As Reported by the Senate Insurance, Commerce and Labor Committee

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Sub. H. B. No. 341

Representative Henne

Cosponsors: Representatives Blair, Schuring, Stebelton, Hackett, Foley, Sears, Hottinger, Amstutz, Hagan, C., Hill, Murray, Thompson
Senators Hite, Beagle, Bacon

A B I L L

To amend sections 3903.81, 3907.14, 3921.10, 3921.13, 3921.19, 3921.22, 3921.28, 3921.29, 3921.30, 3921.31, 3921.33, 3922.01, 3922.02, 3922.03, 3922.04, 3922.05, 3922.06, 3922.09, 3922.10, 3922.11, 3922.14, 3922.15, 3922.16, 3922.19, and 3925.08, to enact new section 3921.35 and sections 3921.101 and 3921.191, and to repeal section 3921.35 of the Revised Code to make changes to the law regulating fraternal benefit societies, the laws regulating insurance company investments, and the law regulating adverse benefit determinations.

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

Section 1. That sections 3903.81, 3907.14, 3921.10, 3921.13, 3921.19, 3921.22, 3921.28, 3921.29, 3921.30, 3921.31, 3921.33, 3922.01, 3922.02, 3922.03, 3922.04, 3922.05, 3922.06, 3922.09, 3922.10, 3922.11, 3922.14, 3922.15, 3922.16, 3922.19, and 3925.08 be amended and new section 3921.35 and sections 3921.101 and 3921.191 of the Revised Code be enacted to read as follows:

Sec. 3903.81. As used in sections 3903.81 to 3903.93 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 3903.82 of the Revised Code.

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

(C) "Company action level RBC" means the product of 2.0 and an insurer's authorized control level RBC.

(D) "Corrective order" means an order issued by the superintendent of insurance in accordance with division (B)(3) of section 3903.84 of the Revised Code specifying corrective actions that the superintendent has determined are required.

(E) "Domestic insurer" means any insurance company organized under Chapter 3907. or 3925. of the Revised Code.

(F) "Foreign insurer" means any insurance company licensed under section 3909.01 or 3927.01 of the Revised Code.

(G) "Life or health insurer" means any insurance company licensed under section 3907.08 or 3909.01 of the Revised Code, ~~or~~ a company possessing a certificate of authority pursuant to section 3929.01 of the Revised Code that writes only accident and health insurance<u>, or a fraternal benefit society licensed under Chapter 3921. of the Revised Code</u>.

(H) "Mandatory control level RBC" means the product of .70 and an insurer's authorized control level RBC.

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

(J) "Negative trend" means a negative trend over a period of

time for a life or health insurer as determined in accordance with the trend test calculation included in the RBC instructions.

(K) "Property and casualty insurer" means any insurance company that has a certificate of authority pursuant to section 3929.01 of the Revised Code. "Property and casualty insurer" does not include monoline mortgage guarantee insurers, financial guarantee insurers, or title insurers.

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

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

(N) "RBC level" means an insurer's company action level RBC, regulatory action level RBC, authorized control level RBC, or mandatory control level RBC.

(O) "RBC plan" means a comprehensive financial plan containing the elements specified in division (B) of section 3903.83 of the Revised Code.

(P) "Revised RBC plan" means an RBC plan rejected by the superintendent of insurance and then revised by an insurer with or without incorporating the superintendent of insurance's recommendation.

(Q) "RBC report" means the report required by section 3903.82 of the Revised Code.

(R) "Regulatory action level RBC" means the product of 1.5 and an insurer's authorized control level RBC.

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

(1) An insurer's statutory capital and surplus as determined in accordance with the statutory accounting applicable to the annual statements prepared on a form adopted under section 3901.77 of the Revised Code, as required to be filed by sections 3907.19, 3909.06, and 3929.30 of the Revised Code;

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

Sec. 3907.14. The capital, surplus, and all accumulations of every domestic life insurance company shall be invested as follows:

(A) A domestic company may acquire, hold, and convey real estate:

(1) Which has been acquired or is acquired for its principal offices, or which is used in connection therewith, provided that it shall not invest more than five per cent of its admitted assets on the preceding thirty-first day of December in such real estate;

(2) Which has been mortgaged to it in good faith by way of security for loans previously contracted or for money due;

(3) Which has been conveyed to it in satisfaction of debts previously contracted in the course of its dealings, or which it may receive in or on account of an exchange for real estate acquired in its operations;

(4) Which it has purchased at sales under mortgages and on any legal process in connection with its investments or under decrees obtained or made for such debts;

(5) Which is acquired, owned, or held for the purpose of developing, improving, or otherwise utilizing such real estate for the production of income, without restriction or limitation as to time, and may acquire, lease, hold, and manage personal property used in connection therewith. No investments in real estate to be

used primarily for recreational, agricultural, or mining purposes shall be made under authority of division (A)(5) of this section and except for investments authorized under divisions (A)(1), (2), (3), and (4) of this section, no domestic life insurance company shall invest in real estate under divisions (A)(5) and (R) of this section a sum exceeding in the aggregate ten per cent of its admitted assets on the preceding thirty-first day of December.

All real estate specified in divisions (A)(3) and (4) of this section, which is not necessary for its accommodation in the convenient transaction of its business, shall be sold by the company and disposed of within five years after it has acquired the title to such real estate or within five years after such real estate has ceased to be necessary for the accommodation of its business, unless the company procures the certificate of the superintendent of insurance that its interests will suffer materially by a forced sale of the real estate, in which event the time for the sale may be extended to such time as the superintendent directs in such certificate.

(B) A domestic company may acquire, hold, and convey tangible personal property or interests therein for the production of income, provided no domestic company shall invest in excess of two per cent of its admitted assets as of the preceding thirty-first day of December under this division.

(C) In loans and liens upon the security of its own policies, not exceeding the reserve or present value of the policies, computed according to any standard authorized by law or according to such higher standard as the company has adopted and maintains on the policy, the reserve being the amount of debts of the life insurance company by reason of its outstanding policies in gross, which may be so treated in the returns for taxation made by it;

(D) In bankers' acceptances and bills of exchange of the kinds and maturities made eligible by law for rediscount with

federal reserve banks, provided that such acceptances and bills of exchange are accepted by a bank or trust company incorporated under the laws of the United States or of this state or any other bank or trust company which is a member of the federal reserve system;

(E) In equipment trust obligations or certificates, security agreements, or other evidences of indebtedness entered into directly or guaranteed by any company operating wholly or partly within the United States or Canada, provided that the debt obligation is secured by a first lien on tangible personal property which is purchased or secured for payment thereof and the debt obligation is repayable within twenty years from the date of issue in annual, semiannual, or more frequent installments beginning not later than the first year after such date;

(F) In bonds issued by or for federal land banks and any debentures issued by or for federal intermediate credit banks under the "Federal Farm Loan Act of 1916," 39 Stat. 360, 12 U.S.C.A. 641 as amended; any debentures issued by or for banks for cooperatives under the "Farm Credit Act of 1933," 48 Stat. 257, 12 U.S.C.A. 131 as amended;

(G) In bonds issued under the "Home Owners' Loan Act of 1933," 48 Stat. 128, 12 U.S.C.A. 1461;

(H) In notes, bonds, debentures, or other such obligations issued by the federal housing administrator;

(I)(1)(a) In bonds or other evidences of indebtedness, not in default as to principal or interest, which are valid obligations issued, assumed or guaranteed by the United States, by any state thereof, by the Commonwealth of Puerto Rico, by any territory or insular possession of the United States, or by the District of Columbia, or which are valid obligations issued, assumed, or guaranteed by any county, municipal corporation, district, or

political subdivision, or by any civil division or public instrumentality of such governmental units, if by statutory or other legal requirements such obligations are payable, as to both principal and interest, from taxes levied upon all taxable property within the jurisdiction of such governmental unit;

(b) In bonds or other obligations issued by or for account of any such governmental unit having a population of five thousand or more by the latest official federal or state census, which are payable as to both principal and interest from revenues or earnings from the whole or any part of a publicly owned utility supplying water, gas, sewage disposal facility, or electricity, or any or all of them, provided that by statute or other applicable legal requirements, rates from the service or operation of such utility must be fixed, maintained, and collected at all times so as to produce sufficient revenues or earnings to pay both principal and interest of such bonds or obligations as they become due;

(c) In any bonds or obligations payable from and secured by revenues of the United States, the Commonwealth of Puerto Rico, or any state or instrumentality of any of them, or of the District of Columbia or of any commission, board, or other instrumentality of one or more of them, provided there is a specific pledge of revenues, and provided that there is adequate provision for payment of interest prior to completion of construction and that rates, fees, tolls, or charges fixed are, after completion of construction, sufficient to pay all expenses of operation and maintenance and the principal and interest when due.

(2) In legally authorized and executed bonds, notes, warrants, and securities which are the direct obligation of or are guaranteed by Canada, or which are the direct obligation of or are guaranteed as to both principal and interest by any province of Canada, or which are the direct obligation of or are guaranteed as

to both principal and interest by any municipality of Canada having a population of fifty thousand or more by the latest official census, and which are not in default as to principal or interest;

(3) In bonds or other evidence of indebtedness, not in default as to principal or interest, which are valid obligations issued, assumed, or guaranteed by the United States, by any state thereof, the Commonwealth of Puerto Rico, or by the District of Columbia, if by statutory or other legal requirements such obligations are payable, as to both principal and interest, from selective taxes levied by such governmental unit.

(J)(1) In mortgage bonds which are the direct obligation of a railroad, and which are the first lien on a substantial portion of its property, situated wholly in the United States or partly in the United States and partly in Canada, the average net yearly earnings of which, after deducting proper charges for maintenance of way and equipment, for the five fiscal years preceding such investments, have been at least one and one-half times the average yearly interest for the same period on its mortgages, bonds, and funded debts, and in the junior mortgage bond issues of such railroad corporations of the same character and under the same conditions where the average net yearly earnings for the five fiscal years preceding such investment, after deducting proper charges for maintenance of way and equipment, have been at least three times the average yearly interest charges on such issues and all prior liens; or in the mortgage bonds of any incorporated railroad company which have been assumed or guaranteed, both as to principal and interest, by any incorporated railroad company whose bonds constitute a legal investment under division (J)(1) of this section. In applying the earnings test to any issuing, assuming, or guaranteeing company, whether or not in legal existence during the whole of such five years next preceding the date of investment

by such insurer, which has at any time during such five-year period acquired the assets of any other company by purchase, merger, consolidation, or otherwise, substantially as an entirety, or has been reorganized pursuant to the bankruptcy law, the earnings of such other predecessor or constituent companies, or of the company so reorganized, available for interest for such portion of such period that has preceded such acquisition, or such reorganization, may be included in the earnings of such issuing, assuming, or guaranteeing company for such portion of such period as is determined in accordance with adjusted or pro forma consolidated earnings statements covering such portion of such period. In such cases the requirements as to earnings shall be based upon the mortgages, bonds, and funded debts as they exist immediately after such acquisitions or such reorganizations.

(2) In mortgage bonds or other interest-bearing obligations of terminal companies organized under the laws of the United States or any state thereof, provided such bonds or obligations have been assumed or guaranteed jointly or severally by two or more railroad corporations whose bonds constitute legal investments under division (J)(1) of this section;

(3) In loans to veterans guaranteed in whole or in part by the United States pursuant to Title III of the "Servicemen's Readjustment Act of 1944," 58 Stat. 284, 38 U.S.C.A. 693, as amended, provided such guaranteed loans are liens upon real estate;

(4) In mortgage bonds which are the direct obligation of and first lien upon the property of a corporation engaged directly and primarily in the production and sale of, or in the purchase and sale of electricity or gas, or in the operation of telephone or telegraph systems or waterworks, or in some combination of them, and situated wholly in the United States, or the Commonwealth of Puerto Rico, or partly in the United States and partly in Canada,

the average net yearly earnings of which, after deducting proper charges for replacements, depreciation, and obsolescence, for the five fiscal years preceding such investment, have been at least one and one-half times the average yearly interest for the same period on its mortgages, bonds, and funded debts;

(5) Any such corporation, or any of its predecessors, constituent, or successor corporations, must have been in business not less than ten years prior to the date of the purchase of such bonds, and must not have defaulted on the interest or principal of any of its bonds or funded debts outstanding during the five years immediately preceding the date of purchase, provided that division (J)(5) of this section does not preclude investments in mortgage bonds of railroads reorganized through purchase of assets, merger, consolidation, bankruptcy proceedings, or otherwise if such bonds are eligible for investment under division (J)(1) of this section;

(6) No investment shall be made under division (J)(1), (2), (4), or (5) of this section if such railroad or other utility corporation and its business, and its issue of bonds, funded debts, and stocks are not under the supervision and control of an authorized state or federal official or commission, provided that division (J)(6) of this section does not apply to the mortgage bonds or other interest-bearing obligations of companies engaged in the operation of telephone or telegraph systems.

(K)(1) In bonds or notes secured by mortgages or deeds of trust which are a first lien upon unencumbered fee simple real estate in any state, the Commonwealth of Puerto Rico, the District of Columbia, or Canada, provided the amount loaned does not exceed eighty per cent of the actual market value of such property.

The actual market value of any such property shall be shown by a valuation and appraisement in writing by a qualified land appraiser.

