state 9399  
whose activities are limited exclusively to the sale of insurance 9400  
and who does not provide any administrative services; 9401

(2) Any person who administers or operates the workers' 9402  
compensation program of a self-insuring employer under Chapter 9403  
4123. of the Revised Code; 9404

(3) Any person who administers pension plans for the benefit 9405  
of the person's own members or employees or administers pension 9406  
plans for the benefit of the members or employees of any other 9407  
person; 9408

(4) Any person that administers an insured plan or a 9409  
self-insured plan that provides life, dental, health, or 9410  
disability benefits exclusively for the person's own members or 9411  
employees; 9412

(5) ~~Any medical care corporation organized under Chapter 9413  
1737. of the Revised Code, prepaid dental plan organization 9414  
organized under Chapter 1736. of the Revised Code, health care 9415~~

~~insuring corporation organized holding a certificate of authority~~ 9416  
~~under Chapter 1738. 1751. of the Revised Code, dental care~~ 9417  
~~corporation organized under Chapter 1740. of the Revised Code,~~ 9418  
~~health maintenance organization organized under Chapter 1742. of~~ 9419  
~~the Revised Code,~~ or an insurance company that is authorized to 9420  
write life or sickness and accident insurance in this state. 9421

(C) "Aggregate excess insurance" means that type of coverage 9422  
whereby the insurer agrees to reimburse the insured employer or 9423  
trust for all benefits or claims paid during an agreement period 9424  
on behalf of all covered persons under the plan or trust which 9425  
exceed a stated deductible amount and subject to a stated maximum. 9426

(D) "Contributions" means any amount collected from a covered 9427  
person to fund the self-insured portion of any plan in accordance 9428  
with the plan's provisions, summary plan descriptions, and 9429  
contracts of insurance. 9430

(E) "Fiduciary" has the meaning set forth in section 9431  
1002(21)(A) of the "Employee Retirement Income Security Act of 9432  
1974," 88 Stat. 829, 29 U.S.C. 1001, as amended. 9433

(F) "Fiscal year" means the twelve-month accounting period 9434  
commencing on the date the plan is established and ending twelve 9435  
months following that date, and each corresponding twelve-month 9436  
accounting period thereafter as provided for in the summary plan 9437  
description. 9438

(G) "Plan" means any arrangement in written form for the 9439  
payment of life, dental, health, or disability benefits to covered 9440  
persons defined by the summary plan description. 9441

(H) "Plan sponsor" means the person who establishes the plan. 9442  
9443

(I) "Self-insurance program" means a program whereby an 9444  
employer provides a plan of benefits for its employees without 9445  
involving an intermediate insurance carrier to assume risk or pay 9446

claims. "Self-insurance program" includes but is not limited to 9447  
employer programs that pay claims up to a prearranged limit beyond 9448  
which they purchase insurance coverage to protect against 9449  
unpredictable or catastrophic losses. 9450

(J) "Specific excess insurance" means that type of coverage 9451  
whereby the insurer agrees to reimburse the insured employer or 9452  
trust for all benefits or claims paid during an agreement period 9453  
on behalf of a covered person in excess of a stated deductible 9454  
amount and subject to a stated maximum. 9455

(K) "Summary plan description" means the written document 9456  
adopted by the plan sponsor which outlines the plan of benefits, 9457  
conditions, limitations, exclusions, and other pertinent details 9458  
relative to the benefits provided to covered persons thereunder. 9459

**Sec. 3999.32.** (A) As used in this section: 9460

(1) "Certificate holder" means any person whose employment or 9461  
retirement status is the basis of eligibility for coverage under a 9462  
group policy of sickness and accident insurance or for enrollment 9463  
under a group contract of a ~~prepaid dental plan organization,~~ 9464  
~~medical care corporation,~~ health care insuring corporation, ~~dental~~ 9465  
~~care corporation,~~ or health maintenance organization. 9466

(2) "Health insurer" means any sickness and accident insurer, 9468  
~~prepaid dental plan organization,~~ ~~medical care corporation,~~ or 9469  
health care insuring corporation, ~~dental care, corporation,~~ ~~or~~ 9470  
~~health maintenance organization.~~ 9471

(B) Each person to whom a group policy or contract of 9472  
sickness and accident insurance or other health care coverage has 9473  
been delivered or issued for delivery in this state by a health 9474  
insurer shall make a reasonable effort to notify every certificate 9475  
holder, or ~~his~~ certificate holder's designee, who is covered under 9476

that policy or contract whenever the person fails to make a 9477  
required premium payment or contribution on behalf of the 9478  
certificate holder and that failure results in the termination of 9479  
coverage. The person shall mail or present the notice to the 9480  
certificate holder or ~~his~~ certificate holder's designee no later 9481  
than five days after the date on which the person receives the 9482  
notice from the health insurer as required under division (D) of 9483  
this section. If a person other than the policyholder or contract 9484  
holder is obligated to make the required premium payment or 9485  
contribution on behalf of the certificate holder, that person 9486  
shall mail or present the notice as required by this section. 9487

(C) The notice required by division (B) of this section shall 9488  
be in writing and shall clearly state that the person failed to 9489  
make the required premium payment or contribution, the reasons for 9490  
the failure, and the effect of the failure on the coverage of the 9491  
certificate holder under the policy or contract. 9492

(D) If a person described in division (B) of this section 9493  
fails to make a required premium payment or contribution on behalf 9494  
of a certificate holder and that failure results in the 9495  
termination of the coverage, the health insurer providing the 9496  
coverage shall notify the person in writing of that person's 9497  
duties as described in divisions (B) and (C) of this section. If a 9498  
person other than the policyholder or contract holder ~~is~~ IS 9499  
obligated to make the required premium payment or contribution on 9500  
behalf of the certificate holder, the insurer shall notify the 9501  
person in writing of that person's duties as described in 9502  
divisions (B) and (C) of this section. 9503

(E) A certificate holder may designate any person to receive 9504  
on ~~his~~ the certificate holder's behalf the notice required by 9505  
division (B) of this section. The certificate holder shall furnish 9506  
the name and address of the person so designated to the person to 9507  
whom the group policy or contract has been delivered or issued for 9508

delivery. 9509

(F) No person shall knowingly fail to comply with division 9510

(B) or (C) of this section. 9511

**Sec. 3999.36.** (A) As used in this section and sections 9512

3999.37 and 3999.38 of the Revised Code: 9513

(1) "Insurer" means any person that is authorized to engage 9514

in the business of insurance in this state under ~~title~~ TITLE XXXIX 9515

of the Revised Code; ~~any prepaid dental plan organization,~~ 9516

~~medical care corporation,~~ health care insuring corporation, ~~dental~~ 9517

~~care corporation,~~ or ~~health maintenance organization;~~ or any other 9518

person engaging either directly or indirectly in this state in the 9519

business of insurance or entering into contracts substantially 9520

amounting to insurance under section 3905.42 of the Revised Code. 9521

(2) "Impaired" or "impairment" means a financial situation in 9522

which the insurer's assets are less than the sum of the insurer's 9523

minimum required capital, minimum required surplus, and all 9524

liabilities, as determined in accordance with the requirements for 9525

the preparation and filing of the insurer's annual financial 9526

statement. 9527

(3) "Chief executive officer" means the person, irrespective 9528

of ~~his~~ the person's title, designated by the board of directors or 9529

trustees of an insurer as the person charged with the 9530

responsibility of administering and implementing the insurer's 9531

policies and procedures. 9532

(B) Whenever a chief executive officer of an insurer knows or 9533

has reason to know that the insurer is impaired, ~~he~~ the chief 9534

executive officer shall provide written notice of the impairment 9535

to the superintendent of insurance and to each member of the board 9536

of directors or trustees of the insurer. The chief executive 9537

officer shall provide the notice as soon as reasonably possible, 9538

but no later than thirty days after ~~he~~ the chief executive officer 9539  
knows or has reason to know of the impairment. No chief executive 9540  
officer shall fail to provide notice in compliance with this 9541  
division. 9542

(C) The notice received by the superintendent under division 9543  
(B) of this section is not a public record under section 149.43 of 9544  
the Revised Code. 9545

**Sec. 4582.041.** (A) Any port authority created under section 9546  
4582.02 of the Revised Code may procure and pay all or any part of 9547  
the cost of group hospitalization, surgical, major medical, 9548  
sickness and accident insurance, or group life insurance, or a 9549  
combination of any of the foregoing types of insurance or coverage 9550  
for full-time employees and their immediate dependents, ~~whether~~ 9551  
issued by an insurance company ~~or a medical care corporation,~~ duly 9552  
authorized to do business in this state. 9553

(B) Any port authority also may procure and pay all or any 9554  
part of the cost of a plan of group hospitalization, surgical, or 9555  
major medical insurance with a health ~~care~~ insuring corporation 9556  
~~organized holding a certificate of authority under Chapter 1738-~~ 9557  
1751. of the Revised Code, provided that each full-time employee 9558  
shall be permitted to: 9559

(1) Exercise an option between a plan offered by an insurance 9560  
company ~~or medical care corporation~~ as provided in division (A) of 9561  
this section and such a plan offered by a health ~~care~~ insuring 9562  
corporation under this division, on the condition that the 9563  
full-time employee shall pay any amount by which the cost of the 9564  
plan offered in this division exceeds the cost of the plan offered 9565  
under division (A) of this section; and 9566

(2) Change from one of the two plans to the other at a time 9567  
each year as determined by the port authority. 9568

**Sec. 4582.29.** (A) Any port authority created under section 9569  
4582.22 of the Revised Code may procure and pay all or any part of 9570  
the cost of group hospitalization, surgical, major medical, 9571  
sickness and accident insurance, or group life insurance, or a 9572  
combination of any of the foregoing types of insurance or coverage 9573  
for full-time employees and their immediate dependents, ~~whether~~ 9574  
issued by an insurance company ~~or a medical care corporation,~~ duly 9575  
authorized to do business in this state. 9576

(B) Any port authority also may procure and pay all or any 9577  
part of the cost of a plan of group hospitalization, surgical, or 9578  
major medical insurance with a health ~~care~~ insuring corporation 9579  
~~organized holding a certificate of authority under Chapter 1738-~~ 9580  
1751. of the Revised Code, provided that each full-time employee 9581  
shall be permitted to: 9582

