As Passed by the House

133rd General Assembly
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2019-2020

Representative Merrin

Cosponsors: Representatives Baldridge, Carruthers, Ghanbari, Jones, Lanese, McClain, Roemer, Rogers, Seitz, Stein, Wiggam

A BILL

To amend sections 167.03, 1751.32, 1751.74, 1751.84, 1753.31, 3901.045, 3901.45, 3901.811, 3901.87, 3902.08, 3903.01, 3903.52, 3903.56, 3903.71, 3903.724, 3903.728, 3903.7211, 3903.74, 3904.01, 3904.16, 3905.051, 3905.14, 3905.84, 3909.04, 3911.24, 3913.11, 3913.40, 3915.05, 3915.053, 3915.073, 3915.13, 3916.171, 3919.14, 3922.11, 3922.14, 3923.021, 3923.04, 3923.53, 3925.09, 3927.08, 3929.04, 3930.10, 3931.03, 3931.99, 3941.46, 3951.04, 3951.10, 3953.14, 3956.01, 3959.01, 3960.07, 3964.19, and 3999.16 and to enact section 1.301 of the Revised Code to enact the "Insurance Code Correction Act" to make technical and corrective changes to the laws governing insurance.

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

Section 1. That sections 167.03, 1751.32, 1751.74, 1751.84, 1753.31, 3901.045, 3901.45, 3901.811, 3901.87, 3902.08, 3903.01, 3903.52, 3903.56, 3903.71, 3903.724, 3903.728,

3903.7211, 3903.74, 3904.01, 3904.16, 3905.051, 3905.14, 3905.84, 3909.04, 3911.24, 3913.11, 3913.40, 3915.05, 3915.053, 3915.073, 3915.13, 3916.171, 3919.14, 3922.11, 3922.14, 3923.021, 3923.04, 3923.53, 3925.09, 3927.08, 3929.04, 3930.10, 3931.03, 3931.99, 3941.46, 3951.04, 3951.10, 3953.14, 3956.01, 3959.01, 3960.07, 3964.19, and 3999.16 be amended and section 1.301 of the Revised Code be enacted to read as follows:

Sec. 1.301. In enacting H.B. 339 of the 133rd general assembly with the stated purpose of correcting nonsubstantive errors in the Revised Code, it is the intent of the general assembly not to make substantive changes in the law in effect on the date of such enactment, except for the changes to sections 167.03 and 3915.13 of the Revised Code. Other than sections 167.03 and 3915.13 of the Revised Code, a section of the Revised Code affected by H.B. 339 of the 133rd general assembly shall be construed as a restatement and correction of, and substituted in a continuing way for, the corresponding statutory provision existing on its date of enactment.

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

(1) Study such area governmental problems common to two or more members of the council as it deems appropriate, including but not limited to matters affecting health, safety, welfare, education, economic conditions, and regional development;

(2) Promote cooperative arrangements and coordinate action among its members, and between its members and other agencies of local or state governments, whether or not within Ohio, and the federal government;

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

the region;

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

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

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

(B) The council may:

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

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

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

(C) The council may, by appropriate action of the governing bodies of the members, perform such other functions and duties as are performed or capable of performance by the

members and necessary or desirable for dealing with problems of mutual concern.

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

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

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

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

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

(1) All premium rate and other payments received for

health care services rendered;

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

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

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

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

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

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

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

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

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

Sec. 1751.74. (A) To implement a quality assurance program required by section ~~1715.73~~ 1751.73 of the Revised Code, a health insuring corporation shall do both of the following:

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

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

(B) A quality assurance program shall:

(1) Establish an internal system capable of identifying

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

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

(3) Require an annual effectiveness review of the program;

(4) Provide a description of how the health insuring corporation intends to do all of the following:

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

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

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

to enrollees or providers;

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

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

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

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

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

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

than the dollar limits, deductibles, or coinsurance provisions that apply to substantially all medical and surgical benefits under the policy, contract, or agreement.

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

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

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

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

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

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

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

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

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

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

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

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

(F) As used in this section:

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

(2) "Autism spectrum disorder" means any of the pervasive developmental disorders or autism spectrum disorder as defined

by the most recent edition of the diagnostic and statistical manual of mental disorders published by the American psychiatric association available at the time an individual is first evaluated for suspected developmental delay.

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

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

(b) Are provided by or under the supervision of any of the following:

(i) A certified Ohio behavior analyst as defined in section 4783.01 of the Revised Code;

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

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

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

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

(6) "Psychiatric care" means direct or consultative

services provided by a psychiatrist licensed in the state in which the psychiatrist practices.

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

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

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

(a) Clinical therapeutic intervention;

(b) Pharmacy care;

(c) Psychiatric care;

(d) Psychological care;

(e) Therapeutic care.

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

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

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

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

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

(D) "Corrective order" means an order issued by the superintendent of insurance specifying corrective actions that the superintendent determines are required.

(E) "Domestic health insuring corporation" means a health insuring corporation domiciled in this state.

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

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

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

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

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

(K) "RBC ~~instruction~~ instructions" means the RBC report, including risk-based capital instructions, as adopted by the

NAIC and as amended by the NAIC from time to time in accordance with the procedures adopted by the NAIC. "RBC instructions" also includes any modifications adopted by the superintendent of insurance, as the superintendent considers to be necessary.

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

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

(N) "RBC report" means the report required by section 1753.32 of the Revised Code.

(O) "Regulatory action level RBC" means the product of 1.5 and a health insuring corporation's authorized control level RBC.

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

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

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

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

Sec. 3901.045. (A) The superintendent of insurance may

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

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

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

(D) The superintendent's authority to receive documents and information under this section, from the persons and subject to the conditions listed in this section, is not limited in any

way by section 1751.19, 3901.36, 3901.44, 3901.48, 3901.70, 3903.11, 3903.722, 3903.7211, 3903.88, ~~3905.492,~~ 3905.50, 3922.21, or 3999.36 of the Revised Code.

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

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

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

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

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

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

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

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

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

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

(2) Make any inquiry toward determining an applicant's sexual orientation or direct any person who provides services to the insurer to investigate an applicant's sexual orientation;

(3) Make a decision adverse to the applicant based on entries in medical records or other reports that show that the applicant has sought an HIV test, consultation regarding the possibility of developing AIDS or an AIDS-related condition, or counseling for concerns related to AIDS from health care professionals unless there has been a diagnosis, confirmed by a positive HIV test, of AIDS or an AIDS-related condition or the applicant has been treated for either.

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

geographic designation to aid in ascertaining the applicant's sexual orientation.

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

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

(4) The insurer shall not ask the applicant whether ~~he~~ the applicant has ever taken an HIV test.

(D)(1) Except as provided in division (D)(2) of this section, no insurer shall cancel a policy of life or sickness and accident insurance, or refuse to renew a policy of life or sickness and accident insurance other than a policy that is renewable at the option of the insurer, based solely on the fact that, after the effective date of the policy, the policyholder is diagnosed as having AIDS, an AIDS-related condition, or an HIV infection.

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

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

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

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

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

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

(1) If it is necessary that the pharmacy audit be performed on the premises of a pharmacy, the auditing entity shall give the pharmacy that is the subject of the audit written notice of the date or dates on which the audit will be performed

and the range of prescription numbers from which the auditing entity will select pharmacy records to audit. Notice of the date or dates on which the audit will be performed shall be given not less than ten business days before the date the audit is to commence. Notice of the range of prescription numbers from which the auditing entity will select pharmacy records to audit shall be received by the pharmacy not less than seven business days before the date ~~of~~ the audit is to commence.

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

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

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

(B)(1) The condition in division (A)(1) of this section does not apply if, prior to the audit, the auditing entity has evidence, from its review of claims data, statements, or

physical evidence or its use of other investigative methods, indicating that fraud or other intentional or willful misrepresentation exists.

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

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

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

(B) As used in this section:

(1) "Nontherapeutic abortion" has the same meaning as in section ~~124.85~~ 9.04 of the Revised Code.

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

Sec. 3902.08. (A) Except as provided in section 3902.03 of the Revised Code, sections 3902.01 to 3902.08 of the Revised Code apply to all policy forms filed on or after ~~three years after the effective date of sections 3902.01 to 3902.08 of the Revised Code~~ January 9, 1983. No policy form shall be delivered or issued for delivery in this state on or after ~~five years after the effective date of sections 3902.01 to 3902.08 of the Revised Code~~ January 9, 1985 unless approved by the superintendent of insurance, or permitted to be issued, pursuant

to sections 3902.01 to 3902.08 of the Revised Code. Any policy form that has been approved or permitted to be issued prior to ~~five years after the effective date of sections 3902.01 to 3902.08 of the Revised Code~~ January 9, 1985, and that meets the standards set by sections 3902.01 to 3902.08 of the Revised Code need not be refiled for approval, but may continue to be lawfully delivered or issued for delivery in this state upon the filing with the superintendent of a list of such forms identified by form number and accompanied by a certificate as to each such form in the manner provided in division (D) of section ~~3902.05~~ 3902.04 of the Revised Code.

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

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

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

(B) "Affiliate" has the same meaning as "affiliate of" or "affiliated with," as defined in section 3901.32 of the Revised Code.

(C) "Assets" means all property, real and personal, of every nature and kind whatsoever or any interest therein.

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

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

(1) A contract for the purchase or sale of a commodity for future delivery on, or subject to the rules of, a board of trade

designated as a contract market by the commodity futures trading commission under the "Commodity Exchange Act," 7 U.S.C. 1 et seq., as amended, or a board of trade outside the United States;

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

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

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

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

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

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

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

(1) The issuance or delivery of contracts of insurance to

persons resident in this state;

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

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

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

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

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

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

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

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

(K) "Federal home loan bank" means an institution chartered under the "Federal Home Loan Bank Act of 1932," 12 U.S.C. 1421, et seq.

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

any state.

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

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

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

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

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

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

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

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

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

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

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

(P) "Insurer" means any person who has done, purports to do, is doing, or is licensed to do an insurance business, and is or has been subject to the authority of, or to liquidation, rehabilitation, reorganization, supervision, or conservation by, any insurance commissioner, superintendent, or equivalent official. For purposes of sections 3903.01 to 3903.59 of the Revised Code, any other persons included under section 3903.03 of the Revised Code are deemed to be insurers.

(Q) "Netting agreement" means:

(1) A contract or agreement, including a master agreement, and any terms and conditions incorporated by reference in such a contract or agreement, that provides for the netting, liquidation, setoff, termination, acceleration, or close out under or in connection with a qualified financial contract, or

any present or future payment or delivery obligations or entitlements under a qualified financial contract, including liquidation or close-out values relating to those obligations or entitlements;

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

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

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

(R) "Preferred claim" means any claim with respect to which the terms of sections 3903.01 to 3903.59 of the Revised Code accord priority of payment from the assets of the insurer.

(S) "Qualified financial contract" means any commodity contract, forward contract, repurchase agreement, securities contract, swap agreement, and any similar agreement that the superintendent may determine by rule or order to be a qualified financial contract for purposes of this chapter.

(T) "Reciprocal state" means any state other than this state in which in substance and effect division (A) of section 3903.18, and sections 3903.52, 3903.53, and 3903.55 to 3903.57

of the Revised Code are in force, in which provisions are in force requiring that the superintendent or equivalent official be the receiver, liquidator, rehabilitator, or conservator of a delinquent insurer, and in which some provision exists for the avoidance of fraudulent conveyances and preferential transfers.

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

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

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

(X) "Special deposit claim" means any claim secured by a deposit made pursuant to statute for the security or benefit of a limited class or classes of persons, but not including any claim secured by assets.

(Y) "State" has the meaning set forth in division (G) of section 1.59 of the Revised Code.

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

(AA) "Swap agreement" has the same meaning as in the federal "Deposit Insurance Act," 64 Stat. 884, 12 U.S.C. 1821(e)

(8)(D), as now and hereafter amended.

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

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

(B) If a domiciliary liquidator is appointed for an insurer not domiciled in a reciprocal state, the superintendent of insurance shall be vested by operation of law with the title

to all of the property, contracts, and rights of action, and all of the books, accounts, and other records of the insurer located in this state, at the same time that the domiciliary liquidator is vested with title in the domicile. The superintendent may file a complaint for a conservation or liquidation order under section 3903.50 or 3903.51 of the Revised Code, or for an ancillary receivership under section 3903.53 of the Revised Code, or after approval by the court may transfer title to the domiciliary liquidator, as the interests of justice and the equitable distribution of the assets require.