In the event the amount loaned under division (K)(1) of this section exceeds eighty per cent of the actual market value of the land, the structures on the land must be insured by an authorized fire insurance company or covered by other comparable indemnification, and the policies or indemnifications shall be payable or assigned to the mortgagee or to a trustee in its behalf and shall be held by the mortgagee or an agent of the mortgagee or by such trustee; or in lieu of holding such policies or indemnifications, the mortgagee may purchase a policy or policies of mortgage protection insurance, payable to the mortgagee or a trustee in its behalf, insuring the mortgagee against loss resulting from the failure of the mortgagor to acquire and maintain, from such an authorized fire insurance company or other comparable source, insurance or indemnification.

(2) In bonds or notes secured by mortgages insured by the federal housing administrator;

(3) In bonds or notes secured by mortgages or deeds of trust which are a first lien on leasehold estates in wholly or partly improved real property, unencumbered, except rentals accruing from the property to the owner of the fee, provided that any loan secured by a leasehold estate must provide for amortization by repayment of principal at least once in each year in amounts sufficient to repay the loan within a period of four-fifths of the unexpired term of the leasehold but within a period of not more than thirty years, and further provided that the amount loaned on the leasehold estate does not exceed seventy-five per cent of total market value of the leasehold estate determined by appraisements in writing made under oath by two real estate owners, residents of the county or local district in which the real estate is located, or by a qualified land appraiser; if the amount loaned exceeds seventy-five per cent of the value of that portion of the leasehold estate represented by the value of the

land, exclusive of improvements on the land, such improvements shall be insured against fire for the benefit of the mortgagee in an amount not less than the difference between seventy-five per cent of the value of such land, exclusive of buildings, and the amount loaned; the policies for such amount shall be payable to and held by the mortgagee or a trustee named in the lease who shall be required by the terms of said lease to use and apply the proceeds of such insurance for repairing, restoring, or rebuilding such buildings;

(4) The following shall not be considered as prior liens or encumbrances in the construction and application of this section: leasehold estates of any duration, rights-of-way, servitudes, joint driveways, easements, party wall agreements, current taxes and assessments not delinquent, and restrictions as to building, use, and occupancy.

(5) This section does not prohibit a domestic life insurance company from renewing or extending a loan for the original or a lesser amount nor does it prohibit a company from accepting as part payment for real estate sold by it a mortgage on the real estate for a greater percentage of the purchase price of the real estate than is otherwise permitted by this section.

(L) In bonds, notes, or other evidences of indebtedness of corporations, trusts, partnerships, or similar business entities organized under the laws of the United States, or any state thereof, the Commonwealth of Puerto Rico, the District of Columbia, or Canada or any province of Canada, secured by assignment of lease or leases or the rentals payable under such leases, of real or personal property or both to (1) the United States or any instrumentality thereof, or any state of the United States, the Commonwealth of Puerto Rico, or the District of Columbia, or any county, city, town, school, or water district, authority, or other political subdivision in any such government,

or Canada, any province of Canada, or any municipal corporation of Canada that has a population of fifty thousand or more by the latest official census; or (2) one or more corporations, trusts, partnerships, or similar business entities organized under the laws of the United States, any state thereof, the Commonwealth of Puerto Rico, the District of Columbia, or Canada or any province of Canada, provided that (a) the fixed rentals assigned shall be sufficient to repay the indebtedness within the unexpired term of the lease, exclusive of the term which may be provided by an enforceable option of renewal; (b) such lessee has not defaulted in payment of interest or principal on any of its bonds, notes, debentures, or other evidences of indebtedness during the five years immediately preceding the date of the investment, and provided the average net earnings available for fixed charges of such lessee under division (L)(2) of this section for not less than five fiscal years preceding such investment have been at least one and one-half times average fixed charges for that period and during either of the last two years of such period, the net earnings available for fixed charges shall have been not less than one and one-half times fixed charges for such year, except that railroad companies and utility companies may qualify as lessees herein by application of the earnings test provided for railroads under division (J)(1) of this section and for utilities under division (J)(4) of this section; and (c) a first lien on the interest of the lessor in the unencumbered property so leased shall be obtained as additional security for the indebtedness;

(M) In ground rents, land trust certificates, or fee ownership certificates representing or evidencing beneficial ownership of or interest in improved real estate under lease for not less than twenty-five years from the date of such lease, in which it must be provided that the lessee shall pay all taxes and assessments levied on or assessed against said real estate, shall maintain the improvements on the real estate in good repair, and

shall provide and maintain fire insurance in an amount equal to the insurable value of the building on the real estate; provided:

(1) The value of the land and improvements shall be evidenced by an appraisement made under oath by a disinterested appraiser resident in and the owner of real estate in the city in which the property is situated, and such appraisement shall not be less than one and sixty-seven hundredths times the amount of such land trust certificates, which amount shall be not less than twenty times the net annual rental distributable to holders of outstanding certificates;

(2) Such beneficial interests shall only be in properties on which actual earning records for five years immediately preceding are available;

(3) Such declaration of trust or other trust instrument shall provide for a depreciation or other similar fund, in an amount which is not less than nine per cent of the net annual distributable rental, for the benefit of the holders of outstanding certificates.

(N)(1) In certificates of deposit or other evidence of indebtedness of a savings and loan association provided the certificates or other evidence of deposit are insured pursuant to the "Financial Institutions Reform, Recovery, and Enforcement Act of 1989," 103 Stat. 183, 12 U.S.C.A. 1811, as amended;

(2) In interest-bearing obligations, including savings accounts and time certificates of deposit of a national bank or state bank provided such bank is a member of the federal deposit insurance corporation created pursuant to the "Banking Act of 1933," 92 Stat. 624, 12 U.S.C.A. 624, as amended.

(O) In obligations issued, assumed, or guaranteed by the international finance corporation or by the international bank for reconstruction and development, the Asian development bank, the

inter-American development bank, the African development bank, or other similar development bank in which the president, as authorized by congress and on behalf of the United States, has accepted membership;

(P)(1) In the preferred stocks of any company organized under the laws of the United States or of any state thereof engaged directly and primarily in the production and sale of, or in the purchase and sale of electricity or gas, or in the operation of telephone or telegraph systems or water works, or in some combination of them, if the average annual net earnings of such company, for not less than five fiscal years preceding purchase thereof, after deduction of interest on all mortgages, bonds, debentures, and funded debts and after deduction of the proper charges for replacements, depreciation, and obsolescence, have been at least two times the average yearly amount which is required to pay the dividends or distributions on all preferred stocks; and in which the mortgages, bonds, debentures, funded debts, and preferred stocks shall not in the aggregate exceed seventy per cent of the total capitalization of such company, including mortgages, bonds, debentures, funded debts, and preferred and common stocks;

(2) In the preferred stocks of any other company organized under the laws of the United States, or of any state thereof if the average annual net earnings of such company for a period of not less than five fiscal years preceding purchase thereof, after deduction of interest on all mortgages, bonds, debentures, and funded debts and after deduction of the proper charges for replacements, depreciation, and obsolescence, have been at least four times the amount which is required to pay the dividends or distributions on all preferred stocks, and in which the mortgages, bonds, debentures, funded debts, and preferred stocks shall not in the aggregate exceed sixty per cent of the total capitalization of

such company, including mortgages, bonds, debentures, funded debts, and preferred and common stocks;

(3) A domestic life insurance company shall not purchase any preferred stocks when the total market values of such stocks then owned with those purchased exceed in the aggregate of book values and purchase price the capital, surplus, and contingency funds, excluding all reserves required by law, of such company on the thirty-first day of December preceding the date of such purchase, or contemplated purchase, provided that in case of appreciations in values of stocks owned the cost rather than the market values shall be used in arriving at such aggregate; the purpose being to restrict the investments of such company in all preferred stocks to capital, surplus, and contingency funds.

(4) In the bonds, notes, debentures, or other evidences of indebtedness of a solvent corporation, trust, partnership, or similar business entity existing under the laws of the United States, of any state thereof, the Commonwealth of Puerto Rico, or Canada or any province of Canada, provided that either:

(a) The bonds, notes, debentures, or other evidences of indebtedness of such corporation, trust, partnership, or similar business entity are rated 1 or 2 by the securities valuation office of the national association of insurance commissioners;

(b) The corporation, trust, partnership, or similar business entity has not defaulted in payment of interest or principal on any of its bonds, notes, debentures, or other evidences of indebtedness during the five years immediately preceding the date of purchase, and the average annual net earnings of such corporation, trust, partnership, or similar business entity that are available for fixed charges for not less than five fiscal years preceding such purchase have been at least one and one-half times the average fixed charges of such corporation, trust, partnership, or similar business entity for that period and during

either of the last two years of such period, the net earnings available for fixed charges shall have been not less than one and one-half times the fixed charges of such corporation, trust, partnership, or similar business entity for such year.

(5) In common stocks or shares of any solvent incorporated company organized under the laws of the United States, or of any state, district, or territory thereof, or the Commonwealth of Puerto Rico, provided that a dividend or distribution has been paid by the corporation in the preceding twelve months upon such stock to be purchased, or that such corporation, together with its predecessor corporation or corporations, has been in existence for a period of at least five years. No domestic company shall invest in common stock or shares under divisions (P)(5) and (R) of this section a sum exceeding in the aggregate ten per cent of its admitted assets on the preceding thirty-first day of December.

(6) In the stocks ~~or,~~ limited liability company membership interests, limited partnership interests, or limited liability partnership interests of insurance, financial, investment, and investment management companies, which investment management companies are registered with the securities and exchange commission under the "Investment Company Act of 1940," 54 Stat. 789, 15 80a-1, as amended, or the stocks, limited liability company membership interests, limited partnership interests, or limited liability partnership interests in an entity wholly owned by a domestic company or by a domestic company and its affiliates, that is formed and maintained to acquire or hold specific assets or liabilities for bankruptcy remoteness or limitation of liability purposes, except its own stock, but no domestic life insurance company shall invest in such stocks ~~or,~~ limited liability company membership interests, or limited liability partnership interests under division (P)(6) of this section, exclusive of its investments in stocks or limited liability

company membership interests of insurance company subsidiaries or subsidiaries engaged exclusively in the ownership of insurance company subsidiaries, a sum exceeding the lesser of fifty per cent of its policyholder surplus or ten per cent of its admitted assets as of the preceding thirty-first day of December unless the approval of the superintendent of insurance is first obtained. Whenever the superintendent has reason to believe that the retention, investment, or acquisition of the stock ~~or,~~ limited liability company membership interest, limited partnership interest, or limited liability partnership interest of any such company substantially lessens competition generally in the business of insurance or creates a monopoly therein the superintendent shall proceed under section 3901.13 of the Revised Code to cause such domestic insurance company to divest itself of such stock ~~or,~~ limited liability company membership interest, limited partnership interest, or limited liability partnership interest.

(7)(a) In bonds, notes, debentures, or other evidences of indebtedness issued, assumed, or guaranteed by a solvent corporation, trust, or partnership formed or existing under the laws of a foreign jurisdiction, provided each such foreign investment is of the same kind and quality as United States investments authorized under this section; or in common or preferred stock ~~or,~~ shares, membership interest, or partnership interest of any solvent ~~corporation~~ business entity formed or existing under the laws of a foreign jurisdiction provided each such foreign investment is of the same kind and quality as United States investments authorized under this section; or in bonds or other evidences of indebtedness issued, assumed, or guaranteed by a foreign jurisdiction.

An insurer shall not invest in foreign investments under division (P)(7) of this section, including investments denominated

in foreign currency, a sum exceeding in the aggregate fifteen per cent of its admitted assets as of the preceding thirty-first day of December. The aggregate amount of investments held by an insurer in a single foreign jurisdiction shall not exceed three per cent of its admitted assets as of the preceding thirty-first day of December.

As used in division (P)(7)(a) of this section, "foreign jurisdiction" means a jurisdiction outside the United States, Puerto Rico, or canada, whose bonds are rated 1 by the securities valuation office of the national association of insurance commissioners.

(b) An insurer may acquire investments denominated in foreign currency whether or not they are foreign investments.

An insurer shall not invest in investments denominated in foreign currency a sum exceeding in the aggregate ten per cent of its admitted assets as of the preceding thirty-first day of December. The aggregate amount of investments denominated in a single foreign currency held by an insurer shall not exceed three per cent of an insurer's admitted assets as of the preceding thirty-first day of December.

(c) As used in division (P)(7) of this section, "foreign currency" means a currency other than that of the United States.

(8) An insurer may invest without limitation in investments of government money market funds. As used in division (P)(8) of this section, "government money market fund" means a mutual fund that at all times invests in obligations issued, guaranteed, or insured by the federal government of the United States, or collateralized repurchase agreements comprised of these obligations, and that qualifies for investment without a reserve pursuant to the purposes and procedures of the securities valuation office of the national association of insurance

commissioners.