(1) Exercise an option between a plan offered by an insurance 9583  
company, ~~hospital service association, or medical care corporation~~ 9584  
as provided in division (A) of this section and a plan offered by 9585  
a health ~~care~~ insuring corporation under this division, on the 9586  
condition that the full-time employee shall pay any amount by 9587  
which the cost of the plan offered in this division exceeds the 9588  
cost of the plan offered under division (A) of this section; and 9589

(2) Change from one of the two plans to the other at a time 9590  
each year as determined by the port authority. 9591

**Sec. 4715.02.** The governor, with the advice and consent of 9592  
the senate, shall appoint a state dental board consisting of seven 9593  
persons, five of whom shall be graduates of a reputable dental 9594  
college, ~~a citizen~~ CITIZENS of the United States, and shall have 9595  
been in the legal and reputable practice of dentistry in the state 9596  
at least five years next preceding ~~his~~ THEIR appointment; one of 9597  
whom shall be a graduate of a reputable school of dental hygiene, 9598

a citizen of the United States, and shall have been in the legal 9599  
and reputable practice of dental hygiene in the state at least 9600  
five years next preceding ~~his~~ the person's appointment; and one of 9601  
whom shall be a member of the public at large who is not 9602  
associated with or financially interested in the practice of 9603  
dentistry. Terms of office shall be for five years, commencing on 9604  
the seventh day of April and ending on the sixth day of April, 9605  
except that upon expiration of the term ending April 25, 1978, the 9606  
new term which succeeds it shall commence on April 26, 1978 and 9607  
end on April 6, 1983; upon expiration of the term ending July 23, 9608  
1974, the new term which succeeds it shall commence on July 24, 9609  
1974 and end on April 6, 1979; and upon expiration of the term 9610  
ending June 24, 1975, the new term which succeeds it shall 9611  
commence on June 25, 1975 and end on April 6, 1980. Each member 9612  
shall hold office from the date of ~~his~~ the member's appointment 9613  
until the end of the term for which ~~he~~ the member was appointed. 9614  
Any member appointed to fill a vacancy occurring prior to the 9615  
expiration of the term for which ~~his~~ the member's predecessor was 9616  
appointed shall hold office for the remainder of such term. Any 9617  
member shall continue in office subsequent to the expiration date 9618  
of ~~his~~ the member's term until ~~his~~ the member's successor takes 9619  
office, or until a period of sixty days has elapsed, whichever 9620  
occurs first. No person so appointed shall serve to exceed two 9621  
terms. The Ohio dental association may submit to the governor the 9622  
names of five nominees for each position to be filled by a dentist 9623  
and from the names so submitted or from others, at ~~his~~ the 9624  
governor's discretion, the governor shall make such appointments; 9625  
provided that all such appointees shall possess the required 9626  
qualifications. The Ohio dental hygienists association, inc. may 9627  
submit to the governor the names of five nominees for each 9628  
position to be filled by a dental hygienist and from the names so 9629  
submitted or from others, at ~~his~~ the governor's discretion, the 9630

governor shall make such appointments; provided that all such 9631  
appointees shall possess the required qualifications. No person 9632  
shall be appointed to the state dental board who is employed by or 9633  
practices in a ~~partnership, association, or~~ corporation ~~organized~~ 9634  
holding a certificate of authority under Chapter ~~1740.~~ 1751. of 9635  
the Revised Code with a person who is a member of the board. 9636

**Sec. 4719.01.** (A) As used in sections 4719.01 to 4719.18 of 9637  
the Revised Code: 9638

(1) "Affiliate" means a business entity that is owned by, 9639  
operated by, controlled by, or under common control with another 9640  
business entity. 9641

(2) "Communication" means a written or oral notification or 9642  
advertisement that meets both of the following criteria, as 9643  
applicable: 9644

(a) The notification or advertisement is transmitted by or on 9645  
behalf of the seller of goods or services and by or through any 9646  
printed, audio, video, cinematic, telephonic, or electronic means. 9647

(b) In the case of a notification or advertisement other than 9648  
by telephone, either of the following conditions is met: 9649

(i) The notification or advertisement is followed by a 9650  
telephone call from a telephone solicitor or salesperson. 9651

(ii) The notification or advertisement invites a response by 9652  
telephone, and, during the course of that response, a telephone 9653  
solicitor or salesperson attempts to make or makes a sale of goods 9654  
or services. As used in division (A)(2)(b)(ii) of this section, 9655  
"invites a response by telephone" excludes the mere listing or 9656  
inclusion of a telephone number in a notification or 9657  
advertisement. 9658

(3) "Gift, award, or prize" means anything of value that is 9659

offered or purportedly offered, or given or purportedly given by 9660  
chance, at no cost to the receiver and with no obligation to 9661  
purchase goods or services. As used in this division, "chance" 9662  
includes a situation in which a person is guaranteed to receive an 9663  
item and, at the time of the offer or purported offer, the 9664  
telephone solicitor does not identify the specific item that the 9665  
person will receive. 9666

(4) "Goods or services" means any real property or any 9667  
tangible or intangible personal property, or services of any kind 9668  
provided or offered to a person. "Goods or services" includes, but 9669  
is not limited to, advertising; labor performed for the benefit of 9670  
a person; personal property intended to be attached to or 9671  
installed in any real property, regardless of whether it is so 9672  
attached or installed; timeshare estates or licenses; and extended 9673  
service contracts. 9674

(5) "Purchaser" means a person that is solicited to become or 9675  
does become financially obligated as a result of a telephone 9676  
solicitation. 9677

(6) "Salesperson" means an individual who is employed, 9678  
appointed, or authorized by a telephone solicitor to make 9679  
telephone solicitations but does not mean any of the following: 9680

(a) An individual who comes within one of the exemptions in 9681  
division (B) of this section; 9682

(b) An individual employed, appointed, or authorized by a 9683  
person who comes within one of the exemptions in division (B) of 9684  
this section; 9685

(c) An individual under a written contract with a person who 9686  
comes within one of the exemptions in division (B) of this 9687  
section, if liability for all transactions with purchasers is 9688  
assumed by the person so exempted. 9689

(7) "Telephone solicitation" means a communication to a 9690  
person that meets both of the following criteria: 9691

(a) The communication is initiated by or on behalf of a 9692  
telephone solicitor or by a salesperson. 9693

(b) The communication either represents a price or the 9694  
quality or availability of goods or services or is used to induce 9695  
the person to purchase goods or services, including, but not 9696  
limited to, inducement through the offering of a gift, award, or 9697  
prize. 9698

(8) "Telephone solicitor" means a person that engages in 9699  
telephone solicitation directly or through one or more 9700  
salespersons either from a location in this state or from a 9701  
location outside this state to persons in this state. "Telephone 9702  
solicitor" includes, but is not limited to, any such person that 9703  
is an owner, operator, officer, or director of, partner in, or 9704  
other individual engaged in the management activities of, a 9705  
business. 9706

(B) A telephone solicitor is exempt from the provisions of 9707  
sections 4719.02 to 4719.18 and section 4719.99 of the Revised 9708  
Code if the telephone solicitor is any one of the following: 9709

(1) A person engaging in a telephone solicitation that is a 9710  
one-time or infrequent transaction not done in the course of a 9711  
pattern of repeated transactions of a like nature; 9712

(2) A person engaged in telephone solicitation solely for 9713  
religious or political purposes; a charitable organization, 9714  
fund-raising counsel, or professional solicitor in compliance with 9715  
the registration and reporting requirements of Chapter 1716. of 9716  
the Revised Code; or any person or other entity exempt under 9717  
section 1716.03 of the Revised Code from filing a registration 9718  
statement under section 1716.02 of the Revised Code; 9719

(3) A person, making a telephone solicitation involving a home solicitation sale as defined in section 1345.21 of the Revised Code, that makes the sales presentation and completes the sale at a later, face-to-face meeting between the seller and the purchaser rather than during the telephone solicitation. However, if the person, following the telephone solicitation, causes another person to collect the payment of any money, this exemption does not apply.

(4) A licensed securities, commodities, or investment broker, dealer, investment advisor, or associated person when making a telephone solicitation within the scope of the person's license. As used in division (B)(4) of this section, "licensed securities, commodities, or investment broker, dealer, investment advisor, or associated person" means a person subject to licensure or registration as such by the securities and exchange commission; the National Association of Securities Dealers or other self-regulatory organization, as defined by 15 U.S.C.A. 78c; by the division of securities under Chapter 1707. Revised Code; or by an official or agency of any other state of the United States.

(5)(a) A person primarily engaged in soliciting the sale of a newspaper of general circulation;

(b) As used in division (B)(5)(a) of this section, "newspaper of general circulation" includes, but is not limited to, both of the following:

(i) A newspaper that is a daily law journal designated as an official publisher of court calendars pursuant to section 2701.09 of the Revised Code;

(ii) A newspaper or publication that has at least twenty-five per cent editorial, non-advertising content, exclusive of inserts, measured relative to total publication space, and an audited circulation to at least fifty per cent of the households in the

newspaper's retail trade zone as defined by the audit. 9751

(6)(a) An issuer, or its subsidiary, that has a class of securities to which all of the following apply: 9752

(i) The class of securities is subject to section 12 of the "Securities Exchange Act of 1934," 15 U.S.C.A. 781, and is registered or is exempt from registration under 15 U.S.C.A. 781(g)(2)(A), (B), (C), (E), (F), (G), or (H); 9754

(ii) The class of securities is listed on the New York stock exchange, the American stock exchange, or the NASDAQ national market system; 9758

(iii) The class of securities is a reported security as defined in 17 C.F.R. 240.11Aa3-1(a)(4). 9761

(b) An issuer, or its subsidiary, that formerly had a class of securities that met the criteria set forth in division (B)(6)(a) of this section if the issuer, or its subsidiary, has a net worth in excess of one hundred million dollars, files or its parent files with the securities and exchange commission an S.E.C. form 10-K, and has continued in substantially the same business since it had a class of securities that met the criteria in division (B)(6)(a) of this section. As used in division (B)(6)(b) of this section, "issuer" and "subsidiary" include the successor to an issuer or subsidiary. 9763

(7) A person soliciting a transaction regulated by the commodity futures trading commission, if the person is registered or temporarily registered for that activity with the commission under 7 U.S.C.A. 1 et. seq. and the registration or temporary registration has not expired or been suspended or revoked; 9773

(8) A person soliciting the sale of any book, record, audio tape, compact disc, or video, if the person allows the purchaser to review the merchandise for at least seven days and provides a 9778

full refund within thirty days to a purchaser who returns the  
merchandise or if the person solicits the sale on behalf of a  
membership club operating in compliance with regulations adopted  
by the federal trade commission in 16 C.F.R. 425;

(9) A supervised financial institution or its subsidiary. As  
used in division (B)(9) of this section, "supervised financial  
institution" means a bank, trust company, savings and loan  
association, savings bank, credit union, industrial loan company,  
consumer finance lender, commercial finance lender, or institution  
described in section 2(c)(2)(F) of the "Bank Holding Company Act  
of 1956," 12 U.S.C.A. 1841(c)(2)(F), as amended, supervised by an  
official or agency of the United States, this state, or any other  
state of the United States; or a licensee or registrant under  
sections 1321.01 to 1321.19, 1321.51 to 1321.60, or 1321.71 to  
1321.83 of the Revised Code.