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

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

(B) Claims belonging to claimants residing in this state may be proved either in the domiciliary state under the law of that state, or in ancillary proceedings, if any, in this state. If a claimant elects to prove ~~his~~ the claimant's claim in this state, ~~he~~ the claimant shall file ~~his~~ the claim with the liquidator in the manner provided in sections 3903.35 and 3903.36 of the Revised Code. The ancillary receiver shall make ~~his~~ a recommendation to the court as under section ~~3939.43~~

3903.43 of the Revised Code. ~~He~~ The ancillary receiver shall also arrange a date for hearing if necessary under section 3903.39 of the Revised Code and shall give notice to the liquidator in the domiciliary state, either by certified mail or by personal service at least forty days prior to the date set for hearing. If the domiciliary liquidator, within thirty days after the giving of such notice, gives notice in writing to the ancillary receiver and to the claimant, either by certified mail or by personal service, of ~~his~~ the domiciliary liquidator's intention to contest the claim, ~~he~~ the domiciliary liquidator shall be entitled to appear or to be represented in any proceeding in this state involving the adjudication of the claim.

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

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

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

(B) It has commenced, or has attempted to commence, any voluntary liquidation or dissolution proceeding, or any proceeding to procure the appointment of a ~~receivor~~ receiver,

liquidator, rehabilitor, sequestrator, conservator, or similar officer for itself;

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

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

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

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

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

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

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

superintendent shall revoke the authority to transact the business of insurance in this state.

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

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

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

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

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

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

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

VIR = .03 + W (R(sub-1) - .03) + W/2(R(sub-2) - .09).

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

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

$$VIR = .03 + W\ (R - .03).$$

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

(4) For other annuities with no cash settlement options

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

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

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

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

	1	2
A	Weighting Factors for Life Insurance	
B	Guarantee Duration (Years)	Weighting Factors
C	10 or less	.50
D	More than 10, but not more than 20	.45
E	More than 20	.35

(E) The weighting factor for single premium immediate annuities and for annuity benefits involving life contingencies

arising from other annuity and guaranteed interest contracts with cash settlement options is .80.

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

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

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

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

(c) As an immediate life annuity.

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

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

(4) The guarantee duration for an annuity or guaranteed

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

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

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

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

Weighting Factors for Annuities and Guaranteed Interest

Contracts

1	2	3	4
A	Weighting Factor for Plan Type		
B Guarantee Duration (Years)	A	B	C
C 5 or less	.80	.60	.50
D More than 5, but not more than 10	.75	.60	.50
E More than 10, but not more than 20	.65	.50	.45
F More than 20	.45	.35	.35

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

(i) For plan type A, .15;

(ii) For plan type B, .25;

(iii) For plan type C, .05.

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

in item (F)(6)(b) increased by .05 for all plan types.

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

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

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

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

(4) The reference interest rate for other annuities with no cash settlement options and for guaranteed interest contracts

with no cash settlement options, such average over the twelve-month period ending on the thirtieth day of June of the calendar year of issue or purchase.

(5) The reference interest rate for all other annuity and guaranteed interest contracts with cash settlement options valued on a change in fund basis is such average over the twelve-month period ending on the thirtieth day of June of the calendar year in which a change in the fund occurs.

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

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

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

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

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

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

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

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

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

~~(a)~~ (1) At least three-fourths of the members of the national association of insurance commissioners voting, but not less than a majority of the total membership;

~~(b)~~ (2) Members of the national association of insurance commissioners representing jurisdictions totaling greater than seventy-five per cent of the direct premiums written as reported in one or more of the following annual statements most recently available prior to the vote in division (C)(1)~~(a)~~ of this section: life, accident, and health annual statements; health annual statements; or fraternal annual statements.

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

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

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

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

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

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

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

(a) Requirements for the format of reports to the superintendent under division (B)(3) of section 3903.729 of the Revised Code that shall include information necessary to determine if the valuation is appropriate and in compliance with sections 3903.72 to 3903.7211 of the Revised Code.

(b) Assumptions for risks over which the company does not have significant control or influence.

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

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

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

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

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

(6) The data and form of the data required under section 3903.7210 of the Revised Code, with whom the data must be

submitted, and other requirements specified by the superintendent, which may include data analyses and reporting of analyses.

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

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

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

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

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

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

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

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

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

obtained by or disclosed to the superintendent or any other person in connection with such reports, documents, materials, and other information;

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

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

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

(B)(1) Except as provided in division (B)(2) of this section and as otherwise provided in this section, a company's confidential information is confidential by law and privileged, is not a public record under section 149.43 of the Revised Code,

shall not be subject to subpoena, and shall not be subject to discovery or admissible in evidence in any private civil action. Except as otherwise provided in this section, neither the superintendent nor any person who received confidential information while acting under the superintendent's authority shall be permitted or required to testify in any private civil action concerning that confidential information.

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

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

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

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

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

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

(2) The superintendent may share confidential information as specified in divisions (C)(1)(a) through (d) of this section only if the recipient agrees, and has the legal authority to agree, to maintain the confidentiality and privileged status of

such documents, materials, data, and other information in the same manner and to the same extent as required for the superintendent.

(D) The superintendent may receive documents, materials, data, and other information, including otherwise confidential and privileged documents, materials, data, or information, from the national association of insurance commissioners and its affiliates and subsidiaries, from regulatory or law enforcement officials of other foreign or domestic jurisdictions, and from the actuarial board for counseling and discipline or its successor. The superintendent shall maintain as confidential or privileged any document, material, data, or other information received with notice or the understanding that it is confidential or privileged under the laws of the jurisdiction that is the source of the document, material, data, or other information.

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

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

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

(H) Notwithstanding divisions (B) to (G) of this section, any confidential information specified in divisions (A)(1)(a)

and (d) of this section are subject to all of the following:

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

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

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

Sec. 3903.74. If any company, corporation, or association required by law to make a deposit with the superintendent of insurance, or other state officer, to secure the contracts ~~or OF~~ of such company, corporation, or association, or for any other purpose, fails to pay any of its liabilities upon such contracts, or other obligations, according to the terms thereof after the liability thereon has been determined, or if such company, corporation, or association, having ceased to do business ~~with~~ within this state, leaves unpaid any such

liability or has become insolvent, the attorney general, on behalf of the superintendent, or such other officer, and upon the application of any person entitled to participate in such deposit, or the proceeds arising therefrom, shall commence a civil action in the court of common pleas of Franklin county, making the company, corporation, or association a party defendant, to determine the rights of all parties claiming any interest in such deposit, to subject the deposit to the payment or satisfaction of all liabilities, and to distribute such fund among the persons entitled thereto.

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

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

(a) A declination of insurance coverage;

(b) A termination of insurance coverage;

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

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

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

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

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

(c) The rescission of a policy.

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

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

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

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

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

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

(2) Obtains information primarily from sources other than

insurance institutions;

(3) Furnishes consumer reports to other persons.

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

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

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

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

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

(3) Is a past or present applicant;

(4) Is a past or present claimant;

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

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

(1) An agent;

(2) The individual who is the subject of the information;

(3) A natural person acting in a personal capacity rather than in a business or professional capacity.

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

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

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

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

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

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

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

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

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

(Q) "Medical record information" means personal information that relates to an individual's physical or mental condition, medical history, or medical treatment and that is obtained from a medical professional or medical care

institution, from the individual, or from the individual's spouse, parent, or legal guardian.

(R) "Personal information" means any individually identifiable information gathered in connection with an insurance transaction from which judgments can be made about an individual's character, habits, avocations, finances, occupation, general reputation, credit, health, or any other personal characteristics. "Personal information" includes an individual's name and address and medical record information but does not include privileged information.

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

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

(1) Pretends to be someone the interviewer is not;

(2) Pretends to represent a person the interviewer is not in fact representing;

(3) Misrepresents the true purpose of the interview;

(4) Refuses to identify self upon request.

(U) "Privileged information" means any individually identifiable information that relates to a claim for life, health, or disability insurance benefits or a civil or criminal proceeding involving an individual, and that is collected in connection with, or in reasonable anticipation of, a claim for life, health, or disability insurance benefits or civil or

criminal proceeding involving an individual. However, information otherwise meeting the requirements of this division shall nevertheless be considered personal information if it is disclosed in violation of section 3904.13 of the Revised Code.

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

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

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

(B) At the time and place fixed for such hearing, the insurance institution, agent, or insurance support organization charged shall have an opportunity to answer the charges against it and present evidence on its ~~behlaf~~ behalf. Upon good cause

shown, the superintendent shall permit any adversely affected person to intervene, appear, and be heard at such hearing by counsel or in person.

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

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

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

~~(A)~~ (1) "Applicant" means a natural person applying for

either of the following:

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

~~(2)~~ (b) An additional line of authority under an existing resident insurance agent license if a criminal ~~record~~ records check has not been obtained within the last twelve months for insurance license purposes.

~~(B)~~ (2) "Fingerprint" means an impression of the lines on the finger taken for the purpose of identification. The impression may be electronic or converted to an electronic format.

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

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

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

the applicant.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(6) Having been convicted of or pleaded guilty or no

contest to a felony regardless of whether a judgment of conviction has been entered by the court;

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

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

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

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

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

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

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

(14) Failing to comply with any official invoice, notice, assessment, or order directing payment of federal, state, or local income tax, state or local sales tax, or workers' compensation premiums;

(15) Failing to timely submit an application for insurance. For purposes of division (B)(15) of this section, a submission is considered timely if it occurs within the time period expressly provided for by the insurer, or within seven days after the insurance agent accepts a premium or an order to bind coverage from a policyholder or applicant for insurance, whichever is later.

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

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

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

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

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

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

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

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

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

(25) In the case of an agent that is a business entity, failing to report an individual licensee's violation to the

department when the violation was known or should have been known by one or more of the partners, officers, managers, or members of the business entity;

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

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

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

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

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

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

product or service is not insurance and is not regulated by the superintendent;

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

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

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

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

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

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

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

licensee is an agent, custodian, vendor, bailee, trustee, or payee;

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

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

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

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

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

the rules adopted under it.

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

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

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

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

(c) If service by ordinary mail fails, the superintendent may cause a summary of the substantive provisions of the notice

to be published once a week for three consecutive weeks in a newspaper of general circulation in the county where the last known place of residence or business of the party is located. The notice is considered served on the date of the third publication.

(d) Any notice required to be served under Chapter 119. of the Revised Code shall also be served upon the party's attorney by ordinary mail if the attorney has entered an appearance in the matter.

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

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

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

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

(1) Assess a civil penalty in an amount not exceeding

twenty-five thousand dollars per violation;

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

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

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

(5) Refuse to issue a license;

(6) Refuse to renew a license;

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

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

(9) Accept a surrender for cause offered by the licensee, which shall be for at least five years and shall prohibit the licensee from seeking any license authorized under this chapter during that time period. A surrender for cause shall be in lieu of revocation or suspension and may include a corrective action order as provided in division (D)(8) of this section.

(E) The superintendent may consider the following factors in denying a license, imposing suspensions, revocations, fines, or other penalties, and issuing orders under this section:

(1) Whether the person acted in good faith;

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

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

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

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

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

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

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

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

(10) Remedial efforts to prevent future violations;

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

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

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

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

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

(G) If a violation described in this section has caused, is causing, or is about to cause substantial and material harm, the superintendent may issue an order requiring that person to cease and desist from engaging in the violation. Notice of the

order shall be mailed by certified mail, return receipt requested, or served in any other manner provided for in this section, immediately after its issuance to the person subject to the order and to all persons known to be involved in the violation. The superintendent may thereafter publicize or otherwise make known to all interested parties that the order has been issued.

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

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

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

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

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

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

(2) Injunctive relief;

(3) Restitution;

(4) Any other appropriate relief.