(Q) In loans upon the pledge of any securities in which such companies are authorized by this section to invest, provided that any loan upon such a pledge shall not exceed eighty per cent of the cash market value of the collateral at the time of the making of such loan and at the end of each twelve-month period thereafter, and such company, through the collateral pledged to it, shall not exceed the amounts which it may, under this section, invest in one corporation so that, in the stocks and securities which may be owned and those which are pledged to it, the limitations in this section might be indirectly evaded;

(R)(1) Any domestic legal reserve life insurance company may loan or invest its funds, to an extent not exceeding in the aggregate five per cent of its total admitted assets, in loans or investments not permitted under this section. Any such company may also invest up to an additional five per cent of its total admitted assets, in loans or investments in small businesses having more than half of their assets or employees in this state and in venture capital firms having an office within this state, provided that, as a condition of a company making an investment in a venture capital firm, the firm must agree to use its best efforts to make investments, in an aggregate amount at least equal to the investment to be made by the company in that venture capital firm, in small businesses having their principal offices within this state and having either more than one-half of their assets within this state or more than one-half of their employees employed within this state.

As used in division (R) of this section:

(a) "Small businesses" means any corporation, partnership, proprietorship, or other entity that either does not have more than four hundred employees, or would qualify as a small business for the purpose of receiving financial assistance from small

business investment companies licensed under the "Small Business Investment Act of 1958," 72 Stat. 689, 15 U.S.C.A. 661, as amended, and rules of the small business administration.

(b) "Venture capital firms" means any corporation, partnership, proprietorship, or other entity, the principal business of which is or will be the making of investments in small businesses.

(c) "Investments" means any equity investment, including limited partnership interests and other equity interests in which liability is limited to the amount of the investment, but does not include general partnership interests or other interests involving general liability.

(2) In the event that, subsequent to being made under provisions of division (R) of this section, an investment is determined to have become qualified as an investment for a domestic life insurance company as provided for in this section, the company may consider such investment as held under the applicable provisions of the foregoing divisions (A) to (Q) of this section and such investment shall no longer be considered as having been made under the provisions of this division.

(S)(1) No domestic life insurance company shall subscribe to or participate in any underwriting for the purchase or sale of securities or property, nor shall it enter into any such transaction for purchase or sale on account of said company jointly with any other person, nor shall any such company enter into any agreement to withhold from sale any of its property, but the disposition of its property shall be at all times within the control of its board of directors. Nothing contained in division (S)(1) of this section shall be construed to invalidate or prohibit an agreement by an insurance company for the purchase for its own account of an entire issue of the securities of a corporation or to invalidate or prohibit an agreement by an

insurance company and one or more other investors to join and share in the purchase of investments for their individual accounts and for bona fide investment purposes.

(2) In the determination of capitalization in this section the value of all bonds, debentures, and funded debts, and nonconvertible or nonparticipating preferred stocks shall be figured at par. Participating or convertible preferred shares shall be figured at par or market on the preceding thirty-first day of December, whichever is higher, and the value of all common shares shall be figured at the market on the preceding thirty-first day of December.

(3) As used in this section:

(a) "Funded debt" means all interest-bearing obligations maturing in more than one year from their issuance and all guaranteed or assumed interest-bearing obligations or stock. Securities or stock of a corporation pledged to secure other funded debt of the corporation are not included in the funded debt.

(b) "Fixed charges" include actual interest incurred in each year on funded and unfunded debt and annual apportionment of debt discount or premium. Where interest is partially or entirely contingent upon earnings, "fixed charges" include contingent interest payments.

(c) "Net earnings available for fixed charges" means income after deducting operating and maintenance expenses, taxes other than income taxes, depreciation, and depletion. Extraordinary, nonrecurring items of income or expense shall be excluded.

(4) Except as provided in a plan of mutualization adopted pursuant to the provisions of sections 3913.01 to 3913.10 of the Revised Code, no domestic life insurance company may invest in or loan upon its own stock, either directly or indirectly.

(5) If the investments of any domestic life insurance company are at the time of the making thereof or on October 13, 1953, otherwise than as authorized in this section, such investments shall not be admitted or accepted as authorized investments for such company.

(6) Any earnings test provided for in this section shall be deemed to have been met if the requirements of such earnings test are met by any company which assumes or guarantees the investment or which assumes or guarantees the performance of any lease which is the security for the investment. In applying any such earnings test, the operations of a company's predecessor companies, if any, for the stipulated period shall be included.

(7) No domestic life insurance company shall at any time have invested in or loaned upon the security of the obligations, property, or securities of a particular corporation, trust, partnership, or similar business entity a sum exceeding the greater of two per cent of its admitted assets as of the preceding thirty-first day of December or twenty-five per cent of that portion of its capital and surplus, or its surplus in the case of a mutual company, that exceeds the minimum required capital and surplus under section 3907.05 of the Revised Code unless the approval of the superintendent of insurance is first obtained. The restrictions of division (S)(7) of this section do not apply to divisions (C), (F), (G), (H), (P)(6), and (R) of this section or to any valid obligation issued, assumed, or guaranteed by the United States, or any state thereof, the Commonwealth of Puerto Rico, the District of Columbia, or Canada or any province of Canada. For purposes of division (S)(7) of this section, such company may, at its option, consider either the lessor or the lessee under division (L) of this section to be the person to whom any such investment or loan is made.

(8) This section does not affect the propriety or legality of

an investment made by a domestic life insurance company which was in accordance with the laws in force at the time of the making of the investment.

Sec. 3921.10. A domestic fraternal benefit society organized on or after January 1, 1997, shall be formed as follows:

(A) Seven or more citizens of the United States, a majority of whom are residents of this state, who desire to form a fraternal benefit society, may make, sign, and acknowledge before some officer competent to take acknowledgement of deeds, articles of incorporation stating all of the following:

(1) The proposed corporate name of the society, which name shall not so closely resemble the name of any society or insurance company as to be misleading or confusing;

(2) The purposes for which it is being formed and the mode in which its corporate powers are to be exercised. Such purposes shall not include more liberal powers than are granted by this chapter.

(3) The names and residences of the incorporators and the names, residences, and official titles of all the officers, trustees, directors, or other persons who are to have and exercise the general control of the management of the affairs and funds of the society for the first year or until the ensuing election at which all such officers shall be elected by the supreme governing body, which election shall be held not later than one year from the date of the issuance of the permanent certificate of authority.

(B) The articles of incorporation, duly certified copies of the society's bylaws and rules, copies of all proposed forms of certificates, applications for certificates, and circulars to be issued by the society, and a bond conditioned upon the return to

applicants of the advanced payments if the organization is not completed within one year, shall be filed with the superintendent of insurance, who may require any other information the superintendent considers necessary. The bond with sureties approved by the superintendent shall be in such amount, not less than three hundred thousand dollars nor more than one million five hundred thousand dollars, as required by the superintendent. All documents filed shall be in the English language. If the purposes of the society conform to the requirements of this chapter and all provisions of the laws of this state have been complied with, the superintendent shall so certify, retain and file the articles of incorporation, and furnish the incorporators a preliminary certificate of authority authorizing the society to solicit members as provided in this section.

(C) No preliminary certificate of authority granted under this section shall be valid after one year from its date or after such additional period, not exceeding one year, as may be authorized by the superintendent upon cause shown, unless the five hundred applicants required in division (D) of this section have been secured and the organization has been completed as provided in this section. The articles of incorporation and all other proceedings thereunder shall be void one year after the date of the preliminary certificate of authority, or at the expiration of the extended period, unless the society has completed its organization and has received a certificate of authority to do business as provided in division (E) of this section.

(D) Upon receipt of a preliminary certificate of authority from the superintendent, the society may solicit members for the purpose of completing its organization, shall collect from each applicant the amount of not less than one regular monthly premium in accordance with its table of rates, and shall issue to each applicant a receipt for the amount so collected. No society shall

incur any liability other than for the return of such advance premium, nor issue any certificate, nor pay, allow, or offer, or promise to pay or allow, any benefit to any person until all of the following apply:

(1) Actual bona fide applications for benefits have been secured aggregating at least two million five hundred thousand dollars on not less than five hundred applicants, and any necessary evidence of insurability has been furnished to and approved by the society.

(2) At least ten subordinate lodges have been established into which the five hundred applicants have been admitted.

(3) There has been submitted to the superintendent, under oath of the president or secretary, or corresponding officer of the society, a list of such applicants, giving their names, addresses, date each was admitted, name and number of the subordinate lodge of which each applicant is a member, amount of benefits to be granted, and premiums for the benefits.

(4) It has been shown to the superintendent, by sworn statement of the treasurer, or corresponding officer of the society, that at least five hundred applicants have each paid in cash at least one regular monthly premium as provided in this section, which premiums in the aggregate amount to at least one hundred fifty thousand dollars, all of which is credited to the fund or funds from which benefits are to be paid and no part of which may be used for expenses. These advance premiums shall be held in trust during the period of organization and if the society has not qualified for a certificate of authority within one year, as provided in this section, the premiums shall be returned to the applicants.

(E) The superintendent may make such examination and require such further information as the superintendent considers

advisable. Upon presentation of satisfactory evidence that the society has complied with all the provisions of law including the surplus requirements of section 3921.101 of the Revised Code, the superintendent shall issue to the society a certificate of authority to that effect and that the society is authorized to transact business pursuant to the provisions of this chapter. The certificate of authority shall be prima facie evidence of the existence of the society at the date of the certificate. The superintendent shall cause a record of the certificate of authority to be made. A certified copy of the record may be given in evidence with like effect as the original certificate of authority.

(F) An incorporated society that was organized prior to January 1, 1997, and that, as of December 31, 1996, is authorized to transact business in this state shall not be required to reincorporate, and may exercise all the rights, powers, and privileges conferred in this chapter and in the society's articles of incorporation to the extent that the articles are consistent with this chapter.

Sec. 3921.101. (A)(1) On and after January 1, 2016, a fraternal benefit society that provides the contractual benefits listed in division (A)(1) of section 3921.16 of the Revised Code in this state in a benefit amount of greater than ten thousand dollars shall have and maintain a surplus of two million five hundred thousand dollars for all lines written.

(2) On and after January 1, 2016, a fraternal benefit society that provides the contractual benefits listed in division (A)(1) of section 3921.16 of the Revised Code in this state in a benefit amount of ten thousand dollars or less shall have and maintain a surplus of five hundred thousand dollars.

(B)(1) On and after January 1, 2016, a fraternal benefit

society that provides the contractual benefits listed in division (A)(2) of section 3921.16 of the Revised Code in this state in a benefit amount of greater than ten thousand dollars shall have and maintain a surplus of two million five hundred thousand dollars for all lines written.

(2) On and after January 1, 2016, a fraternal benefit society that provides the contractual benefits listed in division (A)(2) of section 3921.16 of the Revised Code in this state in a benefit amount of ten thousand dollars or less shall have and maintain a surplus of five hundred thousand dollars.

(C)(1) On and after January 1, 2016, a fraternal benefit society that provides the contractual benefits listed in division (A)(3) of section 3921.16 of the Revised Code in this state in a benefit amount of greater than ten thousand dollars shall have and maintain a surplus in the aggregate of two million five hundred thousand dollars for all lines written.

(2) On and after January 1, 2016, a fraternal benefit society that provides the contractual benefits listed in division (A)(3) of section 3921.16 of the Revised Code in this state in a benefit amount of ten thousand dollars or less shall have and maintain a surplus of five hundred thousand dollars.

(D) On and after January 1, 2016, a fraternal benefit society that provides the contractual benefits listed in division (A)(4) of section 3921.16 of the Revised Code in this state shall have and maintain a surplus of two million five hundred thousand dollars for all lines written.

(E) On and after January 1, 2016, a fraternal benefit society that provides the contractual benefits listed in division (A)(5) of section 3921.16 of the Revised Code in this state shall have and maintain a surplus of two million five hundred thousand dollars for all lines written.

(F) On and after January 1, 2016, a fraternal benefit society that provides the contractual benefits listed in division (A)(6) of section 3921.16 of the Revised Code in this state shall have and maintain a surplus of five hundred thousand dollars.

(G) On and after January 1, 2016, a fraternal benefit society that provides the contractual benefits listed in division (A)(7) of section 3921.16 of the Revised Code in this state shall have and maintain a surplus of two million five hundred thousand dollars for all lines written.

(H) The surplus requirements of this section are not cumulative. A society with a surplus of at least two million five hundred thousand dollars on and after January 1, 2016, satisfies the surplus requirements of this section.

Sec. 3921.13. (A) A domestic fraternal benefit society may, by a reinsurance agreement, cede any individual risk or risks in whole or in part to an insurer, other than another fraternal benefit society, having the power to make such reinsurance and authorized to do business in this state, or if not so authorized, one which is approved by the superintendent of insurance; however, no society may reinsure substantially all of its insurance in force without the written permission of the superintendent. It may take credit for the reserves on the ceded risks to the extent reinsured, but no credit shall be allowed as an admitted asset or as a deduction from liability, to a ceding society for reinsurance made, ceded, renewed, or otherwise becoming effective after January 1, 1997, unless the reinsurance is payable by the assuming insurer on the basis of the liability of the ceding society under the contract or contracts reinsured without diminution because of the insolvency of the ceding society.

(B) Notwithstanding division (A) of this section, a society may reinsure the risks of another society in a consolidation or

merger approved by the superintendent under section 3921.14 of the Revised Code.

(C) A society with assets of less than five billion dollars that provides contract benefits of major medical, medicare supplemental, or long-term care pursuant to division (A)(5) of section 3921.16 of the Revised Code shall reinsure not less than fifty per cent of the risk arising from those contracts if the society's risk based capital is less than three hundred per cent.