(10)(a) An insurance company, association, or other  
organization that is licensed or authorized to conduct business in  
this state by the superintendent of insurance pursuant to Title  
XXXIX of the Revised Code or Chapter ~~1736., 1737., 1738., 1739.,~~  
~~1740., or 1742.~~ 1751. of the Revised Code, when soliciting within  
the scope of its license or authorization.

(b) A licensed insurance broker, agent, or solicitor when  
soliciting within the scope of the person's license. As used in  
division (B)(10)(b) of this section, "licensed insurance broker,  
agent, or solicitor" means any person licensed as an insurance  
broker, agent, or solicitor by the superintendent of insurance  
pursuant to Title XXXIX of the Revised Code.

(11) A person soliciting the sale of services provided by a  
cable television system operating under authority of a  
governmental franchise or permit;

(12) A person soliciting a business-to-business sale under

which any of the following conditions are met:	9812
(a) The telephone solicitor has been operating continuously	9813
for at least three years under the same business name under which	9814
it solicits purchasers, and at least fifty-one per cent of its	9815
gross dollar volume of sales consists of repeat sales to existing	9816
customers to whom it has made sales under the same business name.	9817
(b) The purchaser business intends to resell the goods	9818
purchased.	9819
(c) The purchaser business intends to use the goods or	9820
services purchased in a recycling, reuse, manufacturing, or	9821
remanufacturing process.	9822
(d) The telephone solicitor is a publisher of a periodical or	9823
of magazineS distributed as controlled circulation publicationS as	9824
defined in division (CC) of section 5739.01 of the Revised Code	9825
and is soliciting sales of advertising, subscriptions, reprints,	9826
lists, information databases, conference participation or	9827
sponsorships, trade shows or media products related to the	9828
periodical or magazine, or other publishing services provided by	9829
the controlled circulation publication.	9830
(13) A person that, not less often than once each year,	9831
publishes and delivers to potential purchasers a catalog that	9832
complies with both of the following:	9833
(a) It includes all of the following:	9834
(i) The business address of the seller;	9835
(ii) A written description or illustration of each good or	9836
service offered for sale;	9837
(iii) A clear and conspicuous disclosure of the sale price of	9838
each good or service; shipping, handling, and other charges; and	9839
return policy;	9840
(b) One of the following applies:	9841

(i) The catalog includes at least twenty-four pages of written material and illustrations, is distributed in more than one state, and has an annual postage-paid mail circulation of not less than two hundred fifty thousand households;

(ii) The catalog includes at least ten pages of written material or an equivalent amount of material in electronic form on the internet or an on-line computer service, the person does not solicit customers by telephone but solely receives telephone calls made in response to the catalog, and during the calls the person takes orders but does not engage in further solicitation of the purchaser. As used in division (B)(13)(b)(ii) of this section, "further solicitation" does not include providing the purchaser with information about, or attempting to sell, any other item in the catalog that prompted the purchaser's call or in a substantially similar catalog issued by the seller.

(14) A political subdivision or instrumentality of the United States, this state, or any state of the United States;

(15) A college or university or any other public or private institution of higher education in this state;

(16) A public utility, as defined in section 4905.02 of the Revised Code, that is subject to regulation by the public utilities commission, or its affiliate;

(17) A travel agency or tour promoter that is registered in compliance with section 1333.96 of the Revised Code when soliciting within the scope of the agency's or promoter's registration;

(18) A person that solicits sales through a television program or advertisement that is presented in the same market area no fewer than twenty days per month or offers for sale no fewer than ten distinct items of goods or services; and offers to the purchaser an unconditional right to return any good or service

purchased within a period of at least seven days and to receive a	9873
full refund within thirty days after the purchaser returns the	9874
good or cancels the service;	9875
(19)(a) A person that, for at least one year, has been	9876
operating a retail business under the same name as that used in	9877
connection with telephone solicitation and both of the following	9878
occur on a continuing basis:	9879
(i) The person either displays goods and offers them for	9880
retail sale at the person's business premises or offers services	9881
for sale and provides them at the person's business premises.	9882
(ii) At least fifty-one per cent of the person's gross dollar	9883
volume of retail sales involves purchases of goods or services at	9884
the person's business premises.	9885
(b) An affiliate of a person that meets the requirements in	9886
division (B)(19)(a) of this section if the affiliate meets all of	9887
the following requirements:	9888
(i) The affiliate has operated a retail business for a period	9889
of less than one year;	9890
(ii) The affiliate either displays goods and offers them for	9891
retail sale at the affiliate's business premises or offers	9892
services for sale and provides them at the affiliate's business	9893
premises;	9894
(iii) At least fifty-one per cent of the affiliate's gross	9895
dollar volume of retail sales involves purchases of goods or	9896
services at the affiliate's business premises.	9897
(c) A person that, for a period of less than one year, has	9898
been operating a retail business in this state under the same name	9899
as that used in connection with telephone solicitation, as long as	9900
all of the following requirements are met:	9901
(i) The person either displays goods and offers them for	9902

retail sale at the person's business premises or offers services	9903
for sale and provides them at the person's business premises;	9904
(ii) The goods or services that are the subject of telephone	9905
solicitation are sold at the person's business premises, and at	9906
least sixty-five per cent of the person's gross dollar volume of	9907
retail sales involves purchases of goods or services at the	9908
person's business premises;	9909
(iii) The person conducts all telephone solicitation	9910
activities according to sections 310.3, 310.4, and 310.5 of the	9911
telemarketing sales rule adopted by the federal trade commission	9912
in 16 C.F.R. part 310.	9913
(20) A person who performs telephone solicitation sales	9914
services on behalf of other persons and to whom one of the	9915
following applies:	9916
(a) The person has operated under the same ownership,	9917
control, and business name for at least five years, and the person	9918
receives at least seventy-five per cent of its gross revenues from	9919
written telephone solicitation contracts with persons who come	9920
within one of the exemptions in division (B) of this section.	9921
(b) The person is an affiliate of one or more exempt persons	9922
and makes telephone solicitations on behalf of only the exempt	9923
persons of which it is an affiliate.	9924
(c) The person makes telephone solicitations on behalf of	9925
only exempt persons, the person and each exempt person on whose	9926
behalf telephone solicitations are made have entered into a	9927
written contract that specifies the manner in which the telephone	9928
solicitations are to be conducted and that at a minimum requires	9929
compliance with the telemarketing sales rule adopted by the	9930
federal trade commission in 16 C.F.R. part 310, and the person	9931
conducts the telephone solicitations in the manner specified in	9932
the written contract.	9933

(d) The person performs telephone solicitation for religious 9934  
or political purposes, a charitable organization, a fund-raising 9935  
council, or a professional solicitor in compliance with the 9936  
registration and reporting requirements of Chapter 1716. of the 9937  
Revised Code; and meets all of the following requirements: 9938

(i) The person has operated under the same ownership, 9939  
control, and business name for at least five years, and the person 9940  
receives at least fifty-one per cent of its gross revenues from 9941  
written telephone solicitation contracts with persons who come 9942  
within the exemption in division (B)(2) of this section; 9943

(ii) The person does not conduct a prize promotion or offer 9944  
the sale of an investment opportunity; and 9945

(iii) The person conducts all telephone solicitation 9946  
activities according to sections 310.3, 310.4, and 310.5 of the 9947  
telemarketing sales rules adopted by the federal trade commission 9948  
in 16 C.F.R. part 310. 9949

(21) A person that is a licensed real estate salesperson or 9950  
broker under Chapter 4735. of the Revised Code when soliciting 9951  
within the scope of the person's license; 9952

(22) A publisher that solicits the sale of the publisher's 9953  
periodical or magazine of general, paid circulation, or a person 9954  
that solicits a sale of that nature on behalf of a publisher under 9955  
a written agreement directly between the publisher and the person. 9956  
As used in division (B)(22) of this section, "periodical or 9957  
magazine of general, paid circulation" excludes a periodical or 9958  
magazine circulated only as part of a membership package or given 9959  
as a free gift or prize from the publisher or person. 9960

(23) A person that solicits the sale of food, as defined in 9961  
section 3715.01 of the Revised Code, or the sale of products of 9962  
horticulture, as defined in section 5739.01 of the Revised Code, 9963  
if the person does not intend the solicitation to result in, or 9964

the solicitation actually does not result in, a sale that costs 9965  
the purchaser an amount greater than five hundred dollars. 9966

(24) A funeral director licensed pursuant to Chapter 4717. of 9967  
the Revised Code when soliciting within the scope of that license, 9968  
if both of the following apply: 9969

(a) The solicitation and sale are conducted in compliance 9970  
with 16 C.F.R. part 453, as adopted by the federal trade 9971  
commission, and with sections 1107.33 and 1345.21 to 1345.28 of 9972  
the Revised Code; 9973