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

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

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

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

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

Sec. 3909.04. Every life insurance company organized by act of congress or under the laws of another state of the United States shall file with the superintendent of insurance a

certified copy of its charter, or deed of settlement, together with a statement, under the oath of the president, vice-president, or other chief officer or manager, and the secretary of the company, stating the name of the company, the place where it is located, and the amount of its capital, with a detailed statement of all the facts required in the annual statement of companies organized under sections ~~3907.1~~ 3907.01 to 3907.21~~, inclusive,~~ of the Revised Code, except as to the statement required by division (N) of section 3907.19 of the Revised Code, which statement shall be filed by such company only when required by the superintendent for purposes of actual valuation, as provided by the insurance laws of this state. The statement also shall include a copy of its last annual report, if any was made.

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

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

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

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

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

(2) Complete annual financial statements of the company for the five accounting periods immediately preceding the date

of the resolution, based on generally recognized insurance accounting principles;

(3) A draft of the prospectus to be sent to the policyholders, which shall contain a full disclosure of the details of the proposed conversion;

(4) Such other and further statements, affidavits, books, records, papers, information, and data, as the superintendent may require.

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

(D) Upon completion of the examination, the superintendent shall appoint an appraisal committee, consisting of a fellow of

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

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

(E) Within sixty days after the appraisal committee files its report with the superintendent, the company shall call a meeting of policyholders. Notice of the time and place of such meeting shall be sent by mail to each policyholder at ~~his~~ the policyholder's post office address as it appears on the books of the company, and to the superintendent, at least thirty days

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

(F) If such conversion is approved at such meeting by the affirmative vote of a majority of the policyholders of such company voting at the meeting, the superintendent shall fix the time and place for a public hearing not more than sixty days after the date of such meeting. Otherwise, ~~he~~ the superintendent shall issue an order prohibiting the conversion. Notice of the time and place of such hearing shall be published once each week

for two consecutive weeks in a newspaper of general circulation in the county where the home office of the company is located, and in Franklin county, and the last such publication shall be at least fifteen days prior to the date of such hearing. The expenses of publication of notice shall be paid by the company. At such hearing, the superintendent shall hear any person adversely affected by the conversion, who may present ~~his~~ the person's position, arguments, or contentions, offer and examine witnesses, and present evidence tending to show that such conversion does not meet the requirements contained in division (A) of this section. If the superintendent finds that such conversion meets such requirements, ~~he~~ the superintendent shall issue ~~his~~ a written order accepting the report of the appraisal committee and authorizing the conversion. Otherwise, ~~he~~ the superintendent shall issue such order as is appropriate to ~~his~~ the superintendent's findings.

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

property of the mutual company shall be preserved unimpaired, limited in lien to the property affected by such liens immediately prior to the effective date of the conversion.

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

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

Sec. 3913.40. (A) Any insurer, including any fraternal benefit society, that is organized under the laws of another state and is admitted to transact the business of insurance in this state may become a domestic insurer by complying with all of the requirements of law relative to the organization and licensing of a domestic insurer of the same type and by designating its principal place of business at a place in this state. Such a domestic insurer shall be issued like certificates and licenses to transact business in this state, is subject to the jurisdiction of this state, and shall be recognized as an insurer formed under the laws of this state as of the date of

its original incorporation in its original domiciliary state. The superintendent of insurance shall approve any proposed transfer of domicile under this division unless the superintendent determines that the transfer is not in the interest of policyholders of this state.

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

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

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

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

(2) Every transferring insurer as described in division

(C)(1) of this section shall file new policy forms with the superintendent on or before the effective date of the transfer, but may use existing policy forms with appropriate endorsements if allowed by, and under such conditions as are approved by, the superintendent. Every such insurer shall notify the superintendent of the details of the proposed transfer, and shall file promptly any resulting amendments to corporate documents filed or required to be filed with the superintendent.

(D) Nothing in this section or any other provision of the Revised Code prohibits an insurer from transferring its domicile to this state because its charter, bylaws, or any other organizational document contains characteristics of both a mutual insurance company and a stock insurance company.

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

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

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

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

the overdue premium will be deducted in any settlement under the policy;

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

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

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

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

purchase of paid-up additions.

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

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

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

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

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

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

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

(G) A provision that after three full years' premiums have been paid, the company, at any time while the policy is in force, will advance, on proper assignment of the policy and on the sole security thereof, at a rate of interest calculated pursuant to section 3915.051 of the Revised Code, a sum equal to, or at the option of the owner of the policy, less than, the amount required by section 3915.08 of the Revised Code under the

conditions specified in said section, and that the company will deduct from such loan value any indebtedness not already deducted in determining such value and any unpaid balance of the premium for the current policy year, and may collect interest in advance on the loan to the end of the current policy year. It shall be further stipulated in the policy that failure to repay any such advance or to pay interest does not ~~avoid~~ void the policy unless the total indebtedness thereon to the company equals or exceeds such loan value at the time of such failure nor until one month after notice has been mailed by the company to the last known address of insured and of the assignee.

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

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

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

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

(J) A provision that if, in the event of default in premium payments, the value of the policy is applied to the purchase of other insurance, and if such insurance is in force

and the original policy has not been surrendered to the company and canceled, the policy may be reinstated within three years from such default, upon evidence of insurability satisfactory to the company and payment of arrears of premiums with interest;

(K) A provision that when a policy becomes a claim by the death of the insured, settlement shall be made upon receipt of due proof of death, or not later than two months after receipt of such proof;

(L) A table showing the amounts of installments in which the policy provides its proceeds may be payable;

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

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

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

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

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

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

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

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

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

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

(C) No contract of annuity, except as stated in division (B) of this section, shall be delivered or issued for delivery

in this state unless the contract contains in substance the following provisions, or corresponding provisions that in the opinion of the superintendent of insurance are at least as favorable to the contract owners, relative to the cessation of payment of consideration under the contract:

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

(2) If a contract provides for a lump sum settlement at maturity, or at any other time, that upon surrender of the contract at or prior to the commencement of any annuity payments, the company shall pay in lieu of any paid-up annuity benefit a cash surrender benefit of such amount as is specified in divisions (E), (F), (H), and (J) of this section. The company may reserve the right to defer the payment of such cash surrender benefit for a period not to exceed six months after demand therefor with surrender of the contract. The deferral is contingent upon the company's conveyance of a written request for the deferral to the superintendent and the company's receipt of written approval from the superintendent for the deferral. The request shall address the necessity and equitability to all contract owners of the deferral~~;~~.

(3) A statement of the mortality table, if any, and interest rates used in calculating any minimum paid-up annuity, cash surrender, or death benefits that are guaranteed under the contract, together with sufficient information to determine the amounts of such benefits;

(4) A statement that any paid-up annuity, cash surrender,

or death benefits that may be available under the contract are not less than the minimum benefits required by any statute of the state in which the contract is delivered and an explanation of the manner in which such benefits are altered by the existence of any additional amounts credited by the company to the contract, any indebtedness to the company on the contract, or any prior withdrawals from or partial surrenders of the contract.

Notwithstanding the requirements of this section, any deferred annuity contract may provide that if no considerations have been received under a contract for a period of two full years and the portion of the paid-up annuity benefit at maturity on the plan stipulated in the contract arising from considerations paid prior to such period would be less than twenty dollars monthly, the company may at its option terminate such contract by payment in cash of the then present value of such portion of the paid-up annuity benefit, calculated on the basis of the mortality table, if any, and interest rate specified in the contract for determining the paid-up annuity benefit, and by such payment shall be relieved of any further obligation under such contract.

(D) The minimum values as specified in divisions (E), (F), (G), (H), and (J) of this section of any paid-up annuity, cash surrender, or death benefits available under an annuity contract shall be based upon minimum nonforfeiture amounts as defined in this division.

(1)(a) The minimum nonforfeiture amount at any time at or prior to the commencement of any annuity payments shall be equal to an accumulation up to such time at rates of interest determined in accordance with division (D)(2) of this section of

the net considerations, determined in accordance with division (D)(1)(b) of this section, paid prior to such time, decreased by the sum of:

(i) Any prior withdrawals from or partial surrenders of the contract, accumulated at rates of interest determined in accordance with division (D)(2) of this section;

(ii) An annual contract charge of fifty dollars, accumulated at rates of interest determined in accordance with division (D)(2) of this section;

(iii) Any premium tax paid by the company for the contract, accumulated at rates of interest determined in accordance with division (D)(2) of this section;

(iv) The amount of any indebtedness to the company on the contract, including interest due and accrued.

(b) The net considerations for a given contract year used to define the minimum nonforfeiture amount shall be an amount equal to eighty-seven and one-half per cent of the gross considerations credited to the contract during that contract year.

(2)(a) The interest rate used in determining minimum nonforfeiture amounts under divisions (D)(1) to (4) of this section shall be an annual rate of interest determined as the lesser of three per cent per annum or the following, which shall be specified in the contract if the interest rate will be reset:

(i) The five-year constant maturity treasury rate reported by the federal reserve as of a date or an average over a period, rounded to the nearest one-twentieth of one per cent, specified in the contract, no longer than fifteen months prior to the contract issue date or the redetermination date specified in

division (D)(2)(b) of this section;

(ii) Reduced by one hundred twenty-five basis points;

(iii) Where the resulting interest rate shall not be less than one per cent.

(b) The interest rate determined under division (D)(2)(a) of this section shall apply for an initial period and may be redetermined for additional periods. The redetermination date, basis and period, if any, shall be stated in the contract. The basis is the date or average over a specified period that produces the value of the five-year constant maturity treasury rate to be used at each redetermination date.

(3) During the period or term that a contract provides ~~substantative~~ substantive participation in an equity-indexed benefit, the contract may provide for an increase in the reduction described in division (D)(2)(a)(ii) of this section by a maximum of one hundred basis points to reflect the value of the equity-indexed benefit. The present value at the contract issue date, and at each redetermination date thereafter, of the additional reduction shall not exceed the market value of the benefit. The superintendent may require a demonstration that the present value of the additional reduction does not exceed the market value of the benefit. If the demonstration is not acceptable to the superintendent, the superintendent may disallow or limit the additional reduction.

(4) The superintendent may adopt rules to implement division (D)(3) of this section and to provide for further adjustments to the calculation of minimum nonforfeiture amounts for contracts that provide substantive participation in an equity-indexed benefit and for other contracts for which the

superintendent determines adjustments are justified.

(E) Any paid-up annuity benefit available under a contract shall be such that its present value on the date annuity payments are to commence is at least equal to the minimum nonforfeiture amount on that date. Such present value shall be computed using the mortality table, if any, and the interest rate specified in the contract for determining the minimum paid-up annuity benefits guaranteed in the contract.

(F) For contracts which provide cash surrender benefits, such cash surrender benefits available prior to maturity shall not be less than the present value as of the date of surrender of that portion of the maturity value of the paid-up annuity benefit that would be provided under the contract at maturity arising from considerations paid prior to the time of cash surrender reduced by the amount appropriate to reflect any prior withdrawals from or partial surrenders of the contract, such present value being calculated on the basis of an interest rate not more than one per cent higher than the interest rate specified in the contract for accumulating the net considerations to determine such maturity value, decreased by the amount of any indebtedness to the company on the contract, including interest due and accrued, and increased by any existing additional amounts credited by the company to the contract. In no event shall any cash surrender benefit be less than the minimum nonforfeiture amount at that time. The death benefit under such contracts shall be at least equal to the cash surrender benefit.

(G) For contracts that do not provide cash surrender benefits, the present value of any paid-up annuity benefit available as a nonforfeiture option at any time prior to

maturity shall not be less than the present value of that portion of the maturity value of the paid-up annuity benefit provided under the contract arising from considerations paid prior to the time the contract is surrendered in exchange for, or changed to, a deferred paid-up annuity, such present value being calculated for the period prior to the maturity date on the basis of the interest rate specified in the contract for accumulating the net considerations to determine such maturity value, and increased by any existing additional amounts credited by the company to the contract. For contracts that do not provide any death benefits prior to the commencement of any annuity payments, such present values shall be calculated on the basis of such interest rate and the mortality table specified in the contract for determining the maturity value of the paid-up annuity benefit. However, in no event shall the present value of a paid-up annuity benefit be less than the minimum nonforfeiture amount at that time.