Sec. 3921.19. (A) Each fraternal benefit society authorized to do business in this state shall issue to each owner of a benefit contract a certificate specifying the amount of benefits provided under the contract. The certificate, together with any riders or endorsements attached to the certificate, the laws of the society, the application for membership, the application for insurance and declaration of insurability, if any, signed by the applicant, and all amendments to each such document, constitute the benefit contract, as of the date of issuance, between the society and the owner, and the certificate shall so state. A copy of the application for insurance and declaration of insurability, if any, shall be endorsed upon or attached to the certificate.

All statements made on the application are representations and not warranties. Any waiver of this provision is void.

(B) Any changes, additions, or amendments to the laws of the society duly made or enacted subsequent to the issuance of the certificate, shall bind the owner and the beneficiaries, and shall govern and control the benefit contract in all respects the same as though such changes, additions, or amendments had been made prior to and were in force at the time of the application for insurance, except that no change, addition, or amendment shall destroy or diminish benefits that the society contracted to give the owner as of the date of issuance.

(C) Any person upon whose life a benefit contract is issued prior to attaining the age of majority shall be bound by the terms of the application and certificate and by all of the laws and rules of the society to the same extent as though the age of majority had been attained at the time of application.

(D) A society shall provide in its laws that if its reserves as to all or any class of certificates become impaired its board of directors or corresponding body may require that there shall be paid by the owner to the society the amount of the owner's equitable proportion of such deficiency as ascertained by its board, and that if the payment is not made, either of the following applies:

(1) It shall stand as an indebtedness against the certificate and draw interest not to exceed the rate specified for certificate loans under the certificates;

(2) In lieu of or in combination with division (D)(1) of this section, the owner may accept a proportionate reduction in benefits under the certificate.

The society may specify the manner of the election and which alternative is to be presumed if no election is made.

(E) At least thirty days prior to imposing any indebtedness upon any owner as provided in division (D) of this section, the board of directors or corresponding body shall notify the superintendent of insurance in writing of the board's intent to require the payment and a statement of the reason that request is necessary. The notice shall be confidential and not a public record under section 149.43 of the Revised Code.

(F)(1) Certificates that are delivered or issued for delivery in this state on or after January 1, 1997, but prior to January 1, 1998, shall comply with the requirements that would have applied under the laws in effect on December 31, 1996.

(2) No certificate shall be delivered or issued for delivery in this state on or after January 1, 1998, unless a copy of the form is filed with and approved by the superintendent of insurance in accordance with the provisions of law applicable to like policies issued by life or sickness and accident insurers in this state.

(3) Each life, sickness and accident, or disability insurance certificate, and each annuity certificate, that is delivered or issued for delivery in this state on or after January 1, 1998, shall comply with the standard contract provision requirements applicable to like policies issued by life or sickness and accident insurers in this state, if those requirements are not inconsistent with this chapter. However, a society may provide in its certificates for a grace period of one full month for payment of premiums. A certificate shall also contain a provision that states the amount of premiums that is payable under the certificate and that sets forth the substance of any sections of the society's laws or rules in force at the time of issuance of the certificate which, if violated, will result in the termination or reduction of benefits payable under the certificate. If the laws of the society provide for the expulsion or suspension of a member, the certificate shall also contain a provision stating that any member expelled or suspended, except a member expelled or suspended because of nonpayment of a premium, may maintain, other than during the contestable period for material misrepresentation in the application for membership or insurance, the certificate in force by continuing payment of the required premium.

~~(F)~~(G) Benefit contracts issued on the lives of persons under the society's minimum age for adult membership may provide for transfer of control of ownership to the insured at an age specified in the certificate. A society may require approval of an application for membership in order to effect this transfer, and

may provide in all other respects for the regulation, government, and control of such certificates and all rights, obligations, and liabilities incident to and connected with such certificates. Ownership rights prior to such a transfer shall be specified in the certificate.

~~(G)~~(H) A society may specify the terms and conditions on which benefit contracts may be assigned.

~~(H)~~(I) A copy of any of the documents described in this section, if certified by the secretary or corresponding officer of the society, is prima facie evidence of the terms and conditions of the documents.

Sec. 3921.191. (A) A fraternal benefit society shall provide an applicant for contractual benefits a disclosure statement at the time of sale substantially as follows:

"..... (Name of the fraternal benefit society) IS LICENSED TO DO BUSINESS IN THE STATE OF OHIO. AS A ..... (not-for-profit, tax-exempt, self-governing, or membership organization), FRATERNAL BENEFIT SOCIETIES ARE NOT INCLUDED IN THE OHIO GUARANTY ASSOCIATION. THIS MEANS THAT FRATERNAL BENEFIT SOCIETIES CANNOT BE ASSESSED FOR THE INSOLVENCY OF OTHER LIFE INSURERS OR OTHER FRATERNAL BENEFIT SOCIETIES. BY LAW, A FRATERNAL BENEFIT SOCIETY IS RESPONSIBLE FOR ITS OWN SOLVENCY. IF THERE IS AN IMPAIRMENT OF RESERVES, A CERTIFICATE HOLDER MAY BE ASSESSED A PROPORTIONATE SHARE OF THE IMPAIRMENT. THIS PROCESS IS DESCRIBED IN THE CERTIFICATE ISSUED BY THE SOCIETY."

(B) The statement must be signed by the applicant and maintained in the certificate or contract file by the fraternal benefit society. The statement may be part of the society's membership application or certificate or policy application.

(C) This section is applicable only to new business written

by a fraternal benefit society after the effective date of this section.

Sec. 3921.22. (A) A fraternal benefit society shall hold, invest, and disburse all assets for the use and benefit of the society. No member or beneficiary shall have or acquire individual rights to the assets, or be entitled to any apportionment on the surrender of any part of the assets, except as provided in the benefit contract.

(B) A society may create, maintain, invest, disburse, and apply any special fund or funds necessary to carry out any purpose permitted by the laws of the society. No society shall, directly or indirectly, pay or use, or offer, consent, or agree to pay or use, any of its funds, money, or property for or in aid of any political party, campaign committee, political action committee, continuing association, or any other political organization.

(C) A society may, pursuant to resolution of its supreme governing body, establish and operate one or more separate accounts and issue contracts on a variable basis, subject to the provisions of law regulating life insurers that establish such accounts and issue such contracts including those described in section 3911.011 of the Revised Code. To the extent the society considers it necessary in order to comply with any applicable federal or state law, or any rule issued under that law, the society may do any of the following:

(1) Adopt special procedures for the conduct of the business and affairs of a separate account;

(2) For persons having beneficial interests in the account, provide special voting and other rights, including special rights and procedures relating to investment policy, investment advisory services, selection of certified public accountants, and selection of a committee to manage the business and affairs of the account;

(3) Issue contracts on a variable basis to which divisions (B) and (D) of section 3921.19 of the Revised Code do not apply.

Sec. 3921.28. (A)(1) Each domestic fraternal benefit society and each applicant for a certificate of incorporation as a domestic fraternal benefit society shall be subject to examination by the superintendent of insurance in accordance with section 3901.07 of the Revised Code. Section 3901.07 of the Revised Code shall govern every aspect of the examination, including the circumstances under and frequency with which it is conducted, and the authority of the superintendent and any examiner or other person appointed by the superintendent.

(2)(a) A domestic fraternal benefit society shall be liable for the payment of any additional expense of an examination resulting from unreasonable delays by the society in fulfilling a request for documents or information by the examiner conducting the examination. A delay is deemed unreasonable if the examiner has made two separate unfulfilled requests for the same documents or information. A request for records or information from an examiner shall allow the fraternal benefit society a minimum of ten business days to fulfill the request.

(b) In the event of an unreasonable delay, the examiner shall notify the superintendent, who shall set a hearing, under Chapter 119. of the Revised Code, to determine if there has been an unreasonable delay because of the fraternal benefit society's response to a request for documents or information and to calculate the additional expense incurred by the superintendent as a result of the unreasonable delay.

(3) A summary of the examination of the superintendent and any recommendations or statements of the superintendent that accompany the report, shall be read at the first meeting of the board of directors or corresponding body of the society following

the receipt thereof, and if directed so to do by the superintendent, shall also be read at the first meeting of the supreme legislative or governing body of the society following the receipt thereof. A copy of the report, recommendations, and statements of the superintendent shall be furnished by the society to each member of the board of directors or other governing body.

(B) Each foreign or alien fraternal benefit society transacting or applying for admission to transact business in this state shall be subject to examination by the superintendent in accordance with section 3901.07 of the Revised Code. Section 3901.07 of the Revised Code shall govern every aspect of the examination, including the circumstances under and frequency with which it is conducted, the authority of the superintendent and any examiner or other person appointed by the superintendent, the liability for the assessment of expenses incurred in conducting the examination, and the remittance of the assessment to the superintendent's examination fund.

Sec. 3921.29. No foreign or alien fraternal benefit society shall transact business in this state without a license issued by the superintendent of insurance. Any such society may be licensed to transact business in this state upon filing all of the following with the superintendent:

(A) A duly certified copy of its articles of incorporation;

(B) A copy of its bylaws certified by its secretary or corresponding officer;

(C) A ~~power of attorney to the superintendent~~ written appointment of an agent as prescribed in section 3921.35 of the Revised Code;

(D) A statement of its business made under oath of its president and secretary or corresponding officers in a form

prescribed by the superintendent and duly verified by an examination made by the supervising insurance official of its state of domicile or of any other state, district, territory, province, or country, which examination is satisfactory to the superintendent;

(E) Certification from the proper official of its state, district, territory, province, or country of domicile that the society is legally incorporated and licensed to transact business in that state, district, territory, province, or country;

(F) Copies of its certificate forms;

(G) A description of its investments that shows that its assets are invested in accordance with this chapter;

(H) Any other information the superintendent considers necessary.

Sec. 3921.30. ~~(A)~~ If the superintendent of insurance finds, upon investigation, that a domestic fraternal benefit society has exceeded its powers, has failed to comply with any provision of this chapter, is not fulfilling its contracts in good faith, has a membership of less than four hundred after an existence of one year or more, or is conducting business fraudulently or in a manner hazardous to its members, creditors, the public, or the business, the superintendent shall issue a written notice to the society that sets forth the deficiency and the reasons for the superintendent's dissatisfaction, and that requires the society to correct the deficiency within thirty days after receipt of the notice. If the society fails to correct the deficiency within that thirty-day period, the superintendent shall ~~notify the society of its failure to correct the deficiency and shall require the society to show cause on a date named why it should not be enjoined from carrying on any business until the violation complained of has been corrected, or why an action in quo warranto~~

~~should not be commenced against the society.~~

~~If on that date the society does not present good and sufficient reasons why it should not be enjoined or why such action should not be commenced, the superintendent may present the facts relating thereto to the attorney general. If the attorney general determines that the circumstances warrant, the attorney general shall commence an action to enjoin the society from transacting business or in quo warranto.~~

~~The court shall thereupon notify the officers of the society of a hearing. If after a full hearing it appears that the society should be enjoined or liquidated or a receiver appointed, the court shall enter the necessary order.~~

~~(B) A society enjoined pursuant to division (A) of this section shall not have the authority to do business until all of the following occur:~~

~~(1) The superintendent finds that the violation complained of has been corrected.~~

~~(2) The costs of the action have been paid by the society if the court finds that the society was in default as charged.~~

~~(3) The court has dissolved its injunction.~~

~~(4) The superintendent has reinstated the certificate of authority.~~

~~(C) If the court orders the society liquidated, the society shall be enjoined from carrying on any further business, whereupon the receiver of the society shall proceed at once to take possession of the books, papers, money, and other assets of the society and, under the direction of the court, shall close the affairs of the society and distribute its funds to those entitled to them.~~

~~(D) No action under this section shall be recognized in any~~

~~court of this state unless brought by the attorney general upon request of the superintendent. Whenever a receiver is to be appointed for a domestic society, the court shall appoint the superintendent as the receiver.~~

~~(E) The provisions of this section relating to a hearing by the superintendent, action by the attorney general at the request of the superintendent, hearing by the court, injunction, and receivership shall apply to any society that voluntarily determines to discontinue business.~~

~~(F) Nothing in this section shall be construed as preventing the lodges and members of a society from commencing a civil action against a society for the enforcement of a contract provision or for the resolution of a dispute concerning an interpretation of the society's laws, which action is not based on the superintendent's exercise of authority under this section. A society shall not prohibit a lodge or member from commencing such~~ commence an action against ~~it~~ the society under sections 3903.01 to 3903.59 of the Revised Code.

Sec. 3921.31. ~~(A)~~ If the superintendent of insurance finds, upon investigation, that a foreign or alien fraternal benefit society transacting or applying to transact business in this state has exceeded its powers, has failed to comply with any provision of this chapter, is not fulfilling its contracts in good faith, or is conducting its business fraudulently or in a manner hazardous to its members or creditors or the public, the superintendent shall issue a written notice to the society that sets forth the deficiency and the reasons for the superintendent's dissatisfaction, and that requires the society to correct the deficiency within thirty days after receipt of the notice. If the society fails to correct the deficiency within that thirty-day period, the superintendent shall ~~notify the society of its failure~~

~~to correct the deficiency and shall require the society to show cause on a date named why its license should not be suspended, revoked, or refused.~~

~~If on that date the society does not present good and sufficient reason why its authority to do business in this state should not be suspended, revoked, or refused, the superintendent may suspend or refuse the license of the society to do business in this state until satisfactory evidence is furnished to the superintendent that the suspension or refusal should be withdrawn, or the superintendent may revoke the authority of the society to do business in this state.~~

~~(B) Nothing in this section shall be construed as preventing any foreign or alien society from continuing in good faith all contracts made in this state during the time the society was legally authorized to transact business in this state~~ commence an action against the society under section 3903.71 of the Revised Code.