(b) The person provides to the purchaser of any preneed 9974  
funeral contract a notice that clearly and conspicuously sets 9975  
forth the cancellation rights specified in division (G) of section 9976  
1107.33 of the Revised Code, and retains a copy of the that notice 9977  
signed by the purchaser. 9978

(25) A person, or affiliate thereof, licensed to sell or 9979  
issue Ohio instruments designated as travelers checks pursuant to 9980  
sections 1315.01 to 1315.11 of the Revised Code. 9981

(26) A person that solicits sales from its previous 9982  
purchasers and meets all of the following requirements: 9983

(a) The solicitation is made under the same business name 9984  
that was previously used to sell goods or services to the 9985  
purchaser; 9986

(b) The person has, for a period of not less than three 9987  
years, operated a business under the same business name as that 9988  
used in connection with telephone solicitation; 9989

(c) The person does not conduct a prize promotion or offer 9990  
the sale of an investment opportunity; 9991

(d) The person conducts all telephone solicitation activities 9992  
according to sections 310.3, 310.4, and 310.5 of the telemarketing 9993  
sales rules adopted by the federal trade commission in 16 C.F.R. 9994

part 310;	9995
(e) Neither the person nor any of its principals has been convicted of, pleaded guilty to, or has entered a plea of no contest for a felony or a theft offense as defined in sections 2901.02 and 2913.01 of the Revised Code or similar law of another state or of the United States;	9996 9997 9998 9999 10000
(f) Neither the person nor any of its principals has had entered against them an injunction or a final judgment or order, including an agreed judgment or order, an assurance of voluntary compliance, or any similar instrument, in any civil or administrative action involving engaging in a pattern of corrupt practices, fraud, theft, embezzlement, fraudulent conversion, or misappropriation of property; the use of any untrue, deceptive, or misleading representation; or the use of any unfair, unlawful, deceptive, or unconscionable trade act or practice.	10001 10002 10003 10004 10005 10006 10007 10008 10009
(27) An institution defined as a home health agency in section 3701.88 of the Revised Code, that conducts all telephone solicitation activities according to sections 310.3, 310.4, and 310.5 of the telemarketing sales rules adopted by the federal trade commission in 16 C.F.R. part 310, and engages in telephone solicitation only within the scope of the institution's certification, accreditation, contract with the department of aging, or status as a home health agency; and that meets one of the following requirements:	10010 10011 10012 10013 10014 10015 10016 10017 10018
(a) The institution is certified as a provider of home health services under Title XVIII of the Social Security Act, 49 Stat. 620, 42 U.S.C. 301, as amended; and is registered with the department of health pursuant to division (B) of section 3701.88 of the Revised Code;	10019 10020 10021 10022 10023
(b) The institution is accredited by either the joint commission on accreditation of health care organizations or the	10024 10025

community health accreditation program;	10026
(c) The institution is providing PASSPORT services under the direction of the Ohio department of aging under section 173.40 of the Revised Code;	10027 10028 10029
(d) An affiliate of an institution that meets the requirements of division (B)(27)(a), (b), or (c) of this section when offering for sale substantially the same goods and services as those that are offered by the institution that meets the requirements of division (B)(27)(a), (b), or (c) of this section.	10030 10031 10032 10033 10034
(28) A person licensed to provide a hospice care program by the department of health pursuant to section 3712.04 of the Revised Code when conducting telephone solicitations within the scope of the person's license and according to sections 310.3, 310.4, and 310.5 of the telemarketing sales rules adopted by the federal trade commission in 16 C.F.R. part 310.	10035 10036 10037 10038 10039 10040
<b>Sec. 4729.381.</b> No licensed pharmacist shall be liable for civil damages or in any criminal prosecution arising from the dispensing of a drug based upon a formulary established by a practitioner in a hospital, health <del>maintenance organization</del> <u>insuring corporation</u> , or long-term care facility and requiring the pharmacist to dispense the particular drug.	10041 10042 10043 10044 10045 10046
<b>Sec. 4731.67.</b> Section 4731.66 of the Revised Code does not apply to any of the following referrals by the holder of a certificate under this chapter:	10047 10048 10049
(A) Referrals for physicians' services that are performed by or under the personal supervision of a physician in the same group practice as the referring physician;	10050 10051 10052
(B) Referrals for clinical laboratory services by a certificate holder specializing in the practice of pathology if	10053 10054

those services are provided by or under the supervision of the 10055  
pathologist pursuant to a consultation requested by another 10056  
physician; 10057

(C) Referrals for in-office ancillary services to which all 10058  
of the following apply: 10059

(1) The services are furnished by the referring physician, a 10060  
physician in the same group practice as the referring physician, 10061  
or individuals who are employed by the referring physician or the 10062  
group practice and who are supervised by the referring physician 10063  
or a physician in the group practice, and are furnished either: 10064

(a) In a building in which the referring physician, or 10065  
another physician in the same group practice as the referring 10066  
physician, furnishes physicians' services unrelated to the 10067  
furnishing of designated health services; 10068

(b) In another building used by the referring physician's 10069  
group practice for the centralized provision of the group's 10070  
designated health services. 10071

(2) The services are billed by the physician performing or 10072  
supervising the services, the physician's group practice, or an 10073  
entity wholly owned by the group practice. 10074

(3) The physician's ownership or investment interest in the 10075  
services described in this division meets any other requirements 10076  
that the state medical board applies in rules adopted under 10077  
section 4731.70 of the Revised Code. 10078

(D) "Referrals for in-office ancillary services if the 10079  
third-party payer is aware of and has agreed in writing to 10080  
reimburse the services notwithstanding the financial arrangement 10081  
between the physician and the provider of such ancillary services. 10082

(E) Referrals for services furnished by a health ~~maintenance~~ 10083  
~~organization~~ insuring corporation to an enrollee of the 10084

<del>organization</del> <u>corporation</u> ;	10085
(F) Referrals to a hospital for designated health services,	10086
if all of the following apply:	10087
(1) The financial arrangement between the referring physician	10088
or immediate family member and the hospital consists of an	10089
ownership or investment interest described in division (A)(1) of	10090
section 4731.66 of the Revised Code and not a compensation	10091
arrangement described in division (A)(2) of that section.	10092
(2) The referring physician is authorized to perform services	10093
at the hospital.	10094
(3) The ownership or investment interest is in the hospital	10095
itself and not merely in a subdivision of the hospital.	10096
(G) Referrals to a hospital with which the certificate	10097
holder's or immediate family member's financial relationship does	10098
not relate to the provision of designated health services;	10099
(H) Referrals to a laboratory located in a rural area as	10100
defined in section 1886(d)(2)(D) of the "Social Security Act," 49	10101
Stat. 620 (1935), 42 U.S.C.A. 1395ww(d)(2)(D), as amended, if the	10102
financial relationship consists of an ownership or investment	10103
interest described in division (A)(1) of section 4731.66 of the	10104
Revised Code, and not a compensation arrangement described in	10105
division (A)(2) of that section;	10106
(I) Any other referrals in which the financial relationship	10107
between the certificate holder or immediate family member and the	10108
person furnishing services has been specified in rules adopted by	10109
the state medical board under section 4731.70 of the Revised Code.	10110
<b>Sec. 5111.02.</b> (A) Under the medical assistance program:	10111
(1) Reimbursement by the department of human services to a	10112
medical provider for any medical service rendered under the	10113
program shall not exceed the authorized reimbursement level for	10114

the same service under the medicare program established under 10115  
Title XVIII of the "Social Security Act," 49 Stat. 620 (1935), 42 10116  
U.S.C.A. 301, as amended. 10117

(2) Reimbursement for freestanding medical laboratory charges 10118  
shall not exceed the customary and usual fee for laboratory 10119  
profiles. 10120

(3) The department may deduct from payments for services 10121  
rendered by a medicaid provider under the medical assistance 10122  
program any amounts the provider owes the state as the result of 10123  
incorrect medical assistance payments the department has made to 10124  
the provider. 10125

(4) The department may conduct final fiscal audits in 10126  
accordance with the applicable requirements set forth in federal 10127  
laws and regulations and determine any amounts the provider may 10128  
owe the state. When conducting final fiscal audits, the department 10129  
shall consider generally accepted auditing standards, which 10130  
include the use of statistical sampling. 10131

(5) To the maximum extent that federal laws and regulations 10132  
permit the implementation of such a policy, the department may 10133  
institute a copayment program for all services provided under the 10134  
medical assistance program. The program shall be administered in 10135  
accordance with the applicable requirements set forth in federal 10136  
laws and regulations. 10137

(6) The number of days of inpatient hospital care for which 10138  
reimbursement is made on behalf of a recipient of medical 10139  
assistance to a hospital that is not paid under a 10140  
diagnostic-related-group prospective payment system shall not 10141  
exceed thirty days during a period beginning on the day of the 10142  
recipient's admission to the hospital and ending sixty days after 10143  
the termination of that hospital stay, except that the department 10144  
may make exceptions to this limitation. The limitation does not 10145

apply to children participating in the program for medically 10146  
handicapped children established under section 3701.023 of the 10147  
Revised Code. 10148

(B) The director of human services may adopt, amend, or 10149  
rescind rules under Chapter 119. of the Revised Code establishing 10150  
the amount, duration, and scope of medical services to be included 10151  
in the medical assistance program. Such rules shall establish the 10152  
conditions under which services are covered and reimbursed, the 10153  
method of reimbursement applicable to each covered service, and 10154  
the amount of reimbursement or, in lieu of such amounts, methods 10155  
by which such amounts are to be determined for each covered 10156  
service. Any rules that pertain to nursing facilities or 10157  
intermediate care facilities for the mentally retarded shall be 10158  
consistent with sections 5111.20 to 5111.33 of the Revised Code. 10159

(C) No health ~~maintenance organization~~ insuring corporation 10160  
that has a contract to provide health care services to recipients 10161  
of medical assistance shall restrict the availability to its 10162  
enrollees of any prescription drugs included in the Ohio medicaid 10163  
drug formulary as established under rules of the department. 10164

(D) The division of any reimbursement between a collaborating 10165  
physician or podiatrist and a clinical nurse specialist, certified 10166  
nurse-midwife, or certified nurse practitioner for services 10167  
performed by the nurse shall be determined and agreed on by the 10168  
nurse and collaborating physician or podiatrist. In no case shall 10169  
reimbursement exceed the payment that the physician or podiatrist 10170  
would have received had the physician or podiatrist provided the 10171  
entire service. 10172

**Sec. 5111.17.** (A) As used in this section, "community-based 10173  
clinic" means a clinic that provides prenatal, family planning, 10174  
well child, or primary care services and is funded in whole or in 10175  
part by the state or federal government. 10176

(B) On receipt of a waiver from the United States department of health and human services of any federal requirement that would otherwise be violated, the department of human services shall establish in Franklin, Hamilton, and Lucas counties a managed care system under which designated recipients of medical assistance are required to obtain medical services from providers designated by the department. The department may stagger implementation of the managed care system, but the system shall be implemented in at least one county not later than January 1, 1995, and in all three counties not later than July 1, 1996.