(H) For the purpose of determining the benefits calculated under divisions (F) and (G) of this section, in the case of annuity contracts under which an election may be made to have annuity payments commence at optional maturity dates, the maturity date shall be deemed to be the latest date for which election shall be permitted by the contract, but shall not be deemed to be later than the anniversary of the contract next following the annuitant's seventieth birthday or the tenth anniversary of the contract, whichever is later.

(I) Any contract that does not provide cash surrender benefits or does not provide death benefits at least equal to the minimum nonforfeiture amount prior to the commencement of any annuity payments shall include a statement in a prominent place in the contract that such benefits are not provided.

(J) Any paid-up annuity, cash surrender, or death benefits available at any time, other than on the contract anniversary under any contract with fixed scheduled considerations, shall be calculated with allowance for the lapse of time and the payment of any scheduled considerations beyond the beginning of the contract year in which cessation of payment of considerations under the contract occurs.

(K) For any contract that provides, within the same contract by rider or supplemental contract provision, both annuity benefits and life insurance benefits that are in excess of the greater of cash surrender benefits or a return of the gross considerations with interest, the minimum nonforfeiture benefit shall be equal to the sum of the minimum nonforfeiture benefits for the annuity portion and the minimum nonforfeiture benefits, if any, for the life insurance portion computed as if each portion were a separate contract. Notwithstanding the provisions of divisions (E), (F), (G), (H), and (J) of this section, additional benefits payable:

(1) In the event of total and permanent disability;

(2) As reversionary annuity or deferred reversionary annuity benefits; or

(3) As other policy benefits additional to life insurance, endowment and annuity benefits, and considerations for all such additional benefits shall be disregarded in ascertaining the minimum nonforfeiture amounts, paid-up annuity, cash surrender, and death benefits that may be required by this section.

The inclusion of such additional benefits shall not be required in any paid-up benefits, unless such additional benefits separately would require minimum nonforfeiture amounts,

paid-up annuity, cash surrender, and death benefits.

(L) The superintendent may adopt rules in accordance with Chapter 119. of the Revised Code to implement this section.

Sec. 3915.13. No life insurance company nor any of its agents shall knowingly make, issue, or deliver in this state any policy or contract of life insurance which purports to be issued or to take effect as of a date more than ~~three~~ six months before the application therefor was made, if thereby the premium on such policy or contract is reduced below the premium which would be payable thereon, as determined by the nearest birthday of the insured at the time when such application was made. In determining the date when an application was made, under this section the date of execution of the application or the date of medical examination, where such examination is required, whichever is later, shall govern.

This section does not prohibit the exchange, alteration, or conversion of any policy of life or endowment insurance or any annuity in the manner provided by section 3915.12 of the Revised Code, nor does it invalidate any contract made in violation of this section.

Sec. 3916.171. (A) No person shall commit a fraudulent viatical settlement act.

(B) All of the following acts are fraudulent viatical settlement acts when committed by any person who, knowingly and with intent to defraud and for the purpose of depriving another of property or for pecuniary gain, commits, or permits any of its employees or its agents to commit them:

(1) Presenting, causing to be presented, or preparing with knowledge or belief that it will be presented to or by a

viatical settlement provider, viatical settlement broker, life expectancy provider, viatical settlement purchaser, financing entity, insurer, insurance broker, insurance agent, or any other person, any false material information, or concealing any material information, as part of, in support of, or concerning a fact material to, one or more of the following:

(a) An application for the issuance of a viatical settlement contract or a policy;

(b) The underwriting of a viatical settlement contract or a policy;

(c) A claim for payment or benefit pursuant to a viatical settlement contract or a policy;

(d) Any premiums paid on a policy;

(e) Any payments and changes in ownership or beneficiary made in accordance with the terms of a viatical settlement contract or a policy;

(f) The reinstatement or conversion of a policy;

(g) The solicitation, offer, effectuation, or sale of a viatical settlement contract or a policy;

(h) The issuance of written evidence of a viatical settlement contract or a policy;

(i) A financing transaction;

(j) Any application for or the existence of or any payments related to a loan secured directly or indirectly by any interest in a policy.

(2) Failing to disclose to the insurer, where the insurer has requested such disclosure, that the prospective insured has

undergone a life expectancy evaluation by any person or entity other than the insurer or its authorized representatives in connection with the application, underwriting, and issuance of the policy.

(3) In the furtherance of a fraud or to prevent the detection of a fraud, doing any of the following:

(a) Removing, concealing, altering, destroying, or sequestering from the superintendent of insurance the assets or records of a licensee or another person engaged in the business of viatical settlements;

(b) Misrepresenting or concealing the financial condition of a licensee, financing entity, insurer, or any other person;

(c) Transacting the business of viatical settlements in violation of any law of this state requiring a license, certificate of authority, or other legal authority for the transaction of the business of viatical settlements;

(d) Filing with the superintendent of insurance or the chief insurance regulatory official of another jurisdiction a document containing false information or otherwise concealing from the superintendent any information about a material fact.

(4) Recklessly entering into, negotiating, brokering, or otherwise dealing in a viatical settlement contract involving a policy that was obtained by presenting false, deceptive, or misleading information of any fact material to the policy, or by concealing information concerning any fact material to the policy, for the purpose of misleading and with the intent to defraud the issuer of the policy, the viatical settlement provider, or the viator;

(5) Committing any embezzlement, theft, misappropriation,

or conversion of moneys, funds, premiums, credits, or other property of a viatical settlement provider, insurer, insured, viator, policyowner, or any other person engaged in the business of viatical settlements or insurance;

(6) Employing any plan, financial structure, device, scheme, or artifice to defraud in the business of viatical settlements;

(7) Misrepresenting the state of residence or facilitating the change of the state in which a person owns a policy or the state of residency of a viator to a state or jurisdiction that does not have laws similar to this chapter for the express purposes of evading or avoiding the provisions of this chapter;

(8) In the solicitation, application, or issuance of a policy, employing any device, scheme, or artifice in violation of ~~sections~~ section 3911.09 or 3911.091 of the Revised Code;

(9) Engaging in any conduct related to a viatical settlement contract if the person knows or should have known that the intent of the transaction was to avoid the disclosure and notice requirements of section 3916.06 of the Revised Code;

(10) Entering into a premium finance agreement with any person pursuant to which the person will receive, directly or indirectly, any proceeds, fees, or other considerations from the policy, the owner of the policy, the issuer of the policy, or from any other person with respect to the premium finance agreement or any viatical settlement contract, or from any transaction related to the policy, that are in addition to the amount required to pay the principal, interest, costs, and expenses related to the policy premiums pursuant to the premium finance agreement or subsequent sale of the agreement. Any

payments, charges, fees, or other amounts in addition to the amounts required to pay the principal, interest, costs, and expenses related to policy premiums paid under the premium finance agreement shall be remitted to the original owner of the policy or, if the owner is not living at the time of the determination of the overpayment, to the estate of the owner.

(11) With respect to any viatical settlement contract or a policy, for a viatical settlement broker or an agent registered under this chapter as operating as a viatical settlement broker to knowingly solicit an offer from, effectuate a viatical settlement with, or make a sale to any viatical settlement provider, viatical settlement purchaser, financing entity, or related provider trust that is controlling, controlled by, or under common control with such viatical settlement broker or registered agent unless both of the following are true:

(a) The viatical settlement broker or agent disclosed that affiliation to the viator.

(b) The viatical settlement broker or agent is controlled by or under common control with a person that is regulated under the "Securities Act of 1933" or the "Securities Act of 1934," 15 U.S.C. 77a et seq., as amended.

(12) With respect to any viatical settlement contract or a policy, for a viatical settlement provider to knowingly enter into a viatical settlement contract with a viator if, in connection with such viatical settlement contract, anything of value will be paid to a viatical settlement broker or an agent registered under this chapter as operating as a viatical settlement broker that is controlling, controlled by, or under common control with such viatical settlement provider or the viatical settlement purchaser, financing entity, or related

provider trust that is involved in such viatical settlement contract unless both of the following are true:

(a) The viatical settlement broker or agent disclosed that affiliation to the viator.

(b) The viatical settlement broker or agent is controlled by or under common control with a person that is regulated under the "Securities Act of 1933" or the "Securities Act of 1934," 15 U.S.C. 77a et seq., as amended.

(13) Issuing, soliciting, marketing, or otherwise promoting the purchase of a policy for the purpose of or with emphasis on settling the policy;

(14) Issuing or using a pattern of false, misleading, or deceptive life expectancies;

(15) Issuing, soliciting, marketing, or otherwise promoting stranger-originated life insurance;

(16) Attempting to commit, assisting, aiding or abetting in the commission of, or conspiracy to commit any act or omission specified in divisions (B)(1) to (15) of this section.

Sec. 3919.14. A company or association organized under section 3919.01 of the Revised Code amending its articles of incorporation and its constitution and bylaws is subject to sections 3919.11 and 3919.12 of the Revised Code as to its organization and government, and it shall make separate annual statements to the superintendent of insurance of the business transacted by it under the assessment plan, as required by section ~~3919.01 to 3919.15, inclusive,~~ 3919.16 of the Revised Code, ~~or for the purpose of~~ and of the business transacted by it under the level premium or legal reserve plan, as required by section 3907.19 of the Revised Code.

Sec. 3922.11. (A) The superintendent of insurance shall establish and maintain a system for receiving and reviewing requests for external review for adverse benefit determinations where the determination by the health plan issuer was based on a contractual issue and did not involve a medical judgment or a determination based on any medical information, except for emergency services, as specified in division (C) of section 3922.05 of the Revised Code.

(B) A health plan issuer shall submit a request for external review pursuant to division (B) or (C) of section 3922.05 of the Revised Code to the superintendent, in accordance with any associated rules, policies, or procedures adopted by the superintendent of insurance.

(C) On receipt of a request from a health plan issuer, the superintendent shall consider whether the health care service is a service covered under the terms of the covered person's policy, contract, certificate, or agreement, except that the superintendent shall not conduct a review under this section unless the covered person has exhausted the health plan issuer's internal appeal process, pursuant to sections 3922.03 and 3922.04 of the Revised Code. The health plan issuer and covered person shall provide the superintendent with any information required by the superintendent that is in their possession and is germane to the review.

(D) Unless the superintendent is not able to do so because making the determination requires a medical ~~judgement~~ judgment or a determination based on medical information, the superintendent shall determine whether the health care service at issue is a service covered under the terms of the covered person's contract, policy, certificate, or agreement. The

superintendent shall notify the covered person and the health plan issuer of the superintendent's determination.

(E) If the superintendent notifies the health plan issuer that making the determination requires a medical ~~judgement~~ judgment or a determination based on medical information, the health plan issuer shall initiate an external review under this chapter.

(F) If the superintendent determines that the health service is a covered service, the health plan issuer shall cover the service.

(G) If the superintendent determines that the health care service is not a covered service, the health plan issuer is not required to cover the service or afford the covered person an external review by an independent review organization.

Sec. 3922.14. (A) To be accredited by the superintendent of insurance to conduct external reviews under section 3922.13 of the Revised Code, in addition to the requirements provided in section 3922.13 of the Revised Code and any associated rules adopted by the superintendent, an independent review organization shall do all of the following:

(1) Develop and maintain written policies and procedures that govern all aspects of both the standard external review process and the expedited external review process set forth in this chapter, including a quality assurance mechanism that does all of the following:

(a) Ensures that external reviews are conducted within the time frames prescribed under this chapter and that the required notices are provided in a timely manner;

(b) Ensures the selection of qualified and impartial

clinical reviewers to conduct external reviews on behalf of the independent review organization;

(c) Ensures that chosen clinical reviewers are suitably matched according to their area of expertise to specific cases and that the independent review organization employs or contracts with an adequate number of clinical reviewers to meet this requirement;

(d) Ensures the confidentiality of medical and treatment records and clinical review criteria;

(e) Ensures that any person employed by, or who is under contract with, the independent review organization adheres to the requirements of this chapter.

(2) Maintain a toll-free telephone service to receive information on a twenty-four-hour-a-day, seven-days-a-week basis related to external reviews that is capable of accepting, recording, and providing appropriate instruction to incoming telephone callers during other than normal business hours;

(3) Agree to maintain and provide to the superintendent, upon request and in accordance with any associated rules, policies, or procedures adopted by the superintendent of insurance, the information prescribed in section 3922.17 of the Revised Code.

