

AN ACT

To amend sections 101.271, 124.81, 124.82, 124.822, 124.84, 124.841, 124.92, 124.93, 145.58, 145.581, 305.171, 306.48, 307.86, 339.16, 351.08, 505.60, 742.45, 742.53, 1319.12, 1337.16, 1545.071, 1731.01, 1731.06, 1739.05, 1901.111, 1901.312, 2133.12, 2305.25, 2913.47, 3105.71, 3111.241, 3113.217, 3307.74, 3307.741, 3309.69, 3309.691, 3313.202, 3375.40, 3381.14, 3501.141, 3701.24, 3701.76, 3702.51, 3702.62, 3709.16, 3729.12, 3901.04, 3901.041, 3901.043, 3901.071, 3901.16, 3901.19, 3901.31, 3901.32, 3901.38, 3901.40, 3901.41, 3901.48, 3901.72, 3902.01, 3902.02, 3902.11, 3902.13, 3904.01, 3905.71, 3923.123, 3923.30, 3923.301, 3923.33, 3923.333, 3923.38, 3923.382, 3923.41, 3923.51, 3923.54, 3923.58, 3924.01, 3924.02, 3924.08, 3924.10, 3924.12, 3924.13, 3924.41, 3924.61, 3924.62, 3924.64, 3924.73, 3929.77, 3956.01, 3959.01, 3999.32, 3999.36, 4582.041, 4582.29, 4715.02, 4719.01, 4729.381, 4731.67, 5111.02, 5111.17, 5111.171, 5111.19, 5111.74, 5115.10, 5119.01, 5119.202, 5505.28, 5505.33, and 5923.051; to enact sections 1751.01 to 1751.08, 1751.11 to 1751.21, 1751.25 to 1751.28, 1751.31 to 1751.36, 1751.38, 1751.40, 1751.42, 1751.44 to 1751.48, 1751.51 to 1751.56, 1751.59 to 1751.67, 1751.70, and 1751.71; and to repeal sections 1736.01, 1736.02, 1736.03, 1736.04, 1736.05, 1736.06, 1736.07, 1736.08, 1736.09, 1736.10, 1736.11, 1736.12, 1736.13, 1736.14, 1736.15, 1736.16, 1736.17, 1736.18, 1736.19, 1736.20, 1736.21, 1736.22, 1736.23, 1736.24, 1736.25, 1736.26, 1736.27, 1736.28,

1737.01, 1737.02, 1737.03, 1737.04, 1737.05, 1737.06, 1737.07, 1737.08, 1737.09, 1737.10, 1737.11, 1737.12, 1737.13, 1737.14, 1737.15, 1737.16, 1737.17, 1737.18, 1737.19, 1737.20, 1737.21, 1737.22, 1737.23, 1737.24, 1737.25, 1737.26, 1737.27, 1737.28, 1737.29, 1737.30, 1737.301, 1737.31, 1737.32, 1737.99, 1738.01, 1738.02, 1738.03, 1738.04, 1738.05, 1738.06, 1738.07, 1738.08, 1738.09, 1738.10, 1738.11, 1738.12, 1738.13, 1738.14, 1738.15, 1738.16, 1738.17, 1738.18, 1738.19, 1738.20, 1738.21, 1738.22, 1738.23, 1738.24, 1738.25, 1738.26, 1738.261, 1738.27, 1738.28, 1738.29, 1738.30, 1738.99, 1740.01, 1740.02, 1740.03, 1740.04, 1740.05, 1740.06, 1740.07, 1740.08, 1740.09, 1740.10, 1740.11, 1740.12, 1740.13, 1740.14, 1740.15, 1740.16, 1740.17, 1740.18, 1740.19, 1740.20, 1740.21, 1740.22, 1740.23, 1740.24, 1740.25, 1740.26, 1740.99, 1742.01, 1742.02, 1742.03, 1742.04, 1742.05, 1742.06, 1742.07, 1742.08, 1742.09, 1742.10, 1742.11, 1742.12, 1742.13, 1742.131, 1742.14, 1742.141, 1742.15, 1742.151, 1742.16, 1742.17, 1742.171, 1742.18, 1742.19, 1742.20, 1742.21, 1742.22, 1742.23, 1742.24, 1742.25, 1742.26, 1742.27, 1742.28, 1742.29, 1742.30, 1742.301, 1742.31, 1742.32, 1742.33, 1742.34, 1742.341, 1742.35, 1742.36, 1742.37, 1742.38, 1742.39, 1742.40, 1742.41, 1742.42, 1742.43, 1742.44, and 1742.45 of the Revised Code to provide for the establishment, operation, and regulation of health insuring corporations; to repeal the laws governing prepaid dental plan organizations, medical care corporations, health care corporations, dental care corporations, and health maintenance organizations; to eliminate certain provisions of this act on and after February 9, 2004, by repealing section 1751.64 of the

Revised Code on that date; and to declare an emergency.

Be it enacted by the General Assembly of the State of Ohio:

SECTION 1. That sections 101.271, 124.81, 124.82, 124.822, 124.84, 124.841, 124.92, 124.93, 145.58, 145.581, 305.171, 306.48, 307.86, 339.16, 351.08, 505.60, 742.45, 742.53, 1319.12, 1337.16, 1545.071, 1731.01, 1731.06, 1739.05, 1901.111, 1901.312, 2133.12, 2305.25, 2913.47, 3105.71, 3111.241, 3113.217, 3307.74, 3307.741, 3309.69, 3309.691, 3313.202, 3375.40, 3381.14, 3501.141, 3701.24, 3701.76, 3702.51, 3702.62, 3709.16, 3729.12, 3901.04, 3901.041, 3901.043, 3901.071, 3901.16, 3901.19, 3901.31, 3901.32, 3901.38, 3901.40, 3901.41, 3901.48, 3901.72, 3902.01, 3902.02, 3902.11, 3902.13, 3904.01, 3905.71, 3923.123, 3923.30, 3923.301, 3923.33, 3923.333, 3923.38, 3923.382, 3923.41, 3923.51, 3923.54, 3923.58, 3924.01, 3924.02, 3924.08, 3924.10, 3924.12, 3924.13, 3924.41, 3924.61, 3924.62, 3924.64, 3924.73, 3929.77, 3956.01, 3959.01, 3999.32, 3999.36, 4582.041, 4582.29, 4715.02, 4719.01, 4729.381, 4731.67, 5111.02, 5111.17, 5111.171, 5111.19, 5111.74, 5115.10, 5119.01, 5119.202, 5505.28, 5505.33, and 5923.051 be amended and sections 1751.01, 1751.02, 1751.03, 1751.04, 1751.05, 1751.06, 1751.07, 1751.08, 1751.11, 1751.12, 1751.13, 1751.14, 1751.15, 1751.16, 1751.17, 1751.18, 1751.19, 1751.20, 1751.21, 1751.25, 1751.26, 1751.27, 1751.28, 1751.31, 1751.32, 1751.33, 1751.34, 1751.35, 1751.36, 1751.38, 1751.40, 1751.42, 1751.44, 1751.45, 1751.46, 1751.47, 1751.48, 1751.51, 1751.52, 1751.53, 1751.54, 1751.55, 1751.56, 1751.59, 1751.60, 1751.61, 1751.62, 1751.63, 1751.64, 1751.65, 1751.66, 1751.67, 1751.70, and 1751.71 of the Revised Code be enacted to read as follows:

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

(B) After the general election in each even-numbered year, the clerk of the senate, with the assistance of the department of administrative services, shall estimate the cost of the medical insurance premiums that will be necessary to provide coverage, on the same basis as for a similarly situated state employee, for each person who is elected to a term as senator at such election, or appointed to fill the unexpired portion of any such term, and any of ~~his~~ the senator's dependents qualified for coverage at the time ~~he~~ the senator assumes office. Using this estimate, the clerk shall determine a fixed

amount to be paid by the state in equal monthly installments on behalf of the senator each year of ~~his~~ the senator's term as a medical insurance premium, but in no event in an amount to exceed the total premium required in any month by the contract of the state by the carrier. Any amount not paid in such a case shall be placed in reserve and applied against any subsequent month's premium up to the full amount thereof until the entire amount has been paid along with the original estimate for each month. This fixed amount shall be such that, as nearly as can be predicted, the sum of the monthly premiums paid for the senator during ~~his~~ the senator's term shall equal the total amount of medical insurance premiums that will be paid for such an employee, as required by section 124.82 of the Revised Code, during that term. The senator shall pay the difference between the amount so fixed and the total premium required by the contract of the state with the carrier.

(C) After the general election in each even-numbered year, the executive secretary of the house of representatives, with the assistance of the department of administrative services, shall estimate the cost of the medical insurance premiums that will be necessary to provide coverage, on the same basis as for a similarly situated state employee, for each person who is elected to a term as representative at such election, or appointed to fill the unexpired portion of any such term, and any of ~~his~~ the representative's dependents qualified for coverage at the time ~~he~~ the representative assumes office. Using this estimate, the executive secretary shall determine a fixed amount to be paid by the state in equal monthly installments on behalf of the representative each year of ~~his~~ the representative's term as a medical insurance premium, but in no event in an amount to exceed the total premium required in any month by the contract of the state with the carrier. Any amount not paid in such a case shall be placed in reserve and applied against any subsequent month's premium up to the full amount thereof until the entire reserve has been paid along with the original estimate for each month. This fixed amount shall be such that, as nearly as can be predicted, the sum of the monthly premiums paid for the representative during ~~his~~ the representative's term shall equal the total amount of medical insurance premiums that will be paid for such an employee, as required by section 124.82 of the Revised Code, during that term. The representative shall pay the difference between the amount so fixed and the total premium required by the contract of the state with the carrier.

Sec. 124.81. (A) Except as provided in division (E) of this section, the department of administrative services in consultation with the superintendent of insurance shall negotiate with and, in accordance with the

competitive selection procedures of Chapter 125. of the Revised Code, contract with one or more insurance companies authorized to do business in this state, for the issuance of one of the following:

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

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

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

(B) If a state employee uses all accumulated sick leave and then goes on an extended medical disability, the policyholder shall continue at no cost to the employee the coverage of the group life insurance for such employee for the period of such extended leave, but not beyond three years.

(C) If a state employee insured under a group life insurance policy as provided in division (A) of this section is laid off pursuant to section 124.32 of the Revised Code, such employee by request to the policyholder, made no later than the effective date of the layoff, may elect to continue the employee's group life insurance for the one-year period through which the employee may be considered to be on laid-off status by paying the policyholder through payroll deduction or otherwise twelve times the monthly premium computed at the existing average rate for the group life case for the amount of the employee's insurance thereunder at the time of the employee's layoff. The policyholder shall pay the premiums to the insurance company at the time of the next regular monthly premium payment for the actively insured employees and furnish the company appropriate data as to such laid-off employees. At the time an employee receives written notice of a layoff, the policyholder shall also give such employee written notice of the opportunity to continue group life insurance in accordance with this division. When such laid-off employee is reinstated for active work before the end of the one-year period, the employee shall be

reclassified as insured again as an active employee under the group and appropriate refunds for the number of full months of unearned premium payment shall be made by the policyholder.

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

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

(F) Notwithstanding any other provision of the Revised Code, any public employer, including the state, and any of its political subdivisions, including, but not limited to, any county, county hospital, municipal corporation, township, park district, school district, state institution of higher education, public or special district, state agency, authority, commission, or board, or any other branch of public employment, and any collective bargaining representative of employees of the state or any political subdivision may agree in a collective bargaining agreement that any mutually agreed fringe benefit including, but not limited to, hospitalization, surgical care, major medical care, disability, dental care, vision care, medical care, hearing aids, prescription drugs, group life insurance, sickness and accident insurance, group legal services, or a combination thereof, for employees and their dependents be provided through a mutually agreed upon contribution to a jointly administered trust fund. Amounts from the

fund may be used to pay direct and indirect costs that are attributable to consultants or a third-party administrator and that are necessary to administer this section. The amount, type, and structure of fringe benefits provided under this division is subject to the determination of the board of trustees of the jointly administered trust fund. Notwithstanding any other provision of the Revised Code, competitive bidding does not apply to the purchase of fringe benefits for employees under this division through a jointly administered trust fund.

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

(B) The department may, in addition, in consultation with the superintendent of insurance, negotiate and contract with health ~~care~~ insuring corporations ~~organized holding a certificate of authority under Chapter 1738. 1751. of the Revised Code, in their approved service areas only, for issuance of any policy or policies or contract or contracts of health, medical, hospital, dental, or surgical benefits, or any combination thereof, or with health maintenance organizations organized under Chapter 1742. of the Revised Code, in their service areas only, for issuance of a contract or contracts of health care services, covering state employees who are paid directly by warrant of the auditor of state, including elected state officials. Except for health care corporation and health maintenance organization plans~~ insuring corporations, no more than one insurance carrier or ~~nonprofit~~ health plan; shall be contracted with to provide the same plan of benefits, provided that:

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

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

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

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

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

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

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

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

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.

(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.

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.

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

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

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

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

(2) They shall be based on the class of all officials or employees

ered by the policy.

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

(D) Prior to entering into a contract with an insurance company, ~~medical or health care~~ insuring corporation, ~~or health maintenance organization~~ for the purchase of a long-term care insurance policy under this section, the department shall request the superintendent of insurance to certify the financial condition of the company; or corporation, ~~or organization~~. The department shall not enter into the contract 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.

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

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

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

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

(B) Any political subdivision may negotiate with and may 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 elected officials and employees of the political subdivision. The contract may be entered into without competitive bidding. Any elected official or employee of a political subdivision may elect to participate in any long-term care insurance policy that the political subdivision purchases under this division and any official or employee who does so shall be responsible for paying the entire premium charged, which shall be deducted from ~~his~~ the official's or employee's salary or wage and be remitted directly to the insurance company, ~~medical or health care~~ insuring corporation, ~~or health maintenance organization~~.

(C) Any long-term care insurance policy entered into under this section

is subject to division (C) of section 124.84 of the Revised Code.

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

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

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

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

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

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

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

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

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

(1) A former member receiving benefits pursuant to section 145.32, 145.33, 145.331, 145.34, or 145.46 of the Revised Code for whom eligibility is established more than five years after June 13, 1981, and who, at the time of establishing eligibility, has accrued less than ten years' service credit, exclusive of credit obtained pursuant to section 145.297 or 145.298 of the Revised Code, credit obtained after January 29, 1981, pursuant to section 145.293 or 145.301 of the Revised Code, and credit obtained after May 4, 1992, pursuant to section 145.28 of the Revised Code;

(2) The spouse of the former member;

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

(B) The public employees retirement board may enter into agreements 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 those individuals receiving age and service retirement or a disability or survivor benefit subscribing to the plan, or for PERS retirants employed under section 145.38 of the Revised Code, for coverage of benefits in accordance with division (D)(4)(b) of section 145.38 of the Revised Code. Notwithstanding any other provision of this chapter, the policy or contract may also include coverage for any eligible individual's spouse and dependent children and for any of the individual's sponsored dependents as the board determines appropriate. If all or any portion of the policy or contract premium is to be paid by any individual receiving age and service retirement or a disability or survivor benefit, the individual shall, by written authorization, instruct the board to deduct the premium agreed to be paid by the individual to the company, corporation, or agency.

The board may contract for coverage on the basis of part or all of the cost of the coverage to be paid from appropriate funds of the public employees retirement system. The cost paid from the funds of the system shall be included in the employer's contribution rate provided by sections 145.48 and 145.51 of the Revised Code. The board may by rule provide coverage to ineligible individuals if the coverage is provided at no cost to the retirement system. The board shall not pay or reimburse the cost for coverage under this section or section 145.325 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 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 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 from one plan to another at least once a year at a time determined by the board.

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

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

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

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

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

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

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

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

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

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

(2) 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 deduction of the full premium charged from a recipient's pension, benefit, or allowance, or any other method of payment considered appropriate by the board.

(E) Prior to entering into any agreement or contract with an insurance

company, ~~medical or health care~~ insuring corporation, ~~or health maintenance organization~~ for the purchase of, or participation in, a long-term care insurance policy under this section, the board shall request the superintendent of insurance to certify the financial condition of the company; ~~or corporation, or organization~~. The board shall not enter into the agreement or contract 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.

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

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

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

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

(C) Section 307.86 of the Revised Code does not apply to the purchase

of benefits for county officers or employees under divisions (A) and (B) of this section when those benefits are provided through a jointly administered health and welfare trust fund in which the county or contracting authority and a collective bargaining representative of the county employees or contracting authority agree to participate.

(D) The board of trustees of a jointly administered trust fund that receives contributions pursuant to collective bargaining agreements entered into between the board of county commissioners of any county and a collective bargaining representative of the employees of the county may provide for self-insurance of all risk in the provision of fringe benefits, and may provide through the self-insurance method specific fringe benefits as authorized by the rules of the board of trustees of the jointly administered trust fund. The fringe benefits may include, but are not limited to, hospitalization, surgical care, major medical care, disability, dental care, vision care, medical care, hearing aids, prescription drugs, group life insurance, sickness and accident insurance, group legal services, or a combination of any of the foregoing types of insurance or coverage, for employees and their dependents.

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

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

(G) The board of county commissioners may establish a policy authorizing any county appointing authority to make a cash payment to any officer or employee in lieu of providing a benefit authorized under this section if the officer or employee elects to take the cash payment instead of the offered benefit. A cash payment made to an officer or employee under this division shall not exceed twenty-five per cent of the cost of premiums or payments that otherwise would be paid by the board for benefits for the officer or employee under an offered policy or plan.

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

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

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

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

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

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

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

d 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 contract, the county or contracting authority shall maintain a record of such estimates, including the name of each person from whom an estimate is solicited, for no less than one year after the contract is awarded.

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

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

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

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

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

- (1) Determines that compliance with the requirements of this section would increase, rather than decrease, the cost of such purchase;
- (2) Employs a competent consultant to assist the contracting authority in

procuring appropriate coverages at the best and lowest prices;

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

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

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

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

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

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

(b) The contracting authority develops requests for proposals for leasing the property, specifying the criteria that will be considered prior to leasing the property, including the desired size and geographic location of the property;

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

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

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

Any issuer of policies, contracts, or plans listed in division (F) of this section and any prospective lessor under division (I) of this section may have ~~his~~ the issuer's or prospective lessor's name and address, or the name and address of an agent, placed on a special notification list to be kept by the contracting authority, by sending the contracting authority such name and address. The contracting authority shall send notice to all persons listed on

the special notification list. Notices shall state the deadline and place for submitting proposals. The contracting authority shall mail the notices at least six weeks prior to the deadline set by the contracting authority for submitting such proposals. Every five years the contracting authority may review this list and remove any person from the list after mailing the person notification of such action.

Any contracting authority that negotiates a contract under division (F) of this section shall request proposals and renegotiate with issuers in accordance with that division at least every three years from the date of the signing of such a contract.

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

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

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

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

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

All or any portion of the cost, premium, fees, or charges therefor may be paid in such manner or combination of manners as 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 each year as determined by the convention facilities authority.

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

insurance coverage to other township officers and employees.

The board may also contract for group ~~insurance or~~ health care services with health ~~care~~ insuring corporations ~~organized holding certificates of authority~~ under Chapter ~~1738. 1751.~~ of the Revised Code ~~and health maintenance organizations organized under Chapter 1742. of the Revised Code~~ for township officers and employees. If the board so contracts, it shall provide uniform coverage under any such contracts for township officers and full-time township employees and their immediate dependents and may provide coverage under such contracts for part-time township employees and their immediate dependents, provided that each officer and employee so covered is permitted to:

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

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

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

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

The board may also 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.

(B) A board of township trustees may procure and pay all or any part of the cost of group life insurance to insure the lives of officers and full-time employees of the township. The amount of group life insurance coverage provided by the board to insure the lives of officers of the township shall not exceed fifty thousand dollars per officer.

(C) If a board of township trustees fails to pay one or more premiums for a policy, contract, or plan of insurance or health care services authorized by division (A) of this section and the failure causes a lapse, cancellation, or

other termination of coverage under the policy, contract, or plan, it may reimburse a township officer or employee for, or pay on behalf of the officer or employee, any expenses incurred that would have been covered under the policy, contract, or plan.

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

Sec. 742.45. (A) The board of trustees of the police and firemen's disability and pension 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 policy or contract of health, medical, hospital, or surgical benefits, or any combination thereof, for those individuals receiving service or disability pensions or survivor benefits subscribing to the plan. Notwithstanding any other provision of this chapter, the policy or contract may also include coverage for any eligible individual's spouse and dependent children and for any of the eligible individual's sponsored dependents as the board considers appropriate.

If all or any portion of the policy or contract premium is to be paid by any individual receiving a service, disability, or survivor pension or benefit, the individual shall, by written authorization, instruct the board to deduct from the individual's benefit the premium agreed to be paid by the individual to the company, corporation, or agency.

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

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.

(B) 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 (A) 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 (A) 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 from one plan to another at least once a year at a time determined by the board.

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

(D) The board shall establish by rule requirements for the coordination of any coverage, payment, or benefit provided under this section with any similar coverage, payment, or benefit made available to the same individual by the public employees retirement system, state teachers retirement system, 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. 742.53. (A) As used in this section:

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

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

(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 of a court;

(f) Any licensee as defined either in section 1321.01 or 1321.71 of the Revised Code, or any registrant as defined in section 1321.51 of the Revised Code;

(g) Any public utility.

(B) A collection agency with a place of business in this state may take assignment of another person's accounts, bills, or other evidences of indebtedness in its own name for the purpose of billing, collecting, or filing suit in its own name as the real party in interest.

(C) No collection agency shall commence litigation for the collection of an assigned account, bill, or other evidence of indebtedness unless it has taken the assignment in accordance with all of the following requirements:

(1) The assignment was voluntary, properly executed, and acknowledged by the person transferring title to the collection agency.

(2) The collection agency did not require the assignment as a condition to listing the account, bill, or other evidence of indebtedness with the collection agency for collection.

(3) The assignment was manifested by a written agreement separate from and in addition to any document intended for the purpose of listing the account, bill, or other evidence of indebtedness with the collection agency. The written agreement must state the effective date of the assignment and the consideration paid or given, if any, for the assignment, and must expressly authorize the collection agency to refer the assigned account, bill, or other evidence of indebtedness to an attorney admitted to the practice of law in this state for the commencement 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 account, bill, or other evidence of indebtedness, the court shall separate each disputed account, bill, or other evidence of indebtedness from the action and hear the disputed account, bill, or other evidence of indebtedness on its own merits in a separate action. The court shall charge the filing fee of the separate action to the losing party.

Sec. 1337.16. (A) 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, or legal entity that is self-insured and provides benefits to its employees or members shall require an individual to create or refrain from creating a durable power of attorney for health care, or shall require an individual to revoke or refrain from revoking a durable power of attorney for health care, as a condition of being admitted to a health care facility, being provided health care, being insured, or being the recipient of benefits.

(B)(1) Subject to division (B)(2) of this section, an attending physician

of a principal or a health care facility in which a principal is confined may refuse to comply or allow compliance with the instructions of an attorney in fact under a durable power of attorney for health care on the basis of a matter of conscience or on another basis. An employee or agent of an attending physician of a principal or of a health care facility in which a principal is confined may refuse to comply with the instructions of an attorney in fact under a durable power of attorney for health care on the basis of a matter of conscience.

(2)(a) An attending physician of a principal who, or health care facility in which a principal is confined that, is not willing or not able to comply or allow compliance with the instructions of an attorney in fact under a durable power of attorney for health care to use or continue, or to withhold or withdraw, health care that were given under division (A) of section 1337.13 of the Revised Code, or with any probate court reevaluation order issued pursuant to division (D)(6) of this section, shall not prevent or attempt to prevent, or unreasonably delay or attempt to unreasonably delay, the transfer of the principal to the care of a physician who, or a health care facility that, is willing and able to so comply or allow compliance.

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

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

(D)(1) If the attending physician of a principal and one other physician who examines the principal determine that ~~he~~ the principal is in a terminal condition or in a permanently unconscious state, if the attending physician additionally determines that the principal has lost the capacity to make informed health care decisions for ~~himself~~ the principal and that there is no reasonable possibility that the principal will regain the capacity to make

informed health care decisions for ~~himself~~ the principal, and if the attorney in fact under the principal's durable power of attorney for health care makes a health care decision pertaining to the use or continuation, or the withholding or withdrawal, of life-sustaining treatment, the attending physician shall do all of the following:

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

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

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

(ii) The principal's spouse;

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

(iv) The principal's parents;

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

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

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

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

(b) The requirements of divisions (D)(1)(b), (c), and (d) of this section and, except as provided in division (D)(3)(b) of this section, the provisions

of divisions (D)(3) to (6) of this section shall not apply in connection with the principal if only one individual would have to be notified pursuant to division (D)(1)(b) of this section and that individual is the attorney in fact under the durable power of attorney for health care. However, the attending physician of the principal shall record in the principal's medical record information indicating that no notice was given pursuant to division (D)(1)(b) of this section because of the provisions of division (D)(2)(b) of this section.

(3)(a) Within forty-eight hours after receipt of a notice pursuant to division (D)(1) of this section, any individual so notified shall advise the attending physician of the principal whether ~~he~~ the individual objects on a basis specified in division (D)(4)(c) of this section. If an objection as described in that division is communicated to the attending physician, then, within two business days after the communication, the individual shall file a complaint as described in division (D)(4) of this section in the probate court of the county in which the principal is located. If the individual fails to so file a complaint, ~~his~~ the individual's objections as described in division (D)(4)(c) of this section shall be considered to be void.

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

(4) A complaint of an individual that is filed in accordance with division (D)(3)(a) of this section or of an individual or majority of individuals that is filed in accordance with division (D)(3)(b) of this section shall satisfy all of the following:

(a) Name any health care facility in which the principal is confined;

(b) Name the principal, ~~his~~ the principal's attending physician, and the consulting physician associated with the determination that the principal is in a terminal condition or in a permanently unconscious state;

(c) Indicate whether the plaintiff or plaintiffs object on one or more of the following bases:

(i) To the attending physician's determination that the principal has lost the capacity to make informed health care decisions for ~~himself~~ the principal;

(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 ~~himself~~ the principal;

(iii) That, in exercising ~~his~~ the attorney in fact's 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;

(iv) That the durable power of attorney for health care has expired or otherwise is no longer effective;

(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;

(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;

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

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

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

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

(ii) An order to the attorney in fact to act consistently with the desires of the principal or, if the desires of the principal are unknown, in the best interest of the principal in exercising ~~his~~ the attorney in fact's authority, or to

make only health care decisions pertaining to life-sustaining treatment that are authorized by the durable power of attorney for health care and that are not prohibited under section 1337.13 of the Revised Code;

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

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

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

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

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

(6)(a) A probate court in which a complaint as described in division (D)(4) of this section is filed within the period specified in division (D)(3)(a) or (b) of this section shall conduct a hearing on the complaint after a copy of it and a notice 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 medical procedure, treatment, intervention, or other measure may appear to hasten or increase the risk of the principal's death. 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 health care personnel acting under the direction of the principal's attending physician who carry out the responsibility to provide comfort care to the principal 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 principal, including, but not limited to, 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 medical procedure, treatment, intervention, or other measure may appear to hasten or increase the risk of the principal's death.

(2) If, at any time, a priority individual or any member of a priority class of individuals under division (D)(1)(b) of this section or if, at any time, the individual or a majority of the individuals in the next class of individuals that pertains to the principal in the descending order of priority set forth in that division, believes in good faith that both of the following circumstances apply, the priority individual, the member of the priority class of individuals, or the individual or majority of individuals in the next class of individuals that pertains to the principal may commence an action in the probate court of the county in which a principal who is in a terminal condition or permanently unconscious state is located for the issuance of an order mandating the use or continuation of comfort care in connection with

the principal in a manner that is consistent with sections 1337.11 to 1337.17 of the Revised Code:

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

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

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

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

Sec. 1545.071. The board of park commissioners of any park district may procure and pay all or any part of the cost of group insurance policies that may provide benefits for hospitalization, surgical care, major medical care, disability, dental care, eye care, medical care, hearing aids, or prescription drugs, or sickness and accident insurance or a combination of any of the foregoing types of insurance or coverage for park district officers and employees and their immediate dependents issued by an insurance company, ~~a medical care corporation organized under Chapter 1737. of the Revised Code, or a dental care corporation organized under Chapter 1740. of the Revised Code~~ duly authorized to do business in this state.

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

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

(A) Choose between a plan offered by an insurance company, ~~medical care corporation, or dental care corporation~~ and a plan offered by a health care insuring corporation ~~or health maintenance organization~~ and provided

further that the officer or employee pays any amount by which the cost of the plan chosen by ~~him~~ the officer or employee exceeds the cost of the plan offered by the board under this section;

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

Any appointed member of the board of park commissioners and the spouse and dependent children of the member may be covered, at the option and expense of the member, as a noncompensated employee of the park district under any benefit plan described in division (A) of this section. The member shall pay to the park district the amount certified to it by the benefit provider as the provider's charge for the coverage the member has chosen under division (A) of this section. Payments for coverage shall be made, in advance, 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, disability income, long-term care, hospital indemnity, medicare supplement, specified disease, ~~or vision care, or coverage issued by a health care corporation~~, except where any of the foregoing is offered as an addition, indorsement, or rider to a health benefit plan;

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

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

(F) "Insurer" means an insurance company authorized to do the business of sickness and accident insurance in this state or, for the purposes of this

chapter, a health ~~maintenance organization~~ insuring corporation authorized to issue health ~~benefit care~~ plans in this state.

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

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

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

(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 service or benefits;

(2) Imposes any restrictions on the ability of the insurer to negotiate with providers regarding the level or method of reimbursing for care or services;

(3) Requires the insurer either to include a specific provider or class of providers, or to exclude any class of providers that are generally authorized by law to provide such care, in connection with health care services or benefits under such health benefit plan;

(4) Limits the financial incentives that a health benefit plan may require a beneficiary to pay when a nonplan provider is used on a nonemergency basis;

(5) Prohibits utilization review of any or all treatments and conditions;

(6) Requires the use of specified standards of health care practice in such reviews or requires the disclosure of the specific criteria used in such reviews;

(7) Requires payments to providers for the expenses of responding to utilization review requests;

(8) Imposes liability for delays in performing such review.

(B) Notwithstanding division (A) of this section, every health benefit plan offered or provided by an insurer, other than a health ~~maintenance organization~~ insuring corporation, to a small employer under a qualified alliance program is subject to sections 3923.23, 3923.231, 3923.232, 3923.233, and 3923.234 of the Revised Code and any other provision of the Revised Code that requires the reimbursement, utilization, or consideration of a specific category of licensed or certified health care practitioner.

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

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

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

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

(B) A multiple employer welfare arrangement that is created pursuant to sections 1739.01 to 1739.22 of the Revised Code and that operates a group self-insurance program shall comply with all laws applicable to self-funded programs in this state, including sections 3901.04, 3901.041, 3901.19 to

3901.26, 3901.38, 3901.40, 3901.45, 3901.46, 3902.01 to 3902.14, 3923.30, 3923.301, and 3923.38 of the Revised Code.

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

(D) A multiple employer welfare arrangement created pursuant to sections 1739.01 to 1739.22 of the Revised Code shall provide benefits only to individuals who are members, employees of members, or the dependents of members or employees, or are eligible for continuation of coverage under section ~~1742.34~~ 1751.53 or 3923.38 of the Revised Code or under Title X of the "Consolidated Omnibus Budget Reconciliation Act of 1985," 100 Stat. 227, 29 U.S.C.A. 1161, as amended.

Sec. 1751.01. As used in this chapter:

(A) "Basic health care services" means the following services when medically necessary:

(1) Physician's services, except when such services are supplemental under division (B) of this section;

(2) Inpatient hospital services;

(3) Outpatient medical services;

(4) Emergency health services;

(5) Urgent care services;

(6) Diagnostic laboratory services and diagnostic and therapeutic radiologic services;

(7) Preventive health care services, including, but not limited to, voluntary family planning services, infertility services, periodic physical examinations, prenatal obstetrical care, and well-child care.

"Basic health care services" does not include experimental procedures.

A health insuring corporation shall not offer coverage for a health care service, defined as a basic health care service by this division, unless it offers coverage for all listed basic health care services. However, THIS REQUIREMENT 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.