~~(B)~~(C) The department, by rule adopted under this section, may require any recipients in any other county to receive all or some of their care through managed care organizations that contract with the department and are paid by the department pursuant to a capitation or other risk-based methodology prescribed in the rules, and to receive their care only from providers designated by the organizations.

~~(C)~~(D) In accordance with rules adopted under division ~~(E)~~(G) of this section, the department may issue requests for proposals from managed care organizations interested in contracting with the department to provide managed care to participating medical assistance recipients.

(E) A health ~~maintenance organization~~ insuring corporation under contract with the department under this section may enter into an agreement with any community-based clinic for the provision of medical services to medical assistance recipients participating in the managed care system if the clinic is willing to accept the terms, conditions, and payment procedures established by the health ~~maintenance organization~~ insuring corporation.

~~(D)~~(F) For the purpose of determining the amount the

department pays hospitals under section 5112.08 of the Revised 10208  
Code and the amount of disproportionate share hospital payments 10209  
paid by the medicare program established under Title XVIII of the 10210  
"Social Security Act," 49 Stat. 620 (1935), 42 U.S.C.A. 301, as 10211  
amended, each managed care organization under contract with the 10212  
department to provide managed care to participating medical 10213  
assistance recipients shall keep detailed records for each 10214  
hospital with which it contracts about the cost to the hospital of 10215  
providing the care, payments made by the organization to the 10216  
hospital for the care, utilization of hospital services by medical 10217  
assistance recipients participating in managed care, and other 10218  
utilization data required by the department. 10219

~~(E)~~(G) The department shall adopt rules in accordance with 10220  
Chapter 119. of the Revised Code to implement this section. The 10221  
rules shall include all of the following: 10222

(1) A monthly capitation or other risk-based payment rate 10223  
system for managed care organizations under contract to provide 10224  
managed care to participating medical assistance recipients; 10225

(2) The method by which the department will issue requests 10226  
for proposals from managed care organizations interested in 10227  
providing managed care to participating medical assistance 10228  
recipients, including all of the following: 10229

(a) Public notice of the department's intent to issue a 10230  
request for proposals within a county; 10231

(b) The process for managed care organizations to submit 10232  
letters of interest; 10233

(c) The procurement, selection, and implementation timetable 10234  
within each county; 10235

(d) The time by which the department will furnish interested 10236  
managed care organizations with demographic, cost, and utilization 10237  
data about medical assistance recipients required or permitted to 10238

enroll in a managed care organization in a county.	10239
(3) Performance standards of managed care organizations under contract with the department governing all of the following:	10240
(a) Scope of coverage and benefits;	10241
(a) Scope of coverage and benefits;	10242
(b) Quality assurance performance indicators for services including prenatal care, immunizations, screenings that are part of the early and periodic screening, diagnostic, and treatment program, and any other service specified by the department;	10243
(b) Quality assurance performance indicators for services including prenatal care, immunizations, screenings that are part of the early and periodic screening, diagnostic, and treatment program, and any other service specified by the department;	10244
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(b) Quality assurance performance indicators for services including prenatal care, immunizations, screenings that are part of the early and periodic screening, diagnostic, and treatment program, and any other service specified by the department;	10246
(c) Service delivery system capacity;	10247
(d) Reporting requirements;	10248
(e) Grievance and complaint procedures;	10249
(f) Enrollment and disenrollment procedures;	10250
(g) Stop-loss arrangements;	10251
(h) Marketing;	10252
(i) Consumer and provider advisory councils;	10253
(j) Any other requirement established by the department.	10254
(4) A review process for any managed care organization that has submitted a proposal to have the department reconsider the denial of a contract under this section or termination of a contract entered into under this section;	10255
(4) A review process for any managed care organization that has submitted a proposal to have the department reconsider the denial of a contract under this section or termination of a contract entered into under this section;	10256
(4) A review process for any managed care organization that has submitted a proposal to have the department reconsider the denial of a contract under this section or termination of a contract entered into under this section;	10257
(4) A review process for any managed care organization that has submitted a proposal to have the department reconsider the denial of a contract under this section or termination of a contract entered into under this section;	10258
(5) Any other procedures or requirements the department considers necessary to implement managed care.	10259
(5) Any other procedures or requirements the department considers necessary to implement managed care.	10260
<b>Sec. 5111.171.</b> On receipt of a waiver from the United States department of health and human services of any federal requirement that would be violated by implementation of this section, the department shall establish a case management system to ensure that recipients of medical assistance under this chapter whose medical treatment and care is exceptionally expensive receive medical	10261
<b>Sec. 5111.171.</b> On receipt of a waiver from the United States department of health and human services of any federal requirement that would be violated by implementation of this section, the department shall establish a case management system to ensure that recipients of medical assistance under this chapter whose medical treatment and care is exceptionally expensive receive medical	10262
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services in a cost-effective manner. Recipients identified by the 10267  
department as being subject to this division shall comply with the 10268  
requirements of the case management system as a condition of 10269  
continued eligibility for medical assistance. The department shall 10270  
reimburse a hospital under the medical assistance program for 10271  
emergency services covered by the medical assistance program 10272  
provided to a medical assistance recipient pursuant to section 10273  
1867 of the "Social Security Act," 49 Stat. 620 (1935), 42 10274  
U.S.C.A. 1395dd, as amended, regardless of whether the hospital is 10275  
participating in the case management system. 10276

A hospital's participation in the case management system does 10277  
not prevent its participation in the hospital care assurance 10278  
program established by sections 5112.01 to 5112.21 of the Revised 10279  
Code unless the hospital is operated by a health ~~maintenance~~ 10280  
~~organization~~ insuring corporation. 10281

**Sec. 5111.19.** The department of human services shall adopt 10282  
rules governing the calculation and payment of graduate medical 10283  
education costs associated with services rendered to recipients of 10284  
the medical assistance program after June 30, 1994. The rules 10285  
shall provide for reimbursement of graduate medical education 10286  
costs associated with services rendered to medical assistance 10287  
recipients, including recipients enrolled in health ~~maintenance~~ 10288  
~~organizations~~ insuring corporations, that the department 10289  
determines are allowable and reasonable. 10290

If the department requires a health ~~maintenance organization~~ 10291  
insuring corporation to pay a provider for graduate medical 10292  
education costs associated with the delivery of services to 10293  
medical assistance recipients enrolled in the ~~organization~~ 10294  
corporation, the department shall include in its payment to the 10295  
~~organization~~ corporation an amount sufficient for the ~~organization~~ 10296  
corporation to pay such costs. If the department does not include 10297

in its payments to the ~~organization~~ health insuring corporation 10298  
amounts for graduate medical education costs of providers, all of 10299  
the following apply: 10300

(A) The department shall pay the provider for graduate 10301  
medical education costs associated with the delivery of services 10302  
to medical assistance recipients enrolled in the ~~organization~~ 10303  
corporation; 10304

(B) No provider shall seek reimbursement from the 10305  
~~organization~~ corporation for such costs; 10306

(C) The ~~organization~~ corporation is not required to pay 10307  
providers for such costs. 10308

**Sec. 5111.74.** (A) Not later than July 1, 1995, the department 10309  
of human services shall establish a fair share demonstration 10310  
project in Butler county for two years. The demonstration project 10311  
shall be administered by the Butler county health care management 10312  
board created under division (B) of this section. In establishing 10313  
the project, the department shall enter into an agreement with the 10314  
board, which shall provide that medical assistance services be 10315  
given to designated medical assistance recipients who elect or are 10316  
required by the department to receive their services from or 10317  
through the board or at least one other managed care arrangement 10318  
designated and approved by the department. 10319

The demonstration project shall demonstrate the viability of 10320  
delivering health care services to Butler county medical 10321  
assistance recipients through a cooperative health care purchasing 10322  
plan involving the organization of a managed care network by 10323  
physicians practicing medicine in Butler county and hospitals 10324  
located there. The demonstration project shall restructure the 10325  
medical assistance delivery system to improve the delivery of cost 10326  
effective, quality health care with an emphasis on primary and 10327  
10328

preventive care, and shall prevent cost shifting to the private 10329  
sector. The demonstration project shall demonstrate all of the 10330  
following: 10331

(1) A cost savings through prevention, the use of appropriate 10332  
levels of care, reduced administrative costs, and utilization of 10333  
the demonstration project through primary provider reimbursement 10334  
policies that encourage the delivery of primary and preventive 10335  
care; 10336

(2) The effectiveness of local collaboration and autonomy in 10337  
managing medical assistance expenditures in Butler county; 10338

(3) Improved access to quality health care for Butler 10339  
county's medical assistance recipients, while containing health 10340  
care costs. 10341

The department shall make a grant of two hundred fifty 10342  
thousand dollars to the board on its establishment for operating 10343  
and project expenses. These funds shall be transferred from the 10344  
department's medical assistance account. 10345

(B)(1) There is hereby created the Butler county health care 10346  
management board to administer the fair share demonstration 10347  
project in that county. The board shall consist of the county 10348  
director of human services and the following members: 10349

(a) One representative of each hospital system located in 10350  
Butler county, selected by the hospital; 10351