(B) An independent review organization may not own or control, be a subsidiary of or in any way be owned or controlled by, or exercise control with a health plan issuer, a national, state, or local trade association of health plan issuers, or a national, state, or local trade association of health care providers.

(C)(1) Neither the independent review organization

selected to conduct the external review nor any clinical reviewer assigned by the independent organization to conduct the external review may have a material, professional, familial, or financial affiliation with any of the following:

(a) The health plan issuer that is the subject of the external review, or any officer, director, or management employee of the health plan issuer;

(b) The covered person whose treatment is the subject of the external review;

(c) The health care provider, or the health care provider's medical group or independent practice association, recommending the health care service or treatment that is the subject of the external review;

(d) The facility at which the recommended health care service would be provided;

(e) The developer or manufacturer of the principal drug, device, procedure, or other therapy being recommended for the covered person whose treatment is the subject of the external review.

(2) The superintendent may make a determination as to whether an independent review organization or a clinical reviewer of the independent review organization has a material professional, familial, or financial conflict of interest for purposes of division (C)(1) of this section. In making this determination, the superintendent may take into consideration situations where an independent review organization, or a clinical reviewer, may have an apparent conflict of interest, but that the characteristics of the relationship or connection in question are such that they do not fall under the definition

of conflict of interest provided under division (D)(1) of this section. If the superintendent determines that a conflict of interest exists, the superintendent shall disallow an independent review organization or a clinical reviewer from conducting the external review in question. Such determinations related to conflicts of interest are the sole discretion of the superintendent of insurance.

(D)(1) An independent review organization that is accredited by a nationally recognized private accrediting entity that has independent review accreditation standards that the superintendent has determined are equivalent to or exceed the minimum qualifications of this section shall be presumed in compliance with this section to be eligible for accreditation by the superintendent under section ~~3922.14~~ 3922.13 of the Revised Code.

(2) The superintendent shall initially review and periodically review the independent review organization accreditation standards of a nationally recognized private accrediting entity to determine whether the entity's standards are, and continue to be, equivalent to or exceed the minimum qualifications established under this section. The superintendent may accept a review conducted by the national association of insurance commissioners for the purpose of the determination under this division.

(3) Upon request, a nationally recognized, private accrediting entity shall make its current independent review organization accreditation standards available to the superintendent or the national association of insurance commissioners in order for the superintendent to determine if the entity's standards are equivalent to or exceed the minimum

qualifications established under this section. The superintendent may exclude any private accrediting entity that is not reviewed by the national association of insurance commissioners.

(E) An independent review organization shall be unbiased in its review of adverse benefit determinations and shall establish and maintain written procedures to ensure that it is unbiased.

Sec. 3923.021. (A) As used in this section:

(1) "Benefits provided are not unreasonable in relation to the premium charged" means the rates were calculated in accordance with sound actuarial principles.

(2) "Individual policy of sickness and accident insurance" includes sickness and accident insurance made available by insurers in the individual market to individuals, with or without family members or dependents, through group policies issued to one or more associations or entities.

(B) With respect to any filing, made pursuant to section 3923.02 of the Revised Code, of any premium rates for any individual policy of sickness and accident insurance or certificates made available by an insurer to individuals in the individual market through a group policy or for any indorsement or rider pertaining thereto, the superintendent of insurance may, within thirty days after filing:

(1) Disapprove such filing after finding that the benefits provided are unreasonable in relation to the premium charged. Such disapproval shall be effected by written order of the superintendent, a copy of which shall be mailed to the insurer that has made the filing. In the order, the superintendent shall

specify the reasons for the disapproval and state that a hearing will be held within fifteen days after requested in writing by the insurer. If a hearing is so requested, the superintendent shall also give such public notice as the superintendent considers appropriate. The superintendent, within fifteen days after the commencement of any hearing, shall issue a written order, a copy of which shall be mailed to the insurer that has made the filing, either affirming the prior disapproval or approving such filing after finding that the benefits provided are not unreasonable in relation to the premium charged.

(2) Set a date for a public hearing to commence no later than forty days after the filing. The superintendent shall give the insurer making the filing twenty days' written notice of the hearing and shall give such public notice as the superintendent considers appropriate. The superintendent, within twenty days after the commencement of a hearing, shall issue a written order, a copy of which shall be mailed to the insurer that has made the filing, either approving such filing if the superintendent finds that the benefits provided are not unreasonable in relation to the premium charged, or disapproving such filing if the superintendent finds that the benefits provided are unreasonable in relation to the premium charged. This division does not apply to any insurer organized or transacting the business of insurance under Chapter 3907. or 3909. of the Revised Code.

(3) Take no action, in which case such filing shall be deemed to be approved and shall become effective upon the thirty-first day after such filing, unless the superintendent has previously given to the insurer a written approval.

(C) At any time after any filing has been approved

pursuant to this section, the superintendent may, after a hearing of which at least twenty days' written notice has been given to the insurer that has made such filing and for which such public notice as the superintendent considers appropriate has been given, withdraw approval of such filing after finding that the benefits provided are unreasonable in relation to the premium charged. Such withdrawal of approval shall be effected by written order of the superintendent, a copy of which shall be mailed to the insurer that has made the filing, which shall state the ground for such withdrawal and the date, not less than forty days after the date of such order, when the withdrawal ~~or~~ of approval shall become effective.

(D) The superintendent may retain at the insurer's expense such attorneys, actuaries, accountants, and other experts not otherwise a part of the superintendent's staff as shall be reasonably necessary to assist in the preparation for and conduct of any public hearing under this section. The expense for retaining such experts and the expenses of the department of insurance incurred in connection with such public hearing shall be assessed against the insurer in an amount not to exceed one one-hundredth of one per cent of the sum of premiums earned plus net realized investment gain or loss of such insurer as reflected in the most current annual statement on file with the superintendent. Any person retained shall be under the direction and control of the superintendent and shall act in a purely advisory capacity.

Sec. 3923.04. Except as provided in section 3923.07 of the Revised Code, every policy of sickness and accident insurance delivered, issued for delivery, or used in this state shall contain the standard provisions specified in this section in the words in which the same appear in this section. Such standard

provisions shall be preceded individually by the caption appearing in this section or, at the option of the insurer, by such appropriate individual or group captions or subcaptions as the superintendent of insurance may approve.

(A) A provision as follows: Entire contract; changes. This policy, including the indorsements and the attached papers, if any, constitutes the entire contract of insurance. No change in this policy shall be valid until approved by an executive officer of the insurer and unless such approval be indorsed hereon or attached hereto. No agent has authority to change this policy or to waive any of its provisions.

No statement made by an applicant for a policy of sickness and accident insurance not included therein shall avoid the policy or be used to deny any claim thereunder or be used in any legal proceeding thereunder.

(B) A provision in two parts as follows: Time limit on certain defenses.

(1) After two years from the date of issue of this policy no misstatements, except fraudulent misstatements, made by the applicant in the application for this policy shall be used to void this policy or to deny a claim for loss incurred or disability (as defined in this policy) commencing after the expiration of such two-year period.

The policy provision in division (B)(1) of this section shall not be so construed as to affect any legal requirements for avoidance of a policy or denial of a claim during such initial two-year period, nor to limit the application of divisions (A), (B), (C), (D), and (E) of section 3923.05 of the Revised Code in the event of misstatement with respect to age,

occupation, or other insurance.

A policy which the insured has the right to continue in force subject to its terms by the timely payment of premiums until at least age fifty, or a policy issued after the insured has attained age forty-four and which the insured has the right to continue in force subject to its terms by the timely payment of premiums for at least five years from its date of issue, may contain, in lieu of the foregoing policy provision in division (B)(1) of this section, a provision, from which the clause in parentheses may be omitted at the insurer's option, under the caption Incontestable, as follows: After this policy has been in force for a period of two years during the lifetime of the insured (excluding any period during which the insured is disabled), it shall become incontestable as to the statements contained in the application.

(2) No claim for loss incurred or disability (as defined in this policy) commencing after two years from the date of issue of this policy shall be reduced or denied on the ground that a disease or physical condition not excluded from coverage by name or specific description effective on the date of loss had existed prior to the effective date of coverage of this policy.

No chronic disease or chronic physical condition may be excluded from the coverage of a policy of sickness insurance or from the sickness insurance coverage of a policy of sickness and accident insurance except by name or specific description.

(C) A provision as follows: Grace period. A grace period of _____ days will be granted for the payment of each premium falling due after the first premium, during which grace period this policy shall continue in force.

The insurer shall insert in the blank space in the policy provision in division (C) of this section a number not smaller than seven for weekly premium policies or ten for monthly premium policies or thirty-one for all other policies.

A policy in which the insurer reserves the right to refuse any renewal shall contain a provision, at the beginning of the policy provision in division (C) of this section, as follows: Unless not less than five days prior to the premium due date the insurer has delivered to the insured or has mailed to ~~his~~ the insured's last address as shown by the records of the insurer written notice of its intention not to renew this policy beyond the period for which the premium has been accepted. Each such policy, other than an accident insurance only policy, shall provide in substance, in a provision thereof or in an indorsement thereon or in a rider attached thereto, that the insurer may not refuse renewal of the policy before the first anniversary, or between anniversaries, of its date of issue, and that any non-renewal of the policy by the insurer or insured shall be without prejudice to any claim originating prior to the effective date of non-renewal.

(D) A provision as follows: Reinstatement. If any renewal premium be not paid within the time granted the insured for payment, a subsequent acceptance of premium by the insurer or by any agent duly authorized by the insurer to accept such premium, without requiring in connection therewith an application for reinstatement, shall reinstate this policy. If the insurer or such agent requires an application for reinstatement and issues a conditional receipt for the premium tendered, this policy will be reinstated upon approval of such application by the insurer or, lacking such approval, upon the forty-fifth day following the date of such conditional receipt unless the insurer has

previously notified the insured in writing of its disapproval of such application. The reinstated policy shall cover only loss resulting from such accidental injury as may be sustained after the date of reinstatement and loss due to such sickness as may begin more than ten days after such date. In all other respects the insured and insurer shall have the same rights thereunder as they had under this policy immediately before the due date of the defaulted premium, subject to any provisions indorsed hereon or attached hereto in connection with the reinstatement. Any premium accepted in connection with a reinstatement shall be applied to a period for which premium has not been previously paid, but not to any period more than sixty days prior to the date of reinstatement.

The last sentence of the policy provision in division (D) of this section may be omitted from any policy which the insured has the right to continue in force subject to its terms by the timely payment of premiums until at least age fifty or from any policy issued after the insured has attained age forty-four and which the insured has the right to continue in force subject to its terms by the timely payment of premiums for at least five years from its date of issue.

(E) A provision as follows: Notice of claim. Written notice of claim must be given to the insurer within twenty days after the occurrence or commencement of any loss covered by this policy, or as soon thereafter as is reasonably possible. Notice given by or on behalf of the insured or the beneficiary to the insurer at _____ or to any authorized agent of the insurer, with information sufficient to identify the insured, shall be deemed notice to the insurer.

The insurer shall insert in the blank space in the policy

provision in division (E) of this section the location of such office as it may desire to designate for the purpose of notice.

In a policy providing a loss of time benefit which may be payable for at least two years, an insurer may insert, between the first and second sentences of the policy provision in division (E) of this section, a provision as follows:

Subject to the qualifications set forth below, if the insured suffers loss of time on account of disability for which indemnity may be payable for at least two years, ~~he~~ the insured shall, at least once in every six months after having given notice of claim, give to the insurer notice of continuance of said disability, except in the event of legal incapacity. The period of six months following any filing of proof by the insured or any payment by the insurer on account of such claim or any denial of liability in whole or in part by the insurer shall be excluded in applying this provision. Delay in giving of such notice shall not impair the insured's right to any indemnity which would otherwise have accrued during the period of six months preceding the date on which such notice is actually given.

(F) A provision as follows: Claim forms. The insurer, upon receipt of a notice of claim, will furnish to the claimant such forms as are usually furnished by it for filing proofs of loss. If such forms are not furnished within fifteen days after the giving of such notice the claimant shall be deemed to have complied with the requirements of this policy as to proof of loss upon submitting, within the time fixed in this policy for filing proofs of loss, written proof covering the occurrence, the character and the extent of the loss for which claim is made.