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

- (1) Services of facilities for intermediate or long-term care, or both;
- (2) Dental care services;
- (3) Vision care and optometric services including lenses and frames;
- (4) Podiatric care or foot care services;
- (5) Mental health services including psychological services;
- (6) Short-term outpatient evaluative and crisis-intervention mental health services;
- (7) Medical or psychological treatment and referral services for alcohol and drug abuse or addiction;
- (8) Home health services;
- (9) Prescription drug services;
- (10) Nursing services;
- (11) Services of a dietitian licensed under Chapter 4759. of the Revised Code;
- (12) Physical therapy services;
- (13) Chiropractic services;
- (14) Any other category of services approved by the superintendent of insurance.

(C) "SPECIALTY HEALTH CARE SERVICES" MEANS ONE OF THE SUPPLEMENTAL HEALTH CARE SERVICES LISTED IN DIVISION (B)(1) TO (13) OF THIS SECTION, WHEN PROVIDED BY A HEALTH INSURING CORPORATION ON AN OUTPATIENT-ONLY BASIS AND NOT IN COMBINATION WITH OTHER SUPPLEMENTAL HEALTH CARE SERVICES.

(D) "CLOSED PANEL PLAN" MEANS A HEALTH CARE PLAN THAT REQUIRES ENROLLEES TO USE PARTICIPATING PROVIDERS.

(E) "COMPENSATION" MEANS REMUNERATION FOR THE PROVISION OF HEALTH CARE SERVICES, DETERMINED ON OTHER THAN A FEE-FOR-SERVICE OR

DISCOUNTED-FEE-FOR-SERVICE BASIS.

(E) "Contractual periodic prepayment" means the formula for determining the premium rate for all subscribers of a health insuring corporation.

(G) "Corporation" means a corporation formed under Chapter 1701. or 1702. of the Revised Code or the similar laws of another state.

(H) "Emergency health services" means those health care services that must be available on a seven-days-per-week, twenty-four-hours-per-day basis in order to prevent jeopardy to an enrollee's health status that would occur if such services were not received as soon as possible, and includes, where appropriate, provisions for transportation and indemnity payments or service agreements for out-of-area coverage.

(I) "Enrollee" means any natural person who is entitled to receive health care benefits provided by a health insuring corporation.

(J) "Evidence of coverage" means any certificate, agreement, policy, or contract issued to a subscriber that sets out the coverage and other rights to which such person is entitled under a health care plan.

(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.

(L) "Health care services" means any services involved in or incident to the furnishing of preventive, diagnostic, therapeutic, or rehabilitative care.

(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.

(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.

"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 USED IN CHAPTERS 340. and 5126. OF THE REVISED CODE. EXCEPT AS PROVIDED BY DIVISION (D) OF SECTION 1751.02 of the Revised Code, or as otherwise provided by law, no board, commission, agency, or other entity under the control of a political subdivision may accept insurance risk in providing for health care services. However, nothing in this division shall be construed as prohibiting such entities from purchasing the services of a health insuring corporation or a third-party administrator licensed under Chapter 3959. of the Revised Code.

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

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

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

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

(2) NO HEALTH INSURING CORPORATION MAY OFFER AN OPEN PANEL PLAN, UNLESS THE HEALTH INSURING CORPORATION IS ALSO LICENSED AS AN INSURER UNDER TITLE XXXIX OF THE REVISED CODE, the health insuring corporation, on the effective date of this section, holds a certificate of authority or license to operate under Chapter 1736. or 1740. of the Revised Code, OR AN INSURER LICENSED UNDER TITLE XXXIX OF THE REVISED CODE IS RESPONSIBLE FOR THE OUT-OF-NETWORK RISK AS EVIDENCED BY both an evidence of coverage filing under section 1751.11 of the Revised Code and a policy and certificate filing under section

3923.02 of the Revised Code.

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

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

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

(V) "Provider" means any natural person or partnership of natural persons who are licensed, certified, accredited, or otherwise authorized in this state to furnish health care services, or any professional association organized under Chapter 1785. of the Revised Code, provided that nothing in this chapter or other provisions of law shall be construed to preclude a health insuring corporation, health care practitioner, or organized health care group associated with a health insuring corporation from employing nurse practitioners, dietitians, physicians' assistants, dental assistants, dental hygienists, optometric technicians, or other allied health personnel who are licensed, certified, accredited, or otherwise authorized in this state to furnish health care services.

(W) "PROVIDER SPONSORED ORGANIZATION" MEANS A CORPORATION, AS DEFINED IN DIVISION (G) OF THIS SECTION, THAT IS AT LEAST EIGHTY PER CENT OWNED OR CONTROLLED BY ONE OR MORE HOSPITALS, AS DEFINED IN SECTION 3727.01 OF THE REVISED CODE, OR ONE OR MORE PHYSICIANS LICENSED TO PRACTICE MEDICINE OR SURGERY OR OSTEOPATHIC MEDICINE AND SURGERY UNDER CHAPTER 4731. OF THE REVISED CODE, OR ANY COMBINATION OF SUCH PHYSICIANS AND HOSPITALS. SUCH CONTROL IS PRESUMED TO

EXIST IF AT LEAST EIGHTY PER CENT OF THE VOTING RIGHTS OR GOVERNANCE RIGHTS OF A PROVIDER SPONSORED ORGANIZATION ARE DIRECTLY OR INDIRECTLY OWNED, CONTROLLED, OR OTHERWISE HELD BY ANY COMBINATION OF THE PHYSICIANS AND HOSPITALS DESCRIBED IN THIS DIVISION.

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

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

(Z) "Urgent care services" means those health care services that are appropriately provided for an unforeseen condition of a kind that usually requires medical attention without delay but that does not pose a threat to the life, limb, or permanent health of the injured or ill person, and may include such health care services provided out of the health insuring corporation's approved service area pursuant to indemnity payments or service agreements.

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

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

(C) Except as provided by division (D) of this section, no political subdivision or department, office, or institution of this state, or corporation formed by or on behalf of any political subdivision or department, office, or institution of this state, shall establish, operate, or perform the services of a health insuring corporation. Nothing in this section shall be construed to preclude 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, or a public entity formed by or on behalf of any of these boards, from using managed care techniques in carrying out the board's or public entity's duties pursuant to the requirements of Chapters 307., 329., 340., and 5126. of the Revised Code. However, no such board or public entity may operate so as to compete in the private sector with HEALTH insuring corporations holding certificates of authority under this chapter.

(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.

(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.

(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.

(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.

provider, health delivery network, or intermediary organization, to obtain a certificate of authority as a health insuring corporation under this chapter, unless otherwise provided, in the case of contracts with a self-insured employer, by operation of the "Employee Retirement Income Security Act of 1974," 88 Stat. 829, 29 U.S.C.A. 1001, as amended.

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

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

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

(I) THE SUPERINTENDENT SHALL NOT ISSUE A CERTIFICATE OF AUTHORITY TO A HEALTH INSURING CORPORATION THAT IS A PROVIDER SPONSORED ORGANIZATION UNLESS ALL HEALTH CARE PLANS TO BE OFFERED BY THE HEALTH INSURING CORPORATION PROVIDE BASIC HEALTH CARE SERVICES. Substantially all of the physicians and hospitals with ownership or control of the provider sponsored organization, as defined in division (W) of section 1751.01 of the Revised Code, shall also be participating providers for the provision of basic health care services for health care plans offered by the provider sponsored organization. IF A HEALTH INSURING CORPORATION THAT IS A PROVIDER SPONSORED ORGANIZATION OFFERS HEALTH CARE PLANS THAT DO NOT PROVIDE BASIC HEALTH CARE SERVICES, THE HEALTH INSURING CORPORATION SHALL BE DEEMED, FOR PURPOSES OF SECTION 1751.35 OF THE REVISED CODE, TO HAVE FAILED TO SUBSTANTIALLY COMPLY WITH THIS CHAPTER.

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

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

(K) Any person who violates division (B) of this section, and any health delivery network that fails to comply with division (H) of this section, is

subject to the penalties set forth in section 1751.45 of the Revised Code.

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

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

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

(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;

(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;

(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;

(6) The applicant's projected annual enrollee population over a three-year period;

(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;

(8) A copy of each type of evidence of coverage and identification card or similar document to be issued to subscribers;

(9) A copy of each type of individual or group policy, contract, or agreement to be used;

(10) The schedule of the proposed contractual periodic prepayments or

premium rates, or both, accompanied by appropriate supporting data:

(11) A financial plan which provides a three-year projection of operating results, including the projected expenses, income, and sources of working capital;

(12) The enrollee complaint procedure to be utilized as required under section 1751.19 of the Revised Code;

(13) A description of the procedures and programs to be implemented on an ongoing basis to assure the quality of health care services delivered to enrollees;

(14) A statement describing the geographic area or areas to be served, by county;

(15) A copy of all solicitation documents;

(16) A balance sheet and other financial statements showing the applicant's assets, liabilities, income, and other sources of financial support;

(17) A description of the nature and extent of any reinsurance program to be implemented, and a demonstration that errors and omission insurance and, if appropriate, fidelity insurance, will be in place upon the applicant's receipt of a certificate of authority;

(18) Copies of all proposed or in force related-party or intercompany agreements with an explanation of the financial impact of these agreements on the applicant. If the applicant intends to enter into a contract for managerial or administrative services, with either an affiliated or an unaffiliated person, the applicant shall provide a copy of the contract and a detailed description of the person to provide these services. The description shall include that person's experience in managing or administering health care plans, a copy of that person's most recent audited financial statement, and a completed biographical affidavit on a form acceptable to the superintendent for each of that person's principal officers and board members and for any additional employee to be directly involved in providing managerial or administrative services to the health insuring corporation. If the person to provide managerial or administrative services is affiliated with the health insuring corporation, the contract must provide for payment for services based on actual costs.

(19) A statement from the applicant's board that the admitted assets of the applicant have not been and will not be pledged or hypothecated;

(20) A statement from the applicant's board that the applicant will submit monthly financial statements during the first year of operations;

(21) The name and address of the applicant's Ohio statutory agent for service of process, notice, or demand;

(22) Copies of all documents the applicant filed with the secretary of

state:

(23) The location of those books and records of the applicant that must be maintained in Ohio;

(24) The applicant's federal identification number, corporate address, and mailing address;

(25) An internal and external organizational chart;

(26) A list of the assets representing the initial net worth of the applicant;

(27) If the applicant has a parent company, the parent company's guaranty, on a form acceptable to the superintendent, that the applicant will maintain Ohio's minimum net worth. If no parent company exists, a statement regarding the availability of future funds if needed.

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

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

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

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

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

(a) The solvency of the health insuring corporation;

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

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

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

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

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

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

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

(5) Disapproval of all or a portion of the filing shall be effected by written notice, which shall state the grounds for the order of disapproval and shall be given in accordance with Chapter 119. of the Revised Code.

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

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

basic health care services and supplemental health care services described in the evidence of coverage will be provided to all its enrollees as promptly as is appropriate and in a manner that assures continuity;

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

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

(4) Made appropriate arrangements for an ongoing evaluation and assurance of the quality of health care services provided to enrollees and the adequacy of the personnel, facilities, and equipment by or through which the services are rendered;

(5) Developed a procedure to gather and report statistics relating to the cost and effectiveness of its operations, the pattern of utilization of its services, and the quality, availability, and accessibility of its services.

(C) Within ninety days of the director's receipt of the application for issuance of a certificate of authority, the director shall certify to the superintendent whether or not the applicant meets the requirements of division (B) of this section and sections 3702.51 to 3702.62 of the Revised Code. If the director certifies that the applicant does not meet these requirements, the director shall specify in what respects it is deficient. However, the director shall not certify that the requirements of this section are not met unless the applicant has been given an opportunity for a hearing.

(D) If the applicant requests a hearing, the director shall hold a hearing before certifying that the applicant does not meet the requirements of this section. The hearing shall be held in accordance with Chapter 119. of the Revised Code.

(E) The ninety-day review period provided for under division (C) of this section shall cease to run as of the date on which the notice of the applicant's right to request a hearing is mailed and shall remain suspended until the director issues a final certification order.

Sec. 1751.05. (A) The superintendent of insurance shall issue or deny a certificate of authority to establish or operate a health insuring corporation to any corporation filing an application pursuant to section 1751.03 of the Revised Code within forty-five days of the superintendent's receipt of the

certification from the director of health under division (C) of section 1751.04 of the Revised Code. A certificate of authority shall be issued upon payment of the application fee prescribed in section 1751.44 of the Revised Code if the superintendent is satisfied that the following conditions are met:

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

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

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

(4) The applicant is financially responsible, complies with section 1751.28 of the Revised Code, and may reasonably be expected to meet its obligations to enrollees and prospective enrollees. In making this determination, the superintendent may consider:

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

(b) The adequacy of working capital;

(c) Any agreement with an insurer, a government, or any other person for insuring the payment of the cost of health care services or providing for

automatic applicability of an alternative coverage in the event of discontinuance of the health insuring corporation's operations;

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

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

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

(a) The maintenance of insolvency insurance;

(b) A provision in contracts with providers and health care facilities, BUT NO HEALTH INSURING CORPORATION SHALL RELY SOLELY ON SUCH A PROVISION FOR MORE THAN thirty DAYS;

(c) An agreement with other health insuring corporations or insurers, providing enrollees with automatic conversion rights upon the discontinuation of a health care plan or the health insuring corporation's operations;

(d) Such other methods as approved by the superintendent.

(6) Nothing in the applicant's proposed method of operation, as shown by the information submitted pursuant to section 1751.03 of the Revised Code or by independent investigation, will cause harm to an enrollee or to the public at large, as determined by the superintendent.

(7) Any deficiencies certified by the director have been corrected.

(8) The applicant has deposited securities as set forth in section 1751.27 of the Revised Code.

(B) If an applicant elects to fulfill the requirements of division (A)(5) of this section through an agreement with other health insuring corporations or insurers, the agreement shall require those health insuring corporations or insurers to give thirty days' notice to the superintendent prior to cancellation or discontinuation of the agreement for any reason.

(C) A certificate of authority shall be denied only after compliance with the requirements of section 1751.36 of the Revised Code.

Sec. 1751.06. Upon obtaining a certificate of authority as required under this chapter, a health insuring corporation may do all of the following:

(A) Enroll individuals and their dependents in either of the following circumstances:

(1) The individual resides in the approved service area.

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

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

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

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

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

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

Nothing in this section shall be construed as prohibiting a health insuring corporation without other commercial enrollment from contracting solely with federal health care programs regulated by federal regulatory bodies.

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

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

Sec. 1751.08. (A) Except as otherwise specifically provided in this chapter or Title XXXIX of the Revised Code, provisions of Title XXXIX of

the Revised Code shall not be applicable to any health insuring corporation holding a certificate of authority under this chapter. This division shall not apply to an insurer licensed and regulated pursuant to Title XXXIX of the Revised Code except with respect to its health insuring corporation activities authorized and regulated pursuant to this chapter.

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

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

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

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.

(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.

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

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

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

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

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

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

(c) THE ENROLLEE'S PERSONAL FINANCIAL OBLIGATION FOR NONCOVERED SERVICES;

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

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

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

(3) Unless it provides for the continuation of an enrollee's coverage, in the event that the enrollee's coverage under the policy, contract, certificate, or agreement terminates while the enrollee is receiving inpatient care in a hospital. This continuation of coverage shall terminate at the earliest occurrence of any of the following:

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

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

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

(4) Unless it contains a provision that states, in substance, that the health insuring corporation is not a member of any guaranty fund, and that in the event of the health insuring corporation's insolvency, the enrollee is

protected only to the extent that the hold harmless provision required by section 1751.13 of the Revised Code applies to the health care services rendered;

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

(E) Notwithstanding division (D) of this section, a health insuring corporation may use an evidence of coverage that provides for 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 an evidence of coverage that provides for the coverage of beneficiaries enrolled in the federal employees health benefits program pursuant to 5 U.S.C.A. 8905, or an evidence of coverage that provides for 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 an evidence of coverage that provides for the coverage of beneficiaries under any other federal health care program regulated by a federal regulatory body, if both of the following apply:

(1) The evidence of coverage 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.

(2) The evidence of coverage 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.

Sec. 1751.12. (A)(1) No contractual periodic prepayment and no premium rate for nongroup and conversion policies for health care services, or any amendment to them, may be used by any health insuring corporation at any time until the contractual periodic prepayment and premium rate, or amendment, have been filed with the superintendent of insurance, and shall not be effective until the expiration of sixty days after their filing unless the superintendent sooner gives approval. The superintendent shall disapprove the filing, if the superintendent determines within the sixty-day period that the contractual periodic prepayment or premium rate, or amendment, is not

in accordance with sound actuarial principles or is not reasonably related to the applicable coverage and characteristics of the applicable class of enrollees. The superintendent shall notify the health insuring corporation of the disapproval, and it shall thereafter be unlawful for the health insuring corporation to use the contractual periodic prepayment or premium rate, or amendment.

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

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

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

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

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

(B) Notwithstanding division (A) of this section, a health insuring corporation may use a contractual periodic prepayment or premium rate for policies used for 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 for policies used for the coverage of beneficiaries enrolled in the federal employees health benefits program pursuant to 5 U.S.C.A. 8905, or for policies used for 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 for policies used for the coverage of beneficiaries under any other federal health care program regulated by a federal regulatory body, if both of the following apply:

(1) The contractual periodic prepayment or premium rate 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.

(2) The contractual periodic prepayment or premium rate is filed with the superintendent 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.

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

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

(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.

(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.

(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.

(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.

(2) A health insuring corporation, upon written request, shall assist its contracted providers in finding stop-loss or reinsurance carriers.

(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:

(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 services;

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

"[Provider/Health Care Facility] agrees that in no event, including but

not limited to nonpayment by the health insuring corporation, insolvency of the health insuring corporation, or breach of this agreement, shall [Provider/Health Care Facility] bill, charge, collect a deposit from, seek remuneration or reimbursement from, or have any recourse against, a subscriber, enrollee, person to whom health care services have been provided, or person acting on behalf of the covered enrollee, for health care services provided pursuant to this agreement. This does not prohibit [Provider/Health Care Facility] from collecting co-insurance, deductibles, or copayments as specifically provided in the evidence of coverage, or fees for uncovered health care services delivered on a fee-for-service basis to persons referenced above, nor from any recourse against the health insuring corporation or its successor."

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

THE PROVISIONS REQUIRED BY DIVISION (C)(3) OF THIS SECTION SHALL NOT REQUIRE ANY PROVIDER OR HEALTH CARE FACILITY TO CONTINUE TO PROVIDE ANY COVERED HEALTH CARE SERVICE AFTER THE OCCURRENCE OF ANY OF THE FOLLOWING:

(a) THE END OF THE THIRTY-DAY PERIOD FOLLOWING THE ENTRY OF A LIQUIDATION ORDER UNDER CHAPTER 3903. OF THE REVISED CODE;

(b) THE END OF THE ENROLLEE'S PERIOD OF COVERAGE FOR

A CONTRACTUAL PREPAYMENT OR PREMIUM;

(c) THE ENROLLEE OBTAINS EQUIVALENT COVERAGE WITH ANOTHER HEALTH INSURING CORPORATION OR INSURER, OR THE ENROLLEE'S EMPLOYER OBTAINS SUCH COVERAGE FOR THE ENROLLEE;

(d) THE ENROLLEE OR THE ENROLLEE'S EMPLOYER TERMINATES COVERAGE UNDER THE CONTRACT;

(e) A LIQUIDATOR EFFECTS A TRANSFER OF THE HEALTH INSURING CORPORATION'S OBLIGATIONS UNDER THE CONTRACT UNDER DIVISION (A)(8) OF SECTION 3903.21 OF THE REVISED CODE.

(4) A provision clearly stating the rights and responsibilities of the health insuring corporation, and of the contracted providers and health care facilities, with respect to administrative policies and programs, including, but not limited to, payments systems, utilization review, quality assessment and improvement programs, credentialing, confidentiality requirements, and any applicable federal or state programs;

(5) A provision regarding the availability and confidentiality of those health records maintained by providers and health care facilities to monitor and evaluate the quality of care, to conduct evaluations and audits, and to determine on a concurrent or retrospective basis the necessity of and appropriateness of health care services provided to enrollees. The provision shall include terms requiring the provider or health care facility to make these health records available to appropriate state and federal authorities involved in assessing the quality of care or in investigating the grievances or complaints of enrollees, and requiring the provider or health care facility to comply with applicable state and federal laws related to the confidentiality of medical or health records.

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

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

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

(9) A provision requiring the provider or health care facility to provide

health care services without discrimination on the basis of a patient's participation in the health care plan, age, sex, ethnicity, religion, sexual preference, health status, or disability, and without regard to the source of payments made for health care services rendered to a patient. This requirement shall not apply to circumstances when the provider or health care facility appropriately does not render services due to limitations arising from the provider's or health care facility's lack of training, experience, or skill, or due to licensing restrictions.

(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;

(11) A provision setting forth procedures for the resolution of disputes arising out of the contract;

(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;

(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.

(D) No health insuring corporation contract with a provider or health care facility shall do either of the following:

(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;

(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.

(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.

(F) If an intermediary organization that is not a health delivery network contracting solely with self-insured employers subcontracts with a provider or health care facility, the subcontract with the provider or health care facility shall do all of the following:

(1) Contain the provisions required by divisions (C) and (G) of this section, as made applicable to an intermediary organization, without the

inclusion of inducements or penalties described in division (D) of this section;

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

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

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

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

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

(I) A health insuring corporation shall provide notice of the termination of any contract with a primary care physician or hospital.

(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.

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:

(1) Incapable of self-sustaining employment by reason of mental retardation or physical handicap;

(2) Primarily dependent upon the subscriber for support and maintenance.

(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.

(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 based on health factors set forth in the application, or if the dependent child does not satisfy the conditions of the policy, contract, or agreement as to any requirement for evidence of insurability or any other provision of the policy, contract, or agreement, satisfaction of which is required for coverage thereunder to take effect. In any such case, the terms of the policy, contract, or agreement shall apply with regard to the coverage or exclusion of the dependent from such coverage.

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

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

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

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

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

(C) Where a health insuring corporation demonstrates to the satisfaction of the superintendent that such open enrollment would jeopardize its

economic viability, the superintendent may do any of the following:

- (1) Waive the requirement for open enrollment;
- (2) Impose a limit on the number of applicants and their dependents that must be enrolled;
- (3) Authorize such underwriting restrictions upon open enrollment as are necessary to do any of the following:
 - (a) Preserve its financial stability;
 - (b) Prevent excessive adverse selection;
 - (c) Avoid unreasonably high or unmarketable charges for coverage of health care services.

(D)(1) A request to the superintendent under division (C) of this section for any restriction, limit, or waiver during an open enrollment period must be accompanied by supporting documentation, including financial data. In reviewing the request, the superintendent may consider various factors, including the size of the health insuring corporation, the health insuring corporation's net worth and profitability, the health insuring corporation's delivery system structure, and the effect on profitability of prior open enrollments.

(2) Any action taken by the superintendent under division (C) of this section shall be effective for a period of not more than one year. At the expiration of such time, a new demonstration of the health insuring corporation's need for the restriction, limit, or waiver shall be made before a new restriction, limit, or waiver is granted by the superintendent.

(3) Irrespective of the granting of any restriction, limit, or waiver by the superintendent, a health insuring corporation may reject an applicant or a dependent of the applicant during its open enrollment period if the applicant or dependent:

(a) Was eligible for and was covered under any employer-sponsored health care coverage, or if employer-sponsored health care coverage was available at the time of open enrollment;

(b) Is eligible for conversion or continuation coverage under state or federal law;

(c) Is eligible for medicare, and the health insuring corporation does not have an agreement on appropriate payment mechanisms with the governmental agency administering the medicare program.

(E) A health insuring corporation shall not be required either to enroll applicants or their dependents who are confined to a health care facility because of chronic illness, permanent injury, or other infirmity that would cause economic impairment to the health insuring corporation if such applicants or their dependents were enrolled or to make the effective date of

benefits for applicants or their dependents enrolled under this section earlier than ninety days after the date of enrollment.

(F) A health insuring corporation shall not be required to cover the fees or costs, or both, for any basic health care service related to a transplant of a body organ if the transplant occurs within one year after the effective date of an enrollee's coverage under this section. This limitation on coverage does not apply to a newly born child who meets the requirements for coverage under section 1751.61 of the Revised Code.

(G) Each health insuring corporation required to hold an open enrollment pursuant to division (A) of this section shall file with the superintendent, not later than sixty days prior to the commencement of the proposed open enrollment period, the following documents:

(1) The proposed public notice of open enrollment;

(2) The evidence of coverage approved pursuant to section 1751.11 of the Revised Code that will be used during open enrollment;

(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;

(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;

(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;

(6) Any request for a restriction, limit, or waiver with respect to the open enrollment period, along with any supporting documentation.

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

(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.

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

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

(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;

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

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

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

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

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

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

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

(2) No health insuring corporation may require enrollment to be made in person. Every health insuring corporation shall permit application for coverage by mail. A representative of the health insuring corporation may visit an applicant who has submitted an application by mail, in order to explain the operations of the health insuring corporation and to answer any questions the applicant may have. Every health insuring corporation shall

make open enrollment applications and solicitation documents readily available to any potential applicant who requests such material.

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

(K) This section does not apply to any health insuring corporation that offers only supplemental health care services or specialty health care services, or to any health insuring corporation that offers plans only through Title XVIII or Title XIX of the "Social Security Act," 49 Stat. 620 (1935), 42 U.S.C.A. 301, as amended, and that has no other commercial enrollment, or to any health insuring corporation that offers plans only through other federal health care programs regulated by federal regulatory bodies and that has no other commercial enrollment.

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

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

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

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

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

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

(B) The direct-payment contract offered by the health insuring corporation pursuant to division (A) of this section shall provide benefits comparable to the benefits being provided by any of the individual contracts then being issued to individual subscribers by the health insuring corporation. The contract may contain a coordination of benefits provision as approved by the superintendent of insurance.

(C) The option for conversion shall be available:

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

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

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

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

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

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

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

(E) Written notice of the conversion option provided by this section shall be given to the subscriber by the health insuring corporation by mail. The notice shall be sent to the subscriber's address in the records of the employer upon receipt of notice from the employer of the event giving rise to the conversion option. If the subscriber has not received notice of the conversion privilege at least fifteen days prior to the expiration of the thirty-day conversion period, then the subscriber shall have an additional period within which to exercise the privilege. This additional period shall expire fifteen days after the subscriber receives notice, but in no event shall the period extend beyond sixty days after the expiration of the thirty-day conversion period.

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

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

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

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

(2) Upon the divorce, dissolution, or annulment of the marriage of the

subscriber, to the divorced spouse, or, in the event of annulment, to the former spouse of the subscriber;

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

(C) The direct payment contract offered pursuant to division (B) of this section shall not be made available to an enrollee if any of the following applies:

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

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

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

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

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

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

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

(E) The evidence of coverage of every nongroup contract shall contain notice that an option for conversion to a contract issued on a direct-payment basis is available, in accordance with this section, to any enrollee covered by the contract.

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

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

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

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

(2) Unless otherwise required by state or federal law, no health insuring corporation, or health care facility or provider through which the health insuring corporation has made arrangements to provide health care services, shall discriminate against any individual with regard to enrollment, disenrollment, or the quality of health care services rendered, on the basis of the individual's race, color, sex, age, religion, state of health, or status as a recipient of medicare or medical assistance under Title XVIII or XIX of the "Social Security Act," 49 Stat. 620 (1935), 42 U.S.C.A. 301, as amended. However, a health insuring corporation shall not be required to accept a recipient of medicare or medical assistance, if an agreement has not been reached on appropriate payment mechanisms between the health insuring corporation and the governmental agency administering these programs. Further, except during a period of open enrollment under section 1751.15 of the Revised Code, a health insuring corporation may reject an applicant for nongroup enrollment on the basis of the state of health of the applicant.

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

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

(2) Fraud or forgery;

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

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

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

(C) A subscriber or enrollee may appeal any action or decision of the health insuring corporation under division (B) of this section. To appeal, the

subscriber or enrollee may submit a written complaint to the health insuring corporation pursuant to section 1751.19 of the Revised Code. The subscriber or enrollee may, within thirty days after receiving a written response from the health insuring corporation, appeal the health insuring corporation's action or decision to the superintendent.

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

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

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

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

Sec. 1751.20. (A) No health insuring corporation, or agent, employee, or representative of a health insuring corporation, shall use any advertisement or solicitation document, or shall engage in any activity, that

is unfair, untrue, misleading, or deceptive.

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

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

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

(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.

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.

(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.

(C) The information, documents, testimony, or other records described in division (A) of this section, if otherwise protected under section 2305.251 of the Revised Code, shall not be construed as being available for discovery or for use in any civil action solely on the basis that they were provided by the peer review committee as permitted under division (A) of this section.

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

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

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

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

(2) No health insuring corporation shall invest, without the prior approval of the superintendent, an amount that exceeds twenty-five per cent of its admitted assets as of the immediately preceding thirty-first day of December in real estate used for the accommodation of the health insuring corporation's business operations from which the health insuring corporation does not provide health care services.

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

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

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

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

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

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

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

(C) The interest from the deposit made under division (A) of this section shall accrue to the health insuring corporation that made the deposit. The deposit shall be considered to be an admitted asset of the health insuring corporation.

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

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

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

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

(b) Immediately withdrawable funds on deposit in demand accounts in a bank or trust company, or similar funds that are actually in the health

insuring corporation's principal office or any official branch office at statement date and that are in transit to the bank or trust company with authentic deposit credit given prior to the close of business on the fifth bank business day following the statement date;

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

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

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

(f) Accounts receivable that are not more than ninety days past due;

(g) Amounts due under reinsurance arrangements from insurance companies authorized to do business in this state;

(h) Tax refunds due from the United States or any state;

(i) 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;

(j) 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;

(k) 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;

(l) 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;

(m) 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;

(n) 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;

(o) Interest accrued on secured loans that conform to section 3925.08 of the Revised Code, not exceeding the amount of one year's interest on any loan;

(p) Interest accrued on tax anticipation warrants;

(q) The amortized value of electronic computer or data processing machines or systems purchased for use in connection with the business of the health insuring corporation, including software purchased and developed specifically for the use and purposes of the corporation;

(r) The cost of furniture, equipment, and medical equipment, less accumulated depreciation on the furniture and equipment to be applied pro rata over a period not to exceed five years, and of medical and pharmaceutical supplies, that are under the control of the health insuring corporation, provided these assets do not exceed fifteen per cent of admitted assets;

(s) Amounts due from affiliates to the extent that the affiliate has liquid assets with which to pay the balance and maintain its accounts on a current basis. Any amount outstanding more than three months shall be considered not current.

(2) "Liabilities" means the liabilities of the health insuring corporation as determined by the superintendent of insurance.

(B) All admitted assets of a health insuring corporation must be held in the health insuring corporation's name and must be free and clear of any encumbrances, pledges, or hypothecation.

(C)(1) Every health insuring corporation authorized to provide basic health care services, which health insuring corporation is not a provider sponsored organization, shall maintain total admitted assets equal to at least one hundred ten per cent of the liabilities of the corporation. However, at no time shall the corporation's net worth be less than one million two hundred thousand dollars.

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

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

(4) Every health insuring corporation authorized to provide both basic health care services and supplemental health care services, which health

insuring corporation is not a provider sponsored organization, shall maintain total admitted assets equal to at least one hundred ten per cent of the liabilities of the corporation. However, at no time shall the corporation's net worth be less than one million seven hundred thousand dollars.

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

(6) EVERY HEALTH INSURING CORPORATION AUTHORIZED TO PROVIDE BASIC HEALTH CARE SERVICES, WHICH HEALTH INSURING CORPORATION IS A PROVIDER SPONSORED ORGANIZATION, SHALL MAINTAIN TOTAL ADMITTED ASSETS EQUAL TO AT LEAST ONE HUNDRED TEN PER CENT OF THE LIABILITIES OF THE CORPORATION. HOWEVER, AT NO TIME SHALL THE CORPORATION'S NET WORTH BE LESS THAN ONE MILLION DOLLARS.

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

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

(D) The admitted value of any real estate owned by a health insuring

corporation, whether used for the accommodation of the health insuring corporation's business operations or otherwise, shall be the original cost plus the cost of improvements, less encumbrances and accumulated depreciation.