(b) Two physicians who specialize in pediatrics; two family 10352  
practice physicians; a physician who specializes in obstetrics; an 10353  
emergency department physician; a primary care physician; a 10354  
physician who is a medical specialist; a physician who is a 10355  
surgical specialist; a psychiatrist; and one physician selected at 10356  
large. The physicians shall be selected by the county medical 10357  
society or a similar organization of physicians in the county. 10358

(c) A chiropractor selected by an association of chiropractors in the county;	10359 10360
(d) A licensed registered nurse who is an advanced practice nurse selected by an organization of nurses in the county;	10361 10362
(e) A dentist selected by an organization of dentists in the county;	10363 10364
(f) An optometrist selected by an organization of optometrists in the county;	10365 10366
(g) A psychologist selected by an organization of psychologists in the county;	10367 10368
(h) A representative of child and family health services clinics selected by the child health service consortium of Butler county;	10369 10370 10371
(i) A podiatrist selected by an organization of podiatrists in the county.	10372 10373
(2) All members of the board shall be selected on the basis of their experience with the delivery of health care services to medical assistance recipients. If more than one physician is to be selected from a specialty area, the order of preference for determining board membership shall first be those physicians that have significant experience in providing health care services to medical assistance recipients.	10374 10375 10376 10377 10378 10379 10380
(3) Each member of the board shall serve for the duration of the demonstration project. In the event of a vacancy on the board, a member shall be selected in the same manner as the member <del>he</del> <del>replaces</del> <u>replaced</u> . Members shall not be compensated, but may be reimbursed by the board for their actual and necessary expenses. A majority of the members constitutes a quorum, and the board may take official action only by affirmative vote of a quorum.	10381 10382 10383 10384 10385 10386 10387 10388

(4) Not later than thirty days after July 1, 1993, the  
representatives of the hospital systems in Butler county shall  
select a temporary ~~chairman~~ chairperson, who shall convene the  
board not later than ninety days after July 1, 1993. Once  
convened, the board shall elect a ~~chairman~~ chairperson by a  
majority vote from among its members, and all further meetings  
shall be convened by the ~~chairman~~ chairperson. The board may elect  
officers and shall establish rules and procedures for its  
governance and a schedule of meetings. The board may establish an  
executive committee and such other subcommittees as it determines  
necessary to act on behalf of the board. The county department  
shall provide the board with any clerical, professional, or  
technical assistance it requests.

(C) The Butler county health care management board shall  
develop and implement a plan for the fair share demonstration  
project. The board shall establish educational and case management  
programs as it determines necessary to facilitate access to and  
encourage appropriate utilization of essential preventive medicine  
and primary care services. The board shall have limited immunity  
from antitrust actions in developing and implementing the project.  
The board shall apply for a certificate of authority to establish  
and operate a health ~~maintenance organization~~ insuring corporation  
under Chapter ~~1742-~~ 1751. of the Revised Code. On application of  
the board, the superintendent of insurance shall issue a  
certificate of authority to the board for a two-year period,  
notwithstanding the fact that the board may not meet the  
requirements of Chapter ~~1742-~~ 1751. of the Revised Code. The  
certificate of authority shall be void if the agreement with the  
department is not executed. The superintendent shall retain powers  
and duties under Chapter 3903. of the Revised Code with regard to  
the Butler county health care management board and the  
demonstration project.

The board may do any of the following:	10421
(1) Enter into contracts with any person organized to do business in this state on behalf of the board;	10422 10423
(2) Accept and spend donations, grants, and other funds received by the board;	10424 10425
(3) Employ personnel and professionals that may be needed to assess the feasibility and to develop the demonstration project;	10426 10427
(4) Establish provider agreements in Butler county that will organize a managed health care delivery system for medical assistance recipients and will establish provider reimbursement policies to encourage the delivery of primary health care services;	10428 10429 10430 10431 10432
(5) Monitor the quality of health care delivered to medical assistance recipients in Butler county;	10433 10434
(6) Establish provider agreements with physicians and other health care practitioners that set forth the terms, conditions, and payment procedures for the provision of health care services to medical assistance recipients. Any provider willing to accept such terms and conditions shall be eligible for participation in the project.	10435 10436 10437 10438 10439 10440
(7) Establish, in cooperation with the county medical society, voluntary participation guidelines for the project for physicians in Butler county to ensure that they provide health care services to their fair share of medical assistance recipients in the county. Such guidelines shall be communicated to all medical providers providing services in Butler county.	10441 10442 10443 10444 10445 10446
(8) Require that all medical assistance recipients, other than those described in division (A)(2) of section 5111.01 of the Revised Code, who elect or are required by the department to receive their medical assistance services through the board choose	10447 10448 10449 10450

a physician who is participating in the demonstration project to 10451  
provide all health care services to the recipient, and adopt 10452  
standards for changing physicians, including disenrollment as 10453  
provided by federal law; 10454

(9) So long as it is consistent with federal law, establish a 10455  
co-pay system for the following: 10456

(a) Provision of medical services under the demonstration 10457  
project; 10458

(b) Inappropriate utilization of medical services; 10459

(c) Over-utilization of medical services; 10460

(d) Failure of a medical assistance recipient to appear for a 10461  
scheduled medical appointment. 10462

(10) Enter into agreements with the board of nursing 10463  
authorizing advanced practice nurses, certified nurse 10464  
practitioners, clinical nurse specialists, and certified 10465  
nurse-midwives in Butler county to have prescription powers and 10466  
perform primary care services in collaboration with or under the 10467  
supervision of a physician or podiatrist in accordance with 10468  
division (D) of this section; 10469

(11) Enter into agreements with the state medical board 10470  
authorizing physician assistants in Butler county to have 10471  
prescription powers and perform primary care services under the 10472  
general supervision and authority of a physician in accordance 10473  
with division (D) of this section. 10474

(12) Assign medical assistance recipients, other than those 10475  
described in division (A)(2) of section 5111.01 of the Revised 10476  
Code, who elect or are required by the department to receive their 10477  
medical assistance services through the board, to providers who 10478  
have entered into provider agreements with the board. 10479

(D) The Butler county health care management board shall pass 10480

a resolution by a majority vote establishing the terms and  
conditions under which the scope of practice of advanced practice  
nurses, certified nurse practitioners, clinical nurse specialists,  
certified nurse-midwives, and physician assistants in Butler  
county may be expanded. The expansion of practice for advanced  
practice nurses shall comply with section 4723.56 of the Revised  
Code. The expansion of practice for certified nurse practitioners,  
clinical nurse specialists, and certified nurse-midwives shall  
comply with Chapter 4723. of the Revised Code. The expansion of  
practice for physician assistants shall comply with sections  
4730.06 and 4730.07 of the Revised Code. The resolution shall be  
sent to the board of nursing and the Ohio state medical board with  
a request that the scope of practice of the practitioners be  
amended in accordance with the resolution. On receipt of the  
resolution and request, the board of nursing and the Ohio state  
medical board shall, without amendment, adopt rules establishing  
the terms and conditions for expansion of the scope of practice of  
advanced practice nurses, certified nurse practitioners, clinical  
nurse specialists, certified nurse-midwives, and physician  
assistants in Butler county in accordance with the resolution.  
Such rules shall apply only to such practitioners performing their  
duties in Butler county in conjunction with and in accordance with  
the fair share demonstration project.

(E) The department of human services may negotiate and enter  
into an agreement with the board establishing a comprehensive  
capitated fee for purposes of delivering health care services to  
persons receiving benefits under Chapter 5107. and section  
5111.013 of the Revised Code, if the department obtains a waiver  
from the secretary of the United States department of health and  
human services of any federal regulation that would prohibit or  
restrict the use of federal funds. The department may include  
those persons described in division (A)(2) of section 5111.01 of

the Revised Code in the project as it considers necessary. The 10514  
capitated fee shall be based on historic and expected utilization 10515  
of the medical assistance program by the Butler county medical 10516  
assistance population, adjusted by the current inflation rate, and 10517  
shall be sufficient to ensure that all Butler county primary care 10518  
physicians participating in the demonstration project are 10519  
reimbursed for office visits at a rate of not less than thirty 10520  
dollars per patient during the first year of the project, and not 10521  
less than thirty-five dollars per patient for the second year of 10522  
the project. Any savings of state funds the department of human 10523  
services receives as the result of the demonstration project shall 10524  
be distributed as follows: 10525

(1) One-third of the savings to Butler county for children's 10526  
health programs; 10527

(2) One-third of the savings to the department of human 10528  
services; 10529

(3) One-third of the savings to providers participating in 10530  
the demonstration project. 10531

(F) All provider agreements or any contracts entered into or 10532  
negotiated by the board shall be exempt from any contract 10533  
provision contained in a contract between medical providers and 10534  
health insurers or indemnity insurers licensed to do business in 10535  
this state that provides for a lower payment for the services. 10536

(G) The Butler county health care management board shall, at 10537  
the end of each year of the demonstration project, issue a report 10538  
listing every medical provider practicing in Butler county, the 10539  
degree to which such provider has participated in the 10540  
demonstration project, and the extent to which such provider has 10541  
met the voluntary guidelines adopted by the board under division 10542  
(C)(7) of this section. 10543

(H) The department of human services shall apply for any 10544

federal waiver needed to implement the Butler county fair share demonstration project. 10545  
10546

**Sec. 5115.10.** (A) The disability assistance medical 10547  
assistance program shall consist of a system of managed primary 10548  
care. Until July 1, 1992, the program shall also include limited 10549  
hospital services, except that if prior to that date hospitals are 10550  
required by section 5112.17 of the Revised Code to provide medical 10551  
services without charge to persons specified in that section, the 10552  
program shall cease to include hospital services at the time the 10553  
requirement of section 5112.17 of the Revised Code takes effect. 10554

The state department of human services may require disability 10555  
assistance medical assistance recipients to enroll in health 10556  
~~maintenance organizations, preferred provider organizations,~~ 10557  
insuring corporations or other managed care programs, or may limit 10558  
the number or type of health care providers from which a recipient 10559  
may receive services. 10560

The state department shall adopt rules governing the 10561  
disability assistance medical assistance program established under 10562  
this division. The rules shall specify all of the following: 10563

(1) Services that will be provided under the system of 10564  
managed primary care; 10565

(2) Hospital services that will be provided during the period 10566  
that hospital services are provided under the program; 10567