(G) A provision as follows: Proofs of loss. Written proof of loss must be furnished to the insurer at its office in case of claim for loss for which this policy provides any periodic payment contingent upon continuing loss within ninety days after the termination of the period for which the insurer is liable and in case of claim for any other loss within ninety days after the date of such loss. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity, later than one year from the time proof is otherwise required.

(H) A provision as follows: Time of payment of claims. Indemnities payable under this policy for any loss, other than loss for which this policy provides any periodic payment, will be paid immediately upon, or within thirty days after, receipt of due written proof of such loss. Subject to due written proof of loss, all accrued indemnities for loss for which this policy provides periodic payment will be paid _____ and any balance remaining unpaid upon the termination of liability will be paid immediately upon receipt of due written proof.

The insurer shall insert in the blank space in the provision in division (H) of this section a period for payment which must not be less frequently than monthly. The insurer may at its option omit from the provision in division (H) of this section ", or within thirty days after,".

(I) A provision as follows: Payment of claims. Indemnity for loss of life will be payable in accordance with the beneficiary designation and the provisions respecting such payment which may be prescribed herein and effective at the time

of payment. If no such designation or provision is then effective, such indemnity shall be payable to the estate of the insured. Any other accrued indemnities unpaid at the insured's death may, at the option of the insurer, be paid either to such beneficiary or to such estate. All other indemnities will be payable to the insured.

The insurer may at its option add at the end of the provision in division (I) of this section, the following provisions or either of the following provisions:

(1) If any indemnity of this policy shall be payable to the estate of the insured, or to an insured or beneficiary who is a minor or otherwise not competent to give a valid release, the insurer may pay such indemnity, up to an amount not exceeding _____ dollars, to any relative by blood or connection by marriage of the insured or beneficiary who is deemed by the insurer to be equitably entitled thereto. Any payment made by the insurer in good faith pursuant to this provision shall fully discharge the insurer to the extent of such payment.

(2) Subject to any written direction of the insured in the application or otherwise all or a portion of any indemnities provided by this policy on account of hospital, nursing, medical, or surgical services may, at the insurer's option and unless the insured requests otherwise in writing not later than the time of filing proofs of such loss, be paid directly to the hospital or person rendering such services; but it is not required that the services be rendered by a particular hospital or person.

The insurer shall insert in the blank space in the policy provision in division (I)(1) of this section an amount which

shall not exceed one thousand dollars.

(J) A provision as follows: Physical examination and autopsy. The insurer at its own expense shall have the right and opportunity to examine the person of the insured when and as often as it may reasonably require during the pendency of a claim hereunder and to make an autopsy in case of death where it is not forbidden by law.

(K) A provision as follows: Legal actions. No action at law or in equity shall be brought to recover on this policy prior to the expiration of sixty days after written proof of loss has been furnished in accordance with the requirements of this policy. No such action shall be brought after the expiration of three years after the time written proof of loss is required to be furnished.

(L) A provision as follows: Change of beneficiary. Unless the insured makes an irrevocable designation of beneficiary, the right to change of beneficiary is reserved to the insured and the consent of the beneficiary or beneficiaries shall not be requisite to surrender or assignment of this policy or to any change of beneficiary or beneficiaries, or to any other changes in this policy.

The insurer may at its option omit from the provision in division (L) of this section the following: Unless the insured makes an irrevocable designation of beneficiary.

(M) A provision, which shall be contained in the policy or in an indorsement thereon or in a rider attached thereto, as follows: Cancellation by the insured. Non-cancellation by the insurer. The insured may cancel this policy at any time by written notice delivered or mailed to the insurer, effective

upon receipt or on such later date as may be specified in such notice. In the event of cancellation, the insurer will return promptly the unearned portion of any premium paid. The earned premium shall be computed by the use of the short-rate table last filed with the state official having supervision of insurance in the state where the insured resided when this policy was issued. Cancellation shall be without prejudice to any claim originating prior to the effective date of cancellation. The insurer may not cancel this policy. This provision nullifies any other provision, contained in this policy or in any indorsement hereon or in any rider attached hereto, which provides for cancellation of this policy by the insurer or by the insured.

Sec. 3923.53. (A) Every public employee benefit plan that is established or modified in this state shall provide benefits for the expenses of both of the following:

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

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

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

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

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

(a) One screening mammography every two years;

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

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

(C) As used in this division, "medicare reimbursement rate" means the reimbursement rate paid in this state under the medicare program for screening mammography that does not include digitization or computer-aided detection, regardless of whether the actual benefit includes digitization or computer-aided detection.

(1) Subject to divisions (C)(2) and (3) of this section, if a provider, hospital, or other health care facility provides a service that is a component of the screening mammography benefit in division ~~(B)~~ (A)(1) of this section and submits a separate claim for that component, a separate payment shall be made to the provider, hospital, or other health care facility in an amount that corresponds to the ratio paid by medicare in this state for that component.

(2) Regardless of whether separate payments are made for the benefit provided under division (A)(1) of this section, the total benefit for a screening mammography shall not exceed one hundred thirty per cent of the medicare reimbursement rate in this state for screening mammography. If there is more than one medicare reimbursement rate in this state for screening mammography or a component of a screening mammography, the reimbursement limit shall be one hundred thirty per cent of the lowest medicare reimbursement rate in this state.

(3) The benefit paid in accordance with division (C)(1) of

this section shall constitute full payment. No provider, hospital, or other health care facility shall seek or receive compensation in excess of the payment made in accordance with division (C)(1) of this section, except for approved deductibles and copayments.

(D) The benefits provided under division (A)(1) of this section shall be provided only for screening mammographies that are performed in a facility or mobile mammography screening unit that is accredited under the American college of radiology mammography accreditation program or in a hospital as defined in section 3727.01 of the Revised Code.

(E) The benefits provided under division (A)(2) of this section shall be provided only for cytologic screenings that are processed and interpreted in a laboratory certified by the college of American pathologists or in a hospital as defined in section 3727.01 of the Revised Code.

Sec. 3925.09. No insurance company shall own more than one fourth of the capital stock of a national bank, nor invest in or loan on the stocks and bonds, both included, of any railroad company, to an extent exceeding one fifth of its own capital and surplus, nor in the aggregate shall the investment in and loan on all railroad property exceed one fourth of its own capital and surplus. Not more than one half of its capital and surplus shall be loaned on mortgages of real estate, as provided in ~~sections~~ section 3925.05 of the Revised Code for the investment thereof, and not more than one tenth of the capital and surplus actually existing of such a company shall be invested in a single mortgage. The current market value of the evidences of indebtedness mentioned in this section, in which the accumulations or surplus money above the capital stock of an

insurance company may be loaned or invested, must be at all times during the continuance of the loans at least twenty per cent more than the sum loaned thereon.

Sec. 3927.08. Every insurance company other than a life insurance company, organized by act of congress or under the laws of another state or government, annually, at the time and in the form and manner required of similar companies organized under the laws of this state, shall file a statement of its condition and affairs in the office of the superintendent of insurance. A company organized under or incorporated by a foreign government shall also furnish a supplementary statement for the year ending on the preceding thirty-first day of December, verified by the oath of the manager of such company residing in the United States, which shall comprise a report of its business and affairs in the United States, as required from companies organized in this state, together with any other information that may be required by the superintendent. If such annual statement is satisfactory evidence to the superintendent of the solvency and ability of the company to meet all its engagements at maturity, and that the deposit is maintained as provided by section 3927.06 of the Revised Code, the superintendent shall issue, during the month of January in each year or within sixty days thereafter, renewal certificates of authority to the ~~agent~~ agents of the company, certified copies of which shall be filed in the county recorder's office of each county in which an agency is located and retained therewith for a minimum of two years from the date of filing. Such certificates shall be the authority for such agents to issue new policies in this state for the ensuing year.

Sec. 3929.04. In case of the death of any employee by reason of the wrongful or negligent acts of ~~his~~ the employee's

employer, or negligence or wrongful acts for which said employer is liable, the personal representative of the deceased employee has all the rights and remedies that the employee would have had under ~~section~~ section 3929.03 of the Revised Code had death not resulted.

Sec. 3930.10. There shall be no liability imposed on the part of and no cause of action of any nature arises against the Ohio commercial insurance joint underwriting association, its members, board of governors, agents, or employees, an insurer or its employees, any licensed agent or broker, or the superintendent of insurance ~~of his~~ or the superintendent's authorized representatives, their members or employees, for any action taken by them in the performance of their powers and duties under sections 3930.03 to 3930.17 of the Revised Code. Any reports and communications in connection therewith are not public records.

Sec. 3931.03. The attorney under section 3931.01 of the Revised Code shall file with the superintendent of insurance a declaration, verified by ~~his~~ the attorney's oath, or, when the attorney is a corporation, by the oath of its authorized officers, setting forth:

(A) The name of the attorney and the name or designation under which such contracts are issued, which name or designation shall not be so similar to any other name or designation previously adopted by an attorney, or by any insurance organization in the United States, prior to the adoption of such name or designation by the attorney, as to confuse or deceive, unless such other attorney or organization consents thereto in writing;

(B) The location of the principal office;

(C) The kind of insurance to be effected;

(D) A copy of each form of policy, contract, or agreement under or by which such insurance is to be effected;

(E) A copy of the form of power of attorney under which such insurance is to be effected;

(F) The fact that applications have been made for indemnity upon at least seventy-five separate risks, aggregating not less than one and one-half million dollars, represented by executed contracts or bona fide applications to become concurrently effective;

(G) The fact that there is in the ~~possesison~~ possession of such attorney net assets of not less than three hundred thousand dollars, available for the payment of losses;

(H) A financial statement in the form prescribed for the annual statement;

(I) The instrument authorizing service of process as provided for in section 3931.04 of the Revised Code;

(J) A certificate showing compliance with the deposit requirements, if any, applicable to a mutual insurance company authorized to do the kind or kinds of insurance to be effected;

(K) A copy of all bylaws, codes of regulations, any other document wherein the relationships between the subscribers and between the subscribers and the attorney are set forth, and any amendments to any of the foregoing. Any filing made pursuant to this division shall become effective thirty days from the date of filing, unless disapproved by the superintendent. Any action taken by the superintendent under this division may be appealed pursuant to Chapter 119. of the ~~Reviesd~~ Revised Code.

This division does not apply to filings required pursuant to Chapters 3935. and 3937. of the Revised Code.

Sec. 3931.99. ~~(A)~~ Whoever violates sections 3931.01 to 3931.12, inclusive, of the Revised Code, or fails to comply with any duty imposed ~~upon him~~ by such sections, for which violation or failure no penalty is otherwise provided by law, shall be fined not more than five hundred dollars.

Sec. 3941.46. Any foreign or alien mutual company licensed in this state which is a party to a merger or consolidation shall on or before the effective date thereof file with the superintendent a copy of the agreement. If the surviving company is, at the effective date of the merger or consolidation, licensed as an insurer in this state its license shall continue in effect as though no merger or consolidation had taken place, and on request the superintendent shall transfer to it any additional licenses issued by this state and then held by any nonsurviving insurer which is a party to the merger or consolidation. Revocation or suspension of any of such licenses shall be made only pursuant to the procedures and on the grounds provided in this code, provided, that an additional ground for revocation or suspension of license shall be that the merger or consolidation may ~~save~~ have the effect of substantially lessening competition or tending to create a monopoly as to any line of insurance in this state. On receipt of a copy of the agreement of merger or consolidation to which this section applies, the superintendent shall determine whether such revocation or suspension proceedings should be commenced. In making such determination the superintendent may consider any information on file with any agency, division or department of this or any other state, together with any additional relevant information which shall be furnished by the company or

companies, pursuant to ~~his~~ the superintendent's request. A determination that the merger or consolidation does not violate the additional ground provided in this section shall be conclusively established by the lapse of three months after the effective date of the merger or consolidation without commencement of proceedings to revoke or suspend the license or licenses on that ground.

Sec. 3951.04. The superintendent of insurance shall issue certificates of authority to any person, firm, association, partnership, or corporation making application therefor who is trustworthy and competent to act as a public insurance adjuster in such manner as to safeguard the interest of the public and who ~~have~~ has complied with the prerequisites herein described. A certificate of authority issued to a firm, association, partnership, or corporation shall authorize only the members of the firm, association, or partnership or the officers and directors of the corporation, specified in the certificate of authority to act as a public insurance adjuster.