Sec. 3921.33. (A) Agents of fraternal benefit societies shall be licensed in the manner provided for agents of insurance companies in Chapter 3905. of the Revised Code, and shall be required to complete continuing education as set forth in section 3905.481 of the Revised Code starting with the twenty-four-month period commencing on the first day of January of 1999. However, no written or other examination shall be required of any person whose application for the original issuance of a license to represent a fraternal benefit society as its agent was filed with the superintendent of insurance prior to January 1, 1997.

(B) The following persons shall not be required to be licensed in accordance with division (A) of this section:

(1) Any regularly salaried officer, employee, or member of a licensed society who devotes substantially all of the person's

services to activities other than the solicitation of fraternal insurance contracts from the public, and who receives for the solicitation of any such contracts no commission or other compensation directly dependent upon the amount of business obtained.

The officers, employees, and members described in division (B)(1) of this section also are not subject to examination by the superintendent under Chapter 3905. of the Revised Code.

(2) Any agent or representative of a society who devotes, or intends to devote, less than fifty per cent of the person's time to the solicitation and procurement of insurance contracts for the society. For purposes of division (B)(2) of this section, any person who, in the preceding calendar year, has received a commission or other compensation for soliciting and procuring any of the following contracts on behalf of an individual society is presumed to have devoted, or to have intended to devote, fifty per cent of the person's time to the solicitation and procurement of insurance contracts:

(a) Life insurance contracts that, in the aggregate, exceeded two hundred thousand dollars of coverage for all lives insured for the preceding calendar year;

(b) A permanent life insurance contract offering more than ten thousand dollars of coverage on an individual life;

(c) A term life insurance contract offering more than fifty thousand dollars of coverage on an individual life;

(d) Any insurance contracts other than life that the society may write and that insure the individual lives of more than twenty-five individuals;

(e) Any contract issued on a variable basis, as authorized by division (C) of section 3921.22 of the Revised Code.

(C) Notwithstanding division (B) of this section, any person selling an annuity contract under the authority of division (A)(3) of section 3921.16 of the Revised Code shall be licensed pursuant to Chapter 3905. of the Revised Code.

Sec. 3921.35. (A) Any fraternal benefit society authorized to transact business in this state shall have and maintain an agent upon whom may be served any process, notice, or demand required or permitted by law to be served upon a society.

The agent required under this section may be a natural person residing in this state or a corporation holding a license under the laws of this state that is authorized by its articles of incorporation to act as an agent and that maintains a business address in this state. A statutory agent is not required to be a licensed insurance agent.

(B) The written appointment of an agent shall be in the form the superintendent of insurance prescribes and may include a consent to service of process.

The appointment shall set forth the name and complete address of the agent. The agent shall reside or maintain a business address within this state.

(C) The superintendent shall keep a record of the fraternal benefit societies transacting business in this state and the name and address of their respective agents.

(D)(1) If any agent dies, moves out of the state, or resigns, the society immediately shall appoint another agent and file with the superintendent a written appointment as described in division (B) of this section.

(2) If an agent changes the agent's address, the society or agent immediately shall notify the superintendent of the change, and shall set forth the agent's new address, on a form prescribed

by the superintendent.

(E) An agent may resign by filing with the superintendent a written notice signed by the agent. The agent shall send a copy of the notice to the society at the current or last known address of the society's principal office prior to the date the notice is filed with the superintendent.

The notice required under this division shall set forth the society's name, the current or last known address of the society, the name and address of the agent, the resignation of the agent, and a statement that a copy of the notice has been sent to the society and the date the copy was sent.

The agent's authority to represent the fraternal benefit society shall terminate thirty days after the notice is filed with the superintendent under this division.

(F) A society may revoke the appointment of an agent by filing with the superintendent a written appointment of another agent and a statement that the appointment of the former agent is revoked. The authority of the agent whose appointment has been revoked shall terminate thirty days after the notice required under this division is filed with the superintendent.

(G) Any process, notice, or demand required or permitted by law to be served upon a society may be served by delivering a copy of the process, notice, or demand to the agent of record at the address appearing in the superintendent's records.

If the agent cannot be found, the agent no longer has that address, or the society has failed to maintain an agent as required by this section, the party desiring that the process, notice, or demand be served, or its agent, may file with the superintendent an affidavit stating that one of the foregoing conditions exists and stating the most recent address of the society that the party, after diligent search, has been able to

ascertain.

Upon the filing of the affidavit, service of process, notice, or demand may be initiated upon the superintendent as the society's agent by delivering two copies of the process, notice, or demand to the superintendent. The superintendent shall give notice to the society at its principal office as shown in the superintendent's records or at the address set forth in the affidavit. The superintendent shall give notice by regular mail with a copy of the process, notice, or demand enclosed. After the superintendent has mailed the appropriate documents, service upon the society is deemed complete.

(H) The superintendent shall keep a record of each process, notice, and demand delivered to the superintendent under division (G) of this section or any other law of this state that authorizes service upon the superintendent.

(I) This section does not limit or affect the right to serve any process, notice, or demand upon a society in any other manner permitted by law.

(J) A society shall include a fee of five dollars with any change of agent appointment or change of address. This division does not apply to an agent appointment filed with an original application for a certificate of authority.

(K) If a society fails to appoint or maintain an agent or to notify the superintendent of an agent's change of address, the superintendent shall provide notice of that failure to the society by certified mail. If the society does not remedy the society's failure within thirty days after the date of the mailing of the notice or within any additional time the superintendent allows, the superintendent shall fine the society not less than twenty-five dollars nor more than two hundred dollars per violation. The superintendent also may charge a society a

fifty-dollar fee for each time the superintendent is required to give notice to the society in accordance with division (G) of this section.

(L) The superintendent shall pay all moneys collected by the superintendent in accordance with this section into the state treasury to the credit of the department of insurance operating fund.

Sec. 3922.01. As used in this chapter:

(A) "Adverse benefit determination" means a decision by a health plan issuer:

(1) To deny, reduce, or terminate a requested health care service or payment in whole or in part, including all of the following:

(a) A determination that the health care service does not meet the health plan issuer's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness, including experimental or investigational treatments;

(b) A determination of an individual's eligibility for individual health insurance coverage, including coverage offered to individuals through a nonemployer group, to participate in a plan or health insurance coverage;

(c) A determination that a health care service is not a covered benefit;

(d) The imposition of an exclusion, including exclusions for pre-existing conditions, source of injury, network, or any other limitation on benefits that would otherwise be covered.

(2) Not to issue individual health insurance coverage to an applicant, including coverage offered to individuals through a nonemployer group;

(3) To rescind coverage on a health benefit plan.

(B) "Ambulatory review" has the same meaning as in section 1751.77 of the Revised Code.

(C) "Authorized representative" means an individual who represents a covered person in an internal appeal or external review process of an adverse benefit determination who is any of the following:

(1) A person to whom a covered individual has given express, written consent to represent that individual in an internal appeals process or external review process of an adverse benefit determination;

(2) A person authorized by law to provide substituted consent for a covered individual;

(3) A family member or a treating health care professional, but only when the covered person is unable to provide consent.

(D) "Best evidence" means evidence based on all of the following sources, listed according to priority, as they are available:

(1) Randomized clinical trials;

(2) Cohort studies or case-control studies;

(3) Case series;

(4) Expert opinion.

(E) "Covered person" means a policyholder, subscriber, enrollee, member, or individual covered by a health benefit plan. "Covered person" does include the covered person's authorized representative with regard to an internal appeal or external review in accordance with division (C) of this section. "Covered person" does not include the covered person's representative in any other context.

(F) "Covered benefits" or "benefits" means those health care services to which a covered person is entitled under the terms of a health benefit plan.

(G) "Emergency medical condition" has the same meaning as in section 1753.28 of the Revised Code.

(H) "Emergency services" has the same meaning as in section 1753.28 of the Revised Code.

(I) "Evidence-based standard" means the conscientious, explicit, and judicious use of the current best evidence, based on a systematic review of the relevant research, in making decisions about the care of individuals.

(J) "Facility" means an institution providing health care services, or a health care setting, including hospitals and other licensed inpatient centers, ambulatory, surgical, treatment, skilled nursing, residential treatment, diagnostic, laboratory, and imaging centers, and rehabilitation and other therapeutic health settings.

(K) "Final adverse benefit determination" means an adverse benefit determination that is upheld at the completion of a health plan issuer's internal appeals process.

(L) "Health benefit plan" means a policy, contract, certificate, or agreement offered by a health plan issuer to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services, including benefit plans marketed in the individual or group market by all associations, whether bona fide or non-bona fide. "Health benefit plan" also means a limited benefit plan, except as follows. "Health benefit plan" does not mean any of the following types of coverage: a policy, contract, certificate, or agreement that covers only a specified accident, accident only, credit, dental, disability income, long-term care, hospital indemnity, ~~medicare supplement~~ supplemental coverage, as

described in section 3923.37 of the Revised Code, ~~medicare, tricare,~~ specified disease, or vision care; coverage issued as a supplement to liability insurance; insurance arising out of workers' compensation or similar law; automobile medical payment insurance; or insurance under which benefits are payable with or without regard to fault and which is statutorily required to be contained in any liability insurance policy or equivalent self-insurance; a medicare supplement policy of insurance, as defined by the superintendent of insurance by rule, coverage under a plan through medicare, medicaid, or the federal employees benefit program; any coverage issued under Chapter 55 of Title 10 of the United States Code and any coverage issued as a supplement to that coverage.

(M) "Health care professional" means a physician, psychologist, nurse practitioner, or other health care practitioner licensed, accredited, or certified to perform health care services consistent with state law.

(N) "Health care provider" or "provider" means a health care professional or facility.

(O) "Health care services" means services for the diagnosis, prevention, treatment, cure, or relief of a health condition, illness, injury, or disease.

(P) "Health plan issuer" means an entity subject to the insurance laws and rules of this state, or subject to the jurisdiction of the superintendent of insurance, that contracts, or offers to contract to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services under a health benefit plan, including a sickness and accident insurance company, a health insuring corporation, a fraternal benefit society, a self-funded multiple employer welfare arrangement, or a nonfederal, government health plan. "Health plan issuer" includes a third party administrator licensed under Chapter 3959. of the

Revised Code to the extent that the benefits that such an entity is contracted to administer under a health benefit plan are subject to the insurance laws and rules of this state or subject to the jurisdiction of the superintendent.

(Q) "Health information" means information or data, whether oral or recorded in any form or medium, and personal facts or information about events or relationships that relates to all of the following:

(1) The past, present, or future physical, mental, or behavioral health or condition of a covered person or a member of the covered person's family;

(2) The provision of health care services or health-related benefits to a covered person;

(3) Payment for the provision of health care services to or for a covered person.

(R) "Independent review organization" means an entity that is accredited ~~by a nationally recognized private accrediting organization~~ to conduct independent external reviews of adverse benefit determinations ~~and is accredited~~ pursuant to section 3922.13 of the Revised Code.

(S) "Medical or scientific evidence" means evidence found in any of the following sources:

(1) Peer-reviewed scientific studies published in, or accepted for publication by, medical journals that meet nationally recognized requirements for scientific manuscripts and that submit most of their published articles for review by experts who are not part of the editorial staff;

(2) Peer-reviewed medical literature, including literature relating to therapies reviewed and approved by a qualified institutional review board, biomedical compendia and other medical

literature that meet the criteria of the national institutes of health's library of medicine for indexing in index medicus and elsevier science ltd. for indexing in excerpta medicus;

(3) Medical journals recognized by the secretary of health and human services under section 1861(t)(2) of the federal social security act;

(4) The following standard reference compendia:

(a) The American hospital formulary service drug information;

(b) Drug facts and comparisons;

(c) The American dental association accepted dental therapeutics;

(d) The United States pharmacopoeia drug information.

(5) Findings, studies or research conducted by or under the auspices of a federal government agency or nationally recognized federal research institute, including any of the following:

(a) The federal agency for health care research and quality;

(b) The national institutes of health;

(c) The national cancer institute;

(d) The national academy of sciences;

(e) The centers for medicare and medicaid services;

(f) The federal food and drug administration;

(g) Any national board recognized by the national institutes of health for the purpose of evaluating the medical value of health care services.

(6) Any other medical or scientific evidence that is comparable.

(T) "Person" has the same meaning as in section 3901.19 of the Revised Code.

(U) "Protected health information" means health information related to the identity of an individual, or information that could reasonably be used to determine the identity of an individual.

(V) ~~"Rescission"~~ "Rescind" means ~~a cancellation or discontinuance of coverage that has a retroactive effect~~ to retroactively cancel or discontinue coverage. ~~"Rescission"~~ "Rescind" does not include ~~a cancellation or discontinuance of~~ canceling or discontinuing coverage that only has ~~only~~ a prospective effect or ~~a cancellation or discontinuance of~~ canceling or discontinuing coverage that is effective retroactively to the extent it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage.