(3) The maximum authorized amount, scope, duration, or limit 10568  
of payment for services. 10569

(B) The director of human services shall designate medical 10570  
services providers for the disability assistance medical 10571  
assistance program. The first such designation shall be made not 10572  
later than September 30, 1991. Services under the program shall be 10573  
provided only by providers designated by the director. The 10574

director may require that, as a condition of being designated a  
disability assistance medical assistance provider, a provider  
enter into a provider agreement with the state department. 10575  
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(C) As long as the disability assistance medical assistance  
program continues to include hospital services, the state  
department or a county director of human services may, pursuant to  
rules adopted by the state department under this section, approve  
an application for disability assistance medical assistance for  
emergency inpatient hospital services when care has been given to  
a person who had not completed a sworn application for disability  
assistance at the time the care was rendered, if all of the  
following apply: 10578  
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(1) The person files an application for disability assistance  
within sixty days after being discharged from the hospital or, if  
the conditions of division (D) of this section are met, while in  
the hospital; 10587  
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(2) The person met all eligibility requirements for  
disability assistance at the time the care was rendered; 10591  
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(3) The care given to the person was a medical service within  
the scope of disability assistance medical assistance as  
established under rules adopted by the department of human  
services. 10593  
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(D) If a person files an application for disability  
assistance medical assistance for emergency inpatient hospital  
services while in the hospital, a face-to-face interview shall be  
conducted with the applicant while ~~he~~ the applicant is in the  
hospital to determine whether ~~he~~ the applicant is eligible for the  
assistance. If the hospital agrees to reimburse the county  
department of human services for all actual costs incurred by the  
department in conducting the interview, the interview shall be  
conducted by an employee of the county department. If, at the 10597  
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request of the hospital, the county department designates an 10606  
employee of the hospital to conduct the interview, the interview 10607  
shall be conducted by the hospital employee. 10608

(E) The state department of human services may assume 10609  
responsibility for peer review of expenditures for disability 10610  
assistance medical assistance. 10611

**Sec. 5119.01.** The director of mental health is the chief 10612  
executive and administrative officer of the department of mental 10613  
health. The director may establish procedures for the governance 10614  
of the department, conduct of its employees and officers, 10615  
performance of its business, and custody, use, and preservation of 10616  
departmental records, papers, books, documents, and property. 10617  
Whenever the Revised Code imposes a duty upon or requires an 10618  
action of the department or any of its institutions, the director 10619  
shall perform the action or duty in the name of the department, 10620  
except that the medical director appointed pursuant to section 10621  
5119.07 of the Revised Code shall be responsible for decisions 10622  
relating to medical diagnosis, treatment, rehabilitation, quality 10623  
assurance, and the clinical aspects of the following: licensure of 10624  
hospitals and residential facilities, research, community mental 10625  
health plans, and delivery of mental health services. 10626

The director shall: 10627

(A) Adopt rules for the proper execution of the powers and 10628  
duties of the department with respect to the institutions under 10629  
its control, and require the performance of additional duties by 10630  
the officers of the institutions as necessary to fully meet the 10631  
requirements, intents, and purposes of this chapter. In case of an 10632  
apparent conflict between the powers conferred upon any managing 10633  
officer and those conferred by such sections upon the department, 10634  
the presumption shall be conclusive in favor of the department. 10635

10636

(B) Adopt rules for the nonpartisan management of the 10637  
institutions under the department's control. An officer or 10638  
employee of the department or any officer or employee of any 10639  
institution under its control who, by solicitation or otherwise, 10640  
exerts influence directly or indirectly to induce any other 10641  
officer or employee of the department or any of its institutions 10642  
to adopt the exerting officer's or employee's political views or 10643  
to favor any particular person, issue, or candidate for office 10644  
shall be removed from the exerting officer's or employee's office 10645  
or position, by the department in case of an officer or employee, 10646  
and by the governor in case of the director. 10647

(C) Appoint such employees, including the medical director, 10648  
as are necessary for the efficient conduct of the department, and 10649  
prescribe their titles and duties; 10650

(D) Prescribe the forms of affidavits, applications, medical 10651  
certificates, orders of hospitalization and release, and all other 10652  
forms, reports, and records that are required in the 10653  
hospitalization or admission and release of all persons to the 10654  
institutions under the control of the department, or are otherwise 10655  
required under this chapter or Chapter 5122. of the Revised Code; 10656

(E) Contract with hospitals licensed by the department under 10657  
section 5119.20 of the Revised Code for the care and treatment of 10658  
mentally ill patients, or with persons, organizations, or agencies 10659  
for the custody, supervision, care, or treatment of mentally ill 10660  
persons receiving services elsewhere than within the enclosure of 10661  
a hospital operated under section 5119.02 of the Revised Code; 10662

(F) Exercise the powers and perform the duties relating to 10663  
community mental health facilities and services that are assigned 10664  
to the director under this chapter and Chapter 340. of the Revised 10665  
Code; 10666

(G) Adopt rules under Chapter 119. of the Revised Code for 10667

the establishment of minimum standards, including standards for  
use of seclusion and restraint, of mental health services that are  
not inconsistent with nationally recognized applicable standards  
and that facilitate participation in federal assistance programs;

(H) Develop and implement clinical evaluation and monitoring  
of services that are operated by the department;

(I) At the director's discretion, adopt rules establishing  
standards for the adequacy of services provided by community  
mental health facilities, and certify the compliance of such  
facilities with the standards for the purpose of authorizing their  
participation in the health care plans of ~~medical care~~  
~~corporations under Chapter 1737.,~~ health care insuring  
corporations under Chapter ~~1738.,~~ 1751. and sickness and accident  
insurance policies issued under Chapter 3923. of the Revised Code;

(J) Adopt rules establishing standards for the performance of  
evaluations by a forensic center or other psychiatric program or  
facility of the mental condition of defendants ordered by the  
court under section 2919.271, or 2945.371 of the Revised Code, and  
for the treatment of defendants who have been found incompetent to  
stand trial and ordered by the court under section 2945.38,  
2945.39, 2945.401, or 2945.402 of the Revised Code to receive  
treatment in facilities;

(K) On behalf of the department, have the authority and  
responsibility for entering into contracts and other agreements;

(L) Prepare and publish regularly a state mental health plan  
that describes the department's philosophy, current activities,  
and long-term and short-term goals and activities.

(M) Adopt rules in accordance with Chapter 119. of the  
Revised Code specifying the supplemental services that may be  
provided through a trust authorized by section 1339.51 of the  
Revised Code;

(N) Adopt rules in accordance with Chapter 119. of the Revised Code establishing standards for the maintenance and distribution to a beneficiary of assets of a trust authorized by section 1339.51 of the Revised Code;

(O) As used in division (I) of this section:

(1) "Community mental health facility" means a facility that provides community mental health services and is included in the community mental health plan for the alcohol, drug addiction, and mental health service district in which it is located.

(2) "Community mental health service" means services, other than inpatient services, provided by a community mental health facility.

**Sec. 5119.202.** No third-party payer shall directly or indirectly reimburse, nor shall any person be obligated to pay any hospital for psychiatric services for which a license is required under section 5119.20 of the Revised Code unless the hospital is licensed by the department of mental health.

As used in this section, "third-party payer" means a ~~medical care corporation licensed under Chapter 1737. of the Revised Code,~~ a health care insuring corporation licensed under Chapter ~~1738.~~ 1751. of the Revised Code, an insurance company that issues sickness and accident insurance in conformity with Chapter 3923. of the Revised Code, a state-financed health insurance program under Chapter 3701., 4123., or 5101. of the Revised Code, or any self-insurance plan.

**Sec. 5505.28.** (A) The state highway patrol retirement board may enter into an agreement with insurance companies, ~~medical or health care~~ insuring corporations, ~~health maintenance organizations,~~ or government agencies authorized to do business in the state for issuance of a policy or contract of health, medical,

hospital, or surgical benefits, or any combination thereof, for 10729  
those persons receiving pensions and subscribing to the plan. 10730  
Notwithstanding any other provision of this chapter, the policy or 10731  
contract may also include coverage for any eligible individual's 10732  
spouse and dependent children and for any of the individual's 10733  
sponsored dependents as the board considers appropriate. 10734

If all or any portion of the policy or contract premium is to 10735  
be paid by any individual receiving a service, disability, or 10736  
survivor pension or benefit, the individual shall, by written 10737  
authorization, instruct the board to deduct from the individual's 10738  
pension or benefit the premium agreed to be paid by the individual 10739  
to the company, corporation, or agency. 10740

The board may contract for coverage on the basis of part or 10741  
all of the cost of the coverage to be paid from appropriate funds 10742  
of the state highway patrol retirement system. The cost paid from 10743  
the funds of the system shall be included in the employer's 10744  
contribution rate as provided by section 5505.15 of the Revised 10745  
Code. 10746

(B) If the board provides health, medical, hospital, or 10747  
surgical benefits through any means other than a health 10748  
~~maintenance organization~~ insuring corporation, it shall offer to 10749  
each individual eligible for the benefits the alternative of 10750  
receiving benefits through enrollment in a health ~~maintenance~~ 10751  
~~organization~~ insuring corporation, if all of the following apply: 10752

(1) The health ~~maintenance organization~~ insuring corporation 10753  
provides health care services in the geographical area in which 10754  
the individual lives; 10755

(2) The eligible individual was receiving health care 10756  
benefits through a health maintenance organization or a health 10757  
insuring corporation before retirement; 10758

(3) The rate and coverage provided by the health ~~maintenance~~ 10759  
~~organization~~ insuring corporation to eligible individuals is 10760  
comparable to that currently provided by the board under division 10761  
(A) of this section. If the rate or coverage provided by the 10762  
health ~~maintenance organization~~ insuring corporation is not 10763  
comparable to that currently provided by the board under division 10764  
(A) of this section, the board may deduct the additional cost from 10765  
the eligible individual's monthly benefit. 10766

The health ~~maintenance organization~~ insuring corporation 10767  
shall accept as an enrollee any eligible individual who requests 10768  
enrollment. 10769

The board shall permit each eligible individual to change 10770  
from one plan to another at least once a year at a time determined 10771  
by the board. 10772