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

Sec. 1751.31. (A) Any changes in a health insuring corporation's solicitation document shall be filed with the superintendent of insurance. The superintendent, within sixty days of filing, may disapprove any solicitation document or amendment to it on any of the grounds stated in this section. Such disapproval shall be effected by written notice to the health insuring corporation. The notice shall state the grounds for disapproval and shall be issued in accordance with Chapter 119. of the Revised Code.

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

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

(D) Notwithstanding division (A) of this section, a health insuring corporation may use a solicitation document that the corporation uses in connection with policies for beneficiaries of 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 for policies for beneficiaries of the federal employees health benefits program pursuant to 5 U.S.C.A. 8905, or for policies for beneficiaries of 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 for policies for beneficiaries of any other federal health care program regulated by a federal regulatory body, if both of the following apply:

(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.

(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.

(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.

(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.

(G) NOTHING IN THIS SECTION SHALL PROHIBIT HEALTHY LIFESTYLE PROGRAMS.

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.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Sec. 1751.34. (A) Each health insuring corporation and each applicant for a certificate of authority under this chapter shall be subject to examination by the superintendent of insurance in accordance with section 3901.07 of the Revised Code. Section 3901.07 of the Revised Code shall govern every aspect of the examination, including the circumstances under and frequency with which it is conducted, the authority of the superintendent and any examiner or other person appointed by the

superintendent, the liability for the assessment of expenses incurred in conducting the examination, and the remittance of the assessment to the superintendent's examination fund.

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

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

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

Sec. 1751.35. (A) 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:

(1) 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.

(2) The health insuring corporation fails to issue evidences of coverage in compliance with the requirements of section 1751.11 of the Revised Code.

(3) The contractual periodic prepayments or premium rates used do not comply with the requirements of section 1751.12 of the Revised Code.

(4) 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.

(5) 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.

(6) The health insuring corporation is no longer financially responsible and may reasonably be expected to be unable to meet its obligations to enrollees or prospective enrollees.

(7) The health insuring corporation has failed to implement the complaint system that complies with the requirements of section 1751.19 of the Revised Code.

(8) The health insuring corporation, or any agent or representative of the corporation, has advertised, merchandised, or solicited on its behalf in contravention of the requirements of section 1751.31 of the Revised Code.

(9) The health insuring corporation has unlawfully discriminated against any enrollee or prospective enrollee with respect to enrollment, disenrollment, or price or quality of health care services.

(10) The continued operation of the health insuring corporation would be hazardous or otherwise detrimental to its enrollees.

(11) The health insuring corporation has submitted false information in any filing or submission required under this chapter or any rule adopted under this chapter.

(12) The health insuring corporation has otherwise failed to substantially comply with this chapter or any rule adopted under this chapter.

(13) The health insuring corporation is not operating a health care plan.

(B) A certificate of authority shall be suspended or revoked only after compliance with the requirements of Chapter 119. of the Revised Code.

(C) When the certificate of authority of a health insuring corporation is suspended, the health insuring corporation, during the period of suspension, shall not enroll any additional subscribers or enrollees except newborn children or other newly acquired dependents of existing subscribers or enrollees, and shall not engage in any advertising or solicitation whatsoever.

(D) When the certificate of authority of a health insuring corporation is revoked, the health insuring corporation, following the effective date of the order of revocation, shall conduct no further business except as may be essential to the orderly conclusion of the affairs of the health insuring

corporation. The health insuring corporation shall engage in no further advertising or solicitation whatsoever. The superintendent, by written order, may permit such further operation of the health insuring corporation as the superintendent may find to be in the best interest of enrollees, to the end that enrollees will be afforded the greatest practical opportunity to obtain continuing health care coverage.

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

(B) The recommendations and findings of the director of health with respect to matters subject to the director's consideration under section 1751.04 of the Revised Code, provided in connection with any decision regarding the denial, suspension, or revocation of a certificate of authority, shall be reviewed and considered by the superintendent. After the hearing authorized by division (A) of this section, or upon the failure of the applicant or health insuring corporation to appear at the hearing, the superintendent shall take such action as in accordance with law and the evidence. The action shall be set out in written findings which shall be mailed to the applicant or health insuring corporation with a copy to the director of health. The action of the superintendent is subject to review in accordance with Chapter 119. of the Revised Code, except that a certification by the director under division (D) of section 1751.04 or division (A)(5) of section 1751.35 of the Revised Code that was made in accordance with Chapter 119. of the Revised Code shall be final as to the matters certified.

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

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

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

(C) Sections 3905.01, 3905.03, 3905.05, 3905.16 to 3905.18, 3905.181, 3905.19, 3905.23, 3905.40, 3905.41, 3905.42, 3905.46 to 3905.48, 3905.481, 3905.482, 3905.486, 3905.49, 3905.50, 3905.71 to 3905.79, and

3905.99 Of the Revised Code shall apply to health insuring corporations and the agents of health insuring corporations in the same manner in which these sections apply to insurers and agents of insurers.

Sec. 1751.40. (A) NOTWITHSTANDING ANY PROVISION OF TITLE XXXIX OF THE REVISED CODE, any insurance company holding a certificate of authority issued pursuant to Title XXXIX of the Revised Code, or any corporation that is a subsidiary or affiliate of the insurance company, may apply for and obtain a certificate of authority to organize and operate a health insuring corporation in compliance with this chapter. Notwithstanding any other law that may be inconsistent with this division, any two or more such insurance companies, or subsidiaries or affiliates thereof, may jointly organize and operate a health insuring corporation under this chapter. The business of insurance is deemed to include the providing of health care by a health insuring corporation owned or operated by an insurance company or a subsidiary or affiliate of an insurance company.

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

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

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

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

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

(3) For filing a major modification under section 1751.03 of the Revised Code, three hundred dollars;

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

(5) For all other required filings for which no filing fee is otherwise

provided for by this chapter, fifty dollars.

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

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

(B) If the superintendent or the director of health for any reason has cause to believe that any violation of this chapter has occurred or is threatened, the superintendent or the director may give notice to the health insuring corporation and to the representatives or other persons who appear to be involved in the suspected violation to arrange a conference with the suspected violators or their authorized representatives for the purpose of attempting to ascertain the facts relating to the suspected violation, and, if it appears that any violation has occurred or is threatened, to arrive at an adequate and effective means of correcting or preventing the violation.

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

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

(2) If the superintendent has reasonable cause to believe that an order issued pursuant to this division has been violated in whole or in part, the

superintendent may request the attorney general to commence and prosecute any appropriate action or proceeding in the name of the state against the violators in the court of common pleas of Franklin county. The court in any such action or proceeding may levy civil penalties, not to exceed one hundred thousand dollars per violation, in addition to any other appropriate relief, including requiring a violator to pay the expenses reasonably incurred by the superintendent in enforcing the order. The penalties and fees collected under this division shall be paid into the state treasury to the credit of the department of insurance operating fund.

Sec. 1751.46. (A) The superintendent of insurance and the director of health may contract with qualified persons to make recommendations concerning the determinations required to be made by the superintendent or the director relative to an expansion of a service area pursuant to division (C) of section 1751.03 of the Revised Code, an application for a certificate of authority pursuant to sections 1751.04 and 1751.05 of the Revised Code, a contractual periodic prepayment or premium rate pursuant to section 1751.12 of the Revised Code, and an examination pursuant to division (B) of section 1751.34 of the Revised Code. The recommendations may be accepted in full or in part, or may be rejected, by the superintendent or director.

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

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

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

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

Sec. 1751.48. (A) The superintendent of insurance may adopt rules as

are necessary to carry out the provisions of this chapter. These rules shall be adopted in accordance with Chapter 119, of the Revised Code.

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

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

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

(B) Set forth, within any solicitation document pertaining to the health care plan and within any solicitation materials pertaining to the health care plan that the health insuring corporation provides to any employer or any employee benefit fund, under a heading that reads "Restrictions on Choice of Providers," a clear, concise, and complete statement of the restriction, such statement being subject to prior approval by the superintendent of insurance in accordance with the same form and content requirements that are specified in section 1751.11 of the Revised Code with regard to evidence of coverage.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

3923.123 of the Revised Code upon the termination of the continuation of coverage.

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

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

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

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

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

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

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

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

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

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

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

(b) A period of 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:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(3) "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 contract shall provide that any eligible person may continue the coverage under the contract 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 contract.

(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 contract and an employee who has not been called or ordered to active duty.

(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.

(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.

(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.

(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

vance, 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.

(b) The employer may pay a portion or all of the eligible person's contribution.

(E) The eligible person's right to any continuation of coverage, or the extension of any continuation of coverage, provided under division (B) or (C) of this section ceases on the date on which any of the following occurs:

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

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

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

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

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

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

(2) The level of benefits under the replacement coverage is the same as the level of benefits provided to any similarly situated eligible person who is covered under the group contract and an employee who has not been called or ordered to active duty.

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

(1) Every eligible person is entitled, without any waiting period, to

coverage under the employer's group contract that is in effect at the time of the reservist's return to employment.

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

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

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

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

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

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

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

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

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

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

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

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

(B) This section applies to supplemental sickness and accident insurance policies irrespective of the mode or channel of premium payment to the insurer or of any reduction in the premium by virtue of the insured's membership in any health insuring corporation or the insured's status as an employee.

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

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

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

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

(C) Except as provided for in divisions (E) and (F) of this section, every contract between a health insuring corporation and provider or health care facility shall contain a provision approved by the superintendent of insurance requiring the provider or health care facility to seek compensation solely from the health insuring corporation and not, under any circumstances, from the subscriber or enrollee, except for approved deductibles and copayments.

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

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

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

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

(B) Coverage for a newly born child is effective for a period of thirty-one days from the date of birth.

(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.

(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.

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.

"Screening mammography" does not include diagnostic mammography.

(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:

(1) Screening mammography to detect the presence of breast cancer in adult women;

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

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

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

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

(a) One screening mammography every two years;

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

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

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

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

(E) The benefits provided under division (B)(1) of this section shall be provided only for screening mammographies that are performed in a health care 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.

(F) The benefits provided under divisions (B)(1) and (2) of this section shall be provided according to the terms of the subscriber contract.

(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.

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.

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.

(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:

(1) Require an individual seeking coverage to submit to genetic screening or testing;

(2) Take into consideration, other than in accordance with division (F) of this section, the results of genetic screening or testing;

(3) Make any inquiry to determine the results of genetic screening or testing;

(4) Make a decision adverse to the applicant based on entries in medical records or other reports of genetic screening or testing.

(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.

(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.

(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.

(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.

(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.

Sec. 1751.65. (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.

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

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

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

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

Sec. 1751.66. (A) No individual or group health insuring corporation policy, contract, or agreement that provides coverage for prescription drugs shall limit or exclude coverage for any drug approved by the United States food and drug administration on the basis that the drug has not been approved by the United States food and drug administration for the treatment of the particular indication for which the drug has been prescribed, provided the drug has been recognized as safe and effective for treatment of that indication in one or more of the standard medical reference compendia specified in division (B)(1) of this section or in medical literature that meets the criteria specified in division (B)(2) of this section.

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

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

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

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

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

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

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

(c) Each article meets the uniform requirements for manuscripts submitted to biomedical journals established by the international committee of medical journal editors or is published in a journal specified by the United States department of health and human services pursuant to Section 1861(t)(2)(B) of the "Social Security Act," 107 Stat. 591 (1993), 42 U.S.C. 1395 (x)(t)(2)(B), as amended, as accepted peer-reviewed medical literature.

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

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

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

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

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

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

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

(E) This section applies only to health insuring corporation policies, contracts, and agreements that are described in division (A) of this section

and that are delivered, issued for delivery, or renewed in this state on or after July 1, 1997.

Sec. 1751.67. (A) EACH INDIVIDUAL OR GROUP HEALTH INSURING CORPORATION POLICY, CONTRACT, OR AGREEMENT DELIVERED, ISSUED FOR DELIVERY, OR RENEWED IN THIS STATE THAT PROVIDES MATERNITY BENEFITS SHALL PROVIDE COVERAGE OF INPATIENT CARE AND FOLLOW-UP CARE FOR A MOTHER AND HER NEWBORN AS FOLLOWS:

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

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

WHEN A DECISION IS MADE IN ACCORDANCE WITH DIVISION (B) OF THIS SECTION TO DISCHARGE A MOTHER OR NEWBORN PRIOR TO THE EXPIRATION OF THE APPLICABLE NUMBER OF HOURS OF INPATIENT CARE REQUIRED TO BE

COVERED, THE COVERAGE OF FOLLOW-UP CARE SHALL APPLY TO ALL FOLLOW-UP CARE THAT IS PROVIDED WITHIN FORTY-EIGHT HOURS AFTER DISCHARGE. WHEN A MOTHER OR NEWBORN RECEIVES AT LEAST THE NUMBER OF HOURS OF INPATIENT CARE REQUIRED TO BE COVERED, THE COVERAGE OF FOLLOW-UP CARE SHALL APPLY TO FOLLOW-UP CARE THAT IS DETERMINED TO BE MEDICALLY NECESSARY BY THE PROVIDER RESPONSIBLE FOR DISCHARGING THE MOTHER OR NEWBORN.

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

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

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

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

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

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

(1) REQUIRE A POLICY, CONTRACT, OR AGREEMENT TO COVER INPATIENT OR FOLLOW-UP CARE THAT IS NOT RECEIVED IN ACCORDANCE WITH THE POLICY'S, CONTRACT'S, OR AGREEMENT'S TERMS PERTAINING TO THE PROVIDERS AND FACILITIES FROM WHICH AN INDIVIDUAL IS AUTHORIZED TO RECEIVE HEALTH CARE SERVICES;

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

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

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

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

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

(B) In the case of employees of the state, the employee's authorization shall be directed to and filed with the director of administrative services. In the case of employees of a political subdivision, the employee's authorization shall be directed to and filed with the fiscal officer of such political subdivision. In the case of employees of any institution supported in whole or in part by the state, the employee's authorization shall be directed to and filed with the fiscal officer of such institution.

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

authorized.

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

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

(B) The legislative authority, after consultation with the judges of the municipal court, shall negotiate and contract for, purchase, or otherwise procure group health care coverage for the judges and their spouses and dependents from insurance companies authorized to engage in the business of insurance in this state under Title XXXIX of the Revised Code, ~~medical care corporations organized under Chapter 1737. of the Revised Code, or health care insuring corporations organized holding certificates of authority under Chapter 1738. 1751. of the Revised Code, or health maintenance organizations organized under Chapter 1742. of the Revised Code,~~ except that if the county or municipal corporation served by the legislative authority provides group health care coverage for its employees, the group health care coverage required by this section shall be provided, if possible, through the policy or plan under which the group health care coverage is provided for the county or municipal corporation employees.

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

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

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

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

(B) The legislative authority, after consultation with the clerk and deputy clerks of the municipal court, shall negotiate and contract for, purchase, or otherwise procure group health care coverage for the clerk and deputy clerks and their spouses and dependents from insurance companies authorized to engage in the business of insurance in this state under Title XXXIX of the Revised Code, ~~medical care corporations organized under Chapter 1737. of the Revised Code, or health care insuring corporations organized holding certificates of authority under Chapter 1738. 1751. of the Revised Code, or health maintenance organizations organized under Chapter 1742. of the Revised Code,~~ except that if the county or municipal corporation served by the legislative authority provides group health care coverage for its employees, the group health care coverage required by this section shall be provided, if possible, through the policy or plan under which the group health care coverage is provided for the county or municipal corporation employees.

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

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

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

(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 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.

(2)(a) If, at any time, a person described in division (A)(2)(a)(i) of section 2133.05 of the Revised Code or the individual or a majority of the individuals in either of the first two classes of individuals that pertain to a

declarant in the descending order of priority set forth in division (A)(2)(a)(ii) of section 2133.05 of the Revised Code believes in good faith that both of the following circumstances apply, the person or the individual or majority of individuals in either of the first two classes of individuals may commence an action in the probate court of the county in which a declarant who is in a terminal condition or permanently unconscious state is located for the issuance of an order mandating the use or continuation of comfort care in connection with the declarant in a manner that is consistent with division (E)(1) of this section:

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

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

(b) If a declarant did not designate in ~~his~~ the declarant's declaration a person as described in division (A)(2)(a)(i) of section 2133.05 of the Revised Code and if, at any time, a priority individual or any member of a priority class of individuals under division (A)(2)(a)(ii) of section 2133.05 of the Revised Code or, at any time, the individual or a majority of the individuals in the next class of individuals that pertains to the declarant in the descending order of priority set forth in that division believes in good faith that both of the following circumstances apply, the priority individual, the member of the priority class of individuals, or the individual or majority of individuals in the next class of individuals that pertains to the declarant may commence an action in the probate court of the county in which a declarant who is in a terminal condition or permanently unconscious state is located for the issuance of an order mandating the use or continuation of comfort care in connection with the declarant in a manner that is consistent with division (E)(1) of this section:

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

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

(c) If, at any time, a priority individual or any member of a priority class of individuals under division (B) of section 2133.08 of the Revised Code or, at any time, the individual or a majority of the individuals in the next class of individuals that pertains to the patient in the descending order of priority set forth in that division believes in good faith that both of the following circumstances apply, the priority individual, the member of the priority class of individuals, or the individual or majority of individuals in the next class of individuals that pertains to the patient may commence an action in the

probate court of the county in which a patient as described in division (A) of section 2133.08 of the Revised Code is located for the issuance of an order mandating the use or continuation of comfort care in connection with the patient in a manner that is consistent with division (E)(1) of this section:

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

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

Sec. 2305.25. (A) No health care entity and no individual who is a member of or works on behalf of any of the following boards or committees of a health care entity or of any of the following corporations shall be liable in damages to any person for any acts, omissions, decisions, or other conduct within the scope of the functions of the board, committee, or corporation:

(1) A peer review committee of a hospital, a nonprofit health care corporation which is a member of the hospital or of which the hospital is a member, or a community mental health center;

(2) A board or committee of a hospital or of a nonprofit health care corporation which is a member of the hospital or of which the hospital is a member reviewing professional qualifications or activities of the hospital medical staff or applicants for admission to the medical staff;

(3) A utilization committee of a state or local society composed of doctors of medicine or doctors of osteopathic medicine and surgery or doctors of podiatric medicine;

(4) A peer review committee of nursing home providers or administrators, including a corporation engaged in performing the functions of a peer review committee of nursing home providers or administrators, or a corporation engaged in the functions of another type of peer review or professional standards review committee;

(5) A peer review committee, professional standards review committee, or arbitration committee of a state or local society composed of doctors of medicine, doctors of osteopathic medicine 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;

(10) A quality assurance committee of the central office of the department of rehabilitation and correction or department of mental health;

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

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

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

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

(a) The credentialing and review requirements of the accrediting organization did not apply to the hospital, the qualified person, or the type of

professional care that is the basis of the claim against the hospital.

(b) The hospital failed to comply with all material credentialing and review requirements of the accrediting organization that applied to the qualified person.

(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:

(1) "Data" has the same meaning as in section 2913.01 of the Revised Code and additionally includes any other representation of information, knowledge, facts, concepts, or instructions that are being or have been prepared in a formalized manner.

(2) "Deceptive" means that a statement, in whole or in part, would cause another to be deceived because it contains a misleading representation, withholds information, prevents the acquisition of information, or by any other conduct, act, or omission creates, confirms, or perpetuates a false impression, including, but not limited to, a false impression as to law, value, state of mind, or other objective or subjective fact.

(3) "Insurer" means any person that is authorized to engage in the business of insurance in this state under Title XXXIX of the Revised Code; the Ohio fair plan underwriting association created under section 3929.43 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.

(4) "Policy" means a policy, certificate, contract, or plan that is issued by an insurer.

(5) "Statement" includes, but is not limited to, any notice, letter, or memorandum; proof of loss; bill of lading; receipt for payment; invoice, account, or other financial statement; estimate of property damage; bill for

services; diagnosis or prognosis; prescription; hospital, medical, or dental chart or other record; x-ray, photograph, videotape, or movie film; test result; other evidence of loss, injury, or expense; computer-generated document; and data in any form.

(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, certificate holder, or contract holder of, a policy, contract, or plan of health insurance that provided health insurance coverage for ~~his~~ that party's spouse and dependents immediately prior to the filing of the action, that party shall not cancel or otherwise terminate or cause the termination of such coverage for which the spouse and dependents would otherwise be eligible until the court determines that the party is no longer responsible for providing such health insurance coverage for ~~his~~ that party's spouse and dependents.

(B) If the party responsible for providing health insurance coverage for ~~his~~ that party's spouse and dependents under division (A) of this section fails

to provide that coverage in accordance with that division, the court shall issue an order that includes all of the following:

(1) A requirement that the party make payment to ~~his~~ that party's spouse in the amount of any premium ~~he~~ that party failed to pay or contribution ~~he~~ that party failed to make that resulted in ~~his~~ that party's failure to provide health insurance coverage in compliance with division (A) of this section;

(2) A requirement that the party make payment to ~~his~~ that party's spouse for reimbursement of any hospital, surgical, and medical expenses incurred as a result of ~~his~~ that party's failure to comply with division (A) of this section;

(3) A requirement that, if the party fails to comply with divisions (B)(1) and (2) of this section, the employer of the party deduct from the party's earnings an amount necessary to make any payments required under divisions (B)(1) and (2) of this section.

(C) If the party responsible for providing health insurance coverage for ~~his~~ that party's spouse and dependents under division (A) of this section cancels or otherwise terminates or causes the termination of such coverage for which the spouse and dependents would otherwise be eligible, the spouse may apply to the insurer, health ~~maintenance organization~~ insuring corporation, or other third-party payer that provided the coverage for a policy or contract of health insurance. The spouse and dependents shall have the same rights and be subject to the same limitations as a person applying for or covered under a converted or separate policy under section 3923.32 of the Revised Code upon the divorce, annulment, dissolution of marriage, or the legal separation of the spouse from the named insured.

Sec. 3111.241. (A) As used in this section, "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.

(B) If an administrative officer of a child support enforcement agency issues an administrative support order under section 3111.20, 3111.21, or 3111.22 of the Revised Code, in addition to any requirements in those sections, the agency also shall issue a separate order that includes all of the following:

(1) A requirement that the obligor under the 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 order and a requirement that the obligor, no later than thirty days after the issuance of the order under division (B)(1) of this section, furnish written proof to the child support enforcement agency that 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 under division (B)(1) of this section, furnish written proof to the child support enforcement agency that the required health insurance coverage has been obtained, if that coverage is available through a group health insurance or health care policy, contract, or plan offered by the obligee's employer or through any other group health insurance or health care policy, contract, or plan available to the obligee and if that coverage is available at a more reasonable cost than health insurance coverage for the children through a group health insurance or health care policy, contract, or plan available to

the obligor;

(4) If the obligee is required under division (B)(3) 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 obligee submit a copy of the administrative order issued pursuant to division (B) of this section to the insurer at the time that the obligee makes application to enroll the children in the health insurance or health care policy, contract, or plan;

(5) A list of the group health insurance and health care policies, contracts, and plans that the child support enforcement agency determines are available at a reasonable cost to the obligor or to the obligee and the name of the insurer that issues each policy, contract, or plan;

(6) A statement setting forth the name, address, and telephone number of the individual who is to be reimbursed for out-of-pocket medical, optical, hospital, dental, or prescription expenses paid for each child who is the subject of the administrative child support order and a statement that the insurer that provides the health insurance coverage for the children may continue making payment for medical, optical, hospital, dental, or prescription services directly to any health care provider in accordance with the applicable health insurance or health care policy, contract, or plan;

(7) A requirement that the obligor and the obligee designate the children who are the subject of the administrative child support order as covered dependents under any health insurance or health care policy, contract, or plan for which they contract;

(8) A requirement that the obligor, the obligee, or both of them under a formula established by the child support enforcement agency pay copayment or deductible costs required under the health insurance or health care policy, contract, or plan that covers the children;

(9) If health insurance coverage for the children who are the subject of the administrative order is not 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 is not available at a reasonable cost through a group health insurance or health care policy, contract, or plan offered by the obligee's employer or through any other group health insurance or health care policy, contract, or plan available to the obligee, a requirement that the obligor and the obligee share liability for the cost of the medical and health care needs of the children who are the subject of the administrative order, under an equitable formula established by the agency, and a requirement that if, after the issuance of the order, health insurance coverage for the children who are the subject of the

administrative order becomes available at a reasonable cost through a group health insurance or health care policy, contract, or plan offered by the obligor's or obligee's employer or through any other group health insurance or health care policy, contract, or plan available to the obligor or obligee, the obligor or obligee to whom the coverage becomes available immediately inform the agency of that fact;

(10) A notice that, if the obligor is required under divisions (B)(1) and (2) of this section to obtain health insurance coverage for the children who are the subject of the administrative child support order and if the obligor fails to comply with the requirements of those divisions, the child support enforcement agency immediately shall issue an administrative order to the employer of the obligor, upon written notice from the child support enforcement agency, requiring the employer to take whatever action is necessary to make application to enroll the obligor in any available group health insurance or health care policy, contract, or plan with coverage for the children who are the subject of the administrative child support order, to submit a copy of the administrative order issued pursuant to division (B) of this section to the insurer at the time that the employer makes application to enroll the children in the health insurance or health care policy, contract, or plan, and, if the obligor's application is accepted, to deduct any additional amount from the obligor's earnings necessary to pay any additional cost for that health insurance coverage;

(11) A notice that during the time that an order under this section is in effect, the employer of the obligor is required to release to the obligee or the child support enforcement agency upon written request any necessary information on the health insurance coverage of the obligor, including, but not limited to, the name and address of the insurer and any policy, contract, or plan number, and to otherwise comply with this section and any court order issued under this section;

(12) A statement setting forth the full name and date of birth of each child who is the subject of the administrative child support order;

(13) A requirement that the obligor and the obligee comply with any requirement described in division (B)(1), (2), (3), (4), or (7) of this section that is contained in the order issued under this section no later than thirty days after the issuance of the order.

(C) If an administrative officer of a child support enforcement agency issues an administrative support order under section 3111.20, 3111.21, or 3111.22 of the Revised Code, the child support enforcement agency, in addition to any requirements in those sections and in lieu of an order issued under division (B) of this section, may issue a separate order requiring both

the obligor and the obligee to obtain health insurance coverage for the children who are the subject of the administrative child support order, if health insurance coverage is available for the children and if the agency determines that the coverage is available at a reasonable cost to both the obligor and the obligee and that the dual coverage by both parents would provide for coordination of medical benefits without unnecessary duplication of coverage. If the agency issues an order under this division, it shall include in the order any of the requirements, notices, and information set forth in divisions (B)(1) to (13) of this section that are applicable.

(D) Any administrative order issued under this section shall be binding upon the obligor and the obligee, their employers, and any insurer that provides health insurance coverage for either of them or their children. The agency shall send a copy of any administrative order issued under this section that contains any requirement or notice described in division (B)(1), (2), (3), (4), (7), (8), or (10) of this section by ordinary mail to the obligor, the obligee, and any employer that is subject to the administrative order. The agency shall send a copy of any administrative order issued under this section that contains any requirement contained in division (B)(9) of this section by ordinary mail to the obligor and obligee.

(E) If an obligor does not comply with any administrative order issued under this section that contains any requirement or notice described in division (B)(1), (2), (4), (7), (8), or (10) of this section within thirty days after the administrative order is issued, the child support enforcement agency shall notify the court of common pleas of the county in which the agency is located in writing of the failure of the obligor to comply with the administrative order. Upon receipt of the notice from the agency, the court shall issue an order to the employer of the obligor requiring the employer to take whatever action is necessary to make application to enroll the obligor in any available group health insurance or health care policy, contract, or plan with coverage for the children who are the subject of the administrative child support order, to submit a copy of the administrative order issued pursuant to division (B) of this section to the insurer at the time that the employer makes application to enroll the children in the health insurance or health care policy, contract, or plan, and, if the obligor's application is accepted, to deduct from the wages or other income of the obligor the cost of the coverage for the children. Upon receipt of any court order under this division, the employer shall take whatever action is necessary to comply with the court order.

During the time that any administrative or court order issued under this section is in effect and after the employer has received a copy of the

administrative or court order, the employer of the obligor who is the subject of the administrative or court order shall comply with the administrative or court order and, upon request from the obligee or agency, shall release to the obligee and the child support enforcement agency all information about the obligor's health insurance coverage that is necessary to ensure compliance with this section or any administrative or court order issued under this section, including, but not limited to, the name and address of the insurer and any policy, contract, or plan number. Any information provided by an employer pursuant to this division shall be used only for the purpose of the enforcement of an administrative or court order issued under this section.

Any employer who receives a copy of an administrative or court order issued under this section shall notify the child support enforcement agency of any change in or the termination of the obligor's health insurance coverage that is maintained pursuant to an order issued under this section.

(F) Any insurer that receives a copy of an administrative order issued under this section shall comply with this section and any administrative order issued under this section, regardless of the residence of the children. If an insurer provides health insurance coverage for the children who are the subject of an administrative child support order in accordance with an order issued under this section, the insurer shall reimburse the parent, who is designated to receive reimbursement in the administrative order issued under this section, for covered out-of-pocket medical, optical, hospital, dental, or prescription expenses incurred on behalf of the children subject to the administrative order.

(G) If an obligee under an administrative child support order is eligible for medical assistance under Chapter 5111. or 5115. of the Revised Code and the obligor has obtained health insurance coverage pursuant to an administrative order issued under division (B) of this section, the obligee shall notify any physician, hospital, or other provider of medical services for which medical assistance is available of the name and address of the obligor's insurer and of the number of the obligor's health insurance or 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.

(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.

(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.

(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:

(1) A requirement that the obligor under the child support order obtain health insurance coverage for the children who are the subject of the child support order from an insurer that provides a group health insurance or health care policy, contract, or plan that is specified in the order and a requirement that the obligor, no later than thirty days after the issuance of the order under division (C)(1) of this section, furnish written proof to the child support enforcement agency that 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 child support order;

(2) If the obligor is required under division (C)(1) of this section to obtain health insurance coverage for the children who are the subject of the 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 court order issued pursuant to division (C) 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 order under division (C)(2) of this section, furnish written proof to the child support enforcement agency that division (C)(2) of this section has been complied with;

(3) A requirement that the obligee under the child support order obtain health insurance coverage for the children who are the subject of the child support order from an insurer that provides a group health insurance or health care policy, contract, or plan that is specified in the order and a requirement that the obligee, no later than thirty days after the issuance of the order under division (C)(1) of this section, furnish written proof to the child support enforcement agency that the required health insurance coverage has been obtained, if that coverage is available through a group health insurance or health care policy, contract, or plan offered by the obligee's employer or through any other group health insurance or health

care policy, contract, or plan available to the obligee and if that coverage is available at a more reasonable cost than health insurance coverage for the children through a group health insurance or health care policy, contract, or plan available to the obligor;

(4) If the obligee is required under division (C)(3) of this section to obtain health insurance coverage for the children who are the subject of the child support order, a requirement that the obligee submit a copy of the court order issued pursuant to division (C) of this section to the insurer at the time that the obligee makes application to enroll the children in the health insurance or health care policy, contract, or plan;

(5) A list of the group health insurance and health care policies, contracts, and plans that the court determines are available at a reasonable cost to the obligor or to the obligee and the name of the insurer that issues each policy, contract, or plan;

(6) A statement setting forth the name, address, and telephone number of the individual who is to be reimbursed for out-of-pocket medical, optical, hospital, dental, or prescription expenses paid for each child who is the subject of the support order and a statement that the insurer that provides the health insurance coverage for the children may continue making payment for medical, optical, hospital, dental, or prescription services directly to any health care provider in accordance with the applicable health insurance or health care policy, contract, or plan;

(7) A requirement that the obligor and the obligee designate the children who are the subject of the child support order as covered dependents under any health insurance or health care policy, contract, or plan for which they contract;

(8) A requirement that the obligor, the obligee, or both of them under a formula established by the court pay co-payment or deductible costs required under the health insurance or health care policy, contract, or plan that covers the children;

(9) If health insurance coverage for the children who are the subject of the order is not 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 is not available at a reasonable cost through a group health insurance or health care policy, contract, or plan offered by the obligee's employer or through any other group health insurance or health care policy, contract, or plan available to the obligee, a requirement that the obligor and the obligee share liability for the cost of the medical and health care needs of the children who are the subject of the

order, under an equitable formula established by the court, and a requirement that if, after the issuance of the order, health insurance coverage for the children who are the subject of the order becomes available at a reasonable cost through a group health insurance or health care policy, contract, or plan offered by the obligor's or obligee's employer or through any other group health insurance or health care policy, contract, or plan available to the obligor or obligee, the obligor or obligee to whom the coverage becomes available immediately inform the court of that fact;

(10) A notice that, if the obligor is required under divisions (C)(1) and (2) of this section to obtain health insurance coverage for the children who are the subject of the child support order and if the obligor fails to comply with the requirements of those divisions, the court immediately shall issue an order to the employer of the obligor, upon written notice from the child support enforcement agency, requiring the employer to take whatever action is necessary to make application to enroll the obligor in any available group health insurance or health care policy, contract, or plan with coverage for the children who are the subject of the child support order, to submit a copy of the court order issued pursuant to division (C) of this section to the insurer at the time that the employer makes application to enroll the children in the health insurance or health care policy, contract, or plan, and, if the obligor's application is accepted, to deduct any additional amount from the obligor's earnings necessary to pay any additional cost for that health insurance coverage;

(11) A notice that during the time that an order under this section is in effect, the employer of the obligor is required to release to the obligee or the child support enforcement agency upon written request any necessary information on the health insurance coverage of the obligor, including, but not limited to, the name and address of the insurer and any policy, contract, or plan number, and to otherwise comply with this section and any court order issued under this section;

(12) A statement setting forth the full name and date of birth of each child who is the subject of the child support order;

(13) A requirement that the obligor and the obligee comply with any requirement described in division (C)(1), (2), (3), (4), or (7) of this section that is contained in the order issued under this section no later than thirty days after the issuance of the order.