(W) "Retrospective review" means a review conducted after services have been provided to a covered person.

(X) "Superintendent" means the superintendent of insurance.

(Y) "Utilization review" has the same meaning as in section 1751.77 of the Revised Code.

(Z) "Utilization review organization" has the same meaning as in section 1751.77 of the Revised Code.

Sec. 3922.02. (A) A covered person may make a request for an external review of an adverse benefit determination.

(B) All requests for external review shall be made in writing, ~~except when making a request for an expedited review under section 3922.09 of the Revised Code~~ including by electronic means, by the covered person to the health plan issuer within one hundred eighty days of the date of the final adverse benefit determination ~~in a form prescribed by the superintendent. Requests for an expedited~~. However, in the case of an expedited external

review under section 3922.09 of the Revised Code, the review may be requested orally ~~or by electronic means. When an oral or electronic request for review is made, written confirmation of the request must be submitted to the health plan issuer no later than five days after the initial request was made~~.

(C) An adverse benefit determination shall be eligible for internal appeal or external review, regardless of ~~how small~~ the cost of the requested health care service related to the adverse benefit determination ~~is~~.

Sec. 3922.03. (A) All health plan issuers shall implement an internal appeal process under which a covered person may appeal an adverse benefit determination. This process must be in compliance with the "Patient Protection and Affordable Care Act of 2010," Pub. L. 111-148, 124 Stat. 119, as amended, and the associated regulations, as well as any other applicable state laws or rules or federal regulations.

(B) Review of a final adverse benefit determination shall be through an external review under section 3922.08, 3922.09, or 3922.10 of the Revised Code.

(C) All health plan issuers shall provide notice to covered persons, pursuant to and in accordance with federal regulations, of all internal appeal processes, external review processes, the availability of any applicable office of health insurance assistance, ombudsman program, or other similar program in this state to assist consumers.

Sec. 3922.04. (A) Except as provided in division (E) of this section, a health plan issuer is not required to grant a request for a standard external review made under section 3922.08 or 3922.10 of the Revised Code until the covered person has exhausted the health plan issuer's internal appeal process.

(B) An internal appeal process shall be considered exhausted if a covered person has requested an internal appeal and has not received a written decision from the health plan issuer within the time frame required by ~~23~~ 29 C.F.R. 2560.503-1 or the health plan issuer fails to adhere to all requirements of the internal appeals process.

(C) Notwithstanding division (B) of this section, the internal appeals process will not be deemed exhausted based on de minimis violations that do not cause, and are not likely to cause, prejudice or harm to the covered person so long as the health plan issuer demonstrates that the violation was for good cause or due to matters beyond the control of the health plan issuer and that the violation occurred in the context of an ongoing, good faith exchange of information between the health plan issuer and the covered person, and is not reflective of a pattern or practice of noncompliance, except that:

(1) If the health plan issuer denies a request for external review under this division, the covered person may request written explanation from the health plan issuer, and the health plan issuer shall provide the explanation within ten days, including a specific description of its ~~bases~~ basis, if any, for asserting that the delay should not cause the internal appeals process to be considered exhausted;

(2) The covered person may request review by the superintendent of the health plan issuer's explanation provided under division (C)(1) of this section and if the superintendent affirms the health plan issuer's explanation, the covered person may, within ten days of the superintendent's notice of decision, resubmit and pursue the internal appeal process. Time periods for refiling the internal appeal shall begin to run upon receipt of such notice by the covered person.

(D) Notwithstanding division (B) of this section, a covered

person shall not make a request for an external review of an adverse benefit determination involving a retrospective review determination made pursuant to a utilization review until the covered person has exhausted the health plan issuer's internal appeals process.

(E) A request for an external review of an adverse benefit determination may be made before the covered person has exhausted the health plan issuer's internal appeals procedures whenever the health plan issuer agrees to waive the exhaustion requirement. If the internal appeal process is waived, the covered person may file a request in writing for a standard external review under section 3922.08 or 3922.10 of the Revised Code.

(F) Notwithstanding any other section in this chapter, health plan issuers offering individual health insurance coverage, including coverage offered to individuals through nonemployer groups shall not require more than one level of internal appeal before the individual may request an external review.

Sec. 3922.05. (A) A health plan issuer shall afford the opportunity for an external review by an independent review organization for an adverse benefit determination if the determination involved a medical judgment or if the decision was based on any medical information, pursuant to the following sections:

(1) Section 3922.08 of the Revised Code for a standard review;

(2) Section 3922.09 of the Revised Code for an expedited review;

(3) Section 3922.10 of the Revised Code for reviews involving experimental procedures.

(B) A health plan issuer shall afford the opportunity for an

external review by the superintendent of insurance for an adverse benefit determination by the health plan issuer based on a contractual issue that did not involve a medical judgment or any medical information, pursuant to section 3922.11 of the Revised Code.

(C) For an adverse benefit determination in which emergency medical services have been determined to be not medically necessary or appropriate after an external review pursuant to division (A) of this section, the health plan issuer shall afford the covered person the opportunity for an external review by the superintendent of insurance, based on the prudent layperson standard, pursuant to section 3922.11 of the Revised Code.

(D) Upon receipt of a request for an external review from a covered person, the health plan issuer shall review it for completeness as prescribed under any associated rules, policies, or procedures adopted by the superintendent.

(1) If the request is complete, the health plan issuer shall initiate an external review in accordance with any associated rules, policies, or procedures adopted by the superintendent of insurance and shall notify the covered person in writing, in a form specified by the superintendent of insurance, that the request is complete. This notification shall include both of the following:

(a) The name and contact information for the assigned independent review organization or the superintendent of insurance, as applicable, for the purpose of submitting additional information;

(b) Except for when an expedited request is made under section 3922.09 or 3922.10 of the Revised Code, a statement that the covered person may, ~~with~~ within ten business days after the date of receipt of the notice, submit, in writing, additional

information for either the independent review organization or the superintendent of insurance to consider when conducting the external review.

(2) If the request for an external review is not complete, the health plan issuer shall, in accordance with any associated rules, policies, or procedures adopted by the superintendent of insurance, inform the covered person in writing, including what information is needed to make the request complete.

(E)(1) If the health plan issuer denies a request for an external review on the basis that the adverse benefit determination is not eligible for an external review, the health plan issuer shall notify the covered person in writing of both of the following:

(a) The reason for the denial;

(b) That the denial may be appealed to the superintendent.

(2) If the health plan issuer denies a request for external review on the basis that the adverse benefit determination is not eligible for an external review, the covered person may appeal the denial to the superintendent of insurance.

(3) Regardless of a determination made by a health plan issuer, the superintendent of insurance may determine that a request is eligible for external review. The superintendent's determination shall be made in accordance with the terms of the covered person's benefit plan and shall be subject to all applicable provisions of this chapter.

(F)(1) If an external review of an adverse benefit determination is granted, the superintendent, according to any rules, policies, or procedures adopted by the superintendent shall assign an independent review organization from the list of organizations maintained by the superintendent under section 3922.13 of the Revised Code to conduct the external review and

shall notify the health plan issuer of the name of the assigned independent review organization.

(2) The assignment of an approved independent review organization shall be done on a random basis from those independent review organizations qualified to conduct the review in question based on the nature of the health care service that is the subject of the adverse benefit determination.

(3) The superintendent of insurance shall not choose an independent review organization with a conflict of interest, as prescribed under section 3922.14 of the Revised Code.

(G) In its review of an adverse benefit determination under section 3922.08, 3922.09, or 3922.10 of the Revised Code, an assigned independent review organization is not bound by any decisions or conclusions reached by the health plan issuer during its utilization review process or internal appeals process. The organization is not required to, but may, accept and consider additional information submitted after the end of the ten-business-day period described in division (D)(1)(b) of this section.

(H)(1) An independent review organization assigned to review an adverse benefit determination shall provide written notice of its decision to either uphold or reverse the determination within thirty days of receipt <u>by the health plan issuer</u> of a request for a standard review or a standard review involving an experimental or investigational treatment, or within seventy-two hours of receipt <u>by the health plan issuer</u> of an expedited request.

(2) The written notice shall be sent to all of the following:

(a) The covered person;

(b) The health plan issuer;

(c) The superintendent of insurance.

(3) The written notification shall include all of the following:

(a) A general description of the reason for the request for external review;

(b) The date the independent review organization was assigned by the superintendent of insurance to conduct the external review;

(c) The dates over which the external review was conducted;

(d) The date on which the independent review organization's decision was made;

(e) The rationale for its decision;

(f) References to the evidence or documentation, including any evidence-based standards used, that were considered in reaching its decision.

(I) Upon receipt of a notice by an independent review organization to reverse the adverse benefit determination, a health plan issuer shall immediately provide coverage for the health care service or services in question.

Sec. 3922.06. Except for when an expedited request is made under section 3922.09 or 3922.10 of the Revised Code, an independent review organization shall forward upon receipt a copy of any information received from a covered person pursuant to division (D)(1) of section 3922.05 of the Revised Code, as well as any other information received from the covered person, to the health plan issuer.

Upon receipt of that information or the information described in division (K) of section 3922.10 of the Revised Code, a health plan issuer may reconsider its adverse benefit determination and provide coverage for the health service in question.

Reconsideration of an adverse benefit determination by a

health plan issuer based upon receipt of information under this section shall not delay or terminate an external review.

If a health plan issuer reverses an adverse benefit determination under this section, the health plan issuer shall notify, in writing and within one business day of making such a decision, the covered person, the assigned independent review organization, and the superintendent of insurance.

Upon receipt of such a notification, the assigned independent review organization shall terminate the associated external review.

Sec. 3922.09. (A) A covered person may make a request for an expedited external review, except as provided in division ~~(J)~~(I) of this section:

(1) After an adverse benefit determination, if both of the following apply:

(a) The covered person's treating physician certifies that the adverse benefit determination involves a medical condition that could seriously jeopardize the life or health of the covered person, or would jeopardize the covered person's ability to regain maximum function, if treated after the time frame of an expedited internal ~~review~~ appeal;

(b) The covered person has filed a request for an expedited internal ~~review~~ appeal.

(2) After a final adverse benefit determination, if either of the following apply:

(a) The covered person's treating physician certifies that the adverse benefit determination involves a medical condition that could seriously jeopardize the life or health of the covered person, or would jeopardize the covered person's ability to regain maximum function, if treated after the time frame of a standard

external review;

(b) The final adverse benefit determination concerns an admission, availability of care, continued stay, or health care service for which the covered person received emergency services, but has not yet been discharged from a facility.

(B) Immediately upon receipt of a request for an expedited external review, the health plan issuer shall determine if the request is complete under any associated rules, policies, or procedures adopted by the superintendent of insurance and eligible for expedited external review under division ~~(B)~~(A) of this section. The health plan issuer shall immediately notify the covered person of its determination in accordance with any associated rules, policies, or procedures adopted by the superintendent of insurance.

(C) If a request for an expedited review is complete and eligible, the health plan issuer shall immediately provide or transmit all necessary documents and information considered in making the adverse benefit determination in question to the assigned independent review organization electronically, or by ~~telephone,~~ facsimile~~,~~ or other available expeditious method.

(D) In addition to the information transmitted under division ~~(D)~~(C) of this section, the assigned independent review organization shall also consider relevant information as required under section 3922.07 of the Revised Code.

(E) As expeditiously as the covered person's medical condition requires, but no more than seventy-two hours after ~~being assigned~~ receipt by the health plan issuer of a request for an expedited, external review, the assigned independent review organization shall uphold or reverse the adverse benefit determination.

(F) If a health plan issuer fails to provide the documents

and information as required in division ~~(D)~~(C) of this section, the independent review organization shall not delay the external review and may accordingly reverse the adverse benefit determination.

(G) An independent review organization shall promptly notify the covered person, health plan issuer, and superintendent of insurance of any decision made under this section. If such a notice is not made in writing, the independent review organization, shall provide, within forty-eight hours of making the decision, written confirmation, including the information required under division (H)(3) of section 3922.05 of the Revised Code, of its decision to the covered person, the health plan issuer, and the superintendent of insurance.

(H) Upon receipt of a notice by an independent review organization to reverse the adverse benefit determination, a health plan issuer shall immediately provide coverage for the health care service or services in question.

(I) An expedited, external review may not be provided for retrospective final adverse benefit determinations.

Sec. 3922.10. The provisions of this section apply only to external reviews that involve an experimental or investigational treatment.

(A) A covered person may request an external review of an adverse benefit determination based on the conclusion that a requested health care service is experimental or investigational, except when the requested health care service is explicitly listed as an excluded benefit under the covered person's benefit plan.

(B) To be eligible for an external review under this section, a covered person's treating physician shall certify that one of the following situations is applicable:

(1) Standard health care services have not been effective in improving the condition of the covered person~~;~~.

(2) Standard health care services are not medically appropriate for the covered person~~;~~.

(3) There is no available standard health care ~~services~~ service covered by the health plan issuer that is more beneficial than the requested health care service.

(C)(1) A covered person may request orally or by electronic means an expedited review under this section if the person's treating physician certifies that the requested health care service in question would be significantly less effective if not promptly initiated.