The superintendent shall not issue any certificate of authority to any applicant who is convicted of a felony, or any crime or offense involving fraudulent or dishonest practice or who, within three years preceding the date of filing such application, has been guilty of any practice which would be grounds for suspension or revocation of a certificate of authority as a public insurance adjuster.

Sec. 3951.10. On receipt of a notice pursuant to section 3123.43 of the Revised Code, the superintendent of insurance shall comply with sections 3123.41 to 3123.50 of the Revised Code and any applicable rules adopted under section 3123.63 of the Revised Code with respect to a certificate issued ~~issued~~

pursuant to this chapter.

Sec. 3953.14. (A) Except as provided in Chapter 3953. of the Revised Code the investments of a title insurance company shall be governed by sections 3925.05 to 3925.21~~, inclusive,~~ of the Revised Code.

(B) Provided it shall at all times keep at least one hundred thousand dollars invested in the classes of securities authorized for the investment of capital other than title plant and real estate as provided in division (C) of this section, a title insurance company may invest not more than ten per cent of its admitted assets in a title plant without the prior approval of the superintendent. The title plant shall be considered an admitted asset at the fair value thereof. In determining the fair value of a title plant, no value shall be attributed to furniture and fixtures, and the real estate in which the title plant is housed shall be carried as real estate. The value of title abstracts, title briefs, copies of conveyances or other documents, indices, and other records comprising the title plant, shall be determined by considering the expenses incurred in obtaining them, the age thereof, the cost of replacements less depreciation, and all other relevant factors. Once the value of a title plant has been determined, such value may be increased only by the acquisition of another title plant by purchase, consolidation, or merger; in no event shall the value of the title ~~plan~~ plant be increased by additions made thereto as part of the normal course of abstracting and insuring titles to real estate. Subject to the above limitations and with the approval of the superintendent of insurance, a title insurance company may enter into agreements with one or more other title insurance companies authorized to do business in this state, whereby such companies shall participate in the ownership,

management, and control of a title plant to service the needs of all such companies or such companies may hold stock of a corporation owning and operating a title plant for such purposes; provided that each of the companies participating in the ownership, management, and control of such jointly owned title plant shall keep the sum of one hundred thousand dollars invested as above set forth.

(C) Any title insurance company may purchase, receive, hold, and convey real estate or any interest therein:

(1) Required for its convenient accommodation in the transaction of its business with reasonable regard to future needs;

(2) Acquired in connection with a claim under a policy of title insurance;

(3) Acquired in satisfaction or on account of loans, mortgages, liens, judgments, or decrees, previously owing to it in the course of its business;

(4) Acquired in part payment of the consideration of the sale of real property owned by it if the transaction results in a net reduction in the company's investment in real estate;

(5) Reasonably necessary for the purpose of maintaining or enhancing the sale value of real property previously acquired or held by it under ~~subdivisions~~ division (C)(1), (2), (3), or (4) of this ~~division~~ section.

Sec. 3956.01. As used in this chapter:

(A) "Account" means either of the two accounts created under section 3956.06 of the Revised Code.

(B) "Contractual obligation" means any obligation under a

policy, contract, or certificate under a group policy or contract, or portion of the policy or contract, for which coverage is provided under section 3956.04 of the Revised Code.

(C) "Covered policy or contract" means any policy, contract, or group certificate within the scope of section 3956.04 of the Revised Code.

(D) "Impaired insurer" means a member insurer that, after November 20, 1989, is not an insolvent insurer and is placed under an order of rehabilitation or conservation by a court of competent jurisdiction.

(E) "Insolvent insurer" means a member insurer that, after November 20, 1989, is placed under an order of liquidation by a court of competent jurisdiction with a finding of insolvency.

(F)(1) "Member insurer" means any insurer that holds a certificate of authority or is licensed to transact in this state any kind of insurance for which coverage is provided under section 3956.04 of the Revised Code, and includes any insurer whose certificate of authority or license in this state may have been suspended, revoked, not renewed, or voluntarily withdrawn after November 20, 1989.

(2) "Member insurer" does not include any of the following:

(a) A health insuring corporation;

(b) A fraternal benefit society;

(c) A self-insurance or joint self-insurance pool or plan of the state or any political subdivision of the state;

(d) A mutual protective association;

(e) An insurance exchange;

(f) Any person who qualifies as a "member insurer" under section 3955.01 of the Revised Code and who does not receive premiums on covered policies or contracts;

(g) Any entity similar to any of those described in divisions (F)(2)(a) to (f) of this section.

(3) "Member insurer" includes any insurer that operates any of the entities described in division (F)(2) of this section as a line of business, and not as a separate, affiliated legal entity, and otherwise qualifies as a member insurer.

(G) "Premiums" means amounts received on covered policies or contracts, less premiums, considerations, and deposits returned on the policies or contracts, and less dividends and experience credits on the policies and contracts. "Premiums" does not include either of the following:

(1) Any amounts in excess of one million dollars received on any unallocated annuity contract not issued under a governmental retirement plan established under Section 401, 403(b), or 457 of the "Internal Revenue Code of 1986," 100 Stat. 2085, 26 U.S.C.A. 1, as amended;

(2) Any amounts received for any policies or contracts or for the portions of any policies or contracts for which coverage is not provided under section 3956.04 of the Revised Code. Division (G)(2) of this section shall not be construed to require the exclusion, from assessable premiums, of premiums paid for coverages in excess of the interest limitations specified in division (B)(2)(c) of section 3956.04 of the Revised Code or of premiums paid for coverages in excess of the limitations with respect to any one individual, any one

participant, or any one contract holder specified in division (C)(2) of section 3956.04 of the Revised Code.

(H) "Resident" means any person who resides in this state at the time a member insurer is determined to be an impaired or insolvent insurer and to whom a contractual obligation is owed. A person may be a resident of only one state, which, in the case of a person other than a natural person, shall be its principal place of business. Citizens of the United States who are either residents of a foreign country or residents of a United States possession, territory, or protectorate that does not have an association similar to the association created by this chapter shall be considered residents of the state of domicile of the insurer that issued the policy or contract.

(I) "Structured settlement annuity" means an annuity purchased in order to fund periodic payments for a plaintiff or other claimant in payment for or with respect to personal injury suffered by the plaintiff or other claimant.

(J) "Subaccount" means any of the three subaccounts created under division (A) of section 3956.06 of the Revised Code.

(K) "Supplemental contract" means any agreement entered into for the distribution of policy or contract proceeds.

~~(K)~~(L) "Unallocated annuity contract" means any annuity contract or group annuity certificate that is not issued to and owned by an individual, except to the extent of any annuity benefits guaranteed to an individual by an insurer under that contract or certificate.

Sec. 3959.01. As used in this chapter:

(A) "Administration fees" means any amount charged a

covered person for services rendered. "Administration fees" includes commissions earned or paid by any person relative to services performed by an administrator.

(B) "Administrator" means any person who adjusts or settles claims on, residents of this state in connection with life, dental, health, prescription drugs, or disability insurance or self-insurance programs. "Administrator" includes a pharmacy benefit manager. "Administrator" does not include any of the following:

(1) An insurance agent or solicitor licensed in this state whose activities are limited exclusively to the sale of insurance and who does not provide any administrative services;

(2) Any person who administers or operates the workers' compensation program of a self-insuring employer under Chapter 4123. of the Revised Code;

(3) Any person who administers pension plans for the benefit of the person's own members or employees or administers pension plans for the benefit of the members or employees of any other person;

(4) Any person that administers an insured plan or a self-insured plan that provides life, dental, health, or disability benefits exclusively for the person's own members or employees;

(5) Any health insuring corporation holding a certificate of authority under Chapter 1751. of the Revised Code or an insurance company that is authorized to write life or sickness and accident insurance in this state.

(C) "Aggregate excess insurance" means that type of coverage whereby the insurer agrees to reimburse the insured employer or trust for all benefits or claims paid during an

agreement period on behalf of all covered persons under the plan or trust which exceed a stated deductible amount and subject to a stated maximum.

(D) "Contracted pharmacy" or "pharmacy" means a pharmacy located in this state participating in either the network of a pharmacy benefit manager or in a health care or pharmacy benefit plan through a direct contract or through a contract with a pharmacy services administration organization, group purchasing organization, or another contracting agent.

(E) "Contributions" means any amount collected from a covered person to fund the self-insured portion of any plan in accordance with the plan's provisions, summary plan descriptions, and contracts of insurance.

(F) "Drug product reimbursement" means the amount paid by a pharmacy benefit manager to a contracted pharmacy for the cost of the drug dispensed to a patient and does not include a dispensing or professional fee.

(G) "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.

(H) "Fiscal year" means the twelve-month accounting period commencing on the date the plan is established and ending twelve months following that date, and each corresponding twelve-month accounting period thereafter as provided for in the summary plan description.

(I) "Insurer" means an entity authorized to do the business of insurance in this state or, for the purposes of this section, a health insuring corporation authorized to issue health care plans in this state.

(J) "Managed care organization" means an entity that provides medical management and cost containment services and includes a medicaid managed care organization, as defined in section 5167.01 of the Revised Code.

(K) "Maximum allowable cost" means a maximum drug product reimbursement for an individual drug or for a group of therapeutically and pharmaceutically equivalent multiple source drugs that are listed in the United States food and drug administration's approved drug products with therapeutic equivalence evaluations, commonly referred to as the orange book.

(L) "Maximum allowable cost list" means a list of the drugs for which a pharmacy benefit manager imposes a maximum allowable cost.

(M) "Multiple employer welfare arrangement" has the same meaning as in section 1739.01 of the Revised Code.

(N) "Pharmacy benefit manager" means an entity that contracts with pharmacies on behalf of an employer, a multiple employer welfare arrangement, public employee benefit plan, state agency, insurer, managed care organization, or other third-party payer to provide pharmacy health benefit services or administration. "Pharmacy benefit manager" includes the state pharmacy benefit manager selected under section 5167.24 of the Revised Code.

(O) "Plan" means any arrangement in written form for the payment of life, dental, health, or disability benefits to covered persons defined by the summary plan description and includes a drug benefit plan administered by a pharmacy benefit manager.

(P) "Plan sponsor" means the person who establishes the plan.

(Q) "Self-insurance program" means a program whereby an employer provides a plan of benefits for its employees without involving an intermediate insurance carrier to assume risk or pay claims. "Self-insurance program" includes but is not limited to employer programs that pay claims up to a prearranged limit beyond which they purchase insurance coverage to protect against unpredictable or catastrophic losses.

(R) "Specific excess insurance" means that type of coverage whereby the insurer agrees to reimburse the insured employer or trust for all benefits or claims paid during an agreement period on behalf of a covered person in excess of a stated deductible amount and subject to a stated maximum.

(S) "Summary plan description" means the written document adopted by the plan sponsor which outlines the plan of benefits, conditions, limitations, exclusions, and other pertinent details relative to the benefits provided to covered persons thereunder.

(T) "Third-party payer" has the same meaning as in section 3901.38 of the Revised Code.

Sec. 3960.07. (A) No purchasing group shall conduct business in this state unless it has done both of the following:

(1) Issued a notice to the superintendent of insurance that does all of the following:

(a) Identifies the state in which the purchasing group is domiciled and all other states in which the group intends to do business;

(b) Specifies the lines and classifications of liability

insurance that the purchasing group intends to purchase and specifies the method by which and the person or persons, if any, through whom insurance will be offered to its members whose risks are resident or located in this state;

(c) Identifies the name and domicile of the insurance company from which the purchasing group intends to purchase its insurance;

(d) Identifies the principal place of business of the purchasing group;

(e) Provides any other information that the superintendent may require to verify that the purchasing group is qualified under division (I) of section 3960.01 of the Revised Code.

A purchasing group, within ten days, shall notify the superintendent of any changes in any of the items set forth in division (A)(1) this section.

(2) Registered with the superintendent, paid a filing fee as determined by the superintendent, and consented to the exercise of jurisdiction over it by the superintendent and the courts of this state. The fee shall be paid into the state treasury to the credit of the department of insurance operating fund pursuant to section 3901.021 of the Revised Code.