(C) The board shall, beginning the month following receipt of 10773  
satisfactory evidence of the payment for coverage, pay monthly to 10774  
each recipient of a pension under the state highway patrol 10775  
retirement system who is eligible for medical insurance coverage 10776  
under part B of "The Social Security Amendments of 1965," 79 Stat. 10777  
301, 42 U.S.C.A. 1395j, as amended, the lesser of an amount equal 10778  
to the basic premium for such coverage or an amount equal to the 10779  
basic premium for such coverage in effect on January 1, 1994. 10780

(D) The board shall establish by rule requirements for the 10781  
coordination of any coverage, payment, or benefit provided under 10782  
this section with any similar coverage, payment, or benefit made 10783  
available to the same individual by the public employees 10784  
retirement system, police and firemen's disability and pension 10785  
fund, state teachers retirement system, or school employees 10786  
retirement system. 10787

(E) The board shall make all other necessary rules pursuant 10788  
to the purpose and intent of this section. 10789

Sec. 5505.33. (A) As used in this section: 10790

(1) "Long-term care insurance" has the same meaning as in 10791  
section 3923.41 of the Revised Code. 10792

(2) "Retirement systems" has the same meaning as in division 10793  
(A) of section 145.581 of the Revised Code. 10794

(B) The state highway patrol retirement board shall establish 10795  
a program under which members of the retirement system, employers 10796  
on behalf of members, and persons receiving service or disability 10797  
pensions or survivor benefits are permitted to participate in 10798  
contracts for long-term care insurance. Participation may include 10799  
dependents and family members. If a participant in a contract for 10800  
long-term care insurance leaves ~~his~~ employment, ~~he~~ the person and 10801  
~~his~~ the person's dependents and family members may, at their 10802  
election, continue to participate in a program established under 10803  
this section in the same manner as if ~~he~~ the person had not left 10804  
~~his~~ employment, except that no part of the cost of the insurance 10805  
shall be paid by ~~his~~ the person's former employer. Such program 10806  
may be established independently or jointly with one or more of 10807  
the retirement systems. 10808

(C) The board may enter into an agreement with insurance 10809  
companies, ~~medical or health care~~ insuring corporations, ~~health~~ 10810  
~~maintenance organizations,~~ or government agencies authorized to do 10811  
business in the state for issuance of a long-term care insurance 10812  
policy or contract. However, prior to entering into such an 10813  
agreement with an insurance company, ~~medical or health care~~ 10814  
insuring corporation, ~~or health maintenance organization,~~ the 10815  
board shall request the superintendent of insurance to certify the 10816  
financial condition of the company, or corporation, ~~or~~ 10817  
~~organization~~. The board shall not enter into the agreement if, 10818  
according to that certification, the company, or corporation, ~~or~~ 10819  
~~organization~~ is insolvent, is determined by the superintendent to 10820

be potentially unable to fulfill its contractual obligations, or 10821  
is placed under an order of rehabilitation or conservation by a 10822  
court of competent jurisdiction or under an order of supervision 10823  
by the superintendent. 10824

(D) The board shall adopt rules in accordance with section 10825  
111.15 of the Revised Code governing the program. The rules shall 10826  
establish methods of payment for participation under this section, 10827  
which may include establishment of a payroll deduction plan under 10828  
section 5505.203 of the Revised Code, deduction of the full 10829  
premium charged from a person's service or disability pension or 10830  
survivor benefit, or any other method of payment considered 10831  
appropriate by the board. If the program is established jointly 10832  
with one or more of the other retirement systems, the rules also 10833  
shall establish the terms and conditions of such joint 10834  
participation. 10835

**Sec. 5923.051.** Notwithstanding any collective bargaining 10836  
agreement or other agreement or law to the contrary, the state and 10837  
any agency, authority, commission, or board thereof, shall, at the 10838  
request of any person employed by the entity who is called to 10839  
active duty as specified in division (B) of section 5923.05 of the 10840  
Revised Code, or at the request of the spouse or dependent of that 10841  
person, continue or reactivate the health, medical, hospital, 10842  
dental, vision, and surgical benefits coverage, whether provided 10843  
by an insurance company, ~~medical care corporation,~~ health care 10844  
insuring corporation, ~~health maintenance organization,~~ or other 10845  
health plan or entity, of that person for the duration of the time 10846  
the person is on active duty as described in that division. The 10847  
person or the spouse or dependent thereof who requests the 10848  
continuation or reactivation of the coverage and the employing 10849  
state or agency, authority, commission, or board thereof, each are 10850  
liable for payment of the same costs for the coverage as if the 10851  
person were not on a leave of absence. 10852

**Section 2.** That existing sections 101.271, 124.81, 124.82, 10853  
124.822, 124.84, 124.841, 124.92, 124.93, 145.58, 145.581, 10854  
305.171, 306.48, 307.86, 339.16, 351.08, 505.60, 742.45, 742.53, 10855  
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1742.40, 1742.41, 1742.42, 1742.43, 1742.44, and 1742.45 of the 10893  
Revised Code are hereby repealed. 10894

**Section 3.** (A) The certificate of authority of every prepaid 10895  
dental plan organization, health care corporation, dental care 10896  
corporation, and health maintenance organization licensed to 10897  
operate under Chapter 1736., 1738., 1740., or 1742. of the Revised 10898  
Code, respectively, shall renew, by operation of law, on January 10899  
1, 1998, as a certificate of authority to operate under Chapter 10900  
1751. of the Revised Code. All assets and liabilities of the 10901  
prepaid dental plan organization, health care corporation, dental 10902  
care corporation, or health maintenance organization, including 10903  
all obligations under subscriber contracts delivered, issued for 10904  
delivery, or renewed prior to the effective date of this section, 10905  
shall be assumed by the successor entity. Except as otherwise 10906  
provided in division (B) of this section, such entity shall, no 10907  
later than January 1, 1998, comply with Chapter 1751. of the 10908  
Revised Code. 10909

(B)(1) Each entity described in division (A) of this section 10910  
shall do both of the following: 10911

(a) Comply with sections 1751.19 and 1751.26 of the Revised 10912  
Code no later than six months after the effective date of this 10913  
section. 10914

(b) Comply with section 1751.28 of the Revised Code by making annual deposits with the Superintendent of Insurance, no later than the first day of January of each year, for up to three years, beginning the first day of January immediately following the effective date of this section.

(2) Every contract delivered, issued for delivery, or renewed by an entity described in division (A) of this section prior to the effective date of this section shall comply with section 1751.13 of the Revised Code no later than the contract's first renewal date after the first day of January immediately following the effective date of this section.

(3) Every contract delivered, issued for delivery, or renewed by an entity described in division (A) of this section prior to the effective date of this section shall comply with section 1751.31 of the Revised Code no later than three months after the effective date of this section.

(4) An entity described in division (A) of this section may comply with section 1751.27 of the Revised Code by making annual deposits with the Superintendent of Insurance, not later than the first day of January of each year, for up to three years beginning the first day of January immediately following the effective date of this section. An equal amount shall be deposited each year until the total amount required under section 1751.27 of the Revised Code has been deposited.

**Section 4.** On and after the effective date of this section, the Department of Insurance shall no longer accept new applications for certificates of authority to operate under Chapter 1736., 1737., 1738., 1740., or 1742. of the Revised Code, and shall not issue any such certificates of authority. Any such application received by the Department of Insurance that is pending on the effective date of this section shall be considered

an application for a certificate of authority to operate under 10946  
Chapter 1751. of the Revised Code, and the review period for that 10947  
application shall begin to run on the effective date of this 10948  
section. 10949

**Section 5.** The member of the Board of Directors of the Ohio 10950  
Small Employer Health Reinsurance Program who, on the effective 10951  
date of this section, is serving pursuant to section 3924.08 of 10952  
the Revised Code as the member carrier that is a health 10953  
maintenance organization predominantly in the small employer 10954  
market, shall continue in office until the end of the term for 10955  
which the member was appointed. Thereafter, that appointment shall 10956  
be filled by a member carrier that is a health insuring 10957  
corporation predominantly in the small employer market. 10958

**Section 6.** Section 1751.64 of the Revised Code is hereby 10959  
repealed, effective February 9, 2004. The repeal of that section 10960  
shall apply only to contracts that are delivered, issued for 10961  
delivery, or renewed in this state on or after that date. 10962

**Section 7.** Every provision for mandated health benefits, as 10963  
defined in section 3901.71 of the Revised Code, that is contained 10964  
in Chapter 1751. of the Revised Code, shall be applied to every 10965  
policy, contract, certificate, or agreement of a health insuring 10966  
corporation on the effective date of the section in which the 10967  
provision is contained, notwithstanding section 3901.71 of the 10968  
Revised Code. 10969

**Section 8.** Section 5119.01 of the Revised Code is presented 10970  
in this act as a composite of the section as amended by both Sub. 10971  
H.B. 670 and Am. Sub. S.B. 285 of the 121st General Assembly, with 10972  
the new language of neither of the acts shown in capital letters. 10973  
This is in recognition of the principle stated in division (B) of 10974

section 1.52 of the Revised Code that such amendments are to be 10975  
harmonized where not substantively irreconcilable and constitutes 10976  
a legislative finding that such is the resulting version in effect 10977  
prior to the effective date of this act. 10978

**Section 9.** This act is hereby declared to be an emergency 10979  
measure necessary for the immediate preservation of the public 10980  
peace, health, and safety. The reason for such necessity is that 10981  
current laws governing the regulation of prepaid dental plan 10982  
organizations, medical care corporations, health care 10983  
corporations, dental care corporations, and health maintenance 10984  
organizations do not grant the Superintendent of Insurance the 10985  
authority to regulate all forms of managed care corporations 10986  
currently insuring substantial numbers of Ohio citizens, thereby 10987  
threatening the public health and safety. In order to protect the 10988  
public health and safety of the citizens of this state, the 10989  
Superintendent must have the immediate authority to regulate these 10990  
currently unregulated forms of managed care corporations and to 10991  
strengthen the financial regulation of all corporations engaged in 10992  
managed care in Ohio. Therefore, this act shall go into immediate 10993  
effect. 10994