(2) Immediately upon receipt of a request for an expedited external review, the health plan issuer shall determine if the request is complete under any associated rules, policies, or procedures adopted by the superintendent of insurance and eligible for expedited external review under division ~~(B)~~(C)(1) of this section. The health plan issuer shall immediately notify the covered person of its determination in accordance with any associated rules adopted by the superintendent of insurance.

(D) The health plan issuer shall provide to the assigned independent review organization all documents and information considered in making the adverse benefit determination within whichever of the following applies:

(1) Within five days after the receipt of a request for ~~an~~ a standard external review;

(2) For an expedited external review, immediately electronically, or by ~~telephone,~~ facsimile~~,~~ or any other available expeditious method.

(E) An independent review organization assigned by the

superintendent of insurance under division (F) of section 3922.05 of the Revised Code shall do both of the following:

(1) Select at least one clinical reviewer, pursuant to divisions (F) and (G) of this section to conduct the external review;

(2) Make a decision to uphold or reverse the adverse benefit determination based upon the opinion of the clinical reviewer or reviewers.

(F) In selecting clinical reviewers under division (E) of this section, the assigned independent review organization shall select physicians or other health care professionals who meet the minimum qualifications described in section 3922.15 of the Revised Code~~, and through clinical experience in the last three years, are experts in the treatment of the covered person's condition and have knowledge of the requested health care service~~.

(G) Neither the covered person, nor the health plan issuer, shall choose or have any influence over the choice of the clinical reviewer or reviewers chosen under division (E) of this section.

(H)(1) Each chosen clinical reviewer shall provide a written opinion to the assigned independent review organization on whether the adverse benefit determination should be upheld or reversed.

(2) In reaching such opinions, a clinical reviewer is not bound by any conclusions reached by the health plan issuer during a utilization review process or its internal appeals process.

(3) Any such opinion shall be in writing and shall include all of the following information:

(a) A description of the covered person's condition;

(b) A description of the indicators relevant to determining whether there is sufficient evidence to demonstrate that the recommended or requested therapy is more likely than not to be

more beneficial to the covered person than any available standard health care service, and that the adverse risks of the requested health care service would not be substantially greater than those of available standard health care services;

(c) A description and analysis of any medical or scientific evidence considered in reaching the opinion;

(d) A description and analysis of any evidence-based standard considered;

(e) Information on whether the reviewer's rationale for the opinion is based on division ~~(L)(2)~~(K)(2)(b) or ~~(L)(3)~~(c) of this section.

(I) An external review shall not be delayed due to failure on the part of the health plan issuer to provide the information required under division (D) of this section.

(J)(1) An independent review organization may reverse an adverse benefit determination, if the information required under division (D) of this section is not provided in the allotted time. The ~~external~~ independent review ~~committee~~ organization may also grant a request from the health plan issuer for more time to provide the required information.

(2) If an adverse benefit determination is reversed under division (J)(1) of this section, the independent review organization shall immediately notify the covered person, the health plan issuer, and the superintendent of insurance.

(K)(1) Each clinical reviewer shall review all of the information received pursuant to division (D) of this section, as well as any other information submitted in writing by the covered person pursuant to division (D) of section 3922.05 of the Revised Code.

(2) In addition to the documents and information provided

pursuant to division (D) of this section and division (D) of section 3922.05 of the Revised Code, each clinical reviewer shall consider the following:

(a) Information required under section 3922.07 of the Revised Code;

(b) Whether the requested health care service has been approved by the federal food and drug administration, if applicable, for the condition;

(c) Whether medical or scientific evidence, or evidence-based standards, demonstrate that the expected benefits of the requested health care service is more likely than not to be beneficial to the covered person than any available standard health care service, and that the adverse risks of the requested health care service would not be substantially greater than those of available standard health care services.

(L) Within one business day after the receipt of any such information submitted by the covered person in accordance with division (K)(1) of this section, the independent review organization shall forward the information to the health plan issuer. Upon receipt of any such forwarded information in accordance with division (K)(1) of this section, a health plan issuer may reconsider its adverse benefit determination ~~under~~ as described in section 3922.06 of the Revised Code.

(M)(1) Within thirty days after the date of receipt by the health plan issuer of a request for a standard external review, or within seventy-two hours of receipt by the health plan issuer of a request for an expedited external review, the assigned independent review organization shall provide written notice of its decision to uphold or reverse the adverse benefit determination to the covered person, the health plan issuer, and the superintendent of insurance.

(2)(a) If a majority of the clinical reviewers recommend that the requested health care service should be covered, the independent review organization shall make a decision to reverse the health plan issuer's adverse benefit determination.

(b) If a majority of the clinical reviewers recommend that the recommended or requested health care service or treatment should not be covered, the independent review organization shall make a decision to uphold the health plan issuer's adverse benefit determination.

(c)(i) If the clinical reviewers are evenly split as to whether the adverse benefit determination should be reversed or upheld, the independent review organization shall obtain the opinion of an additional clinical reviewer in order for the independent review organization to make a decision based on the opinions of a majority of the clinical reviewers pursuant to this division.

(ii) The additional clinical reviewer selected shall use the same information to reach an opinion as the clinical reviewers who have already submitted their opinions pursuant to this section.

(iii) The selection of the additional clinical reviewer under this division shall not extend the time within which the assigned independent review organization is required to make a decision.

(3) The independent review organization shall include in the notice provided pursuant to division (M)(1) of this section all of the following:

(a) A general description of the reason for the request for external review;

(b) The written opinion of each clinical reviewer, including the recommendation of each clinical reviewer as to whether the recommended or requested health care service or treatment should be covered and the rationale for that recommendation;

(c) The date the independent review organization was assigned by the superintendent to conduct the external review;

(d) The dates over which the external review was conducted;

(e) The date of its decision;

(f) The principal reason or reasons for its decision;

(g) The rationale for its decision.

(N) Upon receipt of a notice of a decision by an independent review organization pursuant to division (M)(1) of this section reversing the adverse benefit determination, a health plan issuer shall immediately provide coverage of the requested health care service in question.

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 ~~review~~ 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 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 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 ~~enrollee~~ 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 ~~benefit~~ health plan issuer, a national, state or local trade association of ~~benefit plans~~ 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 of the Revised Code.

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

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

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

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

Sec. 3922.15. All clinical reviewers assigned by an independent review organization to conduct external reviews shall have the same license as the health care provider of the service in question, and shall be physicians or other appropriate health care providers who meet all of the following minimum qualifications:

(A) Be an expert in the treatment of the medical condition that is the subject of the external review;

(B) Be knowledgeable about the requested health care service through clinical experience, within the last three years, treating patients with the same, or a similar, medical condition, and, in the case of an external review of an experimental or investigational health care service, be an expert, through clinical experience in the last three years, in the treatment of the covered person's condition and have knowledge of the requested health care service;

(C) Hold a nonrestricted license in a state of the United States and, for physicians, a current certification by a recognized American medical specialty board in the area or areas appropriate to the subject of the external review;

(D) Have no history of disciplinary actions or sanctions, including loss of staff privileges or participation restrictions, that have been taken or are pending by any hospital, governmental agency or unit, or regulatory body that raise a question as to the

clinical reviewer's physical, mental, or professional competence or moral character.

Sec. 3922.16. (A) Nothing in this chapter shall be construed to create a cause of action against any of the following:

(1) An employer that provides health care benefits to employees through a health plan issuer;

(2) A clinical reviewer~~, medical expert,~~ or independent review organization that participates in an external review under this chapter;

(3) A health plan issuer that provides coverage for benefits pursuant to this chapter.

(B) An independent review organization and any ~~medical expert or~~ clinical reviewer an independent review organization uses in conducting an external review under this chapter is not liable in damages in a civil action for injury, death, or loss to person or property and is not subject to professional disciplinary action for making, in good faith, any finding, conclusion, or determination required to complete the external review.

(C) This section does not grant immunity from civil liability or professional disciplinary action to an independent review organization~~, medical expert,~~ or clinical ~~peer~~ reviewer for an action that is outside the scope of authority granted under this chapter.

Sec. 3922.19. (A) Each health plan issuer shall include a description of its external review procedures, including the superintendent's contractual review, in, or attached to, the policy, certificate, membership booklet, or outline of coverage, or other evidence of coverage it provides to covered persons. This disclosure shall be in a form prescribed by the superintendent in any associated rules, policies, or procedures.

(B) The disclosure required by division (A) of this section shall include a statement that informs the covered person of the covered person's right to file a request for an external review of an adverse benefit determination with the health plan issuer. The statement shall do all of the following:

(1) Explain that external review is available when the adverse benefit determination involves an issue of medical necessity, appropriateness, health care setting, and level of care or effectiveness;

(2) Include the telephone number and address of the superintendent;

(3) Inform the covered person that, when filing a request for an external review, the covered person will be required to authorize the release of the covered person's medical records as necessary to conduct the external review.

(C)(1) When a health plan issuer notifies a covered person of an adverse benefit determination, the health plan issuer shall also notify the covered person, in writing, of the covered person's right to request an external review, pursuant to section 3922.08, 3922.09, 3922.10, or 3922.11 of the Revised Code.

(2) As part of the written notice required under division (C)(1) of this section, a health plan issuer shall include all of the following:

(a) Information sufficient to identify the claim or health care service involved, including the health care provider, and the date of service and claim amount, if applicable;

(b) A description of the reason or reasons for the adverse benefit determination, including the denial code, such as the claim adjustment reason code and the remittance advice remark code, and each code's corresponding meaning;

(c) A description of the health plan issuer's standard, if any, that was used in making the determination;

(d) A description of the available internal appeals and external review processes, including information regarding how to initiate an appeal and an external review;

(e) Disclosure of the availability of assistance from the superintendent with the internal appeals and external review processes, including the web site, telephone number, and mailing address of the superintendent's office of consumer services.

(3) In the case of a notice of a final adverse benefit determination subsequent to an internal appeal, in addition to the information required under division (C)(2) of this section, the notice must also include a discussion of the decision.

(4) Any written notice provided under division (C) of this section shall be in a form prescribed by the superintendent of insurance.

(D) For an adverse benefit determination that is not a final adverse benefit determination, the health plan issuer shall include with the notice required under division (C) of this section a statement informing the covered person of all of the following:

(1) If the covered person's treating physician certifies in writing that the covered person has a medical condition where the time frame for completion of an expedited review of an internal appeal involving an adverse benefit determination would seriously jeopardize the life or health of the covered person or jeopardize the covered person's ability to regain maximum function, the covered person may file a request for an expedited external review to be conducted simultaneously with the expedited internal appeal, pursuant to section 3922.09 of the Revised Code.

(2) If the adverse benefit determination involves a denial of

coverage based on a determination that the recommended or requested health care service or treatment is experimental or investigational and the covered person's treating physician certifies in writing that the recommended or requested health care service or treatment that is the subject of the adverse benefit determination would be significantly less effective if not promptly initiated, the covered person may file a request for an expedited external review to be conducted simultaneously with the expedited internal appeal, pursuant to section 3922.09 or 3922.10 of the Revised Code.

(3) If the covered person has requested an internal appeal and the health plan issuer has not issued a written decision to the covered person within thirty days following the date the covered person files the request, and the covered person has not requested or agreed to a delay, the covered person may file a request for external review pursuant to section 3922.08 of the Revised Code and may be considered to have exhausted the health plan issuer's internal appeals process for purposes of section 3922.04 of the Revised Code.

(E) For a final adverse benefit determination, the health plan issuer shall include with the notice required under division (C) of this section a statement informing the covered person of all of the following:

(1) A written request for an external review must be submitted to the health plan issuer within one hundred eighty days after the date of the notice of final adverse benefit determination~~;~~.

(2) If the covered person's treating physician certifies in writing that the covered person has a medical condition for which the time frame for completion of a standard external review pursuant to section 3922.08 of the Revised Code would seriously jeopardize the life or health of the covered person or would

jeopardize the covered person's ability to regain maximum function, the covered person may file a request for an expedited external review pursuant to section 3922.09 of the Revised Code.

(3)(a) If the final adverse benefit determination concerns a health care service for which the covered person received emergency services, but has not been discharged from a facility, the covered person may request an expedited external review pursuant to section 3922.09 of the Revised Code.

(b) If the final adverse benefit determination concerns denial of coverage based on a determination that the recommended or requested health care service or treatment is experimental or investigational, the covered person may file a request for an external review to be conducted pursuant to section 3922.10 of the Revised Code, or if the covered person's treating physician certifies in writing that the recommended or requested health care service that is the subject of the request would be significantly less effective if not promptly initiated, the covered person may request an expedited external review to be conducted under section 3922.10 of the Revised Code.

(F)(1) In addition~~,~~ to any information required to be provided under divisions (D) and (E) of this section, the health plan issuer shall include a description of both the standard and expedited external review procedures the health plan issuer is required to produce pursuant to this chapter, highlighting in the external review procedures the sections of the Revised Code that give the covered person the opportunity to submit additional information.

(2) The health plan issuer shall also include any forms used to process an external review, including an authorization form, or other document approved by the superintendent that complies with the requirements of 45 C.F.R. 164.508, by which the covered person, for purposes of conducting an external review under this

chapter, authorizes the health plan issuer and the covered person's treating health care provider to disclose protected health information, including medical records, concerning the covered person that are related in any manner to the external review.