Division (A)(2) of this section does not apply to a purchasing group to which all of the following apply:

(a) It was domiciled in any state before April 1, 1986, and on and after October 27, 1986;

(b) It purchased insurance from an insurance carrier licensed in any state before and after October 27, 1986;

(c) It was a purchasing group meeting the requirements of

the federal "Product Liability Risk Retention Act of 1981," 95 Stat. 949, 15 U.S.C.A. 3901, before October 27, 1986;

(d) It does not purchase insurance that was not authorized for purposes of an exemption under that act, as in effect before October 27, 1986.

(B) Each purchasing group that is required to give notice pursuant to division (A)(1) of this section also shall furnish any information that may be required by the superintendent to do both of the following:

(1) Determine where the purchasing group is located;

(2) Determine appropriate tax treatment.

(C) ~~Within thirty days after the effective date of this section, any purchasing group that was doing business in this state prior to the enactment of this section shall furnish notice to the superintendent pursuant to division (A)(1) of this section and furnish any information that may be required pursuant to division (B) of this section.~~

~~(D)~~ Sections 3937.01 to 3937.17 of the Revised Code apply to admitted insurers that provide insurance to purchasing groups.

Sec. 3964.19. (A) As used in sections 3964.19 to 3964.194 of the Revised Code:

(1) "Counterparty" means a special purpose financial captive insurance company's parent or an affiliated entity that is an insurer domiciled in this state that cedes life insurance risks to the special purpose financial captive insurance company pursuant to a special purpose financial captive insurance company contract.

(2) "Insolvency" or "insolvent" means that the special purpose financial captive insurance company is unable to pay its obligations when they are due, unless those obligations are the subject of a bona fide dispute.

(3) "Insurance securitization" means a package of related risk transfer instruments, capital market offerings, and facilitating administrative agreements, for which a special purpose financial captive insurance company obtains proceeds, either directly or indirectly, through the issuance of securities, where the investment risk to the holders of the securities is contingent upon the obligations of the special purpose financial captive insurance company to the counterparty under the special purpose financial captive insurance company contract, in accordance with the transaction terms, and pursuant to this section. This includes situations where the securitization proceeds are held in trust to secure the obligations of the special purpose financial captive insurance company under one or more special purpose financial captive insurance company contracts.

(4) "Organizational document" means the special purpose financial captive insurance company's articles of incorporation, bylaws, code of regulations, operating agreement, or other foundational documents that establish the special purpose financial captive insurance company as a legal entity.

(5) "Securities" means debt obligations, equity investments, surplus certificates, surplus notes, funding agreements, derivatives, and other legal forms of financial instruments.

(6) "Special purpose financial captive insurance company contract" means a contract between a special purpose financial

captive insurance company and a counterparty pursuant to which the special purpose financial captive insurance company agrees to provide insurance or reinsurance protection to the counterparty for risks associated with the counterparty's insurance or reinsurance business, and includes a contract entered into under division (F) of this section.

(7) "Special purpose financial captive insurance company securities" means the securities issued by a special purpose financial captive insurance company.

(B) The requirements of this section shall not apply to a specific special purpose financial captive insurance company if the superintendent finds a specific requirement is inappropriate due to the nature of the risks to be insured by the special purpose financial captive insurance company and if the special purpose financial captive insurance company meets the criteria established by rules and regulations adopted and promulgated by the superintendent.

(C)(1) A special purpose financial captive insurance company may not issue a contract for assumption of risk or indemnification of loss other than a special purpose financial captive insurance company contract. However, the special purpose financial captive insurance company may cede a risk assumed through a special purpose financial captive insurance company contract to a third-party reinsurer through the purchase of reinsurance or retrocession protection if approved by the superintendent.

(2) A special purpose financial captive insurance company may enter into contracts and conduct other commercial activities related or incidental to and necessary to fulfill the purposes of special purpose financial captive insurance company

contracts, insurance securitization, and this section. Those activities may include:

(a) Entering into special purpose financial captive insurance company contracts;

(b) Issuing securities of the special purpose financial captive insurance company in accordance with applicable securities law;

(c) Complying with the terms of special purpose financial captive insurance company contracts or securities;

(d) Entering into trust, swap, tax, administration, reimbursement, or fiscal agent transactions;

(e) Complying with trust indenture, reinsurance, retrocession, and other agreements necessary or incidental to effectuate an insurance securitization in compliance with this section and in the plan of operation considered by the superintendent under division (F)(5) of section 3964.03 of the Revised Code.

(D)(1) A special purpose financial captive insurance company may issue securities, subject to and in accordance with applicable law, its plan of operation considered by the superintendent under division (E) of section 3964.03 of the Revised Code, and its organizational documents.

(2) A special purpose financial captive insurance company, in connection with the issuance of securities, may enter into and perform all of its obligations under any required contracts to facilitate the issuance of these securities.

(3) The obligation to repay principal or interest, or both, on the securities issued by the special purpose financial

captive insurance company shall reflect the risk associated with the obligations of the special purpose financial captive insurance company to the counterparty under the special purpose financial captive insurance company contract.

(E)(1)(a) A special purpose financial captive insurance company may enter into ~~asset~~ the following types of transactions for the purposes described in division (E)(1)(b) of this section:

(i) Asset management agreements, including swap agreements~~, guaranteed~~;

(ii) Guaranteed investment contracts~~, or other~~;

(iii) Other transactions with the objective of reducing timing differences in the funding of upfront, or ongoing, transaction expenses, or managing asset, credit, prepayment, or interest rate risk of the investments of the special purpose financial captive insurance company ~~to~~ .

(b) The purpose of the transactions described in division (E)(1)(a) of this section shall be any of the following:

(i) To ensure that the investments are sufficient to assure payment or repayment of the securities, and related interest or principal payments, issued pursuant to a special purpose financial captive insurance company insurance securitization transaction ~~or the~~;

(ii) To ensure that the investments are sufficient to assure payment or repayment of the obligations required under a special purpose financial captive insurance company contract ~~or for any~~;

(iii) Any other purpose approved by the superintendent.

(2) An asset management agreement shall not be entered into under this section by a special purpose financial captive insurance company unless it has been approved by the superintendent.

(F)(1) If a special purpose financial captive insurance company has entered into a special purpose financial captive insurance company contract with a counterparty and the special purpose financial captive insurance company has conducted an insurance securitization that is made up, in part or in whole, of the risks of that contract, then the special purpose financial captive insurance company may enter into a second contract with the counterparty under which the counterparty is held liable for those losses or other obligations that were securitized.

(2) Such obligations may be funded and secured with assets held in trust for the benefit of the counterparty pursuant to agreements contemplated by this section and invested in a manner that meet the criteria in sections 3907.14 and 3907.141 of the Revised Code.

(G)(1) A special purpose financial captive insurance company may enter into agreements with affiliated companies and third parties and conduct business necessary to fulfill its obligations and administrative duties incidental to an insurance securitization and a special purpose financial captive insurance company contract entered into under division (F) of this section.

(2) The agreements may include management and administrative services agreements and other allocation and cost sharing agreements, or swap and asset management agreements, or both, or agreements for other contemplated types of transactions

provided in this section.

(H) A special purpose financial captive insurance company contract entered into under division (F) of this section shall contain all of the following:

(1) A requirement that the special purpose financial captive insurance company do either of the following:

(a) Enter into a trust agreement specifying what recoverables or reserves, or both, the agreement is to cover and to establish a trust account for the benefit of the counterparty and the security holders;

(b) Establish such other methods of security acceptable to the superintendent.

(2) A stipulation that assets deposited in the trust account shall be valued in accordance with their current fair-market value and shall consist only of investments permitted by sections 3907.14 and 3907.141 of the Revised Code;

(3) A requirement that, if a trust arrangement is used, the special purpose financial captive insurance company, before depositing assets with the trustee, execute assignments, execute endorsements in blank, or take such actions as are necessary to transfer legal title to the trustee of all assets requiring assignment, in order that the counterparty, or the trustee upon the direction of the counterparty, may negotiate whenever necessary the assets without consent or signature from the special purpose financial captive insurance company or another entity;

(4) A stipulation that, if a trust arrangement is used, the special purpose financial captive insurance company and the counterparty agree that the assets in the trust account

established pursuant to the contract:

(a) May be withdrawn by the counterparty, or the trustee on its behalf, at any time, but only in accordance with the terms of the contract;

(b) Shall be utilized and applied by the counterparty, without diminution because of insolvency on the part of the counterparty or the special purpose financial captive insurance company, only for the purposes set forth in the credit for reinsurance laws and rules of this state. As used in this division, "counterparty" includes any successor of the counterparty by operation of law, including, subject to the provisions of this section, but without further limitation, any liquidator, rehabilitator, or receiver of the counterparty.

(I) A special purpose financial captive insurance company contract entered into under division (F) of this section may contain provisions that give the special purpose financial captive insurance company the right to seek approval from the counterparty to withdraw from the trust all or part of the assets, or income from them, contained in the trust and to transfer the assets to the special purpose financial captive insurance company if such provisions comply with the credit for reinsurance laws and rules of this state.

(J)(1) A special purpose financial captive insurance company contract entered into under division (F) of this section, meeting the requirements of this section, shall be granted credit for reinsurance treatment or otherwise qualify as an asset or a reduction from liability for reinsurance ceded by a domestic insurer to a special purpose financial captive insurance company as an assuming insurer for the benefit of the counterparty if both of the following apply:

(a) The assets are held or invested in one or more of the forms allowed in sections 3907.14 and 3907.141 of the Revised Code.

(b) The agreement is in compliance with section 3901.64 of the Revised Code.

(2) The contract shall be granted credit or otherwise qualify as an asset or reduction from liability only to the extent of the value of the assets held in trust for, or letters of credit, that meet the requirements set forth in division (C) of section 3964.05 of the Revised Code, or as approved by the superintendent, for the benefit of the counterparty under the special purpose financial captive insurance company contract.

(K) A special purpose financial captive insurance company may make investments that meet the qualifications set forth in sections 3907.14 and 3907.141 of the Revised Code, however these investments shall not be subject to any limitations contained in such sections as to invested amounts. The superintendent may prohibit or limit any investment that threatens the solvency or liquidity of a special purpose financial captive insurance company or that is not made in accordance with the approved plan of operation.

Sec. 3999.16. No officer, director, trustee, agent, or employee of any insurance company, corporation, or association authorized to transact business in this state shall knowingly use underwriting standards or rates that result in unfair discrimination against any handicapped person. This section does not prevent reasonable classifications of handicapped ~~person~~ persons for determining insurance rates.

As used in this section, "handicapped" means a medically

diagnosable, abnormal condition which is expected to continue for a considerable length of time, whether correctable or uncorrectable by good medical practice, which can reasonably be expected to limit the person's functional ability, including but not limited to seeing, hearing, thinking, ambulating, climbing, descending, lifting, grasping, sitting, rising, any related function, or any limitation due to weakness or significantly decreased endurance, so that ~~he~~ the person cannot perform ~~his~~ the person's everyday routine living and working without significantly increased hardship and vulnerability to what are considered the everyday obstacles and hazards encountered by the nonhandicapped.

Section 2. That existing sections 167.03, 1751.32, 1751.74, 1751.84, 1753.31, 3901.045, 3901.45, 3901.811, 3901.87, 3902.08, 3903.01, 3903.52, 3903.56, 3903.71, 3903.724, 3903.728, 3903.7211, 3903.74, 3904.01, 3904.16, 3905.051, 3905.14, 3905.84, 3909.04, 3911.24, 3913.11, 3913.40, 3915.05, 3915.053, 3915.073, 3915.13, 3916.171, 3919.14, 3922.11, 3922.14, 3923.021, 3923.04, 3923.53, 3925.09, 3927.08, 3929.04, 3930.10, 3931.03, 3931.99, 3941.46, 3951.04, 3951.10, 3953.14, 3956.01, 3959.01, 3960.07, 3964.19, and 3999.16 of the Revised Code are hereby repealed.

Section 3. With the exception of amendments made to sections 167.03 and 3915.13 of the Revised Code, it is the intent of the General Assembly for the amendments made in this act to be nonsubstantive as provided in section 1.301 of the Revised Code.