(D) In any action 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 court, in

addition to any requirements in those sections and in lieu of an order issued under division (C) of this section, may issue a separate order requiring both the obligor and the obligee to obtain health insurance coverage for the children who are the subject of the child support order, if health insurance coverage is available for the children and if the court determines that the coverage is available at a reasonable cost to both the obligor and the obligee and that the dual coverage by both parents would provide for coordination of medical benefits without unnecessary duplication of coverage. If the court issues an order under this division, it shall include in the order any of the requirements, notices, and information set forth in divisions (C)(1) to (13) of this section that are applicable.

(E) Any order issued under this section shall be binding upon the obligor and the obligee, their employers, and any insurer that provides health insurance coverage for either of them or their children. The court shall send a copy of any order issued under this section that contains any requirement or notice described in division (C)(1), (2), (3), (4), (7), (8), or (10) of this section by ordinary mail to the obligor, the obligee, and any employer that is subject to the order. The court shall send a copy of any order issued under this section that contains any requirement contained in division (C)(9) of this section by ordinary mail to the obligor and obligee.

(F) If an obligor does not comply with any order issued under this section that contains any requirement or notice described in division (C)(1), (2), (4), (7), (8), or (10) of this section within thirty days after the order is issued, the child support enforcement agency shall notify the court in writing of the failure of the obligor to comply with the order. Upon receipt of the notice from the agency, the court shall issue an order to the employer of the obligor requiring the employer to take whatever action is necessary to make application to enroll the obligor in any available group health insurance or health care policy, contract, or plan with coverage for the children who are the subject of the child support order, to submit a copy of the court order issued pursuant to division (C) of this section to the insurer at the time that the employer makes application to enroll the children in the health insurance or health care policy, contract, or plan, and, if the obligor's application is accepted, to deduct from the wages or other income of the obligor the cost of the coverage for the children. Upon receipt of any order under this division, the employer shall take whatever action is necessary to comply with the order.

During the time that any order issued under this section is in effect and after the employer has received a copy of the order, the employer of the obligor who is the subject of the order shall comply with the order and, upon

request from the obligee or agency, shall release to the obligee and the child support enforcement agency all information about the obligor's health insurance coverage that is necessary to ensure compliance with this section or any order issued under this section, including, but not limited to, the name and address of the insurer and any policy, contract, or plan number. Any information provided by an employer pursuant to this division shall be used only for the purpose of the enforcement of an order issued under this section.

Any employer who receives a copy of an order issued under this section shall notify the child support enforcement agency of any change in or the termination of the obligor's health insurance coverage that is maintained pursuant to an order issued under this section.

(G) Any insurer that receives a copy of an order issued under this section shall comply with this section and any order issued under this section, regardless of the residence of the children. If an insurer provides health insurance coverage for the children who are the subject of a child support order in accordance with an order issued under this section, the insurer shall reimburse the parent, who is designated to receive reimbursement in the order issued under this section, for covered out-of-pocket medical, optical, hospital, dental, or prescription expenses incurred on behalf of the children subject to the order.

(H) If an obligee under a child support order is eligible for medical assistance under Chapter 5111. or 5115. of the Revised Code and the obligor has obtained health insurance coverage pursuant to an order issued under division (C) of this section, the obligee shall notify any physician, hospital, or other provider of medical services for which medical assistance is available of the name and address of the obligor's insurer and of the number of the obligor's health insurance or 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.

(I) Any obligor who fails to comply with an order issued under this

tion is liable to the obligee for any medical expenses incurred as a result of the failure to comply with the order.

(J) Whoever violates an order issued under this section may be punished as for contempt under Chapter 2705. of the Revised Code. If an obligor is found in contempt under that chapter for failing to comply with an order issued under this section and if the obligor previously has been found in contempt under that chapter, the court shall consider the obligor's failure to comply with the court's order as a change in circumstances for the purpose of modification of the amount of support due under the child support order that is the basis of the order issued under this section.

(K) 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.

(L) Notwithstanding section 3109.01 of the Revised Code, if a court issues an order under this section requiring a parent to obtain health insurance coverage for the children who are the subject of a child support order, the order shall remain in effect beyond the child's eighteenth birthday as long as the child continuously attends on a full-time basis any recognized and accredited high school. Any parent ordered to obtain health insurance coverage for the children who are the subject of a child support order shall continue to obtain the coverage for the children under the order, including during seasonal vacation periods, until the order terminates.

Sec. 3307.74. (A) The state teachers 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 those individuals receiving service retirement or a disability or survivor benefit subscribing to the plan. Notwithstanding any other provision of this chapter, the policy or contract may also include coverage for any eligible individual's spouse and dependent children and for any of the individual's sponsored dependents as the board considers appropriate. If all or any portion of the policy or contract premium is to be paid by any individual receiving service retirement or a disability or survivor benefit, the individual shall, by written authorization, instruct the board to deduct the premium agreed to be paid by the individual to the companies, ~~associations~~, corporations, or agencies.

The board may contract for coverage on the basis of part or all of the cost of the coverage to be paid from appropriate funds of the state teachers

retirement system. The cost paid from the funds of the system shall be included in the employer's contribution rate provided by section 3307.53 of the Revised Code.

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.

(B) 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 (A) 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 (A) 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 from one plan to another at least once a year at a time determined by the board.

(C) The board shall, beginning the month following receipt of 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 section, "retirement systems" has the same meaning as in division (A) of section 145.581 of the Revised Code.

The 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 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 board shall request the superintendent of insurance to certify the financial condition of the company; ~~or corporation, or organization.~~ The board 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.

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 3307.281 of the Revised Code, deduction of the full premium charged from a person's service, disability, 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. 3309.69. (A) As used in this section, "ineligible individual" means all of the following:

(1) A former member receiving benefits pursuant to section 3309.34, 3309.35, 3309.36, 3309.38, or 3309.381 of the Revised Code for whom eligibility is established more than five years after June 13, 1981, and who, at the time of establishing eligibility, has accrued less than ten years of service credit, exclusive of credit obtained after January 29, 1981, pursuant to sections 3309.021, 3309.301, 3309.31, and 3309.33 of the Revised Code;

(2) The spouse of the former member;

(3) The beneficiary of the former member receiving benefits pursuant to section 3309.46 of the Revised Code.

(B) The school employees 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 those individuals receiving service retirement or a disability or survivor benefit subscribing to the plan and their eligible dependents.

If all or any portion of the policy or contract premium is to be paid by any individual receiving service retirement or a disability or survivor benefit, the person shall, by written authorization, instruct the board to deduct the premiums agreed to be paid by the individual to the companies, corporations, or agencies.

The board may contract for coverage on the basis of part or all of the cost of the coverage to be paid from appropriate funds of the school employees retirement system. The cost paid from the funds of the system shall be included in the employer's contribution rate provided by sections 3309.49 and 3309.491 of the 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 from one plan to another at least once a year at a time determined by the board.

(D) The board shall, beginning the month following receipt of 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 school employees 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, except that the board shall make no such payment to any ineligible individual. The amount of 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 January 1, 1988.

(E) The board shall establish by rule requirements for the coordination of any coverage, payment, or benefit provided under this section or section 3309.375 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, state teachers retirement system, or state highway patrol retirement system.

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

Sec. 3309.691. The school employees 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 section, "retirement systems" has the same meaning as in division (A) of section 145.581 of the Revised Code.

The 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 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 board shall request the superintendent of insurance to certify the financial condition of the company; or corporation, ~~or organization~~. The board 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.

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 3309.27 of the Revised Code, deduction of the full premium charged from a person's service, disability, 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. 3313.202. (A) The board of education of a school district may procure and pay all or part of the cost of group term life, hospitalization, surgical care, or major medical insurance, disability, dental care, vision care, medical care, hearing aids, prescription drugs, sickness and accident insurance, group legal services, or a combination of any of the foregoing types of insurance or coverage, whether issued by an insurance company or a ~~medical care corporation,~~ health care insuring corporation, ~~dental care~~

~~corporation, or health maintenance organization~~ duly licensed by this state, covering the teaching or nonteaching employees of the school district, or a combination of both, or the dependent children and spouses of such employees, provided if such coverage affects only the teaching employees of the district such coverage shall be with the consent of a majority of such employees of the school district, or if such coverage affects only the nonteaching employees of the district such coverage shall be with the consent of a majority of such employees. If such coverage is proposed to cover all the employees of a school district, both teaching and nonteaching employees, such coverage shall be with the consent of a majority of all the employees of a school district. A board of education shall continue to carry, on payroll records, all school employees whose sick leave accumulation has expired, or who are on a disability leave of absence or an approved leave of absence, for the purpose of group term life, hospitalization, surgical, major medical, or any other insurance. A board of education may pay all or part of such coverage except when such employees are on an approved leave of absence, or on a disability leave of absence for that period exceeding two years. As used in this section, "teaching employees" means any person employed in the public schools of this state in a position for which the person is required to have a certificate or license pursuant to sections 3319.22 to 3319.31 of the Revised Code. "Nonteaching employees" as used in this section means any person employed in the public schools of the state in a position for which the person is not required to have a certificate or license issued pursuant to sections 3319.22 to 3319.31 of the Revised Code.

(B) The board of education of a school district may enter into an agreement with a jointly administered trust fund which receives contributions pursuant to a collective bargaining agreement entered into between the board and any collective bargaining representative of the employees of the board for the purpose of providing for self-insurance of all risk in the provision of fringe benefits similar to those that may be paid pursuant to division (A) of this section, and may provide through the self-insurance method specific fringe benefits as authorized by the rules of the board of trustees of the jointly administered trust fund. Benefits provided under this section include, but are not limited to, hospitalization, surgical care, major medical care, disability, dental care, vision care, medical care, hearing aids, prescription drugs, group life insurance, sickness and accident insurance, group legal services, or a combination of the above benefits, for the employees and their dependents.

(C) Notwithstanding any other provision of the Revised Code, the board of education and any collective bargaining representative of employees of

the board may agree in a collective bargaining agreement that any mutually agreed fringe benefit, including, but not limited to, hospitalization, surgical care, major medical care, disability, dental care, vision care, medical care, hearing aids, prescription drugs, group life insurance, sickness and accident insurance, group legal services, or a combination thereof, for employees and their dependents be provided through a mutually agreed upon contribution to a jointly administered trust fund. The amount, type, and structure of fringe benefits provided under this division are subject to the determination of the board of trustees of the jointly administered trust fund. Notwithstanding any other provision of the Revised Code, competitive bidding does not apply to the purchase of fringe benefits for employees under this division through a jointly administered trust fund.

(D) Any elected or appointed member of the board of education and the dependent children and spouse of the member may be covered, at the option of the member, as an employee of the school district under any benefit plan adopted under this section. The member shall pay to the school district the amount certified for that coverage under division (D)(1) or (2) of this section. Payments for such coverage shall be made, in advance, 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.

For the purposes of determining the cost to board members under this division:

(1) In the case of a benefit plan purchased under division (A) of this section, the provider of the benefits shall certify to the board the provider's charge for coverage under each option available to employees under that benefit plan;

(2) In the case of benefits provided under division (B) or (C) of this section, the board of trustees of the jointly administered trust fund shall certify to the board of education the trustees' charge for coverage under each option available to employees under each benefit plan.

(E) 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. 3375.40. Each board of library trustees appointed pursuant to sections 3375.06, 3375.10, 3375.12, 3375.15, 3375.22, and 3375.30 of the Revised Code may:

(A) Hold title to and have the custody of all real and personal property of the free public library under its jurisdiction;

(B) Expend for library purposes, and in the exercise of the power

enumerated in this section, all moneys, whether derived from the county library and local government support fund or otherwise, credited to the free public library under its jurisdiction and generally do all things it considers necessary for the establishment, maintenance, and improvement of the public library under its jurisdiction;

(C) Purchase, lease, construct, remodel, renovate, or otherwise improve, equip, and furnish buildings or parts of buildings and other real property, and purchase, lease, or otherwise acquire motor vehicles and other personal property, necessary for the proper maintenance and operation of the free public libraries under its jurisdiction, and pay the costs thereof in installments or otherwise. Financing of these costs may be provided through the issuance of notes, through an installment sale, or through a lease-purchase agreement. Any such notes shall be issued pursuant to section 3375.404 of the Revised Code.

(D) Purchase, lease, lease with an option to purchase, or erect buildings or parts of buildings to be used as main libraries, branch libraries, or library stations pursuant to section 3375.41 of the Revised Code;

(E) Establish and maintain a main library, branches, library stations, and traveling library service within the territorial boundaries of the subdivision or district over which it has jurisdiction of free public library service;

(F) Establish and maintain branches, library stations, and traveling library service in any school district, outside the territorial boundaries of the subdivision or district over which it has jurisdiction of free public library service, upon application to and approval of the state library board, pursuant to section 3375.05 of the Revised Code; provided the board of trustees of any free public library maintaining branches, stations, or traveling-book service, outside the territorial boundaries of the subdivision or district over which it has jurisdiction of free public library service, on September 4, 1947, may continue to maintain and operate such branches, stations, and traveling library service without the approval of the state library board;

(G) Appoint and fix the compensation of all of the employees of the free public library under its jurisdiction; pay the reasonable cost of tuition for any of its employees who enroll in a course of study the board considers essential to the duties of the employee or to the improvement of the employee's performance; and reimburse applicants for employment for any reasonable expenses they incur by appearing for a personal interview;

(H) Make and publish rules for the proper operation and management of the free public library and facilities under its jurisdiction, including rules pertaining to the provision of library services to individuals, corporations, or institutions that are not inhabitants of the county;

(I) Establish and maintain a museum in connection with and as an adjunct to the free public library under its jurisdiction;

(J) By the adoption of a resolution accept any bequest, gift, or endowment upon the conditions connected with such bequest, gift, or endowment; provided no such bequest, gift, or endowment shall be accepted by such board if the conditions thereof remove any portion of the free public library under its jurisdiction from the control of such board or if such conditions, in any manner, limit the free use of such library or any part thereof by the residents of the counties in which such library is located;

(K) At the end of any fiscal year by a two-thirds vote of its full membership set aside any unencumbered surplus remaining in the general fund of the library under its jurisdiction for any purpose including creating or increasing a special building and repair fund, or for operating the library or acquiring equipment and supplies;

(L) Procure and pay all or part of the cost of group life, hospitalization, surgical, major medical, disability benefit, dental care, eye care, hearing aids, or prescription drug insurance, or a combination of any of the foregoing types of insurance or coverage, whether issued by an insurance company; or ~~nonprofit medical or dental care~~ a health insuring corporation duly licensed by the state, covering its employees and in the case of hospitalization, surgical, major medical, dental care, eye care, hearing aids, or prescription drug insurance, also covering the dependents and spouses of such employees, and in the case of disability benefits, also covering spouses of such employees. With respect to life insurance, coverage for any employee shall not exceed the greater of the sum of ten thousand dollars or the annual salary of the employee, exclusive of any double indemnity clause that is a part of the policy.

(M) Pay reasonable dues and expenses for the free public library and library trustees in library associations.

Sec. 3381.14. A regional arts and cultural district may procure and pay all or any part of the cost of group hospitalization, surgical, major medical, or sickness and accident insurance or a combination of any of the foregoing for the employees of the district and their immediate dependents, whether issued by an insurance company; ~~nonprofit medical care~~ or a health insuring corporation; ~~or hospital service association~~ duly authorized to do business in this state.

Sec. 3501.141. (A) The board of elections of any county may contract, purchase, or otherwise procure and pay all or any part of the cost of group insurance policies that may provide benefits for hospitalization, surgical care, major medical care, disability, dental care, eye care, medical care,

hearing aids, or prescription drugs, and that may provide sickness and accident insurance, or group life insurance, or a combination of any of the foregoing types of insurance or coverage for the full-time employees of such board and their immediate dependents, whether issued by an insurance company, ~~a health or medical care corporation, a dental care corporation, or a health maintenance organization~~ insuring corporation, duly authorized to do business in this state.

(B) The board of elections of any county may procure and pay all or any part of the cost of group hospitalization, surgical, major medical, or sickness and accident insurance or a combination of any of the foregoing types of insurance or coverage for the members appointed to the board of elections under section 3501.06 of the Revised Code and their immediate dependents when each member's term begins, whether issued by an insurance company or a health ~~or medical care~~ insuring corporation, duly authorized to do business in this state.

Sec. 3701.24. (A) As used in this section and sections 3701.241 to 3701.249 of the Revised Code:

(1) "AIDS" means the illness designated as acquired immunodeficiency syndrome.

(2) "HIV" means the human immunodeficiency virus identified as the causative agent of AIDS.

(3) "AIDS-related condition" means symptoms of illness related to HIV infection, including AIDS-related complex, that are confirmed by a positive HIV test.

(4) "HIV test" means any test for the antibody or antigen to HIV that has been approved by the director of health under division (B) of section 3701.241 of the Revised Code.

(5) "Health care facility" has the same meaning as in section ~~1742.01~~ 1751.01 of the Revised Code.

(6) "Director" means the director of health or any employee of the department of health acting on ~~his~~ the director's behalf.

(7) "Physician" means a person who holds a current, valid certificate issued under Chapter 4731. of the Revised Code authorizing the practice of medicine or surgery and osteopathic medicine and surgery.

(8) "Nurse" means a registered nurse or licensed practical nurse who holds a license or certificate issued under Chapter 4723. of the Revised Code.

(9) "Anonymous test" means an HIV test administered so that the individual to be tested can give informed consent to the test and receive the results by means of a code system that does not link ~~his~~ the identity of the

individual tested to the request for the test or the test results.

(10) "Confidential test" means an HIV test administered so that the identity of the individual tested is linked to the test but is held in confidence to the extent provided by section 3701.24 to 3701.248 of the Revised Code.

(11) "Health care provider" means an individual who provides diagnostic, evaluative, or treatment services. Pursuant to Chapter 119. of the Revised Code, the public health council may adopt rules further defining the scope of the term "health care provider."

(12) "Significant exposure to body fluids" means a percutaneous or mucous membrane exposure of an individual to the blood, semen, vaginal secretions, or spinal, synovial, pleural, peritoneal, pericardial, or amniotic fluid of another individual.

(13) "Emergency medical services worker" means all of the following:

- (a) A peace officer;
- (b) An employee of an emergency medical service organization as defined in section 4765.01 of the Revised Code;
- (c) A firefighter employed by a political subdivision;
- (d) A volunteer firefighter, emergency operator, or rescue operator;
- (e) An employee of a private organization that renders rescue services, emergency medical services, or emergency medical transportation to accident victims and persons suffering serious illness or injury.

(14) "Peace officer" has the same meaning as in division (A) of section 109.71 of the Revised Code, except that it also includes a sheriff and the superintendent and troopers of the state highway patrol.

(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 maintain a statewide public information campaign on the effects of diethylstilbestrol or other nonsteroidal synthetic estrogens for the purpose of educating the public concerning the potential hazards related to exposure to diethylstilbestrol or other nonsteroidal synthetic estrogens and encouraging persons exposed to diethylstilbestrol or other nonsteroidal synthetic estrogens, including those exposed before birth, to seek medical attention for the identification and treatment of any conditions resulting from this exposure.

(B) The director shall maintain a registry of hospitals, clinics, physicians, or other health care providers to whom ~~he~~ the director shall refer persons who make inquiries to the department of health regarding possible exposure to diethylstilbestrol or other nonsteroidal synthetic estrogens. In order to be eligible for listing in the registry, a health care provider shall make an application to the director, and shall have the necessary experience, facilities, and equipment to make examinations for possible effects of diethylstilbestrol or other nonsteroidal synthetic estrogens.

(C) The director shall maintain a registry of persons who have been exposed to diethylstilbestrol or other nonsteroidal synthetic estrogens, including persons exposed before birth, for the purpose of studying and monitoring conditions caused by exposure to diethylstilbestrol or other nonsteroidal synthetic estrogen. No person shall be listed in the registry without ~~his~~ the director's consent.

(D) The director shall make an annual report to the general assembly on the effectiveness of the programs established under this section, and shall make recommendations concerning the programs and possible legislation relating to them.

(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:

(1) A hospital registered under section 3701.07 of the Revised Code;

(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;

(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;

(4) A freestanding dialysis center;

(5) A freestanding inpatient rehabilitation facility;

(6) An ambulatory surgical facility;

(7) A freestanding cardiac catheterization facility;

(8) A freestanding birthing center;

(9) A freestanding or mobile diagnostic imaging center;

(10) A freestanding radiation therapy center.

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.

(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.

(I) "Third-party payer" means a ~~medical care corporation or health care insuring~~ corporation licensed under Chapter ~~1737. or 1738.~~ 1751. of the Revised Code, a health maintenance organization as defined in division (K) of this section, 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 5111. of the Revised Code, or any self-insurance plan.

(J) "Government unit" means the state and any county, municipal corporation, township, or other political subdivision of the state, or any department, division, board, or other agency of the state or a political subdivision.

(K) "Health maintenance organization" means a public or private organization organized under the law of any state that is qualified under section 1310(d) of Title XIII of the "Public Health Service Act," 87 Stat. 931 (1973), 42 U.S.C. 300e--9 ~~or that does all of the following:~~

~~(1) Provides or otherwise makes available to enrolled participants health care services including at least the following basic health care services: usual physician services, hospitalization, laboratory, x-ray, emergency and preventive services, and out-of-area coverage;~~

~~(2) Is compensated, except for copayments, for the provision of basic health care services listed in division (K)(1) of this section to enrolled participants by a payment that is paid on a periodic basis without regard to the date the health care services are provided and that is fixed without regard to the frequency, extent, or kind of health service actually provided;~~

~~(3) Provides physician services primarily either:~~

~~(a) Directly through physicians who are either employees or partners of the organization;~~

~~(b) Through arrangements with individual physicians or one or more groups of physicians organized on a group practice or individual practice basis.~~

(L) "Existing health care facility" means a health care facility that is licensed or otherwise approved to practice in this state, in accordance with

applicable law, is staffed and equipped to provide health care services, and actively provides health services or has not been actively providing health services for less than twelve consecutive months.

(M) "State" means the state of Ohio, including, but not limited to, the general assembly, the supreme court, the offices of all elected state officers, and all departments, boards, offices, commissions, agencies, institutions, and other instrumentalities of the state of Ohio. "State" does not include political subdivisions.

(N) "Political subdivision" means a municipal corporation, township, county, school district, and all other bodies corporate and politic responsible for governmental activities only in geographic areas smaller than that of the state to which the sovereign immunity of the state attaches.

(O) "Affected person" means:

(1) An applicant for a certificate of need, including an applicant whose application was reviewed comparatively with the application in question;

(2) The person that requested the reviewability ruling in question;

(3) Any person that resides or regularly uses health care facilities within the geographic area served or to be served by the health care services that would be provided under the certificate of need or reviewability ruling in question;

(4) Any health care facility that is located in the health service area where the health care services would be provided under the certificate of need or reviewability ruling in question;

(5) Third-party payers that reimburse health care facilities for services in the health service area where the health care services would be provided under the certificate of need or reviewability ruling in question;

(6) Any other person who testified at a public hearing held under division (B) of section 3702.52 of the Revised Code or submitted written comments in the course of review of the certificate of need application in question.

(P) "Osteopathic hospital" means a hospital registered under section 3701.07 of the Revised Code that advocates osteopathic principles and the practice and perpetuation of osteopathic medicine by doing any of the following:

(1) Maintaining a department or service of osteopathic medicine or a committee on the utilization of osteopathic principles and methods, under the supervision of an osteopathic physician;

(2) Maintaining an active medical staff, the majority of which is comprised of osteopathic physicians;

(3) Maintaining a medical staff executive committee that has

hic physicians as a majority of its members.

(Q) "Ambulatory surgical facility" has the same meaning as in section 3702.30 of the Revised Code.

(R) Except as otherwise provided in division (T) of this section, and until the termination date specified in section 3702.511 of the Revised Code, "reviewable activity" means any of the following:

(1) The addition by any person of any of the following health services, regardless of the amount of operating costs or capital expenditures:

(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;

(b) A cardiac catheterization service;

(c) An open-heart surgery service;

(d) Any new, experimental medical technology that is designated by rule of the public health council.

(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;

(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;

(b) The establishment, development, or construction of a new hospital or the relocation of an existing hospital;

(c) The relocation of hospital beds, other than long-term care, perinatal, or pediatric intensive care beds, into or out of a rural area.

(4)(a) The replacement of an existing hospital;

(b) The replacement of an existing hospital obstetric or newborn care unit or freestanding birthing center.

(5)(a) The renovation of a hospital that involves a capital expenditure, obligated on or after the effective date of this amendment, of five million dollars or more, not including expenditures for equipment, staffing, or operational costs. For purposes of division (R)(5)(a) of this section, a capital expenditure is obligated:

(i) When a contract enforceable under Ohio law is entered into for the construction, acquisition, lease, or financing of a capital asset;

(ii) When the governing body of a hospital takes formal action to commit its own funds for a construction project undertaken by the hospital

as its own contractor;

(iii) In the case of donated property, on the date the gift is completed under applicable Ohio law.

(b) The renovation of a hospital obstetric or newborn care unit or freestanding birthing center that involves a capital expenditure of five million dollars or more, not including expenditures for equipment, staffing, or operational costs.

(6) Any change in the health care services, bed capacity, or site, or any other failure to conduct the reviewable activity in substantial accordance with the approved application for which a certificate of need was granted, if the change is made prior to the date the activity for which the certificate was issued ceases to be a reviewable activity;

(7) Any of the following changes in perinatal bed capacity or pediatric intensive care bed capacity:

(a) An increase in bed capacity;

(b) A change in service or service-level designation of newborn care beds or obstetric beds in a hospital or freestanding birthing center, other than a change of service that is provided within the service-level designation of newborn care or obstetric beds as registered by the department of health;

(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:

(i) The greater of its fair market value or the cost of its lease or purchase;

(ii) The cost of installation and any other activities essential to the acquisition of the equipment and its placement into service.

(11) The addition of another cardiac catheterization laboratory to an existing cardiac catheterization service.

(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:

(1) The establishment, development, or construction of a new long-term care facility;

(2) The replacement of an existing long-term care facility;

(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;

(4) Any of the following changes in long-term care bed capacity:

(a) An increase in bed capacity;

(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;

(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.

(5) Any change in the health services, bed capacity, or site, or any other failure to conduct the reviewable activity in substantial accordance with the approved application for which a certificate of need concerning long-term care beds was granted, if the change is made within five years after the implementation of the reviewable activity for which the certificate was granted;

(6) The expenditure of more than one hundred ten per cent of the maximum expenditure specified in a certificate of need concerning long-term care beds;

(7) Any transfer of a certificate of need that concerns long-term care beds and was 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 such a certificate of need upon completion of the project, and any transfer of the controlling interest in an entity that holds such a certificate of need. However, the transfer of a certificate of need that concerns long-term care beds and was issued prior to April 20, 1995, or agreement to transfer such a certificate of need from the person to whom the certificate was issued to an affiliated or related person does not constitute a reviewable transfer of a certificate of need for 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.

(T) "Reviewable activity" does not include any of the following activities:

- (1) Acquisition of computer hardware or software;
- (2) Acquisition of a telephone system;
- (3) Construction or acquisition of parking facilities;
- (4) Correction of cited deficiencies that are in violation of federal, state, or local fire, building, or safety laws and rules and that constitute an imminent threat to public health or safety;
- (5) Acquisition of an existing health care facility that does not involve a change in the number of the beds, by service, or in the number or type of health services;
- (6) Correction of cited deficiencies identified by accreditation surveys of the joint commission on accreditation of healthcare organizations or of the American osteopathic association;
- (7) Acquisition of medical equipment to replace the same or similar equipment for which a certificate of need has been issued if the replaced equipment is removed from service;
- (8) Mergers, consolidations, or other corporate reorganizations of health care facilities that do not involve a change in the number of beds, by service, or in the number or type of health services;
- (9) Construction, repair, or renovation of bathroom facilities;
- (10) Construction of laundry facilities, waste disposal facilities, dietary department projects, heating and air conditioning projects, administrative offices, and portions of medical office buildings used exclusively for physician services;
- (11) Acquisition of medical equipment to conduct research required by the United States food and drug administration or clinical trials sponsored by the national institute of health. Use of medical equipment that was acquired without a certificate of need under division (T)(11) of this section

and for which premarket approval has been granted by the United States food and drug administration to provide services for which patients or reimbursement entities will be charged shall be a reviewable activity.

(12) Removal of asbestos from a health care facility.

Only that portion of a project that meets the requirements of division (T) of this section is not a reviewable activity.

(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.

(V) "Children's hospital" means any of the following:

(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;

(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;

(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.

(W) "Long-term care facility" means any of the following:

(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;

(2) The portion of any facility, including a county home or county nursing home, that is certified as a skilled nursing facility or a nursing facility under Title XVIII or XIX of the "Social Security Act";

(3) The portion of any hospital that contains beds registered under section 3701.07 of the Revised Code as skilled nursing beds or long-term care beds.

(X) "Long-term care bed" means a bed in a long-term care facility.

(Y) "Perinatal bed" means a bed in a hospital that is registered under section 3701.07 of the Revised Code as a newborn care bed or obstetric bed, or a bed in a freestanding birthing center.

(Z) "Freestanding birthing center" means any facility in which deliveries routinely occur, regardless of whether the facility is located on the campus

of another health care facility, and which is not licensed under Chapter 3711. of the Revised Code as a level one, two, or three maternity unit or a limited maternity unit.

(AA)(1) "Reviewability ruling" means a ruling issued by the director of health under division (A) of section 3702.52 of the Revised Code as to whether a particular proposed project is or is not a reviewable activity.

(2) "Nonreviewability ruling" means a ruling issued under that division that a particular proposed project is not a reviewable activity.

(BB)(1) "Metropolitan statistical area" means an area of this state designated a metropolitan statistical area or primary metropolitan statistical area in United States office of management and budget bulletin No. 93-17, June 30, 1993, and its attachments.

(2) "Rural area" means any area of this state not located within a metropolitan statistical area.

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.

(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.

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.

No member of the board shall be appointed as health officer or ward physician.

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 ~~nonprofit~~ medical care a health insuring corporation duly authorized to do business in

this state.

Notwithstanding section 3917.01 of the Revised Code, the board of health of any health district may purchase group life insurance authorized by this section by reason of payment of premiums therefor by the board 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. 3729.12. Not later than a date specified by the director of health, the Ohio health care data center shall make its first submission of a report containing the health care information specified in this section to the governor, the speaker of the house of representatives, the president of the senate, and the chairpersons of the standing committees of the house of representatives and the senate that have primary responsibility for the consideration of health legislation. Each year thereafter, the data center shall submit a report not later than the thirty-first day of December. The report shall contain, to the extent possible with the data collected under sections 3729.15 to 3729.45 of the Revised Code, an analysis of all of the following:

(A) The one hundred high priority diagnoses and one hundred high priority medical procedures that account for eighty per cent of public and private health care costs in this state, and diagnoses and medical procedures for which a disproportionate share of public and private expenditures are consumed relative to the total number of diseases diagnosed and medical procedures performed;

(B) The relationship between:

(1) Health care costs, access, outcomes, continuity of care, and professional practice patterns for selected diseases and procedures;

(2) An individual's source of payment, age, geographic location, sex, race, and income.