Sec. 3925.08. Funds accumulated in the course of business, or surplus money above the capital stock, of any company organized under any law of this state, for the purpose provided in section 3925.01 of the Revised Code, shall only be loaned or invested in the securities listed in sections 3925.05 and 3925.06 of the Revised Code, or in the following:

(A)(1) Bonds and mortgages on unencumbered real estate within this or any other state worth twenty-five per cent more than the sum loaned thereon, exclusive of buildings, unless such buildings are insured in some company authorized to do business in this state, and the policy is transferred to the company making the investment; or, in lieu of transferring such policies, the mortgagee may purchase a policy or policies of mortgage protection insurance, payable to the mortgagee or a trustee in its behalf, insuring the mortgagee against loss resulting from the failure of the mortgagor to acquire and maintain, from such an authorized insurance company, insurance in the amount required by this section;

(2) Bonds or notes secured by mortgages insured by the federal housing administrator;

(3) Loans to veterans guaranteed in whole or in part by the United States pursuant to Title III of the "Servicemen's Readjustment Act of 1944," 58 Stat. 284, 38 U.S.C. 693, as amended, provided such guaranteed loans are liens upon real estate.

(B)(1) Legally authorized and executed bonds, notes,

warrants, and securities which are the direct obligation of or are guaranteed as to both principal and interest by Canada, or which are the direct obligation of or are guaranteed as to both principal and interest by any province of Canada, or which are the direct obligation of or are guaranteed as to both principal and interest by any municipal corporation of Canada having a population of one hundred thousand or more by the latest official census, and which are not in default as to principal or interest;

(2) Obligations issued, assumed, or guaranteed by the international finance corporation or by the international bank for reconstruction and development, the Asian development bank, the inter-American development bank, the African development bank, or similar development bank in which the president, as authorized by congress and on behalf of the United States, has accepted membership.

(C) Bonds or other evidences of indebtedness, not in default as to principal or interest, which are valid obligations issued, assumed, or guaranteed by the United States, by any state thereof, the Commonwealth of Puerto Rico, by any territory or insular possession of the United States, or by the District of Columbia, or which are valid obligations issued, assumed, or guaranteed by any county, municipal corporation, district, or political subdivision, or by any civil division or public instrumentality of such governmental units, if by statutory or other legal requirements such obligations are payable, as to both principal and interest, from taxes levied upon all taxable property within the jurisdiction of such governmental unit, or in bonds or other obligations issued by or for account of any such governmental unit having a population of five thousand or more by the latest official federal or state census, which are payable as to both principal and interest from revenues or earnings from the whole or any part of a publicly owned utility, provided that by statute or

other applicable legal requirements, rates from the service or operation of such utility must be fixed, maintained, and collected at all times so as to produce sufficient revenues or earnings to pay both principal and interest of such bonds or obligations as they become due, and in any bonds or obligations issued or guaranteed by the United States, any state, the District of Columbia, the Commonwealth of Puerto Rico, any county, municipal corporation, district, political subdivision, civil division, commission, board, authority, agency, or other instrumentality of one or more of them, provided there is a specific pledge of revenues, earnings, or other adequate security and provided that no prior or parity obligation of the same issuer, payable from revenues or earnings from the same source, has been in default as to principal or interest during the five years next preceding the date of such investment, but such issuer need not have been in existence for that period, and obligations acquired under this section may be newly issued, and further provided that there is adequate provision for payment of expenses of operation and maintenance and the principal and interest on all obligations when due;

(D)(1) Bonds or other evidences of indebtedness, bearing or accruing interest, issued, assumed, or guaranteed by any solvent corporation, trust, partnership, or similar business entity organized and existing under the laws of this or any other state, or of the United States, the Commonwealth of Puerto Rico, or of the District of Columbia, or of Canada or any province of Canada, upon which there is no existing interest or principal default, provided that either:

(a) The bonds or other evidences of indebtedness are rated 1 or 2 by the securities valuation office of the national association of insurance commissioners;

(b) The corporation, together with its predecessor

corporation or corporations, or the trust, partnership, or similar business entity, has been in existence for a period of at least five years.

(2) Stocks ~~or,~~ limited liability company membership interests, limited partnership interests, or limited liability partnership interests of any insurance, financial, investment, ~~and~~ or investment management companies, which investment management companies are registered with the securities and exchange commission under the "Investment Company Act of 1940," 54 Stat. 789, 15 U.S.C. 80a-1, as amended, or the stocks, limited liability company membership interests, limited partnership interests, or limited liability partnership interests in an entity wholly owned by a domestic company or by a domestic company and its affiliates, that is formed and maintained to acquire or hold specific assets or liabilities for bankruptcy remoteness or limitation of liability purposes, except its own stock, and stocks ~~or,~~ limited liability company membership interests, limited partnership interests, limited liability partnership interests, bonds, notes, and debentures of any company which is organized for, and limited in its operations to, the financing of insurance premiums, upon approval of such investments by the superintendent of insurance; except that approval shall not be required for the purchase of the outstanding stocks ~~or,~~ limited liability company membership interests, limited partnership interests, or limited liability partnership interests of any such company, if investment in each such company does not exceed in the aggregate two and one-half per cent of the total admitted assets of the company making the investment as of the preceding thirty-first day of December. Whenever the superintendent has reason to believe that the retention, investment, or acquisition of the stock ~~or,~~ limited liability company membership interest, limited partnership interest, or limited liability partnership interest of any such company substantially lessens competition generally in the

business of insurance or creates a monopoly therein the superintendent shall proceed under section 3901.13 of the Revised Code to cause such domestic insurance company to divest itself of such stock ~~or~~, limited liability company membership interest, limited partnership interest, or limited liability partnership interest.

(3) Other stocks, limited liability company membership interests, or limited partnership interests, or limited liability partnership interests of any solvent corporation organized under the laws of this or any other state, or of the United States, or of the District of Columbia, or of Canada or any province of Canada, provided that a dividend or distribution has been paid by the ~~corporation~~ business entity in the preceding twelve months upon the stock, membership interest, or partnership interest to be purchased or such ~~corporation~~ business entity, together with its predecessor ~~corporation~~ entity or ~~corporations~~ entities, has been in existence for a period of at least five years.

(4) A domestic company may acquire, hold, and convey tangible personal property or interests therein for the production of income, provided no domestic company shall invest in excess of two per cent of its admitted assets as of the preceding thirty-first day of December under this division.

(5) In equipment trust obligations or certificates, security agreements, or other evidences of indebtedness entered into directly or guaranteed by any company operating wholly or partly within the United States or Canada, provided that such debt obligation is secured by a first lien on tangible personal property which is purchased or secured for payment thereof and such debt obligation is repayable within twenty years from the date of issue in annual, semiannual, or more frequent installments beginning not later than the first year after such date.

(6) An insurer may invest without limitation in investments

of government money market funds. As used in division (D)(6) of this section, "government money market fund" means a fund that at all times invests in obligations issued, guaranteed, or insured by the federal government of the United States or collateralized repurchase agreements comprised of such obligations, and that qualifies for investment without a reserve pursuant to the purposes and procedures of the securities valuation office of the national association of insurance commissioners.

(E) Negotiable promissory notes maturing in not more than six months from the date thereof, secured by collateral security through the transfer of any of the classes of securities described in this section or in sections 3925.05 and 3925.06 of the Revised Code, with absolute power of sale within twenty days after default in payment at maturity;

(F)(1) Repurchase agreements with, and interest-bearing obligations, including savings accounts and time certificates of deposit of, a national bank of the United States, a commonwealth bank of Puerto Rico, a chartered bank of Canada, or a state bank, provided such bank is either a member of the federal deposit insurance corporation created pursuant to the "Banking Act of 1933," as amended, or the Canada deposit insurance corporation created pursuant to the act of parliament known as the "Canada Deposit Insurance Corporation Act," as amended.

(2) Certificates of deposit, savings share accounts, investment share accounts, stock deposits, stock certificates, or other evidences of indebtedness of a savings and loan association, provided all such evidences of indebtedness are insured pursuant to the "Financial Institutions Reform, Recovery, and Enforcement Act of 1989," 103 Stat. 183, 12 U.S.C.A. 1811, as amended;

(3) Bankers' acceptances and bills of exchange of the kinds and maturities made eligible by law for rediscount with the federal reserve banks, provided that the same are accepted by a

bank or trust company incorporated under the laws of the United States or of this state or any other bank or trust company which is a member of the federal reserve system.

(G) Any securities issued as a result of any reorganization, or capital or debt adjustment, in whole or in part, in exchange for securities acquired by it prior to such reorganization, or capital or debt adjustment;

(H)(1) In bonds, notes, debentures, or other evidences of indebtedness issued, assumed, or guaranteed by a solvent corporation, trust, or partnership formed or existing under the laws of a foreign jurisdiction, provided each such foreign investment is of the same kind and quality as United States investments authorized under this section; or in common or preferred stock ~~or,~~ shares, membership interests, or partnership interests of any solvent ~~corporation~~ business entity formed or existing under the laws of a foreign jurisdiction, provided each such foreign investment is of the same kind and quality as United States investments authorized under this section; or in bonds or other evidences of indebtedness issued, assumed, or guaranteed by a foreign jurisdiction.

An insurer shall not invest in foreign investments under division (H) of this section, including investments denominated in foreign currency, a sum exceeding in the aggregate fifteen per cent of its admitted assets as of the preceding thirty-first day of December. The aggregate amount of investments held by an insurer in a single foreign jurisdiction shall not exceed three per cent of its admitted assets as of the preceding thirty-first day of December.

As used in division (H)(1) of this section, "foreign jurisdiction" means a jurisdiction outside the United States, Puerto Rico, or Canada whose bonds are rated 1 by the securities valuation office of the national association of insurance

commissioners.

(2) An insurer may acquire investments denominated in foreign currency whether or not they are foreign investments.

An insurer shall not invest in investments denominated in foreign currency a sum exceeding in the aggregate ~~ten~~ fifteen per cent of its admitted assets as of the preceding thirty-first day of December. The aggregate amount of investments denominated in a single foreign currency held by an insurer shall not exceed three per cent of an insurer's admitted assets as of the preceding thirty-first day of December.

(3) As used in division (H) of this section, "foreign currency" means a currency other than that of the United States.

(I)(1) Any securities or other property not permitted under section 3925.05, 3925.06, 3925.08, or 3925.20 of the Revised Code to an extent not exceeding in the aggregate six per cent of the total admitted assets of such company on the preceding thirty-first day of December, within the limitations prescribed in division (J) of this section. Any such company may also invest up to an additional five per cent of the total admitted assets of such company on the preceding thirty-first day of December, within the limitations prescribed in division (J) of this section, in loans or investments in small businesses having more than half of their assets or employees in this state and in venture capital firms having an office within this state, provided that, as a condition of a company making an investment in a venture capital firm, the firm must agree to use its best efforts to make investments, in an aggregate amount at least equal to the investment to be made by the company in that venture capital firm, in small businesses having their principal offices within this state and having either more than one-half of their assets within this state or more than one-half of their employees employed within this state.

As used in division (I) of this section:

(a) "Small businesses" means any corporation, partnership, proprietorship, or other entity that either does not have more than four hundred employees, or would qualify as a small business for the purpose of receiving financial assistance from small business investment companies licensed under the "Small Business Investment Act of 1958," 72 Stat. 689, 15 U.S.C.A. 661, as amended, and rules of the small business administration.

(b) "Venture capital firms" means any corporation, partnership, proprietorship, or other entity, the principal business of which is or will be the making of investments in small businesses.

(c) "Investments" means any equity investment, including limited partnership interests and other equity interests in which liability is limited to the amount of the investment, but does not include general partnership interests or other interests involving general liability.

(2) In the event that, subsequent to being made under this division, a loan or investment is determined to have become qualified as a loan or investment under any of the divisions (A) to (F) of this section or under section 3925.05, 3925.06, or 3925.20 of the Revised Code, the company may consider such loan or investment as held under such other statutory provision and such loan or investment shall no longer be considered as having been made under this division.

(J) No domestic insurance company shall at any time have invested a sum exceeding five per cent of its admitted assets as of the preceding thirty-first day of December in the bonds, notes, debentures, other evidences of indebtedness, and stocks of a particular corporation, trust, partnership, or similar business entity, except for investments authorized under divisions (A) and

(D)(2) of this section, and no domestic insurance company together with its subsidiary, if any, shall at any time own directly or indirectly more than twenty-five per cent of the outstanding bonds, notes, debentures, other evidences of indebtedness, and stocks of any corporation, except for investments authorized under divisions (A) and (D)(2) of this section.

This section does not affect the propriety or legality of an investment made by such domestic insurance company which was in accordance with the laws in force at the time of the making of the investment.

Section 2. That existing sections 3903.81, 3907.14, 3921.10, 3921.13, 3921.19, 3921.22, 3921.28, 3921.29, 3921.30, 3921.31, 3921.33, 3922.01, 3922.02, 3922.03, 3922.04, 3922.05, 3922.06, 3922.09, 3922.10, 3922.11, 3922.14, 3922.15, 3922.16, 3922.19, and 3925.08 and section 3921.35 of the Revised Code are hereby repealed.

Section 3. That sections 3903.81, 3921.10, 3921.13, 3921.19, 3921.22, 3921.28, 3921.29, 3921.30, 3921.31, and 3921.33 of the Revised Code, as amended by Sections 1 and 2 of this act shall take effect January 1, 2013.