(C) The differences in administrative expenses for delivery of health care in the public sector versus the private sector;

(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:

(a) Long-term care facilities;

(b) Hospital inpatient services;

(c) Hospital outpatient services;

(d) Home-based health care;

(e) Physicians' services;

(f) Allied health services;

(g) Pharmaceuticals;

(h) Durable medical equipment and medical and surgical products;

- (i) Mental health services;
- (j) Other health services selected by the director of health.

(2) The factors that have contributed to the expenditure increases in each of the categories specified by division (D)(1) of this section.

(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;

(F) The distribution of emergency medical services among the population of this state, and the relationship between:

- (1) Access to emergency medical services;
- (2) An individual's source of payment, age, geographic location, sex, race, and income.

(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;

(H) The percentage of individuals who seek or register for health care services that:

- (1) Are diagnosed or treated;
- (2) Are denied services;
- (3) Receive primary care services from emergency facilities.

(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;

(J) The relationship between:

- (1) Long-term care facility admission, transfer, and length-of-stay;
- (2) An individual's source of payment, age, geographic location, sex, race, and income.

(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 hundred members or more, that is attributable to each of the following:

- (1) Charity care;
- (2) Courtesy care;
- (3) Contractual allowances;
- (4) The medical assistance program;

(5) The medicare program;

(6) Bad debts.

(L) The relationship between the number and type of pharmaceutical prescriptions and each of the following:

(1) An individual's source of payment, age, geographic location, and sex;

(2) Use of a therapeutic formulary by disease category.

(M) The extent to which physicians and other health care providers selected by the director provide primary care services to indigent individuals and the type of primary care services provided;

(N) Public or private provider reimbursement strategies that have been effective in containing health care costs;

(O) The effectiveness of quality improvement programs introduced by health care organizations, including health ~~maintenance organizations~~ insuring corporations and independent practice associations, or health care plans in improving the general quality of health care in this state;

(P) The comparison of health care costs, access, outcomes, continuity of care, and professional practice patterns in this state with other states and countries;

(Q) State and local statutes, ordinances, or rules that may contribute to health care cost increases and suggested changes in the regulatory framework to reduce costs without adversely affecting quality or access;

(R) The increase in health care costs that can be attributed to increases in malpractice insurance premiums and increases in the practice of defensive medicine;

(S) The total number of visits by medical assistance program recipients and medicare beneficiaries to clinics versus primary care health care practitioner offices in this state, categorized by type of clinic or primary care practitioner and diagnosis;

(T) Variations in treatment, costs, and medical outcome of a range of diagnoses selected by the director according to practitioner specialty versus primary care case management with global fees and comparison of individuals' source of payment, age, geographic location, sex, race, and income;

(U) The major components of the cost of long-term care facilities and the variations in the costs of the components according to diagnosis, the resident's level of functioning, facility size and geographic location, and source of payment;

(V) Factors that account for increases in the utilization of long-term care facilities in comparison with home and community outpatient care;

(W) The effect of health care utilization and costs on the general health of residents of this state and the effect of ~~behavioral~~ behavioral risk factors, including tobacco use, alcohol and substance abuse, lack of exercise, being overweight, and other factors selected by the director;

(X) The effect of utilization of preventive health care services on health care costs and outcomes, categorized by age, occupation, and type of health care coverage;

(Y) The number of individuals in each county who received services the previous calendar year from a public health care program administered in whole or in part by the department of mental retardation and developmental disabilities or a county board of mental retardation and developmental disabilities, compared to the number of individuals in each county who applied and were found eligible for those services that year but did not receive them;

(Z) The number of individuals in each county that received services the previous calendar year from a public health care program administered in whole or in part by the department of mental health, a community mental health board, or a board of alcohol, drug abuse, and mental health services, compared to the number of individuals in each county who applied and were found eligible for those services that year but did not receive them.

The report must comply with section 3729.46 of the Revised Code.

Sec. 3901.04. (A) As used in this section:

(1) "Laws of this state relating to insurance" include but are not limited to ~~Chapters 1736., 1737., 1738., 1739. notwithstanding section 1739.02, 1740., and 1742. Chapter 1751. notwithstanding section 1742.30 1751.08,~~ Title XXXIX, sections 5725.18 to 5725.25, and Chapter 5729. of the Revised Code.

(2) "Person" has the meaning defined in division (A) of section 3901.19 of the Revised Code.

(B) Whenever it appears to the superintendent of insurance, from ~~his~~ the superintendent's files, upon complaint or otherwise, that any person has engaged in, is engaged in, or is about to engage in any act or practice declared to be illegal or prohibited by the laws of this state relating to insurance, or defined as unfair or deceptive by such laws, or when the superintendent believes it to be in the best interest of the public and necessary for the protection of the people in this state, the superintendent or anyone designated by the superintendent under ~~his~~ the superintendent's official seal may do any one or more of the following:

(1) Require any person to file with the superintendent, on a form that is appropriate for review by the superintendent, an original or additional

statement or report in writing, under oath or otherwise, as to any facts or circumstances concerning the person's conduct of the business of insurance within this state and as to any other information that the superintendent considers to be material or relevant to such business;

(2) Administer oaths, summon and compel by order or subpoena the attendance of witnesses to testify in relation to any matter which, by the laws of this state relating to insurance, is the subject of inquiry and investigation, and require the production of any book, paper, or document pertaining to such matter. A subpoena, notice, or order under this section may be served by certified mail, return receipt requested. If the subpoena, notice, or order is returned because of inability to deliver, or if no return is received within thirty days of the date of mailing, the subpoena, notice, or order may be served by ordinary mail. If no return of ordinary mail is received within thirty days after the date of mailing, service shall be deemed to have been made. If the subpoena, notice, or order is returned because of inability to deliver, the superintendent may designate a person or persons to effect either personal or residence service upon the witness. Service of any subpoena, notice, or order and return may also be made in any manner authorized under the Rules of Civil Procedure. Such service shall be made by an employee of the department designated by the superintendent, a sheriff, a deputy sheriff, an attorney, or any person authorized by the Rules of Civil Procedure to serve process.

In the case of disobedience of any notice, order, or subpoena served on a person or the refusal of a witness to testify to a matter regarding which ~~he~~ the person may lawfully be interrogated, the court of common pleas of the county where venue is appropriate, on application by the superintendent, may compel obedience by attachment proceedings for contempt, as in the case of disobedience of the requirements of a subpoena issued from such court, or a refusal to testify therein. Witnesses shall receive the fees and mileage allowed by section 2335.06 of the Revised Code. All such fees, upon the presentation of proper vouchers approved by the superintendent, shall be paid out of the appropriation for the contingent fund of the department of insurance. The fees and mileage of witnesses not summoned by the superintendent or ~~his~~ the superintendent's designee shall not be paid by the state.

(3) In a case in which there is no administrative procedure available to the superintendent to resolve a matter at issue, request the attorney general to commence an action for a declaratory judgment under Chapter 2721. of the Revised Code with respect to the matter.

(4) Initiate criminal proceedings by presenting evidence of the

ion of any criminal offense established under the laws of this state relating to insurance to the prosecuting attorney of any county in which the offense may be prosecuted. At the request of the prosecuting attorney, the attorney general may assist in the prosecution of the violation with all the rights, privileges, and powers conferred by law on prosecuting attorneys including, but not limited to, the power to appear before grand juries and to interrogate witnesses before grand juries.

Sec. 3901.041. The superintendent of insurance shall adopt, amend, and rescind rules and make adjudications, necessary to discharge ~~his~~ the superintendent's duties and exercise ~~his~~ the superintendent's powers, including, but not limited to, ~~his~~ the superintendent's duties and powers under ~~Chapters 1737., 1738., and 1740.~~ Chapter 1751. and Title XXXIX of the Revised Code, subject to ~~sections 119.01 to 119.13~~ Chapter 119. of the Revised Code.

Sec. 3901.043. The superintendent of insurance may adopt rules in accordance with Chapter 119. of the Revised Code to establish reasonable fees for any service or transaction performed by the department of insurance pursuant to section ~~1738.04, 1742.03~~ 1751.03, 3901.321, 3901.341, 3907.09, 3907.10, 3907.11, 3907.12, 3911.011, 3913.31, 3915.14, 3917.06, 3918.07, 3923.02, 3935.04, 3937.03, 3953.28, 3957.12, or 3957.13 of the Revised Code or any provision in sections 3913.01 to 3913.23 or in Chapter 3905. of the Revised Code, if no fee is otherwise provided under Title XVII or XXXIX of the Revised Code for such service or transaction. Any fee collected pursuant to those rules shall be paid into the state treasury to the credit of the department of insurance operating fund.

Sec. 3901.071. All moneys collected by the superintendent of insurance for expenses incurred by ~~him~~ the superintendent in conducting examinations pursuant to the Revised Code of the financial affairs of any insurance company doing business in this state, for which the insurance company examined is required to pay the costs, shall be paid to the superintendent. The superintendent shall deposit the money in the state treasury to the credit of the superintendent's examination fund, which is hereby established. Any funds expended or obligated therefrom by the superintendent shall be expended or obligated solely for defrayment of the costs of examinations of the financial affairs of insurance companies made by the superintendent pursuant to the Revised Code. For purposes of this section, "insurance company" means any domestic or foreign stock company, risk retention group, mutual company, mutual protective association, fraternal benefit society, reciprocal or inter-insurance exchange, ~~nonprofit medical care corporation,~~ and health care insuring corporation, ~~and nonprofit dental care~~

~~corporation~~, regardless of the type of coverage written, benefits provided, or guarantees made by each.

Sec. 3901.16. Any association, company, or corporation, including a health insuring corporation, which violates any law relating to the superintendent of insurance, any provision of Chapter 1751. Of the Revised Code, or any insurance law of this state, for the violation of which no forfeiture or penalty is elsewhere provided in the Revised Code, shall forfeit and pay not less than one thousand nor more than ten thousand dollars, to be recovered by an action in the name of the state and on collection to be paid to the superintendent, who shall pay such sum into the state treasury.

Sec. 3901.19. As used in sections 3901.19 to 3901.26 of the Revised Code:

(A) "Person" means any individual, corporation, association, partnership, reciprocal exchange, inter-insurer, fraternal benefit society, title guarantee and trust company, ~~prepaid dental plan organization, medical care corporation, health care insuring corporation, dental care corporation, health maintenance organization incorporated under Chapter 1735., 1736., 1737., 1738., 1740., or 1742. of the Revised Code,~~ and any other legal entity.

(B) "Residents" includes any individual, partnership, or corporation.

(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.

(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. 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.

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.

(B) For the purpose of preventing the unfair use of information which may have been obtained by such beneficial owner, director, or officer by reason of ~~his~~ the beneficial owner's, director's, or officer's relationship to such company, any profit realized by ~~him~~ the beneficial owner, director, or officer from any purchase and sale, or any sale and purchase, of any equity security of such company within any period of less than six months, unless such security was acquired in good faith in connection with a debt previously contracted, shall inure to and be recoverable by the company, irrespective of any intention on the part of such beneficial owner, director, or officer in entering into such transaction of holding the security purchased or of not repurchasing the security sold for a period exceeding six months. Suit to recover such profit may be instituted at law or in equity in any court of competent jurisdiction by the company, or by the owner of any security of the company in the name and in behalf of the company if the company fails or refuses to bring such suit within sixty days after request or fails diligently to prosecute the same thereafter; but no such suit shall be brought more than two years after the date such profit was realized. Division (B) of this section shall not be construed to cover any transaction where such beneficial owner was not such both at the time of purchase and sale, or the sale and purchase, of the security involved, or any transaction or transactions which the superintendent of insurance by rules may exempt as not comprehended within the purpose of division (B) of this section.

(C) No such beneficial owner, director, or officer, directly or indirectly, shall sell any equity security of such company if the person selling the security or ~~his~~ the person's principal does not own the security sold, or if owning the security, does not deliver it against such sale within twenty days thereafter, or does not within five days after such sale deposit it in the mails or other usual channels of transportation; but no person shall be deemed to have violated division (C) of this section if ~~he~~ the person proves that notwithstanding the exercise of good faith ~~he~~ the person was unable to make such delivery or deposit within such time, or that to do so would cause undue inconvenience or expense.

(D) A domestic insurance company having at least fifty shareholders or any other person soliciting proxies with respect to such domestic insurance company shall not solicit voting proxies from any shareholder or other person except upon a proxy statement and pursuant to a notice of meeting,

which statement and notice have been submitted to the superintendent of insurance at least ten days prior to being mailed to the intended recipients. Such proxy statement and notice of meeting shall make such disclosures pertinent to the business to be carried on at the meeting or meetings with respect to which such proxies are solicited and such notices are given as the superintendent by rule requires. The superintendent shall retain such proxy material for examination by any interested party for at least one year.

(E) Division (B) of this section does not apply to any purchase and sale, or sale and purchase, and division (C) of this section does not apply to any sale, of an equity security of a domestic stock insurance company not then or theretofore held ~~by him~~ in an investment account, by a dealer in the ordinary course of ~~his~~ the dealer's business and incident to the establishment or maintenance by ~~him~~ the dealer of a primary or secondary market for such security. The superintendent of insurance may, by such rules as ~~he~~ the superintendent considers necessary or appropriate in the public interest, describe and define the terms and conditions with respect to securities held in an investment account and transactions made in the ordinary course of business and incident to the establishment or maintenance of a primary or secondary market.

(F) Divisions (A), (B), and (C) of this section do not apply to foreign or domestic arbitrage transactions unless made in contravention of such rules as the superintendent of insurance may adopt in order to carry out the purposes of this section.

(G) "Equity security" when used in this section means any stock or similar security; or any security convertible, with or without consideration, into such a security, or carrying any warrant or right to subscribe to or purchase such a security; or any such warrant or right; or any other security which the superintendent of insurance determines to be of similar nature and considers necessary or appropriate, by such rules as ~~he~~ the superintendent may prescribe in the public interest or for the protection of investors, to treat as an equity security.

(H) The superintendent of insurance may adopt, amend, and rescind rules, pursuant to Chapter 119. of the Revised Code, which will enable ~~him~~ the superintendent to carry out the duties imposed ~~upon him~~ by this section.

(I) This section applies to health insuring corporations in the same manner in which this section applies to domestic stock insurance companies.

Sec. 3901.32. As used in sections 3901.32 to 3901.37 of the Revised Code:

(A) "Affiliate of" or "affiliated with" a specific person means a person that, directly or indirectly, through one or more intermediaries, controls, is

controlled by, or is under common control with, the person specified.

(B) "Control," including "controlling," "controlled by," and "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. 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 or evidencing a right to acquire a voting security.

Sec. 3901.38. (A) As used in this section:

(1) "Beneficiary" means any policyholder, subscriber, member, employee, or other person who is eligible for benefits under a benefits contract.

(2) "Benefits contract" means a sickness and accident insurance policy providing hospital, surgical, or medical expense coverage, or a health maintenance organization insuring corporation contract, ~~preferred provider~~

~~organization—contract~~, or other policy or agreement under which a third-party payer agrees to reimburse for covered health care or dental services rendered to beneficiaries, up to the limits and exclusions contained in the benefits contract.

(3) "Completed claim" means a proof of loss or a claim for payment for health care services which has been submitted to the appropriate claims processing office of the third-party payer accompanied by sufficient documentation for the third-party payer to determine proof of loss and reasonably required by the third-party payer to accept or reject the claim.

(4) "Hospital" has the same meaning set forth in section 3727.01 of the Revised Code.

(5) "Proof of loss" means a claim for payment for health care services which has been submitted to the appropriate claims processing office of the third-party payer accompanied by sufficient documentation for the third-party payer to determine benefits payable under the benefits contract and reasonably required by the third-party payer to accept or reject the claim.

(6) "Provider" means a hospital, nursing home, physician, podiatrist, dentist, pharmacist, chiropractor, or other licensed health care provider entitled to reimbursement by a third-party payer for services rendered to a beneficiary under a benefits contract.

(7) "Reimburse" means indemnify, make payment, or otherwise accept responsibility for payment for health care services rendered to a beneficiary, or arrange for the provision of health care services to a beneficiary.

(8) "Third-party payer" means any of the following:

(a) An insurance company;

(b) A health ~~maintenance organization~~ insuring corporation;

(c) A preferred provider organization;

(d) A labor organization;

(e) An employer;

(f) ~~A prepaid dental plan organization~~ An intermediary organization, as defined in section 1751.01 Of the Revised Code, that is not a health delivery network contracting solely with self-insured employers;

(g) An administrator subject to sections 3959.01 to 3959.16 of the Revised Code;

(h) A HEALTH DELIVERY NETWORK, AS DEFINED IN SECTION 1751.01 OF THE REVISED CODE;

(i) Any other person that is obligated pursuant to a benefits contract to reimburse for covered health care services rendered to beneficiaries under such contract.

(B)(1) Except as provided in division (B)(2) of this section, within twenty-four days of the receipt of a completed claim from a provider or a beneficiary for reimbursement for health care services rendered by the provider to a beneficiary, a third-party payer shall, in accordance with division (D) of this section, make payment of any amount due on such claim.

(2) A third-party payer and a provider may, in negotiating a reimbursement contract, agree to any time period by which a third-party payer shall, subject to division (D) of this section, make payment of any amount due on a completed claim. Nothing in this division shall be construed as limiting in any manner the application of the requirements of this section to any benefits or reimbursement contract.

(3) Any provider or beneficiary aggrieved with respect to any act of a third-party payer that such provider or beneficiary believes to be a violation of division (B)(1) or (2) of this section may file a written complaint with the superintendent of insurance. If a series of such complaints is received by the superintendent with respect to a particular third-party payer and if, after investigation, the superintendent finds that such third-party payer has engaged in a series of such violations which, taken together, constitute a consistent pattern or a practice of such third-party payer to violate division (B)(1) or (2) of this section, the superintendent shall issue an order requiring such third-party payer to cease and desist from engaging in such violations and to pay a late payment penalty as specified in divisions (B)(4) and (5) of this section with respect to the claims the superintendent finds were not timely paid. In the order, the superintendent shall specify the reasons for ~~his~~ the superintendent's finding and order and state that a hearing conducted pursuant to Chapter 119. of the Revised Code shall be held within fifteen days after requested in writing by the third-party payer. The provisions of this division (B)(3) of this section are in addition to, and not in lieu of, such other remedies as providers and beneficiaries may otherwise have by law.

(4)(a) The late payment penalty shall be computed based upon the number of days that have elapsed between the date payment is due in accordance with division (B)(1) or (2) of this section and the date payment is actually sent.

(b) The interest rate for determining the amount of the late payment penalty shall be the rate agreed to by the provider and the third-party payer or the rate specified by and determined in accordance with division (A) of section 1343.01 of the Revised Code.

(5) A provider and a third-party payer may enter into a contractual agreement in which the timing of payments by the third-party payer is not

directly related to the receipt of a completed claim. Such contractual arrangement may include periodic interim payment arrangements, capitation payment arrangements, or other payment arrangements acceptable to the provider and the third-party payer. Except as agreed to under such contract, this section does not apply to such payment arrangements.

(6) Any late payment penalty due and payable by a third-party payer in accordance with this section shall not be used to reduce benefits or payments otherwise payable under a benefits contract.

(C) No third-party payer shall refuse to process or pay within the time period required under division (B)(1) or (2) of this section a completed claim submitted by a provider on the ground the beneficiary has not been discharged from the hospital or the treatment has not been completed, if the submitted claim covers services actually rendered and charges actually incurred over at least a thirty-day period.

(D)(1) ~~Notwithstanding~~ NOTWITHSTANDING section 1742.10 or division (I)(2) of section 3923.04 of the Revised Code, a reimbursement contract entered into or renewed on or after ~~the effective date of this section~~ JUNE 29, 1988, between a third-party payer and a hospital shall provide that reimbursement for any service provided by a hospital pursuant to a reimbursement contract and covered under a benefits contract shall be made directly to the hospital.

(2) If the third-party payer and the hospital have not entered into a contract regarding the provision and reimbursement for covered services, the third-party payer shall accept and honor a completed and validly executed assignment of benefits with a hospital by a beneficiary, except when the third-party payer has notified the hospital in writing of the conditions under which the third-party payer will not accept and honor an assignment of benefits. Such notice shall be made annually.

(3) A third-party payer may not refuse to accept and honor a validly executed assignment of benefits with a hospital pursuant to division (D)(2) of this section for medically necessary hospital services provided on an emergency basis.

(E) A series of violations which taken together, constitute a consistent pattern or a practice of violation of any of the provisions of this section is an unfair and deceptive act pursuant to sections 3901.19 to 3901.23 of the Revised Code and is subject to proceedings pursuant to those sections.

Sec. 3901.40. No insurance company, ~~medical care corporation, health care insuring corporation, or self-insurance plan, or dental care corporation~~ authorized to do business in this state shall include or provide in its policies or subscriber agreements for benefit payments or reimbursement for services

in any hospital which is not certified or accredited as provided in division (A) of section 3727.02 of the Revised Code. No hospital located in this state shall charge any insurance company, ~~medical care corporation~~, health care insuring corporation, ~~dental care corporation~~, federal, state, or local government agency, or person for any services rendered unless the hospital is certified or accredited as provided in division (A) of section 3727.02 of the Revised Code. "Hospital" as used in this section means only those institutions included within the definition of that term contained in section 3727.01 of the Revised Code, and the prohibitions in this section do not apply to facilities excluded from that definition.

Sec. 3901.41. (A) An insurance company licensed to transact business in this state, or a health insuring corporation holding a certificate of authority under Chapter 1751. Of the Revised Code, shall notify the superintendent of insurance and deliver a copy of any order or judgment to the superintendent within thirty days of the happening in another state of any one or more of the following:

- (1) Suspension or revocation of its right to transact business;
- (2) Receipt of an order to show cause why its license should not be suspended or revoked;
- (3) Imposition of a penalty on it for any violation of the insurance laws of such other state.

(B) Whenever the superintendent finds that an insurance company or a health insuring corporation has failed to notify the superintendent and to deliver a copy of any order or judgment to ~~him~~ the superintendent pursuant to division (A) of this section, ~~he~~ the superintendent may order a hearing to be held not less than thirty days after the service of notice, to require it to show cause why an order should not be made by the superintendent, as a result of the violation of division (A) of this section, directing the company or corporation to suspend any transaction of business in this state or levying a penalty against the company in an amount not to exceed five hundred dollars. All such hearings shall be conducted, and may be appealed, in accordance with ~~sections 119.01 to 119.13~~ Chapter 119. of the Revised Code.

Sec. 3901.48. (A) The original work papers of a certified public accountant performing an audit of an insurance company or health insuring corporation doing business in this state that is required by rule or by any section of the Revised Code to file an audited financial report with the superintendent of insurance shall remain the property of the certified public accountant. Any copies of these work papers voluntarily given to the superintendent shall be the property of the superintendent. The original work

papers or any copies of them, whether in possession of the certified public accountant or the department of insurance, are confidential and are not a public record as defined in section 149.43 of the Revised Code. The original work papers and any copies of them are not subject to subpoena and shall not be made public by the superintendent or any other person. However, the original work papers and any copies of them may be released by the superintendent to the insurance regulatory authority of any other state if that authority agrees to maintain the confidentiality of the work papers or copies and if the work papers and copies are not public records under the laws of that state.

(B) The work papers of the superintendent or of the person appointed by ~~him the superintendent~~, resulting from the conduct of an examination made pursuant to section 3901.07 of the Revised Code, are confidential and are not a public record as defined in section 149.43 of the Revised Code. The original work papers and any copies of them are not subject to subpoena and shall not be made public by the superintendent or any other person. However, the original work papers and any copies of them may be released by the superintendent to the insurance regulatory authority of any other state if that authority agrees to maintain the confidentiality of the work papers or copies and if the work papers and copies are not public records under the laws of that state.

(C) The work papers of the superintendent or of any person appointed by the superintendent, resulting from the conduct of a performance regulation examination made pursuant to authority granted under section 3901.011 of the Revised Code, are confidential and are not a public record as defined in section 149.43 of the Revised Code. The original work papers and any copies of them are not subject to subpoena and shall not be made public by the superintendent or any other person. However, the original work papers and any copies of them may be released by the superintendent to the insurance regulatory authority of any other state if that authority agrees to maintain the confidentiality of the work papers or copies and if the work papers and copies are not public records under the laws of that state.

Sec. 3901.72. Any person may advance to a domestic insurance company or a health ~~maintenance organization~~ insuring corporation any sum of money necessary for the purpose of the insurance company's or health ~~maintenance organization's~~ insuring corporation's business, or to enable the insurance company or health ~~maintenance organization~~ insuring corporation to comply with any law, or as a cash guarantee fund. Such money, and interest agreed upon, not exceeding ten per cent per annum or the total of four hundred basis points plus the rate on United States treasury notes or

bonds closest in maturity to the final repayment date of the money so advanced, whichever is greater, shall not be a liability or claim against the insurance company or health ~~maintenance organization~~ insuring corporation, or any of its assets, except as provided in this section, and shall be repaid only out of the surplus earnings of such insurance company or health ~~maintenance organization~~ insuring corporation. Except as ordered by the superintendent of insurance, no part of the principal or interest thereof shall be repaid until the surplus of the insurance company or health ~~maintenance organization~~ insuring corporation remaining after such repayment is equal in amount to the principal of the money so advanced. Such advancement and repayment shall be subject to the approval of the superintendent, provided that this section shall not affect the power to borrow money which any such insurance company or health ~~maintenance organization~~ insuring corporation possesses under other laws. No commission or promotion expenses shall be paid by the insurance company or health ~~maintenance organization~~ insuring corporation, in connection with the advance of any such money to the insurance company or health ~~maintenance organization~~ insuring corporation, and the amount of any such unpaid advance shall be reported in each annual statement.

Sec. 3902.01. (A) The purpose of sections 3902.01 to 3902.08 of the Revised Code is to establish minimum standards for language used in policies and certificates of life insurance and annuities, credit life insurance and credit disability insurance, and sickness and accident insurance, and subscriber policies or certificates of ~~medical care corporations~~, health ~~care insuring corporations~~, ~~dental care corporations~~, and health ~~maintenance organizations~~, delivered or issued for ~~deliver~~ delivery in this state, to facilitate ease of reading by insureds and subscribers.

(B) Sections 3902.01 to 3902.08 of the Revised Code are not intended to increase the risk assumed by insurance companies or other entities subject to sections 3902.01 to 3902.08 of the Revised Code or to supersede their obligation to comply with the substance of other applicable insurance laws. Sections 3902.01 to 3902.08 of the Revised Code are not intended to impede flexibility and innovation in the development of policy forms or content, or to lead to the standardization of policy forms or content.

Sec. 3902.02. As used in sections 3902.01 to 3902.08 of the Revised Code:

(A) "Policy" or "policy form" means any policy, contract, plan or agreement of life insurance and annuities, credit life insurance and credit disability insurance, and sickness and accident insurance, and subscriber policies, contracts, certificates, and agreements of ~~medical care~~

~~corporations, health care~~ insuring corporations, ~~dental care corporations, and health maintenance organizations,~~ delivered or issued for delivery in this state by any company subject to sections 3902.01 to 3902.08 of the Revised Code; any certificate, contract or policy issued by a fraternal benefit society; any certificate issued pursuant to a group insurance policy delivered or issued for delivery in this state; and any evidence of coverage issued by a ~~health maintenance organization~~ insuring corporation.

(B) "Company" or "insurer" means any entity authorized to do the business of life insurance and annuities, sickness and accident insurance, credit life insurance, or credit disability insurance; a fraternal benefit society; and a medical care corporation; ~~a health care~~ insuring corporation; ~~a dental care corporation; and a health maintenance organization.~~

Sec. 3902.11. As used in sections 3902.11 to 3902.14 of the Revised Code:

(A) "Beneficiary" has the same meaning as in division (A)(1) of section 3901.38 of the Revised Code.

(B) "Plan of health coverage" means any of the following if the policy, contract, or agreement contains a coordination of benefits provision:

(1) An individual or group sickness and accident insurance policy ~~or an individual or group contract of a health maintenance organization,~~ which policy ~~or contract~~ provides for hospital, dental, surgical, or medical services;

(2) Any individual or group contract ~~that provides dental benefits of a~~ health insuring corporation, which contract provides for hospital, dental, surgical, or medical services;

(3) Any other individual or group policy or agreement under which a third-party payer provides for hospital, dental, surgical, or medical services;

~~(4) An individual or group contract of a health care corporation.~~

(C) "Provider" has the same meaning as in division (A)(6) of section 3901.38 of the Revised Code.

(D) "Third-party payer" has the same meaning as in division (A)(8) of section 3901.38 of the Revised Code, ~~and includes any health care corporation.~~

Sec. 3902.13. (A) A plan of health coverage determines its order of benefits using the first of the following that applies:

(1) A plan that does not coordinate with other plans is always the primary plan.

(2) The benefits of the plan that covers a person as an employee, member, insured, or subscriber, other than a dependent, is the primary plan. The plan that covers the person as a dependent is the secondary plan.

(3) When more than one plan covers the same child as a dependent of

different parents who are not divorced or separated, the primary plan is the plan of the parent whose birthday falls earlier in the year. The secondary plan is the plan of the parent 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), and (5) of this section determines the order of benefits, the primary plan is the plan that covered an employee, member, insured, or subscriber longer. The secondary plan is the plan that covered that person the shorter time.

(B) When a plan of health coverage is determined to be a secondary plan it acts to provide benefits in excess of those provided by the primary plan.

(C) The secondary plan shall not be required to make payment in an amount which exceeds the amount it would have paid if it were the primary plan, but in no event, when combined with the amount paid by the primary plan, shall payments by the secondary plan exceed one hundred per cent of

expenses allowable under the provisions of the applicable policies and contracts.

(D) A third-party payer may require a beneficiary to file a claim with the primary plan before it determines the amount of its payment obligation, if any, with regard to that claim.

(E) Nothing in this section shall be construed to require a plan to make a payment until it determines whether it is the primary plan or the secondary plan and what benefits are payable under the primary plan.

(F) A plan may obtain any facts and information necessary to apply the provisions of this section, or supply this information to any other third-party payer or provider, or any agent of such third-party payer or provider, without the consent of the beneficiary. Each person claiming benefits under the plan shall provide any information necessary to apply the provisions of this section.

(G) If the amount of payments made by any plan is more than should have been paid, the plan may recover the excess from whichever party received the excess payment.

(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;

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

(3) Is a past or present applicant;

(4) Is a past or present claimant;

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

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

(1) An agent;

(2) The individual who is the subject of the information;

(3) A natural person acting in a personal capacity rather than in a business or professional capacity.

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

(L)(1) "Insurance support organization" means any person that regularly engages, in whole or in part, in the practice of assembling or collecting information about natural persons for the primary purpose of providing the

information to an insurance institution or agent for insurance transactions, including both of the following:

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

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

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

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

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

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

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

(Q) "Medical record information" means personal information that relates to an individual's physical or mental condition, medical history, or medical treatment and that is obtained from a medical professional or medical care institution, from the individual, or from the individual's spouse, parent, or legal guardian.

(R) "Personal information" means any individually identifiable

information gathered in connection with an insurance transaction from which judgments can be made about an individual's character, habits, avocations, finances, occupation, general reputation, credit, health, or any other personal characteristics. "Personal information" includes an individual's name and address and medical record information but does not include privileged information.

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

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

(1) Pretends to be someone ~~he~~ the interviewer is not;

(2) Pretends to represent a person ~~he~~ the interviewer is not in fact representing;

(3) Misrepresents the true purpose of the interview;

(4) Refuses to identify ~~himself~~ self upon request.

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

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

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

Sec. 3905.71. As used in sections 3905.71 to 3905.79 of the Revised Code:

(A) "Actuary" means a person who is a member in good standing of the American academy of actuaries.

(B) "Insurer" means any person licensed to do business in this state under Chapter ~~1736., 1737., 1738., 1740., 1742.,~~ 1751. or 1761. of the

Revised Code or Title XXXIX of the Revised Code.

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

(D)(1) "Managing general agent" means any person that does all of the following:

(a) Manages all or part of the insurance business of an insurer, including the management of a separate division, department, or underwriting office, or negotiates and binds ceding reinsurance contracts on behalf of an insurer;

(b) Acts as an agent for the insurer, whether known as a managing general agent, manager, or other similar term;

(c) With or without the authority of the insurer, separately or together with affiliates, does both of the following:

(i) Produces, directly or indirectly, and underwrites an amount of gross direct written premium equal to or more than five per cent of the policyholder surplus of the insurer as reported in the last annual statement of the insurer in any one year;

(ii) Adjusts or pays claims, or negotiates reinsurance on behalf of the insurer.

(2) "Managing general agent" does not include any of the following:

(a) An employee of the insurer;

(b) A United States manager of the United States branch of an alien insurer;

(c) An underwriting manager that, pursuant to contract, manages all or a part of the insurance operations of the insurer, is under common control with the insurer, subject to sections 3901.32 to 3901.37 of the Revised Code, and whose compensation is not based on the volume of premiums written;

(d) The attorney authorized by and acting for the subscribers of a reciprocal insurer or inter-insurance exchange under powers of attorney;

(e) An administrator licensed pursuant to Chapter 3959. of the Revised Code whose activities on behalf of an insurer are limited to administrative services involving underwriting or the payment of claims, and do not include the management of all or part of the insurance business of the insurer.

(E) "Underwrite" or "underwriting" means the authority to accept or reject risk on behalf of an insurer.

Sec. 3923.123. (A) As used in this section:

(1) "Association" means a voluntary unincorporated association of insurers formed for the sole purpose of enabling cooperative action to provide health coverage in accordance with this section.

(2) "Insurer" includes any insurance company authorized to do the

business of sickness and accident insurance in this state, ~~medical care corporation organized under Chapter 1737. of the Revised Code, and any health care insuring corporation organized~~ holding a certificate of authority under Chapter 1738. 1751. of the Revised Code, dental care corporation organized under Chapter 1740. of the Revised Code, or hospital maintenance organization organized under Chapter 1742. of the Revised Code.

(3) "Insured" means a person covered under a group policy or contract issued pursuant to this section.

(4) "Qualified unemployed person" means one who became unemployed while a resident of this state from employment or self-employment and has since been continuously unemployed or is employed only so that ~~he~~ the person does not have, or have a right to purchase, group health coverage. An individual who is, or who becomes, covered by medicare is not a qualified unemployed person. A person eligible for coverage under this section, who is also eligible for continuation of coverage under section ~~1737.30, 1738.26, 1742.34, 1751.53~~ or 3923.38 of the Revised Code, may elect either coverage, but not both. A person who elects continuation of coverage under ~~any either~~ of such sections may, upon the termination of the continuation of coverage, elect any coverage available under this section.

(B) Any insurer may join with one or more other insurers, in an association, to offer, sell, and issue to a policyholder or subscriber selected by the association a policy or contract of group health coverage, covering residents of this state who are qualified unemployed persons and the spouses or dependents of such residents. The coverage shall be offered, issued, and administered in the name of the association. Membership in the association shall be open to any insurer and each insurer which participates shall be liable for a specified percentage of the risks. The policy or contract may be executed on behalf of the association by a duly authorized person.

(C) The persons eligible for coverage under the policy or contract shall be all residents of this state who are qualified unemployed persons and their spouses and dependents, subject to reasonable underwriting restrictions to be set forth in the plan of the association. The policy or contract may provide basic hospital and surgical coverage, basic medical coverage, major medical coverage, and any combination of these; provided that it shall not be required as a condition for obtaining major medical coverage that any basic coverage be taken.

(D) The association shall file with the superintendent of insurance any policy, contract, certificate, or other evidence of coverage, application, or other forms pertaining to such insurance together with the premium rates to

be charged therefor. The superintendent may approve, disapprove, and withdraw approval of the forms in accordance with section 3923.02 of the Revised Code, 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

ract 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 established under division (I) of section 5119.01 of the Revised Code;

(2) Such benefit shall be subject to reasonable limitations, and may be subject to reasonable deductibles and co-insurance costs.

(3) In order to qualify for participation under this division, every facility specified in this division shall have in effect a plan for utilization review and a plan for peer review and every person specified in this division shall have in effect a plan for peer review. Such plans shall have the purpose of ensuring high quality patient care and effective and efficient utilization of available health facilities and services.

(4) Such payment for benefits shall not be greater than usual, customary, and reasonable.

(5) For purposes of this division, "community mental health facility" means a facility as defined in section 3923.28 of the Revised Code.

(6)(a) Services performed under the clinical supervision of a licensed physician or licensed psychologist, in order to be reimbursable under the coverage required in division (A) of this section, shall meet both of the following requirements:

(i) The services shall be performed in accordance with a treatment plan that describes the expected duration, frequency, and type of services to be performed;

(ii) The plan shall be reviewed and approved by a licensed physician or licensed psychologist every three months.

(b) Payment of benefits for services reimbursable under division (A)(6)(a) of the section shall not be restricted to services described in the

treatment plan or conditioned upon standards of a licensed physician or licensed psychologist, which at least equal the requirements of division (A)(6)(a) of this section.

(B) Payment for benefits for alcoholism treatment for outpatient, inpatient, and intermediate primary care for each eligible employee and dependent 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 licensed psychologist, whether performed in an office, or in a hospital or a community mental health facility or alcoholism treatment facility so long as the hospital, community mental health facility, or alcoholism treatment facility is approved by the joint commission on accreditation of hospitals or certified by the department of health;

(2) The benefits provided under this division shall be subject to reasonable limitations and may be subject to reasonable deductibles and co-insurance costs.

(3) A licensed physician or licensed psychologist shall every three months certify a patient's need for continued services performed by such facilities.

(4) In order to qualify for participation under this division, every facility specified in this division shall have in effect a plan for utilization review and a plan for peer review and every person specified in this division shall have in effect a plan for peer review. Such plans shall have the purpose of ensuring high quality patient care and efficient utilization of available health facilities and services. Such person or facilities shall also have in effect a program of rehabilitation or a program of rehabilitation and detoxification.

(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 3923.331 to 3923.339 of the Revised Code:

(A) "Applicant" means:

(1) In the case of an individual medicare supplement policy, the person who seeks to contract for insurance benefits; and

(2) In the case of a group medicare supplement policy, the proposed certificate holder.

(B) "Certificate" means, for purposes of section 3923.33 and sections 3923.331 to 3923.339 of the Revised Code, any certificate delivered or issued for delivery in this state under a group medicare supplement policy.

(C) "Certificate form" means the form on which the certificate is delivered or issued for delivery by the issuer.

(D) "Direct response insurance policy" means a medicare supplement policy or certificate marketed without the direct involvement of an insurance agent.

(E) "Issuer" includes insurance companies, fraternal benefit societies, health ~~maintenance organizations~~ insuring corporations, and any other entities delivering or issuing for delivery in this state medicare supplement policies or certificates.

(F) "Medicare" means the "Health Insurance for the Aged Act," Title XVIII of the Social Security Amendments of 1965, 79 Stat. 291, 42 U.S.C.A. 1395, as then constituted or later amended.

(G) "Medicare supplement policy" means a group or individual policy of sickness and accident insurance or a subscriber contract of health ~~maintenance organizations~~ insuring corporations or any other issuers, other than a policy issued pursuant to a contract under section 1876 of the "Social Security Act," 49 Stat. 620 (1935), 42 U.S.C.A., 1395mm, as amended, or an issued policy under any demonstration project specified in 42 U.S.C.A. 1395ss(g)(1), which is advertised, marketed, or designed primarily as a

supplement to reimbursements under medicare for the hospital, medical, or surgical expenses of persons eligible for medicare.

(H) "Policy form" means the form on which the policy is delivered or issued for delivery by the issuer.

Sec. 3923.333. Medicare supplement policies shall return to policyholders benefits that are reasonable in relation to the premium charged. The superintendent of insurance shall issue reasonable rules to establish minimum standards for loss ratios of medicare supplement policies on the basis of incurred claims experience, or incurred health care expenses where coverage is provided by a health ~~maintenance organization~~ insuring corporation on a service rather than reimbursement basis, and earned premiums in accordance with accepted actuarial principles and practices.

Sec. 3923.38. (A) As used in this section:

(1) "Group policy" includes any group sickness and accident policy or contract delivered, issued for delivery, or renewed in this state on or after June 28, 1984, and any private or public employer self-insurance plan or other plan that provides, or provides payment for, health care benefits for employees resident in this state other than through an insurer, or health care insuring corporation, ~~or health maintenance organization~~, to which both of the following apply:

(a) The policy insures employees for hospital, surgical, or major medical insurance on an expense incurred or service basis, other than for specified diseases or for accidental injuries only.

(b) The policy is in effect and covers an eligible employee at the time the employee's employment is terminated.

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

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

(b) The employee is entitled, at the time of the termination of ~~his~~ the employee's employment, to unemployment compensation benefits under Chapter 4141. of the Revised Code.

(c) The employee is not, and does not become, covered by or eligible for coverage by medicare under Title XVIII of the Social Security Act, as amended.

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

which the person was not covered immediately prior to such termination. A person eligible for continuation of coverage under this section, who is also eligible for coverage under section 3923.123 of the Revised Code, may elect either coverage, but not both. A person who elects continuation of coverage may elect any coverage available under section 3923.123 of the Revised Code upon the termination of the continuation of coverage.

(3) "Group rate" means, in the case of an employer self-insurance or other health benefits plan, the average monthly cost per employee, over a period of at least twelve months, of the operation of the plan that would represent a group insurance rate if the same coverage had been provided under a group sickness and accident insurance policy.

(B) A group policy shall provide that any eligible employee may continue the employee's hospital, surgical, and medical insurance under the policy, for the employee and the employee's eligible dependents, for a period of six months after the date that the insurance coverage would otherwise terminate by reason of the termination of ~~his~~ the employee's employment. Each certificate of coverage, or other notice of coverage, issued to employees under the policy shall include a notice of the employee's privilege of continuation.

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

(1) Continuation need not include dental, vision care, prescription drug benefits, or any other benefits provided under the policy in addition to its hospital, surgical, or major medical benefits.

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

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

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

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

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

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

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

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

(b) A period of 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 to the extent of its accrued liabilities and extensions of benefits as if the replacement had not occurred.

(D) This section does not apply to an employer's self-insurance plan if federal law supersedes, preempts, prohibits, or otherwise precludes its application to such plans.

Sec. 3923.382. (A) As used in this section:

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

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

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

(2) "Group plan" includes any private or public employer self-insurance plan that satisfies all of the following:

(a) The plan is established or modified in this state on or after ~~the effective date of this section~~ APRIL 17, 1991.

(b) The plan provides, or provides payment for, health benefits for employees resident in this state other than through an insurer; or health maintenance organization, health care insuring corporation, or medical care corporation.

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

(3) "Group rate" means the average monthly cost per employee, over a period of at least twelve months of the operation of a group plan, that would represent a group insurance rate if the same coverage had been provided under a group sickness and accident insurance policy.

(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.

(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.

(3) Each certificate or other evidence of coverage issued by an employer to an employee under the group plan shall include a notice of the eligible person's right of continuation of coverage.

(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.

(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 plan on the due date of each payment.

(b) The employer may pay a portion or all of the eligible person's contribution.

(E) The eligible person's right to any continuation of coverage, or the extension of any continuation of coverage, provided under division (B) or (C) of this section ceases on the date on which any of the following occurs:

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

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

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

(4) The group plan, or participation under the group plan, is terminated, unless the employer, in accordance with division (F) of this section, replaces

the coverage with similar coverage under another group plan or other group health plan or arrangement.

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

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

(2) The level of benefits under the replacement coverage is the same as the level of benefits provided to any similarly situated eligible person who is covered under the group plan and an employee who has not been called or ordered to active duty.

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

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

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

(H)(1) No employer shall fail to provide for a continuation of coverage, or an extension of a continuation of coverage, in a group plan as required by and in accordance with the terms and conditions set forth under this section.

(2) No employer shall fail to issue a certificate or other evidence of coverage in compliance with division (D)(3) of this section.

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

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

(J) This section does not apply to a group plan under either of the following circumstances:

(1) The group plan is subject to section 5923.051 of the Revised Code.

(2) The application of this section is superseded, preempted, prohibited, or otherwise precluded by federal law.

Sec. 3923.41. As used in sections 3923.41 to 3923.48 of the Revised Code:

(A) "Long-term care insurance" means any insurance policy or rider advertised, marketed, offered, or designed to provide coverage for not less than one year for each covered person on an expense incurred, indemnity, prepaid, or other basis, for one or more necessary or medically necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance, or personal care services, provided in a setting other than an acute care unit of a hospital. "Long-term care insurance" includes group and individual annuities and life insurance policies or riders that provide directly or supplement long-term care benefits, and policies or riders that provide for payment of benefits based on cognitive impairment or the loss of functional capacity. "Long-term care insurance" includes group and individual policies or riders whether issued by insurers, fraternal benefit societies, or health and medical care insuring corporations, ~~prepaid health plans, or health maintenance organizations~~. "Long-term care insurance" does not include any insurance policy that is offered primarily to provide basic medicare supplement coverage, basic hospital expense coverage, basic medical-surgical expense coverage, hospital confinement indemnity coverage, major medical expense coverage, disability income protection coverage, accident only coverage, specified disease or specified accident coverage, or limited benefit health coverage.

With regard to life insurance, "long-term care insurance" does not include life insurance policies that accelerate the death benefits specifically for one or more of the qualifying events of terminal illness, medical conditions requiring extraordinary medical intervention, or permanent institutional confinement; that provide the option of a lump sum payment for those benefits; and in which neither the benefits nor the eligibility for the benefits is conditioned upon the receipt of long-term care.

Notwithstanding any other provision contained in sections 3923.41 to 3923.48 of the Revised Code, any product advertised, marketed, or offered as long-term care insurance shall be subject to sections 3923.41 to 3923.48 of the Revised Code.

(B) "Applicant" means either of the following:

(1) In the case of an individual long-term care insurance policy, the person who seeks to contract for benefits;

(2) In the case of a group long-term care insurance policy, the proposed certificate holder.

(C) "Certificate" means any certificate issued under a group long-term care insurance policy that has been delivered, issued for delivery, or used in or outside this state.

(D) "Group long-term care insurance" means a form of long-term care

insurance covering any group of two or more employees, members, or other persons, with or without one or more of their dependents and members of their immediate families. Such insurance may be offered to groups without regard to the purpose or type of group or the occupation of the employees, members, and other persons insured under the policy.

(E) "Policy" means any policy, contract, rider, or endorsement delivered, issued for delivery, or used in or outside this state by an insurer, fraternal benefit society, or health or medical care insuring corporation; prepaid health plan, or health maintenance organization.

Sec. 3923.51. (A) As used in this section, "official poverty line" means the poverty line as defined by the United States office of management and budget and revised by the secretary of health and human services under 95 Stat. 511, 42 U.S.C.A. 9902, as amended.

(B) Every insurer that is authorized to write sickness and accident insurance in this state may offer group contracts of sickness and accident insurance to any charitable foundation that is certified as exempt from taxation under section 501(c)(3) of the "Internal Revenue Code of 1986," 100 Stat. 2085, 26 U.S.C.A. 1, as amended, and that has the sole purpose of issuing certificates of coverage under these contracts to persons under the age of nineteen who are members of families that have incomes that are no greater than three hundred per cent of the official poverty line.

(C) Contracts offered pursuant to division (B) of this section are not subject to any of the following:

(1) Sections 3923.122, 3923.24, and 3923.29 of the Revised Code;

(2) Any other sickness and accident insurance coverage required under this chapter on ~~the effective date of this section~~ August 3, 1989. Any requirement of sickness and accident insurance coverage enacted after that date applies to this section only if the subsequent enactment specifically refers to this section.

(3) Chapter ~~1742~~ 1751 of the Revised Code.

Sec. 3923.54. (A) As used in this section, "screening mammography" means a radiologic examination utilized to detect unsuspected breast cancer at an early stage in asymptomatic women and includes the x-ray examination of the breast using equipment that is dedicated specifically for mammography including, but not limited to, 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.

"Screening mammography" does not include diagnostic mammography.

(B) Each employer in this state that provides, in whole or in part, health care benefits for its employees under a policy of sickness and accident insurance issued in accordance with Chapter 3923. of the Revised Code shall also provide to its employees benefits for the expenses of both of the following:

(1) Screening mammography to detect the presence of breast cancer in adult women;

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

(C) An employer may comply with division (B) of this section in any of the following ways:

(1) By providing the benefits under a health ~~maintenance organization~~ insuring corporation contract issued in accordance with Chapter ~~1742.~~ 1751. of the Revised Code or a policy of sickness and accident insurance issued in accordance with Chapter 3923. of the Revised Code;

(2) By reimbursing the employee for the direct health care provider charges associated with receipt of the covered service;

(3) By making any other arrangement that provides the benefits described in division (B) of this section.

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

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

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

(a) One screening mammography every two years;

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

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

(E)(1) The benefits provided under division (B)(1) of this section need not exceed eighty-five dollars per year.

(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.

(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.

(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.

Sec. 3923.58. (A) As used in sections 3923.58 and 3923.59 of the Revised Code:

(1) "Case characteristics," "eligible employee," "health benefit plan," "late enrollee," "MEWA," and "pre-existing conditions provision" have the same meanings as in section 3924.01 of the Revised Code.

(2) "Insurer" means any sickness and accident insurance company authorized to issue health benefit plans in this state, or MEWA authorized to issue insured health benefit plans in this state. "Insurer" does not include any health ~~maintenance organization~~ insuring corporation that is owned or operated by an insurer.

(3) "Small employer" means any person, firm, corporation, or partnership actively engaged in business whose total employed work force, on at least fifty per cent of its working days during the preceding year, consisted of at least two unrelated eligible employees but no more than twenty-five eligible employees, the majority of whom were employed within this state. In determining the number of eligible employees, companies that are affiliated companies or that are eligible to file a combined tax return for purposes of state taxation shall be considered one employer. In determining whether the members of an association are small employers, each member of the association shall be considered as a separate person, firm, corporation, or partnership.

(4) "Small employer group" means any group consisting of all of the eligible employees of a small employer, except those employees who are covered, or are eligible for coverage, under any other private or public health benefits arrangement, including the medicare program established under Title XVIII of the "Social Security Act," 49 Stat. 620 (1935), 42 U.S.C.A. 301, as amended, or any other act of congress or law of this or any other state of the United States that provides benefits comparable to the benefits provided under this section.

(B) Beginning in January of each year, insurers shall accept applicants for open enrollment coverage, as set forth in divisions (B)(1) and (2) of this section, in the order in which they apply for coverage and subject to the limitation set forth in division (G) of this section:

(1) Insurers in the business of issuing health benefit plans to small employer groups shall accept small employer groups for which coverage is

not otherwise available and for whom coverage had not been terminated by the employer or by an insurer ~~or~~ health maintenance organization, or health insuring corporation during the preceding twelve-month period;

(2) Insurers in the business of issuing individual policies of sickness and accident insurance as contemplated by section 3923.021 of the Revised Code, except individual policies issued pursuant to section 3923.122 of the Revised Code, shall either accept individuals pursuant to the open enrollment requirements of section 3941.53 of the Revised Code, if subject to that section, or accept for coverage pursuant to this section individuals to whom both of the following conditions apply:

(a) The individual is not applying for coverage as an employee of an employer, as a member of an association, or as a member of any other group.

(b) The individual is not covered, and is not eligible for coverage, under any other private or public health benefits arrangement, including the medicare program established under Title XVIII of the "Social Security Act," 49 Stat. 620 (1935), 42 U.S.C.A. 301, as amended, or any other act of congress or law of this or any other state of the United States that provides benefits comparable to the benefits provided under this section, any medicare supplement policy, or any conversion or continuation of coverage policy under state or federal law.

(C) An insurer shall offer to any individual or small employer group accepted under this section the small employer health care plan established by the board of directors of the Ohio small employer health reinsurance program under division (A) of section 3924.10 of the Revised Code or a health benefit plan that is substantially similar to the small employer health care plan in benefit plan design and scope of covered services.

An insurer may offer other health benefit plans in addition to, but not in lieu of, the plan required to be offered under this division. These additional health benefit plans shall provide, at a minimum, the coverage provided by the small employer health care plan or any health benefit plan that is substantially similar to the small employer health care plan in benefit plan design and scope of covered services.

For purposes of this division, the superintendent of insurance shall determine whether a health benefit plan is substantially similar to the small employer health care plan in benefit plan design and scope of covered services.

(D) Health benefit plans issued under this section may establish pre-existing conditions provisions that exclude or limit coverage for a period of up to twelve months following the individual's effective date of coverage

and that may relate only to conditions during the six months immediately preceding the effective date of coverage. However, an insurer may exclude a late enrollee for a period of up to eighteen months following the individual's date of application for coverage.

(E) Premiums charged to groups or individuals under this section may not exceed an amount that is two and one-half times the highest rate charged any other group with similar case characteristics or any other individual to which the insurer is currently accepting new business, and for which similar copayments and deductibles are applied.

(F) In offering health benefit plans under this section, an insurer may require the purchase of health benefit plans that condition the reimbursement of health services upon the use of a specific network of providers.

(G)(1) In no event shall an insurer be required to accept annually under this section either individuals or small employer groups that, in the aggregate, would cause the insurer to have a total number of new insureds that is more than one-half per cent of its total number of insured individuals in this state per year, as contemplated by section 3923.021 of the Revised Code, and small group certificate holders of health benefit plans in this state per year, calculated as of the immediately preceding thirty-first day of December and excluding the insurer's medicare supplement policies and conversion or continuation of coverage policies under state or federal law and any policies described in division (N) of this section. If an insurer is subject to, and elects to operate under, the individual open enrollment requirements of section 3941.53 of the Revised Code, in no event shall the insurer be required to accept annually under this section small employer groups that would cause the insurer to have a total number of new insureds that is more than one-half per cent of its total number of small group certificate holders calculated as set forth in division (G)(1) of this section.

(2) An officer of the insurer shall certify to the department of insurance when it has met the enrollment limit set forth in division (G)(1) of this section. Upon providing such certification, the insurer shall be relieved of its open enrollment requirement under this section for the remainder of the calendar year.

(H) An insurer shall not be required to accept under this section applicants who, at the time of enrollment, are confined to a health care facility because of chronic illness, permanent injury, or other infirmity that would cause economic impairment to the insurer if the applicants were accepted, or to make the effective date of benefits for individuals or groups accepted under this section earlier than ninety days after the date of

acceptance.

(I) The requirements of this section do not apply to any insurer that is currently in a state of supervision, insolvency, or liquidation. If an insurer demonstrates to the satisfaction of the superintendent that the requirements of this section would place the insurer in a state of supervision, insolvency, or liquidation, the superintendent may waive or modify the requirements of division (B) or (G) of this section. The actions of the superintendent under this division shall be effective for a period of not more than one year. At the expiration of such time, a new showing of need for a waiver or modification by the insurer shall be made before a new waiver or modification is issued or imposed.

(J) No hospital, health care facility, or health care practitioner, and no person who employs any health care practitioner, shall balance bill any individual or dependent of an individual or any eligible employee or dependent of an employee for any health care supplies or services provided to the individual or dependent or the eligible employee or dependent, who is insured under a policy or enrolled under a health benefit plan issued under this section. The hospital, health care facility, or health care practitioner, or any person that employs the health care practitioner, shall accept payments made to it by the insurer under the terms of the policy or contract insuring or covering such individual as payment in full for such health care supplies or services.

As used in this division, "hospital" has the same meaning as in section 3727.01 of the Revised Code; "health care practitioner" has the same meaning as in section 4769.01 of the Revised Code; and "balance bill" means charging or collecting an amount in excess of the amount reimbursable or payable under the policy or health care service contract issued to an individual or group under this section for such health care supply or service. "Balance bill" does not include charging for or collecting copayments or deductibles required by the policy or contract.

(K) An insurer shall pay an agent a commission in the amount of five per cent of the premium charged for initial placement or for otherwise securing the issuance of a policy or contract issued to an individual or small employer group under this section, and four per cent of the premium charged for the renewal of such a policy or contract. The superintendent may adopt, in accordance with Chapter 119. of the Revised Code, such rules as are necessary to enforce this division.

(L) Except as otherwise provided in this section, sections 3924.01 to 3924.06 of the Revised Code apply to all health benefit plans issued under this section.

(M) Individuals accepted for coverage under this section may be issued contracts and certificates subject to the requirements of section 3923.12 of the Revised Code. The coverage issued to such individuals is not subject to the requirements of section 3923.021 of the Revised Code.

(N) This section does not apply to any policy that provides coverage for specific diseases or accidents only, or to any hospital indemnity, medicare supplement, long-term care, disability income, one-time-limited-duration policy of no longer than six months, or other policy that offers only supplemental benefits.

Sec. 3924.01. As used in sections 3924.01 to 3924.14 of the Revised Code:

(A) "Actuarial certification" means a written statement prepared by a member of the American academy of actuaries, or by any other person acceptable to the superintendent of insurance, that states that, based upon the person's examination, a carrier offering health benefit plans to small employers is in compliance with sections 3924.01 to 3924.14 of the Revised Code. "Actuarial certification" shall include a review of the appropriate records of, and the actuarial assumptions and methods used by, the carrier relative to establishing premium rates for the health benefit plans.

(B) "Adjusted average market premium price" means the average market premium price as determined by the board of directors of the Ohio small employer health reinsurance program either on the basis of the arithmetic mean of all carriers' premium rates for an SEHC plan sold to groups with similar case characteristics by all carriers selling SEHC plans in the state, or on any other equitable basis determined by the board.

(C) "Base premium rate" means, as to any health benefit plan that is issued by a carrier and that covers at least two but no more than fifty employees of a small employer, the lowest premium rate for a new or existing business prescribed by the carrier for the same or similar coverage under a plan or arrangement covering any small employer with similar case characteristics.

(D) "Carrier" means any sickness and accident insurance company or health ~~maintenance organization~~ insuring corporation authorized to issue health benefit plans in this state or a MEWA. A sickness and accident insurance company that owns or operates a health ~~maintenance organization~~ insuring corporation, either as a separate corporation or as a line of business, shall be considered as a separate carrier from that health ~~maintenance organization~~ insuring corporation for purposes of sections 3924.01 to 3924.14 of the Revised Code.

(E) "Case characteristics" means, with respect to a small employer, the

geographic area in which the employees work; the age and sex of the individual employees and their dependents; the appropriate industry classification as determined by the carrier; the number of employees and dependents; and such other objective criteria as may be established by the carrier. "Case characteristics" does not include claims experience, health status, or duration of coverage from the date of issue.

(F) "Dependent" means the spouse or child of an eligible employee, subject to applicable terms of the health benefits plan covering the employee.

(G) "Eligible employee" means an employee who works a normal work week of twenty-five or more hours. "Eligible employee" does not include a temporary or substitute employee, or a seasonal employee who works only part of the calendar year on the basis of natural or suitable times or circumstances.

(H) "Financially impaired" means a program member that, after April 14, 1993, is not insolvent but 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.

(I) "Health benefit plan" means any hospital or medical expense policy or certificate or any health plan provided by a carrier, that is delivered, issued for delivery, renewed, or used in this state on or after the date occurring six months after ~~the effective date of this amendment~~ November 24, 1995. "Health benefit plan" does not include policies covering only accident, credit, dental, disability income, long-term care, hospital indemnity, medicare supplement, specified disease, or vision care; coverage under a one-time-limited-duration policy of no longer than six months; ~~coverage issued by a health care corporation; coverage issued by a prepaid dental plan organization solely or in conjunction with a carrier;~~ coverage issued as a supplement to liability insurance; insurance arising out of a workers' compensation or similar law; automobile medical-payment insurance; or insurance under which benefits are payable with or without regard to fault and which is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.

(J) "Initial enrollment period" means the thirty-day period immediately following any service waiting period established by an employer.

(K) "Late enrollee" means an eligible employee or dependent who requests enrollment in a small employer's health benefit plan following the initial enrollment period provided under the terms of the first plan for which the employee or dependent was eligible through the small employer, unless

any of the following apply:

(1) The individual:

(a) Was covered under another health benefit plan at the time the individual was eligible to enroll;

(b) States, at the time of the initial eligibility, that coverage under another health benefit plan was the reason for declining enrollment;

(c) Has lost coverage under another health benefit plan as a result of the termination of employment, a reduction of hours worked per week, the termination of the other plan's coverage, death of a spouse, or divorce; and

(d) Requests enrollment within thirty days after the termination of coverage under another health benefit plan.

(2) The individual is employed by an employer who offers multiple health benefit plans and the individual elects a different health benefit plan during an open enrollment period.

(3) A court has ordered coverage to be provided for a spouse or minor child under a covered employee's plan and a request for enrollment is made within thirty days after issuance of the court order.

(L) "MEWA" means any "multiple employer welfare arrangement" as defined in section 3 of the "Federal Employee Retirement Income Security Act of 1974," 88 Stat. 832, 29 U.S.C.A. 1001, as amended, except for any arrangement which is fully insured as defined in division (b)(6)(D) of section 514 of that act.

(M) "Midpoint rate" means, for small employers with similar case characteristics and plan designs and as determined by the applicable carrier for a rating period, the arithmetic average of the applicable base premium rate and the corresponding highest premium rate.

(N) "Pre-existing conditions provision" means a policy provision that excludes or limits coverage for charges or expenses incurred during a specified period following the insured's effective date of coverage as to a condition which, during a specified period immediately preceding the effective date of coverage, had manifested itself in such a manner as would cause an ordinarily prudent person to seek medical advice, diagnosis, care, or treatment or for which medical advice, diagnosis, care, or treatment was recommended or received, or a pregnancy existing on the effective date of coverage.

(O) "Service waiting period" means the period of time after employment begins before an eligible employee may enroll in any applicable health benefit plan offered by the small employer.

(P)(1) "Small employer" means any person, firm, corporation, partnership, or association actively engaged in business whose total

oyed work force consisted of, on at least fifty per cent of its working days during the preceding year, at least two but no more than fifty eligible employees, the majority of whom were employed within the state.

(2) In determining the number of eligible employees for purposes of division (P)(1) of this section, companies which are affiliated companies or which are eligible to file a combined tax return for purposes of state taxation shall be considered one employer. Except as otherwise specifically provided, provisions of sections 3924.01 to 3924.14 of the Revised Code that apply to a small employer that has a health benefit plan shall continue to apply until the plan anniversary following the date the employer no longer meets the requirements of this division.

(Q) "SEHC plan" means an Ohio small employer health care plan, which is a health benefit plan for small employers established by the board in accordance with section 3924.10 of the Revised Code.

Sec. 3924.02. (A) An individual or group health benefit plan is subject to sections 3924.01 to 3924.14 of the Revised Code if it provides health care benefits covering at least two but no more than fifty employees of a small employer, and if it meets either of the following conditions:

(1) Any portion of the premium or benefits is paid by a small employer, or any covered individual is reimbursed, whether through wage adjustments or otherwise, by a small employer for any portion of the premium.

(2) The health benefit plan is treated by the employer or any of the covered individuals as part of a plan or program for purposes of section 106 or 162 of the "Internal Revenue Code of 1986," 100 Stat. 2085, 26 U.S.C.A. 1, as amended.

(B) Notwithstanding division (A) of this section, divisions (G) to (J) of section 3924.03 of the Revised Code and section 3924.04 of the Revised Code do not apply to health benefit policies that are not sold to owners of small businesses as an employment benefit plan. Such policies shall clearly state that they are not being sold as an employment benefit plan and that the owner of the business is not responsible, either directly or indirectly, for paying the premium or benefits.

(C) Every health benefit plan offered or delivered by a carrier, other than a health ~~maintenance organization~~ insuring corporation, to a small employer is subject to sections 3923.23, 3923.231, 3923.232, 3923.233, and 3923.234 of the Revised Code and any other provision of the Revised Code that requires the reimbursement, utilization, or consideration of a specific category of a licensed or certified health care practitioner.

(D) Except as expressly provided in sections 3924.01 to 3924.14 of the Revised Code, no health benefit plan offered to a small employer is subject

to any of the following:

(1) Any law that would inhibit any carrier from contracting with providers or groups of providers with respect to health care services or benefits;

(2) Any law that would impose any restriction on the ability to negotiate with providers regarding the level or method of reimbursing care or services provided under the health benefit plan;

(3) Any law that would require any carrier to either include a specific provider or class of provider when contracting for health care services or benefits, or to exclude any class of provider that is generally authorized by statute to provide such care.

Sec. 3924.08. (A) The board of directors of the Ohio small employer health reinsurance program shall consist of nine appointed members who shall serve staggered terms as determined by the initial board for its members and by the plan of operation of the program for members of subsequent boards. Within thirty days after April 14, 1993, the members of the board shall be appointed, as follows:

(1) The chairperson of the senate committee having jurisdiction over insurance shall appoint the following members:

(a) Two member carriers that are small employer carriers;

(b) One member carrier that is a health ~~maintenance organization~~ insuring corporation predominantly in the small employer market;

(c) One representative of providers of health care.

(2) The chairperson of the committee in the house of representatives having jurisdiction over insurance shall appoint the following members:

(a) One member carrier that is a small employer carrier;

(b) One member carrier whose principal health insurance business is in the large employer market;

(c) One representative of an employer with fifty or fewer employees;

(d) One representative of consumers in this state.

(3) The superintendent shall appoint a representative of a member carrier operating in the small employer market who is a fellow of the society of actuaries.

The superintendent, a member of the house of representatives appointed by the speaker of the house of representatives, and a member of the senate appointed by the president of the senate, shall be ex-officio members of the board. The membership of all boards subsequent to the initial board shall reflect the distribution described in division (A) of this section.

The chairperson of the initial board and each subsequent board shall represent a small employer member carrier and shall be elected by a

y of the voting members of the board. Each chairperson shall serve for the maximum duration established in the plan of operation.

(B) Within one hundred eighty days after the appointment of the initial board, the board shall establish a plan of operation and, thereafter, any amendments to the plan that are necessary or suitable, to assure the fair, reasonable, and equitable administration of the program. The board shall, immediately upon adoption, provide to the superintendent copies of the plan of operation and all subsequent amendments to it.

(C) The plan of operation shall establish rules, conditions, and procedures for all of the following:

(1) The handling and accounting of assets and moneys of the program and for an annual fiscal reporting to the superintendent;

(2) Filling vacancies on the board;

(3) Selecting an administering insurer, which shall be a carrier as defined in section 3924.01 of the Revised Code, and setting forth the powers and duties of the administering insurer;

(4) Reinsuring risks in accordance with sections 3924.07 to 3924.14 of the Revised Code;

(5) Collecting assessments subject to section 3924.13 of the Revised Code from all members to provide for claims reinsured by the program and for administrative expenses incurred or estimated to be incurred during the period for which the assessment is made;

(6) Providing protection for carriers from the financial risk associated with small employers that present poor credit risks;

(7) Establishing standards for the coverage of small employers that have a high turnover of employees;

(8) Establishing an appeals process for carriers to seek relief when a carrier has experienced an unfair share of administrative and credit risks;

(9) Establishing the adjusted average market premium prices for use by the SEHC plan for groups of two to twenty-five employees and for groups of twenty-six to fifty employees that are offered in the state;

(10) Establishing participation standards at issue and renewal for reinsured cases;

(11) Reinsuring risks and collecting assessments in accordance with division (G) of section 3924.11 of the Revised Code;

(12) Any additional matters as determined by the board.

Sec. 3924.10. (A) The board of directors of the Ohio small employer health reinsurance program shall design the SEHC plan which, when offered by a carrier, is eligible for reinsurance under the program. The board shall establish the form and level of coverage to be made available by carriers in

their SEHC plan. In designing the plan the board shall also establish benefit levels, deductibles, coinsurance factors, exclusions, and limitations for the plan. The forms and levels of coverage established by the board shall specify which components of a health benefit plan offered by a small employer carrier may be reinsured. The SEHC 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 date that the program becomes operational and as a condition of transacting business in this state, renew coverage provided to any individual or group under its SEHC plan.

(F) A carrier shall not be required to renew coverage where the superintendent finds that renewal of coverage would place the carrier in a financially impaired condition. The superintendent shall determine when the carrier is no longer financially impaired and is, therefore, subject to the guaranteed renewability requirements.

Sec. 3924.12. (A) Except as provided in division (B) of this section, premium rates charged for coverage reinsured by the Ohio small employer

health reinsurance program shall be established as follows:

(1) For whole group reinsurance coverage, one and one-half times the adjusted average market premium price established by the program for that classification or group with similar characteristics and coverage, with respect to the eligible employees of a small employer and their dependents, all of whose coverage is reinsured with the program, minus a ceding expense factor determined by the board of directors of the program;

(2) For individual reinsurance coverage, five times the adjusted average market premium price established by the program for an individual in that classification or group with similar characteristics and coverage, with respect to an eligible employee or ~~his~~ the employee's dependents, minus a ceding expense factor determined by the board.

(B) Premium rates charged for reinsurance by the program to a health ~~maintenance organization~~ insuring corporation that is approved by the secretary of health and human services as a federally qualified health maintenance organization pursuant to the "Social Security Act," 49 Stat. 620 (1935), 42 U.S.C.A. 301, as amended, and as such is subject to requirements that limit the amount of risk that may be ceded to the program, may be modified to reflect the portion of risk that may be ceded to the program.

Sec. 3924.13. (A) Following the close of each calendar year, the administering insurer of the Ohio small employer health reinsurance program shall determine the net premiums, the program expenses for administration, and the incurred losses, if any, for the year, taking into account investment income and other appropriate gains and losses. For purposes of this section, health benefit plan premiums earned by MEWAs shall be established by adding paid claim losses and administrative expenses of the MEWA. Health benefit plan premiums and benefits paid by a carrier that are less than an amount determined by the board of directors of the program to justify the cost of collection shall not be considered for purposes of determining assessments. For purposes of this division, "net premiums" means health benefit plan premiums, less administrative expense allowances.

(B) Any net loss for the year shall be recouped first by assessments of carriers in accordance with this division. Assessments shall be apportioned by the board among all carriers participating in the program in proportion to their respective shares of the total premiums, net of reinsurance premiums paid for coverage under this program earned in the state from health benefit plans covering small employers that are issued by participating members during the calendar year coinciding with or ending during the fiscal year of the program, or on any other equitable basis reflecting coverage of small

employers as may be provided in the plan of operation. An assessment shall be made pursuant to this division against a health ~~maintenance organization~~ insuring corporation that is approved by the secretary of health and human services as a federally qualified health maintenance organization pursuant to the "Social Security Act," 49 Stat. 620 (1935), 42 U.S.C.A. 301, as amended, subject to an assessment adjustment formula adopted by the board for such health ~~maintenance organizations~~ insuring corporations that recognizes the restrictions imposed on the ~~organizations~~ entities by federal law. The adjustment formula shall be adopted by the board prior to the first anniversary of the program's operation. In no event shall the assessment made pursuant to this division exceed, on an annual basis, one per cent of the carrier's Ohio small employer group premium as reported on its most recent annual statement filed with the superintendent of insurance. If an excess is actuarially projected, the superintendent may take any action necessary to lower the assessment to the maximum level of one per cent.

(C) If assessments exceed actual losses and administrative expenses of the program, the excess shall be held at interest and used by the board to offset future losses or to reduce program premiums. As used in this division, "future losses" includes reserves for incurred but not reported claims.

(D) Each carrier's proportion of participation in the program shall be determined annually by the board based on annual statements and other reports deemed necessary by the board and filed by the carrier with the board. MEWAs shall report to the board claims payments made and administrative expenses incurred in this state on an annual basis on a form prescribed by the superintendent.

(E) Provision shall be made in the plan of operation for the imposition of an interest penalty for late payment of assessments.

(F) A carrier may seek from the superintendent a deferment, in whole or in part, from any assessment issued by the board. The superintendent may defer, in whole or in part, the assessment of a carrier if, in the opinion of the superintendent, payment of the assessment would endanger the carrier's ability to fulfill its contractual obligations.

(G) In the event an assessment against a carrier is deferred in whole or in part, the amount by which the assessment is deferred may be assessed against the other carriers in a manner consistent with the basis for assessments set forth in this section. In such event, the other carriers assessed shall have a claim in the amount of the assessment against the carrier receiving the deferment. The carrier receiving the deferment shall remain liable to the program for the amount deferred. The superintendent may attach appropriate conditions to any deferment.

Sec. 3924.41. (A) As used in sections 3924.41 and 3924.42 of the Revised Code, "health insurer" means any sickness and accident insurer; ~~health maintenance organization, preferred provider organization, or health care insuring corporation, medical care corporation, dental care corporation, or prepaid dental plan organization.~~ "Health insurer" also includes any group health plan as defined in section 607 of the federal "Employee Retirement Income Security Act of 1974," 88 Stat. 832, 29 U.S.C.A. 1167.

(B) Notwithstanding any other provision of the Revised Code, no health insurer shall take into consideration the availability of, or eligibility for, medical assistance in this state under Chapter 5111. of the Revised Code or in any other state pursuant to Title XIX of the "Social Security Act," 49 Stat. 620 (1935), 42 U.S.C.A. 301, as amended, when determining an individual's eligibility for coverage or when making payments to or on behalf of an enrollee, subscriber, policyholder, or certificate holder.

Sec. 3924.61. As used in sections 3924.61 to 3924.74 of the Revised Code:

(A) "Account holder" means the natural person who opens a medical savings account or on whose behalf a medical savings account is opened.

(B) "Eligible medical expense" means any expense for a service rendered by a licensed health care provider or a ~~christian-science~~ Christian Science practitioner, or for an article, device, or drug prescribed by a licensed health care provider or provided by a ~~christian-science~~ Christian Science practitioner, when intended for use in the mitigation, treatment, or prevention of disease; or premiums paid for comprehensive sickness and accident insurance, coverage under a health care plan of a ~~health maintenance organization insuring corporation~~ organized under Chapter ~~1742.~~ 1751. of the Revised Code, long-term care insurance as defined in section 3923.41 of the Revised Code, Medicare supplemental coverage as defined in section 3923.33 of the Revised Code, or payments made pursuant to cost sharing agreements under comprehensive sickness and accident plans. An "eligible medical expense" does not include expenses otherwise paid or reimbursed, including medical expenses paid or reimbursed under an automobile or motor vehicle insurance policy, a workers' compensation insurance policy or plan, or an employer-sponsored health coverage policy, plan, or contract.

(C) "Qualified dependent" means a child of an account holder when any of the following applies:

(1) The child is under nineteen years of age, or is under twenty-three years of age and a full-time student at an accredited college or university;

(2) The child is not self-sufficient due to physical or mental disorders or

impairments;

(3) The child is legally entitled to the provision of proper or necessary subsistence, education, medical care, or other care necessary for the child's health, guidance, or well-being and is not otherwise emancipated, self-supporting, married, or a member of the armed forces of the United States.

Sec. 3924.62. (A) A medical savings account may be opened by or on behalf of any natural person, to pay the person's eligible medical expenses and the eligible medical expenses of that person's spouse or qualified dependent. A medical savings account may be opened by or on behalf of a person only if that person participates in a sickness or accident insurance plan, a plan offered by a health ~~maintenance organization~~ insuring corporation organized under Chapter ~~1742.~~ 1751. of the Revised Code, or a self-funded, employer-sponsored health benefit plan established pursuant to the "Employee Retirement Income Security Act of 1974," 88 Stat. 832, 29 U.S.C.A. 1001, as amended. While the medical savings account is open, the account holder shall continue to participate in such a plan.

(B) A person who refuses to participate in a policy, plan, or contract of health coverage that is funded by the person's employer, and who receives additional monetary compensation by virtue of refusing that coverage, may not open a medical savings account unless the medical savings account also is sponsored by the person's employer.

Sec. 3924.64. (A) At the time a medical savings account is opened, an administrator for the account shall be designated. If an employer opens an account for an employee, the employer may designate the administrator. If an account is opened by any person other than an employer, or if an employer chooses not to designate an administrator for an account opened for an employee, the account holder shall designate the administrator. The administrator shall manage the account in a fiduciary capacity for the benefit of the account holder.

(B) Medical savings accounts shall be administered by one of the following:

(1) A federally or state-chartered bank, savings and loan association, savings bank, or credit union;

(2) A trust company authorized to act as a fiduciary;

(3) An insurer authorized under Title XXXIX of the Revised Code to engage in the business of sickness and accident insurance;

(4) A dealer or salesperson licensed under Chapter 1707. of the Revised Code;

(5) An administrator licensed under Chapter 3959. of the Revised Code;

(6) A certified public accountant;

(7) An employer that administers an employee benefit plan subject to regulation under the "Employee Retirement Income Security Act of 1974," 88 Stat. 829, 29 U.S.C.A. 1001, as amended, or that maintains medical savings accounts for its employees;

(8) Health ~~maintenance organizations~~ insuring corporations organized under Chapter ~~1742~~, 1751, of the Revised Code.

(C) Each administrator shall send to the account holder, at least annually, a statement setting forth the balance remaining in the account holder's account and detailing the activity in the account since the last statement was issued. Upon an administrator's receipt of a written request from an account holder for a current statement, the administrator shall promptly send the statement to the account holder.

(D) When an account holder documents to the administrator of the account the account holder's payment of, or the account holder's obligation for, an eligible medical expense for the account holder, the account holder's spouse, or qualified dependents, the administrator shall reimburse the account holder for, or shall pay for, the eligible medical expense with funds from the account holder's account, if sufficient funds are available in the account holder's account. If there are not sufficient funds in the account to fully reimburse the account holder or pay the expenses, the administrator shall reimburse the account holder or pay the expenses using whatever funds are in the account. The reimbursement or payment shall be made within thirty days of the administrator's receipt of the documentation. At the time of making the reimbursement or payment, the administrator shall notify the account holder if the medical expense does not count toward meeting the deductible or other obligation for the receipt of benefits that is required by the insurer or other third-party payer providing health coverage to the account holder. The administrator shall keep a record of the amounts disbursed from the account for documented eligible medical expenses and of the dates on which the expenses were incurred. This record shall be made available to any sickness and accident insurer or other third-party payer providing health coverage to the account holder, for use by the insurer or third-party payer in determining whether the account holder has met the deductible or other obligation required for the receipt of benefits from the insurer or third-party payer.

(E) When an account is opened, the administrator shall give written notice to the account holder of the date of the last business day of the administrator's business year.

Sec. 3924.73. (A) As used in this section:

(1) "Health care insurer" means any person legally engaged in the business of providing sickness and accident insurance contracts in this state, a health ~~maintenance organization~~ insuring corporation organized under Chapter ~~1742.~~ 1751. of the Revised Code, or any legal entity that is self-insured and provides health care benefits to its employees or members.

(2) "Small employer" has the same meaning as in division (P) of section 3924.01 of the Revised Code.

(B)(1) Subject to division (B)(2) of this section, nothing in sections 3924.61 to 3924.74 of the Revised Code shall be construed to limit the rights, privileges, or protections of employees or small employers under sections 3924.01 to 3924.14 of the Revised Code.

(2) If any account holder enrolls or applies to enroll in a policy or contract offered by a health care insurer providing sickness and accident coverage that is more comprehensive than, and has a deductible amount that is less than, the coverage and deductible amount of the policy under which the account holder currently is enrolled, the health care insurer to which the account holder applies may subject the account holder to the same medical review, waiting periods, and underwriting requirements to which the health care insurer generally subjects other enrollees or applicants, unless the account holder enrolls or applies to enroll during a designated period of open enrollment.

Sec. 3929.77. The joint underwriting association shall be governed by a board of governors consisting of nine members seven of whom shall be selected from the members of the joint underwriting association and appointed by the superintendent of insurance. Five members shall be selected from insurers and corporations domiciled in this state. Two members shall be selected from insurers and corporations domiciled outside this state. One member shall be an insurance agent licensed and writing insurance in this state. One member shall represent the interests of consumers and shall neither be a member of, or associated with, a health care provider or profession nor associated with an insurance company or ~~an association organized~~ a health insuring corporation holding a certificate of authority under Chapter ~~1737., 1738., or 1740.~~ 1751. of the Revised Code. The directors of the stabilization reserve fund shall serve as ex officio members of the board of governors.

Sec. 3956.01. As used in this chapter:

(A) "Account" means either of the two accounts created under section 3956.06 of the Revised Code.

(B) "Contractual obligation" means any obligation under a policy, contract, or certificate under a group policy or contract, or portion of the

policy or contract, for which coverage is provided under section 3956.04 of the Revised Code.

(C) "Covered policy or contract" means any policy, contract, or group certificate within the scope of section 3956.04 of the Revised Code.

(D) "Impaired insurer" means a member insurer that, after ~~the effective date of this section~~ November 20, 1989, is not an insolvent insurer, and to which either of the following applies:

(1) The insurer is considered by the superintendent to be potentially unable to fulfill its contractual obligations;

(2) The insurer is placed under an order of rehabilitation or conservation by a court of competent jurisdiction.

(E) "Insolvent insurer" means a member insurer that, after ~~the effective date of this section~~ November 20, 1989, is placed under an order of liquidation by a court of competent jurisdiction with a finding of insolvency.

(F)(1) "Member insurer" means any insurer that holds a certificate of authority or is licensed to transact in this state any kind of insurance for which coverage is provided under section 3956.04 of the Revised Code, and includes any insurer whose certificate of authority or license in this state may have been suspended, revoked, not renewed, or voluntarily withdrawn after ~~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 or group annuity certificate that is not issued to and owned by an individual, except to the extent of any annuity benefits guaranteed to an individual by an insurer under that contract or certificate.

Sec. 3959.01. (A) "Administration fees" means any amount charged a covered person for services rendered. "Administration fees" includes commissions earned or paid by any person relative to services performed by an administrator.

(B) "Administrator" means any person who adjusts or settles claims on, residents of this state in connection with life, dental, health, or disability insurance or self-insurance programs. "Administrator" does not include any of the following:

(1) An insurance agent or solicitor licensed in this state whose activities

are limited exclusively to the sale of insurance and who does not provide any administrative services;

(2) Any person who administers or operates the workers' compensation program of a self-insuring employer under Chapter 4123. of the Revised Code;

(3) Any person who administers pension plans for the benefit of the person's own members or employees or administers pension plans for the benefit of the members or employees of any other person;

(4) Any person that administers an insured plan or a self-insured plan that provides life, dental, health, or disability benefits exclusively for the person's own members or employees;

(5) Any ~~medical care corporation organized under Chapter 1737. of the Revised Code, prepaid dental plan organization organized under Chapter 1736. of the Revised Code, health care~~ insuring corporation organized holding a certificate of authority under Chapter 1738. 1751. of the Revised Code, dental care corporation organized under Chapter 1740. of the Revised Code, health maintenance organization organized under Chapter 1742. of the Revised Code, or an insurance company that is authorized to write life or sickness and accident insurance in this state.

(C) "Aggregate excess insurance" means that type of coverage whereby the insurer agrees to reimburse the insured employer or trust for all benefits or claims paid during an agreement period on behalf of all covered persons under the plan or trust which exceed a stated deductible amount and subject to a stated maximum.

(D) "Contributions" means any amount collected from a covered person to fund the self-insured portion of any plan in accordance with the plan's provisions, summary plan descriptions, and contracts of insurance.

(E) "Fiduciary" has the meaning set forth in section 1002(21)(A) of the "Employee Retirement Income Security Act of 1974," 88 Stat. 829, 29 U.S.C. 1001, as amended.

(F) "Fiscal year" means the twelve-month accounting period commencing on the date the plan is established and ending twelve months following that date, and each corresponding twelve-month accounting period thereafter as provided for in the summary plan description.

(G) "Plan" means any arrangement in written form for the payment of life, dental, health, or disability benefits to covered persons defined by the summary plan description.

(H) "Plan sponsor" means the person who establishes the plan.

(I) "Self-insurance program" means a program whereby an employer provides a plan of benefits for its employees without involving an

intermediate insurance carrier to assume risk or pay claims. "Self-insurance program" includes but is not limited to employer programs that pay claims up to a prearranged limit beyond which they purchase insurance coverage to protect against unpredictable or catastrophic losses.

(J) "Specific excess insurance" means that type of coverage whereby the insurer agrees to reimburse the insured employer or trust for all benefits or claims paid during an agreement period on behalf of a covered person in excess of a stated deductible amount and subject to a stated maximum.

(K) "Summary plan description" means the written document adopted by the plan sponsor which outlines the plan of benefits, conditions, limitations, exclusions, and other pertinent details relative to the benefits provided to covered persons thereunder.

Sec. 3999.32. (A) As used in this section:

(1) "Certificate holder" means any person whose employment or retirement status is the basis of eligibility for coverage under a group policy of sickness and accident insurance or for enrollment under a group contract of a ~~prepaid dental plan organization, medical care corporation, health care insuring corporation, dental care corporation, or health maintenance organization.~~

(2) "Health insurer" means any sickness and accident insurer, ~~prepaid dental plan organization, medical care corporation, or~~ health care insuring corporation, ~~dental care corporation, or health maintenance organization.~~

(B) Each person to whom a group policy or contract of sickness and accident insurance or other health care coverage has been delivered or issued for delivery in this state by a health insurer shall make a reasonable effort to notify every certificate holder, or ~~his~~ certificate holder's designee, who is covered under that policy or contract whenever the person fails to make a required premium payment or contribution on behalf of the certificate holder and that failure results in the termination of coverage. The person shall mail or present the notice to the certificate holder or ~~his~~ certificate holder's designee no later than five days after the date on which the person receives the notice from the health insurer as required under division (D) of this section. If a person other than the policyholder or contract holder is obligated to make the required premium payment or contribution on behalf of the certificate holder, that person shall mail or present the notice as required by this section.

(C) The notice required by division (B) of this section shall be in writing and shall clearly state that the person failed to make the required premium payment or contribution, the reasons for the failure, and the effect of the failure on the coverage of the certificate holder under the policy or contract.

(D) If a person described in division (B) of this section fails to make a required premium payment or contribution on behalf of a certificate holder and that failure results in the termination of the coverage, the health insurer providing the coverage shall notify the person in writing of that person's duties as described in divisions (B) and (C) of this section. If a person other than the policyholder or contract holder ~~is~~ IS obligated to make the required premium payment or contribution on behalf of the certificate holder, the insurer shall notify the person in writing of that person's duties as described in divisions (B) and (C) of this section.

(E) A certificate holder may designate any person to receive on ~~his~~ the certificate holder's behalf the notice required by division (B) of this section. The certificate holder shall furnish the name and address of the person so designated to the person to whom the group policy or contract has been delivered or issued for delivery.

(F) No person shall knowingly fail to comply with division (B) or (C) of this section.

Sec. 3999.36. (A) As used in this section and sections 3999.37 and 3999.38 of the Revised Code:

(1) "Insurer" means any person that is authorized to engage in the business of insurance in this state under ~~title~~ TITLE XXXIX of the Revised Code; ~~any prepaid dental plan organization, medical care corporation, health care insuring corporation, dental care corporation, or health maintenance organization;~~ or any other person engaging either directly or indirectly in this state in the business of insurance or entering into contracts substantially amounting to insurance under section 3905.42 of the Revised Code.

(2) "Impaired" or "impairment" means a financial situation in which the insurer's assets are less than the sum of the insurer's minimum required capital, minimum required surplus, and all liabilities, as determined in accordance with the requirements for the preparation and filing of the insurer's annual financial statement.

(3) "Chief executive officer" means the person, irrespective of ~~his~~ the person's title, designated by the board of directors or trustees of an insurer as the person charged with the responsibility of administering and implementing the insurer's policies and procedures.

(B) Whenever a chief executive officer of an insurer knows or has reason to know that the insurer is impaired, ~~he~~ the chief executive officer shall provide written notice of the impairment to the superintendent of insurance and to each member of the board of directors or trustees of the insurer. The chief executive officer shall provide the notice as soon as

reasonably possible, but no later than thirty days after ~~he~~ the chief executive officer knows or has reason to know of the impairment. No chief executive officer shall fail to provide notice in compliance with this division.

(C) The notice received by the superintendent under division (B) of this section is not a public record under section 149.43 of the Revised Code.

Sec. 4582.041. (A) Any port authority created under section 4582.02 of the Revised Code may procure and pay all or any part 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 immediate dependents, ~~whether~~ issued by an insurance company ~~or a medical care corporation~~, duly authorized to do business in this state.

(B) Any port authority also may procure and pay all or any part of the cost of a plan of group hospitalization, surgical, or major medical insurance with a health ~~care~~ insuring corporation ~~organized holding a certificate of authority~~ 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 such a plan offered by a health ~~care~~ insuring corporation under this division, on the condition that the full-time employee shall pay any 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 each year as determined by the port authority.

Sec. 4582.29. (A) Any port authority created under section 4582.22 of the Revised Code may procure and pay all or any part 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 immediate dependents, ~~whether~~ issued by an insurance company ~~or a medical care corporation~~, duly authorized to do business in this state.

(B) Any port authority also may procure and pay all or any part of the cost of a plan of group hospitalization, surgical, or major medical insurance with a health ~~care~~ insuring corporation ~~organized holding a certificate of authority~~ 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; ~~hospital service association, 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 any 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 each year as determined by the port authority.

Sec. 4715.02. The governor, with the advice and consent of the senate, shall appoint a state dental board consisting of seven persons, five of whom shall be graduates of a reputable dental college, ~~a citizen~~ CITIZENS of the United States, and shall have been in the legal and reputable practice of dentistry in the state at least five years next preceding ~~his~~ THEIR appointment; one of whom shall be a graduate of a reputable school of dental hygiene, a citizen of the United States, and shall have been in the legal and reputable practice of dental hygiene in the state at least five years next preceding ~~his~~ the person's appointment; and one of whom shall be a member of the public at large who is not associated with or financially interested in the practice of dentistry. Terms of office shall be for five years, commencing on the seventh day of April and ending on the sixth day of April, except that upon expiration of the term ending April 25, 1978, the new term which succeeds it shall commence on April 26, 1978 and end on April 6, 1983; upon expiration of the term ending July 23, 1974, the new term which succeeds it shall commence on July 24, 1974 and end on April 6, 1979; and upon expiration of the term ending June 24, 1975, the new term which succeeds it shall commence on June 25, 1975 and end on April 6, 1980. Each member shall hold office from the date of ~~his~~ the member's appointment until the end of the term for which ~~he~~ the member was appointed. Any member appointed to fill a vacancy occurring prior to the expiration of the term for which ~~his~~ the member's predecessor was appointed shall hold office for the remainder of such term. Any member shall continue in office subsequent to the expiration date of ~~his~~ the member's term until ~~his~~ the member's successor takes office, or until a period of sixty days has elapsed, whichever occurs first. No person so appointed shall serve to exceed two terms. The Ohio dental association may submit to the governor the names of five nominees for each position to be filled by a dentist and from the names so submitted or from others, at ~~his~~ the governor's discretion, the governor shall make such appointments; provided that all such appointees shall possess the required qualifications. The Ohio dental hygienists association, inc. may submit to the governor the names of five nominees for each position to be filled by a dental hygienist and from the names so submitted or from others, at ~~his~~ the governor's discretion, the governor shall make such appointments; provided that all such appointees

shall possess the required qualifications. No person shall be appointed to the state dental board who is employed by or practices in a ~~partnership, association, or corporation~~ organized holding a certificate of authority under Chapter ~~1740~~ 1751, of the Revised Code with a person who is a member of the board.

Sec. 4719.01. (A) As used in sections 4719.01 to 4719.18 of the Revised Code:

(1) "Affiliate" means a business entity that is owned by, operated by, controlled by, or under common control with another business entity.

(2) "Communication" means a written or oral notification or advertisement that meets both of the following criteria, as applicable:

(a) The notification or advertisement is transmitted by or on behalf of the seller of goods or services and by or through any printed, audio, video, cinematic, telephonic, or electronic means.

(b) In the case of a notification or advertisement other than by telephone, either of the following conditions is met:

(i) The notification or advertisement is followed by a telephone call from a telephone solicitor or salesperson.

(ii) The notification or advertisement invites a response by telephone, and, during the course of that response, a telephone solicitor or salesperson attempts to make or makes a sale of goods or services. As used in division (A)(2)(b)(ii) of this section, "invites a response by telephone" excludes the mere listing or inclusion of a telephone number in a notification or advertisement.

(3) "Gift, award, or prize" means anything of value that is offered or purportedly offered, or given or purportedly given by chance, at no cost to the receiver and with no obligation to purchase goods or services. As used in this division, "chance" includes a situation in which a person is guaranteed to receive an item and, at the time of the offer or purported offer, the telephone solicitor does not identify the specific item that the person will receive.

(4) "Goods or services" means any real property or any tangible or intangible personal property, or services of any kind provided or offered to a person. "Goods or services" includes, but is not limited to, advertising; labor performed for the benefit of a person; personal property intended to be attached to or installed in any real property, regardless of whether it is so attached or installed; timeshare estates or licenses; and extended service contracts.

(5) "Purchaser" means a person that is solicited to become or does become financially obligated as a result of a telephone solicitation.

(6) "Salesperson" means an individual who is employed, appointed, or authorized by a telephone solicitor to make telephone solicitations but does not mean any of the following:

(a) An individual who comes within one of the exemptions in division (B) of this section;

(b) An individual employed, appointed, or authorized by a person who comes within one of the exemptions in division (B) of this section;

(c) An individual under a written contract with a person who comes within one of the exemptions in division (B) of this section, if liability for all transactions with purchasers is assumed by the person so exempted.

(7) "Telephone solicitation" means a communication to a person that meets both of the following criteria:

(a) The communication is initiated by or on behalf of a telephone solicitor or by a salesperson.

(b) The communication either represents a price or the quality or availability of goods or services or is used to induce the person to purchase goods or services, including, but not limited to, inducement through the offering of a gift, award, or prize.

(8) "Telephone solicitor" means a person that engages in telephone solicitation directly or through one or more salespersons either from a location in this state or from a location outside this state to persons in this state. "Telephone solicitor" includes, but is not limited to, any such person that is an owner, operator, officer, or director of, partner in, or other individual engaged in the management activities of, a business.

(B) A telephone solicitor is exempt from the provisions of sections 4719.02 to 4719.18 and section 4719.99 of the Revised Code if the telephone solicitor is any one of the following:

(1) A person engaging in a telephone solicitation that is a one-time or infrequent transaction not done in the course of a pattern of repeated transactions of a like nature;

(2) A person engaged in telephone solicitation solely for religious or political purposes; a charitable organization, fund-raising counsel, or professional solicitor in compliance with the registration and reporting requirements of Chapter 1716. of the Revised Code; or any person or other entity exempt under section 1716.03 of the Revised Code from filing a registration statement under section 1716.02 of the Revised Code;

(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.

(6)(a) An issuer, or its subsidiary, that has a class of securities to which all of the following apply:

(i) The class of securities is subject to section 12 of the "Securities Exchange Act of 1934," 15 U.S.C.A. 78l, and is registered or is exempt from registration under 15 U.S.C.A. 78l(g)(2)(A), (B), (C), (E), (F), (G), or (H);

(ii) The class of securities is listed on the New York stock exchange, the American stock exchange, or the NASDAQ national market system;

(iii) The class of securities is a reported security as defined in 17 C.F.R. 240.11Aa3-1(a)(4).

(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.

(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;

(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 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:

(a) The telephone solicitor has been operating continuously for at least three years under the same business name under which it solicits purchasers,

and at least fifty-one per cent of its gross dollar volume of sales consists of repeat sales to existing customers to whom it has made sales under the same business name.

(b) The purchaser business intends to resell the goods purchased.

(c) The purchaser business intends to use the goods or services purchased in a recycling, reuse, manufacturing, or remanufacturing process.

(d) The telephone solicitor is a publisher of a periodical or of magazineS distributed as controlled circulation publicationS as defined in division (CC) of section 5739.01 of the Revised Code and is soliciting sales of advertising, subscriptions, reprints, lists, information databases, conference participation or sponsorships, trade shows or media products related to the periodical or magazine, or other publishing services provided by the controlled circulation publication.

(13) A person that, not less often than once each year, publishes and delivers to potential purchasers a catalog that complies with both of the following:

(a) It includes all of the following:

(i) The business address of the seller;

(ii) A written description or illustration of each good or service offered for sale;

(iii) A clear and conspicuous disclosure of the sale price of each good or service; shipping, handling, and other charges; and return policy;

(b) One of the following applies:

(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 full refund within thirty days after the purchaser returns the good or cancels the service;

(19)(a) A person that, for at least one year, has been operating a retail business under the same name as that used in connection with telephone solicitation and both of the following occur on a continuing basis:

(i) The person either displays goods and offers them for retail sale at the person's business premises or offers services for sale and provides them at the person's business premises.

(ii) At least fifty-one per cent of the person's gross dollar volume of retail sales involves purchases of goods or services at the person's business premises.

(b) An affiliate of a person that meets the requirements in division (B)(19)(a) of this section if the affiliate meets all of the following requirements:

(i) The affiliate has operated a retail business for a period of less than one year;

(ii) The affiliate either displays goods and offers them for retail sale at the affiliate's business premises or offers services for sale and provides them at the affiliate's business premises;

(iii) At least fifty-one per cent of the affiliate's gross dollar volume of retail sales involves purchases of goods or services at the affiliate's business premises.

(c) A person that, for a period of less than one year, has been operating a retail business in this state under the same name as that used in connection with telephone solicitation, as long as all of the following requirements are met:

(i) The person either displays goods and offers them for retail sale at the person's business premises or offers services for sale and provides them at

the person's business premises;

(ii) The goods or services that are the subject of telephone solicitation are sold at the person's business premises, and at least sixty-five per cent of the person's gross dollar volume of retail sales involves purchases of goods or services at the person's business premises;

(iii) The person conducts all telephone solicitation activities according to sections 310.3, 310.4, and 310.5 of the telemarketing sales rule adopted by the federal trade commission in 16 C.F.R. part 310.

(20) A person who performs telephone solicitation sales services on behalf of other persons and to whom one of the following applies:

(a) The person has operated under the same ownership, control, and business name for at least five years, and the person receives at least seventy-five per cent of its gross revenues from written telephone solicitation contracts with persons who come within one of the exemptions in division (B) of this section.

(b) The person is an affiliate of one or more exempt persons and makes telephone solicitations on behalf of only the exempt persons of which it is an affiliate.

(c) The person makes telephone solicitations on behalf of only exempt persons, the person and each exempt person on whose behalf telephone solicitations are made have entered into a written contract that specifies the manner in which the telephone solicitations are to be conducted and that at a minimum requires compliance with the telemarketing sales rule adopted by the federal trade commission in 16 C.F.R. part 310, and the person conducts the telephone solicitations in the manner specified in the written contract.

(d) The person performs telephone solicitation for religious or political purposes, a charitable organization, a fund-raising council, or a professional solicitor in compliance with the registration and reporting requirements of Chapter 1716. of the Revised Code; and meets all of the following requirements:

(i) The person has operated under the same ownership, control, and business name for at least five years, and the person receives at least fifty-one per cent of its gross revenues from written telephone solicitation contracts with persons who come within the exemption in division (B)(2) of this section;

(ii) The person does not conduct a prize promotion or offer the sale of an investment opportunity; and

(iii) The person 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.

(21) A person that is a licensed real estate salesperson or broker under Chapter 4735. of the Revised Code when soliciting within the scope of the person's license;

(22) A publisher that solicits the sale of the publisher's periodical or magazine of general, paid circulation, or a person that solicits a sale of that nature on behalf of a publisher under a written agreement directly between the publisher and the person. As used in division (B)(22) of this section, "periodical or magazine of general, paid circulation" excludes a periodical or magazine circulated only as part of a membership package or given as a free gift or prize from the publisher or person.

(23) A person that solicits the sale of food, as defined in section 3715.01 of the Revised Code, or the sale of products of horticulture, as defined in section 5739.01 of the Revised Code, if the person does not intend the solicitation to result in, or the solicitation actually does not result in, a sale that costs the purchaser an amount greater than five hundred dollars.

(24) A funeral director licensed pursuant to Chapter 4717. of the Revised Code when soliciting within the scope of that license, if both of the following apply:

(a) The solicitation and sale are conducted in compliance with 16 C.F.R. part 453, as adopted by the federal trade commission, and with sections 1107.33 and 1345.21 to 1345.28 of the Revised Code;

(b) The person provides to the purchaser of any preneed funeral contract a notice that clearly and conspicuously sets forth the cancellation rights specified in division (G) of section 1107.33 of the Revised Code, and retains a copy of the that notice signed by the purchaser.

(25) A person, or affiliate thereof, licensed to sell or issue Ohio instruments designated as travelers checks pursuant to sections 1315.01 to 1315.11 of the Revised Code.

(26) A person that solicits sales from its previous purchasers and meets all of the following requirements:

(a) The solicitation is made under the same business name that was previously used to sell goods or services to the purchaser;

(b) The person has, for a period of not less than three years, operated a business under the same business name as that used in connection with telephone solicitation;

(c) The person does not conduct a prize promotion or offer the sale of an investment opportunity;

(d) The person 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;

(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;

(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.

(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:

(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;

(b) The institution is accredited by either the joint commission on accreditation of health care organizations or the community health accreditation program;

(c) The institution is providing PASSPORT services under the direction of the Ohio department of aging under section 173.40 of the Revised Code;

(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.

(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.

Sec. 4729.381. 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

~~maintenance organization~~ insuring corporation, or long-term care facility and requiring the pharmacist to dispense the particular drug.

Sec. 4731.67. 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:

(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;

(B) Referrals for clinical laboratory services by a certificate holder specializing in the practice of pathology if those services are provided by or under the supervision of the pathologist pursuant to a consultation requested by another physician;

(C) Referrals for in-office ancillary services to which all of the following apply:

(1) The services are furnished by the referring physician, a physician in the same group practice as the referring physician, or individuals who are employed by the referring physician or the group practice and who are supervised by the referring physician or a physician in the group practice, and are furnished either:

(a) In a building in which the referring physician, or another physician in the same group practice as the referring physician, furnishes physicians' services unrelated to the furnishing of designated health services;

(b) In another building used by the referring physician's group practice for the centralized provision of the group's designated health services.

(2) The services are billed by the physician performing or supervising the services, the physician's group practice, or an entity wholly owned by the group practice.

(3) The physician's ownership or investment interest in the services described in this division meets any other requirements that the state medical board applies in rules adopted under section 4731.70 of the Revised Code.

(D) "Referrals for in-office ancillary services if the third-party payer is aware of and has agreed in writing to reimburse the services notwithstanding the financial arrangement between the physician and the provider of such ancillary services.

(E) Referrals for services furnished by a health ~~maintenance organization~~ insuring corporation to an enrollee of the ~~organization corporation~~;

(F) Referrals to a hospital for designated health services, if all of the following apply:

(1) The financial arrangement between the referring physician or immediate family member and the hospital consists of an ownership or investment interest described in division (A)(1) of section 4731.66 of the Revised Code and not a compensation arrangement described in division (A)(2) of that section.

(2) The referring physician is authorized to perform services at the hospital.

(3) The ownership or investment interest is in the hospital itself and not merely in a subdivision of the hospital.

(G) Referrals to a hospital with which the certificate holder's or immediate family member's financial relationship does not relate to the provision of designated health services;

(H) Referrals to a laboratory located in a rural area as defined in section 1886(d)(2)(D) of the "Social Security Act," 49 Stat. 620 (1935), 42 U.S.C.A. 1395ww(d)(2)(D), as amended, if the financial relationship consists of an ownership or investment interest described in division (A)(1) of section 4731.66 of the Revised Code, and not a compensation arrangement described in division (A)(2) of that section;

(I) Any other referrals in which the financial relationship between the certificate holder or immediate family member and the person furnishing services has been specified in rules adopted by the state medical board under section 4731.70 of the Revised Code.

Sec. 5111.02. (A) Under the medical assistance program:

(1) Reimbursement by the department of human services to a medical provider for any medical service rendered under the program shall not exceed the authorized reimbursement level for the same service under the medicare program established under Title XVIII of the "Social Security Act," 49 Stat. 620 (1935), 42 U.S.C.A. 301, as amended.

(2) Reimbursement for freestanding medical laboratory charges shall not exceed the customary and usual fee for laboratory profiles.

(3) The department may deduct from payments for services rendered by a medicaid provider under the medical assistance program any amounts the provider owes the state as the result of incorrect medical assistance payments the department has made to the provider.

(4) The department may conduct final fiscal audits in accordance with the applicable requirements set forth in federal laws and regulations and determine any amounts the provider may owe the state. When conducting final fiscal audits, the department shall consider generally accepted auditing standards, which include the use of statistical sampling.

(5) To the maximum extent that federal laws and regulations permit the

implementation of such a policy, the department may institute a copayment program for all services provided under the medical assistance program. The program shall be administered in accordance with the applicable requirements set forth in federal laws and regulations.

(6) The number of days of inpatient hospital care for which reimbursement is made on behalf of a recipient of medical assistance to a hospital that is not paid under a diagnostic-related-group prospective payment system shall not exceed thirty days during a period beginning on the day of the recipient's admission to the hospital and ending sixty days after the termination of that hospital stay, except that the department may make exceptions to this limitation. The limitation does not apply to children participating in the program for medically handicapped children established under section 3701.023 of the Revised Code.

(B) The director of human services may adopt, amend, or rescind rules under Chapter 119. of the Revised Code establishing the amount, duration, and scope of medical services to be included in the medical assistance program. Such rules shall establish the conditions under which services are covered and reimbursed, the method of reimbursement applicable to each covered service, and the amount of reimbursement or, in lieu of such amounts, methods by which such amounts are to be determined for each covered service. Any rules that pertain to nursing facilities or intermediate care facilities for the mentally retarded shall be consistent with sections 5111.20 to 5111.33 of the Revised Code.

(C) No health ~~maintenance organization~~ insuring corporation that has a contract to provide health care services to recipients of medical assistance shall restrict the availability to its enrollees of any prescription drugs included in the Ohio medicaid drug formulary as established under rules of the department.

(D) The division of any reimbursement between a collaborating physician or podiatrist and a clinical nurse specialist, certified nurse-midwife, or certified nurse practitioner for services performed by the nurse shall be determined and agreed on by the nurse and collaborating physician or podiatrist. In no case shall reimbursement exceed the payment that the physician or podiatrist would have received had the physician or podiatrist provided the entire service.

Sec. 5111.17. (A) As used in this section, "community-based clinic" means a clinic that provides prenatal, family planning, well child, or primary care services and is funded in whole or in part by the state or federal government.

(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 Code and the amount of disproportionate share hospital payments paid by the medicare program established under Title XVIII of the "Social Security Act," 49 Stat. 620 (1935), 42 U.S.C.A. 301, as amended, each managed care organization under contract with the department to provide managed care to participating medical assistance recipients shall keep detailed records for each hospital with which it contracts about the cost to the hospital of providing the care, payments made by the organization to the hospital for the care, utilization of hospital services by medical assistance recipients participating in managed care, and other utilization data required by the department.

~~(E)(G)~~ The department shall adopt rules in accordance with Chapter 119. of the Revised Code to implement this section. The rules shall include all of the following:

(1) A monthly capitation or other risk-based payment rate system for managed care organizations under contract to provide managed care to

participating medical assistance recipients;

(2) The method by which the department will issue requests for proposals from managed care organizations interested in providing managed care to participating medical assistance recipients, including all of the following:

(a) Public notice of the department's intent to issue a request for proposals within a county;

(b) The process for managed care organizations to submit letters of interest;

(c) The procurement, selection, and implementation timetable within each county;

(d) The time by which the department will furnish interested managed care organizations with demographic, cost, and utilization data about medical assistance recipients required or permitted to enroll in a managed care organization in a county.

(3) Performance standards of managed care organizations under contract with the department governing all of the following:

(a) Scope of coverage and benefits;

(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;

(c) Service delivery system capacity;

(d) Reporting requirements;

(e) Grievance and complaint procedures;

(f) Enrollment and disenrollment procedures;

(g) Stop-loss arrangements;

(h) Marketing;

(i) Consumer and provider advisory councils;

(j) Any other requirement established by the department.

(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;

(5) Any other procedures or requirements the department considers necessary to implement managed care.

Sec. 5111.171. 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 services in a cost-effective manner. Recipients identified by the department as being subject to this division shall comply with the requirements of the case management system as a condition of continued eligibility for medical assistance. The department shall reimburse a hospital under the medical assistance program for emergency services covered by the medical assistance program provided to a medical assistance recipient pursuant to section 1867 of the "Social Security Act," 49 Stat. 620 (1935), 42 U.S.C.A. 1395dd, as amended, regardless of whether the hospital is participating in the case management system.

A hospital's participation in the case management system does not prevent its participation in the hospital care assurance program established by sections 5112.01 to 5112.21 of the Revised Code unless the hospital is operated by a health ~~maintenance organization~~ insuring corporation.

Sec. 5111.19. The department of human services shall adopt rules governing the calculation and payment of graduate medical education costs associated with services rendered to recipients of the medical assistance program after June 30, 1994. The rules shall provide for reimbursement of graduate medical education costs associated with services rendered to medical assistance recipients, including recipients enrolled in health ~~maintenance organizations~~ insuring corporations, that the department determines are allowable and reasonable.

If the department requires a health ~~maintenance organization~~ insuring corporation to pay a provider for graduate medical education costs associated with the delivery of services to medical assistance recipients enrolled in the ~~organization corporation~~, the department shall include in its payment to the ~~organization corporation~~ an amount sufficient for the ~~organization corporation~~ to pay such costs. If the department does not include in its payments to the ~~organization~~ health insuring corporation amounts for graduate medical education costs of providers, all of the following apply:

(A) The department shall pay the provider for graduate medical education costs associated with the delivery of services to medical assistance recipients enrolled in the ~~organization corporation~~;

(B) No provider shall seek reimbursement from the ~~organization corporation~~ for such costs;

(C) The ~~organization corporation~~ is not required to pay providers for such costs.

Sec. 5111.74. (A) Not later than July 1, 1995, the department of human services shall establish a fair share demonstration project in Butler county

or two years. The demonstration project shall be administered by the Butler county health care management board created under division (B) of this section. In establishing the project, the department shall enter into an agreement with the board, which shall provide that medical assistance services be given to designated medical assistance recipients who elect or are required by the department to receive their services from or through the board or at least one other managed care arrangement designated and approved by the department.

The demonstration project shall demonstrate the viability of delivering health care services to Butler county medical assistance recipients through a cooperative health care purchasing plan involving the organization of a managed care network by physicians practicing medicine in Butler county and hospitals located there. The demonstration project shall restructure the medical assistance delivery system to improve the delivery of cost effective, quality health care with an emphasis on primary and preventive care, and shall prevent cost shifting to the private sector. The demonstration project shall demonstrate all of the following:

- (1) A cost savings through prevention, the use of appropriate levels of care, reduced administrative costs, and utilization of the demonstration project through primary provider reimbursement policies that encourage the delivery of primary and preventive care;
- (2) The effectiveness of local collaboration and autonomy in managing medical assistance expenditures in Butler county;
- (3) Improved access to quality health care for Butler county's medical assistance recipients, while containing health care costs.

The department shall make a grant of two hundred fifty thousand dollars to the board on its establishment for operating and project expenses. These funds shall be transferred from the department's medical assistance account.

(B)(1) There is hereby created the Butler county health care management board to administer the fair share demonstration project in that county. The board shall consist of the county director of human services and the following members:

- (a) One representative of each hospital system located in Butler county, selected by the hospital;
- (b) Two physicians who specialize in pediatrics; two family practice physicians; a physician who specializes in obstetrics; an emergency department physician; a primary care physician; a physician who is a medical specialist; a physician who is a surgical specialist; a psychiatrist; and one physician selected at large. The physicians shall be selected by the county medical society or a similar organization of physicians in the county.

(c) A chiropractor selected by an association of chiropractors in the county;

(d) A licensed registered nurse who is an advanced practice nurse selected by an organization of nurses in the county;

(e) A dentist selected by an organization of dentists in the county;

(f) An optometrist selected by an organization of optometrists in the county;

(g) A psychologist selected by an organization of psychologists in the county;

(h) A representative of child and family health services clinics selected by the child health service consortium of Butler county;

(i) A podiatrist selected by an organization of podiatrists in the county.

(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.

(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 ~~he replaces~~ replaced. 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.

(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:

(1) Enter into contracts with any person organized to do business in this state on behalf of the board;

(2) Accept and spend donations, grants, and other funds received by the board;

(3) Employ personnel and professionals that may be needed to assess the feasibility and to develop the demonstration project;

(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;

(5) Monitor the quality of health care delivered to medical assistance recipients in Butler county;

(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.

(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.

(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 a physician who is participating in the demonstration project to provide all health care services to the recipient, and

adopt standards for changing physicians, including disenrollment as provided by federal law;

(9) So long as it is consistent with federal law, establish a co-pay system for the following:

(a) Provision of medical services under the demonstration project;

(b) Inappropriate utilization of medical services;

(c) Over-utilization of medical services;

(d) Failure of a medical assistance recipient to appear for a scheduled medical appointment.

(10) Enter into agreements with the board of nursing authorizing advanced practice nurses, certified nurse practitioners, clinical nurse specialists, and certified nurse-midwives in Butler county to have prescription powers and perform primary care services in collaboration with or under the supervision of a physician or podiatrist in accordance with division (D) of this section;

(11) Enter into agreements with the state medical board authorizing physician assistants in Butler county to have prescription powers and perform primary care services under the general supervision and authority of a physician in accordance with division (D) of this section;

(12) Assign 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, to providers who have entered into provider agreements with the board.

(D) The Butler county health care management board shall pass 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 capitated fee shall be based on historic and expected utilization of the medical assistance program by the Butler county medical assistance population, adjusted by the current inflation rate, and shall be sufficient to ensure that all Butler county primary care physicians participating in the demonstration project are reimbursed for office visits at a rate of not less than thirty dollars per patient during the first year of the project, and not less than thirty-five dollars per patient for the second year of the project. Any savings of state funds the department of human services receives as the result of the demonstration project shall be distributed as follows:

(1) One-third of the savings to Butler county for children's health programs;

(2) One-third of the savings to the department of human services;

(3) One-third of the savings to providers participating in the demonstration project.

(F) All provider agreements or any contracts entered into or negotiated by the board shall be exempt from any contract provision contained in a contract between medical providers and health insurers or indemnity insurers licensed to do business in this state that provides for a lower payment for the services.

(G) The Butler county health care management board shall, at the end of each year of the demonstration project, issue a report listing every medical provider practicing in Butler county, the degree to which such provider has participated in the demonstration project, and the extent to which such provider has met the voluntary guidelines adopted by the board under division (C)(7) of this section.

(H) The department of human services shall apply for any federal

waiver needed to implement the Butler county fair share demonstration project.

Sec. 5115.10. (A) The disability assistance medical assistance program shall consist of a system of managed primary care. Until July 1, 1992, the program shall also include limited hospital services, except that if prior to that date hospitals are required by section 5112.17 of the Revised Code to provide medical services without charge to persons specified in that section, the program shall cease to include hospital services at the time the requirement of section 5112.17 of the Revised Code takes effect.

The state department of human services may require disability assistance medical assistance recipients to enroll in health ~~maintenance organizations, preferred provider organizations,~~ insuring corporations or other managed care programs, or may limit the number or type of health care providers from which a recipient may receive services.

The state department shall adopt rules governing the disability assistance medical assistance program established under this division. The rules shall specify all of the following:

(1) Services that will be provided under the system of managed primary care;

(2) Hospital services that will be provided during the period that hospital services are provided under the program;

(3) The maximum authorized amount, scope, duration, or limit of payment for services.

(B) The director of human services shall designate medical services providers for the disability assistance medical assistance program. The first such designation shall be made not later than September 30, 1991. Services under the program shall be provided only by providers designated by the director. The 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.

(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:

(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;

(2) The person met all eligibility requirements for disability assistance at the time the care was rendered;

(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.

(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 request of the hospital, the county department designates an employee of the hospital to conduct the interview, the interview shall be conducted by the hospital employee.

(E) The state department of human services may assume responsibility for peer review of expenditures for disability assistance medical assistance.

Sec. 5119.01. The director of mental health is the chief executive and administrative officer of the department of mental health. The director may establish procedures for the governance of the department, conduct of its employees and officers, performance of its business, and custody, use, and preservation of departmental records, papers, books, documents, and property. Whenever the Revised Code imposes a duty upon or requires an action of the department or any of its institutions, the director shall perform the action or duty in the name of the department, except that the medical director appointed pursuant to section 5119.07 of the Revised Code shall be responsible for decisions relating to medical diagnosis, treatment, rehabilitation, quality assurance, and the clinical aspects of the following: licensure of hospitals and residential facilities, research, community mental health plans, and delivery of mental health services.

The director shall:

(A) Adopt rules for the proper execution of the powers and duties of the department with respect to the institutions under its control, and require the performance of additional duties by the officers of the institutions as necessary to fully meet the requirements, intents, and purposes of this chapter. In case of an apparent conflict between the powers conferred upon any managing officer and those conferred by such sections upon the department, the presumption shall be conclusive in favor of the department.

(B) Adopt rules for the nonpartisan management of the institutions

er the department's control. An officer or employee of the department or any officer or employee of any institution under its control who, by solicitation or otherwise, exerts influence directly or indirectly to induce any other officer or employee of the department or any of its institutions to adopt the exerting officer's or employee's political views or to favor any particular person, issue, or candidate for office shall be removed from the exerting officer's or employee's office or position, by the department in case of an officer or employee, and by the governor in case of the director.

(C) Appoint such employees, including the medical director, as are necessary for the efficient conduct of the department, and prescribe their titles and duties;

(D) Prescribe the forms of affidavits, applications, medical certificates, orders of hospitalization and release, and all other forms, reports, and records that are required in the hospitalization or admission and release of all persons to the institutions under the control of the department, or are otherwise required under this chapter or Chapter 5122. of the Revised Code;

(E) Contract with hospitals licensed by the department under section 5119.20 of the Revised Code for the care and treatment of mentally ill patients, or with persons, organizations, or agencies for the custody, supervision, care, or treatment of mentally ill persons receiving services elsewhere than within the enclosure of a hospital operated under section 5119.02 of the Revised Code;

(F) Exercise the powers and perform the duties relating to community mental health facilities and services that are assigned to the director under this chapter and Chapter 340. of the Revised Code;

(G) Adopt rules under Chapter 119. of the Revised Code for 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 those persons receiving pensions and subscribing to the plan. Notwithstanding any other provision of this chapter, the policy or contract may also include coverage for any eligible individual's spouse and dependent children and for any of the individual's sponsored dependents as the board considers appropriate.

If all or any portion of the policy or contract premium is to be paid by any individual receiving a service, disability, or survivor pension or benefit, the individual shall, by written authorization, instruct the board to deduct from the individual's pension or benefit the premium agreed to be paid by the individual to the company, corporation, or agency.

The board may contract for coverage on the basis of part or all of the cost of the coverage to be paid from appropriate funds of the state highway patrol retirement system. The cost paid from the funds of the system shall be included in the employer's contribution rate as provided by section 5505.15 of the Revised Code.

(B) 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 (A) 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 (A) 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 from one plan to another at least once a year at a time determined by the board.

(C) The board shall, beginning the month following receipt of satisfactory evidence of the payment for coverage, pay monthly to each recipient of a pension under the state highway patrol retirement system who

is eligible for medical insurance coverage under part B of "The Social Security Amendments of 1965," 79 Stat. 301, 42 U.S.C.A. 1395j, as amended, the lesser of an amount equal to the basic premium for such coverage or an amount equal to the basic premium for such coverage in effect on January 1, 1994.

(D) The board shall establish by rule requirements for the coordination of any coverage, payment, or benefit provided under this section 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, state teachers retirement system, or school employees retirement system.

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

Sec. 5505.33. (A) As used in this section:

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

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

(B) The state highway patrol retirement board shall establish a program under which members of the retirement system, 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 person and ~~his~~ the person'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 person had not left ~~his~~ employment, except that no part of the cost of the insurance shall be paid by ~~his~~ the person's former employer. Such program may be established independently or jointly with one or more of the retirement systems.

(C) The 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 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 board shall request the superintendent of insurance to certify the financial condition of the company; or corporation, ~~or organization~~. The board shall not enter into the agreement if, according to that certification, the company; or corporation, ~~or organization~~ is insolvent, is determined by the

endent 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 5505.203 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. 5923.051. Notwithstanding any collective bargaining agreement or other agreement or law to the contrary, the state and any agency, authority, commission, or board thereof, shall, at the request of any person employed by the entity who is called to active duty as specified in division (B) of section 5923.05 of the Revised Code, or at the request of the spouse or dependent of that person, continue or reactivate the health, medical, hospital, dental, vision, and surgical benefits coverage, whether provided by an insurance company, ~~medical care corporation~~, health care insuring corporation, ~~health maintenance organization~~, or other health plan or entity, of that person for the duration of the time the person is on active duty as described in that division. The person or the spouse or dependent thereof who requests the continuation or reactivation of the coverage and the employing state or agency, authority, commission, or board thereof, each are liable for payment of the same costs for the coverage as if the person were not on a leave of absence.

SECTION 2. That existing sections 101.271, 124.81, 124.82, 124.822, 124.84, 124.841, 124.92, 124.93, 145.58, 145.581, 305.171, 306.48, 307.86, 339.16, 351.08, 505.60, 742.45, 742.53, 1319.12, 1337.16, 1545.071, 1731.01, 1731.06, 1739.05, 1901.111, 1901.312, 2133.12, 2305.25, 2913.47, 3105.71, 3111.241, 3113.217, 3307.74, 3307.741, 3309.69, 3309.691, 3313.202, 3375.40, 3381.14, 3501.141, 3701.24, 3701.76, 3702.51, 3702.62, 3709.16, 3729.12, 3901.04, 3901.041, 3901.043, 3901.071, 3901.16, 3901.19, 3901.31, 3901.32, 3901.38, 3901.40, 3901.41, 3901.48, 3901.72, 3902.01, 3902.02, 3902.11, 3902.13, 3904.01, 3905.71, 3923.123, 3923.30, 3923.301, 3923.33, 3923.333, 3923.38, 3923.382, 3923.41, 3923.51, 3923.54, 3923.58, 3924.01, 3924.02, 3924.08, 3924.10, 3924.12, 3924.13,

3924.41, 3924.61, 3924.62, 3924.64, 3924.73, 3929.77, 3956.01, 3959.01, 3999.32, 3999.36, 4582.041, 4582.29, 4715.02, 4719.01, 4729.381, 4731.67, 5111.02, 5111.17, 5111.171, 5111.19, 5111.74, 5115.10, 5119.01, 5119.202, 5505.28, 5505.33, and 5923.051 and sections 1736.01, 1736.02, 1736.03, 1736.04, 1736.05, 1736.06, 1736.07, 1736.08, 1736.09, 1736.10, 1736.11, 1736.12, 1736.13, 1736.14, 1736.15, 1736.16, 1736.17, 1736.18, 1736.19, 1736.20, 1736.21, 1736.22, 1736.23, 1736.24, 1736.25, 1736.26, 1736.27, 1736.28, 1737.01, 1737.02, 1737.03, 1737.04, 1737.05, 1737.06, 1737.07, 1737.08, 1737.09, 1737.10, 1737.11, 1737.12, 1737.13, 1737.14, 1737.15, 1737.16, 1737.17, 1737.18, 1737.19, 1737.20, 1737.21, 1737.22, 1737.23, 1737.24, 1737.25, 1737.26, 1737.27, 1737.28, 1737.29, 1737.30, 1737.301, 1737.31, 1737.32, 1737.99, 1738.01, 1738.02, 1738.03, 1738.04, 1738.05, 1738.06, 1738.07, 1738.08, 1738.09, 1738.10, 1738.11, 1738.12, 1738.13, 1738.14, 1738.15, 1738.16, 1738.17, 1738.18, 1738.19, 1738.20, 1738.21, 1738.22, 1738.23, 1738.24, 1738.25, 1738.26, 1738.261, 1738.27, 1738.28, 1738.29, 1738.30, 1738.99, 1740.01, 1740.02, 1740.03, 1740.04, 1740.05, 1740.06, 1740.07, 1740.08, 1740.09, 1740.10, 1740.11, 1740.12, 1740.13, 1740.14, 1740.15, 1740.16, 1740.17, 1740.18, 1740.19, 1740.20, 1740.21, 1740.22, 1740.23, 1740.24, 1740.25, 1740.26, 1740.99, 1742.01, 1742.02, 1742.03, 1742.04, 1742.05, 1742.06, 1742.07, 1742.08, 1742.09, 1742.10, 1742.11, 1742.12, 1742.13, 1742.131, 1742.14, 1742.141, 1742.15, 1742.151, 1742.16, 1742.17, 1742.171, 1742.18, 1742.19, 1742.20, 1742.21, 1742.22, 1742.23, 1742.24, 1742.25, 1742.26, 1742.27, 1742.28, 1742.29, 1742.30, 1742.301, 1742.31, 1742.32, 1742.33, 1742.34, 1742.341, 1742.35, 1742.36, 1742.37, 1742.38, 1742.39, 1742.40, 1742.41, 1742.42, 1742.43, 1742.44, and 1742.45 of the Revised Code are hereby repealed.

SECTION 3. (A) The certificate of authority of every prepaid dental plan organization, health care corporation, dental care corporation, and health maintenance organization licensed to operate under Chapter 1736., 1738., 1740., or 1742. of the Revised Code, respectively, shall renew, by operation of law, on January 1, 1998, as a certificate of authority to operate under Chapter 1751. of the Revised Code. All assets and liabilities of the prepaid dental plan organization, health care corporation, dental care corporation, or health maintenance organization, including all obligations under subscriber contracts delivered, issued for delivery, or renewed prior to the effective date of this section, shall be assumed by the successor entity. Except as otherwise provided in division (B) of this section, such entity shall, no later than January 1, 1998, comply with Chapter 1751. of the Revised Code.

(B)(1) Each entity described in division (A) of this section shall do both

of the following:

(a) Comply with sections 1751.19 and 1751.26 of the Revised Code no later than six months after the effective date of this section.

(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 Chapter 1751. of the Revised Code, and the review period for that application shall begin to run on the effective date of this section.

SECTION 5. The member of the Board of Directors of the Ohio Small Employer Health Reinsurance Program who, on the effective date of this section, is serving pursuant to section 3924.08 of the Revised Code as the member carrier that is a health maintenance organization predominantly in the small employer market, shall continue in office until the end of the term

for which the member was appointed. Thereafter, that appointment shall be filled by a member carrier that is a health insuring corporation predominantly in the small employer market.

SECTION 6. Section 1751.64 of the Revised Code is hereby repealed, effective February 9, 2004. The repeal of that section shall apply only to contracts that are delivered, issued for delivery, or renewed in this state on or after that date.

SECTION 7. Every provision for mandated health benefits, as defined in section 3901.71 of the Revised Code, that is contained in Chapter 1751. of the Revised Code, shall be applied to every policy, contract, certificate, or agreement of a health insuring corporation on the effective date of the section in which the provision is contained, notwithstanding section 3901.71 of the Revised Code.

SECTION 8. Section 5119.01 of the Revised Code is presented in this act as a composite of the section as amended by both Sub. H.B. 670 and Am. Sub. S.B. 285 of the 121st General Assembly, with the new language of neither of the acts shown in capital letters. This is in recognition of the principle stated in division (B) of section 1.52 of the Revised Code that such amendments are to be harmonized where not substantively irreconcilable and constitutes a legislative finding that such is the resulting version in effect prior to the effective date of this act.

SECTION 9. This act is hereby declared to be an emergency measure necessary for the immediate preservation of the public peace, health, and safety. The reason for such necessity is that current laws governing the regulation of prepaid dental plan organizations, medical care corporations, health care corporations, dental care corporations, and health maintenance organizations do not grant the Superintendent of Insurance the authority to regulate all forms of managed care corporations currently insuring substantial numbers of Ohio citizens, thereby threatening the public health and safety. In order to protect the public health and safety of the citizens of this state, the Superintendent must have the immediate authority to regulate these currently unregulated forms of managed care corporations and to strengthen the financial regulation of all corporations engaged in managed care in Ohio. Therefore, this act shall go into immediate effect.

Speaker _____ of the House of Representatives.

President _____ of the Senate.

Passed _____, 20____

Approved _____, 20____

Am. Sub. S. B. No. 67

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Governor.

The section numbering of law of a general and permanent nature is complete and in conformity with the Revised Code.

Director, Legislative Service Commission.

Filed in the office of the Secretary of State at Columbus, Ohio, on the
____ day of _____, A. D. 20____.

Secretary of State.

File No. _____ Effective Date _____